Risks of State and Private Hospital Psychiatrists in Involuntary Hospitalization in Re: Right To Treatment*

ROBERT L. SADOFF, M.D.**

Patients who are involuntarily committed to state or private hospitals, either for emergency reasons under the involuntary commitment sections of the state code or because they have been found not guilty by reason of insanity, have a constitutional and statutory right to adequate treatment as postulated in recent cases beginning with *Rouse v. Cameron*[1] in 1966, *Wyatt v. Stickney*[2] in Alabama in 1970–72, and most recently in *Donaldson v. O'Connor*.[3] *Wyatt*, now called *Wyatt v. Hardin*, had gone to appeal to the Fifth Circuit and was upheld even with the companion but opposite case of *Burnham v. Georgia*,[4] which indicated at the lower level that there was no right to treatment. The *Donaldson v. O'Connor* decision is more complex because it not only allows for the constitutional right to treatment, but also has awarded money damages to Donaldson for the fourteen years of confinement that he spent at Florida State Hospital in Chattahoochie, Florida.

What are the implications—and the potential risks—of these findings to state and private hospital psychiatrists? First, it should be noted that the patient who is so committed does have a proper right to adequate treatment. This does not imply a guarantee of cure or early discharge, or any specific type of treatment. That treatment is prescribed by the physician in charge of the patient. The court merely has mandated that the treatment be specifically prescribed for each individual and that such treatment be regularly reviewed. The court did not specify what types of treatment had to be given but did mandate individual treatment plans rather than the general milieu treatment that many patients had received when the patient-doctor ratio was excessive for optimal care.

These court holdings have imposed a number of significant changes on the practice of psychiatry within state hospitals and in some private hospitals. Previous standards for such practice had been espoused by the Joint Commission on Accreditation of the American Hospital Association and by various committees of the AMA and APA. The standards newly set forth, especially in the *Wyatt* case by Judge Johnson, are minimal ones, some of which do not meet the required standards of the medical profession. The impact of these court findings, however, has been to reveal the inadequate funding by state legislatures of the care of the mentally ill. Judge Johnson had given the state of Alabama, for example, six months to implement the court order, and when the implementation was not effected, a dispute arose between the branches of government; *i.e.*, whether the courts could in fact impose sanctions upon the legislatures to order them to spend more money in a particular area.

---

* Delivered at the third annual educational meeting co-sponsored by the Academy and the Committee on Law and Psychiatry of the APA, March 13, 1975, in Las Vegas, Nevada. The paper has been revised to include recent court decisions.

** Dr. Sadoff is Associate Clinical Professor of Psychiatry, University of Pennsylvania; Lecturer in Law, Villanova University; and Director, Center For Studies in Social-Legal Psychiatry, University of Pennsylvania.

The decision was appealed to the Fifth Circuit Court of Appeals and was upheld by that court and is now granted constitutional approval.

The United States Supreme Court ruled unanimously on June 26, 1975, that mental patients who are not dangerous to themselves or others have a constitutional right to be treated or else released from state hospitals. According to the ruling written by Justice Potter Stewart: "A finding of mental illness cannot alone justify a state's locking a person up against his will and keeping him indefinitely in simple custodial confinement. . . . There is no constitutional basis for confining mentally ill persons involuntarily if they are dangerous to no one and can live safely in freedom."

The Supreme Court took no action on Donaldson's monetary damages against the doctors, but rather sent the case back to the lower court for further evidence on whether Dr. O'Connor and his colleagues should have to pay damages. The question according to the court was whether Dr. O'Connor was unaware that the actions he was taking violated Donaldson's constitutional right or whether he had intended actually to violate those rights.

What are the implications of this ruling by the Supreme Court? Recent surveys of state psychiatric hospital administrators indicate no great changes in policies or practices or effects on their patients, since most of the larger states have already instituted many of the reforms indicated by the Supreme Court ruling. Most states do not hospitalize a person against his will unless he is a danger to himself or others and do not keep him in a hospital involuntarily unless adequate treatment is provided. In some of the smaller states, however, where less funding is available for the care and treatment of mental patients, there may be some changes in the treatment of these patients. Those who are not dangerous may need to be transferred to other situations, including outpatient facilities, halfway houses, smaller institutions or even their homes.

