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Psychiatrists' Failure to Inform: Is There Substantial Financial Exposure?

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Psychiatrists regularly fail to obtain informed consent by not fully informing their patients of the risks of psychotropic drugs as well as overstating their benefits. As the wave of lawsuits against manufacturers for failure to warn wane, will such psychiatrists be next and do they risk substantial liability?

Keywords: informed consent; involuntary medication; antipsychotics; civil rights; battery; perjury

Psychiatric drugs are causing huge amounts of physical harm, including severely limited lives and early death. Tragically, this is not offset by corresponding benefits, because the ability of psychiatric drugs to successfully treat the conditions for which they are prescribed is limited. In fact, they are often counterproductive. This is particularly true of the neuroleptics, often also called by the misnomer "antipsychotics." It is also true of the selective serotonin reuptake inhibitor (SSRI) antidepressants and their cousins, as well as the stimulants used to treat children and now adults with attention deficit hyperactivity disorder (ADHD). In addition, these antidepressant and ADHD drugs cause people to become psychotic in a substantial percentage of cases, which often leads to misdiagnosing an underlying mental illness and results in ever-increasing doses of the stronger, more debilitating neuroleptics.

The scope of the harm is immense. It is likely the toll greatly exceeds that from Vioxx. The neuroleptics, old and new, disable many people who take them and substantially reduce life spans (Joukama et al., 2006; Straus et al., 2004; Waddington et al., 2003). Similarly, it has been reliably estimated the antidepressants have caused 23,000 suicides (Healy, 2004).

These facts are virtually never disclosed to patients, thus breaching the obligation to obtain informed consent, and often legally constituting battery. In forced drugging proceedings, psychiatrists testifying as witnesses regularly testify untruthfully, which constitutes perjury. This results in the courts being duped into forcing hundreds of thousands of unwilling people to take harmful drugs. The threat of involuntary commitment for failure to comply keeps many more taking these drugs in spite of their desire to reduce or eliminate them. People's lives are being ruined and shortened needlessly, because there are better alternatives. The legal system has not yet done much to hold psychiatrists accountable for this harm, but that may change.

PSYCHIATRIC DRUGS: THE FACTS

The disability rate of people diagnosed with mental illness in the United States has increased six-fold since the introduction of the supposed miracle drug Thorazine in 1955 to treat people diagnosed with schizophrenia (Whitaker, 2005). Thorazine and its cousins, Prolixin, Mellaril, Navane, Trilafon, Stelazine, Haldol, and so forth, are often referred to as the classic neuroleptics, whose allure has largely faded with the expiration of their patents. They cause tardive dyskinesia (TD), which is a largely irreversible movement disorder, at a rate of approximately 5% per year of drug exposure (Breggin, 1997; Jackson, 2005), and neuroleptic malignant syndrome (NMS), which is an often fatal disease characterized by muscular rigidity and high fever (Pelonero, Levenson, & Pandurangi, 1998).

Starting in 1990, a new generation of neuroleptics was introduced for the treatment of schizophrenia, including Clozaril, Zyprexa, Risperdal, Seroquel, and Abilify. These drugs are termed "atypicals" because they supposedly have lower toxicity and are more effective. Neither of these marketing assertions has proven true (Lieberman et al., 2005). In addition to it being entirely unclear that these drugs cause less tardive dyskinesia or neuroleptic malignant syndrome (Stip, 2002), this class of drugs is causing massive amounts of diabetes and other metabolic problems (Ananth, Venkatesh, Burgoyne, & Gunatilake, 2002; Berenson, 2006). The latest trend is to use the drugs on children, particularly those in state custody, with devastating effects on their health and lives (Bittigau, et al., 2002; Olney, Farber, Wozniak, Jevtovic-Todorovic, & Ikonomidou, 2000).

These drugs are also deadly, with a recent study concluding they increase mortality by 2.5 times *for each drug prescribed* (Waddington et al., 2003).

For most patients these drugs are terrible to experience. At common doses, they turn people into zombies, often cause an uncontrollable agitation, called *akathisia*, which can be so distressing it causes people to kill themselves (or get violent) (American Psychiatric Association, 2000), and, as mentioned, create serious health problems. They also often do not even help much with the "positive symptoms," such as hearing voices and delusions (Jackson, 2005).

The tragedy is that nonmedication approaches have been shown to work, leading to much better lives for many people (e.g. Karon & Vandenbos, 1996; Mosher, 1999). In fact, a conservative estimate is the current pervasive reliance on psychiatric drugs for the treatment of schizophrenia is at least doubling the number of people who become permanently disabled (Whitaker, 2002, 2005).

