

## The Right to Refuse Treatment: Administrative Considerations\*

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The problem is to free men, not from control but from certain kinds of control, and it can be solved only if our analysis takes all consequences into account . . . .

B. F. Skinner, *Beyond Freedom and Dignity*

The psychiatric administrator tends to view the subject "the right to refuse treatment" with trepidation, particularly if he is responsible for a public psychiatric hospital to which involuntary patients are committed. It is there that the passing of the patient from one treatment program to another stops. Other administrators representing community out-patient clinics, mental health centers, day treatment programs, private, veterans', university, and general hospitals tend to approach the subject more philosophically when faced with the administrative implications of this right. They ask the following questions:

1. What authority should the state delegate to the profession for managing the fate of persons who are involuntarily sent to mental institutions?
2. Is law or psychiatry the ultimate decision maker?
3. How can a severely ill, psychotic patient with impaired insight and judgment be left to decide to refuse treatment to his potential ruin or the endangerment of others, when the treatment he needs is aimed at the very dysfunctions that impair his decision-making ability?
4. What role should coercion play, if any, and with what safeguards?
5. Isn't the endorsement of the "right to refuse treatment," for patients who continue to require confinement, likely to create a movement away from therapeutic care? Wouldn't this movement affect staff morale and thus availability, and modify the treatment milieu, straining the positive staff relationship with patients?
6. In extreme form — isn't granting "the right to refuse treatment" really granting the right to die?
7. How can an expert psychiatric administrator take the manifest content of a patient expressing a decision to refuse treatment while in distress or despair to mean more than the latent content of the situation, in which the cry for help is implied?

Those who ask these questions tend to agree on the right of the

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psychiatric patient to dignity, privacy, and confidentiality. They believe that the patient is entitled to understand his health problems and their treatment. They also agree on the patient's right to consent to or to refuse treatment under the "appropriate" conditions. A new "model of man" highlights to them the creative side of the human being, with emphasis on and acceptance of individual differences, and the desire to go beyond the biological values of subsistence and survival.<sup>1</sup>

"The right to refuse treatment" is intricately related to the "right to treatment." In 1960, Birnbaum advocated the recognition and enforcement of the legal right of the mentally ill patients of public mental hospitals to adequate medical treatment.<sup>2</sup> The objectives of this advocacy were to safeguard the legal process, to protect the individual's need for adequate treatment, to prevent community neglect, and to encourage mental health professionals to promulgate standards of care.<sup>3</sup>

No state had recognized access to adequate treatment as a right until then, despite widespread knowledge that public psychiatric hospitals were often ill-equipped to provide proper treatment. The community psychiatric revolution resulted in major reforms following "Action for Mental Health"<sup>4</sup> and the community mental health center legislation in 1962. Guidelines for community participation in the development of these centers, and the individual's participation in the planning of his treatment, were significant elements of this movement and were soon reflected in the Joint Commission's *Standards for Psychiatric Hospitals*.<sup>5</sup> The "right to treatment" advocates won a major victory in the case of *Rouse v. Cameron*. Congress established a statutory "right to treatment" in the 1964 Hospitalization of the Mentally Ill Act. While this right has broad applicability, it remains closely tied to involuntary treatment and indeterminate detention.<sup>6</sup> It is evident that the "right to treatment" imposes a duty on the hospital to provide treatment opportunities. It is unclear, however, whether this right entails a duty to be treated on the part of the patient.

Class action and landmark suits (*Wyatt v. Stickney*, *Donaldson v. O'Connor*, etc.) became widespread. They were first embraced by the mental health professionals as "sweetheart suits," but later were rejected as "harassment" by mental health officials who faced serious frustrations in responding to them.<sup>7</sup> Increasing numbers of patients and patient advocates enunciated the right to refuse psychiatric treatment in general, and created intense pressures to develop prohibitive safeguards against a variety of modes of psychiatric treatment in particular. No form of treatment (ECT,<sup>8</sup> psychosurgery, milieu therapy, behavior therapy, psychopharmacology, hypnosis, suggestion, etc.) escaped attack. Organized psychiatry found it essential to introduce provisions to override a patient's refusal of ECT and other therapies. The American Psychiatric Association announced a position statement on involuntary hospitalization for the mentally ill,<sup>9</sup> providing the patient with the full rights of due process, including the

... right to seek a judicial determination of the need for his continued hospitalization at reasonable intervals of time, and not less than every six months, that in such proceedings the patient be entitled to legal counsel and to examination by one or more independent psychiatrists,

and that the burden of proof of the need for continued hospitalization rest with the responsible treatment authority or agency.

