Lasting Rights and Last Rites: A Case Report

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The contrast between legal and clinical perceptions of reality, characterized as discrete versus continuous in nature, generates dilemmas for both professions. Individuals in conflict with either system are especially vulnerable to the philosophical serrations at the interface between psychiatry and the law. A case example, which serves to magnify the gripping impact of these diverse and powerful institutions, raises various issues for examination and discussion.

Differences between clinical and legal perceptions of the same phenomena have been profiled by Gutheil and Mills[1] who contrast clinical realities, derived primarily from empirical approaches and deductive reasoning, with legal realities, derived from a theoretical orientation and inductive reasoning. Whereas clinical realities are based on continuous events, legal realities are based on discrete events.[1]

In their argument for the application of applied clinical ethics as a working model in the analysis of issues in forensic psychiatry, Ciccone and Clements[2] contrast the value systems of psychiatry and the law and the goals of healing versus punishment. Dissection of these differences in perceptions, orientations, paradigms of reasoning, value systems, and goals results in useful information—in theory. In practice, however, we witness collisions of these divergent and powerful forces which are neither innocuous nor easily prevented.

The following tragedy—costly to two patients—is submitted as a case in point. Once conscious, the anxiety generated by intrapsychic conflicts is difficult to ignore. Can the same psychologic principles be generalized to conflicts between groups, given enough data and time? The issues raised by the case example are discussed with intent to demonstrate the personified effects of conflicts between the therapeutic society and the just society.[2]

Case Report

After his impulsive discontinuation of lithium carbonate and a week's history of escalating problems with emotional and physical controls, this 27-year-old, single physically healthy college student was admitted to a midwestern state mental hospital on an emergency Court Or-

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der of Detention based on "dangerousness to self and others." Just before admission, he battered his car with the sun roof, which he ripped from its hinges. Before and after admission, he consistently refused drug treatment, stating that he was not mentally ill and that he did not require treatment of any form.

The onset of his seven-year well-documented history of episodic manic behavior and subjective reports of "depression from lithium" coincided with the ending of a love relationship while in college. The acute stages of his disorder characteristically include grandiose, expansive, and delusional ideation, flight of ideas, pressured speech, impaired judgement, excessive religiosity, hyperactivity, impulsivity, agitation, and threatening and violent behavior. Each of his nine previous hospitalizations was involuntary. A review of hospital records of the previous four years revealed 14 incidents requiring seclusion and restraint, the last of which occurred just four months before this admission—the consequence of picking up another patient and throwing him across a hall after an argument.

The patient threatened legal action if coerced to take medication, and he recruited the assistance of a patients' rights advocacy agency the representative of which also threatened legal action on behalf of the patient's right to refuse treatment. Admittedly intimidated, attending physicians concluded that the patient was competent to refuse treatment and therefore confined orders for injectable neuroleptic medication to 24-hour time periods based on daily assessments of the patient's apparent degree of dangerousness. Drug treatment (haloperidol, 5 mg intramuscularly) was sporadic. Seclusion and restraint were required on 11 occasions during the first 29 days of hospitalization for verbal and physical threats to staff and patients. On the 30th day (a Saturday), before the officer of the day was able to assess his condition, the subject attacked a fellow patient whose injuries resulted in death shortly thereafter. Characteristic of his need to dominate other patients, the subject maintained that this 62-year-old and frail fellow patient had been threatening him over a period of time.

After this tragic event, the patient's rights advocate continued to intervene on behalf of the patient's right to refuse neuroleptic medication; however, the subject began to accept lithium carbonate while in seclusion. Within several days he was transferred to a maximum security unit where, without apparent remorse, he was persuaded to cooperate with both oral neuroleptic and lithium carbonate treatment. The patient was charged with involuntary manslaughter. After a plea of "not guilty" in the context of conflicting psychiatric testimony, the judgement—delayed by three months—was "not guilty by reason of insanity."

Discussion

The issues in this case are legion. A patient who had a history of manifest violence, who met the dangerousness standard for involuntary admission, who refused medication and threatened legal action if coerced, who was considered competent to refuse medication

and was thereby inadequately medicated, who was charged with involuntary manslaughter (for the death of a fellow patient), and who was found competent to stand trial, entered a plea of not guilty and was judged to be not guilty by reason of insanity. His competency to stand trial was influenced by medication.[3,4]

The Issue of Legal Influence on Clinical Practice Clinical reality and legal reality collide where this patient's continuous history of dangerousness intersects with his apparent competency to refuse treatment at a discrete point in time. The increasing tendency to establish ethics as rights[5] has resulted in an erosion of the clinical prerogative. A vestigial prerogative was further ineffectualized by legal threats[6] and legal precedents,[6,7] to a point that physiologic realities were ignored. Gutheil and Mills[1] noted that situations such as this "bestow on the patient all the risks and none of the benefits of psychopharmacology" (p. 19). Wood[8] has suggested the establishment of a third agency, administrative in nature, to reconcile differences between psychiatry and the law.

The Issue of Dangerousness Despite the position of the American Psychiatric Association's Task Force on Violence,[9] psychiatrists' ability to predict dangerousness remains a controversial issue.[10] The legal system has established a precedent in favor of predictability of dangerousness by psychiatrists.[11] In the case report, there was a clear history of short- and long-term dangerousness requiring frequent involuntary hospitalizations, seclusions, and restraints. Concern about the patient's clinical realities was obvious and documented: there was repeated patient-initiated discontinuation of psychotropic medication and subsequent refusal, a precipitating event of destruction of property, and lack of verbal and physical controls during this hospitalization requiring frequent seclusion and restraint. In apparent deference to legal threats and legal precedent, the patient was undermedicated. The discrete episodes of imminent or overt dangerousness were treated with injectable antipsychotic medication, but hardly enough to establish blood levels adequate to sustain self-control and/or self-awareness of the need to cooperate with lithium therapy, the apparent treatment of choice.

