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**COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON**

In re the Detention of L.K.

Appellant.

RESPONDENTS' BRIEF

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I. INTRODUCTION

The Involuntary Treatment Act (RCW 71.05) allows a physician to petition the court for an order authorizing involuntary treatment with antipsychotic medication when a patient refuses their medication and decompensates, causing danger to themselves or to others, and prolonging the course of their hospitalization. While civilly committed to Western State Hospital, L.K. refused to take her prescribed antipsychotic medication, causing her condition to deteriorate. This event followed a pattern of prior medication discontinuations, and L.K. became so psychotic and disruptive that her physician, Dr. Nagavedu Raghunath, could not have a rational conversation with her about the benefits and risks of taking medication. Dr. Raghunath filed a petition asking the superior court to make a substituted judgment and order the involuntary administration of the antipsychotic Risperdal. A commissioner held a hearing and granted the petition. The Pierce County Superior Court denied her motion to revise.

L.K. now appeals, asserting that the order allowing involuntary administration of Risperdal is unlawful because Dr. Raghunath did not attempt to obtain her informed consent prior to seeking the court order. L.K. argues that the lower court erred in finding that efforts to provide informed consent were futile, and that the order violated both statutory requirements to obtain informed consent and constitutional due process rights.

This Court should affirm the order below because the record amply demonstrates that L.K. was too psychotic to discuss *any* medications, including the ones specifically proposed to the court for involuntary administration. Treatment professionals such as Dr. Raghunath must be afforded the discretion to exercise their professional judgment in situations where patients lack capacity to offer informed consent, subject to judicial review. Regardless, L.K.'s due process rights were protected because the court conducted the same judicial hearing that would have occurred if L.K. had the capacity to consent but refused.

II. COUNTERSTATEMENT OF THE ISSUES

1. Dr. Raghunath determined that L.K. lacked capacity to give informed consent for treatment with antipsychotic medication. Was this exercise of professional judgment sufficient under RCW 71.05.215(2)(a) when the result was that L.K. received the same judicial proceeding under RCW 71.05.217(7) that she would have if she had possessed the capacity to consent and refused?

2. Did the court violate L.K.'s due process rights when it accepted Dr. Raghunath's professional opinion regarding L.K.'s inability to provide informed consent and ordered involuntary treatment with antipsychotic medication only after conducting an adversarial hearing and making a substituted judgment finding under RCW 71.05.217(7)?

3. Was there sufficient evidence for the court to rule on L.K.'s desires regarding the proposed treatment when Dr. Raghunath testified that her mental illness was causing her to refuse all antipsychotic medication?

III. COUNTERSTATEMENT OF THE FACTS

L.K. is a 48-year-old woman who experiences schizoaffective disorder, bipolar type, with a long history of psychiatric treatment. Her sixth admission to Western State Hospital occurred in 2017 following an assault on five nurses at Swedish Hospital, an act for which she was found not competent to stand trial. CP 5-9, 11-12, 31. Upon entering a long-term commitment order to Western State Hospital, the Pierce County Superior Court commissioner found that L.K. has “episodes of agitation, erratic behavior on the ward, delusional belief interferes with medication regimen . . . needs the hospital to assist in deescalation [sic] of her agitation[.]” CP 12. In a subsequent order for involuntary medication, the court found that “Patient has a long history of noncompliance with psychotropic medications, has a long history of bizarre and somatic delusional thought processes, auditory hallucinations, and aggressive behavior.” CP 22.

In August 2018, Dr. Nagavedu Raghunath, a Western State Hospital psychiatrist, filed another petition for involuntary medications in which he described L.K.'s delusional beliefs, and aggressive verbal and physical

behaviors. CP 29-34. The court granted the petition for Clozapine oral with Fluphenazine intra-muscular backup. CP 39-42.

By early 2019, L.K. was again highly decompensated because she was refusing the Clozapine, which is available only in oral form. Dr. Raghunath therefore filed another petition for involuntary medication in February 2019 asking for Risperdal oral, and Risperdal and Fluphenazine intra-muscular backups. Dr. Raghunath's petition noted numerous instances of violent and delusional behavior by L.K. CP 47-52. At the March 2019 hearing on the petition, Dr. Raghunath testified to instances of L.K. hitting peers, disrobing, calling 911, and verbally threatening staff. RP 5-6, March 1, 2019 (RP Vol. I).

