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## Unreasonable: Involuntary Medications, Incompetent Criminal Defendants, and the Fourth Amendment

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# Unreasonable: Involuntary Medications, Incompetent Criminal Defendants, and the Fourth Amendment

DORA W. KLEIN\*

## TABLE OF CONTENTS

I.	LEGAL PROTECTIONS AGAINST INVOLUNTARY MEDICAL TREATMENT .....	000
II.	JUSTIFICATIONS AND LIMITATIONS .....	000
	A. <i>Police Powers and Autonomous Decisionmaking</i> .....	000
	B. <i>The Due Process Clause and Medical Appropriateness</i> .....	000
	C. <i>The Fourth Amendment and Reasonableness</i> .....	000
III.	INCOMPETENT CRIMINAL DEFENDANTS AND INVOLUNTARY ANTIPSYCHOTIC MEDICATIONS .....	000
	A. <i>Schizophrenia and Incompetence to Stand Trial</i> .....	000
	B. <i>Antipsychotic Medications 101</i> .....	000
	1. <i>Side Effects of First-Generation Antipsychotics</i> .....	000
	2. <i>Side Effects of Second-Generation Antipsychotics</i> .....	000
	a. <i>Obesity</i> .....	000
	b. <i>Diabetes</i> .....	000
	C. <i>The Inadequacies of Medical Appropriateness</i> .....	000
IV.	LESSONS FROM THE FOURTH AMENDMENT: HOW MUCH HARM CAN ONE TRIAL JUSTIFY? .....	000

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A. “Risk, Trauma, or Pain” .....	000
B. <i>Measuring the Government’s Interest in Criminal Prosecutions</i> .....	000
V. CONCLUSION .....	000

Involuntary medical treatment—treatment that is administered at the direction of the government, over the objection of the patient—potentially compromises several individual constitutional interests. By definition, involuntary medical treatment burdens the individual’s interest in making an autonomous decision to refuse medical treatment, an interest protected by the Due Process Clause.<sup>1</sup> Involuntary medical treatment that is administered for the purpose of obtaining evidence of a crime additionally threatens the individual’s interest in avoiding unreasonable governmental intrusions upon his privacy and personal security, an interest protected by the Fourth Amendment.<sup>2</sup>

Like all individual constitutional rights, rights under both the Due Process Clause and the Fourth Amendment can be outweighed by sufficiently important government interests.<sup>3</sup> To determine whether involuntary medical treatment violates the Due Process Clause, courts ask whether the government’s interest that the treatment advances is important enough to justify compromising the individual’s interest in making an autonomous decision to refuse medical treatment.<sup>4</sup> Involuntary treatment must also be medically appropriate, but any physical harms that the treatment might cause are not balanced directly against the government’s interest. For example, if the government sought to administer involuntary antipsychotic medications for the purpose of rendering a criminal defendant competent to stand trial, a court would ask whether the medications were medically appropriate, but would not ask whether

1. See U.S. CONST. amend. V; U.S. CONST. amend. XIV.

2. See U.S. CONST. amend. IV. Other interests potentially compromised by involuntary medical treatment include the First Amendment right to religious freedom and the Eighth Amendment protection against cruel and unusual punishment. These additional interests are beyond the scope of this Article.

3. See Erwin Chemerinsky, *The Supreme Court, 1988 Term—Foreword: The Vanishing Constitution*, 103 HARV. L. REV. 43, 90 (1989) (“Because no constitutional rights are absolute, virtually every constitutional case involves the question whether the government’s action is justified by a sufficient purpose.”). One scholar has suggested that “[t]he only truly absolute right may be the First Amendment freedom to believe.” Edward J. Imwinkelried, *Can We Rely on the Alleged Constitutional Right to Informational Privacy to Secure Genetic Privacy in the Courtroom?*, 31 SETON HALL L. REV. 926, 928 (2001).

4. See *Youngberg v. Romeo*, 457 U.S. 307, 320 (1982) (“In determining whether a substantive right protected by the Due Process Clause has been violated, it is necessary to balance ‘the liberty of the individual’ and ‘the demands of an organized society.’” (quoting *Poe v. Ullman*, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting))).

[VOL. 46: 1, 2009]

*Involuntary Medications*

SAN DIEGO LAW REVIEW

the government's interest in bringing the defendant to trial justified the potential harms of the medications.<sup>5</sup> Involuntary antipsychotic medications would be prohibited if the harmfulness made the treatment medically inappropriate.

To determine whether involuntary medical treatment violates the Fourth Amendment, courts ask whether the government's interest that the treatment advances is important enough to justify compromising the individual's interest in protecting his privacy and physical security.<sup>6</sup> Any physical harms that the treatment might cause are balanced directly against the government's interest. For example, if the government sought to compel a criminal defendant to undergo surgery to remove a bullet from his body for the purpose of proving that he had committed a crime, a court would ask whether the government's interest in obtaining the bullet justified the potential harms of the surgery.<sup>7</sup> Involuntary surgery would be unreasonable, and therefore prohibited, if the government's interest did not justify the harmfulness.

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5. See *Sell v. United States*, 539 U.S. 166, 180–81 (2003). The *Sell* test is presented *infra* notes 81–82 and accompanying text.

6. See *Bell v. Wolfish*, 441 U.S. 520, 559 (1979) (“The test of reasonableness under the Fourth Amendment . . . requires a balancing of the need for the particular search against the invasion of personal rights that the search entails.”). In many Fourth Amendment cases, a warrant issued upon probable cause, or probable cause and exigent circumstances that excuse the failure to obtain a warrant, establishes a sufficiently important government interest to justify a search or seizure. See William J. Stuntz, *O.J. Simpson, Bill Clinton, and the Transsubstantive Fourth Amendment*, 114 HARV. L. REV. 842, 847 (2001) (“Whether the police suspect a house shelters a murder weapon or a stash of marijuana, the standard is the same: the police cannot search unless they have probable cause to believe evidence of crime will be found, plus either a warrant or the ability to show that getting one was not feasible.”). In these cases, courts consider that the “Fourth Amendment has itself struck the balance between privacy and public need” through the warrant and probable cause requirements. *Zurcher v. Stanford Daily*, 436 U.S. 547, 559 (1978). In other Fourth Amendment cases, though, probable cause is not sufficient to justify a search or seizure. For example, the Supreme Court has ruled that “[a] compelled surgical intrusion into an individual’s body for evidence . . . implicates expectations of privacy and security of such magnitude that the intrusion may be ‘unreasonable’ even if likely to produce evidence of a crime.” *Winston v. Lee*, 470 U.S. 753, 759 (1985). Involuntary medical treatment cases are thus a special kind of Fourth Amendment case, in which the existence of probable cause does not necessarily mean that a search is reasonable. Some scholars have referred to these cases as involving “hyper-intrusive” searches. See Ric Simmons, *Can Winston Save Us from Big Brother? The Need for Judicial Consistency in Regulating Hyper-Intrusive Searches*, 55 RUTGERS L. REV. 547, 548 (2003) (proposing category); Michael J. Zydney Mannheim, *Coerced Confessions and the Fourth Amendment*, 30 HASTINGS CONST. L.Q. 57, 108 (2002) (adopting category).

7. See *Winston*, 470 U.S. at 760–62.

This Article contends that when the government seeks to administer involuntary antipsychotic medications to an incompetent<sup>8</sup> criminal defendant, the Due Process Clause analysis—which asks whether involuntary medical treatment is medically appropriate, not whether it is reasonable—inadequately protects the defendant’s interest in being free from physical harms that are not justified by the government’s interest in rendering him competent to stand trial. Courts routinely decide that administering involuntary antipsychotic medications to incompetent criminal defendants is medically appropriate, but arguably the question that courts should be deciding is whether administering involuntary antipsychotic medications is reasonable—that is, whether the government’s interest in bringing the defendant to trial is important enough to justify the harms of involuntary antipsychotic medications.

Consider, for example, the case of Herbert Evans. Evans has a long history of paranoid schizophrenia.<sup>9</sup> In 2002, when he was seventy-four years old, Evans was charged with several federal offenses, but because of his paranoid delusions, he was found incompetent to stand trial.<sup>10</sup> Evans refused to take voluntarily the antipsychotic medications that might have alleviated his delusions and rendered him competent to stand trial.<sup>11</sup> The government then sought an order allowing the antipsychotic medications to be administered involuntarily.<sup>12</sup>

In support of its decision granting the government’s request to administer involuntary antipsychotic medications to Evans, the district court wrote a brief opinion stating that “the government has shown sufficient proof” of all of the findings required for an order allowing involuntary medications, including a finding “that such medicine is medically appropriate.”<sup>13</sup> The Fourth Circuit reversed, in part because the district court was “without adequate information” to conclude that antipsychotic medications were medically appropriate for Evans, “an elderly man with diabetes, hypertension, and asthma who takes a number of medications to treat these conditions.”<sup>14</sup> The Fourth Circuit then set

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8. “Incompetent” as used in the Article means “incompetent to stand trial,” unless otherwise specified. The criteria for competence to stand trial are discussed *infra* note 108.

9. *United States v. Evans*, 404 F.3d 227, 241 (4th Cir. 2005) (“Evans’s delusions of governmental conspiracies . . . have persisted longer than 40 years . . .”); *United States v. Evans*, 293 F. Supp. 2d 668, 671 (W.D. Va. 2003) (referring to Evans’s “long history of treatment for psychiatric problems” and “paranoid schizophrenia of a long-standing nature”).

10. *Evans*, 293 F. Supp. 2d. at 670.

11. *Id.*

12. *Id.*

13. *United States v. Evans*, No. 102CR00136, 2004 WL 533473, at \*2 (W.D. Va. Mar. 18, 2004).

14. *Evans*, 404 F.3d at 240–41.

[VOL. 46: 1, 2009]

*Involuntary Medications*  
SAN DIEGO LAW REVIEW

out a long list of requirements that the government must satisfy to support a finding of medical appropriateness, including the requirement of a detailed treatment plan specifying particular medications, dosages, and likely side effects.<sup>15</sup>

On remand, the district court found that the government's evidence satisfied most of the Fourth Circuit's requirements.<sup>16</sup> The district court ruled, though, that the government had not submitted a sufficiently detailed plan for responding to the possibility that antipsychotic medications would exacerbate Evans's diabetes.<sup>17</sup> The court therefore authorized the government to implement its involuntary antipsychotic medication treatment plan, but only until Evans's diabetes becomes insulin-dependent: "I will direct that, in the event that Evans'[s] diabetes worsens to the point of requiring daily insulin shots, the government must cease treatment with the antipsychotic currently in use and return to this court with a new proposal."<sup>18</sup> The Fourth Circuit issued a per curiam opinion summarily affirming the district court's order permitting the government to administer involuntary antipsychotic medications.<sup>19</sup>

That the district court is prepared to allow the government to continue administering involuntary antipsychotic medications to Evans until he requires daily injections of insulin, even though the court has not explained why the charges against Evans justify this level of harm,<sup>20</sup>

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15. *Id.* at 240–42. The court ruled that "[t]he government must propose a course of treatment in which it specifies the particular drug to be administered," and must "explain how it reached its conclusions" regarding medical appropriateness "with respect to Evans as an individual." *Id.* at 240. Further, the government "must set forth the particular medication, including the dose range, it proposes to administer to Evans to restore his competency" and "must also relate the proposed treatment plan to the individual defendant's particular medical condition." *Id.* at 242. Finally, the government

must spell out why it proposed the particular course of treatment, provide the estimated time the proposed treatment plan will take to restore the defendant's competence and the criteria it will apply when deciding when to discontinue the treatment, describe the plan's probable benefits and side effect risks for the defendant's particular medical condition, show how it will deal with the plan's probable side effects, and explain why, in its view, the benefits of the treatment plan outweigh the costs of its side effects.

*Id.* at 242 (footnote and citations omitted).

16. *United States v. Evans*, 427 F. Supp. 2d 696, 705 (W.D. Va. 2006).

17. *Id.*

18. *Id.* at 706.

19. *United States v. Evans*, 199 F. App'x 290, 290 (4th Cir. 2006).

20. The district court based its conclusion that the government has an "important" interest in bringing Evans to trial on the fact that Evans "is charged with a felony for

captures the inadequacy of the due process test for deciding when to allow the government to administer involuntary medical treatment for the purpose of rendering a defendant competent to stand trial. As cases like *Evans* demonstrate, “medically appropriate” is an inadequate standard for protecting an incompetent defendant’s interest in avoiding harms from involuntary antipsychotic medications that are not justified by the government’s interest in bringing him to trial.

Part I of this Article discusses the legal protections against involuntary medical treatment. In the typical right to refuse treatment case, a patient’s interests are divided—the patient’s interest in autonomous decisionmaking about his health requires that he be allowed to refuse medical treatment, but the patient’s interest in preserving his health, and perhaps even his life, requires that he be administered involuntary treatment. Generally, when a patient chooses to refuse treatment at the expense of his own life or health, courts have ruled that the government’s interest in preserving the patient’s life or health is insufficient to justify involuntary treatment.<sup>21</sup> In a small subset of right to refuse treatment cases, however, the government seeks to administer involuntary treatment for some purpose other than preserving the patient’s life or health. Part II examines such cases, including several Supreme Court cases decided under the Due Process Clause and several decided under the Fourth Amendment. As Part III explains, in following the Supreme Court’s decisions in the Due Process Clause cases, trial courts have permitted the government to administer involuntary antipsychotic medications that risk causing, and in some cases have caused, harms that are at least as severe as harms that in the

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which the maximum term of imprisonment is ten years.” *United States v. Evans*, No. 102CR00136, 2004 WL 533473, at \*2 (W.D. Va. Mar. 18, 2004). The Fourth Circuit agreed: “We think it beyond dispute that the Government does have an important interest in trying a defendant charged with a felony carrying a maximum punishment of 10 years imprisonment.” *United States v. Evans*, 404 F.3d 227, 238 (4th Cir. 2005). The complexities of measuring the importance of the government’s interest in bringing a defendant to trial are discussed *infra* notes 195–217 and accompanying text.

21. See John Alan Cohan, *Judicial Enforcement of Lifesaving Treatment for Unwilling Patients*, 39 CREIGHTON L. REV. 849, 881 (2006) (“Courts today are usually vigilant to protect the right of competent adults to refuse medical treatment, even lifesaving procedures.”); Andrea Marsh, *Testing Pregnant Women and Newborns for HIV: Legal and Ethical Responses to Public Health Efforts to Prevent Pediatric AIDS*, 13 YALE J.L. & FEMINISM 195, 247 (2001) (noting that “the Court has reaffirmed the competent adult’s right to refuse life-preserving medical treatment, indicating that the state’s interest in preserving life does not trump individual autonomy so long as the individual’s wishes regarding life does not trump individual autonomy so long as the individual’s wishes regarding treatment can be determined to a sufficient degree of certainty” (footnote omitted)); Melvin I. Urofsky, *Do Go Gentle into That Good Night: Thoughts on Death, Suicide, Morality and the Law*, 59 ARK. L. REV. 819, 824 (2007) (“In the 1970s and 1980s, state courts reaffirmed the notion that a competent person, voluntarily making a knowledgeable decision, had the legal right to refuse or terminate treatment.”).

[VOL. 46: 1, 2009]

*Involuntary Medications*

SAN DIEGO LAW REVIEW

Fourth Amendment cases prompted the Supreme Court to rule that involuntary medical treatment was not justified. Part IV analyzes the government's interest in rendering criminal defendants competent to stand trial, proposing that a Fourth Amendment-like balancing test—instead of the current due process medical appropriateness test—would better ensure that courts decide to allow involuntary antipsychotic medications only when the government's interest in rendering a criminal defendant competent to stand trial is important enough to justify the harms. The Article concludes that under the current due process test, incompetent criminal defendants are being subjected to harms that might not be justified by the government's interest in bringing them to trial.

