

9-1-1993

## Health Care Advance Directives: Implications for Florida Mental Health Patients

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### Recommended Citation

Lester J. Perling, *Health Care Advance Directives: Implications for Florida Mental Health Patients*, 48 U. Miami L. Rev. 193 (1993)  
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# COMMENTS

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*The only purpose for which power can be rightfully exercised over any other member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant.*

John Stuart Mill<sup>1</sup>

### I. INTRODUCTION

Although Mill's stand against coercion is probably intuitively attractive to most people, the health care system in America generally, and to a greater extent the mental health system, are reluctant to give effect to such principles.<sup>2</sup> Coercion still exists both in its hard form of

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1. JOHN STUART MILL, *ON LIBERTY* 22 (London, John W. Parker & Son, 2d ed. 1859) (1859). Mill may have intended for his broad notion of self-determination to apply only to the choices made by the competent. JEFFRIE G. MURPHY, *RETRIBUTION, JUSTICE, AND THERAPY* 165 (1979). One wonders, however, if Mill were alive today whether he would make such a distinction in light of the concept of advance directives. Whatever Mill's intent may have been, his words are applicable to advance directives to control one's future psychiatric treatment.

2. Phil Fennell, *Inscribing Paternalism in the Law: Consent to Treatment and Mental Disorder*, 17 J.L. & Soc'y 29, 29 (1990) ("Nowhere is the tension between autonomy and

forced decision-making<sup>3</sup> and in its softer form, paternalism.<sup>4</sup> Psychiatric patients' attempts to refuse or, alternatively, request a specific treatment are often ignored.<sup>5</sup>

Historically, medical practice did not include the notion that a patient is entitled to participate in health care decision-making; paternalism was the predominant ethical theory.<sup>6</sup> Physicians initially resisted efforts to promote patient participation in decision-making.<sup>7</sup> Increasingly, however, physicians are confronted with patients who have

paternalism more evident than in relation to the treatment of mentally disordered patients."'). Scholarly articles continue to reflect this paternalistic attitude. One commentator makes the bold assertion "it is undisputed that the state has a legitimate interest in preventing the mentally ill from harming themselves . . . ." 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, 337 (1992) (emphasis added). Even authors writing in support of self-determination for mental health patients make this assumption. Donald N. Bersoff, *Autonomy for Vulnerable Populations: The Supreme Court's Reckless Disregard for Self-Determination and Social Science*, 37 VILL. L. REV. 1569, 1571 (1992) (supporting the government's "role as a beneficent and loving parent").

3. A former mental health patient, now a patients' rights advocate, asserts that "[t]he mental health system . . . is coercive . . . because all 'mental patients' are presumed by treaters and the staff alike to be unaware of their own needs and unable to provide for them . . . ." Judi Chamberlin, *Refusing Treatment: The Patient's View*, in REFUSING TREATMENT IN MENTAL HEALTH INSTITUTIONS — VALUES IN CONFLICT 163, 167 (A. Edward Doudera & Judith P. Swazey eds., 1982).

One of the more blatant forms of coercion in a psychiatric hospital is a physician's threat not to discharge a patient if she does not consent to treatment. *See, e.g.*, MURPHY, *supra* note 1, at 194. Coercion, however, may be more subtle. Chronic mental health patients become passive and tend to abdicate control of their lives to professionals. CHARLES W. LIDZ ET AL., INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY 111 (1984). One example is a patient whose doctors perceived the patient's passivity during a voluntary admission interview to mean that she thought the decision to enter a psychiatric hospital was unimportant. Her physicians ignored the absence of overt consent and asked her to sign a consent form that they knew she could not read. *Id.* Refusals to give consent may be futile. Hospital staff may use the patient's delusions to convince her to consent. *Id.* at 117. In one case, although the physician believed the patient was incompetent, he had her husband convince her to consent. *Id.* Later, when the patient wanted to leave, she was hurried to the ward. *Id.* An extreme form of coercion, but one sometimes used, is physical force. *Id.* at 120. In addition to physical force, physicians use the "force of law" when unwilling patients are brought to the hospital involuntarily, but physicians convince the patients to admit themselves voluntarily. *Id.* Even the method in which the consent forms are presented may be coercive. *Id.* at 123. Lack of privacy may inhibit full discussion, and staff may ask patients to sign forms in distracting settings. *Id.* Further, the forms may be presented as routine or with a number of other forms, thereby de-emphasizing their significance. *Id.* at 124.

4. In this context, paternalism may be thought of as a physician operating under the belief that she can make decisions for the patient—in the patient's best interest—because of her superior training, knowledge, and experience. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 212-13 (3d ed. 1989).

5. *See infra* part II.

6. JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 2 (1984); *Developments in the Law, Medical Technology and the Law*, 103 HARV. L. REV. 1519, 1643 (1990) [hereinafter *Developments*].

7. *Developments*, *supra* note 6, at 1643; *see also* KATZ, *supra* note 6, at 1-29.

asserted (in court and otherwise) a desire to make their own judgments.<sup>8</sup>

The notion of autonomy and, more specifically, self-determination drive patients' claims to the predominant role in medical decision-making.<sup>9</sup> The importance of self-determination in health care decision-making is predicated on the notion that the patient's well-being will best be served by giving effect to the patient's own subjective judgments.<sup>10</sup> Self-determination ensures that patients are shown the proper respect as persons and are protected from arbitrary control by others.<sup>11</sup> Just as important, self-determination allows individuals to define their own values and character and to "integrat[e] [these] within a chosen life-style."<sup>12</sup>

The principle of self-determination has been taken to what may be its ultimate point—the right of a competent<sup>13</sup> adult to issue general guidelines or specific instructions for medical care through an advance directive or living will that health care providers must follow if the individual later becomes unable to state his preferences.<sup>14</sup> This right persists even if the patient's instructions ultimately may result in death as a result of his disease. But does this right of self-determination extend far enough to implicate a mental health patient's<sup>15</sup> right to control his psy-

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8. E.g., BEAUCHAMP & CHILDRESS, *supra* note 4, at 209-10; *Developments*, *supra* note 6, at 1643.

9. For a thorough discussion of autonomy in this context see generally BEAUCHAMP & CHILDRESS, *supra* note 4, at 67-74; Gerald Dworkin, *Autonomy and Informed Consent*, in 3 MAKING HEALTH CARE DECISIONS 63 (President's Comm'n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research ed., 1982); Bersoff, *supra* note 2, at 1569-87; and Bruce J. Winick, *On Autonomy: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1705 (1992).

10. 1 MAKING HEALTH CARE DECISIONS, *supra* note 9, at 15, 44 (commission report on informed consent); Winick, *supra* note 9, at 1755-71.

11. 1 MAKING HEALTH CARE DECISIONS, *supra* note 9, at 45.

12. *Id.* at 46.

13. "Competent," as it is used here, refers to an individual who is legally competent to execute an advance directive: physically and mentally able to communicate a willful and knowing health care decision. See *infra* text accompanying note 170. Incompetence cannot be assumed merely because an individual has been diagnosed as having a mental illness or has entered a psychiatric hospital voluntarily or involuntarily. The law presumes an individual is competent unless legally determined otherwise. Bruce J. Winick, *Competency to Consent to Treatment: The Distinction between Assent and Objection*, in ESSAYS IN THERAPEUTIC JURISPRUDENCE 41, 60-63 (David B. Wexler & Bruce J. Winick eds., 1991) (noting that, although mental illness may impair competency, mentally ill persons have a significant capacity for rational thought); see also John Parry, *Incompetency, Guardianship, and Restoration*, in THE MENTALLY DISABLED AND THE LAW 369, 375 (Samuel J. Brakel et al. eds., 3d ed. 1985) (discussing the legal distinctions between incompetency and involuntary commitment); ALAN A. STONE, *MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION* 102 (1975) (noting that incompetence does not necessarily follow commitment); Barbara A. Weiner, *Rights of Institutionalized Patients*, in THE MENTALLY DISABLED AND THE LAW, *supra*, at 251, 258-59 (advocating the right to be presumed competent).

14. See *infra* part III.

15. The terminology used to denote an individual involved with the mental health system is

chiatric treatment during periods of incompetence? This Comment addresses that question as it relates to Florida.

A competent individual in Florida has a well-established right to refuse unwanted medical treatment. The Florida Legislature has found "that every competent adult has the fundamental right of self-determination regarding decisions pertaining to his own health, including the right to choose or refuse medical treatment."<sup>16</sup> To give meaning to the right of self-determination, the Health Care Advance Directives Act<sup>17</sup> ("Advance Directives Act") allows a competent adult to direct his future health care through the use of a health care advance directive. More significantly, mental health patients in Florida also have a statutory right to forego psychiatric treatment.<sup>18</sup>

The Advance Directives Act defines an advance directive as "a witnessed written document or oral statement in which instructions are given by a principal or in which the principal's desires are expressed concerning *any aspect* of the principal's health care, and includes, but is not limited to, the designation of a health care surrogate [or] a living will . . . ."<sup>19</sup> A health care surrogate is "any competent adult expressly designated by a principal to make health care decisions on behalf of the principal upon the principal's incapacity."<sup>20</sup> In the context of this statute, a living will pertains only to instructions regarding life-prolonging procedures.<sup>21</sup>

In exploring the use of advance directives in a mental health context, Part II of this Comment considers the assumptions and values creating the controversy associated with the right of mentally ill persons to direct their psychiatric care. Part III defines the concept of the mental health advance directive. Part IV analyzes a patient's right to self-determination in Florida and the impact this legal doctrine may have on the use of mental health advance directives. Finally, Part V applies the Advance Directives Act and other Florida law to the use of advance directives in a mental health context, demonstrates that the law supports this expansion, and addresses some practical issues for implementing mental health advance directives.

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not without controversy. This Comment uses "patient" consistently with the terminology used by courts and legislatures and with the common usage.

16. FLA. STAT. § 765.102(1) (1993).

17. *Id.* § 765.

18. *Id.* § 394.459(3)(a). See *infra* text accompanying notes 201-02.

19. FLA. STAT. § 765.101(1) (1993) (emphasis added).

20. *Id.* § 765.101(16).

21. *Id.* § 765.101(12)(b).

## II. THE CONTROVERSY BEHIND THE RIGHT TO CONTROL PSYCHIATRIC TREATMENT

An individual's right to control her own mental health care, particularly her right to refuse treatment when she is not competent, is the subject of considerable controversy. An appreciation of the position of mentally ill persons in society is necessary before one can understand the controversy behind the right. Thomas Szasz, who may be the most radical theorist in this regard, has compared the plight of individuals labeled as mentally ill to that of persons accused of being witches during the Inquisition.<sup>22</sup> In his view, the various psychiatric diagnostic categories are used to label socially unacceptable behavior and to justify controlling individuals exhibiting that behavior.<sup>23</sup>

A similar, but somewhat less radical view, which does not necessarily reject the existence of psychiatric illness, also asserts that psychiatry's primary purpose is social control.<sup>24</sup> According to this theory, defining disturbing behavior in medical terms facilitates social control because it assumes that the individual is not acting freely and that he may not be capable of doing so.<sup>25</sup> This assumption justifies depriving individuals of their rights and confining them against their will.<sup>26</sup>

Even if one does not accept all of the assumptions of these theories, they provide insight into one possible reason for the controversy behind the right to control one's psychiatric treatment. If society's goal for this treatment is in fact control, it seemingly would not accept the notion of greater rights for psychiatric patients to resist control. Even those rejecting the social control theories concede that mental health patients are not accepted as full members of society. As one commentator wrote, "[t]he 'mentally ill' are . . . fundamentally unworthy" in the eyes of society.<sup>27</sup> These same negative attitudes do not exist for most "physical" illnesses.<sup>28</sup> It is against this normative and attitudinal backdrop that the right to control psychiatric treatment is played out.

