Right to Refuse Treatment: Impact of *Rivers v. Katz*

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This article examines the impact of the New York court decision, *Rivers v. Katz*, which in June 1986 dramatically changed the state procedure for responding to involuntarily committed psychiatric patients who formally refused psychopharmacologic treatment. The court rejected the medically administered review process that had been used to respond to involuntarily committed psychiatric patients who formally refused medication, and replaced it with a judicial determination of competent and "substituted judgment" provided by the court. Post-*Rivers*, the rate of patients consistently refusing treatment decreased, and the time from refusal to resolution increased. The clinical, legal, and economic implications of the *Rivers* procedure are discussed.

The committed psychiatric patient's right to refuse treatment became an issue in the early 1970's and resulted in litigation based on the individual's right to privacy and the individual's right to decide what will be done with his body.[1] This right to refuse treatment flows from a significant body of medical case law describing an individual's right to control his life and his right to refuse to follow the advice of medical experts, even when it seems clear that following such advice would immeasurably improve his lot. The voluntarily hospitalized psychiatric patient, like medical and surgical counterparts, may refuse treatment, except in emergency circumstances, unless found legally incompetent to do so. The involuntary patient was regarded to be incompetent regarding treatment decisions as a result of the involuntary hospitalization. Some have held that a constitutional right to refuse treatment can be derived from: (1) the First Amendment guarantee of free speech—some describe psychiatric medications as mind-altering substances which destroy the capacity for free speech; (2) the Eighth Amendment guarantee of freedom from cruel and unusual punishment—some characterize psychiatric treatment for the mentally ill as punishment; (3) the Fourteenth Amendment guarantees of a right to due process and a right to equal protection—some argue that medical patients have a right to refuse medication and it is unfair to deny involuntary psychiatric patients these rights; and (4) the generalized right

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to privacy, which is evoked from the First, Fourth, Fifth, and Ninth Amendments—the right to privacy rests on no specific constitutional wording and has usually been limited by the courts to matters involving procreation and the family.

Psychiatrists have had a great interest in furthering patient participation in the treatment process and have also been supportive of patients in their attempts to assert and preserve their legal rights. American psychiatrists, along with others, have been sensitive to human rights.[2] The doctor-patient relationship is at times more, and at times less, a partnership in the healing enterprise, but at all times the doctor has a fiduciary relationship with the patient and an ethical obligation to be mindful of the patient's best interest.

Against this background of public and professional concern, the problems of protecting the involuntary patient's legal right to refuse treatment have been approached differently in various states. In some states the patient, as part of the commitment process, is found to be incompetent to refuse treatment. Some jurisdictions use a clinical administrative review process. Other states require a judicial determination of competence and a substituted decision provided by the judge.

Many investigations have been initiated in an attempt to understand the clinical, legal, and ethical application of the right to refuse treatment of the involuntary patient through systematic study of the circumstances surrounding medication refusal. In 1983, Marder *et al.*[4] compared refusing versus nonrefusing patients in a Los Angeles VA hospital and found refusers to have more somatic concerns, hostility, and thought disorder. Marder *et al.*'s article suggested that many VA patients not given the choice to refuse medications would have refused had the choice existed. Hassenfeld and Grumet[5] outlined administrative procedures for override of refusal in New York State and found that refusers had lengths of stay in the hospital nearly double that of a control group of nonrefusers. The review procedure for override of refusal in Oregon was studied by Bloom *et al.*,[6] Young *et al.*,[7] and Godard *et al.*[8]. They found that refusers were characteristically seriously ill, unemployed, single, and with histories of prior private psychiatric hospitalization. Most refused because of denial of their illness or delusional thinking about the medications. The majority of refusals were eventually subjected to override by Oregon's informal review proceedings. Appelbaum and Gutheil[9] studied the effects of the Massachusetts model for treatment review, which requires a court hearing. They determined that, if given a choice, a substantial number of patients will refuse medication during their hospitalization; however, relatively few would consistently refuse in a manner that would require outside intervention to resolve. Nonetheless, they concluded that due to the large number of patients involved, the review system might indeed produce a negative effect on the care of many thousands of patients in Massachusetts.