This position statement made no reference to a "right to refuse treatment" and implied that the court should rule in the case of a patient's desire to discontinue treatment in the face of the staff's insistence on continuing hospitalization and treatment.

Not until 1975 did the American Psychiatric Association's Task Force on the Right to Treatment recognize the patient's right to refuse treatment.<sup>10</sup> The position paper of this task force asserts that,

except in emergencies, if a patient, who is *competent* to participate in treatment decisions, declines to accept treatment recommended by staff, we accept the patient's right to refuse. If the physician believes that a patient is not competent to participate in treatment decisions, he should ask a *court* to rule on the patient's competency . . . in cases where the patient refuses treatment which is deemed essential by the medical staff, and where this refusal is supported by the judiciary, the medical staff should review whether his *right to care should be implemented in another facility*.

"Another facility" to which the patient shall be passed is in all likelihood a public psychiatric hospital, whose administrator has to face the same questions again.

But unlike his colleague the clinical psychiatrist, the psychiatric administrator is inclined to look at the refusal to participate in treatment not only as a clinical manifestation with social implications, but also as a decision to reckon with, and sometimes counter. His treatment program could be paralyzed by the negative impact of such decisions if they were resorted to by a significant number of patients. He has to concern himself with the impact of such decisions on his staff, his patients, and the community. The staff, if stripped of their "caregiving" prerogatives, may become demoralized and feel a sense of impotence. A shift in the dynamics of their relationships with patients may dull their efforts at maintaining a therapeutic community. The patients may regress and find reinforcement of their deeply ingrained feeling that nobody really cares. Emphasis on discipline may become overriding, as it begins to fill the vacuum left by the refusal of treatment. The community may suffer an increase in criminality and deviance. The community may lose faith in a system of care it already holds in suspicion.

The literature is rich in articles on patients' rights which describe in considerable detail whose decision is required to do what action: to order restraints, to prescribe psychotropic drugs, to withhold access to the telephone, and so forth. However, the central issue of the decision-making process in the patient and its parallel process in staff has not received sufficient attention. I shall now turn briefly to it, since I am convinced that it is important to the identification of answers to the questions raised earlier.

In considering whether or not to participate in treatment, regardless of his state of rationality and ambivalence, the patient in fact undertakes a subjective inducement-contribution calculation. He evaluates what is "in it"

for him and what he is “in for.” His psychiatric condition, to the extent it interferes with his objectivity and judgment, becomes a significant force as he weighs what he perceives to be:

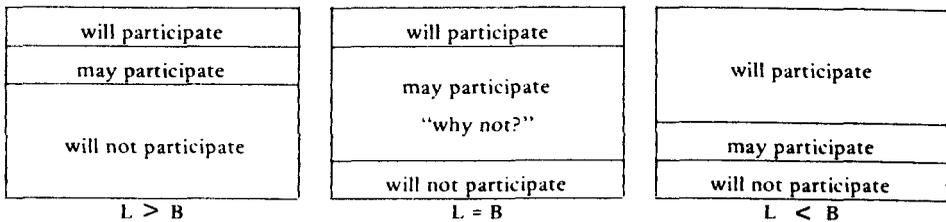
The *benefits* (B) of participation – psychological, social, and economic; present and future

AGAINST

The *liabilities* (L) incurred by such participation – economic, personal, social, and outcome-related.