In regard to informed consent, Dr. Raghunath testified that L.K. has historically objected to Clozaril because of the necessary blood draws, because she thought she had no blood to give in her body, because it made her too drowsy, and because she believes she has no mental illness. RP Vol. I 8. On cross-examination he clarified that he had not specifically discussed Risperdal, the medication at issue in the March 2019 hearing, with L.K. before filing the petition, because "she is not able to negotiate on *any* medication so she doesn't want the medications." RP Vol. I 15 (emphasis added).

The court commissioner entered an order for involuntary Risperdal oral, and Risperdal and Fluphenazine injectable if L.K. refused. CP 57. The court made findings of her delusional and violent behavior as “reflective of her decompensation.” CP 56-57. The order also contained a finding of substituted judgment: “The Respondent would consent to being treated with antipsychotic medication if the Respondent were capable of making a rational decision concerning treatment and this Court is hereby substituting its judgment for that of the Respondent.” CP 57 ¶ 6.

L.K. sought revision of the court commissioner’s order in the Pierce County Superior Court. CP 60-80. Superior Court Judge James Orlando, a former mental health court commissioner, denied the revision. RP 20, March 22, 2019 (RP Vol. II); CP 118-119. In his oral ruling, Judge Orlando cited L.K.’s state of decompensation and disruptive behavior. RP Vol. II 19. He concluded that “an attempt to obtain informed consent from somebody who is actively psychotic, schizophrenic, threatening, abusive, disrobing, etc., is an exercise in futility. It’s not what I think the statute contemplated.” RP Vol. II 20:4-8. The court further noted that informed consent presupposes competency, and implies that the patient can “choose between an alternative course [of medications] in a rational thought process, as opposed to a delusional belief system.” RP Vol. II 20:16-18.

L.K. now appeals the decision of the superior court.

IV. ARGUMENT

L.K. argues that Dr. Raghunath, the petitioning psychiatrist, failed to seek informed consent as required in RCW 71.05.215 and RCW 71.05.217, and in doing so, deprived L.K. of her constitutional right to refuse antipsychotic medication. L.K. also argues that the superior court erred in affirming an unlawful medication override order.

There is no Washington State case law on what constitutes informed consent for purposes of a medication override proceeding under RCW 71.05.215 and RCW 71.05.217. This court should give substantial weight to the professional judgment of the physician in those circumstances where the patient is so decompensated and delusional that the physician determines that communication with the patient for purposes of informed consent is futile. Otherwise, informed consent is reduced to an empty formality.

A. Standard of Review

This case was subject to revision below, therefore the Court reviews the superior court's decision, not the court commissioner's decision. The record is reviewed for evidence sufficient to support the superior court's finding. *State v. Ramer*, 151 Wn.2d 106, 113, 86 P.3d 132 (2004). Legal conclusions flowing from such findings and testimony are reviewed de novo. *State v. Lopez*, 190 Wn.2d 104, 117, 410 P.3d 1117 (2018).

Constitutional questions are questions of law and reviewed de novo. *In re Detention of Morgan*, 180 Wn.2d 312, 319, 330 P.3d 774 (2014).

B. Federal and State Caselaw Recognizes That Compelling State Interests Can Justify Overriding a Patient's Lack of Consent

There are important constitutional liberty and privacy interests of individuals in avoiding the unwanted administration of antipsychotic medication. But courts have recognized that there are circumstances in which legitimate and compelling state interests can override an individual's lack of consent to such medication. In the criminal context, courts have found two broad justifications for overriding those interests: dangerousness and competency to stand trial. *See, e.g., Washington v. Harper*, 494 U.S. 210, 221, 110 S. Ct. 1028, 108 L. Ed. 2d 178 (1990); *Sell v. United States*, 539 U.S. 166, 180, 123 S. Ct. 2174, 156 L. Ed. 2d 197 (2003).

Apart from the criminal law context, Washington courts have identified four compelling state interests to override a lack of consent for general medical treatments: (1) the preservation of life; (2) the protection of interests of innocent third parties; (3) the prevention of suicide; and (4) maintenance of the ethical integrity of the medical profession. *In re Guardianship of Ingram*, 102 Wn.2d 827, 842, 689 P.2d 1363 (1984);

In re Welfare of Colyer, 99 Wn.2d 114, 660 P.2d 738 (1983).¹ This list is not exhaustive. *In re Schuoler*, 106 Wn.2d 500, 508, 723 P.2d 1103 (1986). For example, preventing the prolonged detention of an involuntarily committed person in a state hospital at state expense also has been held to constitute a compelling state interest for the purpose of overriding a lack of consent for psychiatric treatment. *Id.*; *Matter of Detention of B.M.*, 7 Wn. App. 2d 70, 432 P.3d 459 (2019).

