

My Father's Advocacy for a Right to Treatment

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My father, Dr. Morton Birnbaum (may his memory be a blessing), unfortunately passed away in November of 2005, but it seems like just yesterday to my five siblings and me. I was in the middle of medical school training at the time. Toward the end of my medical school tenure, with the help of some members of the psychiatry faculty, I began to read through my father's law and psychiatry articles, detailing his life-long advocacy on behalf of the mentally ill.

I had not read his articles previously, since I had always relied on him for a steady stream of information. As I found myself gravitating toward psychiatry in my own clinical work, and now, at the outset of my psychiatry residency training, I felt compelled to review his articles more thoroughly.

I began this undertaking, not only as a gesture of my own healing and remembering, but also because I wanted to shift his work in my mind from hearsay and childhood recollections to a more mature and germane understanding. His stories seemed like folklore to me growing up, but they are now becoming a reality for me in my daily work with the mentally ill. Given the nature of his efforts on the right to treatment, I thought that this exercise of reviewing his work would be a valuable retrospective to share with the forensic psychiatry community as well.

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Always for the Underdog

I suppose that my father's struggle on behalf of the mentally ill was born of his deep-seated sense of compassion for the disenfranchised. As a child growing up in an indigent Yiddish-speaking immigrant family in Brooklyn, he experienced disadvantage firsthand as his parents struggled to make ends meet. His father, my grandfather, worked as a chicken plucker on Coney Island Avenue, and his mother, my grandmother, sewed wherever she could find work, sometimes in clothing factories.

My father dropped out of high school before returning to Erasmus Hall night high school, graduated from Columbia College, and served in the U.S. Navy. He earned a law degree from Columbia University and later a medical degree from New York Medical College, working odd jobs throughout to finance his way. He was the first in his family to attain such advanced degrees.

My father established himself as a medical internist, in the heart of Bedford-Stuyvesant, Brooklyn, serving the medical needs of the indigent poor of the neighborhood, and so he reserved his *pro bono* law work for late nights and weekends. He thrived on crusading for a worthy cause and challenging the *status quo*, and always had a sense of humor and defiance about him. In 1955, in his first lawsuit, he sued the Good Humor Corporation for overcharging the public for orange juice and I-stix, described as a frozen fruit confection. He said that he was representing the wishes of more than eight million citizens.

As a postdoctoral fellow in a Social Medicine program at Harvard University in the late 1950s, he

developed his legal concept of the right to treatment while thinking about catastrophic illness. He honed in on state mental hospitals, as he recognized an area where improvement in care and treatment was needed. He delightfully recalled to me that he had had a lot of time to think that year, like Einstein in the patent office.

Early Memories

The bulk of my father's right-to-treatment litigation battles were waged before my birth, but I was privy to his endless stories and recollections while growing up. He spoke about his court cases with nostalgia, and he longed for the next big battle. As a child, I didn't understand exactly what battle was being fought, but I knew that there was an important struggle brewing, as much within the courtrooms as within my father.

He had a small office in our house in Brooklyn that was littered with medical and law journals and newspaper clippings, in which he stacked countless boxes. To this day, I am not sure how he fit so many cardboard legal boxes in just one small room. He used red ink to encircle the injustices that he would next tackle. The same red ink stained his suits and, especially, the pockets of his white coats.

He was a dreamer and a fighter, and most of all he expected rejection along the way. "The mentally ill invite rejection," he was fond of saying, and that extended to his work on their behalf. He fancied himself a Don Quixote, tilting at windmills.

Growing up, I often noticed that my father seemed discouraged and isolated. Sometimes in frustration he would toss his boxes of legal papers in the den and then as the stacks of yellow legal pad papers lay strewn at his feet, he would bend down and collect himself and the papers yet again. The few times that he asked my siblings and me to skip school to watch him in court were frightening experiences for us. On one occasion, the judge ordered marshals to remove my father from the courtroom because of his unrelenting objections. My poor, petrified sister started to cry since she didn't understand what was happening; nor did I. My protective mother decided that that would be the last time that we young children would watch him argue in the courtroom, and so I had the chance to see him in that role on only a few occasions.