Should the patient judge that  $L > B$ , he tends to shun participation. Should he appraise  $L = B$ , he tends to become indifferent to the alternatives before him, but likely to pursue additional information or advice on which to base his decision. In this state, he may accept authoritative professional opinion more readily. Should  $L < B$ , the patient tends to participate. As his treatment progresses, the patient may revise his appraisal using this dynamic formula; that is, if he finds that his liabilities from participation exceed his benefits, he may resume his search for alternatives. This process has major implications for program planning. In the patient’s decision to engage in or refuse treatment, a most influential factor is the education and orientation he receives concerning the process and potential outcome of the proposed treatment. The manner and method by which a patient is approached with varying treatment choices; the reputation, legitimacy, and authority of the treatment staff; and his trust in the program determine the frequency and extent to which the patient really participates in treatment.

One may diagram the relationship which exists between benefit and liability in this fashion:



One may infer further that the more genuinely humanistic, sensitive, and authoritative (not authoritarian) the treatment program is, the more likely the patient is to participate.<sup>11</sup> Since diminished insight and disturbed judgment are frequent findings in mentally ill individuals who are confronted by the necessity to participate in decisions about engaging in treatment, it would not seem surprising that the psychiatric administrator often finds himself playing an objectifying and rectifying role *vis-a-vis* the decision-making disability of his patient. The extent of the administrator’s participation depends on the degree of this disability, which varies and changes in time and in relation to the type and severity of the illness.

The steps taken by the administrator to make his decision are similar, but they encompass broader responsibility for a more complex framework involving the patient, the treatment environment, and the community. He

starts with the position that the psychiatric patient who is sufficiently intact to enter into decision-making without impairment is like other medical patients and is entitled to refuse treatment altogether or to refuse certain types of treatment. The procedural guidelines for the right of the patient to refuse treatment are familiar. The physician finds that he should cover three issues, the most important of which is the question of incompetence. If he should honor an incompetent patient's refusal of treatment, he would be liable for malpractice for failing to advise the family of the need for treatment. Also, the physician has to honor the patient's wish even in the event of serious deterioration of his condition; conversely, he has to exercise care in proceeding to treat a competent patient not to use the authorization of a family member rather than the patient's own, since no one has the authority to consent for an adult who possesses his mental faculties.<sup>12</sup> In contrast, similar decisions concerning children (especially mentally ill children) and mentally incompetent persons present added complexity. For some of these patients, the world has always been alien territory filled with accusers and persecutors who are bent on assaulting them. Others feel unworthy and undeserving of life. They have powerful convictions and do not respond positively to the mere offer of help. They usually reject it, being unaware of their need for treatment.

Of these persons, Katz says:

Few persons involuntarily committed to mental hospitals by either civil or criminal proceedings are aware of being in need of treatment. Instead they blame past and present behavior on parents, spouses, friends, neighbors, institutions, and society . . . . They assert that if the world around them would change and respond more appropriately to their needs, they would not get into further trouble, though the time when this alone might have been sufficient belongs to a distant past. They perceive only dimly, if at all, that now the world within them compels them to engage in behavior destructive to themselves and others, or that treatment could give them some appreciation of their conflicts and maladaptations which might modify their interactions with themselves and others.<sup>13</sup>

He goes on to say that,

It is difficult to define the ambit of mental illness associated with 'dangerousness' and 'being in need of treatment' for purposes of coerced confinement-treatment, as compared to the ease of relating examples which illustrate that society grants the right to 'normal' persons to pursue a course of self-destructive actions.

Katz continues, "persons whom society involuntarily commits and wishes to treat, cannot be treated without coercion." Gradually, one hopes to "achieve greater intrapsychic freedom for a person against whom such restrictions are initially invoked, though on other grounds." Any deprivation of liberty rests on the way society views deviant behavior and the value preferences it wishes to advance. The law must play a crucial role in defining the psychiatrist's

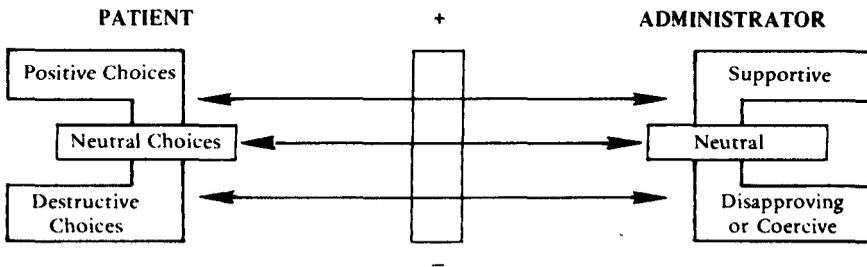
authority to administer and to treat.