1. The statutory framework for informed consent and a court order for involuntary medication

Two statutes govern informed consent and the process for a court to authorize involuntary medication. First, RCW 71.05.215(2)(a) directs the Health Care Authority to promulgate rules for administration of involuntary antipsychotic medication. The rules shall require “[a]n attempt to obtain the informed consent of the person prior to administration of antipsychotic medication.” RCW 71.05.215(2)(a). This statute also requires rules regarding documentation of the “attempt” to obtain informed consent.

¹ Neither *Ingram* nor *Colyer* dealt with involuntarily committed persons. *Ingram* considered the issue of informed consent for incapacitated persons in the community, while *Colyer* dealt with end-of-life decision making. But both cases discussed compelling state interests that may override lack of consent for medical treatment and are relevant for that purpose here.

RCW 71.05.215(2)(e).² The statute does not define “attempt.” The Health Care Authority has implemented the statute in rule.³

A court can order the involuntary medication of an individual committed under RCW 71.05.320(4) only if it proves by clear, cogent, and convincing evidence that (1) there is a compelling state interest in overriding the lack of consent to the administration of antipsychotic medications, (2) the treatment with the proposed antipsychotic medications is necessary and effective, and (3) there is no effective medically acceptable alternative treatment. RCW 71.05.217(7). The court is to make specific findings of fact concerning:

- (i) The existence of one or more compelling state interests;
- (ii) the necessity and effectiveness of the treatment; and
- (iii) the person's desires regarding the proposed treatment. If the patient is unable to make a rational and informed decision about consenting to or refusing the proposed treatment, the court shall make a substituted judgment for the patient as if he or she were competent to make such a determination.

RCW 71.05.217(7)(b). This statute directs the court to make a substituted judgment for a patient who lacks capacity to give informed consent.

² The record is silent on the documentation in the patient chart of any attempt to make informed consent. That question was not asked by either party in the hearing, nor was the issue raised in revision. *See* RCW 71.05.215(2)(e).

³ Wash. St. Reg. 19-13-057 (WAC 182-538D-0526(3)(c) - Health Care Authority, *Rule-Making Order CR-103E*, <https://www.hca.wa.gov/assets/103E-19-13-057.pdf>).

C. Dr. Raghunath's Exercise of Professional Judgment in Assessing L.K.'s Competence to Give Informed Consent Did Not Violate Her Right to Due Process

L.K. argues that Dr. Raghunath violated her due process right to refuse antipsychotic medication by failing to ask for her informed consent. Br. of Appellant at 12. The record demonstrates that Dr. Raghunath determined, as a matter of professional judgment, that L.K. lacked capacity to give informed consent. “[S]he’s not able to negotiate on any medication so she doesn’t want to take the medications.” RP Vol. I 15:11-12. He then appropriately petitioned the court under RCW 71.05.217(7).

In requiring the court to make substituted judgment, RCW 71.05.217(7)(b) accounts for those situations where the patient cannot provide informed consent because of his or her decompensated state, and it does not require a formalistic “attempt” to secure informed consent where the patient lacks capacity to give it.

Both the court commissioner and the superior court found that L.K.’s lack of capacity to provide consent was evident in the record. The court commissioner ruled: “She thinks she has not [sic] mental illness and does not need treatment. . . . She was starting to improve but as of January she stopped Clozaril and other medications.” CP 56. “She does not think she has a mental health disorder. She thinks she has medical issues, none of which are true with regard to the things that she thinks she has.”

RP Vol. I 20:23-25. Reviewing the record, the superior court agreed: “She’s refused medications for a variety of delusional beliefs.” RP Vol II 20:3-4.

L.K. emphasizes the mandatory nature of statutes, and attempts to constitutionalize Dr. Raghunath’s determination, in the exercise of his professional judgment, that L.K. was unable to provide informed consent before he petitioned for court approval to administer the medications. Br. Appellant at 14-20. Her argument is unavailing for several reasons.

First, RCW 71.05.215(2) is a mandatory directive to the Health Care Authority to promulgate rules regarding antipsychotic medication. The statute is not a directive to physicians. L.K. makes no attempt to argue noncompliance with the rule the Health Care Authority adopted, WAC 182-538D-0526(3)(c). Wash. St. Reg. 19-13-057. Moreover, an alleged violation of a rulemaking directive cannot be bootstrapped into a constitutional violation. If a statute creates a procedure, it does not create a substantive constitutional right. *DeLong v. Parmelee*, 157 Wn. App. 119, 163, 236 P.3d 936 (2010).