The Issue of Patient's Rights to Refuse Treatment In the aftermath of initial landmark definitions of emergency exceptions to the patient's right to refuse treatment,[7] clinicians pondered the impracticality[12,13] and protested the possible dangerousness of such constraints.[14] Subsequently, legal permutations have shown more confidence in the judgement of qualified professionals.[15,16] Clinically, it has been demonstrated that drug treatment refusal—the lasting right—is more likely a product of disordered thinking (grandiosity and denial) than of rational concerns about side effects.[17]

The disparity between a patient's need for involuntary hospitalization on the basis of dangerousness and his or her competence to refuse treatment with the exception of dangerousness is underscored in the case example. The limitation to one state[18] of incompetence to

refuse treatment as a criterion for involuntary commitment speaks to the trend for separate tests.[19] If, however, competence to make treatment decisions were determined at the time of commitment,[20,21] the outcome in the case example may have been less controversial and ultimately not harmful to anyone.

The Issue of Competency to Refuse treatment Although determinations of competence to refuse treatment are derived from various time-tested criteria with wide variance in challenge to the patients' cognitive abilities,[22] another dimension, the patient's affective appreciation for his or her situation, has received little attention.[23] As a rule, the desired results, which consider the balance of clinical, societal, and individual patient interests, influence the choice of tests for competency.[22] In retrospect, the case reported herein was an exception. Given this patient's past and present history of dangerous behaviors, was competence to refuse treatment a relevant issue?

Different tests for different capacities account for some of the clinical convolutions in this case study. Although arguments have been offered for a concept of global incompetence,[24] tests for competency remain quite specific to individual decisions. Criteria for involuntary commitment, competency to refuse treatment, competency to stand trial, and sanity at the time of the offense apply in this case. Although it is arguable that for different issues different tests are appropriate, it is clinically difficult to reconcile that the same patient meets the criteria for civil commitment (based on dangerousness), competency to refuse treatment, and the insanity defense within the same acute, untreated episode. The tests ignore a sense of reality based on continuous events.

The Ethical Issues The growth of rights in medicine has created a number of problems for society,[5] not the least of which is how to balance each right against other rights—in this case example, the rights of the individual against rights for other patients. Another issue is how to safeguard these principles, such as the patient's right to refuse treatment, without compromising other ethical standards, such as the physician's primary mandate to heal.[25]

Whether the patient is suffering at the mercy of his illness or at the mercy of his treatment depends, in part, on the perceptions, orientations, paradigms, values, and goals of the observer. One viewpoint, the mind-controlling nature of antipsychotic medication, is in stark contrast to that which considers the mind-controlling nature of psychosis.[26] In the case example, ethical principles focus on treatment, not only on the basis of dangerousness, but also in regard to reversibility of deterioration, to opportunity for improvement, and to shortening hospitalization.[15] Whereas in the case example the subject's right are upheld, his needs were ignored,[25] as were the needs and rights of other patients, in retrospect.

The Issue of Least Invasive/Restrictive Treatment This same scenario might have developed given similar circumstances—competence to refuse treatment—had this patient been admitted

to a maximal security facility at the onset, i.e., a more restrictive environment. Patients' rights advocates[27] might raise questions about suitability of less invasive/restrictive treatment. Suitability of options less restrictive than hospitalization for dangerous patients is dependent on patient acceptance of "invasive" treatment or by a "best interests" decision[28] by a legal guardian.[29] Although underused,[30] commitments to halfway houses or outpatient or daycare programs are possibilities for some patients.

The Issue of Rights for Others Enforcement of the rights and principles relevant to the protection of members of society results in referral of deviant members to clinicians[31] and/or law enforcement officers. Ecologic principles apply to the social systems in which individuals negotiate sanctioned behaviors or suffer disallowances such as psychiatric hospitalization or incarceration.[32] Although through different mechanisms, law and forensic psychiatry can be viewed as having control of misbehavior as a common task.[33] As clinicians responsible for patient management, forensic psychiatrists are increasingly limited in their prerogative to control behavior. Within the confines of hospital walls, converse ecologic principles apply: the rights of other patients and the rights of staff[34] are seemingly blurred in favor of individual rights.

The Issue of Cost The impact of treatment refusal that results in increased intensity and duration of human suffering is not without financial implications. A study led by this author of drug treatment refusal in a maximal security forensic hospital determined that the average refuser costs the state $17,000 more than the average nonrefuser (unpublished data). The costs of defending patients who become legal clients, as in this case example, are of considerable magnitude. Another kind of cost involves life and quality of life issues.

The Issue of Compassion Both patients in the case example are victims. The surviving patient is living evidence of the need for early application of effective clinical measures to prevent deterioration and dangerous behaviors. As another set of rights comes into focus for the subject in connection with his criminal charges, he can be seen even more clearly as a victim. He is not only a victim of the dynamics of his illness but also of the dynamics of conflict between clinical and legal realities. With the advantage of this case in review, it becomes particularly difficult to deny the continuous nature of the "discrete" events discussed.

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