Although the studies noted have de-

scribed different procedures for responding to treatment refusal on the part of involuntary patients, to our knowledge none has examined the transition from one approach to another. An opportunity to study the change from an administrative to a legal procedure occurred in New York State as a result of court action. Before the June 10, 1986, *Rivers v. Katz*[3] decision, New York State regulations required a clinical administrative review when an involuntarily hospitalized (civilly committed) patient wrote a letter formally rejecting pharmacologic treatment. This mechanism called for treatment over involuntarily hospitalized patients' objections if they lacked insight and judgment and it was in their best interest to be treated or if nontreatment would make the least restrictive environment an unachievable goal. These clinical decisions were made by appropriate clinical staff and consultants, and recourse to the courts was not necessary. New York's highest court, the Court of Appeals, unanimously found in *Rivers* that, in nonemergency situations, involuntarily hospitalized patients may not be forced to take psychotropic medication without a judicial review of their competence and, if incompetent, a substituted treatment decision made by the judge. Substituted judgment, in this context, requires the judge to "prescribe" medication for the mentally ill.

The *Rivers* decision requires that the administrative procedure which existed in New York State before June 10, 1986, be carried out, followed by a judicial hearing. The administrative procedure, which now became the initial step of *Rivers*, entailed, in the private setting, a review by a psychiatric consultant of the treating physician's recommendation that treatment be initiated over objection. If the clinical director of the unit agreed with the treating physician and consultant, treatment could be initiated over objection. If the consulting psychiatrist or the clinical director disagreed with the treating physician, the proposed psychopharmacologic treatment could not be given over the patient's objection. The *Rivers* decision mandated that if, after all these steps had been followed, the treating physician's recommendation for pharmacotherapy was upheld, a *de novo* hearing to determine the competency of the patient would be held. This hearing is a full judicial hearing. If the judge finds the patient incompetent with regard to this decision about pharmacotherapy, the judge makes a substituted judgment. In practice, the patient is represented by an attorney from the Mental Health Legal Services, an agency of the judicial department of New York State charged with providing legal representation to patients regarding issues of retention and treatment. The hospital retains an attorney to argue the treating physician's position. In the public hospital setting the procedure before *Rivers* involved having the patient's objection reviewed by a consulting psychiatrist who was not in the employ of the public hospital. If this consultant agreed with the treating physician, the objection to the treatment was reviewed by the Medical Director of the public hospital and by the regional office of the state mental health system. Similar to the pri-

vate setting, this public hospital pre-*Rivers* administrative procedure became the first components of the *Rivers* mechanism.

Our study sought to determine if the positive effects of the new judicial review mechanism outweighed the negative effects, which would allow the conclusion that *Rivers* was on balance helpful. We pursued two levels of investigation. On the one hand, we sought to examine the number of patients initiating formal action, the time to a final decision regarding each patient's medication refusal, and each refusing patient's total length of stay. These were considerations we investigated quantitatively using the available data in hospital charts. At the same time, we sought to examine the impact of *Rivers* on the psychiatric hospital. This was not easily quantifiable but nonetheless crucial to the understanding of the effect of the decision. We will present the quantitative findings in the Results section; we will review our qualitative findings in the Discussion section.

Methods

The study was carried out in two settings. One setting was the psychiatric service of an 800-bed private university hospital. This 107-bed psychiatric service has approximately 1,250 admissions per year and admits both voluntary and involuntary patients. The service incorporated a 22-bed community mental health center floor; other specialized units included affective disorders, neuropsychiatry, and behavioral medicine. The other setting was a state-operated psychiatric hospital with a census of approximately 850 patients and approximately 1,300 admissions per year. A large number of patients were severely and chronically mentally ill, and psychogeriatric patients constituted a significant minority. Specialized services included a forensic unit and a university-affiliated program for the evaluation and treatment of the young chronic patient.