Second, L.K.’s reliance on *Harper* provides little guidance to the case at hand. In *Harper*, the U.S. Supreme Court addressed the question of “whether a judicial hearing is required before the State may treat a mentally ill prisoner with antipsychotic drugs against his will,” and held that an administrative proceeding is constitutionally acceptable and a judicial

hearing is not required. *Harper*, 494 U.S. at 213, 236. Here, there is no question that L.K. had a statutorily required judicial hearing. RCW 71.05.217(7)(c).

Finally, L.K.'s construction of RCW 71.05.215(2)(a) and RCW 71.05.217(7)(b) elevates form over substance. L.K. argues that the conditional provision of RCW 71.05.217(7)(b) "does not negate the statutory requirement of RCW 71.05.215(2)(a)." Br. of Appellant at 31. Under L.K.'s argument, the only permissible "attempt" is a formulaic statement of the benefits and risks of the specific antipsychotic medications followed by a request for consent, which must be provided even if the patient has no ability to comprehend the information and make a rational decision. Courts are to interpret statutes in a manner that avoids absurd results. *Kilian v. Anderson*, 147 Wn.2d 16, 21, 50 P.3d 638 (2002). Requiring a useless act is an absurd result. *See Buckner, Inc. v. Berkey Irr. Supply*, 89 Wn. App. 906, 914, 951 P.2d 338 (1998) (it would be absurd result to read court rule as requiring meaningless and useless duplication); *Northlake Concrete Prod., Inc. v. Wylie*, 34 Wn. App. 810, 818, 663 P.2d 1380 (1983) (applying rule of statutory construction to require useless work would be absurd result). In this case, a formal request for informed consent was useless—the superior court found such an

interpretation “an exercise in futility. It’s not what I think the statute contemplated.” RP Vol. II 20:7-8.

1. This Court should follow the approach of federal courts and hold that an “attempt” at obtaining informed consent is satisfied through the exercise of professional judgment

This court should hold that, to the extent RCW 71.05.215(2) requires an “attempt” to obtain informed consent, that requirement is satisfied when the physician exercises professional judgment about whether the patient is competent to make such a decision and determines the patient lacks the necessary capacity. If the patient is incompetent, consent to a formulaic statement of the benefits and risks of antipsychotic medications is not required before petitioning the court. Due process rights are still protected by a judicial proceeding.

This is the approach of the federal courts following the direction of the U.S. Supreme Court in *Youngberg v. Romeo*, 457 U.S. 307, 102 S. Ct. 2452, 73 L. Ed. 2d 28 (1982). In *Youngberg*, the court held that decisions made by a professional are “presumptively valid” and civil rights liability may be imposed only when the decision is a “substantial departure from professional judgment, practice or standards[.]” *Id.* at 323. This approach reflects the view that professionals are in a better position than courts to make treatment decisions, and courts should defer to professional

judgment on which of several professionally acceptable choices should be made. *Id.* at 321. The Third Circuit has held that “antipsychotic drugs may be constitutionally administered to an involuntarily committed mentally ill patient whenever, in the exercise of professional judgment, such an action is deemed necessary to prevent the patient from endangering himself or others.” *Rennie v. Klein*, 720 F.2d 266, 269 (3d Cir. 1983); *accord Project Release v. Prevost*, 722 F.2d 960, 977-81 (2d Cir. 1983); *Johnson v. Silvers*, 742 F.2d 823 (4th Cir. 1984).

L.K.’s countervailing view is that the legislature gave treatment professionals no ability to exercise professional judgment because, by implication, those physicians cannot be trusted to determine whether an “attempt” at informed consent is futile or not because of the patient’s incapacity to understand. Br. of Appellant at 35. But, the U.S. Supreme Court has noted that “due process is not violated by use of informal traditional medical investigative techniques.” *Parham v. J.R.*, 442 U.S. 584, 607, 99 S. Ct. 2493, 61 L. Ed. 2d 101 (1979).

Either way, whether an “attempt” is the formal request seeking informed consent of the patient, or a more flexible exercise of professional judgment, the patient still gets her day in court before any medications can be administered. She still receives due process.