My father spoke about his cases in rambling, fierce tangents, culminating with fist-banging emphasis on

the kitchen table. He would calm himself down afterward by a late night walk around our Brooklyn block, inviting my siblings and me to walk with him and the dog, so that we could help him think out loud. If we walked for a particularly long time, we would make it to the Kings Highway subway station, where he relished a glass of stale seltzer that he purchased from the fountain for 75 cents and a chat with the owner of the newsstand about the world's many problems.

My father spoke incessantly about the troubles of the mentally ill, remarkably and admirably. As his daughter, I heard his recurrent refrain, whether on a short trip to the grocery store or a longer car ride. In fact, he really could not last for more than a few short hours without raising the issues of the plight of the mentally ill. This was his passion, a *raison d'être*.

Early Resistance to the Right to Treatment

The idea that the mentally ill should have a constitutional right to adequate medical treatment was initially introduced by my father in an article published in 1960 by the American Bar Association.¹ It is noteworthy that my father's legal advocacy campaign on behalf of the mentally ill began with much resistance and little acclaim. In fact, over the course of two years, 50 different publications refused to publish his original article. Finally in 1960, he persuaded the editors of the *ABA Journal* to publish it.

In the now landmark article, my father advocated for the recognition of a constitutional right to adequate treatment, arguing that the involuntarily committed mentally ill were prisoners in state psychiatric hospitals, were not receiving adequate medical treatment, and were being deprived of liberty without due process. He claimed understaffing and overcrowding by citing Dr. Harry Solomon, Emeritus Professor of Psychiatry at Harvard Medical School, in Solomon's address to the American Psychiatric Association. For example, in 1958, 545,000 people were institutionalized in nonfederal public mental institutions that had a capacity of only 520,000 beds, and of these, 85,000 beds were considered to be unacceptable on the basis of fire and health hazards by the states in which they were located. My father reasoned that the neglect of the mentally ill was a basic philosophical problem that in turn posed a legal problem. He asserted his main thesis, a legal argument for a constitutional right to adequate medical treatment. He

claimed that, absent the provision of adequate treatment, institutionalization provides no hope of recovery and amounts to a substantive violation of the Due Process Clause:

If the right to treatment were to be recognized, our substantive constitutional law would then include the concepts that if a person is involuntarily institutionalized in a mental institution because he is sufficiently mentally ill to require institutionalization for care and treatment, he needs, and is entitled to, adequate medical treatment; that being mentally ill is not a crime . . . and that substantive due process of law does not allow a mentally ill person who has committed no crime to be deprived of his liberty by indefinitely institutionalizing him in a mental prison . . . ; the courts must be prepared to hold that if an inmate is being kept in a mental institution against his will, he must be given proper medical treatment or else the inmate can obtain his release at will despite the existence or severity of his mental illness [Ref. 1, p 503].

Whenever he spoke of his original article, which he felt proposed a commonsense and fundamental moral decency, he would also recall his amazement at the lack of response to his publication. Running his hands over his gray-haired head, he would exclaim with disbelief, "Boy-oh-boy! I thought once it got published, the doors would break down, and everyone would say 'What a wonderful idea; you discovered a new penicillin.' But nobody broke down the doors."

Only through the connection of a close friend did my father persuade the *New York Times*² to print an article describing the publication of his legal concept. Fortuitously, two patients in two separate state mental hospitals happened to come across the article and contacted my father for his legal help. Both patients, Edward Stephens and Kenneth Donaldson, eventually became plaintiffs in his litigation suits against state mental hospitals.

Not only did my father articulate the legal postulate, but he then spent the next decades of his life independently litigating the right to treatment in the courts, with the goal of improving the care of the mentally ill. Especially noteworthy was the fact that he financed the cases out of his own pocket, unsure if he would ever receive reimbursement. So, the cases of the mentally ill indeed became his very own quixotic crusade.

Stephens and Sanism

Edward Stephens was diagnosed with paranoid schizophrenia and was involuntarily committed for more than 30 years at Creedmoor State Hospital in

New York City. Mr. Stephens asked my father to aid him in his efforts to be released and to obtain proper care and treatment. On 12 separate occasions, my father presented Stephens' claims before New York and Federal courts, including the Supreme Court on three occasions. No court consented to hear his claim of inadequate treatment.