Patients included in the study were those writing letters formally exercising their right to refuse medication during the year before *Rivers* and the year after *Rivers* at both the private psychiatric hospital and the state-operated hospital. Charts of all patients initiating a formal refusal of prescribed medications over this two-year period were reviewed by three of the authors (JRC, JFT, CDC). The review included the date of writing the refusal letter, the time to resolution, and the nature of the resolution, i.e., whether it was the patient rescinding the refusal of medication, an emergency override of the patient's refusal, or administrative or legal action. In examining the number of patients initiating formal action pre- and post-*Rivers*, it was important to ascertain the number of patients "at risk," defined as the number of patients present in the hospital at the beginning of each study period, plus the number admitted during each study period. Subtracting the number taking formal action from the number at risk yields the number taking no action in a given time period.

Basic data regarding patients at risk are presented in Table 1. Although some

Table 1
Private Hospital

	Pre-*Rivers*		Post-*Rivers*	
	Refusers (39)	At Risk (1,299)	Refusers (16)	At Risk (1,359)
Sex				
Male	7	564	5	614
Female	32	629	11	634
Unknown		106		111
Race				
White	35	932	10	945
Black	4	191	6	230
Other	0	176	0	184
Age				
≤21	5	297	3	254
22–35	15	507	5	493
36–54	8	312	7	393
55–64	2	76	0	88
>65	9	107	1	141
Marital status				
Never married	14	607	10	588
Married	10	272	4	314
Separated	5	57	1	67
Divorced	5	91	1	99
Widowed	5	51	0	59
Unknown	0	225	0	232
Diagnosis (DSM-III)				
Schizophrenia, paranoid type	6	42	5	69
Schizophrenia, nonparanoid	3	50	1	36
Schizoaffective	7	36	2	39
Major depression	2	368	2	509
Bipolar disorder	11	84	2	84
Organic mental disorders (except intoxication)	3	36	0	41
Other	7	427	4	498
Unknown		256		83

missing data regarding characteristics of the at risk populations are evident, this represents the most complete data available for these time periods and does not affect the statistical analyses to be conducted. The "other" category within "diagnosis" includes varying patterns of abuse of a variety of substances.

Results

For each of the two hospitals, the number of patients pre- and post-*Rivers* initiating formal action was examined using a chi-square technique in relation to the total number of patients taking no action at each institution for the year before and the year after *Rivers*. At the private hospital the number taking action declined from 39 to 16, representing 3.0 and 1.2 percent of patients "at risk." This change was significant at the $p < .01$ level (chi-square = 9.2, $df = 1$, uncorrected). At the state-operated hospital, the number declined from 107 to 40, representing 4.5 and 1.6 percent of pa-

tients "at risk." This change was significant at the $p < .001$ level (chi-square = 33.0, $df = 1$, uncorrected).

Pre-*Rivers*, the ratio of patients initiating formal action to patients taking no action was greater at the state-operated hospital than at the private hospital (chi-square = 5.25, $p < .05$, $df = 1$, uncorrected). However, no significant difference was found post-*Rivers* (chi-square = 1.19, $p > .05$, $df = 1$, uncorrected) in terms of this ratio.

At the private hospital, the average time to resolution pre-*Rivers* was 10.5 days, and the average time to resolution post-*Rivers* was 31.4 days; for the state-operated hospital, these times were 21.1 and 68.2 days, respectively. Analysis of variance suggested that the time to resolution was significantly greater ($p < .005$, $F = 7.29$, $df = 1,194$) for the state than for the private hospital patients, whereas across both institutions the time to resolution was significantly greater ($p < 0.001$, $F = 16.4$, $df = 1,194$) after *Rivers*. The absence of a significant interaction effect ($p < .12$, $F = 2.44$, $df = 1,194$) in the analysis of variance model suggested that there was no differential impact of the *Rivers* decision on the two hospitals.

