One Right Too Many*

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For all too many years, few people gave much thought to the civil rights of hospitalized mental patients. More recently, fortunately, that situation has largely changed. The right to treatment, involuntary hospitalization, and now the right to refuse treatment, are among the issues which are predominant. The ofttimes delicate balance may not always be resolved in favor of the patient's needs, a situation which may well occur with reference to the right to refuse treatment. It is my thesis that this right cannot be of benefit to the involuntarily hospitalized psychiatric patient. When rights are not consonant with needs, they lose much of their value.

The Right to Treatment

In what history may well record as the turning point of patients' rights, Morton Birnbaum proposed the right to treatment in 1960.[1] He defined it as ". . . the legal right of a mentally ill inmate of a public mental institution to adequate medical treatment for his mental illness." Throughout the decade of the 1960s, as Birnbaum chronicles,[2] his proposition gained very little ground. In the past several years, however, it has attained the prominence it deserves.

The United States Supreme Court, in its unanimous decision in the Donaldson case, avoided answering the question of whether the right to treatment is guaranteed by the Constitution.[3] The American Psychiatric Association has come out in strong support of this right,[4,5] and in the State of New York, among others, it has been recognized by statute[6] and held to be constitutionally required in a unanimous decision by the state's highest court.[7] How one defines the right to treatment is open to some discussion, but one court has stated that, as a minimum, adequate treatment includes a humane psychological and physical environment, qualified staff in numbers sufficient to administer required treatment, and an individualized treatment plan for each patient.[8]

The right to treatment also provides some of the justification for involuntary hospitalization. The propriety of committing patients against their will has been questioned by psychiatrists[9] and by attorneys.[10] The American Psychiatric Association, however, remains in support of the necessity for legal provisions for involuntary hospitalization of the mentally ill.[11] In the State of New York, the criteria for involuntary care and treatment are threefold: ". . . a person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment."[12]

In an earlier paper,[13] my colleagues and I presented the position that the right to treatment is more fundamental than that of unrestricted liberty. We saw the quality of

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life as being of the utmost significance in determining the meaningfulness of liberty, and concluded that "We cannot surrender to the temptation to uphold an absolute right to liberty and, because of it, abrogate or negate many others."

Peele and associates[14] also make the case for involuntary hospitalization. They feel that patients are well served by this procedure, and that to discontinue it would be to ignore present reality. It is their impression that about three-quarters of such patients derive important benefits from involuntary hospitalization, that it alleviates needless suffering, and that it is the humanitarian thing to do. Treatability is recommended for inclusion as a factor in deciding to hospitalize a patient involuntarily. The temporary deprivation of liberty thus created would be on behalf of the patient's best interest.

In presenting a series of case reports of patients who have "died with their rights on," because of greater concern for liberty than for life, Treffert[15] dramatically demonstrates how allowing more prominence to the right to be sick than to the right to assistance and relief is ". . . a dubious and hollow legal triumph." Responding to the critics of involuntary hospitalization, I have pointed out how by upholding the right to adequate treatment we ". . . maximize our ability to assist in the attainment of the most important civil liberty which can be granted to the seriously ill patient—freedom from psychosis."[16] Indeed, it would not be stretching the point too far to postulate that, for some patients, there may be a right to involuntary hospitalization in order to guarantee their right to adequate treatment.

While discussions about the ethics of treatment as a rationale for deprivation of liberty continue, another aspect of the situation—the right to refuse treatment—looms to endanger the well-being of the patient.

The Right to Refuse Treatment

The right to refuse treatment is one of the newest proposed rights of mental patients. Friedman and Halpern[17] state that it is not inconsistent with the right to treatment, and Carnahan[18] considers the two rights to be correlative, indicating that each implies or complements the other. Such views may be reflective of their training as attorneys and their outlook as civil libertarians. As a clinical psychiatrist, the only relationship I can see is that these two rights are antithetical to one another. I have already expressed my sentiment that, in the hierarchy of rights, the right to treatment is of paramount importance to the mental patient. The right to refuse treatment can only negate the right to treatment. If, as a consequence of refusing treatment, the patient receives none, his right to treatment has been violated.