## I. LEGAL PROTECTIONS AGAINST INVOLUNTARY MEDICAL TREATMENT

Historically, the primary legal source of protection for an individual's right to refuse unwanted medical treatment was tort law, in particular the law of battery.<sup>22</sup> Not until late in the twentieth century did courts recognize a constitutionally protected interest in refusing medical treatment.<sup>23</sup> One of the first cases to recognize this constitutional protection was *In re Quinlan*, decided by the New Jersey Supreme Court in 1976.<sup>24</sup> Twenty-one-year-old Karen Quinlan had been in a persistent vegetative state for several months, breathing by means of a respirator with little hope of recovery or improvement, when her family decided that she

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22. See *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 269 (1990); see also *Washington v. Glucksberg*, 521 U.S. 702, 703 (1997) (“The constitutionally protected right to refuse lifesaving hydration and nutrition that was discussed in *Cruzan* was . . . grounded in the Nation's history and traditions, given the common-law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment.” (citation omitted)); I. Glenn Cohen, *The Constitution and the Rights Not to Procreate*, 60 STAN. L. REV. 1135, 1155–56 (2008) (“The belief that an individual is sovereign over his body . . . stands behind a number of familiar legal doctrines like the right to be free from battery, the right to give informed consent, and the right to refuse medical treatment.” (footnote omitted)).

23. See *Glucksberg*, 521 U.S. at 723 (noting that in *Cruzan*, the Court “assumed that the Constitution granted competent persons a ‘constitutionally protected right to refuse lifesaving hydration and nutrition.’” (quoting *Cruzan*, 497 U.S. at 279)); *Vacco v. Quill*, 521 U.S. 793, 800 (1997) (“Everyone, regardless of physical condition, is entitled, if competent, to refuse unwanted life saving treatment . . .”); *Cruzan*, 497 U.S. at 269.

24. See Kristen M. Dama, *Redefining a Final Act: The Fourteenth Amendment and States' Obligation to Prevent Death Row Inmates from Volunteering to Be Put to Death*, 9 U. PA. J. CONST. L. 1083, 1099 (2007) (“In 1976, in *In re Quinlan*, the New Jersey Supreme Court established a right to refuse lifesaving medical treatment; this was one of the first, and most direct, affirmations of this right.” (footnote omitted)).



would not have wanted to be kept alive under such circumstances.<sup>25</sup> When Quinlan's physician refused to disconnect her from the respirator, her father petitioned the court for the right to do so.<sup>26</sup> The state of New Jersey argued that its interests in the preservation of life and in the independent functioning of the medical profession justified continued treatment.<sup>27</sup> The court ruled that if her family, her doctor, and the hospital ethics committee all agreed that she had no reasonable chance of recovery, Quinlan's life-sustaining treatment could be terminated.<sup>28</sup> Although the court did reference the "very great" invasiveness of Quinlan's treatment—"24 hour intensive nursing care, antibiotics, the assistance of a respirator, a catheter and feeding tube"<sup>29</sup>—the court did not base its ruling on any physical harms that Quinlan might have experienced because of continued treatment.<sup>30</sup> Instead, the court decided that continued treatment would harm Quinlan's autonomy and privacy interests.<sup>31</sup> Quinlan had a constitutional right to refuse medical treatment, but because of her medical condition, she could not assert that right herself.<sup>32</sup> Allowing someone else to refuse medical treatment for her would "vindicate" her right of privacy,<sup>33</sup> even though it would also cause her physical harm.<sup>34</sup>

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25. 348 A.2d 801, 814 (N.J. Super. Ct. Ch. Div. 1975) ("Karen Quinlan is quoted as saying she never wanted to be kept alive by extraordinary means. The statements attributed to her by her mother, sister and a friend are indicated to have been made essentially in relation to instances where close friends or relatives were terminally ill."), *modified and remanded*, 355 A.2d 647 (N.J. 1976), *cert. denied*, 429 U.S. 922 (1976).

26. *Id.*

27. *In re Quinlan*, 355 A.2d 647, 651–52, 663 (N.J. 1976).

28. *Id.* at 671–72.

29. *Id.* at 664.

30. *Id.* at 662–64. The parties disputed whether Quinlan was capable of experiencing pain. See ROBERT A. BURT, *TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONS* 147–48 (1979). Not disputed, though, was the fact that discontinuing treatment would likely hasten Quinlan's death. *In re Quinlan*, 355 A.2d at 655.

31. *In re Quinlan*, 355 A.2d at 663 ("The Court in *Griswold* found the unwritten constitutional right of privacy to exist in the penumbra of specific guarantees of the Bill of Rights . . . . Presumably this right is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances . . . ." (citations omitted)).

32. *Id.* ("[I]f Karen were herself miraculously lucid for an interval (not altering the existing prognosis of the condition to which she would soon return) and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death.")

33. *Id.* at 664 ("[Karen's] right of privacy in respect of the matter before the Court is to be vindicated by Mr. Quinlan as guardian, as hereinabove determined."); see also *id.* ("The only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render their best judgment, subject to the qualifications hereinafter stated, as to whether she would exercise it in these circumstances.")

34. Or more precisely, discontinuing medical treatment would allow Quinlan's illness to cause her physical harm. See *supra* note 30.

[VOL. 46: 1, 2009]

*Involuntary Medications*  
SAN DIEGO LAW REVIEW

The United States Supreme Court, in *Cruzan v. Director, Missouri Department of Health*, similarly acknowledged a constitutionally protected interest in refusing unwanted medical treatment.<sup>35</sup> Like Karen Quinlan, Nancy Cruzan was in a persistent vegetative state kept alive by a feeding tube when her parents decided that she would not have wanted to continue receiving such treatment—treatment that would prolong her life but would not offer any real hope of recovery.<sup>36</sup> As in *Quinlan*, the Court in *Cruzan* found that unwanted medical treatment would harm Cruzan not physically but psychically; or as Justice O'Connor's concurring opinion explained, such unwanted treatment "burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment."<sup>37</sup> Even though Cruzan's autonomy interest in refusing treatment could not be exercised on her behalf without harming her physical health, the Court ruled that the government's interest in preserving Cruzan's health could not justify continued treatment that she would not want.<sup>38</sup>

Most right to refuse treatment cases are like *Quinlan* and *Cruzan*—cases in which an individual's interest in making an autonomous choice to refuse medical treatment is at odds with the government's interest in preserving the individual's life or health. In such cases, courts routinely rule that the government's interest does not justify abridging the individual's interest.<sup>39</sup> What, though, of cases in which the government's purpose for seeking to administer involuntary medical treatment is not to preserve a

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35. 497 U.S. 261, 278 (1990) ("The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions."); see also *id.* at 287 (O'Connor, J., concurring) ("Because our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause.")

36. *Id.* at 266–68.

37. *Id.* at 289 (O'Connor, J., concurring).

38. *Id.* at 280.

39. See, e.g., *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 305 (Cal. Ct. App. 1986); *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 224 (Cal. Ct. App. 1984); *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 638 (Mass. 1986); see also Norman L. Cantor, *Twenty-Five Years After Quinlan: A Review of the Jurisprudence of Death and Dying*, 29 J.L. MED. & ETHICS 182, 183–84 (2001) ("The cases acknowledge a legitimate governmental interest in promoting sanctity of human life, but they also tend to find that a patient's liberty interests (self-determination and bodily integrity) simply outweigh the state's abstract interest in sanctity of life."); Jaime Staples King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J.L. & MED. 429, 468 (2006) (noting "the primacy in the law of an individual's autonomy over her health and the ability of a competent individual to make medical decisions that may not be in her best medical interest").

patient's life or health? What kind of government interest can justify involuntary medical treatment that not only compromises autonomous decisionmaking but also causes physical harms?

## II. JUSTIFICATIONS AND LIMITATIONS

In cases like *Quinlan* and *Cruzan*, the government's interest that involuntary treatment promotes is the life or health of the person who is refusing treatment.<sup>40</sup> Occasionally, though, the government seeks to administer involuntary treatment not to preserve the treatment-refusing person's life or health but to achieve some other interest, such as protecting the public from a smallpox epidemic, combating drunk driving, or obtaining evidence of a crime.<sup>41</sup> In these cases, it has come to matter whether the government's actions are recognized as a search or seizure that implicates the Fourth Amendment or are instead characterized only as an interference with autonomous decisionmaking that implicates the Due Process Clause. Under the Fourth Amendment, involuntary treatment must be reasonable, given the weight of the government's interest that the involuntary treatment advances. But under the Due Process Clause generally, and in particular under the test recently set forth by the Supreme Court in *Sell v. United States*, courts ask not whether involuntary treatment is reasonable but rather whether it is medically appropriate.<sup>42</sup>

The path that led to *Sell* and the medical appropriateness standard began with *Jacobson v. Massachusetts*, the first Supreme Court case to rule on the constitutionality of administering involuntary medical treatment for police power purposes.<sup>43</sup> Between *Jacobson* and *Sell*, the Court developed a due process jurisprudence that defines autonomous decisionmaking as the individual constitutional interest that is infringed by unjustified involuntary medical treatment. As a result, the Due Process Clause permits government actions that interfere with autonomous decisionmaking if those actions promote government interests that are important enough to justify such interference.

### A. Police Powers and Autonomous Decisionmaking

The Supreme Court first considered the possibility that compelling

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40. *In re Quinlan*, 355 A.2d. 647, 651–52 (N.J. 1976); *Cruzan*, 497 U.S. at 280.

41. *Winston v. Lee*, 470 U.S. 753, 763–66 (1985) (evidence of a crime); *Schmerber v. California*, 384 U.S. 757, 769–72 (1966) (drunk driving and evidence of a crime); *Jacobson v. Massachusetts*, 197 U.S. 11, 26–28 (1905) (smallpox).

42. *Sell v. United States*, 539 U.S. 166, 177, 181 (2003); *see also Riggins v. Nevada*, 504 U.S. 127, 135 (1992); *Washington v. Harper*, 494 U.S. 210, 221–22 (1990).

43. 197 U.S. 11, 14–15 (1905).

[VOL. 46: 1, 2009]

*Involuntary Medications*

SAN DIEGO LAW REVIEW

people to submit to unwanted medical procedures might be a valid exercise of the government's police powers in *Jacobson v. Massachusetts*.<sup>44</sup> Henry Jacobson objected that a Massachusetts law requiring him to be vaccinated against smallpox was an invasion of his "liberty," was "unreasonable, arbitrary, and oppressive," and was "an assault upon his person."<sup>45</sup> The Court rejected Jacobson's arguments, ruling that when faced with an impending smallpox epidemic, the state of Massachusetts was justified in compelling its residents, including Jacobson, to be vaccinated.<sup>46</sup> The Court seemed to view Jacobson as something of a free-rider—someone who wanted to enjoy the benefits of a safe, healthy community but who was not willing to accept the responsibility of following the community's health and safety regulations: "We are not prepared to hold that a minority, residing or remaining in any city or town where smallpox is prevalent . . . may thus defy the will of its constituted authorities, acting in good faith for all, under the legislative sanction of the State."<sup>47</sup>

Although the Court upheld Massachusetts's law and its application to Jacobson, it also suggested that there are limits not only on the individual's right to refuse to be vaccinated but also on the government's right to compel such treatment.<sup>48</sup> The *Jacobson* Court thus did not endorse compulsory vaccinations, even if justified by an impending epidemic, irrespective of the amount of physical harm the vaccination would cause. Instead, the Court imposed an upper limit on the amount of harm that the government could cause, writing that if "a particular condition of [a person's] health or body" would make vaccination "cruel and inhuman in the last degree," a court should intervene to "protect the health and life of the individual concerned."<sup>49</sup>

When *Jacobson* was decided, the Supreme Court had not yet defined

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44. *Id.*

45. *Id.* at 26.

46. *Id.* at 38–39.

47. *Id.* at 37.

48. *Id.* at 38–39.

49. *Id.* *Jacobson* is in one sense about the individual's right to refuse medical treatment but it is also in another sense about the government's options when confronted with an emergency. In emergency situations, the government is justified in using appropriate force even if it causes serious physical harm. *See, e.g.,* *Whitley v. Albers*, 475 U.S. 312, 326 (1986) (allowing use of deadly force to end a prison riot); *Tennessee v. Garner*, 471 U.S. 1, 11 (1985) (allowing use of deadly force to apprehend a fleeing felon if "the officer has probable cause to believe that the suspect poses a threat of serious physical harm").

substantive due process in terms of personal autonomy.<sup>50</sup> Then, the substantive liberty that the Due Process Clause protected was primarily economic.<sup>51</sup> But the Supreme Court's current substantive due process jurisprudence protects not so much individual economic liberty as individual "privacy," "dignity," and "autonomy."<sup>52</sup> In its modern substantive due process cases, the Court has identified the individual liberty interest that is at stake as the interest in making autonomous decisions.<sup>53</sup> The government satisfies its due process obligations by not interfering in individual decisions and violates due process by imposing an "undue burden" on individual decisions.<sup>54</sup> A due process injury either occurs or

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50. See B. Jessie Hill, *The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines*, 86 TEX. L. REV. 277, 296 n.82 (2007) ("Jacobson was a *Lochner*-era case. The doctrine of substantive due process was of course liberally applied in the *Lochner* era but largely to strike down laws on the grounds that they interfered with economic rights, not fundamental personal rights.").

51. See Jed Rubenfeld, *The Right of Privacy*, 102 HARV. L. REV. 737, 742 (1989) ("From the late 1870's to the turn of the century, the Court formulated an interpretation of due process in which the predominant figure was a fundamental, potentially inviolate 'liberty of contract' with which legislatures had no power to interfere.").

52. See *Lawrence v. Texas*, 539 U.S. 558, 578 (2003) (ruling that the "right to liberty under the Due Process Clause" encompasses "the personal and private life of the individual"); *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 772 (1986) (protecting right to make decision that is "basic to individual dignity and autonomy"); *Roe v. Wade*, 410 U.S. 113, 153 (1973) (recognizing a "right of privacy" that is "founded in the Fourteenth Amendment's concept of personal liberty"); *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965) (referring to the "zone of privacy created by several fundamental constitutional guarantees").

53. Justice Douglas's concurring opinion in *Doe v. Bolton*, a companion case to *Roe v. Wade*, identifies three categories of decisions that the Due Process Clause protects:

First is the autonomous control over the development and expression of one's intellect, interests, tastes, and personality. . . . Second is freedom of choice in the basic decisions of one's life respecting marriage, divorce, procreation, contraception, and the education and upbringing of children. . . . Third is the freedom to care for one's health and person, freedom from bodily restraint or compulsion, freedom to walk, stroll, or loaf.

*Doe v. Bolton*, 410 U.S. 179, 211–13 (1973) (Douglas, J., concurring). In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Court made this understanding of due process clear:

These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life.

505 U.S. 833, 851 (1992).

54. See *Casey*, 505 U.S. at 874–79 (developing "undue burden" test); see also Radhika Rao, *Reconceiving Privacy: Relationships and Reproductive Technology*, 45 UCLA L. REV. 1077, 1079 (1998) (stating that "privacy is the quintessential negative right—a right to be free from governmental interference"); Rubenfeld, *supra* note 51, at 784 ("The principle of the right to privacy . . . is the fundamental freedom not to have one's life too totally determined by a progressively more normalizing state."). Some scholars, though, have argued for a more expansive, positive-right understanding of the

[VOL. 46: 1, 2009]

*Involuntary Medications*

SAN DIEGO LAW REVIEW

does not occur at the moment the government prevents an individual from making an autonomous decision.<sup>55</sup> A violation of due process does not require that the individual experience any additional harms as a result of the government's interference with autonomous decisionmaking.<sup>56</sup> Thus, if the government lacks sufficient justification for overriding an individual's decision to refuse medical treatment, then the person who has been physically harmed by involuntary medical treatment has experienced exactly the same due process injury—unjustified interference with the right to make autonomous decisions—as has the person who has not been physically harmed, or who has even been physically benefited, by involuntary medical treatment.