The total length of stay for refusing patients pre- and post-*Rivers* at both institutions was reviewed. At the private hospital, the average length of stay for study patients pre-*Rivers* was 50.5 days, and the average length of stay post-*Rivers* was 59.6; for the state-operated hospital, these times were 697.3 and 592.7 days, respectively. Analysis of variance revealed that with respect to refusing patients' length of stay, neither the difference between institutions ($p < .09$, $F = 2.91$, $df = 1,194$) nor the differences pre- and post-*Rivers* ($p < .99$, $F = 0.02$, $df = 1,194$) was significant at the customary $p < .05$ level.

The kinds of resolution of the medication refusal were examined pre- and post-*Rivers* for both hospitals. For both institutions, the distribution of resolution categories was different at a statistically significant level pre- versus post-*Rivers*, as shown in Table 3.

Demographic and diagnostic information with respect to the 4 groups of refusers is shown in Tables 1 and 2. Inspection of Tables 1 and 2 suggests that these were no demographic changes in the populations at risk pre- and post-*Rivers* at either the private hospital or the public hospital.

Discussion

Studies of the frequency of medication refusal suggest that between 22 and 48 percent of civilly committed psychiatric patients will refuse treatment with medication at some point in their hospitalization. However, fewer do so consistently and in a way that leads to a procedural review. This smaller group has been reported to range from 1 to 15 percent.[10] The patients in our study requiring a procedural review fit into the latter group. The rate of refusal at the private hospital was 2.9 percent pre-*Rivers* and 1.2 percent post-*Rivers*, whereas at the public hospital, it was 4.5 percent pre-*Rivers* and 1.6 percent post-*Rivers*. The sharp decline of the rate of refusal at both institutions resulted in fewer in-

Table 2
State Operated Hospital

	Pre-*Rivers*		Post-*Rivers*	
	Refusers (107)	At Risk (2,362)	Refusers (40)	At Risk (2,474)
Sex				
Male	57	1,298	23	1,361
Female	50	1,064	17	1,113
Race				
White	85	1,749	26	1,779
Black	20	541	12	588
Other	2	72	2	107
Age				
≤21	5	229	2	242
22–35	52	837	17	911
36–54	33	626	16	664
55–64	9	190	4	191
>65	8	431	1	373
Unknown		49		93
Marital status				
Never married	65	1,411	15	1,456
Married	6	254	4	291
Separated	2	140	1	164
Divorced	24	288	8	310
Widowed	10	197	2	170
Unknown		72		83
Diagnosis (DSM-III)				
Schizophrenia, paranoid type	41	639	25	582
Schizophrenia, nonparanoid	13	332	5	303
Schizoaffective	6	107	1	142
Major depression	3	120	0	129
Bipolar disorder	25	214	7	249
Organic mental disorders (except intoxication)	8	134	0	133
Other	11	816	2	936
Unknown		256		83

dividuals having their objections to medication reviewed by others not directly involved in their care, a change presumably not in the patient's best interest.

One might argue that the patients significantly decreased their resistance and reluctance to taking medications post-*Rivers*, for reasons substantially unrelated to the change mandated by the *Rivers* decision. However, we are unaware of any other event occurring at about the time of *Rivers* that would account for this change in number of patients who refused treatment. We are aware from interviews with psychiatrists, nurses, and other professional members of the hospital staff that before *Rivers*, when a patient objected to medication, the patient was usually encouraged by the staff to write a letter to initiate a formal review. When the patient had difficulty composing the letter, hospital staff were eager to provide assistance. In part, this was due to the fact that staff could expect that the administrative re-

view would provide a rapid resolution of the issue. Following *Rivers*, the staff might wish to avoid a formal review, given the associated delay in the courts arriving at a decision, the financial cost, and the onerous, additional administrative work involved in preparing for court, as our observation suggests. Furthermore, hospital counsel at the private hospital and the Attorney General's Office at the public hospital discourage use of the *Rivers* mechanism based on legal considerations.