The American Psychiatric Association has recently adopted a task force report which, among other declarations, accepts the patient's right to refuse treatment "except in emergencies," a term which is not defined. Such a position is, to me, appalling, and can have only invidious consequences for the involuntarily hospitalized patient. The position paper recommendations hinge on the competency of the patient to participate in treatment decisions. Where the physician believes the patient to be incompetent, it is suggested that a court be asked to rule. Proposing resolution in court will, I believe, do little more than delay necessary therapy, prolong hospitalization, clog the courtrooms, and abdicate to judges the making of treatment decisions which are the proper province of psychiatrists. Ultimately, in cases wherein the court supports the patient's refusal of essential treatment, ". . . the medical staff should review whether his right to care should be implemented in another facility." Just what this alternative facility might be is nowhere stated by APA. Can it be other than a return to the abhorrent snake pits of old, with wards filled with untreated psychotics?

It is axiomatic in medicine that the patient is hardly in the best position to prescribe his own treatment. The involuntarily hospitalized psychiatric patient has, as indi-

cated by such status, a judgmental impairment. How, then, can we say that he is able to make an informed choice as to whether or not treatment is indicated? In my experience, the psychiatric inpatient refusing treatment does so for reasons related to his psychosis and thought disorder. Examples would be an irrational fear, paranoid ideation referable to treatment or therapist, atonement for presumed guilt (by remaining ill), or seeing oneself as unworthy of treatment. To allow this form of psychopathology free rein is to perpetrate a gross injustice on the patient.

It would be difficult, if not impossible, to justify involuntary hospitalization if no treatment were provided, even if such were the result of the patient's refusal. As physicians, we would be placed in the paradoxical situation of being potentially liable for poor medical practice. Furthermore, relief of patients' suffering is an ethical responsibility of our profession. From the patient's standpoint, about all that would really be accomplished is the unnecessary prolongation of his hospital stay. It would take significantly longer for the patient to regain his mental health, and therefore his liberty. In a sense, then, he would merely be imprisoned.

Those who have agitated for the elimination of laws permitting involuntary hospitalization have, thus far, had little impact. Such attempts as have been made to abolish medical certification for admission have met with virtually no success. One must wonder if this right to refuse treatment may be an "end-run" device to accomplish the same ends. The biggest loser would, of course, be the mentally ill patient. The psychiatric hospital, in turn, would be rendered incapable of performing its function as a therapeutic instrument.

In my opinion, the involuntary patient has no right to refuse such treatment as may be considered standard and well accepted by the psychiatric profession. It is difficult to envision how, for practical purposes, milieu therapy can be avoided by a hospitalized patient, although patients can, and often do, passively resist verbal and activities therapies. Medication is commonly refused, either overtly or covertly by such mechanisms as "cheeking." It is generally accepted that pharmacotherapy is the single most beneficial aspect of the modern treatment of psychosis (particularly schizophrenia[19]) and as such, necessary for most hospitalized patients. The usual practice is to give medication intramuscularly to those patients who do not cooperate with the oral route of administration. This type of treatment must be included among those which patients have no right to refuse. Techniques of behavior modification have been shown to be useful in alleviating some of the symptoms of mental illness, particularly the socially debilitating ones. So long as the reinforcements are positive, there is little that one can consider objectionable. Rechter and Vrablic[20] contend that the right to treatment includes aversive conditioning paradigms. A closed ward, with its attendant restrictions and controls, as I have shown elsewhere,[21] may be necessary to provide that treatment which is essential to the patient's improvement. Electroconvulsive therapy, the subject of emotion-laden controversy, remains a very effective treatment for some conditions. Its use should not be unduly restricted, as has happened in California.[22]

It is not my feeling that all forms of treatment must be given to the patient whether or not he agrees. Experimental programs, particularly those involving physical methods such as medication, continue to require the fully informed consent of the subject. Surgical intervention is another example of a procedure for which the patient should retain the right of refusal, assuming his or her mental competence to give or withhold consent.

Thus far, my remarks have been confined to the involuntarily hospitalized patient. For the person admitted to a mental hospital on a voluntary basis, the applicable legal standards for such status require at least a modicum of insight on the part of the patient. The voluntary patient may well have a right to refuse treatment, particularly by exercising the right to request his or her release from the hospital. Once the patient has been discharged from the hospital to the community, there is very little that can be said or done about his refusal of treatment, and in all too many cases, this is most unfortunate.

Conclusion

Many civil rights due mental patients are just beginning to receive recognition. These rights help to remove the stigma and isolation long associated with patienthood, and enable patients to rejoin the mainstream of humanity. The most important of these rights is the right to treatment. Unless, however, one sees severe mental illness as a pleasant experience, and if freedom is to be more than just another word, the right to refuse treatment is one right too many.

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