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22. THOMAS SZASZ, *THE MANUFACTURE OF MADNESS* 3-134 (1970).

23. *Id.*

24. See JONAS ROBITSCHER, *THE POWERS OF PSYCHIATRY* 162-65, 347-71 (1980); Ronald Leifer, *Introduction: The Medical Model as the Ideology of the Therapeutic State*, 11 J. MIND & BEHAV. 247 (1990).

25. Leifer, *supra* note 24, at 252.

26. *Id.*; see also PETER R. BREGGIN, *TOXIC PSYCHIATRY* 21-46 (1991) (detailing the use of drugs to control behavior); Seth Farber, *Institutional Mental and Social Control: The Ravages of Epistemological Hubris*, 11 J. MIND & BEHAV. 285 (1990) (arguing that institutional mental health seeks social control).

27. Farber, *supra* note 26, at 293; see also BREGGIN, *supra* note 26, at 26 ("The notion of madness or derangement has many connotations, mostly negative . . .").

28. ROBITSCHER, *supra* note 24, at 232.

### A. *The Right to Refuse Treatment*

At its core, the right to refuse psychiatric treatment is based on the same values of autonomy and self-determination as the right to refuse treatment generally. But the right to refuse psychiatric treatment generates greater controversy. For example, although the right to die gets more attention, the right to refuse psychiatric drugs is more contentious.<sup>29</sup> Both concern a right to refuse highly intrusive interventions. The right to die, however, is ironically less regulated than the right to control one's mind.<sup>30</sup> This may be due, at least in part, to judges' attitudes towards mental health patients, to the extent their attitudes reflect society's.<sup>31</sup>

Some view the right to refuse psychiatric treatment within a political framework.<sup>32</sup> In this context, the struggle to secure an absolute right to refuse psychiatric treatment is compared to the struggle for civil and women's rights.<sup>33</sup> Like those situations, when a group that society perceives as being unable to speak for itself begins to do so, a social upheaval ensues.<sup>34</sup> Mental health professionals, like slavemasters and men, see themselves as "benevolent" and see patients as "needy and helpless."<sup>35</sup> Mental health professionals are threatened when patients assert control over their own lives. Consequently, they will object and proclaim their own beneficence.<sup>36</sup> At the same time, mental health professionals will point out the harmful consequences to patients if they achieve their goal of self-determination and, on this basis, fight to maintain control.<sup>37</sup>

This control is difficult to justify because weighing the risks and benefits of consenting to treatment is value-laden.<sup>38</sup> Forcibly medicating a patient accords greater weight to freedom from mental illness<sup>39</sup> than to the moral "costs of overriding the patient's wishes and exposing . . . her to [unwanted] side effects."<sup>40</sup> Although the physician's treat-

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29. Parry, *supra* note 13, at 472.

30. *Id.*

31. See *id.*; see also Michael L. Perlin, *Pretexts and Mental Disability Law: The Case of Competency*, 47 U. MIAMI L. REV. 625, 629 (1993) ("Judges . . . , consciously or unconsciously, often rely on reductionist, prejudicial stereotypes in their decisionmaking . . .").

32. E.g., Chamberlin, *supra* note 3, at 167.

33. *Id.*

34. *Id.*

35. *Id.* at 168.

36. *Id.*

37. *Id.*

38. Ellen W. Clayton, *From Rogers to Rivers: The Rights of the Mentally Ill to Refuse Medication*, 13 AM. J.L. & MED. 7, 19 (1987).

39. This assumes, for the moment, that psychotropic drugs have that impact.

40. Clayton, *supra* note 38, at 19.

ment choice may be objectively<sup>41</sup> in the patient's best interests, society generally does not support the position of always intervening in a person's best interest unless the stakes are very high.<sup>42</sup> Even then, individuals are usually free to engage in life-threatening activities if that is their choice.<sup>43</sup>

Those who oppose the unfettered right to refuse psychiatric treatment often rely on the medical profession's interests in having its ethical obligations honored.<sup>44</sup> In the psychiatric context, the ethical problems of physicians are accorded greater weight than in a termination of life support scenario because psychiatric patients are often committed to the physician's care and they cannot discharge them.<sup>45</sup> Another common argument used in opposition to the right to refuse psychiatric treatment, particularly medication, is that the treatment refusal results from the patient's illness and, therefore, should not be honored.<sup>46</sup> Studies show-

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41. The physician's choice may be objective to the degree that medical research may support the physician's decision based on amelioration of symptoms or some other criteria, and that the majority of people would agree with the physician. *See id.* at 21.

42. Laws requiring the use of motorcycle helmets are an excellent example. In 1975, forty-seven states had such laws; but by 1980, only seventeen states required adults to wear helmets. DONALD VANDEVEER, *PATERNALISTIC INTERVENTION* 307 (1986). Subsequently, fatalities increased by forty-six percent. *Id.* One possible justification for repealing these laws is based on the notion that it is morally wrong to interfere with a competent person's choices if he is not harming others. *Id.* at 307-08. A more current example is bungee jumping. Bungee jumping involves jumping off of various types of platforms with an elastic cord tied around the ankle or waist. After two recent deaths, only three states (including Florida) moved to regulate the "sport." Larry McShane, *Bungee Jumpers in Stretch Run for Their Rights*, L.A. TIMES, Nov. 22, 1992, at A34. One author summed up the argument in favor of allowing the activity by quoting one bungee operator as saying that "in the end, it boils down to personal freedom." Jesse Snyder, *Newsday Student Briefing Page on the News*, NEWSDAY, Sept. 3, 1992, at 20.

43. The Supreme Court of Florida recently reasoned in the context of a blood transfusion refusal case involving a mother with minor children that "[s]ociety does not . . . disparage or preclude one from performing an act of bravery resulting in the loss of that person's life simply because that person has parental responsibilities." *In re Dubreuil*, 629 So. 2d 819, 826 (Fla. 1993).

44. *See Clayton, supra* note 38, at 23-24; *see also* Samuel J. Brakel & John M. Davis, *Taking Harms Seriously: Involuntary Mental Patients and the Right to Refuse Treatment*, 25 IND. L. REV. 429, 430 (1991).

45. Brakel & Davis, *supra* note 44 (noting that psychiatrists are "cornered into ethical and legal no-win positions as they must watch patients, committed to their charges by the state because the patients are incapable of recognizing their need for treatment, fall prisoner to this 'liberty interest' they have chosen to exercise.") (footnotes omitted). *But see infra* notes 71-74.

46. *E.g.*, *Guardianship of Roe*, 583 N.E.2d 1282, 1285 (Mass. 1992) ("[T]he [trial] judge determined that the ward is 'incompetent to make medical treatment decisions . . . due to his mental illness.'"); Steven K. Hoge et al., *A Prospective, Multicenter Study of Patients' Refusal of Antipsychotic Medication*, 47 ARCHIVES GEN. PSYCHIATRY 949, 955 (1990) (finding that the majority of "medication refusers" were judged incompetent by their physicians); Gladys Kessler, *Remarks on the Judge's Role and Moral Certainty*, 19 L. MED. & HEALTH CARE 34, 34 (1991) (noting that the issue of incompetency is not raised unless the patient rejects the treatment options pressed on her by her "all knowing doctor"); Nancy K. Rhoden, *The Presumption for Treatment: Has It Been Justified?*, 13 L. MED. & HEALTH CARE 65, 65 (1985) (rejecting the use of a



ing that refusal actually correlates with the severity of side effects undermine this view.<sup>47</sup>

The usual justifications for involuntary treatment of psychiatric patients are the state's *parens patriae* and police powers.<sup>48</sup> The *parens patriae* doctrine developed out of the monarch's common law prerogative to act as the guardian of all "lunatics."<sup>49</sup> The Supreme Court of Florida has used the *parens patriae* doctrine to justify the state's right to involuntarily hospitalize mentally ill individuals who need treatment but are unable to make this decision for themselves.<sup>50</sup> Some argue that the *parens patriae* power is only justified, if at all, when the individual is incompetent; otherwise, the individual's liberty right trumps.<sup>51</sup> It is primarily this power that a patient's right to refuse treatment and the use of advance directives implicates.

A state's police power allows it to confine mentally ill individuals solely to protect society from dangers posed by such individuals.<sup>52</sup> This

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physician's recommendation as evidence of incompetency). One commentator made the interesting point that a patient's decision to consent to treatment is rarely questioned in this manner. Winick, *supra* note 13, at 51-58 (noting that competency is not questioned when a patient gives an informed consent and such decisions do not receive judicial scrutiny as treatment refusals do).

47. See Theodore Van Putten et al., *Subjective Response to Antipsychotic Drugs*, 38 ARCHIVES GEN. PSYCHIATRY 187 (1981); Theodore Van Putten, *Why Do Schizophrenic Patients Refuse to Take Their Drugs?*, 31 ARCHIVES GEN. PSYCHIATRY 67 (1974).

48. See generally Samuel J. Brakel, *Involuntary Institutionalization, in THE MENTALLY DISABLED AND THE LAW*, *supra* note 13, at 21, 24-25. One study concluded that if patients had an absolute right to refuse medication, a significant number would do so "resulting in prolonged hospitalization, increased morbidity both for the patient and for fellow patients, disruption of the therapeutic milieu, and a considerable investment of time on the part of clinical staff." Hoge et al., *supra* note 46, at 955. One could also argue that the state has an economic interest in treating mentally ill individuals. The argument rests on the notion that through treatment these persons may return to productive life, thus reducing the state's economic burden. Cf. VANDEVEER, *supra* note 42, at 309-12 (discussing this argument in the context of motorcycle helmet laws, among others). These factors have one thing in common: increased cost. See Jessica Litman, Note, *A Common Law Remedy for Forcible Medication of the Institutionalized Mentally Ill*, 82 COLUM. L. REV. 1720, 1723 (1982) (noting that the current system of limited patient rights is cost efficient).

49. Mary C. McCarron, Comment, *The Right to Refuse Antipsychotic Drugs: Safeguarding the Mentally Incompetent Patient's Right to Procedural Due Process*, 73 MARQ. L. REV. 477, 489-90 (1990).

50. *In re Beverly*, 342 So. 2d 481, 485 (Fla. 1977). The United States Supreme Court also has recognized that the states are vested with *parens patriae* power to protect persons unable to care for themselves. *Hawaii v. Standard Oil Co.*, 405 U.S. 251, 257 (1972).

51. See Clayton, *supra* note 38, at 29; Litman, *supra* note 48, at 1743; McCarron, *supra* note 49, at 491.

52. *In re Beverly*, 342 So. 2d at 486 (quoting *O'Connor v. Donaldson*, 422 U.S. 563, 582-83 (1975) (Burger, C.J., concurring)); see also *Foucha v. Louisiana*, 112 S. Ct. 1780, 1784 (1992) ("[K]eeping [a patient] against his will in a mental institution is improper absent a determination . . . of current mental illness and dangerousness."). The public generally assumes that mentally ill persons are frequently dangerous. BRUCE J. ENNIS, *PRISONERS OF PSYCHIATRY: MENTAL PATIENTS, PSYCHIATRISTS, AND THE LAW* 225 (1972). Evidence suggests that this is not true and

same justification is used when the state takes measures against a patient to prevent harm to other patients and staff within an institution.<sup>53</sup> The obvious underlying goal in these instances is behavior control rather than treatment.<sup>54</sup> When a patient is medicated, secluded, or restrained for behavior control rather than treatment, however, the right to refuse treatment is not technically implicated. In this situation, the state must use the least restrictive means necessary to achieve this control.<sup>55</sup> Even in this context, advance directives may be given effect. The patient may state that, to her, the least restrictive means of control is seclusion or restraint rather than medication. Reference to the potential side effects of medication could support her statement. If the patient's preferred method of control would be effective and within the hospital's power to effectuate, the patient's rights should trump the state's preference for any particular method of control. Police power will still prove to be a limitation on the use of mental health advance directives because of the state's interest in protecting third parties but will not limit their validity.