My father vehemently argued that Stephens was receiving inadequate treatment. For one year, not a single note had been placed in his chart by any doctor, nurse, or attendant. The physician-patient ratio at Creedmoor Hospital was lower than at Sing Sing prison, a New York maximum-security prison. Stephens worked seven days a week in the kitchen, for which he received no pay. An elderly, bedridden patient on Stephens' ward was found choked to death one morning, killed during a sexual assault by the sole attendant in charge of the ward at night. Yet the judges denied Stephens' claim of inadequate care. Because of a change in administrative policy, Stephens was eventually discharged to a residential hotel and transferred from the state hospital rolls to the welfare rolls, but not because of any medical or legal developments.

At some time while litigating the *Stephens* case, my father coined the term "sanism," now in widespread use. It became his rallying cry for the opposition that he encountered in the courts. He defined sanism as a prejudice against the mentally ill and as a rejection phenomenon. I include his own words in describing the attitude:

Sanism is the irrational thinking, feeling and behavior patterns of response by an individual or by a society to the irrational behavior (and too often even the rational behavior) of a mentally ill individual. It is morally reprehensible because it is an unnecessary and disabling burden that is added by our prejudiced society to the very real affliction of severe mental illness. . . . It should be clearly understood that sanists are bigots. . . . Gradually I realized that our society's irrational mechanisms of oppression of blacks . . . were similar in operational procedures to the operation of our society's irrational mechanisms of oppression of the involuntarily civilly committed. . . [Ref. 3, pp 105-6].

In coining the term sanism, my father most alluded to his many conversations with his friend and law school classmate, Florynce Kennedy, the notable African-American feminist lawyer, who profoundly influenced his own thinking.

One of my father's favorite stories illustrates the sanism that he encountered in the courts while arguing an appeal in the *Stephens* case. He had arrived at

court early on the day of the appeal and so he sat in the back and listened to the cases that preceded his. In all three cases (the first involving a convicted armed robber, the second a heroin dealer, and the third a recidivist pimp), counsel sought release for each defendant on procedural grounds, and the judges patiently listened to and weighed counsel's arguments. In striking contrast, when my father argued for Stephens, claiming that a patient with paranoid schizophrenia is not dangerous to himself or others, the judges immediately interrupted my father's arguments and, with sheer incredulity, asked if he was seriously recommending that an insane man be released from the hospital. My father decried the judges' discriminatory attitude as typifying sanism.

My father recounted a New York Supreme Court judge, who, during one of his oral arguments, cautioned my father, "Counselor, if you are really suggesting to me that I should let a crazy man out of a state hospital while he is still crazy merely because he is not getting proper care and treatment, then you must think that I am crazy. . ." (Ref. 3, p 113).

The First Victories

The first significant judicial breakthrough occurred in *Rouse v. Cameron*⁴ when the U.S. Court of Appeals from the District of Columbia, in a decision written by Chief Judge David Bazelon, held that a statutory right to treatment existed under the revisions of the District of Columbia Mental Health Code. Judge Bazelon found that a District of Columbia statute mandated treatment for a patient committed to Saint Elizabeth's Hospital, after a finding of not guilty by reason of insanity, thereby becoming the first appellate judge to recognize the right to treatment. He further remarked that the hospital need not show that the treatment will cure or improve the patient's condition, but only that there is a *bona fide* effort to do so.

In an editorial regarding the *Rouse* decision, my father criticized the decision as not enough.³ While a statutory right may have been recognized, it was not adequately defined, effectively enforced, or properly implemented at the time. Furthermore, the *Rouse* court avoided deciding the more basic issue of whether there is a constitutional right to treatment.

In 1971 my father became involved in a class action suit, brought as *Wyatt v. Stickney*⁵ by more than 5,000 patients in Bryce Hospital, a state mental hos-

pital in Tuscaloosa, Alabama. My father served as original co-counsel for the plaintiffs and helped to coordinate the *amici* parties. A U.S. District Court judge, Frank M. Johnson, held that involuntarily civilly committed patients are entitled to adequate care and treatment, or else they are being deprived of their liberty without due process of law, as required by the Fourteenth Amendment to the United States Constitution. The court decided that the treatment at Bryce was grossly deficient and failed to satisfy minimum medical and constitutional standards. It ordered that formal hearings be held at which *amici* parties could submit proposed standards for constitutionally adequate treatment and present expert testimony in support of their proposals to define, enforce, and implement the right to treatment.