Whatever else is desirable or undesirable about this understanding of substantive due process, it inadequately protects an incompetent criminal defendant's interest in avoiding unreasonable harms when the government

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right to privacy. *See, e.g.*, April L. Cherry, *Roe's Legacy: The Nonconsensual Medical Treatment of Pregnant Women and Implications for Female Citizenship*, 6 U. PA. J. CONST. L. 723, 751 (2004) ("If understood as decisional autonomy, then the notion of privacy expands to include an affirmative state obligation to ensure that women, regardless of whether they are pregnant, get to make decisions regarding health care autonomously, not without context, but without familial or state coercion."); Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1478 (1991) ("The definition of privacy as a purely negative right serves to exempt the state from any obligation to ensure the social conditions and resources necessary for self-determination and autonomous decisionmaking.").

55. *Cf. Shaheed-Muhammad v. Dipaolo*, 138 F. Supp. 2d 99, 101 (D. Mass. 2001) ("Intangible rights . . . are abridged the moment a state silences free speech or prevents a citizen from following the precepts of his religion. While the violation may be accompanied by psychological or even physical injury, the severity of incursion is not necessarily measured in those terms.").

56. A violation of the autonomy interest protected by the Due Process Clause necessarily causes not a physical harm but a kind of psychological, spiritual, metaphysical, or otherwise intangible, nonphysical harm—the harm of not being able to make an autonomous decision. *See id.* ("[T]he harms proscribed by the First Amendment, Due Process, or Equal Protection are assaults on individual freedom and personal liberty, even on spiritual autonomy, and not on physical well-being."). Thus, the Due Process Clause protects against the nonphysical harms that result from unjustified interference with an individual's right to autonomously decide to refuse medical treatment. The Due Process Clause does not, however, necessarily protect against any physical harms caused by involuntary medical treatment. This does not mean that violations of the Due Process Clause cannot cause physical harms. Rather, it means only that a government action that has violated due process has not necessarily caused a physical injury. *Cf. Rowe v. Shake*, 196 F.3d 778, 781–82 (7th Cir. 1999) (noting that "[a] prisoner is entitled to judicial relief for a violation of his First Amendment rights aside from any physical, mental, or emotional injury he may have sustained").

seeks to administer involuntary antipsychotic medications for the purpose of bringing the defendant to trial. The Supreme Court has ruled that in these cases, antipsychotic medications must be “medically appropriate.”<sup>57</sup> By explicitly requiring that involuntary medications be medically appropriate, the Court would seem to be suggesting that trial courts might in some cases refuse to authorize involuntary antipsychotic medications on the basis of medical inappropriateness. But as originally conceived by the Supreme Court in *Washington v. Harper*, the medical appropriateness standard was not intended to serve as a check on unjustified administration of involuntary antipsychotic medications.<sup>58</sup> And even though in *Sell* the Court might have intended medical appropriateness to be a check, in practice it has not served this purpose.

### *B. The Due Process Clause and Medical Appropriateness*

*Washington v. Harper* was the Supreme Court’s first involuntary antipsychotic medication case.<sup>59</sup> The Court observed that Walter Harper, a prison inmate, “possesses a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment.”<sup>60</sup> The Court rejected, though, Harper’s argument that the Due Process Clause prevented the state from administering involuntary medication to him unless he had been found incompetent to make his own medical treatment decisions.<sup>61</sup> Much of the Court’s reasoning rests on Harper’s status as a prisoner<sup>62</sup> and the duties of the prison administrators.<sup>63</sup> Although the Court did acknowledge the potential of antipsychotic medications to cause physically harmful

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57. *Sell v. United States*, 539 U.S. 166, 181 (2003) (requiring that “the court must conclude that administration of the drugs is medically appropriate” (emphasis omitted)); *see also Riggins v. Nevada*, 504 U.S. 127, 135 (1992) (“medically appropriate”); *Washington v. Harper*, 494 U.S. 210, 227 (1990) (“in the inmate’s medical interest”).

58. *See infra* notes 68–70 and accompanying text.

59. 494 U.S. 210, 215–16 (1990).

60. *Id.* at 221–22.

61. *Id.* Generally, incompetence to make medical treatment decisions is a requirement of involuntary medication administered under the government’s *parens patriae* powers but not its police powers. *See Rogers v. Okin*, 634 F.2d 650, 657 (1st Cir. 1980) (“[T]he *sine qua non* for the state’s use of its *parens patriae* power as justification for the forceful administration of mind-affecting drugs is a determination that the individual to whom the drugs are to be administered lacks the capacity to decide for himself whether he should take the drugs.”).

62. *E.g., Harper*, 494 U.S. at 222 (“The extent of a prisoner’s right under the Clause to avoid the unwanted administration of antipsychotic drugs must be defined in the context of the inmate’s confinement.”).

63. *E.g., id.* at 225 (“Prison administrators have not only an interest in ensuring the safety of prison staffs and administrative personnel, but also the duty to take reasonable measures for the prisoners’ own safety.” (citation omitted)).

[VOL. 46: 1, 2009]

*Involuntary Medications*

SAN DIEGO LAW REVIEW

side effects,<sup>64</sup> its analysis balanced Harper's liberty interest in refusing unwanted medications—whether physically harmful or not—against the state's interest in safely maintained prisons.<sup>65</sup> The interest in safely maintained prisons prevailed.<sup>66</sup> The Court held that “given the requirements of the prison environment, the Due Process Clause permits the state to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will, if the inmate is dangerous to himself or others and the treatment is in the inmate's medical interest.”<sup>67</sup>

The Supreme Court did not intend for this “in the inmate's medical interest” requirement to limit the government's ability to administer involuntary antipsychotic medications. Instead, the Court included this requirement to address concerns raised in a dissenting opinion that different, more rigorous procedural requirements were needed to ensure that prison psychiatrists would not administer involuntary antipsychotic medications solely for institutional convenience—that is, to control the behavior of prisoners rather than to treat their mental illnesses.<sup>68</sup> The majority concluded, though, that such procedural protections were unnecessary.<sup>69</sup> Thus, in *Harper*, the medical appropriateness requirement simply reflects the Court's belief that prison psychiatrists can be trusted to prescribe only those treatments that are medically appropriate.<sup>70</sup>

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64. *Id.* at 229–30.

65. *Id.* at 236 (finding that Washington's policy “is an accommodation between an inmate's liberty interest in avoiding the forced administration of antipsychotic drugs and the State's interests in providing appropriate medical treatment to reduce the danger that an inmate suffering from a serious mental disorder represents to himself or others”).

66. *Id.* at 225 (“There are few cases in which the State's interest in combating the danger posed by a person to both himself and others is greater than in a prison environment, which, by definition, is made up of persons with a demonstrated proclivity for antisocial criminal, and often violent, conduct.” (internal quotation marks omitted)).

67. *Id.* at 227.

68. *Id.* at 249 (Stevens, J., dissenting) (arguing that the state's policy allows “forced psychotropic medication on the basis of purely institutional concerns”).

69. *Id.* at 233. The Court explained:

There is no indication that any institutional biases affected or altered the decision to medicate respondent against his will . . . . In the absence of record evidence to the contrary, we are not willing to presume that members of the staff lack the necessary independence to provide an inmate with a full and fair hearing in accordance with the Policy.

*Id.*

70. *Id.* at 231 (“[W]e conclude that an inmate's interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by medical professionals rather than a judge.”); *id.* at 233 (“The risks associated with antipsychotic drugs are for the most part medical ones, best assessed by medical professionals.”). The problem, though, is that while medical professionals might well be better than judges at



*Riggins v. Nevada* is the Court's only other pre-*Sell* case to address the administration of involuntary antipsychotic medications for the purpose of advancing the government's interest in criminal prosecutions.<sup>71</sup> In *Riggins*, the Court considered David Riggins's argument that the state had unjustifiably compelled him to take antipsychotic medications during his first-degree murder trial.<sup>72</sup> Unlike *Harper*, *Riggins* involved a criminal defendant rather than a convicted prisoner,<sup>73</sup> and the state's purpose for administering involuntary antipsychotic medications had nothing to do with prison safety.<sup>74</sup> Nevertheless, the Court both began and ended its analysis of Riggins's claim with *Harper*:<sup>75</sup> "Under *Harper*, forcing antipsychotic drugs on a convicted prisoner is impermissible absent a finding of overriding justification and a determination of medical appropriateness. The Fourteenth Amendment affords at least as much protection to persons the State detains for trial."<sup>76</sup>

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assessing the medical risks of involuntary treatment, medical professionals are not better at deciding whether the government's interest that the involuntary treatment advances is important enough to justify the medical risks. See David L. Bazelon, *Institutionalization, Deinstitutionalization, and the Adversary Process*, 75 COLUM. L. REV. 897, 910 (1975) ("The medical disciplines can no more judge the legitimacy of state intervention into the lives of disturbed or disturbing individuals than a prosecutor can judge the guilt of a person he has accused.").

71. 504 U.S. 127, 133–38 (1992).

72. *Id.* at 133.

73. Courts apply a highly deferential standard of scrutiny to government actions that infringe upon prisoners' constitutional rights. *Turner v. Safley*, 482 U.S. 78, 89 (1987) (ruling that "when a prison regulation impinges on inmates' constitutional rights, the regulation is valid if it is reasonably related to legitimate penological interests"). Although prisoners do not lose all constitutional rights as a result of their convictions, they retain only those constitutional protections that are not "incompatible with the objectives of incarceration." *Hudson v. Palmer*, 468 U.S. 517, 523 (1984); *Hanna v. Toner*, 630 F.2d 442, 444 (6th Cir. 1980) ("Prisoners do not lose all of their constitutional rights when they enter a penal institution. Rather they retain all of their constitutional rights except for those which must be impinged upon for security or rehabilitative purposes.").

74. In *Riggins*, the Court assumed that the state's purpose for administering involuntary antipsychotic medications was to maintain Riggins's competence to stand trial. See *Riggins*, 504 U.S. at 136 (hypothesizing that the trial court "simply weighed the risk that the defense would be prejudiced by changes in Riggins'[s] outward appearance against the chance that Riggins would become incompetent if taken off Mellaril, and struck the balance in favor of involuntary medication").

75. *Id.* at 133 ("Our discussion in *Washington v. Harper* provides useful background for evaluating this claim." (citation omitted)).

76. *Id.* at 135. Justice Kennedy, in a concurring opinion, recognized the inappropriateness of relying on *Harper*: "This is not a case like *Washington v. Harper*, in which the purpose of the involuntary medication was to ensure that the incarcerated person ceased to be a physical danger to himself or others." *Id.* at 140 (Kennedy, J., concurring in the judgment) (citation omitted). The dissenting justices, Thomas and Scalia, also noted that the Court was inappropriately relying on *Harper*:

This case differs from *Harper* because it involves a pretrial detainee and not a convicted prisoner. The standards for forcibly medicating inmates well may

[VOL. 46: 1, 2009]

*Involuntary Medications*

SAN DIEGO LAW REVIEW

As in *Harper*, the *Riggins* Court acknowledged that antipsychotic medications can cause physically harmful side effects.<sup>77</sup> These physically harmful side effects make involuntary medications' interference with individual liberty "particularly severe."<sup>78</sup> But in considering whether the state's interest in bringing Riggins to trial justified involuntary medications, there was no assessment of the physical harms that Riggins himself might have experienced.<sup>79</sup> The harmfulness of antipsychotics is in effect already written into the *Harper* and *Riggins* due process test—a test that is substantially the same as the *Sell* test.<sup>80</sup>

In *Sell v. United States*, the Supreme Court set forth a four-factor test for determining when the government may administer involuntary medications for the purpose of rendering a defendant competent to stand trial.<sup>81</sup> This test allows involuntary medications when (1) "important" government interests are at stake, (2) medication will "significantly further" those important government interests, (3) involuntary medication is "necessary to further" those interests, and (4) medication is "medically appropriate, i.e., in the patient's best medical interest in light of his

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differ from those for persons awaiting trial. The Court, however, does not rely on this distinction in departing from *Harper*; instead, it purports to be applying *Harper* to detainees.

*Id.* at 157 (Thomas, J., dissenting).

77. *Id.* at 133–34.

78. *Id.* at 134.

79. *Id.* at 134–35. The Court did note that the medication might have made Riggins drowsy or confused, but these side effects were important not because they might have been physically harmful but because they might have interfered with Riggins's Sixth Amendment right to a fair trial. *See id.* at 137 ("It is clearly possible that such side effects had an impact upon not just Riggins' outward appearance, but also the content of his testimony on direct or cross examination, his ability to follow the proceedings, or the substance of his communication with counsel."); *see also id.* at 142 (Kennedy, J., concurring in the judgment) ("If the defendant takes the stand, as Riggins did, his demeanor can have a great bearing on his credibility and persuasiveness, and on the degree to which he evokes sympathy.").

80. The *Sell* Court explicitly relied on both *Harper* and *Riggins*:

These two cases, *Harper* and *Riggins*, indicate that the Constitution permits the Government involuntarily to administer antipsychotic drugs to a mentally ill defendant facing serious criminal charges in order to render that defendant competent to stand trial, but only if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the fairness of the trial, and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests.

539 U.S. 166, 179 (2003).

81. *Id.* at 180–81.

medical condition.”<sup>82</sup>

Thus, under *Harper*, *Riggins*, and *Sell*, involuntary medications are permitted so long as they are justified by an “important” government interest, are properly tailored to advance that interest,<sup>83</sup> and are “medically appropriate.”<sup>84</sup> Under the Fourth Amendment, however, involuntary medical treatment must be more than medically appropriate; it must also not be unreasonably harmful.

### C. *The Fourth Amendment and Reasonableness*

The Fourth Amendment guarantees the right of people “to be secure in their persons.”<sup>85</sup> And the Fourth Amendment guarantees, especially, the right of people suspected by the government of having committed a crime to be secure in their persons.<sup>86</sup> Although the prototypical Fourth Amendment case involves a search or seizure for the purpose of obtaining evidence of a crime, the Supreme Court has often broadly described the function of the Fourth Amendment as protecting individuals against unjustified government intrusions upon their privacy and personal security.<sup>87</sup> And administering involuntary antipsychotic medications for the purpose of rendering a defendant competent to stand trial is a potentially unjustified intrusion by the government upon the

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82. *Id.* (emphases omitted).

83. Tailoring is unlikely to serve as a check against unjustified administration of involuntary antipsychotic medications because antipsychotic medications are the intervention most likely to render a defendant with schizophrenia, or another psychotic disorder, competent to stand trial. *See infra* note 114.

84. *See Sell*, 539 U.S. at 179–82 (following *Harper* and *Riggins*).

85. The Fourth Amendment provides:

The right of the people to be secure in their persons, houses, papers and effects, against unreasonable searches and seizures, shall not be violated, and no warrants shall issue, but upon probable cause, supported by oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.

U.S. CONST. amend. IV.

86. *See* Carol S. Steiker, *Second Thoughts About First Principles*, 107 HARV. L. REV. 820, 820 (1994) (noting that “the Fourth Amendment structures the investigative process by restricting many of the most effective means of detecting law-breaking and apprehending law-breakers”).