### B. Antipsychotic Medications<sup>56</sup>

Antipsychotic medications may be the most controversial issue in

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in any event that psychiatrists are not reliable predictors of dangerousness. *Id.* at 225-27; *Id.* at 25-36. This data is the foundation for the argument that involuntary hospitalization on the basis of dangerousness is not justified. STONE, *supra* note 13, at 25-36. Other commentators, although accepting the data, assert that reliance on the data ignores the moral responsibility to protect society to the extent possible. MURPHY, *supra* note 1, at 160-61.

53. See Clayton, *supra* note 38, at 29; Litman, *supra* note 48, at 1738; McCarron, *supra* note 49, at 491.

54. See Michael R. Flaherty, Annotation, *Nonconsensual Treatment of Involuntarily Committed Mentally Ill Persons with Neuroleptic or Antipsychotic Drugs as Violative of State Constitutional Guaranty*, 74 A.L.R.4th 1099, 1102 (1989). Arguably, these measures are in themselves treatment because they relieve symptoms of the patient's mental illness. See *Washington v. Harper*, 494 U.S. 210, 223 n.8, 227 (1990). But see *id.* at 249-50 (Stevens, J., dissenting) (assuming the goal to be behavior control, not treatment).

55. The United States Supreme Court appeared to have weakened this requirement by its support of the professional judgment standard in *Youngberg v. Romeo*, 457 U.S. 307, 319-22 (1982) (holding that due process required only that a hospital exercise professional judgment in its decision to physically restrain a mentally retarded patient for his safety or that of others and that the Court would not examine alternative forms of treatment). The Court, however, has recently supported the doctrine of least restrictive alternatives, at least in the context of medicating a prisoner during trial. *Riggins v. Nevada*, 112 S. Ct. 1810, 1815-16 (1992) (holding that the state violated a prisoner's due process rights when it medicated him against his will without considering less intrusive alternatives).

56. Antipsychotic medications (also called neuroleptics and, incorrectly, major tranquilizers) are used in the treatment of psychosis. Thomas G. Gutheil & Paul S. Appelbaum, "Mind Control," "Synthetic Sanity," "Artificial Competence," and *Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication*, 12 HOFSTRA L. REV. 77, 79 (1983). Psychosis is a "major mental disorder . . . in which a person's ability to think, respond emotionally, remember, communicate, interpret reality, and behave appropriately is sufficiently impaired so as to interfere

the debate over the right to refuse treatment.<sup>57</sup> Physicians have used antipsychotic medications to treat schizophrenia<sup>58</sup> and other forms of psychoses since the 1950s.<sup>59</sup> According to studies, these drugs limit schizophrenia's most oppressive symptoms but do not lead to a cure.<sup>60</sup> Antipsychotic medications have had a profound effect on hospital atmosphere<sup>61</sup> and have reduced the need for and length of hospitalization.<sup>62</sup> Although there is substantial evidence of the positive effects of these medications,<sup>63</sup> evidence also shows that they produce substantial side effects that range from minor, temporary problems to major, permanent disabilities and even death.<sup>64</sup> Additionally, physicians frequently misuse antipsychotic medications because of poor diagnosis or inappropriate dosaging<sup>65</sup> or because of improper motivation such as punishment.<sup>66</sup> These issues underlie the controversy over the right to refuse psychiatric treatment, particularly medications, as well as a patient's desire to express that right.

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grossly with the capacity to meet the ordinary demands of life." AMERICAN PSYCHIATRIC GLOSSARY 139 (Evelyn M. Stone ed., 6th ed. 1985).

57. See Gutheil & Appelbaum, *supra* note 56, at 77 (noting that "these cases have created a storm of controversy in both the medical and legal professions . . ."); Brief of the American Orthopsychiatric Association, *Riese v. St. Mary's Hosp. & Medical Ctr.*, 774 P.2d 698 (Cal. 1989) (No. S004002) (discussing implications of forced medication as a matter of mental health policy).

58. Schizophrenia is a "large group of disorders . . . manifested by characteristic disturbances of language and communication, thought, perception, affect, and behavior." AMERICAN PSYCHIATRIC GLOSSARY, *supra* note 56, at 149 (emphasis omitted). These symptoms sometimes express themselves as hallucinations, delusions, mood swings, and "bizarre" behavior. *Id.* Not all scholars accept the notion that schizophrenia exists as a disease entity. Rather, some see it as a label applied to individuals with unusual and socially unacceptable behavior and a means to control these individuals. E.g., BREGGIN, *supra* note 26, at 21-46; Theodore R. Sarbin, *Toward the Obsolescence of the Schizophrenia Hypothesis*, 11 J. MIND & BEHAV. 259 (1990). See generally SZASZ, *supra* note 22 (comparing the mental health movement to the Inquisition).

59. Alexander D. Brooks, *Law and Antipsychotic Medications*, 4 BEHAVIORAL SCI. & L. 247, 248 (1986); McCarron, *supra* note 49, at 480.

60. Cichon, *supra* note 2, at 294; Litman, *supra* note 48, at 1726; McCarron, *supra* note 49, at 481.

61. Brooks, *supra* note 59, at 248.

62. Brakel & Davis, *supra* note 44, at 449-50; Brooks, *supra* note 59, at 248; Cichon, *supra* note 2, at 292-93.

63. See, e.g., Brakel & Davis, *supra* note 44, at 444-61 and citations therein; Cichon, *supra* note 2, at 292-95.

64. Common temporary side effects include muscle spasms (dystonia); motor restlessness (akathesia); and sleepiness (akinesia). The most common serious side effect is tardive dyskinesia which manifests itself by grotesque movements of the tongue, face, mouth, and limbs. For long-term medication users, the condition is irreversible and usually not discovered until it has become severely disabling. Rarely, death may result from a condition known as neuroleptic malignant syndrome which is characterized by a sudden steep elevation in body temperature. See Brakel & Davis *supra* note 44, at 461-64; Brooks, *supra* note 59, at 249-50; Cichon, *supra* note 2, at 297-310; Litman, *supra* note 48, at 1726-27.

65. See Cichon, *supra* note 2, at 296; McCarron, *supra* note 49, at 483.

66. See Brooks, *supra* note 59, at 252.

## III. THE MENTAL HEALTH CARE ADVANCE DIRECTIVE

The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research found that honoring an advance directive shows respect for self-determination.<sup>67</sup> It does so by providing reassurance that "a course of conduct promotes [a] patient's subjective, individual evaluation of well-being."<sup>68</sup> Additionally, honoring the advance directive shows respect for the patient as an individual.<sup>69</sup> Although the President's Commission may not have been necessarily addressing mental health issues when it wrote those words, applying them in a mental health context furthers the same values that the Commission promoted.<sup>70</sup>

The suggestion that advance directives be used for mental health care is not new. The concept has arisen in two contexts: an advance directive binding oneself to future treatment during periods of incompetency even though one might later refuse such treatment<sup>71</sup> and an advance directive rejecting certain or all treatment.<sup>72</sup> One also may state a preference for a particular form of treatment.<sup>73</sup>

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67. 1 MAKING HEALTH CARE DECISIONS, *supra* note 9, at 49.

68. *Id.*

69. *Id.*

70. Not all theorists would agree with this statement. A counterargument is that in some cases physicians are justified in overriding a patient's wishes because the patient would thank the physician if she could. STONE, *supra* note 13, at 66-70. The test is whether a reasonable person would want to be treated that way. *Id.* at 69; see also Elyn R. Saks, *Competency to Refuse Psychotropic Medication: Three Alternatives to the Law's Cognitive Standard*, 47 U. MIAMI L. REV. 689 (1993) (reviewing the basis of the "thank you" theory and its relationship to other competency theories). A second counterargument uses the "different person" theory. Under this theory, when a person is mentally ill, it is not the person's "true" self speaking. The true person's wishes are not being furthered. According to this theory, this would be true even when the person is considered legally competent to execute an advance directive, as long as she is mentally ill. Saks, *supra*, at 697-700; see also John Churchill, *Advance Directives: Beyond Respect for Freedom*, in ADVANCE DIRECTIVES IN MEDICINE 171, 172-74 (Chris Hackler et al. eds., 1989) (expressing concern about the use of advance directives when the self cannot be identified). Another commentator presents a similar theory under the rubric "psychological continuity." This commentator, however, concludes that although the individual's personal identity may vary this does not by itself counsel against using advance directives. Allen Buchanan, *Advance Directives and the Personal Identity Problem*, 17 PHIL. & PUB. AFFAIRS 277 (1988). Not all commentators share Buchanan's view that the psychological continuity issue does not make advance directives inappropriate. E.g., Jennifer Radden, *Planning for Mental Disorder: Buchanan and Brock on Advance Directives in Psychiatry*, 18 SOC. THEORY & PRAC. 165 (1992) (expressing concern about personality changes).

71. The so-called "Ulysses contract." See *infra* text accompanying notes 74-77.

72. Such an advance directive has been more commonly referred to as a "living will." This name is inadequate to describe the breadth of an advance directive's coverage. See *infra* text accompanying note 171.

73. See Jean Hopfensperger, *Mental Patients Can Direct Treatment with a "Living Will,"* MINNEAPOLIS STAR TRIB., Jan. 17, 1992, at 1B (describing an advance directive containing treatment preferences). Statements of treatment preferences are just that—preferences.

The type of advance directive that binds one to treatment during periods of incompetency is commonly referred to as a "Ulysses contract."<sup>74</sup> The concept emerged, in part, as a reaction to involuntary hospitalization criteria.<sup>75</sup> The contract is designed to empower competent individuals to give legally enforceable instructions applicable during future episodes of acute mental illness when they refuse treatment but do not meet civil commitment criteria.<sup>76</sup> Such a contract authorizes involuntary hospitalization and may specify certain forms of treatment when the enumerated diagnostic criteria are met.<sup>77</sup>

In 1982, Thomas Szasz was one of the first to propose a mental health advance directive.<sup>78</sup> Szasz's conception never really caught on. Recently, however, the concept is receiving renewed attention in the

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Statements of preference, unlike those rejecting certain treatments, do not legally bind physicians to treat a patient as requested if they do not agree with the patient's treatment choice. See FLA. STAT. § 394.460 (1993) (giving physicians the right not to treat a patient); Clayton, *supra* note 38, at 25-26 (professionals are not forced to do what they do not want to do).

74. See JOHN ELSTER, *ULLYSSES AND THE SIRENS* 38 (1979) ("Persons with periodically recurring mental illness may (but rarely do) bind themselves in advance, by issuing instructions that when the next episode occurs, the instructions that will then be issued . . . are not to be obeyed."). This type of advance directive was so named because of Ulysses' instructions to his crew to tie him to the mast of their ship before they approached the lure of the Sirens and not to untie him until they had passed, regardless of what he said. 2 THE GREEK MYTHS 361 (Robert Graves trans., 1955).

75. See Rebecca S. Dresser, *Ulysses and the Psychiatrists: A Legal and Policy Analysis of the Voluntary Commitment Contract*, 16 HARV. C.R.-C.L. L. REV. 777, 779-81 (1982); see also R. E. Reinert, *A Living Will for a Commitment Hearing*, 31 HOSP. & COMMUNITY PSYCHIATRY 857 (1980) (discussing the restrictive procedural requirements for involuntary hospitalization). The concept is not without its current advocates, although generally discredited by those concerned with patients' civil rights. See generally Marilyn K. Rosenson & Agnes M. Kasten, *Another View of Autonomy: Arranging for Consent in Advance*, 17 SCHIZOPHRENIA BULL. 1 (1991). But see Joseph A. Rogers and J. Benedict Centifanti, *Beyond "Self-Paternalism": A Response to Rosenson and Kasten*, 17 SCHIZOPHRENIA BULL. 9 (1991).

76. Dresser, *supra* note 75, at 777.

77. *Id.* at 780.