In both institutions, there was a significant increase in the amount of time that it took to bring cases to resolution. The average time to resolution at the private hospital was 10 days pre-*Rivers* and 31 days post-*Rivers*, while at the public hospital, it was 21 days pre-*Rivers* and 68 days post-*Rivers*. This time to resolution means that patients are remaining in the hospital without indicated pharmacotherapy, a situation likely to increase the length of the hospitalization. Not only does that mean that patients are away from their work and their homes longer, but also there is an increased direct economic burden on the health care system. Patients remaining in the hospital awaiting legal procedures at the private institution incur charges in excess of $500 per day. Post-*Rivers*, the charges reflecting the added time to resolution were more than $10,500 per patient. At the public hospital the cost of 21 days in the hospital while awaiting legal resolution pre-*Rivers* must be compared with the financial burden of 68 days awaiting resolution post-*Rivers*. The procedure itself is a cumbersome, time-consuming mechanism that involves significant additional expense; the legal expense to the private hospital is more than $2,000 per hearing. This figure does not include the cost of time of the psychiatrist, the professional staff of the hospital, other attorneys, court personnel, or the judge.

The increased amount of time that it took to bring cases to resolution was determined by the court's schedule, typically three to six weeks after recording the request. It took 50 days to have a hearing for the one patient in the private hospital whose objection was resolved at a hearing. In the other cases that were resolved by other mechanisms, a hearing had been either scheduled and not yet held, or had not yet been scheduled by the court. In the public hospital setting, 15 people had hearings that took an average of 51 days. Once again, a number of people who had other resolutions had not yet had court hearings scheduled or had had court hearings scheduled, but resolutions occurred before the scheduled court hearing took place. It is also possible that a certain number of patients for whom emergencies arose had "timely" hearings from the court's perspective of "timely," but not from a clinical perspective. Delays of several days to a week in instituting pharmacotherapy can lead to a significant deterioration in a patient's clinical condition, resulting in an emergency. From a clinical standpoint, these problems are usually much better avoided by initiating treatment before the situation has erupted into an emergency. There is added danger to patients and staff as a

patient's condition becomes more and more tenuous. The risk of potential violence to other patients on the unit is something that the clinicians should weigh, and this may influence clinical treatment and discharge decisions, as will be discussed more fully below. The court, focused narrowly on a single individual and more specifically on this individual's rights, does not have the opportunity to encompass the broader concerns.

In this sample, the reasons for refusing medication were rarely independent of an ongoing psychosis. When not related to a psychotic process, patients' concerns were usually accommodated and medications changed or delayed. This partially explains the low percentage of patients who formally refused treatment, both in our study and in prior studies of patients' right to refuse treatment.

Overall, the Court of Appeals' effort in *Rivers* to safeguard patient rights through the mechanism of a full judicial hearing does not appear to be accomplishing its intent. Data from the private hospital indicate that only 1 of 16 patients who formally refused medication was afforded a judicial hearing, whereas at the public hospital, 15 of 40 patients enjoyed such a hearing. As noted in Table 3, refusals not coming to a hearing were resolved in a variety of ways. The judicial procedure does not appear to be an efficient means for resolving treatment refusals. The length of time between refusal and the resolution of the issue was significantly increased, with only a minority of patients who were refusing medication receiving a full hearing.

Are these negative consequences outweighed by positive effects? Have any legally competent individuals been protected from being inappropriately treated? Two clinicians and an ethicist reviewed the charts (JRC, JFT, CDC) and, in their judgment, found no patients at the public hospital who appeared to have benefited from the *Rivers* decision; in their judgment there were no marginal cases. At the private psychiatric hospital, in their view, there were no patients who benefited from the *Rivers* mechanism, although there were two marginal cases. These two cases involved patients with uncertain diagnoses. Mechanisms already in place before *Rivers* were sufficient to resolve these marginal cases; these include the involuntary commitment appeal mechanism, a clinical administrative review procedure for patients refusing medication, and the involvement of the Mental Hygiene Legal Service, described above.