87. *E.g.*, *United States v. Martinez-Fuerte*, 428 U.S. 543, 554 (1976) (“The Fourth Amendment imposes limits on search-and-seizure powers in order to prevent arbitrary and oppressive interference by enforcement officials with the privacy and personal security of individuals.”); *Camara v. Mun. Court*, 387 U.S. 523, 528 (1967) (“The basic purpose of [the Fourth] Amendment, as recognized in countless decisions of this Court, is to safeguard the privacy and security of individuals against arbitrary invasions by governmental officials.”); *Schmerber v. California*, 384 U.S. 757, 767 (1966) (“The overriding function of the Fourth Amendment is to protect personal privacy and dignity against unwarranted intrusion by the State.”).

[VOL. 46: 1, 2009]

*Involuntary Medications*

SAN DIEGO LAW REVIEW

defendant's privacy and personal security.<sup>88</sup> Thus, the Fourth Amendment cases involving involuntary medical treatment provide useful insights into how courts should decide whether to allow the government to administer involuntary antipsychotic medications to incompetent criminal defendants.

The two seminal cases in which the Supreme Court considered whether the Fourth Amendment permits involuntary medical treatment for the purpose of obtaining evidence of a crime are *Schmerber v. California* and *Winston v. Lee*.<sup>89</sup> In *Schmerber*, the Court ruled that compelling Armando Schmerber, whom the police suspected of having driven under the influence of alcohol, to submit to a blood test did not violate the Fourth Amendment.<sup>90</sup> The Court noted that blood tests are "a commonplace in these days of periodic physical examinations" and also that "for most people the procedure involves no risk, trauma, or pain."<sup>91</sup> Moreover, such tests are both "highly effective" in determining whether an individual is intoxicated<sup>92</sup> as well as necessary for achieving the public health goal of diminishing drunk driving.<sup>93</sup> The Court was careful to state that its decision was limited to approving the minor intrusion of a blood test and was not a license allowing more substantial intrusions.<sup>94</sup>

In *Winston v. Lee*, the Court demonstrated that it meant what it had

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88. Cf. *Washington v. Harper*, 494 U.S. 210, 229 (1990) ("The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty."); see also *id.* at 237 (Stevens, J., concurring in part and dissenting in part) ("The invasion is particularly intrusive if it creates a substantial risk of permanent injury . . ."); *Riggins v. Nevada*, 504 U.S. 127, 134 (1992) ("In the case of antipsychotic drugs like Mellaril, that interference is particularly severe . . .").

89. See *Winston v. Lee*, 470 U.S. 753, 755 (1985); *Schmerber*, 384 U.S. at 767.

90. 384 U.S. at 771.

91. *Id.*

92. *Id.*

93. See *Winston*, 470 U.S. at 763 (explaining that "given the difficulty of proving drunkenness by other means, . . . results of the blood test were of vital importance if the State were to enforce its drunken driving laws"); see also William G. Ross, *Constitutional Law—Search and Seizure—Court-Ordered Surgical Removal of a Bullet from an Unconsenting Defendant for Evidentiary Purposes Held Reasonable Under the Fourth Amendment*, 55 TEX. L. REV. 147, 157 (1977) (noting "[t]he direct deterrent relationship between blood tests and a reduction in drunken driving").

94. *Schmerber v. California*, 384 U.S. 757, 772 (1966) ("That we today hold that the Constitution does not forbid the States minor intrusions into an individual's body under stringently limited conditions in no way indicates that it permits more substantial intrusions, or intrusions under other conditions."). Not all of the Justices shared the majority's assessment of a blood test as a minor intrusion. Justice Fortas called the blood test "an act of violence." *Id.* at 779 (Fortas, J., dissenting). Justice Douglas called it "forcible bloodletting." *Id.* at 779 (Douglas, J., dissenting).

said in *Schmerber* about not authorizing more substantial intrusions.<sup>95</sup> Rudolph Lee was charged with attempted robbery and malicious wounding; the state alleged that Lee and his intended victim, Ralph Watkinson, had exchanged gunshots, with a bullet from Watkinson's gun ending up lodged in Lee's chest.<sup>96</sup> The government wanted to compel Lee to undergo surgery so that the bullet could be removed and tested to prove Lee's identity as the person who attempted to rob Watkinson.<sup>97</sup> The potential harmfulness of the surgery to Lee was uncertain, seemingly because doctors were unsure about how difficult it would be to locate the bullet.<sup>98</sup> The surgery might but might not have required "extensive probing and retracting of the muscle tissue," which might but might not have caused tissue damage and infection.<sup>99</sup> The Supreme Court did not allow the government to compel this surgery, in part because of the uncertainty about its harmfulness,<sup>100</sup> in part because any involuntary surgery is a substantial intrusion,<sup>101</sup> and in part because the government did not have a compelling need to recover the bullet.<sup>102</sup>

These Fourth Amendment cases take a better approach than does *Sell* to deciding whether to allow involuntary medical treatment. The Fourth Amendment approach balances the likelihood and the severity of any physical harms that the defendant might experience as a result of the involuntary treatment against the government's interest that the treatment promotes. The blood test in *Schmerber* was reasonable because it posed virtually no risk of any physical harm and was "highly effective" in

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95. 470 U.S. at 755.

96. *Id.*

97. *Id.*

98. *Id.* at 764.

99. *Id.* The appellate court summarized the risks:

[O]ne surgeon testified that the procedure, excluding the anesthesia, would take only 15–20 minutes; another surgeon predicted the procedure could take up to 2 1/2 hours to complete. An expert testified that there was virtually no risk of muscle or tissue damage; another stated that these problems were possibilities. Several doctors testified that the procedure would be considered "minor surgery"; another doctor claimed that there was no such thing as minor surgery.

*Lee v. Winston*, 717 F.2d 888, 900 (4th Cir. 1983).

100. *Winston v. Lee*, 470 U.S. 753, 766 (1985) ("The medical risks of the operation, although apparently not extremely severe, are a subject of considerable dispute; the very uncertainty militates against finding the operation to be 'reasonable.'"); *id.* at 764 ("The court properly took the resulting uncertainty about the medical risks into account.").

101. *Id.* at 759 ("A compelled surgical intrusion into an individual's body for evidence, however, implicates expectations of privacy and security of such magnitude that the intrusion may be 'unreasonable' even if likely to produce evidence of a crime.").

102. *Id.* at 765 ("[A]lthough we recognize the difficulty of making determinations in advance as to the strength of the case against respondent, petitioners' assertions of a compelling need for the bullet are hardly persuasive.").

[VOL. 46: 1, 2009]

*Involuntary Medications*  
SAN DIEGO LAW REVIEW

identifying drunk drivers,<sup>103</sup> while the surgery in *Winston* was unreasonable because it posed an uncertain risk of possibly serious physical harm and was not essential to the government's case against the defendant.<sup>104</sup> The due process approach to deciding whether to allow involuntary medications—the *Sell* approach—is inadequate because it is not so much a balancing test as a categorical or threshold test. It does not ask courts to weigh the potential harms that an incompetent criminal defendant is likely to experience as a result of the medications against the government's interest in bringing that defendant to trial. Instead, *Sell* asks courts to decide whether the government has an “important” interest and also to decide, but as a separate inquiry, whether involuntary antipsychotics are “medically appropriate.”<sup>105</sup>

### III. INCOMPETENT CRIMINAL DEFENDANTS AND INVOLUNTARY ANTIPSYCHOTIC MEDICATIONS

#### A. *Schizophrenia and Incompetence to Stand Trial*

Schizophrenia is widely considered to be among the most serious of mental illnesses.<sup>106</sup> Its overarching impairment is a loss of contact with reality, including such symptoms as delusions, or beliefs not based in reality, and hallucinations, or perceptual experiences not based in reality.<sup>107</sup>

Some defendants with schizophrenia, or a related psychotic disorder, have delusional beliefs that preclude their ability to understand the trial process or to assist their attorneys and that therefore make them incompetent

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103. *Schmerber v. California*, 384 U.S. 757, 771 (1966).

104. *Winston*, 470 U.S. at 755.

105. See *supra* notes 81–82 and accompanying text (discussing *Sell* test).

106. See Steven M. Paul, *Introduction: The New Pharmacotherapy of Schizophrenia*, in CURRENT ISSUES IN THE PHARMACOTHERAPY OF SCHIZOPHRENIA xvii (Alan Breier et al. eds., 2001) (referring to schizophrenia as “arguably the most severe and disabling of the major psychiatric disorders”). According to the American Psychiatric Association, “[t]he characteristic symptoms of Schizophrenia involve a range of cognitive and emotional dysfunctions that include perception, inferential thinking, language and communication, behavioral monitoring, affect, fluency and productivity of thought and speech, hedonic capacity, volition and drive, and attention.” AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 299 (4th ed. text rev. 2000) [hereinafter DSM-IV-TR].

107. See GERALD C. DAVISON & JOHN M. NEALE, ABNORMAL PSYCHOLOGY 284–85 (8th ed. 2001) (defining *delusions* as “beliefs held contrary to reality” and *hallucinations* as “sensory experiences in the absence of any stimulation from the environment”).

to stand trial.<sup>108</sup> For example, defendants with schizophrenia have been found incompetent to stand trial because they have delusional beliefs either about the facts of the crime—such as a defendant’s belief that “he had not in fact murdered his mother, as he had used only rubber bullets”<sup>109</sup> or that “people who are killed are not really dead”<sup>110</sup>—or about the judicial process—such as a defendant’s belief that he was being “persecuted by ‘right wingers’ and the government”<sup>111</sup> or that “the police are trying to get him to ‘the court of lords.’”<sup>112</sup> Although treatment recommendations for schizophrenia include not only antipsychotic medications but also psychosocial therapies,<sup>113</sup> it is treatment with medications that is most likely to alleviate the acute symptoms of psychosis.<sup>114</sup>

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108. To be competent to stand trial, a defendant must possess both “sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding” and “a rational as well as factual understanding of the proceedings against him.” *Drope v. Missouri*, 420 U.S. 162, 172 (1975) (quoting *Dusky v. United States*, 362 U.S. 402, 402 (1960)); *see also* 18 U.S.C. § 4241(a) (2000) (instructing trial courts to hold competency hearings if “there is reasonable cause to believe that the defendant may presently be suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense”). The competence requirement protects the defendant’s right to a fair trial:

Unless a defendant is competent, the State cannot put him on trial. Competence to stand trial is rudimentary, for upon it depends the main part of those rights deemed essential to a fair trial, including the right to effective assistance of counsel, the rights to summon, to confront, and to cross-examine witnesses, and the right to testify on one’s own behalf or to remain silent without penalty for doing so.

*Riggins v. Nevada*, 504 U.S. 127, 139–40 (1992) (Kennedy, J., concurring in the judgment).

109. *Amador v. State*, 712 So. 2d 1179, 1181 (Fla. Dist. Ct. App. 1998).

110. *United States v. Weston*, 206 F.3d 9, 12 (D.C. Cir. 2000).

111. *United States v. Evans*, No. 102CR00136, 2004 WL 533473, at \*1 (W.D. Va. Mar. 18, 2004), *vacated and remanded*, 404 F.3d 227 (4th Cir. 2005).

112. *Commonwealth v. Crowley*, 471 N.E.2d 353, 355 (Mass. 1984).

113. *See* Anthony F. Lehman et al., *The Schizophrenia Patient Outcomes Research Team (PORT): Updated Treatment Recommendations 2003*, 30 SCHIZOPHRENIA BULL. 193, 201 (2004) (“For most persons with schizophrenia, the combination of psychopharmacologic and psychosocial interventions improves outcomes.”).

114. *See* John M. Kane, *Conventional Neuroleptic Treatment: Current Status, Future Role*, in *THE NEW PHARMACOTHERAPY OF SCHIZOPHRENIA* 89, 90 (Alan Breier ed., 1996) (describing antipsychotic medications as “the primary modality in the treatment of an acute episode or an acute exacerbation of a schizophrenic illness”); Thomas H. McGlashan, *Rationale and Parameters for Medication-Free Research in Psychosis*, 32 SCHIZOPHRENIA BULL. 300, 301 (2006) (noting that antipsychotic medications are “the most rapid, effective, and economical treatment for active psychosis”).

[VOL. 46: 1, 2009]

*Involuntary Medications*

SAN DIEGO LAW REVIEW

*B. Antipsychotic Medications 101*

For many people with schizophrenia, antipsychotic medications are lifesaving, literally as well as figuratively.<sup>115</sup> But even when taken voluntarily, these medications are not without significant problems, including the likelihood of serious side effects.<sup>116</sup> A large part of the difficulty in treating schizophrenia is finding an antipsychotic medication that does not cause intolerable side effects.<sup>117</sup> The American Psychiatric

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115. As one schizophrenia researcher explains:

Active psychosis is a dangerous, life-threatening state. Behavior is often unpredictable because of misperceptions, misconceptions, and irrational thinking. The gravest dangers are suicide, homicide, and physical injury. Almost as important are paralyzes of judgment and empathy resulting in violations of social convention and trust and leading ultimately to social isolation and stigmatization. For persons in this state of mind, antipsychotic medications are unquestionably a powerful therapeutic tool.

McGlashan, *supra* note 114, at 300.

Before the development of antipsychotics, schizophrenia was essentially untreatable, and the back wards of state hospitals were filled with people who had little to no chance of ever leaving:

Prior to 1950, effective drugs for treating psychotic patients were virtually nonexistent, and psychotic patients were usually permanently or semipermanently hospitalized; by 1955, more than half a million psychotic persons in the United States were residing in mental hospitals. In 1956, a dramatic and steady reversal in this trend began. By 1983, fewer than 220,000 were institutionalized. This decline occurred despite a doubling in the numbers of admissions to state hospitals. By the early 1990s, people with schizophrenia were routinely stabilized on medication and discharged from institutions quite rapidly. What accounted for this dramatic shift was a class of drugs called the phenothiazines.

ROBERT M. JULIEN, A PRIMER OF DRUG ACTION: A COMPREHENSIVE GUIDE TO THE ACTIONS, USES, AND SIDE EFFECTS OF PSYCHOACTIVE DRUGS 346–47 (10th ed. 2005) (footnote omitted) (emphasis omitted).

116. According to the American Psychiatric Association:

Side effects of medications are a crucial aspect of treatment because they often determine medication choice and are a primary reason for medication discontinuation. Side effects can complicate and undermine antipsychotic treatment in various ways. The side effects themselves may cause or worsen symptoms associated with schizophrenia, including negative, positive, and cognitive symptoms and agitation. In addition, these side effects may contribute to risk for other medical disorders. Finally, these side effects often are subjectively difficult to tolerate and may affect the patient's quality of life and willingness to take the medication.

AM. PSYCH. ASS'N, PRACTICE GUIDELINES FOR THE TREATMENT OF PATIENTS WITH SCHIZOPHRENIA 66–67 (2d ed. 2004) [hereinafter APA PRACTICE GUIDELINES].

117. One recent study designed to evaluate the effectiveness of various antipsychotic medications in treating people with chronic schizophrenia reported that of nearly 1500 subjects, between sixty-four and eighty-two percent discontinued treatment



Association defines a “recommended dose” of antipsychotic medication as “that which is both effective and not likely to cause side effects that are subjectively difficult to tolerate.”<sup>118</sup>

There are two categories of antipsychotic medications, each with its own set of risks. The first category, called first-generation antipsychotics, typical antipsychotics, or neuroleptics,<sup>119</sup> has as its most serious risk neurological syndromes such as tardive dyskinesia,<sup>120</sup> while the second category, called second-generation or atypical antipsychotics, is more likely to cause metabolic disorders such as diabetes.<sup>121</sup>

### 1. Side Effects of First-Generation Antipsychotics

The first generation of antipsychotic medications was developed in the 1950s, and these drugs are believed to alleviate psychotic symptoms primarily by blocking the activity of the neurotransmitter dopamine in certain areas of the brain.<sup>122</sup> This dopamine-blocking effect can also lead to neurological disorders.<sup>123</sup> Perhaps the most serious neurological disorder that typical antipsychotics cause is tardive dyskinesia, which is characterized by involuntary, irregular movements.<sup>124</sup> Common symptoms include tongue twisting and lip smacking as well as hyperkinetic movements of the arms, legs, and trunk.<sup>125</sup> Tardive dyskinesia is not curable, and the standard treatment recommendation—discontinuation of

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during the first phase of the study. Jeffrey A. Lieberman et al., *Effectiveness of Antipsychotic Drugs in Patients with Chronic Schizophrenia*, 353 NEW ENG. J. MED. 1209, 1215 (2005). The study’s authors attributed the high rate of treatment discontinuation to “intolerable side effects.” *Id.* at 1218 (“There were no significant differences among the drugs in the time until discontinuation of treatment owing to intolerable side effects.”).