78. Thomas S. Szasz, *The Psychiatric Will: A New Mechanism for Protecting Persons Against "Psychosis" and Psychiatry*, 37 AM. PSYCHOLOGIST 762, 766 (1982) ("[C]ompetent . . . adults should have a recognized right to reject involuntary psychiatric interventions that they may be deemed to require in the future, when they are not competent to make decisions concerning their own welfare."). *Contra* Paul Chodoff & Roger Peele, *The Psychiatric Will of Dr. Szasz*, 13 HASTINGS CENTER REP. 11 (1983). At least one commentator recommends use of the Ulysses contract to protect against court-appointed attorneys who believe that mental illness is a myth. Reinert, *supra* note 75, at 858.

literature,<sup>79</sup> in the broadcast media<sup>80</sup> and in at least two states legislatures.<sup>81</sup> As noted above, the advance directive is generally thought of as a mechanism to refuse unwanted treatment, including hospitalization, and to state treatment preferences. Additionally, an advance directive can be used simply to designate a surrogate, familiar with the patient's values, to make decisions for her. Whatever the nature of the instructions contained in an advance directive, the value of self-determination is being furthered.

#### IV. THE RIGHT TO SELF-DETERMINATION IN FLORIDA

The right to control one's own medical care in Florida, as in all states, is based primarily on the rights guaranteed by the state's constitution and statutes as interpreted by Florida courts. Federal law also is implicated to the extent that it provides any greater rights than state law or that it requires any procedural protection for patients exercising their rights.

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79. See, e.g., ALLEN E. BUCHANAN & DON W. BROCK, *DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING* 350-57 (1989) (comprehensively reviewing the moral and ethical arguments supporting the use of mental health advance directives); Paul S. Appelbaum, *Advance Directives for Psychiatric Treatment*, 42 *HOSP. & COMMUNITY PSYCHIATRY* 983 (1991) (reviewing the pros and cons of advance directives); Audrey Macklin, *Bound to Freedom: The Ulysses Contract and the Psychiatric Will*, 45 *U. TORONTO FAC. L. REV.* 37 (1987) (comparing advance directives to Ulysses contracts); John W. Parry, *The Court's Role in Decisionmaking Involving Incompetent Refusals of Life-Sustaining Care and Psychiatric Medications*, 14 *MENTAL & PHYSICAL DISABILITY L. REP.* 468, 474 (1990) (stating that current living will and consent statutes do not apply to psychiatric treatment refusals and that it is uncertain if institutions would honor them, especially if patient control were perceived as necessary); Radden, *supra* note 70 (arguing that the use of advance directives in psychiatry is not justified); Deborah S. Pinkney, *Advance Directive Could Give Mentally Ill More Treatment Control*, *AM. MED. NEWS*, Dec. 16, 1991, at 3, 22 (describing the potential benefits of advance directives).

80. *Mentally Ill Homeless & Intervention* (National Public Radio broadcast, Nov. 29, 1992).

81. Minnesota has specifically recognized by statute mental health advance directives. The statute requires that, except in an emergency, incompetent persons who have an advance directive must be treated in accordance with that directive with regard to electroshock therapy and neuroleptic medication. *MINN. STAT. ANN.* § 253B.03(6b) (West 1992 & Supp. 1993). Court orders also can override medication refusals. *Id.* § 253B.03(6c)(c). The statute specifically provides that instructions can be given both to consent to and to refuse treatment. *Id.* § 253B.03(6d)(a). Except in an emergency, voluntary patients' instructions cannot be overridden unless the patient is committed as mentally ill and a court orders the treatment. *Id.* § 253B.03(6d)(d); see generally Gayle Dixon, *The Minnesota Advance Psychiatric Directive: Protecting Patient Decision Making*, 75 *MED. L. & POL'Y* 33 (1992); Roberto Cuca, Note, *Ulysses in Minnesota: First Steps Toward a Self-Binding Psychiatric Advance Directive Statute*, 78 *CORNELL L. REV.* 1152 (1993). For a discussion of the background of this statute, see Hopfensperger, *supra* note 73. Massachusetts's advance directive statute specifically defines health care decisions to include mental health decisions. *MASS. GEN. LAWS ANN.* ch. 201D, § 1 (West 1992 & Supp. 1993).

## A. Federal Law

### 1. FEDERAL CASE LAW

The United States Supreme Court assumed in *Cruzan v. Director, Missouri Department of Health* that individuals possess a "constitutionally protected liberty interest in refusing unwanted medical treatment . . . ." <sup>82</sup> *Cruzan* is the Court's most recent statement concerning an individual's right to refuse treatment.

The *Cruzan* Court cited three earlier decisions involving psychiatric patients to support the right to refuse treatment: *Washington v. Harper*,<sup>83</sup> *Vitek v. Jones*,<sup>84</sup> and *Parham v. J.R.*<sup>85</sup> First, in *Harper*, the Court recognized that mentally ill convicted prisoners possess "a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment."<sup>86</sup> Second, the *Cruzan* Court cited *Vitek* for the proposition that a prisoner's "transfer to a mental hospital coupled with mandatory behavior modification implicated liberty interests."<sup>87</sup> Finally, quoting *Parham*, the Court noted that "'a child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment.'"<sup>88</sup>

The United States Supreme Court's recognition of a competent patient's liberty interest in refusing unwanted medical care is helpful to Florida mental health patients attempting to control their future care. It does not, however, implicate the use of advance directives because Nancy Cruzan had not left any written instructions regarding her care in the event of incompetency. In fact, the *Cruzan* Court specifically declined to determine whether a state might be required to defer to the decisions of a surrogate appointed by the patient.<sup>89</sup>

### 2. FEDERAL STATUTES

By enacting the Patient Self-Determination Act ("PSDA"), Congress partially made the determination that the *Cruzan* Court declined to

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82. 497 U.S. 261, 278 (1990). In a footnote, the court rejected the notion that the right to privacy encompasses the right to refuse treatment. *Id.* at 279 n.7.

83. 494 U.S. 210 (1990).

84. 445 U.S. 480 (1980).

85. 442 U.S. 584 (1979).

86. 494 U.S. at 221-22, *quoted in Cruzan*, 497 U.S. at 278.

87. 497 U.S. at 278.

88. *Id.* at 278-79.

89. *Id.* at 287 n.12.

make.<sup>90</sup> The PSDA requires that covered entities<sup>91</sup> inquire of every adult patient upon admission whether the patient has executed an advance directive and provide written information concerning the patient's rights under state statutory and case law to make her own decisions concerning medical care. This information must include the right to accept or refuse medical or surgical treatment and the right to formulate advance directives if state law grants this right.<sup>92</sup>

Although these provisions are generally procedural, there is one important substantive requirement. The hospital may "not . . . condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive."<sup>93</sup>

Was the PSDA intended to apply to patients being admitted to psychiatric hospitals? The PSDA itself does not distinguish between types of hospitals but merely uses the term "hospital." More significantly, the PSDA's requirements specifically apply to community mental health centers that provide partial hospitalization services.<sup>94</sup> It is unlikely that Congress intended the PSDA to apply to providers of partial psychiatric hospitalization services and not to providers of full psychiatric hospitalization services.

Assuming that the PSDA does apply to psychiatric hospitals, did Congress intend for it to apply to mental health advance directives or only the more traditional form of living will? The language of the PSDA itself does not differentiate between types of advance directives. In fact, as already noted, an advance directive for the PSDA's purposes is whatever state law says it is.<sup>95</sup> Further, the legislative history of the PSDA does not indicate that Congress intended its provisions to apply only in limited circumstances. In introducing the bill to the House of Representatives, Congressman Sander M. Levin said that he was doing so "with the purpose of ensuring that a person's right to determine their [sic] own health care future is respected."<sup>96</sup> Similarly, on its introduc-

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90. 42 U.S.C.A. §§ 1395cc(f) & 1396a(w) (West 1992 & Supp. 1993). The PSDA (an amendment to the Social Security Act establishing the Medicare and Medicaid programs) applies to entities participating in the Medicare or Medicaid programs. *Id.* Therefore, the PSDA applies to all Florida state psychiatric hospitals and any private hospital participating in either program.

91. Any service provider participating in Medicare or Medicaid are considered entities. *Id.* § 1396a(w)(1).

92. *Id.* § 1396a(w)(1)(A)(i). The implementing regulations are found in Advance Directives—Requirements for Providers, 42 C.F.R. § 489.102 (1993). The Act defines advance directives to be a written instrument, recognized under state law, relating to an incapacitated individual's health care. 42 U.S.C.A. § 1395cc(f)(3) (West 1992 & Supp. 1993).

93. 42 U.S.C.A. § 1395cc(f)(1)(C) (West 1992 & Supp. 1993).

94. *Id.* § 1395cc(e)(2).

95. *See supra* note 92.

96. 136 CONG. REC. E943 (daily ed. Apr. 3, 1990).



tion in the Senate, Senator John Danforth said that this bill "will protect a person's right to self-determination in health care decisions."<sup>97</sup> Senator Danforth went on to say that "[p]eople clearly have an indisputable right to refuse treatment."<sup>98</sup>

Both Senator Danforth<sup>99</sup> and Congressman Levin<sup>100</sup> used as examples, however, cases of termination of artificial life support. One should not take these examples to automatically exclude other situations. They were probably used because they were topical.<sup>101</sup> If Congress intended for the provisions of the PSDA to apply so narrowly, one would expect that Congress would have included appropriate language in the legislation. Congress did not.

Further assuming that the PSDA applies to mental health advance directives, then upon admission hospitals must inform adult patients of their rights under state law to make treatment decisions. This includes the right to refuse treatment and to execute an advance directive. This requirement raises three important issues for those patients being admitted who do not have advance directives.

The first issue is competency. The PSDA does not address this issue. Theoretically, then, hospitals are required to follow the same requirements for competent as well as incompetent patients.<sup>102</sup> The United States Supreme Court requires Florida to ensure that patients who are admitting themselves voluntarily are competent to give informed consent for admission.<sup>103</sup> This issue of competency, therefore, should not arise for these patients. For patients who are adjudicated incompetent or whose competency status is uncertain, the exercise of informing them of their rights may be a hollow one because they cannot understand all of the ramifications of electing whether to exercise their

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97. 135 CONG. REC. S13566 (daily ed. Oct. 17, 1989).

98. *Id.*

99. *Id.* at S13567 (referring, among others, to Nancy Cruzan).

100. 136 CONG. REC. E943 (daily ed. Apr. 3, 1990) (referring to the case of Nancy Cruzan).

101. Both Senator Danforth and Congressman Levin referred to the then-recent case of Nancy Cruzan. See *supra* notes 96, 99.

102. See Karen N. Swisher, *Implementing the PSDA for Psychiatric Patients: A Common-Sense Approach*, 2 J. CLINICAL ETHICS 199, 199 (1991). Arguably, a covered entity may not have to inform a patient who already has been adjudicated incompetent because at that point she does not have the right to execute an advance directive. Nonetheless, nothing in the PSDA indicates that the requirement only applies if the patient can exercise her right at that time.

103. *Zinerman v. Burch*, 494 U.S. 113, 132-38 (1990). If the patient is not competent, an evaluation must be conducted to determine whether he meets the criteria for involuntary examination. If not, he cannot be admitted. *Id.* at 134-35. Whether this holding is applicable to other states is unclear because the facts of the case apply to Florida's mental health system. This is the very problem that the Ulysses contract was intended to address. But see Bruce J. Winick, *Competency to Consent to Voluntary Hospitalization: A Therapeutic Jurisprudence Analysis of Zinerman v. Burch*, in *ESSAYS IN THERAPEUTIC JURISPRUDENCE*, *supra* note 13, at 83 (arguing that this interpretation is dicta and its impact on practice and future court decisions is uncertain).

rights. It may be inappropriate to rigidly follow the requirements of the PSDA for these patients. Legally incompetent patients have guardians to whom this information may be given, but it is questionable whether this practice would be acceptable because the PSDA is silent on the issue. Indeed, Congress may need to amend the PSDA, or the Department of Health and Human Services may need to develop regulations to address this problem.<sup>104</sup>

The second issue is whether it is appropriate to discuss these subjects at the time a psychiatric patient is admitted.<sup>105</sup> Patients being admitted to a psychiatric hospital are, by definition, in a problematic emotional or cognitive state. One must question the patient's ability to fully comprehend an explanation of her rights at this time or even the therapeutic appropriateness of explaining them in that context. The question of whether to give depressed or suicidal patients information about their right to die serves as an obvious example.<sup>106</sup> Once again, it may be necessary to implement the PSDA flexibly to ensure that the rights it confers to patients are not empty.