The reality is these drugs are most often used by the mental health system to subdue and control individuals whose behavior is disturbed and/or disturbing. The courts have been enlisted to force these drugs on unwilling patients in proceedings that can fairly be termed shams and in which the psychiatrists testifying in favor of the forced drugging regularly commit perjury. Before discussing forced psychiatric drugging, however, it has been estimated SSRI antidepressants, such as Prozac, Paxil, and Zoloft, cause psychotic reactions in 5%–20% of patients, who then often are misdiagnosed with serious mental illness rather than having the problem attributed to the drug (Breggin, 2003; Whitaker, 2005). The same process of psychotic reaction, often leading to diagnoses of serious mental illness, occurs with the stimulants, such as Ritalin, given to children to control them after being diagnosed with ADHD. Current estimates of psychotic reactions to these ADHD drugs are in the 5%–10% range (Breggin, 2002; Jackson, 2005).

COURT-ORDERED PSYCHIATRIC DRUGGING

People have a fundamental, although not absolute, right under the 14th Amendment to be free of unwanted psychiatric drugs (*Mills v. Rogers*, 1982; *United States v. Sell*, 2003; *Washington v. Harper*, 1990). In *Mills v. Rogers*, the United States Supreme Court held the constitutional protection under the 14th Amendment of the United States Constitution is intertwined with state law, and if state rights are broader than federal constitutional protections, the state rights "would define the actual [federal] substantive rights possessed by a person living within that State." Court-ordered psychiatric drugging arises in a number of contexts. The most common are civil inpatient and outpatient commitment proceedings, competence to stand trial proceedings, and in prisons. The U.S. Supreme Court case of *Sell v. United States* involved competence to stand trial, and defined the federal constitutional protections in that setting. The U.S. Supreme Court has never ruled on the precise parameters of 14th Amendment rights in the civil context, but because of its use of well-established constitutional principles, the following rules it announced are presumably applicable

> First, a court must find that *important* governmental interests are at stake.
> Second, the court must conclude that involuntary medication will *significantly further* those concomitant state interests.
> Third, the court must conclude that involuntary medication is *necessary* to further those interests. The court must find that any alternative, less intrusive treatments are unlikely to achieve substantially the same results.
> Fourth, ... the court must conclude that administration of the drugs is *medically appropriate*, that is, in the patient's best medical interest in light of his medical condition (*United States v. Sell*, 2003).

In the civil context, except in emergencies, it is only someone who has been found incompetent to make the decision who can be court ordered to submit to psychiatric drugs (*Rivers v. Katz*, 1986). Where such a determination has been made and without relying on *Sell*, the Alaska Supreme Court recently utilized the same sort of analysis as contained in *Sell* in finding Alaska's forced drugging unconstitutional for failure to require *the court* to find the drug(s) in the patient's *best interest* and there are *no less restrictive alternatives* available (*Myers v. Alaska Psychiatric Institute*, 2006). The governmental interests involved are public safety, exercised under the "police power," which is restricted to short-term emergency situations, and the second is to act in the best interests of someone who is incompetent under what is called the *parens patriae* doctrine, which basically means the state is stepping in and acting on behalf of someone as would the parent of a minor.

In light of the dubious, at best, efficacy of the drugs, and the extreme harm they cause, it does not seem possible to actually meet the best interests standard. However, the pervasive message that these drugs are safe and effective, including meretricious court testimony by psychiatrists, results in the courts and the attorneys assigned to represent psychiatric defendants giving short shrift to people's rights. *People's rights are dishonored as a matter of course in these proceedings.*

Psychiatrist E. Fuller Torrey (1997) touts psychiatrists' lying to the courts: "It would probably be difficult to find any American Psychiatrist working with the mentally ill who has not, at a minimum, exaggerated the dangerousness of a mentally ill person's behavior to obtain a judicial order for commitment." (152) Dr. Torrey also quotes psychiatrist Paul Applebaum as saying when "confronted with psychotic persons who might well benefit

from treatment, and who would certainly suffer without it, mental health professionals and judges alike were reluctant to comply with the law," noting that in "'the dominance of the commonsense model,' the laws are sometimes simply disregarded." (151). This has also been recognized by perhaps the leading commentator on this area of the law, New York Law School professor Michael Perlin (1993/1994):

> Courts accept ... testimonial dishonesty, ... specifically where witnesses, especially expert witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends." ...
>
> Experts frequently ... and openly subvert statutory and case law criteria that impose rigorous behavioral standards as predicates for commitment....
>
> This combination ... helps define a system in which (1) dishonest testimony is often regularly (and unthinkingly) accepted; (2) statutory and case law standards are frequently subverted; and (3) insurmountable barriers are raised to insure that the allegedly "therapeutically correct" social end is met.... In short, the mental disability law system often deprives individuals of liberty disingenuously and upon bases that have no relationship to case law or to statutes.