This shift will bring about dangers to the patients, as discussed by Slovenko and Luby in their paper, "From Moral Treatment to Railroading out of the State Hospital."[5] They point to the grossly inadequate facilities available for such patients and in fact the dangerous conditions which many patients unaccustomed to living outside of institutions face when placed in the center city ghettos, where they are subject to assault, robbery, rape and death, through violence or neglect. The authors conclude by saying, "It is necessary to look at the adequacy of all facilities for the handicapped, and not simply at the state hospital, which is only a small part of the problem. . . . In other words, the state may be held to have a duty to provide adequately for the needs of all its people. . . . To cast the mental hospital population into the community seems as ludicrous as to cast a one legged man in the role of Tarzan. Even the adequate person finds it difficult to cope in today's community."

Treffert, in his classical paper, "Dying with your Rights On,"[6] presents a series of case reports of psychiatric patients who "died with their rights on"; *i.e.*, situations in which scrupulous concern for the patient's rights overshadowed or outweighed reasonable concern for the patient's life.

The implication of all of these cases and reports appears to be an interruption of a pendulum swing that goes back and forth between patients' rights and patients' safety. At one time a number of suicides in prisons led to an insistence that all individuals arrested for criminal behavior and showing signs of emotional illness should be sent to hospitals and not to lockups or county prisons. Since then, the insistence upon patients' rights not to be sent to mental hospitals, under the influence of Thomas Szasz and others, has sent these same people back to prisons, where they are "dying with their rights on." What is needed, of course, is an adequate institution for offenders which is staffed by competent physicians.

Prior to the recent Supreme Court decision in *Donaldson*, the APA filed an *amicus curiae* brief. In sum the brief is divided into two parts, the first upholding the constitutional right to treatment in the Donaldson case. In the second part the *amicus* brief

opposes the lower court's standard for personal liability, which it insists will hamper enforcement of the patient's right to treatment. It argues that the remedies require institutional overhaul and reinforcement of society's responsibility for providing adequate funding and staffing, rather than the conclusion that, as the Fifth Circuit held, "the doctor who works on the staff of an overcrowded hospital is personally liable for damages to patients he or she is unable to treat."[7]

The thrust of the argument against personal liability is that it will seriously lessen the quality of care currently available, even though that care is admitted to be insufficient.

Following this background, we may now proceed to the basic issue at hand: the risks taken by state and private hospital psychiatrists working within this apparently confused period of transition. On the one hand, as seen above, the risk of liability for damages in right-to-treatment cases has motivated institutional psychiatrists to release many patients. On the other hand, however, psychiatrists have been blamed and in fact sued by families of victims of assaultive and homicidal behavior of patients who had been prematurely released from hospitals.

One such premature release occurred in California a few years ago when a very large, frightening-looking man, who had been hospitalized after being found not guilty by reason of insanity for killing relatives of his, was returned to his home, where he shortly killed his parents. The newspapers considered this early release to be predicated on the fault of the psychiatrist for not being able accurately to predict dangerous or violent behavior in individuals.

In Pennsylvania there was a similar incident of a man who had killed his aunt in California sixteen years prior to his release from the state hospital for the criminally insane. After "thorough treatment" he was placed on work release in the community, and after about four or six weeks on the street, in a halfway house situation, he proceeded to molest and kill two young boys. He was aware of his dangerousness and had asked the authorities not to release him, and when they did he was frightened of his own violent behavior. After he had committed the later homicides he insisted that he should never be released again because he had no control, or felt he had no control, over his behavior.

Doctors are in the business of treating illness, whether it be physical or mental. The aim of intensive psychiatric treatment, whether it be in state or in private hospitals, is to try to get the patient out of the hospital in a most expeditious and safe manner. Rare instances as cited above, however, have deterred psychiatrists from early release when there is any question of dangerous potential, whether or not they have scientific or valid evidence for making such predictions or assumptions.

Recently conflicting decisions have appeared concerning whether a therapist has to warn the potential victim of the violence threatened by his patient. The case centers around a 1969 California matter in which a patient, a twenty-six-year-old student at Berkeley, shot and stabbed to death a twenty-year-old student. Earlier that year the patient had told a psychologist during psychotherapy that he intended to kill the girl when she returned home from a trip. The parents of the victim later argued that the girl was easily identifiable and the psychologist was obligated to warn her. The lower court indicated that this matter is best left to the doctor. "Little imagination is required to recognize the offense against the psychotherapist-patient privilege which would result from the rules sought by the plaintiff."

On appeal, however, the California Supreme Court ruled that a doctor or psychotherapist who knows or should know that a patient may harm someone is legally obliged to warn the potential victim. The court emphasized that a therapist who uses sound professional judgment would not be liable for making a mistake in estimating potential danger.[8] This controversy centers around the confidentiality of the therapist-patient relationship and the privilege of the psychiatrist to withhold information in court proceedings.