The third issue is closely related to the first two—the coercive environment of the psychiatric hospital.<sup>107</sup> Because the patient is in a vulnerable emotional state and possibly of uncertain competence when she is admitted to a hospital, she may be inclined to follow the “advice” of hospital personnel to not execute an advance directive or not refuse specific forms of treatment. Likewise, many patients are eager to be released from the hospital and would do whatever they think will advance this goal. The hospital staff would, therefore, be free to treat a patient in what they consider to be her best interest. By the time that the patient is stable and better able to comprehend her rights to control her treatment, she may have forgotten the discussion concerning her rights, if she even understood her rights at the time.

Although these are serious issues, they can be addressed and will be

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104. The preamble to the proposed rules implementing the PSDA mentioned this issue, but the subject is not addressed in the regulations. 57 Fed. Reg. 8194, 8197 (1992). The preamble suggested that facilities give the information to the “family or surrogate to the extent that it issues other materials about policies and procedures to the family of the incapacitated patient or to a surrogate or other concerned person in accordance with State law.” *Id.* The facility still should give the information to the patient when he is able to understand it. *Id.*

105. An important issue beyond the scope of this Comment involves the therapeutic appropriateness of discussing the right-to-die aspects of advance directives with psychiatric patients during the admission process for psychiatric treatment or even later in their stay.

106. See Linda Ganzini et al., *Is the Patient Self-Determination Act Appropriate for Elderly Persons Hospitalized for Depression?*, 4 J. CLINICAL ETHICS 46 (1993) (arguing against discussing advance directives and the right to die when depressed elderly patients are admitted to a psychiatric unit).

107. See *supra* note 3.

below. First, however, one must determine the extent of a patient's rights under Florida law.

### B. *Florida Law*

The rights that the Florida Constitution, statutes, and case law grant to patients extend considerably beyond those provided by the United States Constitution and federal statutes, as interpreted by the United States Supreme Court.

#### 1. THE FLORIDA CONSTITUTION

The Florida Constitution provides that "[e]very natural person has the right to be let alone and free from governmental intrusion into his private life except as otherwise provided herein."<sup>108</sup> Although the United States Supreme Court found that no generalized privacy interest exists in the right to refuse medical treatment, Florida residents have a constitutionally guaranteed right to privacy that is broader than the right provided by the United States Constitution.<sup>109</sup> The Supreme Court of Florida has construed this provision to give Florida residents the right to refuse unwanted medical care subject to certain state interests.

#### 2. FLORIDA CASE LAW

No Florida court has published an opinion specifically addressing the right to refuse psychiatric treatment. Yet, Florida courts have addressed the right to refuse treatment in the context of general medical care in language broad enough to include the right to refuse psychiatric treatment.

The line of cases involving the right to refuse treatment began in 1978 with *Satz v. Perlmutter*.<sup>110</sup> Mr. Perlmutter was a competent elderly man who sought to have the hospital remove the artificial life support that was keeping him alive.<sup>111</sup> The court held that a competent, adult patient has the right to refuse or discontinue treatment based "upon the constitutional right to privacy . . . an expression of sanctity of individual free choice and self-determination."<sup>112</sup> The court limited this right based upon four state interests: (1) the preservation of life; (2) the protection of innocent third parties; (3) suicide prevention; and (4) the maintenance of the ethical integrity of the medical profession.<sup>113</sup>

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108. FLA. CONST. art. I, § 23 (amended 1980).

109. *Winfield v. Division of Pari-Mutuel Wagering*, 477 So. 2d 544, 548 (Fla. 1985).

110. 362 So. 2d 160 (Fla. 4th DCA 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980).

111. *Id.* at 161.

112. *Id.* at 162 (quoting *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 426 (Mass. 1977)).

113. *Id.* at 162.

In discussing the state's interest in preserving life, the court distinguished between curable and incurable afflictions.<sup>114</sup> The court based its decision on the fact that Mr. Perlmutter's situation was terminal.<sup>115</sup> It construed the protection of innocent third parties as generally involving a patient's minor children.<sup>116</sup>

The court differentiated Mr. Perlmutter's intent from suicide by noting that "a death producing agent" would not be the cause of his death; the fulfillment of his request would lead to his natural death.<sup>117</sup> The court also found it significant that Mr. Perlmutter's basic wish was to live and that he did not self-induce his affliction.<sup>118</sup> Importantly, the court did not limit its discussion to the removal of a life-prolonging device, but included the refusal of a positive step, such as surgery or chemotherapy, to prolong a hopeless situation.<sup>119</sup>

The ethical integrity of the medical profession and the ability of hospitals effectively to care for their patients were the last state interests the court considered. The court reasoned that prevailing medical ethics recognized the right to refuse necessary medical treatment under circumstances such as these.<sup>120</sup> More importantly, the court went on to say that "if the doctrines of informed consent and right of privacy have as their foundations the right to bodily integrity . . . and control of one's own fate, then those rights are superior to the institutional considerations."<sup>121</sup> This statement begins the court's erosion of the state's interest in the ethical integrity of the medical profession as a consideration.

The next case in this line, *John F. Kennedy Hospital v. Bludworth*,<sup>122</sup> extended the right to refuse treatment to incompetent, terminally ill patients on artificial life support.<sup>123</sup> The court carefully framed its discussion, however, to exclude situations where the patient's life could be saved.<sup>124</sup> The importance of this case is the holding that court approval prior to terminating life support is not necessary and "could render the right of the incompetent a nullity."<sup>125</sup> The court went on to hold that the patient's family or guardian, under the substituted judg-

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114. *Id.*

115. *Id.*

116. *Id.*

117. *Id.*

118. *Id.* at 163.

119. *Id.*

120. *Id.*

121. *Id.* at 163-64 (quoting *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 427 (Mass. 1977)).

122. 452 So. 2d 921 (Fla. 1984).

123. The patient in this case had a "Mercy Will and Last Testament" indicating the patient's desire not to be kept alive by means of artificial life support. *Id.* at 922.

124. *Id.* at 924.

125. *Id.* at 925.

ment doctrine, could exercise this right.<sup>126</sup> The court recognized living wills as persuasive evidence of the patient's intent and stated that they "should be given great weight" by the person exercising substituted judgment.<sup>127</sup>

The Supreme Court of Florida further expanded the right to refuse medical treatment to competent patients on artificial life support systems who are not terminally ill. In *Wons v. Public Health Trust of Dade County*,<sup>128</sup> the court considered the case of a Jehovah's Witness who refused a life-saving blood transfusion.<sup>129</sup> In discussing the state's interest in preserving life, the court reaffirmed the right to refuse medical treatment "regardless of whether [the patient's] refusal to do so arises from fear of adverse reaction, religious belief, recalcitrance or cost."<sup>130</sup> Mrs. Wons had two minor children, and thus the court found it necessary to consider the interests of innocent third parties under the state's *parens patriae* power. It determined that, because there were other family members willing to care for the children, they were not being abandoned and that the state's interest was not sufficiently compelling to override Mrs. Wons' constitutional rights.<sup>131</sup>

The court's opinion expresses the ethical underpinnings of the right to refuse medical treatment in very broad language:

Running through all of these decisions . . . is the courts' deeply imbedded belief, rooted in our constitutional traditions, that an individual has a fundamental right to be left alone so that he is free to lead his private life according to his own beliefs free from unreasonable governmental interference. Surely nothing, in the last analysis, is more private or more sacred than one's . . . view of life, and here the courts, quite properly, have given great deference to the individual's right to make decisions vitally affecting his private life according to his own conscience. *It is difficult to overstate this right because it is, without exaggeration, the very bedrock on which this country was founded.*<sup>132</sup>

The broadest right to refuse treatment is found in the recent case of

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126. *Id.* at 926. The court defined substituted judgment as a situation where the family member or guardian substitutes her judgment for what she believes the patient, if competent, would have done under the circumstances. *Id.*

127. *Id.*

128. 500 So. 2d 679 (Fla. 3d DCA 1987), *aff'd*, 541 So. 2d 96 (Fla. 1989).

129. *Id.* at 680. The trial court ordered the hospital to administer the blood, and Mrs. Wons survived the illness. *Id.* at 683. The appellate court determined that the case was not moot because it was a recurring issue that would otherwise escape review. *Id.* at 684.

130. *Id.* at 685 (quoting *St. Mary's Hosp. v. Ramsey*, 465 So. 2d 666, 668 (Fla. 4th DCA 1985)).

131. *Wons*, 541 So. 2d at 97. The Supreme Court of Florida recently reaffirmed this holding. *In re Dubreuil*, 629 So. 2d 819 (Fla. 1993).

132. *Wons*, 500 So. 2d at 686-87 (emphasis added).

In re *Guardianship of Browning*.<sup>133</sup> The court held that the guardian of an incompetent patient suffering from an incurable, but not terminal, condition may exercise the patient's right of self-determination by refusing life-sustaining treatment.<sup>134</sup> The court reasoned that by "[r]ecognizing that one has the inherent right to make choices about medical treatment, we necessarily conclude that *this right encompasses all medical choices*. A competent individual has the constitutional right to refuse medical treatment *regardless* of his or her medical condition."<sup>135</sup> In holding that this right includes all relevant decisions about one's health, the court noted that no reason exists to qualify the right based on type of medical procedure—that is, whether the procedure is life-prolonging, life-maintaining, or life-sustaining.<sup>136</sup> In fact, the court quoted a passage from *Bouvia v. Superior Court*<sup>137</sup> in which the Court of Appeals of California reasoned that the individual's perception of the quality of her life overrides any physician's estimate of the remaining quantity of her life.<sup>138</sup>

The court went on to discuss the four state interests identified in *Satz*.<sup>139</sup> It began by stating that "[t]he state has a duty to assure that a person's wishes regarding medical treatment are respected."<sup>140</sup> The court's discussion of the state's interest in preserving life (which it called the strongest interest) somewhat contradicts its earlier discussion of the breadth of the right to refuse treatment as well as its decision in *Wons*. The court implied that the state has a greater interest if the patient's disease is curable than if it is not. The court may be retreating from its earlier position. But, given the very strong terms it used in granting a broad right to refuse treatment and its use of *Bouvia*, this is not likely. In any event, this possible limitation is irrelevant to the present discussion because schizophrenia is not generally considered to be curable.<sup>141</sup>

The court added nothing to its doctrine on the interests of innocent third parties or suicide. It essentially eliminated the maintenance of the

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133. 568 So. 2d 4 (Fla. 1990).

134. *Id.* at 7-8. Mrs. Browning had a living will refusing artificial, life-prolonging treatment including artificial feeding if she developed a terminal condition. *Id.* at 8. After suffering a stroke, she was artificially fed by a nasogastric tube (a feeding tube inserted through the nose directly into the stomach) that the nursing home in which Mrs. Browning was living refused to discontinue. *Id.* Mrs. Browning's guardian filed a court petition to have the tube removed. *Id.*

135. *Id.* at 10 (emphasis added).

136. *Id.* at 11 n.6.

137. 225 Cal. Rptr. 297 (Cal. Ct. App. 1986).