118. APA PRACTICE GUIDELINES, *supra* note 116, at 11.

119. These drugs are called “neuroleptics” because they cause disorders with the same symptoms as neurological diseases. See DAVISON & NEALE, *supra* note 107, at 305; JULIEN, *supra* note 115, at 345 n.1.

120. See *infra* Part III.B.1 (discussing side effects of first-generation antipsychotic medications).

121. See *infra* Part III.B.2 (discussing side effects of second-generation antipsychotic medications).

122. JULIEN, *supra* note 115, at 340 (“Early scientific evidence favored a pure dopamine theory of schizophrenia: the disorder arises from dysregulation in certain brain regions of the dopamine system, resulting in a relative surplus of dopamine in the brain. Antipsychotic drugs therefore work by blocking dopamine receptors, an action that qualifies them as dopamine receptor antagonists.” (citation and emphases omitted)).

123. Parkinson’s disease, for example, is caused by the death of dopamine-producing cells in the motor area of the brain. Nat’l Inst. of Neurological Disorders and Stroke, NINDS Parkinson’s Disease Information Page (Oct. 17, 2008), [http://www.ninds.nih.gov/disorders/parkinsons\\_disease/parkinsons\\_disease.htm](http://www.ninds.nih.gov/disorders/parkinsons_disease/parkinsons_disease.htm) (“Parkinson’s disease (PD) belongs to a group of conditions called motor system disorders, which are the result of the loss of dopamine-producing brain cells.”).

124. JULIEN, *supra* note 115, at 353.

125. *Id.*

[VOL. 46: 1, 2009]

*Involuntary Medications*

SAN DIEGO LAW REVIEW

antipsychotic medications—amounts to exchanging the symptoms of one horrific, incurable disorder for another.<sup>126</sup> Once tardive dyskinesia develops, the patient's choices are to treat the psychosis and endure the tardive dyskinesia or to treat the tardive dyskinesia and endure the psychosis.<sup>127</sup>

Two other very disabling neurological disorders that the typical antipsychotics can cause are dystonia and akathisia.<sup>128</sup> Dystonia is characterized by sustained muscle spasms that produce involuntary movements and abnormal postures.<sup>129</sup> Akathisia is characterized by feelings of restlessness and anxiety.<sup>130</sup> At its most severe, the experience of akathisia is so distressing that some people become suicidal.<sup>131</sup>

In addition to these neurological side effects, the first-generation antipsychotic medications can also cause a long list of other kinds of side effects, including sedation, impaired cognitive functioning, autonomic effects such as blurred vision and reduced blood pressure, and a rare but potentially fatal reaction, neuroleptic malignant syndrome.<sup>132</sup>

## 2. Side Effects of Second-Generation Antipsychotics

In the 1990s, researchers developed a new generation of antipsychotic medications that are believed to alleviate psychotic symptoms by altering the activity of dopamine and an additional neurotransmitter, usually

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126. *Id.* (noting that tardive dyskinesia is “often irreversible”).

127. See Nat'l Inst. of Neurological Disorders and Stroke, NINDS Tardive Dyskinesia Information Page (Feb. 14, 2007), <http://www.ninds.nih.gov/disorders/tardive/tardive.htm> (“There is no standard treatment for tardive dyskinesia. Treatment is highly individualized. The first step is generally to stop or minimize the use of the neuroleptic drug. However, for patients with a severe underlying condition this may not be a feasible option.”).

128. JULIEN, *supra* note 115, at 352.

129. *Id.*

130. *Id.* (“Akathisia [is] a syndrome of the subjective feeling of anxiety, accompanied by restlessness, pacing, constant rocking back and forth, and other repetitive, purposeless actions.”).

131. E. Cem Atbaşoğlu et al., *The Relationship of Akathisia with Suicidality and Depersonalization Among Patients with Schizophrenia*, 13 J. NEUROPSYCHIATRY & CLINICAL NEUROSCIENCES 336, 336 (2001) (“Akathisia, characterized by a state of subjective and motor restlessness, is a common and unpleasant side effect of antipsychotic medication. Case reports have described both suicidality and violence as being precipitated by this distressing condition.” (footnotes omitted)).

132. JULIEN, *supra* note 115, at 354–55.

serotonin.<sup>133</sup> These drugs were initially praised as “wonder drugs,” capable of treating people who had not responded to other, typical medications yet not likely to produce any of the neurological side effects commonly observed with the older antipsychotics—hence the term “atypical.”<sup>134</sup> Both of these early assessments have proven to have been overly optimistic. Atypicals do work when other drugs have not, but some people still are unresponsive even to these newer medications.<sup>135</sup> Moreover, whereas atypicals were initially thought not to cause the same neurological disorders as the typical antipsychotics, more recent data suggests that the difference is in the dosage—that atypicals, if administered in doses comparable to the typical antipsychotics, produce similar levels of neurological side effects.<sup>136</sup> And like the traditional antipsychotics, the atypicals also cause a long list of other side effects, ranging in seriousness from life-threatening—agranulocytosis (a loss of white blood cells) and myocarditis (inflammation of the heart muscle) are two potentially fatal side effects of Clozaril,<sup>137</sup> the most risky but in

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133. *Id.* at 341–42 (“There is no consensus concerning the biological mechanisms that might impart and define an atypical antipsychotic. Atypical antipsychotics display more than one mechanism for achieving atypicality. Almost all of these drugs are antagonists at dopamine-2 receptors and have a second action, usually antagonism of the serotonin 5-HT<sub>2</sub> receptors.” (citations omitted)).

134. *See id.* at 346, 360–61.

135. *Id.* at 360 (estimating that between thirty and sixty percent of people who were unresponsive to other drugs improved on Clozaril, one of the first atypical antipsychotics). Some recent research suggests that, in general, atypical antipsychotics are no more effective than the typical medications. *See* Shôn Lewis & Jeffrey Lieberman, *CATIE and CUtLASS: Can We Handle the Truth?*, 192 *BRITISH J. PSYCHIATRY* 161, 161–63 (2008).

136. Shitij Kapur et al., *Relationship Between rDopamine D<sub>2</sub> Occupancy, Clinical Response, and Side Effects: A Double-Blind PET Study of First-Episode Schizophrenia*, 157 *AM. J. PSYCHIATRY* 514, 517 (2000); Lieberman et al., *supra* note 117, at 1218 (suggesting that administering high doses of first generation antipsychotics “may have biased previous comparisons of first- and second-generation drugs”).

137. *See* Jose Ma. J. Alvir et al., *Clozapine Induced Agranulocytosis: Incidence and Risk Factors in the United States*, 329 *NEW ENG. J. MED.* 162, 162–67 (1993) (reporting incidence and fatality rate from agranulocytosis in patients treated with Clozaril); J.G. Kilian et al., *Myocarditis and Cardiomyopathy Associated with Clozapine*, 354 *LANCET* 1841, 1841 (1999) (“Clozapine therapy may be associated with potentially fatal myocarditis and cardiomyopathy in physically healthy young adults with schizophrenia.”).

[VOL. 46: 1, 2009]

*Involuntary Medications*

SAN DIEGO LAW REVIEW

many cases the most effective atypical antipsychotic<sup>138</sup>—to fairly minor, including dry mouth, headaches, and insomnia.<sup>139</sup>

Although life-threatening side effects are rare, the second-generation antipsychotics commonly cause metabolic disorders such as obesity and hyperglycemia.<sup>140</sup> Perhaps because these disorders are not uncommon among the general population, courts in some cases seem rather unconcerned about these side effects. The court in *United States v. Archuleta*, for example, appears to be as indifferent as the court in *Evans*<sup>141</sup> to the effect that involuntary antipsychotic medications will have on Archuleta's diabetes: "Any health side effects, such as aggravation of diabetes, are medically treatable and such treatments are commonplace and successful in this area of medical practice."<sup>142</sup> In *United States v. Weston*, the court allowed the government to continue administering involuntary antipsychotic medications despite Weston's physician's testimony that the medications were responsible for Weston's seventy-pound weight gain.<sup>143</sup> The court confessed that it was "troubled by the defendant's weight gain on the anti-psychotic medications"<sup>144</sup> but nevertheless found that the medications'

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138. See Robert W. Buckman & Randy D. Malan, *Clozapine for Refractory Schizophrenia: The Illinois Experience*, 60 J. CLINICAL PSYCHIATRY (SUPPLEMENT 1) 18, 18 (1999) (noting that Clozaril "has become the gold standard for treating drug-resistant patients"); Juan R. Bustillo et al., *The Psychosocial Treatment of Schizophrenia: An Update*, 158 AM. J. PSYCHIATRY 163, 173 (2001) (noting that "[s]uperiority for previously resistant psychotic symptoms has been demonstrated only for clozapine").

139. JULIEN, *supra* note 115, at 364 (listing insomnia and headache as common side effects of Risperdal); *id.* at 366 (listing dry mouth as a side effect of Zyprexa).

140. "The safety advantages of the atypical drugs have been questioned because of their propensity to induce weight gain and alter glucose and lipid metabolism." Lieberman et al., *supra* note 117, at 1210; see also JULIEN, *supra* note 115, at 369–72.

141. See *supra* notes 16–20 and accompanying text (discussing the *Evans* case).

142. *United States v. Archuleta*, No. 2:05CR0676 TC, 2006 WL 2476070, at \*4 (D. Utah, Aug. 24, 2006), *aff'd*, 218 F. App'x 754 (10th Cir. 2007).

143. According to the district court that monitored Weston's progress while he was being administered involuntary antipsychotics:

On June 20, 2004, Mr. Weston's weight was recorded at 317 pounds. The defendant has gained 70 pounds since he was initially placed at Butner. A general practitioner brought in to evaluate Mr. Weston described him as "morbidly obese." With regard to this issue, Dr. Johnson has testified that "the principal contributor in his weight gain is clearly his medication use. There is no doubt about that. It is associated with significant weight gain."

*United States v. Weston*, 326 F. Supp. 2d 64, 67–68 (D.D.C. 2004) (2004 progress hearing) (citations omitted).

144. *Id.* at 68.

“continued use remains medically appropriate.”<sup>145</sup>

Despite the sanguine attitudes of these courts toward defendants who have become morbidly obese or who are well on their way to developing insulin-dependent diabetes, neither of these conditions is insignificant. Both cause a wide range of long-term, exceedingly harmful, potentially fatal complications, some of which can be difficult if not impossible to treat fully.

#### *a. Obesity*

This disease presently is the topic of several conversations among legal scholars; all of these conversations reflect the recognition that obesity is a serious, life-threatening illness. First, some courts have decided that morbid obesity can be grounds for removing a child from his or her parents’ care.<sup>146</sup> These decisions—rightly, most commentators seem to believe—place obesity in the same category as other, more traditional forms of child abuse.<sup>147</sup> Second, tort theory has been widely discussed as a possible basis for suing manufacturers whose products might cause obesity.<sup>148</sup> And finally, government taxation and other

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145. *Id.* After more than two years of involuntary treatment with antipsychotic medications, however, Weston remained too delusional to be brought to trial. In 2004, the government conceded that further involuntary treatment was unlikely to render Weston competent. *United States v. Weston*, No. 98-357 (EGS), 2004 U.S. Dist. LEXIS 23579, at \*3 (D.D.C. Nov. 22, 2004).

146. See Shireen Arani, Case Comment, *State Intervention in Cases of Obesity-Related Medical Neglect*, 82 B.U. L. REV. 875, 875–76 (2002) (discussing the case of an obese three-year-old child removed from her parents’ custody because they refused to follow medical advice regarding her diet); Laura A. Kelley, *What Should Be the Standards for Intervening Between Parent and Child? The Parental Prosecution for a Young Boy’s Obesity*, 9 BUFF. WOMEN’S L.J. 7, 8–10 (2001) (discussing the case of an obese four-year-old boy, who was placed in foster care and whose parents were charged with criminal neglect); see also Lindsey Murtagh, *Judicial Interventions for Morbidly Obese Children*, 35 J.L. MED. & ETHICS 497, 497 (2007) (noting that “courts in California, Iowa, Indiana, New Mexico, Pennsylvania, and Texas . . . have recognized morbid obesity as an issue warranting state intervention into the family unit”).

147. See, e.g., Marshall L. Wilde, *Bioethical and Legal Implications of Pediatric Gastric Bypass*, 40 WILLAMETTE L. REV. 575, 576 (2004) (“The modern recognition of pediatric obesity as a threat to long-term health has given rise to a legal recognition that parents who fail to treat their child’s obesity can be held accountable for medical neglect.”).

148. E.g., *Pelman v. McDonald’s Corp.*, 237 F. Supp. 2d 512, 531–32 (S.D.N.Y. 2003), *vacated in part and remanded*, 396 F.3d 508 (2d Cir. 2005) (suit against McDonald’s filed by parents of two obese teenagers alleging deceptive acts, negligence, and failure to warn); M. Gregg Bloche, *Obesity and the Struggle Within Ourselves*, 93 GEO. L.J. 1335, 1356 (2005) (arguing that “[f]oods that fail the consumer expectations or risk-utility tests for defective design should be subject to liability” but also predicting that “the difficulty of proving causation-in-fact (by tying a food product to a person’s illness) will typically preclude pro-plaintiff judgments”); Rogan Kersh & James A. Morone, *Obesity, Courts, and the New Politics of Public Health*, 30 J. HEALTH POL.

[VOL. 46: 1, 2009]

*Involuntary Medications*

SAN DIEGO LAW REVIEW

forms of regulation to combat the “obesity epidemic”<sup>149</sup> have been proposed.<sup>150</sup>

Obesity may well be the leading cause of preventable deaths in the United States.<sup>151</sup> Obesity is responsible for 300,000 deaths per year, and people who are obese have a fifty to one hundred percent increased risk of premature death from weight-related health problems.<sup>152</sup> The Social Security Administration regards obesity as a potential disability.<sup>153</sup> In 2004, the Health and Human Services Secretary announced that Medicare would begin to pay for some types of obesity treatments, noting that “[o]besity is a critical public health problem in our country that causes millions of Americans to suffer unnecessary health problems and to die prematurely.”<sup>154</sup> According to the Centers for Disease Control and Prevention, obesity “substantially” increases the risk of death from such causes as hypertension, type II diabetes, coronary artery disease, stroke, gallbladder

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POL’Y & L. 839, 863 (2005) (“Tort lawyers have filed dozens of class-action suits on behalf of obese litigants.”); Jeremy H. Rogers, Note, *Living on the Fat of the Land: How to Have Your Burger and Sue It Too*, 81 WASH. U. L.Q. 859, 883 (2003) (recommending class action lawsuits against “Big Food”).

149. Marlene B. Schwartz & Kelly D. Brownell, *Actions Necessary to Prevent Childhood Obesity: Creating the Climate for Change*, 35 J.L. MED. & ETHICS 78, 78 (2007) (noting the use of “terms like ‘epidemic,’ ‘crisis,’ and ‘emergency’”).