At the state-operated hospital, there were 14 hearings during the post-*Rivers* time period. At one of these hearings the patient was found competent to make a decision about treatment. At another hearing, the patient was found incompetent to make a treatment decision, but medication was not ordered for this demented elderly patient because the judge decided medication would not benefit the patient. In the other 12 hearings, medication was ordered for two to three months. After the expiration of the period of treatment ordered by the court,

Table 3
Categories of Resolution Pre- and Post-*Rivers*

	Private Hospital				State-operated Hospital			
	Pre		Post		Pre		Post	
	n	%	n	%	n	%	n	%
Acceptance of medication	7	18	2	13	8	7	7	1
Letter rescinding formal refusal	6	15	4	25	19	18	7	1
Clinical administrative agreement with patient's refusal	0	0	0	0	5	5	0	0
Judicial agreement with patient's refusal	0	0	1	6	0	0	2	5
Clinical administrative override	23	59	0	0	67	63	0	0
Judicial override	0	0	0	0	0	0	13	33
Emergency medication	0	0	2	13	2	2	1	3
Discharge	3	8	4	25	5	5	3	7
Transfer	0	0	3	19	1	1	1	3
Failure to return from leave	0	0	0	0	0	0	2	5
Rivers decision pending	0	0	0	0	0	0	3	7
No information	0	0	0	0	0	0	1	3
Total	39	100	16	101	107	101	40	100

some of the chronically mentally ill may require renewed *Rivers* hearings.

The hospital systems have tried to respond to the administrative and legal demands of the *Rivers* mechanism in a variety of ways. One way was the transfer of a patient refusing treatment. The private hospital may transfer a patient to a public setting. If, during the emergency room evaluation, a patient is identified as requiring involuntary psychiatric hospitalization and likely to refuse treatment, the option of committing the patient to the state-operated hospital is available. In the state-operated setting there were two transfers, one to another state-operated hospital and the second back to the county jail. In those cases where it seemed clear to the hospital attorneys that the court would almost certainly support patients' refusal of medication, the hospitals at times discharged the patients either to their families or to their own living arrangements. Although these patients were not "well," their discharge was consistent with the *quid pro quo* of involuntary hospitalization under the *parens patriae* doctrine—the patient's liberty rights are abridged only to provide evaluation or treatment, and if they have received maximum benefit from nonpharmacologic intervention available in the setting and no pharmacologic intervention can be provided the patient's liberty rights should not be abridged. A third response was to avoid the use of the judicial mechanism for patients who would otherwise have had an administrative mechanism instituted. While this gave added time which could be used to facilitate all-important clinical approaches to working with patients refusing treatment, it also added days to the hospitalization during which the pa

tient did not receive indicated psychotropic medication.

A variety of problems arose as a result of the additional time to resolution created by the time it took to have a judicial hearing as mandated by *Rivers*. During the extended delay to resolution post-*Rivers*, some patients decompensated and required the use of emergency medication, seclusion, or restraint. Some patients not only refused psychoactive medications, but also after a time refused food, fluids, and other medications. For the chronic, debilitated elderly patient, the *Rivers* decision may be especially dangerous. Patients who refuse medications may deteriorate and, secondary to their increased level of psychiatric disturbance, may also refuse foods and fluids, creating life-threatening situations, especially for the elderly. Patients' families often have pressed for treatment and have been frustrated by what they perceived as a threat to their family member's health. In the private hospital, insurance coverage was often exhausted during the waiting period and significant economic burdens were placed on the patient, family, and hospital. The increased focus on administrative and judicial concerns may also serve to distract staff from the primary task of the hospital, namely the provision of clinical care.