138. *Browning*, 568 So. 2d at 10-11 (quoting *Bouvia*, 225 Cal. Rptr. at 304-05).

139. *Id.* at 13-14; see *supra* text accompanying notes 110-21.

140. *Browning*, 568 So. 2d at 13.

141. See *supra* note 60 and accompanying text.

ethical integrity of the medical profession as a legitimate state interest.<sup>142</sup> This is significant because that interest is frequently cited in discussions of treatment refusal in a psychiatric context<sup>143</sup> and is mentioned specifically in the Health Care Advance Directives Act.<sup>144</sup>

Finally, the *Browning* court discussed the procedures for decision making. The court reaffirmed its earlier position that a judicial proceeding is not necessary.<sup>145</sup> Further, the court recognized that not all patients will appoint surrogates to carry out their written instructions and held that, in those cases, a close family member or friend may do so.<sup>146</sup> Although at first glance this appears to be a minor point, it is not because Florida's current advance directive statute does not specifically provide for written instructions without an appointed surrogate except in a decision concerning the artificial prolongation of life.<sup>147</sup>

In *re Dubreuil* is the most recent Supreme Court of Florida case regarding the right of a competent individual to refuse unwanted medical care in a non-terminal situation.<sup>148</sup> Although the primary holding of this case merely reaffirms *Wons*, the court's language in getting to that point may be its broadest yet.<sup>149</sup>

The court not only opined that the state must not interfere with a person's health care decisions, it went further and asserted that "[t]he state has a duty to assure that a person's wishes regarding medical treatment are respected."<sup>150</sup> Discussing the hospital's role when a third party questions the patient's wishes, the court reasoned that "a health care provider's function is to provide medical treatment in accordance with the patient's wishes and best interests, not as a 'substitute parent' supervening the wishes of a competent adult. Accordingly, a health care provider must comply with the wishes of a patient to refuse medical treatment unless ordered to do otherwise by a court of competent jurisdiction."<sup>151</sup> In this regard, the court receded from its holding in *Wons* by placing the burden on the state to assert its interests where the state

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142. The court called this interest the "least significant" and reasoned that "the ethical integrity of the medical profession alone could never override [constitutional] rights." *Browning*, 568 So. 2d at 14 (quoting *Public Health Trust of Dade County v. Wons*, 541 So. 2d 96, 101 (Fla. 1989) (Ehrlich, C.J., concurring)).

143. See *supra* text accompanying notes 41-42.

144. See *infra* text accompanying note 168.

145. *In re Guardianship of Browning*, 568 So. 2d 4, 15.

146. *Id.* at 15 n.15.

147. See *infra* text accompanying notes 159-63.

148. 629 So. 2d 819 (Fla. 1993).

149. *Id.*

150. *Id.* at 822 (quoting *In re Guardianship of Browning*, 568 So. 2d 4, 13-14).

151. *Id.* at 823.

chooses to intervene rather than the hospital.<sup>152</sup>

In summary, a competent adult in Florida has the right to refuse medical treatment for essentially any reason regardless of whether his condition is terminal. This right also applies to incompetent patients who, while competent, expressed their wishes in writing or appointed a surrogate to speak for them. The state has three, arguably four, interests that, depending on the facts, may override the patient's wishes: preserving life (weakened by the courts' decisions almost to the point of nonexistence); protecting innocent third parties; preventing suicide; and, arguably, maintaining the ethical principles of the medical profession (again, so weakened as to be of questionable significance).<sup>153</sup>

One could make a compelling argument based on this line of cases alone that a competent individual has the right to have a mental health advance directive followed during periods of incompetency. It is not necessary to make this argument, however, because statutory law goes further in defining this right.

### 3. FLORIDA STATUTES

Florida statutory law further undergirds a patient's broad rights of self-determination. One of the basic rights given to all hospital patients in Florida is the right to refuse any treatment.<sup>154</sup>

#### a. Health Care Advance Directives Act<sup>155</sup>

The Advance Directives Act simplified the invocation of the right to refuse treatment. The Advance Directives Act provides for an individual, referred to as the principal,<sup>156</sup> to designate a health care surrogate to make health care decisions for the principal upon a determination that the principal is incapacitated.<sup>157</sup> The designation, which must meet certain formalities required by the statute, may include specific instructions for the surrogate to follow.<sup>158</sup> The Advance Directives Act does not provide specifically for the use of written advance instructions without

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152. *Id.* If the provider wishes to circumvent the patient's wishes, it must notify the state's attorney who then has the discretion to seek court intervention or not. *Id.*

153. See *infra* text accompanying notes 227-38 for a discussion of how these state interests affect the use of mental health advance directives.

154. FLA. STAT. § 381.026 (1993) (also providing that the right may be limited by other laws).

155. *Id.* § 765.

156. "'Principal' means a competent adult executing an advance directive and on whose behalf health care decisions are to be made." *Id.* § 765.101(14).

157. *Id.* § 765.202. Florida's "durable" power of attorney act provides that the power is revoked if the donor is adjudged incompetent after the power is granted. *Id.* § 709.08(2). It is, therefore, not durable enough to assist mental health patients in determining the course of their care while incompetent.

158. *Id.* § 765.203.



the appointment of a surrogate.<sup>159</sup> But it does provide for a proxy who can make health care decisions for the principal if she has not executed an advance directive or did not designate a surrogate.<sup>160</sup> The Advance Directives Act defines who the proxy will be in a priority order, beginning with the principal's court-appointed guardian and then moving through her family and friends.<sup>161</sup> The proxy is required to base his decisions on what he reasonably believes the patient would have decided under the circumstances.<sup>162</sup> This implies that the Advance Directives Act requires the proxy to follow the instructions in the advance directive, thereby indicating that the legislature anticipated advance directives without designated surrogates. Furthermore, the holding of *Browning* requires this result.<sup>163</sup>

In accord with the PSDA, the Advance Directives Act requires that health care facilities<sup>164</sup> supply each patient with information concerning her rights pertaining to advance directives in addition to relevant facility policies and inquire whether the patient has an advance directive.<sup>165</sup> Additionally, the facility is subject to fine and loss of licensure if it requires an individual to execute or revoke an advance directive as a condition of treatment.<sup>166</sup>

The legislature based the Advance Directives Act on its finding "that every competent adult patient has the fundamental right of self-determination regarding choosing or refusing medical treatment."<sup>167</sup> The right to decide is made subject to such societal interests as the "protection of human life and the preservation of ethical standards in the medical profession."<sup>168</sup>

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159. This is specifically addressed only in the context of a living will that applies to life-sustaining treatment. *Id.* § 765.303(2).

160. *Id.* § 765.401(1).

161. *Id.*

162. *Id.* § 765.401(2).

163. See *supra* text accompanying note 146.

164. This term includes hospitals licensed in Florida. FLA. STAT. § 765.101(7) (1993). The definition does not limit the term "hospital" to general medical hospitals.

165. *Id.* § 765.110(1).

166. *Id.* § 765.110(2); FLA. ADMIN. CODE ANN. r. 59A-3.190 (1993).

167. FLA. STAT. § 765.102(1) (1993).

168. *Id.* The legislature's choice in using these two specific interests is interesting, given how the courts have weakened them. The fact that the legislature enacted this statute after *Browning* may indicate that it specifically intended the courts to accord greater weight to these interests. How the courts will interpret this passage remains to be seen, but they must give greater deference to a constitutionally-protected fundamental right, which the Supreme Court of Florida has construed the right to refuse treatment to be, than a statement of legislative intent. *State ex rel. West v. Butler*, 69 So. 771 (Fla. 1915). Accordingly, the courts' position should not change. The Advance Directives Act's provisions are "cumulative to the existing law regarding an individual's right to consent, or refuse to consent, to medical treatment . . . ." FLA. STAT. § 765.106 (1993). This provision should inform interpretation of the legislature's finding that the state has an interest

The legislature's stated intent in passing the Advance Directives Act was to establish a procedure, less costly and less restrictive than a guardianship, that would "allow a person to plan for incapacity by designating another person to direct the course of his medical treatment upon his incapacity."<sup>169</sup> The Advance Directives Act defines "incapacity" and "incompetent" as "physically or mentally unable to communicate a willful and knowing health care decision."<sup>170</sup> A health care decision means, in relevant part, "[i]nformed consent, refusal of consent, or withdrawal of consent to *any and all* health care . . . ."<sup>171</sup> The Advance Directives Act does not define "medical care" or "health care"—a potentially significant omission.

There is no extrinsic indication whether the legislature intended the Advance Directives Act to apply to psychiatric treatment. Its structure and some of its language, however, make it reasonable to construe the Advance Directives Act as including psychiatric treatment. For example, it specifically applies to hospitalized (voluntary or involuntary) mental health patients with the capacity to make health care decisions.<sup>172</sup>

Structurally, the Advance Directives Act has separate provisions for advance directives covering life-prolonging procedures, namely living wills, and advance directives generally. Obviously, the legislature intended the Advance Directives Act to apply to more than end-of-life decisions. The legislature made this intent clear when it changed the name of the statute.<sup>173</sup>

The Advance Directives Act applies to "any and all" health care decisions.<sup>174</sup> The plain meaning of these words is certainly broad enough to encompass mental health care.<sup>175</sup> Furthermore, the Advance Directives Act prohibits the inference that because a patient is in a psychiatric hospital, voluntarily or involuntarily, the patient is incompetent.<sup>176</sup> This provision would not have been necessary if the legislature did not intend that advance directives be used in psychiatric hospitals.

The Advance Directives Act presumes that a principal is capable of

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in protecting human life and the ethical standards of the medical profession because it demonstrates an intent not to disturb previous court decisions such as *Browning*.

169. FLA. STAT. § 765.102(2) (1993).

170. *Id.* § 765.101(9).

171. *Id.* § 765.101(6)(a) (emphasis added).

172. *Id.* § 765.204(1) (prohibiting an inference of incapacity solely from a patient's voluntary or involuntary hospitalization).

173. The Advance Directives Act was formerly known as The Right to Decline Life Prolonging Procedures. The name changed in the 1993 Florida Statutes. *Id.* § 765.

174. See *supra* note 171 and accompanying text.

175. Florida's canons of statutory construction require consideration first of the plain meaning of the language. *St. Petersburg Bank & Trust Co. v. Hamm*, 414 So. 2d 1071, 1073 (Fla. 1982).

176. FLA. STAT. § 765.204(1) (1993).

making health care decisions unless she is found to be incapacitated. It then describes the procedure for rebutting this presumption.<sup>177</sup> This procedure requires the concurrence of two physicians, including the principal's attending physician.<sup>178</sup> Once the physicians determine that the patient is incapacitated, the surrogate must be notified in writing.<sup>179</sup> The surrogate then has the authority to act for the principal pursuant to the principal's instructions until a determination is made that the principal has regained capacity.<sup>180</sup> This provision appears to contemplate the use of advance directives in a psychiatric context in which individuals move in and out of competency. Presumably, although it is not mentioned, a court's finding of incompetency under the relevant sections of the Florida Mental Health Act<sup>181</sup> or the Guardianship statute<sup>182</sup> would also trigger the advance directive. The Advance Directives Act provides that if a court appoints a guardian of the principal's property or person after a surrogate has been designated, the surrogate continues to be responsible for making health care decisions.<sup>183</sup>

The Advance Directives Act allows the principal to revoke an advance directive or appointment of a surrogate at any time.<sup>184</sup> The revocation may be written, oral, or by physical destruction of the written document.<sup>185</sup> The Advance Directives Act, however, does not require that the principal be competent when she revokes her advance directive.

This omission poses a potential problem for the use of advance directives by psychiatric patients because, once again, the possibility exists that physicians and hospital staff will coerce the patient.<sup>186</sup> This is especially true when an involuntary patient is dependent upon her physician's recommendation that she be discharged.<sup>187</sup> One way to resolve this problem of coercion is to require that a patient be competent (as measured by the same standard required for execution of an advance directive) for a revocation to be valid. The legislature could make this change, but legal precedent also supports this argument without such legislation.