The psychiatric administrator, aware of the potential tyranny of coercion, tends to choose methods of intervention which require collaboration between patients and therapists. The development and expression of ambivalence leads to difficult problems. However, the imposition of a "duty to be treated" for a limited period may help resolve some difficulties. The imposition of organic treatment modalities could be limited to circumstances in which a person can be quickly returned to his prior functioning, leading to his discharge, or can reclaim his ability to decide on further treatment. The amount of time required will vary depending on the nature of the mental illness and the kind and extent of the dangerousness involved.

It is essential to have the patient express preference and be actively involved in selecting or rejecting certain types of treatment. From the traditional types of psychiatric treatment, the psychotherapeutic model can be used only with the collaboration of the patient, but the organic model can be used even in the absence of the patient's cooperation. In the psychiatric hospital, use of organic methods should be limited to patients who accept them by choice, or who are in the throes of acute, severe distress which requires the brief application of organic therapies.

A dynamic treatment relationship must be negotiated and revised on a continuing basis. The decrease in the number of court commitments and the dramatic increase in informal and voluntary admissions attest that a substantial number of patients in mental hospitals have adopted a voluntary, participatory approach to their treatment.

The psychiatric administrator is inclined to support the patient's healthy and growth-inducing choices. The administrator feels constrained over choices which lack positive movement, and reacts negatively to the patient's destructive choices.



The psychiatric administrator tends to view decisions concerning participation in or refusal of treatment as medical-social-political decisions which must be carefully analyzed<sup>14</sup> as to the amount of intelligence that went into them, the alternatives reviewed, the prescription of action, the invocation of rules, and the application of a solution which, once appraised in terms of the objectives of the decision, may suggest termination.

The human cost to the patient, to the staff, to the treatment program and to society must also be considered. One should do everything possible to insure that neglect, under whatever guise, does not replace care.

## References

- 1 Bertalanffy L: General Systems Theory. George Braziller, 1968
- 2 Birnbaum M: The right to treatment. American Bar Association Journal, 46:499-505 (1960)
- 3 Katz J: The right to treatment – an enchanting legal fiction, in Morris GH, ed. The Mentally Ill and the Right to Treatment, Springfield, Illinois, Charles C. Thomas, 1970, pp. 3-36
- 4 Joint Commission on Mental Illness and Health, Action for Mental Health. Basic Books, 1961.
- 5 Joint Commission on Accreditation of Hospitals, Accreditation Manual for Psychiatric Facilities -- 1972. Chicago, 1972
- 6 Katz, *op. cit.*, n. 3
- 7 McGarry AL: The holy legal war against state-hospital psychiatry. The New England Journal of Medicine, 294:318-320 (1976)
- 8 California enacts rigid shock therapy controls, Psychiatric News, February 5, 1975, pp. 1, 4-7
- 9 American Psychiatric Association, Position statement on involuntary hospitalization of the mentally ill (revised), American Journal of Psychiatry, 130:392 (1973)
- 10 Herndon A: APA declares support for right to treatment. Psychiatric News, Vol. X, No. 14, pp. 1, 25
- 11 Scott WG, Mitchell TR: Organization Theory: A Structural and Behavioral Analysis. Homewood, Illinois, Irwin-Dorsey, 1972, pp. 172-6
- 12 Hayt E: Law of Hospital, Physician and Patient. Berwyn, Illinois: Physicians Record Company, 1972, pp. 408-12
- 13 Katz, *op. cit.*, n. 3, pp. 19-22
- 14 Lasswell HD: The Decision Process: Seven Categories of Functional Analysis. College Park, Maryland: Bureau of Governmental Research, 1956