Psychiatrists have largely gotten away with this thus far because of the prevailing attitude that protesting patients are just crazy and don't know what is good for them. However, this free ride may come to an end fairly soon.

CONSENT, INFORMED CONSENT, BATTERY, AND THE RIGHT TO SELF-DETERMINATION

At common law the failure to obtain consent is battery (Hull, 2002):

> [A]n unconsented touching is a battery under the law, apart from exceptional, emergency situations where consent is presumed physicians need their patients' consent in order to ply their craft. Absent such consent, surgery becomes stabbing, chemotherapy becomes poisoning, and urological examinations become sexual assaults. Nor is the defense of good intentions a sufficient excusing factor. The consent of the patient is recognized in the law as essential, and the provision of unwanted medical care is not excused by the benevolent intentions of the provider.

This common law rule has been changed by statute in some states, although the Arizona Supreme Court recently struck down such a state statute (*Duncan v. Scottsdate Medical Imaging*, 2003). Some states make the distinction between total lack of consent, which they find constitutes battery, and failure to obtain *informed* consent, *i.e.*, failing to provide adequate information, which is considered malpractice rather than battery (e.g., *Cobbs v. Grant*, 1972). Other states hold that failure to obtain *informed* consent does constitute battery (*Shadrick v. Coker*, 1998). In still other states, even the lack of any consent is considered a malpractice claim, not battery (*Lugenbuhl v. Dowling*, 1997). To confuse the matter even more, in the *Lugenbuhl* case, which ruled the lack of any consent at all is a medical malpractice claim, not battery, the Louisiana Supreme Court stated where there was failure to obtain such consent "some of the damages generally awarded in battery cases are applicable," holding "damages for deprivation of self-determination, insult to personal integrity, invasion of privacy, anxiety, worry and mental distress are actual and compensatory."

All of this is unnecessarily confusing, because the bottom line is psychiatrists are financially liable for failure to obtain informed consent.

Before this topic is left, however, a couple of points should be made about what seems to be an inconsistent body of law. First, case law develops from the specific facts in the case at hand and different facts can cause distinctions to be drawn with different results. Second, the underlying assumption in the courts considering these cases to be malpractice, rather than battery, is based on the premise the failure to obtain informed consent was unintentional. To the extent information necessary to informed consent is deliberately withheld, or false information given, then this logically moves the situation back into the battery arena as an intentional act, which was recognized in the *Duncan v. Scottsdale Medical Imaging* case. In this regard, reckless disregard, is the same as an intentional act. In other words, it is a battery where the truth was not told to the patient because the prescribing physician recklessly failed to apprise him or herself of the actual benefits and harms, or even made a "substantial mistake."

WHAT IS INFORMED CONSENT?

As with whether failure to obtain consent or informed consent is a battery or malpractice, states vary as to what constitutes informed consent. *Cobbs v. Grant* (1972) is considered to have a good discussion of the general law:

> [A]n integral part of the physician's overall obligation to the patient . . . is a duty of reasonable disclosure of the available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each.
>
> A concomitant issue is the yardstick to be applied in determining reasonableness of disclosure. This defendant and the majority of courts have related the duty to the custom of physicians practicing in the community. The majority rule is needlessly overbroad. Even if there can be said to be a medical community standard as to the disclosure requirement for any prescribed treatment, it appears so nebulous that doctors become, in effect, vested with virtual absolute discretion. . . . 'Nor can we ignore the fact that to bind the disclosure obligation to medical usage is to arrogate the decision on revelation to the physician alone. Respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves.' Unlimited discretion in the physician is irreconcilable with the basic right of the patient to make the ultimate informed decision regarding the course of treatment to which he knowledgeably consents to be subjected." . .
>
> A mini-course in medical science is not required; the patient is concerned with the risk of death or bodily harm, and problems of recuperation. Second, there is no physician's duty to discuss the relatively minor risks inherent in common procedures, when it is common knowledge that such risks inherent in the procedure are of very low incidence. . . .
>
> [W]hen a given procedure inherently involves a known risk of death or serious bodily harm, a medical doctor has a duty to disclose to his patient the potential of death or serious harm, and to explain in lay terms the complications that might possibly occur. Beyond the foregoing minimal disclosure, a doctor must also reveal to his patient such additional information as a skilled practitioner of good standing would provide under similar circumstances.
>
> In sum, the patient's right of self-decision is the measure of the physician's duty to reveal. That right can be effectively exercised only if the patient possesses adequate information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is whatever information is material to the decision. Thus the test for determining whether a potential peril must be divulged is its materiality to the patient's decision.