150. See Kelly D. Brownell, *Get Slim With Higher Taxes*, N.Y. TIMES, Dec. 15, 1994, at A29; Hanna Rosin, *The Fat Tax*, NEW REPUBLIC, May 18, 1998, at 19, cited in Richard A. Epstein, *What (Not) To Do About Obesity: A Moderate Aristotelian Answer*, 93 GEO. L.J. 1361, 1375 (2005); Jeff Strnad, *Conceptualizing the “Fat Tax”*: *The Role of Food Taxes in Developed Economies*, 78 S. CAL. L. REV. 1221, 1224–27 (2005) (discussing “junk-food taxes” and “fat taxes”).

151. OFFICE OF THE SURGEON GEN., U.S. DEP’T OF HEALTH AND HUMAN SERVS., THE SURGEON GENERAL’S CALL TO ACTION TO PREVENT AND DECREASE OVERWEIGHT AND OBESITY 8 (2001), available at <http://www.surgeongeneral.gov/topics/obesity/calltoaction/CalltoAction.pdf> [hereinafter SURGEON GENERAL’S CALL TO ACTION].

152. David Burnett, *Fast-Food Lawsuits and the Cheeseburger Bill: Critiquing Congress’s Response to the Obesity Epidemic*, 14 VA. J. SOC. POL’Y & L. 357, 358 (2007) (citing SURGEON GENERAL’S CALL TO ACTION, *supra* note 151, at 8); see also WORLD HEALTH ORG., TECHNICAL REPORT SERIES NO. 894, OBESITY: PREVENTING AND MANAGING THE GLOBAL EPIDEMIC 2 (2000) (describing obesity as “one of the most significant contributors to ill health” and “a key risk factor in the natural history of other chronic and noncommunicable diseases”).

153. See Frank S. Bloch, *Medical Proof, Social Policy, and Social Security’s Medically Centered Definition of Disability*, 92 CORNELL L. REV. 189, 221 n.1 (2007) (“SSA also acknowledges that obesity is a medically determinable impairment that may, on its own, warrant a finding of disability.” (citing Titles II and XVI: Evaluation of Obesity, S.S.R. 00-3p (Cum. Ed. 2000))).

154. Press Release, HHS Announces Revised Medicare Obesity Coverage Policy (July 15, 2004), <http://www.hhs.gov/news/press/2004pres/20040715.html>.

disease, and respiratory illnesses, as well as some cancers.<sup>155</sup> Furthermore, “[h]igher body weights are also associated with an increase in mortality from all causes.”<sup>156</sup>

*b. Diabetes*

Diabetes is a metabolic illness.<sup>157</sup> Type I diabetes is caused when the body’s immune system destroys the pancreatic cells that produce insulin, a hormone that regulates conversion of glucose to energy.<sup>158</sup> People with type I diabetes must receive insulin by either injection or a pump.<sup>159</sup> People with type II diabetes initially produce insulin but their cells do not properly absorb it.<sup>160</sup> Over time, though, the pancreas loses its ability to produce insulin.<sup>161</sup> Type II diabetes may be treatable with oral medication, although more severe cases require treatment with insulin.<sup>162</sup>

When the body lacks sufficient insulin, glucose builds up in the bloodstream, producing a condition called hyperglycemia.<sup>163</sup> If untreated, hyperglycemia can lead to ketoacidosis, which can progress to a diabetic coma.<sup>164</sup> High blood glucose levels also may damage the eyes, causing blurred vision and possibly leading to blindness.<sup>165</sup> Damage to nerves in any part of the body is another possible consequence of high blood glucose levels.<sup>166</sup> Diabetes can damage both the nerves and the blood vessels to the feet, causing poor circulation and possibly leading to

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155. NAT’L INSTS. OF HEALTH, PUBL’N NO. 00-4084, THE PRACTICAL GUIDE: IDENTIFICATION, EVALUATION, AND TREATMENT OF OVERWEIGHT AND OBESITY IN ADULTS 5 (2000), available at [http://www.nhlbi.nih.gov/guidelines/obesity/prctgd\\_c.pdf](http://www.nhlbi.nih.gov/guidelines/obesity/prctgd_c.pdf).

156. *Id.*

157. Corinne P. Maskaleris, *Understanding Type II Diabetes: A Primer*, 16 EXPERIENCE 40, 40 (2006); see also Am. Diabetes Ass’n, Type 1 Diabetes, <http://www.diabetes.org/type-1-diabetes.jsp> (last visited Jan. 26, 2009).

158. CTRS. FOR DISEASE CONTROL & PREVENTION, DEP’T OF HEALTH AND HUMAN SERVS., NATIONAL DIABETES FACT SHEET: GENERAL INFORMATION AND NATIONAL ESTIMATES ON DIABETES IN THE UNITED STATES 1 (2003), available at [http://www.cdc.gov/diabetes/pubs/pdf/ndfs\\_2003.pdf](http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2003.pdf) [hereinafter DIABETES FACT SHEET].

159. *Id.* at 2.

160. *Id.* at 1.

161. *Id.*

162. *Id.* at 2.

163. Am. Diabetes Ass’n, Hyperglycemia, <http://www.diabetes.org/type-1-diabetes/hyperglycemia.jsp> (last visited Jan. 26, 2009).

164. DIABETES FACT SHEET, *supra* note 158, at 7 (“Uncontrolled diabetes often leads to biochemical imbalances that can cause acute life-threatening events, such as diabetic ketoacidosis and hyperosmolar (nonketotic) coma.”).

165. *Id.* (“Diabetes is the leading cause of new cases of blindness among adults aged 20–74 years.”).

166. High blood glucose levels can cause several types of nerve damage, or diabetic neuropathies. See Am. Diabetes Ass’n, Diabetic Neuropathy (Nerve Damage) and Diabetes, <http://www.diabetes.org/type-1-diabetes/diabetic-neuropathy.jsp> (last visited Jan. 26, 2009).

[VOL. 46: 1, 2009]

*Involuntary Medications*

SAN DIEGO LAW REVIEW

amputation.<sup>167</sup> High blood glucose levels, especially if combined with high blood pressure, can also cause kidney damage and lead to end-stage renal disease—kidney failure requiring dialysis or a transplant.<sup>168</sup> People with diabetes are more likely to die from pneumonia or influenza, and are more likely to suffer a stroke, than are people who do not have diabetes.<sup>169</sup> Diabetes, especially in people with high blood pressure and high cholesterol, causes heart disease, which is the leading cause of death among people with diabetes.<sup>170</sup> In 2002, diabetes was the sixth leading cause of death in the United States.<sup>171</sup>

*C. The Inadequacies of Medical Appropriateness*

*Sell* charges courts with the task of deciding whether involuntary antipsychotic medications are “medically appropriate,” which the Court defines as “in the patient’s best medical interest in light of his medical condition.”<sup>172</sup> For several reasons, this medical appropriateness standard does little if anything to guarantee that the harms of involuntary antipsychotic medications will be justified by the government’s interest in rendering a defendant competent to stand trial. One problem with medical appropriateness is that in applying this standard, many courts have deferred more or less completely to government physicians’ statements that antipsychotic medications are “the standard of care” for people diagnosed with a psychotic disorder. For example, the court in *United States v. Archuleta* decided, “[A]s to the medical appropriateness of medication, the doctor stated that ‘antipsychotic medication is the standard of care for psychosis, and in Mr. Archuleta’s case, schizophrenia,

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167. DIABETES FACT SHEET, *supra* note 158, at 7 (“More than 60% of nontraumatic lower-limb amputations occur among people with diabetes.”).

168. *Id.* at 6 (“Diabetes is the leading cause of end-stage renal disease, accounting for 44 percent of new cases [in 2002].”).

169. *Id.* Additionally, “[p]eople with diabetes are more susceptible to many other illnesses and, once they acquire these illnesses, often have worse prognoses.” *Id.*

170. According to the Centers for Disease Control and Prevention, “Cardiovascular disease affects millions of adults with diabetes and is a major cause of morbidity and mortality among persons with diabetes. In 2003, 5.2 million persons aged 35 years and older with diabetes reported being diagnosed with a cardiovascular disease condition (i.e., coronary heart disease, stroke, or other heart condition).” Ctrs. for Disease Control and Prevention, Number (in millions) of Persons with Diabetes Aged 35 Years and Older with Self-Reported CVD Conditions, United States, 1997–2003, <http://www.cdc.gov/diabetes/statistics/cvd/fig1.htm> (last visited Jan. 26, 2009).

171. DIABETES FACT SHEET, *supra* note 158, at 6.

172. *Sell v. United States*, 539 U.S. 166, 181 (2003).



it is the only effective treatment for it.”<sup>173</sup> The court’s consideration of medical appropriateness in *United States v. Renshaw* was similarly concise: “[T]he Court finds the administration of the antipsychotic medication is medically appropriate. The Forensic Evaluation indicates that the administration of antipsychotic medication is a standard component of treatment for anyone with the Defendant’s mental condition.”<sup>174</sup> And in *United States v. Cortez-Perez*: “Defendant suffers from Chronic Schizophrenia which will not likely be controlled without standard medication. The proposed medication is [the] widely available standard treatment for persons suffering from the serious mental illness that the Defendant suffers.”<sup>175</sup>

On one hand, the equation of medical appropriateness with the standard of care for schizophrenia cannot be what the *Sell* Court intended, because if medical appropriateness were nothing more than the standard of care, then antipsychotics would be appropriate for every defendant diagnosed with schizophrenia—and the medical appropriateness standard would be rendered meaningless.

Perhaps, however, trial courts should not be criticized too harshly for these circumventions of *Sell*’s intent, because it is not apparent how, under *Sell*, courts could do much better. Antipsychotic medications are in fact the standard of care for schizophrenia. And antipsychotic medications are generally medically appropriate for people with schizophrenia. All antipsychotics do have the potential to cause very disabling and even life-threatening side effects.<sup>176</sup> But given that schizophrenia is itself very disabling<sup>177</sup> and even life-threatening,<sup>178</sup> it is the rare person with

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173. 218 F. App’x 754, 757 (10th Cir. 2007). A few courts have taken the medical appropriateness question more seriously. For example, in *United States v. McCray*, 474 F. Supp. 2d 671 (D.N.J. 2007), the court denied the government’s motion for involuntary medication, in part because:

[T]he risk of Defendant suffering serious side effects is not insubstantial. When the risks of serious side effects are balanced against the questions that exist affecting the potential effectiveness of drug treatment, the Court cannot conclude by clear and convincing evidence that the potential benefits that outweigh the substantial risks.

*Id.* at 682. A few courts, though, grant the government’s motion with only the most cursory attention to medical appropriateness. *E.g.*, *United States v. Ballesteros*, No. 2:04-CR-0144-GEB, 2006 WL 224437, at \*5 (E.D. Cal. Jan. 25, 2006) (“Dr. Sarrazin’s testimony that the administration of the described antipsychotic medications is medically appropriate is credited.”); *United States v. Martin*, No. 1:04MJ00183, 2005 WL 1895110, at \* 4 (W.D. Va. Aug. 10, 2005) (“Finally, I find that the administration of the recommended medication is medically appropriate.”).

174. *United States v. Renshaw*, No. 4:06CR-31-M, 2007 WL 2746675, at \*2 (W.D. Ky. Sept. 18, 2007).

175. *United States v. Cortez-Perez*, No. 06-CR-1290-WQH, 2007 WL 2695867, at \*4 (S.D. Cal. Sept. 10, 2007).

176. *See supra* Part III.B (discussing side effects of antipsychotic medications).

177. *See* Kim T. Mueser & Susan R. McGurk, *Schizophrenia*, 363 LANCET 2063,

[VOL. 46: 1, 2009]

*Involuntary Medications*

SAN DIEGO LAW REVIEW

schizophrenia for whom antipsychotic medications can be declared medically inappropriate.

That antipsychotic medications are not medically inappropriate, though, does not mean that these medications cannot be unreasonably harmful when administered for the purpose of rendering a defendant competent to stand trial. When someone with schizophrenia chooses to take antipsychotic medications voluntarily, for the purpose of alleviating his own psychotic symptoms, then it is sensible to assume that for that person, the benefits justify the harms. But when the government seeks to administer antipsychotic medications involuntarily, for the purpose of advancing the government's interest in bringing a defendant to trial, a court should decide whether the benefits to the government justify the harms to the defendant.<sup>179</sup>

Several commentators have proposed that under *Sell*, courts should interpret "medically appropriate" to mean treatment that, in a civil context, a physician would be willing to prescribe.<sup>180</sup> But harms that a patient is willing to accept for herself, when she concludes that the benefits to her own well-being are worth those harms, are not necessarily the same harms that a court should accept for her, when the purpose of administering the medications is to benefit the government. Put differently, should the fact that some people decide to take antipsychotic

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2063 (2004) ("Schizophrenia is a mental illness that is among the world's top ten causes of long-term disability."). For a compelling first-person account of schizophrenia, see generally ELYN R. SAKS, *THE CENTER CANNOT HOLD: MY JOURNEY THROUGH MADNESS* (2007).

178. Schizophrenia is associated with "an alarmingly high" rate of suicide. Alan Breier, *Introduction: A New Era in the Pharmacotherapy of Psychotic Disorders*, 62 J. CLINICAL PSYCHIATRY (SUPPLEMENT 2) 3, 3 (2001); see also JULIEN, *supra* note 115, at 337 (reporting that "approximately 10 to 15 percent of individuals with schizophrenia take their own lives, usually within the first 10 years of developing the disorder").

179. This is why the issue of side effects is not a strictly medical one. The decision to be made is not whether the benefits to the defendant justify the risk of side effects but rather whether the benefits to the government justify the risk of side effects. See *supra* note 70.

180. See *Developments in the Law: The Law of Mental Illness*, 121 HARV. L. REV. 1114, 1130 (2008) (proposing that medical appropriateness be defined as treatment that is "the 'right treatment for the condition,' assuming the defendant was not on trial"); Rebekah W. Page, Comment, *Forcible Medication and the Fourth Amendment: A New Framework for Protecting Nondangerous Mentally Ill Pretrial Detainees Against Unreasonable Governmental Intrusions into the Body*, 79 TUL. L. REV. 1065, 1087 (2005) (arguing that "there should be a separate, medical determination that antipsychotic medication is the best treatment option for the patient, regardless of the government's interest in the matter").

medications voluntarily for the purpose of enhancing their own well-being help to justify a court's decision to compel people to take these medications involuntarily for the purpose of furthering the government's interest in bringing them to trial? It is hard to imagine that the answer should be anything other than no: Administering a voluntary medication that both benefits and harms the individual who is taking the medication is very different from administering an involuntary medication that benefits the government and harms the individual.<sup>181</sup>

Some courts have proposed that administering involuntary antipsychotic medications does benefit as well as harm the defendant, even if it also benefits the government. For example, in approving involuntary medication for the purpose of rendering the defendant competent to stand trial, the court in *United States v. Algere* wrote that “[t]he proposed treatment has numerous potential positive effects and is expected to significantly improve Algere’s quality of life.”<sup>182</sup> It is of course true that schizophrenia is a disease that causes tremendous suffering, and it is also true that antipsychotic medications often alleviate at least some of that suffering. But as the court explained in *United States v. Dumeny*, “[t]he issue before the court is not whether Mr. Dumeny should voluntarily accept treatment, but whether the court should order him to do so against his will.”<sup>183</sup> Justifying involuntary medication on the grounds that it will benefit the defendant fails to take adequate account of the defendant’s own decision not to take the medications voluntarily. If the defendant believed that the medication’s benefits to him justified the medication’s harms, he would choose to take the medication voluntarily.<sup>184</sup> And

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181. The Supreme Court recognized this distinction in *Winston v. Lee*, explaining that voluntary general anesthesia is different from involuntary general anesthesia:

When conducted with the consent of the patient, surgery requiring general anesthesia is not necessarily demeaning or intrusive. In such a case, the surgeon is carrying out the patient’s own will concerning the patient’s body and the patient’s right to privacy is therefore preserved. In this case, however, the Court of Appeals noted that the Commonwealth proposes to take control of respondent’s body, to “drug this citizen—not yet convicted of a criminal offense—with narcotics and barbiturates into a state of unconsciousness,” and then to search beneath his skin for evidence of a crime. This kind of surgery involves a virtually total divestment of respondent’s ordinary control over surgical probing beneath his skin.