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177. *Id.* § 765.204(2).

178. *Id.*

179. *Id.*

180. *Id.* § 765.204(2) & (3).

181. *Id.* § 394.467(3)(c).

182. *Id.* § 744.331.

183. *Id.* § 765.205(3).

184. *Id.* § 765.104(1).

185. *Id.*

186. See *supra* text accompanying note 3. Patient advocates in Florida who are educating mental health patients about advance directives have found that many patients are reluctant to execute the directives out of fear that physicians will not treat them. Telephone Interview with Joanie Halberg, Mental Health Assoc. of Dade County, Fla. (Mar. 14, 1993).

187. See MURPHY, *supra* note 1, at 187-88.

In Florida, an individual must be competent to revoke a will.<sup>188</sup> The formalities required for an advance directive are similar to a will.<sup>189</sup> Furthermore, both are designed to give effect to the maker's intent when the maker cannot. Requiring capacity to revoke an advance directive furthers the same policy as the requirement of capacity to revoke a will. So doing would reinforce the patient's right to refuse treatment.<sup>190</sup>

Finally, the Advance Directives Act includes a provision that allows a "patient's family, the health care facility, . . . the attending physician, or any other interested person" to seek judicial intervention in the surrogate's decision.<sup>191</sup> The party requesting judicial intervention must believe that the surrogate's decision is not in accord with the patient's wishes or the Advance Directives Act; that the advance directive is ambiguous or that the patient changed her mind; or that the surrogate was improperly designated or the designation is no longer effective.<sup>192</sup> These limited justifications for intervention clearly indicate that disagreement with the patient's decision, or a third party's concern about the consequences to the patient, are not sufficient for judicial intervention.

#### b. The Florida Mental Health Act<sup>193</sup>

Florida's Mental Health Act establishes the rights of all civil patients<sup>194</sup> in psychiatric hospitals as well as the criteria and procedures for involuntary hospitalization, examination, and treatment. In enacting

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188. *Tonnellier v. Tonnellier*, 181 So. 150, 151 (1938) (revocation requires the same capacity as execution).

189. A testator must sign the will in the presence of two attesting witnesses. FLA. STAT. § 732.502(1) (1993). Similarly, the principal must sign the advance directive in the presence of two attesting witnesses. *Id.* § 765.202(1).

190. Requiring competency to revoke would not prevent the physician from coercing a patient to consent to treatment. In fact, the physician may have incentive to find that a patient is competent to revoke an advance directive so that she could then coerce the patient into consenting to unwanted treatment. Ultimately, the solution to this problem may become more obvious after continued experience with the use of advance directives in this context and third-party monitoring.

191. FLA. STAT. § 765.105 (1993).

192. *Id.*

193. *Id.* §§ 394.451 - 394.4789.

194. The topic discussed in this Comment is relevant to forensic psychiatric patients, but its application in that context is beyond the scope of this Comment. These patients are individuals involved with the mental health system as a result of some action of the criminal court, such as evaluation or treatment for competency to stand trial or a trial court finding of insanity. It is interesting that when a forensic patient refuses treatment and no emergency exists, treatment can be administered by court order only. The court must use substituted judgment in these circumstances and must consider the patient's expressed preferences, the probability of adverse side effects, the prognosis without treatment, and the prognosis with treatment. *Id.* § 916.107(3). Arguably, this statute provides greater protection to the forensic patient than the civil patient. No such requirements exist for the guardian advocate appointed to make treatment decisions for the civil patient. See *infra* text accompanying notes 214-15.

the Mental Health Act, the legislature purported to ensure that "individual dignity and human rights be guaranteed to all persons admitted to mental health facilities or being detained [for involuntary examination]." <sup>195</sup> Another important aspect of legislative intent is that "the least restrictive means of intervention be employed based on the individual needs of each patient . . . ." <sup>196</sup>

The Mental Health Act provides that "[n]o person who is receiving treatment for mental illness in a facility shall be deprived of any constitutional rights." <sup>197</sup> This clause is limited to the extent that general law limits the rights of any individual adjudicated incompetent. <sup>198</sup> The *Browning* decision held that the Florida Constitution gives incompetent patients the right to refuse treatment through either a surrogate or written instructions. <sup>199</sup> Thus, the right to privacy and its subordinate right to refuse medical treatment survive psychiatric hospitalization and incompetence. The state's *parens patriae* and police powers may trump these rights. <sup>200</sup>

The Mental Health Act also requires that each patient entering a facility be asked to give express and informed consent to treatment and admission. <sup>201</sup> It further requires that when a voluntary patient refuses to consent or revokes consent he must be discharged within three days unless he meets the criteria for involuntary admission, in which case commitment proceedings must be initiated within those three days. <sup>202</sup> The PSDA limits the applicability of this provision when a patient has an advance directive. The PSDA prohibits discrimination by hospitals against patients with advance directives. <sup>203</sup> Certainly situations could arise in which a patient so restricts the hospital that there would be nothing that the hospital could do for the patient. Other, less limiting cases could arise as well. For example, a patient's advance directive or surrogate could refuse a specific medication, but this would not prevent the

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195. FLA. STAT. § 394.453(1)(a) (1993).

196. *Id.*

197. *Id.* § 394.459(1). The term "facility" includes all hospitals designated for the evaluation, diagnosis, care, treatment, training, or hospitalization of the mentally ill. This includes private facilities. *Id.* § 394.455(6).

198. *Id.* § 394.459(1) (stating that "if such a person is adjudicated incompetent . . . his rights may be limited to the same extent the rights of any incompetent person are limited by general law.").

199. See *supra* text accompanying notes 133-53.

200. See *supra* notes 48-54 and accompanying text.

201. FLA. STAT. § 394.459(3)(a) (1993) (applying only to competent patients).

202. *Id.* § 394.459(3)(a). The language of the statute seemingly allows a hospital to discharge a patient with an advance directive when he becomes incompetent during his stay if he does not meet the standard for involuntary treatment and his advance directive refuses some or all treatment.

203. See *supra* text accompanying note 93.

use of other medications or other treatment modalities. The PSDA's nondiscrimination provision should prevent the hospital from refusing to admit or to continue to treat the patient simply because the patient limits the hospital's treatment choices where other viable treatments remain.

When a patient refuses treatment and is held pending involuntary commitment proceedings, the Mental Health Act allows the hospital to render the least restrictive<sup>204</sup> emergency treatment available, without judicial intervention, to any patient who refuses treatment if the hospital determines that treatment is necessary for the safety of the patient or others.<sup>205</sup> If the refused treatment is "essential to appropriate care for the patient" then the hospital administrator must petition for a hearing to determine whether the patient is competent to consent for himself.<sup>206</sup>

The key issue here involves determining the type of emergency that will allow the hospital to override the patient's advance directive. A hospital could legitimately exercise police power to protect third parties from danger.<sup>207</sup> As previously stated, however, the hospital must use any available, acceptable alternative to the refused treatment.<sup>208</sup>

The analysis changes when the patient's well-being is at stake in the emergency. The patient must be considered the judge of what is best for her. The hospital should follow her instructions or those of her surrogate because the advance directive tends to further the patient's values and wishes. To do otherwise would be to undermine the notion of self-determination that advance directives protect. In an analogous situation involving an individual's physical health, this issue probably would not even arise because few people would question the validity of the advance directive for the physically infirm.

The Mental Health Act also grants the patient the right to two representatives if the patient lacks a guardian.<sup>209</sup> The representatives receive notice when the patient is involuntarily admitted to the hospital or the hospital files a petition to change the patient's voluntary status to

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204. See *supra* text accompanying note 55 for a discussion of the least restrictive treatment requirement and the use of advance directives.

205. FLA. STAT. § 394.459(3)(a) (1993).

206. *Id.* The statute does not define "appropriate care." Because the administrator must take action in the circumstances described, it is reasonable to infer that the statute refers to care for the patient in an "administrative" context rather than a safety context. That is, the facility's best interests may be the consideration rather than the patient's best interests. This understanding would explain the additional procedural safeguards the statute requires.

207. See Parry, *supra* note 13, at 474; *supra* text accompanying notes 52-54. This assumes that a hospital's use of the state's police power will be legitimate. This assumption surely overstates reality.

208. See *supra* text accompanying note 55.

209. FLA. STAT. § 394.459(12)(a) (1993). The patient may designate one representative, and the facility designates the other (or both if the patient fails to designate the first) according to statutory listing of next of kin in the order the state prefers. *Id.* § 394.459(12)(b).

involuntary.<sup>210</sup> The ability to designate a representative is important because, presumably, the patient may designate her health care surrogate as her representative to ensure that the surrogate is informed of her admission and ongoing status.

The requirements for involuntary examination and involuntary hospitalization implicate the extent to which the patient can determine the treatment she receives. The relevant portions of these standards are essentially the same: (1) the patient has refused voluntary examination or treatment or is unable to determine for herself whether examination or treatment is necessary; and (2) without care or treatment she is likely to neglect herself and this neglect poses a real threat of substantial harm to her well being; or there is a substantial likelihood that without care or treatment she will cause serious bodily harm to herself or others.<sup>211</sup>

Although the determination of the patient's competency to consent to treatment is a separate decision from that to commit her, a court makes them concurrently.<sup>212</sup> According to this section, "a patient is incompetent to consent to treatment if his judgment is so affected by his mental illness that he lacks the capacity to make a well-reasoned, willful, and knowing decision concerning treatment."<sup>213</sup> If the court finds that the patient is incompetent to consent to treatment, it must appoint a guardian advocate<sup>214</sup> to act on the patient's behalf in providing informed consent.<sup>215</sup>

The competency standard used by the Mental Health Act slightly differs from the one used in the Advance Directives Act. The Mental Health Act bases its standard on the patient's *ability to make* a decision;<sup>216</sup> the Advance Directives Act bases its standard on *communicating* the decision.<sup>217</sup> In practice, the difference is irrelevant because the

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210. *Id.* § 394.459(12)(a).

211. *Id.* §§ 394.463(1), 394.467(1).

212. *Id.* § 394.467(3)(c). This is consistent with the Health Care Advance Directives Act's provision that voluntary or involuntary psychiatric hospitalization does not imply that the patient lacks capacity. See *supra* text accompanying note 176.

213. FLA. STAT. § 394.459(3)(a) (1993).

214. A guardian advocate's sole responsibility is the "custody and control of the patient's competence to consent to treatment." *Id.* § 394.455(15).

215. Dade County, Florida's largest county, has four guardian advocates for county residents who are hospitalized and adjudicated incompetent. A court appoints guardian advocates only when patients refuse treatment. Notably, guardian advocates consent to treatment at least ninety-nine percent of the time. Telephone Interview with Judge Lewis Kimler, General Master, Dade County, Fla. Probate Court (Mar. 17, 1993). The court instructs guardian advocates to consider the patient's wishes but then to decide using a best interest standard. Judge Kimler has not been faced with an advance directive, but if he were, he would consider it without feeling bound by it because the statute does not specifically address mental health advance directives. *Id.*

216. See *supra* note 213 and accompanying text.

217. See *supra* note 170 and accompanying text.

ability to make a decision is meaningless without the *ability to communicate it*.<sup>218</sup> This discrepancy, therefore, should not create a problem in implementing advance directives in the mental health context.

Another difference that may create a legal issue regarding whether to extend advance directives to the mental health field is in the procedures required to determine capacity. The Mental Health Act requires a judicial decision, but the Advance Directives Act requires a medical decision.<sup>219</sup> The Advance Directives Act's procedure appears to be based on the *Browning* decision holding that judicial determination is unnecessary.<sup>220</sup> This does not mean that a judicial determination would be ineffective. The competency hearing under the Mental Health Act will develop the same evidence that physicians use under the Advance Directives Act. The patient, therefore, would receive the same, if not greater, due process. Accordingly, the differing procedures for determining capacity should not counsel against mental health patients using advance directives.