In interpreting the Involuntary Treatment Act, the Washington Supreme Court acknowledged that “there is a danger that excessive judicial deference will be given to the opinions of mental health professionals, thereby effectively insulating their commitment recommendations from judicial review.” *In re LaBelle*, 107 Wn.2d 196, 208, 728 P.2d 138 (1986). Here, the factual basis for the petition was presented to the court, there was no excessive deference, and no insulation from judicial review. A judicial hearing is mandatory before antipsychotic medications can be involuntarily administered. RCW 71.05.217(7); *Matter of Detention of B.M.*, 7 Wn. App. 2d at 79; see also *In re Schuoler*, 106 Wn.2d at 511 (“Here, review by a judge provides sufficient protection against an erroneous decision.”)

D. The Court Order Authorizing Antipsychotic Medications Was Lawful.

L.K.’s second argument is that the Superior Court erred in denying revision of the court’s commissioner’s “unlawful” order authorizing involuntary antipsychotic treatment. Br. of Appellant at 22-38. Here, L.K. doubles-down on her first argument that the legislature, in enacting RCW 71.05.215(2)(a), afforded no room for mental health physicians to assess whether an “attempt” at informed consent is futile or not because of the patient’s incapacity to understand. L.K. also argues that the superior

court erred in failing to revise an order that lacked specific findings of fact regarding “the person’s desires regarding the proposed treatment.” RCW 71.05.217(7)(b)(iii).

1. The superior court’s order regarding an “attempt” at informed consent was lawful

L.K. argues that the superior court’s denial of revision was error because a formal “attempt” to seek informed consent under RCW 71.05.215(2)(a) is a predicate to obtaining a court order under RCW 71.05.217(7). L.K. correctly notes that the doctrine of informed consent rests on the premise that “every human being of adult years and *sound mind* has a right to determine what shall be done with his own body.” Br. of Appellant at 23 (emphasis added) (citations omitted). But she then disregards the need for sound mind—that a patient must have the capacity to engage in “a discussion of the risks involved so that the person can make an intelligent decision.” *See* Br. of Appellant at 25.

The informed consent doctrine is not constitutional. Rather, the doctrine is a direct corollary of tort common law and the long recognized values of bodily integrity and self-determination. Informed consent law emerged from the tort law of battery, which was applied to unauthorized touching by a physician. *Mills v. Rogers*, 457 U.S. 291, 295 n.4, 102 S. Ct. 2442, 73 L. Ed. 2d 16 (1982); *Schloendorff v.*

Society of New York Hospital, 211 N.Y. 125, 129-30, 105 N.E. 92 (1914) (all adults with “sound mind[s]” have the right to decide what is done or not done to their bodies.). The informed consent doctrine requires that a patient’s consent, or lack of consent, be made in a competent, knowledgeable, and voluntary manner to be legally valid. See *Stewart-Graves v. Vaughn*, 162 Wn.2d 115, 122-23, 170 P.3d 1151 (2007); *Keogan v. Holy Family Hospital*, 95 Wn.2d 306, 313-14, 622 P.2d 1246 (1980); *ZeBrath v. Swedish Hospital Medical Center*, 81 Wn.2d 12, 499 P.2d 1 (1972).

The common-law doctrine of informed consent, although not constitutional, can encompass a liberty interest of a competent individual to refuse medical treatment. *Cruzan by Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 277, 279 n. 7, 110 S. Ct. 2841, 111 L. Ed. 2d 224 (1990) (the right to refuse medical treatment is more aptly framed as a Fourteenth Amendment liberty interest rather than a right of privacy interest). Because involuntary medication implicates a Due Process interest, certain procedural protections are required prior to the involuntary administration of antipsychotic medication. *Harper*, 494 U.S. at 235.

In this case, the procedural protections of RCW 71.05.217(7) were applied, and no medication was involuntarily administered before an adversarial hearing was held. The informed consent doctrine does not

elevate RCW 71.05.215(2)(a) into a constitutional requirement that supersedes the procedural protections in RCW 71.05.217(7) or that somehow makes the superior court's proceedings and decision unlawful. L.K. simply ignores those situations where the patient is not of "sound mind" and due to psychosis cannot make an "intelligent decision." Br. of Appellant at 23, 25. There is no constitutional requirement that each physician undertake a ritualistic recitation of benefits and risks regardless of the patient's capacity to understand and consent.

Not every person involuntarily committed is legally incompetent. RCW 71.05.360(1)(b); *Schuoler*, 106 Wn.2d at 505 ("These individuals may or may not be legally incompetent."). But not all patients have the capacity to rationally weigh benefits and risks of taking medications. In that case, the courts are directed to make substituted judgment. RCW 71.05.217(7)(b).