470 U.S. 753, 765 (1985) (citation omitted).

182. *United States v. Algere*, 396 F. Supp. 2d 734, 746 (E.D. La. 2005).

183. *United States v. Dumeny*, 295 F. Supp. 2d 131, 133 (D. Me. 2004).

184. See *Cobbs v. Grant*, 502 P.2d 1, 10 (Cal. 1972) (explaining that “a medical doctor, being the expert, appreciates the risks inherent in the procedure he is prescribing, the risks of a decision not to undergo the treatment, and the probability of a successful outcome of the treatment” but that “[t]he weighing of these risks against the individual subjective fears and hopes of the patient is not an expert skill”—instead, it is “a nonmedical judgment reserved to the patient alone”); Kevin W. Williams, *Managing Physician Financial Conflicts of Interest in Clinical Trials Conducted in the Private*

[VOL. 46: 1, 2009]

*Involuntary Medications*

SAN DIEGO LAW REVIEW

while some people with schizophrenia are incapable of understanding the harms and benefits of antipsychotic medications, courts deem such people incompetent to make their own medical treatment decisions and appoint others to make those decisions for them.<sup>185</sup> Most defendants who are incompetent to stand trial, though, have not been ruled incompetent to make their own medical treatment decisions.<sup>186</sup> Moreover, the

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*Practice Setting*, 59 FOOD & DRUG L.J. 45, 50 (2004) (noting that “the patient’s best interest” is not necessarily the same as “the best medical treatment in a given situation” because the patient’s best interest cannot be determined without considering “the individual patient’s philosophical, moral, and religious beliefs; economic constraints; family situation; and a myriad of other interests to which the physician is not privy”).

185. See William M. Brooks, *Reevaluating Substantive Due Process as a Source of Protection for Psychiatric Patients to Refuse Drugs*, 31 IND. L. REV. 937, 1002 (1998) (“The state interest in forcibly medicating patients in order to provide treatment to legally competent patients who could benefit from treatment is not sufficiently compelling. It is well-settled that the government may not confine for compulsory treatment individuals who are mentally ill, but are not dangerous.” (citing *Jones v. United States*, 463 U.S. 354, 370 (1983); *O’Connor v. Donaldson*, 422 U.S. 563, 576 (1975); *Project Release v. Prevost*, 722 F.2d 960, 973 (2d Cir. 1983); *Doremus v. Farrell*, 407 F. Supp. 509, 514 (D. Neb. 1975))).

186. Russell Weston, for example, was administered involuntary medications for more than two years but was never found to be incompetent to make his own medical decisions. See *United States v. Weston*, 69 F. Supp. 2d 99, 112 (D.D.C. 1999) (“Despite the defendant’s suggestion that the Court determine whether he is functionally competent to make medical decisions and, if he is not, to appoint a guardian ad litem, the defendant has failed to present any evidence to contradict Dr. Johnson’s opinion that he is competent to consent to the medication.” (emphasis omitted)). One scholar has argued that “virtually all defendants who are incompetent to stand trial are also incompetent to make treatment decisions.” CHRISTOPHER SLOBOGIN, *MINDING JUSTICE: LAWS THAT DEPRIVE PEOPLE WITH MENTAL DISABILITY OF LIFE AND LIBERTY* 230 (2006); see also Robert F. Schopp, *Involuntary Treatment and Competence to Proceed in the Criminal Process: Capital and Noncapital Cases*, 24 BEHAV. SCI. & L. 495, 503–08 (2006) (proposing that incompetent criminal defendants are necessarily incompetent to make medical treatment decisions, although arguably assuming a standard of competency to make medical treatment decisions that is more demanding than any actual standard). It is most likely true that a good many more defendants do lack the capacity to understand the harms and benefits of antipsychotic medications than are currently being found incompetent to make treatment decisions. But there are reasons why a defendant might be incompetent to stand trial but nevertheless be competent to make treatment decisions. One reason is that tests of competency to make treatment decisions are usually narrowly focused cognitive tests that do not take account of impairments in emotion, volition, or other psychological functions, or even of cognitive capacities unrelated to understanding the direct harms and benefits of medications. See Marsha Garrison, *The Empire of Illness: Competence and Coercion in Health-Care Decisionmaking*, 49 WM. & MARY L. REV. 781, 789–90 (2007) (“What these varied tests [of competence to make treatment decisions] share is an exclusive focus on cognitive capacity. A patient may be confused, combative, depressed, or despairing. But if she can accurately describe the treatment choice, its corollary risks, and its potential benefits to her, she is competent to consent

government cannot add together all of the incidental benefits of antipsychotic medications to justify involuntary administration of these medications for the purpose of rendering a defendant competent to stand trial. If rendering the defendant competent to stand trial is the government interest that justifies the involuntary medications, then whether the medications benefit the defendant is irrelevant. If benefit to the individual were the government interest that justified the involuntary medications, as it is in some civil commitments, then the government would need to satisfy the requirements of such a commitment—requirements that usually include dangerousness to self as well as incompetence to make medical treatment decisions.<sup>187</sup>

In sum, the “medically appropriate” standard allows trial courts to all but ignore the harms that a defendant might experience if administered involuntary antipsychotic medications—even though the harms might outweigh the benefit the government will derive from administering the medications. Asking whether antipsychotic medications are medically appropriate inadequately protects defendants from harms that are not justified by a sufficiently important government interest, because if the defendant has been properly diagnosed with schizophrenia, the answer will almost invariably be yes, regardless of how substantial the risk of harms—or even how substantial the experience of actual harms—and regardless of how important the government’s interest in bringing the defendant to trial, so long as the government’s interest is some degree of “important.” Instead, what courts should ask is whether the government’s interest in bringing the defendant to trial is important enough to justify the harms of involuntary antipsychotic medications.

#### IV. LESSONS FROM THE FOURTH AMENDMENT: HOW MUCH HARM CAN ONE TRIAL JUSTIFY?

##### A. “Risk, Trauma, or Pain”

In *Winston* and *Schmerber*, the Supreme Court was reluctant to allow

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under all existing standards.”). Moreover, some defendants are incompetent to stand trial because of circumscribed delusional beliefs about some aspect of the trial process. *See supra* notes 109–12 and accompanying text (describing delusional beliefs of some defendants found incompetent to stand trial). But so long as the defendant’s delusional system does not encompass his physicians or other medical professionals, or drug manufacturers, it is possible that a defendant who is incompetent to stand trial could be capable of making a competent decision regarding his own medical treatment.

187. *Cf. Sell v. United States*, 539 U.S. 166, 181 (2003) (“We emphasize that the court applying these standards is seeking to determine whether involuntary administration of drugs is necessary significantly to further a particular governmental interest, namely, the interest in rendering the defendant *competent to stand trial*.”).

[VOL. 46: 1, 2009]

*Involuntary Medications*

SAN DIEGO LAW REVIEW

involuntary medical treatment for the purpose of advancing the government's interests if the treatment the government sought to order was likely to cause any physical harms at all.<sup>188</sup> Compared to the physical harms that Lee might have experienced as a result of bullet removal surgery,<sup>189</sup> the physical harms that defendants might experience, and in some cases have actually experienced, as a result of involuntary antipsychotic medications are arguably at least as substantial.<sup>190</sup>

No court has allowed the government to compel a defendant to submit to what the court has deemed "major surgery" for the purpose of promoting the government's interest in obtaining evidence of a crime: Whenever a court finds that a proposed surgical procedure is "major," the government's request to compel the surgery is denied.<sup>191</sup> In denying these requests, courts cite the "risk, trauma, or pain" that major surgery

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188. See *Winston v. Lee*, 470 U.S. 753, 759 (1985); *Schmerber v. California*, 384 U.S. 757, 768 (1966).

189. See *supra* notes 98–99 and accompanying text (discussing risks to Lee of bullet removal surgery).

190. See *supra* Part III.B (discussing risks of antipsychotic medications).

191. On one hand are the courts that find a proposed involuntary surgery to be major and then deny the government's request to compel the defendant to undergo the surgery. *E.g.*, *Bowden v. State*, 510 S.W.2d 879, 881 (Ark. 1974) (disallowing "major intrusion into the petitioner's body involving trauma, pain and possible risk of life even when performed in a proper medical environment with the most careful and skilled attention"); *People v. Smith*, 362 N.Y.S.2d 909, 914 (N.Y. Sup. Ct. 1974) ("[T]he proposed operation would constitute a major intrusion into the body of the respondent that would involve trauma and pain and a possible risk of life and is over and beyond the minor intrusion standard set down in *Schmerber v. California*."); *State v. Allen*, 291 S.E.2d 459, 463 (S.C. 1982) (finding that removing bullet would require "major surgery procedures involving a substantial intrusion into [the defendant's] body and risk to his health, safety or life"); *cf.* *United States v. Garcia-Ortiz*, 261 F. Supp. 2d 56, 61 (D.P.R. 2003) (denying government request for involuntary surgery because court could not conclude that the surgery would not threaten the defendant's safety); *Bloom v. Starkey*, 409 N.Y.S.2d 773, 774 (N.Y. App. Div. 1978) (same). On the other hand are the courts that find a proposed involuntary surgery not to be major and then grant the government's request to compel the defendant to undergo the surgery. *E.g.*, *United States v. Crowder*, 543 F.2d 312, 316 (D.C. Cir. 1976) ("The operation was minor . . ."); *Hughes v. United States*, 429 A.2d 1339, 1341 (D.C. 1981) (accepting trial court's finding that "the removal of the presumed bullets from under appellant's skin would be a minor surgical procedure involving virtually no risk"); *Creamer v. Georgia*, 192 S.E.2d 350, 353 (Ga. 1972) (concluding that "the removal of the bullet from the defendant's body would amount to a minor intrusion into his person"); *State v. Richards*, 585 S.W.2d 505, 506 (Mo. Ct. App. 1979) ("There would [be] no danger to life, limb, tissue, muscle, or ligaments."); *State v. Avila*, 910 S.W.2d 505, 509 (Tex. App. 1994) ("[T]he threat, if any, to Avila's health and safety was minimal."); *Allen*, 291 S.E.2d at 463 (finding "that the bullet lodged superficially beneath Allen's skin could be removed, without any harm or risk of life or injury, by minor surgery and under local anesthetic").

involves.<sup>192</sup> But the “risk, trauma, or pain” that attends antipsychotic medications can be just as great. It is inconceivable that a court that has denied involuntary surgery because the defendant might suffer an infection or tissue damage would, given an equivalently important government interest, allow involuntary medications when the defendant might develop tardive dyskinesia or diabetes.

### *B. Measuring the Government’s Interest in Criminal Prosecutions*

Under *Sell*, courts must decide whether the government’s interest in rendering a defendant competent to stand trial is “important.”<sup>193</sup> In some ways, this inquiry resembles the Fourth Amendment balancing of individual harms and government benefits.<sup>194</sup> The difference, though, is that the *Sell* inquiry regarding the weight of the government’s interest is not one side of a test that directly compares harms and benefits but rather is, like “medical appropriateness,” a categorical or threshold test. Unlike the Fourth Amendment cases, courts do not ask whether the government’s interest is important enough to justify the harms of involuntary treatment. Instead, courts ask simply whether the government’s interest meets some abstract or absolute measure of “important.”

Courts have struggled to identify criteria that will allow them to classify the government’s interest in bringing defendants to trial as either “important” or “not important.” One initial problem is that in some sense, the government’s interest in prosecuting every criminal charge against every defendant is important.<sup>195</sup> On the other hand, though, *Sell* requires that courts consider the government’s interest in prosecuting some charges

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192. *E.g.*, *Bowden*, 510 S.W.2d at 881 (refusing to order removal of bullet because “[i]t is uncontroverted that the proposed operation constitutes medically a major intrusion into the petitioner’s body involving trauma, pain and possible risk of life even when performed in a proper medical environment with the most careful and skilled attention”); *Allen*, 291 S.E.2d at 463 (“I find that removal of the bullet from the defendant, Walter Childers, Jr., would require major surgery procedures involving a substantial intrusion into his body and risk to his health, safety or life.”); *see also* *Schmerber v. California*, 384 U.S. 757, 771 (1966) (setting forth “risk, trauma, or pain” as a factor influencing reasonableness of involuntary treatment).

193. *Sell v. United States*, 539 U.S. 166, 179 (2003).

194. *See* *Winston v. Lee*, 470 U.S. 753, 761, 765 (1985) (including the government’s need for the evidence that might be obtained as a factor for courts to consider when assessing reasonableness); *Schmerber*, 384 U.S. at 771 (finding involuntary blood test did not violate Fourth Amendment in part because it was “highly effective” in identifying drunk drivers).

195. *See Sell*, 539 U.S. at 180 (“[T]he Government seeks to protect through application of the criminal law the basic human need for security.”); *Riggins v. Nevada*, 504 U.S. 127, 135–36 (1992) (“Constitutional power to bring an accused to trial is fundamental to a scheme of ‘ordered liberty’ and prerequisite to social justice and peace.” (quoting *Illinois v. Allen*, 397 U.S. 337, 347 (1970) (Brennan, J., concurring))).

[VOL. 46: 1, 2009]

*Involuntary Medications*  
SAN DIEGO LAW REVIEW

against some defendants to be important and its interest in prosecuting other charges against other defendants to be not important.<sup>196</sup> Identifying which charges against which defendants are serious enough to make the government's interest in prosecuting those charges "important," and which are not, is a more complex task than at first it might seem.<sup>197</sup>

One measure that many courts have used to assess the seriousness of criminal charges is the sentence that a defendant will receive if found guilty. This approach has a certain logical simplicity: The greater the sentence, the more serious must be the charge. But beneath this surface simplicity lies the not-at-all simple question whether to measure a defendant's prospective sentence in terms of the statutory maximum or in terms of an expected guidelines range. For example, in *Archuleta* the defendant was charged with providing false information—lying about a prior mental health commitment—in the acquisition of a firearm.<sup>198</sup> The government argued that the charge was serious because the statutory maximum sentence was ten years.<sup>199</sup> *Archuleta* argued that the relevant punishment was the expected sentence under the U.S. Sentencing Guidelines Manual, which according to *Archuleta* was at most between twelve to sixteen months.<sup>200</sup> *Archuleta* further argued that this expected sentence, combined with the fact that he had already been in custody almost that long, made the government's interest in rendering him competent to stand trial not important.<sup>201</sup> Most courts that look to sentencing to determine whether the government's interest in rendering a defendant competent to stand trial is important conclude what the *Archuleta* court concluded, that the statutory maximum is the proper measure of the government's interest,<sup>202</sup> although some courts have ruled that an expected guidelines sentence is the proper measure.<sup>203</sup>

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196. See *Sell*, 539 U.S. at 180 (“[A] court must find that important governmental interests are at stake.”); *id.* at 179 (“[T]he Constitution permits the Government involuntarily to administer antipsychotic drugs to a mentally ill defendant facing serious criminal charges in order to render that defendant competent to stand trial . . .”).

197. For a comprehensive discussion of the difficulties involved in assessing the weight of the government's interest in adjudicating different criminal charges, see generally Eugene Volokh, *Crime Severity and Constitutional Line-Drawing*, 90 VA. L. REV. 1957 (2004).

198. *United States v. Archuleta*, 218 F. App'x 754, 755 (10th Cir. 2007).

199. *Id.* at 758.