#### c. Electroconvulsive and Psychosurgical Procedures<sup>221</sup>

The statute governing electroconvulsive and psychosurgical procedures requires the patient's or guardian's written informed consent before procedures may be administered.<sup>222</sup> It does not make an exception for emergency treatment, and thus the right to refuse these treatments is absolute. The patient's absolute right to refuse does not, however, imply that an incompetent patient's guardian advocate may not consent if she believes this treatment is in the patient's best interest. An advance directive should be given effect in this situation because the legislature has placed the decision solely within the patient's discretion.

### V. MENTAL HEALTH ADVANCE DIRECTIVES IN FLORIDA

The Florida Constitution, cases, and statutes, along with the Patient Self-Determination Act, combine to provide a solid basis that supports the use of mental health advance directives. The Florida Constitution and case law grant broad rights of self-determination to patients. Even

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218. For an interesting discussion of the role of communication in competency proceedings, see Susan Stefan, *Silencing the Different Voice: Competence, Feminist Theory and Law*, 47 U. MIAMI L. REV. 763 (1993). The author wishes to express his gratitude to Professor Stefan for her invaluable guidance and support.

219. See *supra* text accompanying notes 177-90, 212.

220. See *supra* text accompanying note 146.

221. FLA. STAT. § 458.325 (1993).

222. *Id.* § 458.325(1). The patient or guardian must be informed of the procedure's purpose, its common side effects, alternate treatments, the approximate number of procedures considered necessary, and the patient or guardian may revoke consent prior to or between treatments.



without the Advance Directives Act, the Supreme Court of Florida has found that an equivalent right to self-determination exists under the Florida Constitution.<sup>223</sup> The court has interpreted the right to refuse treatment in broad terms<sup>224</sup> and held that almost any reason or no reason would be sufficient to exercise this right.<sup>225</sup> Furthermore, the court has extended this right to all medical decisions, regardless of the type of procedure or its purpose.<sup>226</sup>

As previously noted, the Supreme Court of Florida made these rights subject to four state interests. The first is the preservation of life. Courts have subordinated this interest, however, to the individual's right of self-determination.<sup>227</sup> This same reasoning should apply to mental health patients and their treatment. Allowing this, however, would conflict with the Mental Health Act. As already noted, it allows a patient to be involuntarily hospitalized if the patient's safety or well-being is threatened.<sup>228</sup> This use of the state's *parens patriae* power directly opposes the patient's right of self-determination.

The psychiatric patient's situation is clearly analogous to a situation where a Jehovah's Witness refuses a blood transfusion. In both cases the patient may have no underlying terminal condition, yet her treatment refusal may lead to her death or disability. Application of the state's *parens patriae* power could conceivably prevent harm in either case. The Supreme Court of Florida held in *Wons*, a blood transfusion refusal case, that a patient's privacy right is superior to the state's interest in preserving life.<sup>229</sup> The result should be no different for psychiatric patients. Arguably, to the extent that the Mental Health Act utilizes the state's *parens patriae* power, it is unconstitutional in light of *Wons* and *Browning*.<sup>230</sup>

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223. See *supra* text accompanying notes 110-47.

224. See *supra* text accompanying note 153.

225. See *supra* text accompanying note 130.

226. See *supra* text accompanying note 136.

227. See *supra* text accompanying notes 128-38.

228. See *supra* text accompanying note 211.

229. See *supra* text accompanying notes 128-32. If the court had used freedom of religion as the basis of its decision, one could distinguish *Wons* on that basis. The court, however, did not choose to do so. Additionally, if the state has no interest, without more, in *life* itself, it surely has no interest in the individual's *quality* of life. Arguably, it is economically inefficient to allow psychiatric patients to remain untreated because such patients may be unproductive; they also may be unproductive *with* treatment. Certainly, treatment itself is costly.

230. As far as I know, no one has developed this radical argument. A commitment based on danger to others, however, is not different from many other health care situations where treatment could help a patient who refuses to seek care. For example, the state would presumably not forcibly treat an individual with cancer or heart disease. Query whether there is a principled way to constitutionally distinguish between such situations. Unfortunately, it is beyond the scope of this Comment to do so.

The state's second interest is in the protection of innocent third parties. Courts generally consider this interest in relation to a patient's minor children.<sup>231</sup> In the mental health context, however, one could raise this issue in relation to protection of members of society generally and of other patients and hospital staff specifically.<sup>232</sup>

As this interest relates to the patient's minor children, the Supreme Court of Florida held in *Wons* that where there is an alternative source of care for the child, such as a spouse or other family members, the state's interest does not override the patient's rights.<sup>233</sup> This same reasoning applies to mental health patients. The Mental Health Act's use of the state's police power to protect society from dangerous individuals or to protect other patients and staff within the hospital falls within this same state interest although it may trump a patient's right of self-determination to some extent.<sup>234</sup>

The third state interest is prevention of suicide. The courts differentiate the right-to-die cases from suicide by pointing to the fact that in right-to-die cases, it is the patient's underlying disease that would be the cause of death and not an extraneous agent. Unlike suicide, the patient in right-to-die cases has no independent wish to die.<sup>235</sup> The state could argue that when a psychiatric patient refuses treatment and is unable or unwilling to care for herself to the extent that her life is threatened, then she is, in effect, committing suicide. One could counter this argument by pointing out that the underlying disease is actually placing the psychiatric patient's life at risk and that this disease is not self-inflicted. Furthermore, the patient probably would prefer to live a happy life, but the quality of her life may be unacceptable as a result of her underlying disease. As already noted, the individual's perception of her quality of life overrides outside concerns about her quantity of life.<sup>236</sup>

The Supreme Court of Florida held that the final state interest is maintenance of the ethical integrity of the medical profession and that the institutional concerns this interest raises are subordinate to the patient's right to privacy.<sup>237</sup> The Advance Directives Act also pays homage to this interest. In light of the constitutional basis of a patient's right to privacy, however, the privacy right trumps any statement of legislative intent.<sup>238</sup>

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231. See *supra* text accompanying note 116.

232. In other words, use the state's police power. See *supra* text accompanying notes 52-54.

233. See *supra* text accompanying note 131.

234. See *supra* text accompanying notes 52-55.

235. See *supra* text accompanying notes 117-18.

236. See *supra* text accompanying note 138.

237. See *supra* text accompanying notes 120-21.

238. See *supra* note 168.

Combining the strength of this constitutionally-based case law with the rights granted by the Advance Directives Act in language clearly broad enough to include mental health, the right of mental health patients in Florida to use advance directives is clear. No state interest, other than protection of third parties that deals with control rather than treatment, is paramount over the individual's right to self-determination.

Practical concerns exist that could inhibit mental health patients from fully realizing their rights.<sup>239</sup> The first hurdle is to establish competency at the time the patient executes the advance directive. This should not be a concern because the law presumes individuals to be competent until adjudicated or determined incompetent.<sup>240</sup> This means, therefore, that the law should presume an advance directive valid unless contrary evidence is sufficient to rebut this presumption. Concerns about this issue arise in the mental health context only because of the stereotypes associated with mental illness.<sup>241</sup>

Another potential problem is the method used to inform a facility of the existence of an advance directive when a patient is involuntarily admitted and not able to communicate this fact.<sup>242</sup> The state could develop a centralized computer filing system that could keep advance directives submitted by potential patients. State hospitals could access this database whenever a patient is admitted and the patient is not able to provide the information. Also, patients who routinely go to the same hospitals or mental health clinics could give those facilities copies of their advance directives for the institutions' records. The patient also could give a copy to her surrogate or to a patient advocacy group that might become aware of her hospitalization. Finally, the patient could carry a wallet-size copy.

To deal with the potential for coercion if hospital personnel fulfill the requirements of the PSDA, outside ombudsmen, patient advocates, or legal aid groups could be used to inform patients of their rights and to

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239. This Comment addresses some of the more difficult implementation problems, although it is beyond its scope to develop a detailed implementation plan.

240. FLA. STAT. § 765.204(1) (1993).

241. *See supra* text accompanying notes 27, 52. The Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C.A. § 12101 (West Supp. 1993) may protect psychiatric patients from the effects of this type of stereotyping. In passing the ADA, Congress found that discrimination persists in institutional and health services and that individuals with disabilities encounter discrimination in the form of overprotective rules and policies, among others. *Id.* § 12101(a). "Disability" includes "mental impairments." *Id.* § 12102(2)(A). Arguably, the ADA's coverage is broad enough to protect psychiatric patients from discrimination in implementing patients' advance directives.

242. These concerns are addressed to medically indigent patients who must rely on the state's mental health system. Private patients, while still subject to coercion, will usually not face these practical concerns because they can give a copy of their advance directives to their physicians and to the hospitals in which their physicians practice.

assist patients who wish to execute an advance directive. These same groups could be called in to verify a patient's intent to revoke an advance directive. This would ensure that the patient's execution or revocation of an advance directive is voluntary and that the patient has the requisite capacity.

## VI. CONCLUSION

Although one can distinguish the defining a patient's right to privacy from mental health cases by the fact that the privacy right cases do not arise in a psychiatric context, there is a principled way to make this argument. No statute can take away a patient's constitutional rights. In fact, the Mental Health Act specifically grants the right to refuse treatment.<sup>243</sup> Certainly the state has the power to control individuals in order to protect third parties, but this power emanates from a very different moral basis than the state's *parens patriae* power. Paternalism long ago lost its dominant role as the basis for determining a patient's right to control her own health care. No basis exists for it to remain dominant in the *mental* health context.

One obvious alternative that would avoid any question of the applicability of advance directives to mental health patients is the enactment of a statute that specifically provides this right, such as Minnesota's.<sup>244</sup> This solution has the drawback of "ghettoizing" mental health patients as a separate class.<sup>245</sup>

The Massachusetts approach, which defines health care decisions to include mental health treatment decisions, is preferable.<sup>246</sup> This, however, may not be politically feasible. The best assurance of the right to execute mental health advance directives, therefore, may be a Supreme Court of Florida decision holding that an individual's right to privacy as determined in such cases as *Wons* and *Browning* constitutionally mandates acceptance of mental health advance directives.

Certainly there are drawbacks associated with the use of mental health advance directives. Probably the most significant concern is an individual's ability to anticipate future circumstances and to account for

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243. See *supra* text accompanying notes 201-02.

244. See *supra* note 81.

245. Minnesota used a separate statute because it was not politically feasible to include this right in the state's living will statute. Supporters of the right of mental health patients to use advance directives preferred a unified statute. Even with the separate statute, however, judges look for ways to avoid the advance directive and order treatment against the patient's wishes. Telephone Interview with Kathy Kosnoff, Staff Attorney, Minnesota Mental Health Law Project (Jan. 14, 1993).

246. See *supra* note 81.

all contingencies.<sup>247</sup> One can use that same argument against all advance directives, however, and it has no special force when applied to mental health advance directives. If that argument is valid, the appropriateness of the general concept of advance directives is suspect. One may never account for every contingency when making any decision—the same is true with advance directives. But as long as society believes that self-determination is a value worth protecting, no principled method exists to distinguish between general medical treatment and psychiatric treatment.

Applying advance directives in a psychiatric treatment context preserves the right of self-determination for the incompetent psychiatric patient. These individuals cannot always rely on family or friends to ensure that their wishes are fulfilled. Psychiatric patients are frequently in an adversarial position with the hospital that is “treating” them. Even if family or friends attempt to carry the patient’s banner, courts often thwart this effort, frequently at the hospital’s behest. Advance directives, therefore, may be the only way to preserve the patient’s right to self-determination. The Florida Constitution and statutes and courts’ interpretation of them clearly support the use of advance directives by Florida mental health patients to control their psychiatric treatment.

LESTER J. PERLING

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247. Appelbaum, *supra* note 79, at 983.