If we include patient-doctor privacy as part of the treatment procedure, then the right to adequate treatment, in my opinion, should include the right to confidentiality and privacy. This recent California Supreme Court holding increases the risk for the practicing psychiatrist in keeping information confidential. Thus, if any patient treated by a psychiatrist tells the psychiatrist that he has homicidal intentions and the therapist does not reveal these intentions to the potential victim, then he may be liable for civil damages to the family of the victim.

Thus, discounting the usual areas of malpractice in psychiatry as outlined by Bellamy[9] and Dawidoff,[10] we can identify two recent areas of risk for practicing psychiatrists, including private and state hospital psychiatrists. In the first place, the private psychiatrist treating a person who utters violent threats has a duty to reveal these threats to potential victims. If he does not do so, he may be liable for personal damages or open to charges of negligence under the Malpractice Code. Most psychiatrists, however, adhere scrupulously to the notion of secrecy between themselves and their patients in the interest of a confidential doctor-patient relationship. The APA Statement of Ethics for Psychiatrists reads: "A physician may not reveal the confidences entrusted to him in the course of medical attendance or the deficiencies he may observe in the character of patients unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community." Furthermore, "A psychiatrist may release confidential information only with the authorization of the patient or *under proper legal compulsion.* The continuing duty of the psychiatrist to protect the patient includes fully apprising him of the connotations of waiving the privilege of privacy. . . . Psychiatrists at times may find it necessary in order to protect the patient or the community from *imminent danger* to reveal confidential information disclosed by the patient."[11] Thus, even within the code of ethics of the APA, the psychiatrist may warn potential victims if his prediction of dangerousness or violent behavior by their patient is reasonable.

What are the risks to a psychiatrist in such a situation? One is that if he fails to properly alert the potential victim he may be liable to suit in the event of a tragedy. On the other hand, if he does notify the potential victim and his warning is premature and unjustified, does the patient have grounds to sue for breach of confidentiality? One possible relevant case occurred in Utah several years ago when a practicing psychiatrist was treating a man who was courting the daughter of a colleague. When the colleague wrote to the psychiatrist and asked him whether his patient would be a suitable husband for his daughter, the psychiatrist wrote back and indicated that his patient was fairly seriously ill and he would not advise marriage between his patient and the colleague's daughter. He did so without the consent of his patient and was sued because of his alleged disclosure of confidential information.[12]

The whole area of confidentiality, privilege and informed consent, in my opinion, is a part of the right to adequate treatment. The person receiving adequate psychiatric treatment has a right to a confidential relationship with his doctor, a right to seal the lips of his doctor from testifying against him except where prohibited by law under the privilege statutes, and also has a firm right to informed consent about what the doctor will do with the information he receives during the course of therapy with the patient. He also has a right to know the limits of confidentiality, the circumstances under which the doctor will not uphold the confidential relationship. Even with the evaluating, non-treating psychiatrist, the patient has a right to know what will be done with the information he gives to the examining psychiatrist and what consequences could befall him because of its revelation.[13]

On the more formal side of the cases involving the right to treatment, the risks to the practicing psychiatrist appear as follows: if the hospital psychiatrist discharges a patient prematurely, before he is ready to go, because he still possesses the potentiality for dangerous or violent behavior, he may be sued by the victim. On the other hand,

if he keeps the patient too long, as in *Donaldson*, he may be sued for not providing adequate treatment and yet keeping the patient in the hospital when it is not necessary. Thus it becomes imperative for a psychiatrist working in state hospitals for involuntarily committed patients to evaluate all patients scrupulously on a regular basis to see whether they are being afforded adequate treatment. If the treatment is not adequate and there is no likelihood of dangerous or violent behavior, then they should be discharged.

Still another issue involved is that of the right to refuse treatment. Suppose the patient refuses treatment, though he is involuntarily committed and has a right to adequate treatment. Should he then be discharged? The answer is not a simple one. It depends upon the severity of illness of the patient. If the patient is mentally ill and in need of treatment even though he refuses it, then he needs to be in the hospital and to receive adequate treatment. Often the psychiatrist alone should not be held responsible for this decision, since the patient's liberty and freedom are at stake. In such a case I would recommend involving the committing judge to help make the decision about ordering the patient to receive treatment even though he refuses it. In this situation the doctor should have a good case for determining the necessity of treatment before calling in the judge for his order.