That is exactly what happened here. Judge Orlando reviewed the trial court record and concluded that, given L.K.'s mental condition, a formal offer to obtain informed consent was "an exercise in futility". RP Vol II 20:4-7. He observed that a request to provide informed consent "presuppose[s] that somebody was going to be competent to make that decision." RP Vol. II 20:13-14. Because L.K. lacked the competence to understand a request for informed consent, Judge Orlando made the

substituted judgment authorized under RCW 71.05.217(7)(b). L.K. received the procedural protections required by due process.

2. The court made findings in regard to L.K.'s desires, and therefore the order was lawful

Finally, L.K. argues that the superior court erred in affirming the court commissioner's order because the commissioner did not take into account L.K.'s "desires regarding the proposed treatment,"—i.e., the specific medications proposed in the petition: Risperdal and Fluphenazine—in accordance with RCW 71.05.217(7)(b)(iii). Br. of Appellant 36.

In fact, the record clearly shows L.K.'s desire not to have *any* treatment. Dr. Raghunath testified about L.K.'s historical opposition to Clozaril. RP Vol. I 8. He also explained how her lack of insight caused her to oppose *all* antipsychotic medications, which would include Risperdal and Fluphenazine, which he was now proposing to the court. "She doesn't want to take any medication because she doesn't want to -- she doesn't have any mental illness." RP Vol. I 14:23-24. "[S]he's not able to negotiate on any medication so she doesn't want to take medications." RP Vol. I 15:11-12.

Based on substantial evidence in the record, the court commissioner found, "She does not think she has a mental disorder. She thinks she has medical issues, none of which are true[.]" RP Vol. I 20:23-24. Reviewing

that evidence, the superior court concluded, “She’s refused medications for a variety of delusional beliefs.” RP Vol. II 20:3-4. Both the commissioner’s ruling and the superior court’s order comport with the statutory requirement to have findings of fact that reflect “the person's desires regarding the proposed treatment.” RCW 71.05.217(7)(b)(iii).

L.K. attempts to draw the facts of her case close to those in *Schuoler*, where no attempt was made to discern the patient’s wishes about proposed electroconvulsant therapy. Br. of Appellant at 34-38; *In re Schuoler*, 106 Wn.2d at 508. As described above, however, the court commissioner and the superior court made findings about L.K.’s view of antipsychotic medication. *Supra* at 19-20. In *Schuoler*, the trial court denied the patient counsel’s request for more time in order to call the family for testimony. *In re Schuoler*, 106 Wn.2d at 508. Here, L.K. did not appear at the hearing, RP Vol. I 2, and neither L.K. nor her family expressed any desire to come to court. Dr. Raghunath also testified that he knew of no family opinions about L.K.’s medications. RP Vol. I 9. The facts of this case and *Schuoler* are distinguishable.

V. CONCLUSION

The Court of Appeals should affirm the decision below. The doctrine of informed consent does not require useless formalism in those situations where an involuntarily committed patient cannot comprehend the

information the physician provides. The patient's constitutional right to refuse antipsychotic medication is protected through an adversarial hearing in a judicial proceeding.

RESPECTFULLY SUBMITTED this 18th day of September, 2019.

ROBERT W. FERGUSON
Attorney General

A handwritten signature in black ink, appearing to read "Eric Nelson", written over a horizontal line.

ERIC NELSON, WSBA No. 27183
Assistant Attorney General
Attorneys for Respondent DSHS

CERTIFICATE OF SERVICE

I, *Christine Townsend*, state and declare as follows:

I am a citizen of the United States of America and over the age of 18 years and I am competent to testify to the matters set forth herein. On September 18, 2019, I served a true and correct copy of this **RESPONDENTS' BRIEF** and this **CERTIFICATE OF SERVICE** on the following parties to this action, as indicated below:

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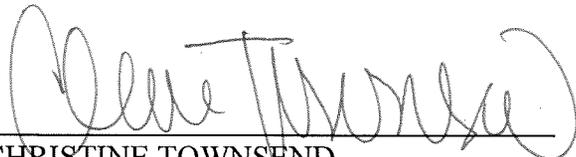
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I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

DATED this 18th day of September 2019, at Tumwater, Washington.



CHRISTINE TOWNSEND
Legal Assistant

SOCIAL AND HEALTH SERVICES DIVISION, ATTORNEY GENERALS OFFICE

September 18, 2019 - 4:27 PM

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