Why did the number of patients formally refusing medication decrease? We know that before the *Rivers-Katz* decision hospital staff actively encouraged patients to put their refusal of medication into a formal framework, because the writing of a letter that makes the refusal formal triggered the clinical and administrative review procedure. This procedure was done in a timely fashion and usually completed within one week in the private hospital and in the public hospital within three weeks. This administrative procedure was responsive to both the hospitals' and patients' needs. The hospitals' need for a speedy decision regarding the initiation of treatment with medication, and the patients' need for second and third opinions to safeguard the patient from arbitrary action by a single individual were both met. The *Rivers* decision created a formal judicial hearing with attorneys and court dates and testimony. As *Rivers* was implemented, staff learned that it took months to have a judicial hearing. They experienced the courts' sense of "timeliness" and the backlogged court calendars that added to the length of time between the initiation of the formal refusal and the adjudication. This indeterminate period was disruptive to the care of the particular individual patient and to the ward routine. As hospitals learned of the increased amount of time, there was perhaps further reluctance to initiate *Rivers* procedures, particularly if it was thought that making good faith efforts to avoid the adversarial setting would allow the therapeutic alliance to develop. Likewise, before *Rivers*, staff might actively encourage patients to write a formal refusal in instances where the issue of competence or best course of action was unclear; but after *Rivers* and its cumbersome mechanism, the scales tipped against encouraging patients to write formal refusals, and as a result

fewer patients had their objections formally heard.

Hospitals appeared to have made good faith efforts to implement the *Rivers*' procedures immediately upon learning of the decision. The day after the *Rivers*' decision was announced, there were meetings on all hospital units of the private and the public hospital at which the hospital staff explained the new law and made immediate efforts to follow the letter and the spirit of the law. A number of patients immediately refused to take medications that they had been on for some time. Continuing good faith efforts must, however, be influenced by the realities of both the legal system and the medical care system. Both law and ethics must accurately understand the institutional systems and take into account sociological knowledge of how such systems structure individual actions. This predictable effect is found in other states. In Massachusetts, where there is now a formal procedure, there appears to be fewer formal reviews than in Oregon, which has an administrative procedure. As noted elsewhere, the informal procedure allows not only for ease of initiation of the process but also, therefore, encourages more people to refuse, which, in turn, produces more reviews and a lower percentage of refusal overrides. Most of the uncertain cases, the ones that most need review, are heard, whereas the very formal and even cumbersome New York State mechanism makes it less likely for such gray area cases to be reviewed. In summary, staff became understandably and predictably eager to find satisfactory mechanisms to respond to patients' refusal of medication, other than the *Rivers* procedure, which is inherently time consuming, expensive, and adversarial.

Conclusion

Our study suggests that the *Rivers* procedure significantly decreased the number of patients formally refusing prescribed medication, while increasing the time to resolution for those individuals who refused. We did not find clinical or legal benefits to the patients, and to the extent that indicated pharmacotherapy was delayed, the patients' welfare was eroded. There was no indication that the new mechanism better protects patients' rights, or on balance provides for better treatment. In our view, New York State went from a clinical administrative procedure that was clinically and legally responsive to patients, to the post-*Rivers* judicial procedure that diminished responsiveness, increased expense, and decreased the number of patients who had formal reviews of their refusal; in the process, the quality of care for some patients was significantly reduced.

Further investigation of the changes post-*Rivers* is indicated. Studies in other parts of New York State would be useful. In addition, empirical data about individuals who refused treatment pre- and post-*Rivers* may help to answer the question of what has happened to those patients who, before *Rivers*, would have formally refused pharmacotherapy and post-*Rivers* have not. Another question to be studied is the cost of *Rivers* to the system. The minimum direct cost of the

hearing and the indirect costs may not be justified by benefit to patients when an alternative procedure would be responsive to their legal rights and medical needs. Also not addressed in this article is the issue of the proper role of the judge. With the administrative review procedure, there was a nonjudicial determination of that patient's competence and medical decision-making about treatment. Post-*Rivers*, there is a judicial determination of competence and a judicial determination about treatment. Other jurisdictions may wish to look at the New York experience before deciding which alternative would best advance public policy.

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