200. *Id.*

201. *Id.* at 758–59.

202. *Id.* at 759; *Developments in the Law: The Law of Mental Illness*, 121 HARV. L. REV. 1114, 1126 (2008) (“Most courts have judged the importance of bringing a



Another yardstick that some courts have used to assess seriousness is how a legislature has designated the charges. Not surprisingly, the government's interest in rendering a defendant competent to stand trial is more likely to be found to be important when the charges against the defendant are "felonies," while the interest in rendering competent to stand trial a defendant charged with "misdemeanors," or with offenses that are otherwise not felonies, such as probation violations, is less likely to be important.<sup>204</sup>

A few courts have rejected any bright-line rules for measuring the seriousness of criminal charges. These courts' inquiries, which are quite fact-intensive, come close to the kind of balancing test that asks whether the government's interest in bringing a particular defendant to trial is important enough to justify the harms of involuntary treatment.<sup>205</sup> In *United States v. Lindauer*, for example, Susan Lindauer—whom every mental health expert, government as well as defense, agreed experienced paranoid and grandiose delusions that made her incompetent to stand trial<sup>206</sup>—was charged with acting and conspiring to act as an unregistered

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defendant to trial based on the maximum penalty the defendant could face if convicted."). In these cases, courts often state that they are following the Supreme Court's approach to determining seriousness when the question is whether the defendant has a right to a jury trial. *See, e.g.*, *United States v. Evans*, 404 F.3d 227, 237 (4th Cir. 2005) ("In *Duncan v. Louisiana* . . . the Supreme Court observed that the Sixth Amendment's right to trial by jury exists only in 'serious' criminal cases . . . . More recent right-to-jury cases have explicitly found that the primary measure of seriousness is 'the maximum penalty attached to the offense.'" (citations omitted)). Other courts cite the objectivity of statutory maximums. *See, e.g.*, *United States v. Green*, 532 F.3d 538, 549 (6th Cir. 2008) (holding that "the maximum statutory penalty is the most objective means of determining the seriousness of a crime and the standard we adopt").

203. *E.g.*, *United States v. Hernandez-Vasquez*, 506 F.3d 811, 821 (9th Cir. 2007) (using the predicted guidelines sentence, rather than the statutory maximum, to measure seriousness); *United States v. Thrasher*, 503 F. Supp. 2d 1233, 1237 (W.D. Mo. 2007) (same); *United States v. Schloming*, No. 05-5017 (TJB), 2006 WL 1320078, at \*6 (D. N.J. May 12, 2006) ("Had it been the Supreme Court's intention to classify a charge as serious based on the maximum penalty, it could have done so.").

204. *E.g.*, *Born v. Thompson*, 117 P.3d 1098, 1102 (Wash. 2005) ("The government simply does not have the same interest in prosecuting misdemeanor defendants as it does in prosecuting defendants charged with felonies."); *United States v. Kourey*, 276 F. Supp. 2d 580, 585 (S.D. W.Va. 2003) ("Defendant is not facing serious criminal charges upon which he will be tried. Rather, Defendant is charged with violating the terms and conditions of his supervised release imposed for his admitted commission of a Class A misdemeanor."). *But see* *United States v. Everage*, No. 05-11-DLB, 2006 WL 1007274, at \*1 (E.D. Ky. Apr. 17, 2006) ("Although Defendant is charged with two misdemeanors, they both allegedly involve threats to others, one with a firearm. The Court therefore concludes Defendant is charged with serious crimes.").

205. Although most courts do not undertake it, the fact-intensive inquiry is what *Sell* mandates: Courts "must consider the facts of the individual case in evaluating the Government's interest in prosecution." 539 U.S. 166, 180 (2003).

206. *United States v. Lindauer*, 448 F. Supp. 2d 558, 559 (S.D.N.Y. 2006) ("At least a half dozen mental health professionals, including a psychologist and a psychiatrist

[VOL. 46: 1, 2009]

*Involuntary Medications*

SAN DIEGO LAW REVIEW

agent of the foreign country of Iraq.<sup>207</sup> Rather than consult any objective measure, such as the statutory maximum sentences or the legislature's classifications of the charges, the court considered the improbability that Lindauer's actions could have caused any real harm. The court observed that Lindauer "could not act successfully as an agent of the Iraqi government without in some way influencing normal people . . . and the record shows that even lay people recognize that she is seriously disturbed."<sup>208</sup> Similarly, in *United States v. Dumeny*, the court decided that despite being charged with an offense that carried a ten-year statutory maximum sentence, Jason Dumeny could not be administered involuntary medications because the one charge against him—possession of a firearm by a person previously committed to mental health treatment—did not involve any violence.<sup>209</sup>

Many cases are like *Dumeny*, cases in which the seriousness of the charges against the defendant is debatable. These are the cases in which a balancing test could make the most difference in protecting the defendant's interest in avoiding unreasonable harms: If the importance of the government's interest is unclear, then a high risk of side effects, or even a low risk of more serious side effects, should cause a court to rule that involuntary antipsychotics are not justified, while a low risk of minor side effects would support a decision allowing involuntary antipsychotics.

In some cases, though, the charges against the defendant are

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retained by the defense, and several psychologists and psychiatrists employed, and one psychiatrist retained, by the government, have found her mentally incompetent to stand trial . . .").

207. *Id.*

208. *Id.* at 571; *see also id.* at 571–72 (“[T]here is no indication that Lindauer ever came close to influencing anyone, or could have. The indictment charges only what it describes as an unsuccessful attempt to influence an unnamed government official . . .”).

209. 295 F. Supp. 2d 131, 132–33 (D. Me. 2004). The court reasoned that:

Mr. Dumeny is currently charged under 18 U.S.C. § 922(g)(4) with possession of firearms by a person previously committed to a mental health institute. Without diminishing the potential seriousness of this charge, which carries significant potential penalties, *see* 18 U.S.C. § 924(a)(2), it is noteworthy that Mr. Dumeny has been charged with possession only. He has not been charged with improper use of the firearms. Although the Forensic Evaluation Report makes reference to Mr. Dumeny's violent proclivities, the only criminal charge before the court at this time is the possession charge. This court concludes in view of the pending charge, the government interest at stake is insufficient for this court to mandate intrusive involuntary treatment of Mr. Dumeny.

*Id.*

unquestionably very serious. Russell Weston, for example, was charged with two counts of murder and one count of attempted murder after he opened fire in the U.S. Capitol building, killing two guards and wounding a third.<sup>210</sup> In *Weston*, one of the district court's opinions stated that "if a compelling case ever existed . . . that would justify forcibly medicating the defendant solely to become competent to stand trial, this case clearly meets that standard,"<sup>211</sup> while the D.C. Circuit wrote that "[t]he government's interest in finding, convicting, and punishing criminals reaches its zenith when the crime is the murder of federal police officers."<sup>212</sup>

When the charges against an incompetent defendant are clearly very serious, the government's interest in rendering the defendant competent to stand trial will likely be important enough to justify the harms of involuntary antipsychotic medications. But even in cases involving charges that are clearly very serious, some "special circumstances" might diminish the government's interest in bringing a particular defendant to trial.<sup>213</sup> For example, when a defendant is charged with committing especially serious crimes, like Weston, the government's interest in rendering the defendant competent to stand trial will sometimes be diminished, at least to some extent, by the ability to detain under civil commitment statutes defendants who are both mentally ill and

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210. *United States v. Weston*, 134 F. Supp. 2d 115 (D.D.C. 2001), *aff'd*, 255 F.3d 873 (D.C. Cir. 2001), *cert. denied*, 534 U.S. 1067 (2001); *United States v. Weston*, 69 F. Supp. 2d 99 (D.D.C. 1999), *rev'd*, 206 F.3d 9 (D.C. Cir. 2000). Russell Weston, forty-three years old with a long history of mental illness, believed that the world was threatened by "Black Heva," a deadly plague that Weston could stop by accessing a secret time machine located in the "great safe of the U.S. Senate." Weston further believed, according to the report of a prison psychiatrist who evaluated him, that:

While "working for NASA" in the early 1980's, he developed a "Ruby Satellite System," a powerful reverse time machine that enables users to "push time in reverse . . . by passing us through the Jurassic Sea, putting us into another time frame." For those like Weston with access to the "Ruby Satellite System," nothing is permanent—the user can simply reverse time. If convicted and executed, Weston will "simply be time reversed, put into a safe in the Capitol, and be able to resume his life at whatever point he chooses."

*United States v. Weston*, 206 F.3d 9, 19–20 (D.C. Cir. 2000) (Tatel, J., concurring).

The *Weston* cases were decided before *Sell*, but like *Sell* they relied on *Harper* and *Riggins*. See, e.g., *Weston*, 255 F.3d at 876 ("In *Washington v. Harper* and later in *Riggins v. Nevada*, the Supreme Court recognized that the government may, under certain circumstances, forcibly administer antipsychotic medication to a prisoner or criminal defendant despite his liberty interest, provided such medication is 'medically appropriate.'"); *Weston*, 69 F. Supp. 2d at 105–06 (discussing *Harper* and *Riggins*).

211. *Weston*, 69 F. Supp. 2d at 111.

212. *Weston*, 255 F.3d at 881.

213. The *Sell* Court referred to factors that might diminish the government's interest in bringing a defendant to trial as "[s]pecial circumstances." *Sell v. United States*, 539 U.S. 166, 180 (2003) ("Special circumstances may lessen the importance of that interest [in prosecution].").

[VOL. 46: 1, 2009]

*Involuntary Medications*  
SAN DIEGO LAW REVIEW

dangerous—like Weston.<sup>214</sup> Perhaps ironically, one outcome for the defendant might well be the same—involuntary antipsychotic medications—whether a court allows such medications for the purpose of diminishing the defendant’s dangerousness or for the purpose of rendering him competent to stand trial. Still, there might be some advantages to pursuing civil commitment rather than a criminal trial. In some cases, civil commitment might be more likely than criminal prosecution to promote effective long-term treatment of the defendant’s mental illness, a result that would benefit both the defendant and the government.<sup>215</sup> For example, civil commitment might be more likely to keep the defendant in the community, to include psychosocial therapies in addition to antipsychotic medications, and to foster a therapeutic relationship between

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214. *Id.* (“The defendant’s failure to take drugs voluntarily . . . may mean lengthy confinement in an institution for the mentally ill—and that would diminish the risks that ordinarily attach to freeing without punishment one who has committed a serious crime.”). Indeed, when the court ruled that continued involuntary medication was not likely to render Weston competent to stand trial, Weston was committed under 18 U.S.C. § 4246, which allows for the civil commitment of someone previously detained as incompetent to stand trial if that person “is presently suffering from a mental disease or defect as a result of which his release would create a substantial risk of bodily injury to another person or serious damage to property of another.” 18 U.S.C.S. § 4246 (LexisNexis 2008); *see also* 18 U.S.C.S. § 4241 (LexisNexis 2008) (“If, at the end of the time period specified, it is determined that the defendant’s mental condition has not so improved as to permit the proceedings to go forward, the defendant is subject to the provisions of sections 4246 and 4248.”); *United States v. Weston*, No. 98–357 (EGS), 2004 U.S. Dist. LEXIS 23579, at \*2–6 (D.D.C. Nov. 22, 2004).

215. Effective long-term treatment of those defendants whose criminal acts were committed while they were actively mentally ill—Weston again, for example—promotes the criminal justice goal of deterring future criminal acts. Of course, civil commitment cannot satisfy all of the goals of the criminal justice system. *See United States v. Weston*, 255 F.3d 873, 882 (D.C. Cir. 2001) (“The civil commitment argument . . . ignores the retributive, deterrent, communicative, and investigative functions of the criminal justice system, which serve to ensure that offenders receive their just deserts, to make clear that offenses entail consequences, and to discover what happened through the public mechanism of trial.”); *see also* SLOBOGIN, *supra* note 186, at 230 (agreeing with the *Weston* court that civil commitment is an inadequate substitute for criminal prosecution). But not even criminal prosecutions usually satisfy all of the goals of the criminal justice system. Plea bargains, for example, are a common compromise between prosecutors, who offer lesser sentences, and criminal defendants, who in exchange for these lesser sentences give up their rights to a fair trial. *See* Frank H. Easterbrook, *Plea Bargaining as Compromise*, 101 YALE L.J. 1969, 1975 (1992) (referring to prosecutors “purchasing procedural entitlements with lower sentences”); Ronald Wright & Marc Miller, *Honesty and Opacity in Charge Bargains*, 55 STAN. L. REV. 1409, 1417 (2003) (“Extremely low trial rates, perhaps in conjunction with low acquittal rates, may indirectly suggest the presence of an excessive trial penalty, and the diminution of justice that comes with it.”).

the defendant and his treatment providers. Involuntary medications administered for the purpose of diminishing a defendant's dangerousness are of course involuntary, but involuntary medications administered for the purpose of rendering a defendant competent to stand trial are not only involuntary but also adversarial. Administering antipsychotic medications that are both involuntary and adversarial will perhaps make the defendant's experience doubly aversive and will perhaps thereby diminish the chances that he will respond favorably to the involuntary treatment and will then choose to continue to receive treatment voluntarily once the conditions that justify the involuntary treatment have ended.

An additional consideration that might diminish the government's interest is that even when administering involuntary medications succeeds in rendering a defendant competent to stand trial, the government's interest that has been advanced is the interest in prosecuting the charges against only that one particular defendant. In contrast, in some cases, such as *Schmerber*, an involuntary medical procedure, such as a blood test, advances a broader government interest, such as the interest in administering the whole system of drunk driving laws.<sup>216</sup> The inability to bring to trial any single, individual defendant does not threaten the whole system of criminal prosecutions.<sup>217</sup> Thus, even when the charges against an incompetent defendant are undeniably serious, the government's interest in bringing the defendant to trial might not always be important enough to justify the harms of involuntary antipsychotic medications.

## V. CONCLUSION

Under the due process test that the Supreme Court developed in *Harper*, *Riggins*, and *Sell*, trial courts routinely permit the government to administer involuntary antipsychotic medications to incompetent criminal defendants because such medications are "medically appropriate" for defendants diagnosed with schizophrenia and because the government's interest in prosecuting criminal charges is "important."<sup>218</sup> But these

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216. See *supra* note 93.

217. See Michael K. Gottlieb, *Executions and Torture: The Consequences of Overriding Professional Ethics*, 6 YALE J. HEALTH POL'Y L. & ETHICS 351, 373 (2006) ("It is not the criminal justice system, *en toto*, that is being obstructed or impeded. Rather it is the prescribed justice in a particular case in which a certain punishment . . . is undeliverable."); Michael G. Rogers, *Bodily Intrusion in Search of Evidence: A Study in Fourth Amendment Decisionmaking*, 62 IND. L.J. 1181, 1199 (1987) ("The blood tests . . . served a substantial public interest in deterring drunk driving. The blood tests also provided reliable scientific evidence that would be more useful in court than alternative evidence . . . . Bullet-retrieval surgery, however, serves no public interest beyond bringing a particular criminal to justice." (footnote omitted)).

218. *Sell v. United States*, 539 U.S. 166, 180–81 (2003); *Riggins v. Nevada*, 504 U.S. 127, 134–35 (1992); *Washington v. Harper*, 494 U.S. 210, 226–27 (1990).

[VOL. 46: 1, 2009]

*Involuntary Medications*

SAN DIEGO LAW REVIEW

separate categorical or threshold standards fail to adequately protect incompetent criminal defendants from harms that are not justified by the government's interest in bringing them to trial. A test like the Fourth Amendment's balancing test, which would require courts to weigh the defendant's interest in avoiding the harms of involuntary antipsychotic medications directly against the government's interest in rendering the defendant competent to stand trial, would better ensure that incompetent criminal defendants are not subject to harms that are unreasonable.