Here, too, in the case of the patient's right to refuse treatment, the hospital psychiatrist may be at risk. Certainly there are emergency situations which require emergency treatment despite the fact the patient may refuse to receive it. Other patients' lives or the patient's own life may be in jeopardy, and he may require emergency treatment on the part of the treating psychiatrist. Under all emergency treatment doctrines the emergency treatment would be upheld by the court. Follow-up treatment, however, beyond the original crisis situation, ought to be cleared through the court of jurisdiction. Why should the treating psychiatrist take the risk of being sued for assault and battery or imposing treatment against the person's will when he can avoid such jeopardy by involving the judge as a treating partner? I would advise any psychiatrist in a state hospital or private hospital, treating a patient who is involuntarily committed and who refuses to receive the treatment to which he has a right, to include the judge in the decision-making process. The judge has immunity and can be of great help to the practicing psychiatrist in these cases. If the judge refuses to support the request for treatment, then perhaps the patient should not be confined in that hospital. There might come a time, however, when a judge would refuse to support the enforcement of treatment upon a person whom he has involuntarily committed to the hospital for treatment. It is this kind of illogical dilemma that may face psychiatrists working in state and private hospitals. In these cases it appears that the psychiatrist has little choice but to obey the orders of the court and to enter those orders as such on the hospital record, spelling out the whole situation: that the patient has been ordered to remain in the hospital; that, although he has a right to receive adequate treatment which is being made available to him, he has refused to accept the treatment; and that the court has refused to support the doctor's wish to enforce the treatment. In essence, the patient becomes a "boarder" in the hospital, and his position should be so clarified on the records.

In summary, psychiatrists have been afraid that legal encroachment on their practice by the right-to-treatment rulings will effectively hinder therapy with hospitalized patients. This need not be the case; in fact, treatment can be enhanced and improved if the courts are able to obtain increased funding from the state legislatures for treatment purposes. This task, however, psychiatry has had little success in accomplishing during the past several years. Also, the changing laws do tend to present risks to the practicing psychiatrist, risks which he must avoid by including the judge as a partner in treatment, especially when decisions are made about patients whose freedom and liberty are in jeopardy. None of the rulings thus far has told the psychiatrist how to practice psychiatry; they have prescribed individual treatment for individual patients, and when such treatment is available and possible, these rulings are to be commended and approved.

What the psychiatrist must avoid, however, is being caught in the middle of administrative or legal battles between the courts and the legislatures in which he is forced to provide inadequate treatment and then is blamed for it as the scapegoat. We must be ever cognizant of our precarious position during these changing times and protect ourselves whenever possible. We are not expected to predict accurately when a patient may become violent, but certainly if there is great likelihood that he will do so, and specifically to a particular person, we are obliged to continue treating the person or to alert the potential victim, under the newer rules.

Perhaps the best way of summing up the apparent dilemmas involved is to say that the best practice of psychiatry, including maintaining the confidentiality of the doctor-patient relationship except under emergency circumstances, will decrease the risks to the treating psychiatrist. That is, adhering to traditional wise concepts of treatment, while being alert to the changing roles expected of us and the changing concepts within the law, should be the ideal formula. We must continue to be alert to the changes while practicing good medicine.

References

1. Rouse v Cameron, 373 F 2d 451 (1966)
2. Wyatt v Stickney, 344 F Supp 373 (MD Ala 1972)
3. Donaldson v O'Connor, 390 US 971 (1968)
4. Burnham v Georgia (Civil Action #16385, ND Ga)
5. Slovenko R and Luby ED: From moral treatment to railroading out of the mental hospital. Bulletin of the American Acad Psychiatry and the Law, 2:223–236, Dec 1974
6. Treffert DA: Dying with your rights on. Presented at 127th Annual Meeting, APA, Detroit, May 7, 1974
7. Amicus Brief in Donaldson v O'Connor—Official actions.
8. Tarasoff v Regents of the Univ of California, 33 Cal App 3d 275 (1973)
9. Bellamy: Malpractice risks confronting the psychiatrist: A nationwide fifteen-year study of appellate court cases, 1946–1961. Amer J Psychiat 118:709, 1962
10. Dawidoff DJ: The Malpractice of Psychiatrists. Charles C Thomas, Springfield, Ill, 1973
11. Statement of ethics for psychiatrists. Amer J Psychiat 130:9, Sept 1973, p 1063
12. Berry v Moench, 8 Utah 2d 191, 331 P 2d 814 (1958)
13. Sadoff RL: Informed consent, confidentiality and privilege in psychiatry: practical applications. Bulletin of the American Acad Psychiatry & the Law, 2:101–106, June 1974