Under Alaska Statutes 47.30.837 (1992), pertaining to the administration of psychotropic drugs, "informed" is defined to mean "that the evaluation facility or designated treatment facility has given the patient all information that is material to the patient's decision to give or withhold consent, including

> (A) an explanation of the patient's diagnosis and prognosis, or their predominant symptoms, with and without the medication;
>
> (B) information about the proposed medication, its purpose, the method of its administration, the recommended ranges of dosages, possible side effects and benefits, ways to treat side effects, and risks of other conditions, such as tardive dyskinesia;
>
> (C) a review of the patient's history, including medication history and previous side effects from medication;
>
> (D) an explanation of interactions with other drugs, including over-the-counter drugs, street drugs, and alcohol;
>
> (E) information about alternative treatments and their risks, side effects, and benefits, including the risks of nontreatment . . .

This raises the question of what liability might attach to psychiatrists' failure to obtain informed consent.

PSYCHIATRISTS' POTENTIAL EXPOSURE

Space does not allow a full discussion of potential causes of actions which might be brought against psychiatrists, but a few thoughts about various types of lawsuits will be presented.

Tort Litigation

In spite of the harm being caused by neuroleptics, with rare exceptions, people injured by them have an extraordinarily hard time obtaining representation for personal injury cases. One reason is the belief that victims had little prospect of earning significant income. However, it is simply not true that people diagnosed with serious mental illness have to have low to nonexistent economic prospects. It would be surprising if any reader was not aware of a bright college or graduate student who had a breakdown while in school, was put on psychiatric drugs, and never returned to what could have been a very successful life path. Many, or even most, of these bright, competent, high-achieving young adults, with real help (or many even if left to their own devices), could and would have recovered to fulfill their potential. Their economic loss from being permanently disabled by neuroleptics is substantial. For states where battery is the cause of action, damages are presumed.

We have recently seen at least one billion-dollar case, and some close to that, against drug manufacturers for failure to tell the truth about psychiatric drugs. As the warnings about these drugs become sufficient, liability shifts to the psychiatrists who don't provide sufficient information to obtain *informed* consent. Another potential category of personal injury cases is when the drugs have caused someone to commit suicide or a violent act against someone else. It is well established that the neuroleptics and the SSRI

antidepressants cause suicide or violence, including homicide. The amount of damages (liability) in such cases can be substantial because there often is a very well-established earnings loss.

Perhaps the most heartbreaking class of potential cases are those where children have been psychiatrically drugged. More and more, and younger and younger children are being prescribed neuroleptics, which have never been approved for such use. (Olfson, Blanco, Liu, Moreno, & Laje 2006). The health impacts, including brain damage, will be substantial. It is not unlikely that the tremendous increase in prescribing atypical neuroleptics to children is a significant contributor to the increase in U.S. pediatric diabetes. The damages (liability) for this can be enormous.

Federal Civil Rights Litigation

Under 42 U.S.C. § 1983, anyone who violates a citizen's constitutional rights "under color of state law" can be sued for damages in federal court. Psychiatrists who obtain court orders to forcibly medicate their patients without providing the court with sufficient information to make an informed decision whether it is in the patient's best interest to be forcibly medicated have presumably violated their patients civil rights under color of state law and are liable in damages.

Qui Tam or Private Attorney General Litigation

Perhaps of even greater potential are the numerous statutes, sometimes referred to as *qui tam*, allowing private citizens to sue for a penalty, part of which the government or some specified public institution will receive. There appears to be a massive amount of what can be labeled-Medicaid/Medicare fraud associated with the prescribing of these drugs, and this is another potential source of liability.

Securities Fraud

Under federal securities law it is illegal to make any untrue statement of a material fact or omit a material fact or engage in any act that would operate as a fraud or deceit in connection with the purchase or sale of securities (Securities Exchange Act Rules, 1934). The Sarbanes Oxley Act (2002) also imposed liabilities on corporate officials. Psychiatrists who publish misleading articles that overstate the benefits and understate the harm could potentially be liable for astronomical amounts of damages to shareholders when stock prices drop after the facts come out.

CONCLUSION

For various reasons, psychiatrists have not heretofore often been held legally responsible for their failure to adequately inform their patients about the true efficacy and known harms of the drugs they prescribe with ubiquity. This has likely lulled them into a false sense of security because there are various factors at work, which could loose a tidal wave of legal cases against those who do not adequately inform their patients about the benefits and harms, including the efficacy of other approaches and of nontreatment.

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