The scope of the hearings was extended to include other Alabama state mental hospitals and Partlow State School and Hospital for the mentally retarded. Therefore, all patients in the state mental institutions in Alabama, both voluntary and involuntary, were included in the court's follow-up orders.

The *Wyatt* court proceeded to delineate three fundamental requirements that public institutions must fulfill to ensure that adequate treatment is provided to involuntarily hospitalized patients: a humane psychological and physical environment, adequate staffing, and individualized treatment plans.

My father pointed out that a significant historical breakthrough occurred when the defendants themselves, led by Dr. Stonewall B. Stickney, the Alabama Mental Health Commissioner, actually conceded at the outset of the proceedings that the patients had a right to treatment.⁶⁻⁸ *Wyatt* therefore not only marked the first time that an American court clearly recognized the concept of the right to treatment, it also marked the first time that personnel of a state mental hospital agreed during litigation that their patients had this right.

My father also pointed out that while the court did accept the standards that were drafted by the *amici curiae* (who later formed the Mental Health Law Project), the court rejected a set of even higher standards—staffing ratios, for example—that were recommended by Dr. Jack Ewalt, Chairman of the Department of Psychiatry of Harvard Medical School.

My father commented that while the *Wyatt* case was a breakthrough in recognizing the right to treatment and providing objective standards for practical implementation, a shortcoming of the case was in the

enforcement of the concept. The court chose injunction as the method of enforcing these objective standards. *Habeas corpus* hearings were not ordered if the standards were not met, and no one suggested actions for injuries due to inadequate treatment under the federal civil rights laws.

A Landmark Case

My father was perhaps most involved in the *Donaldson*⁹ case, which started in the early 1960s. He ultimately escalated the plaintiff's case to the Supreme Court of the United States in 1975, where he worked with lawyers from the American Civil Liberties Union, headed by Bruce Ennis, who then assumed the position of primary counsel.

Kenneth Donaldson was 34 years of age, married with three children, and working in a General Electric defense plant, when he suffered a "nervous breakdown." Hospitalized at Marcy State Hospital in New York in 1943 for four months, he underwent electroconvulsive therapy and then attempted to resume a normal life. In the mid-1950s he developed paranoid delusions that he was being poisoned, harassed, and slandered by people making derogatory comments. In January 1957, at his parents' instigation, he was committed to the Florida State Hospital at Chattahoochee at which time he received a diagnosis of paranoid schizophrenia. The committing judge told Donaldson that he was being sent to the hospital for a "few weeks" to take some of "this new medication," after which the judge said that he was certain that Donaldson would be "alright" and would "come back here." Donaldson was not released until 14 years later in July 1971, and only after protracted litigation.

Like Stephens in Creedmoor, he contacted my father from the Florida State Hospital after chancing across the *New York Times* article describing the "Right to Treatment" legal argument. Mr. Donaldson sought release from the hospital because, he claimed, he was receiving inadequate treatment.

My father responded to Mr. Donaldson's letter by traveling to Florida to meet with him, after which he agreed to offer him legal counsel. A lengthy correspondence between my father and Mr. Donaldson ensued, as well as frequent meetings at the Florida State Hospital.

Dr. O'Connor, the acting clinical director of the hospital and Mr. Donaldson's attending physician from the time of his admission in January 1957 until

the middle of 1959, claimed that Mr. Donaldson was receiving "milieu therapy," which consisted of keeping him in a large room with other patients, for most of his time in the hospital. Mr. Donaldson had been confined to a locked room with 60 beds. Mr. Donaldson argued that for 15 years, he received merely "custodial care" but not treatment for the supposed illnesses for which he was admitted. Mr. Donaldson was routinely denied activities that would have contributed to establishing a sense of independence and responsibility, including grounds privileges and occupational therapy. In the 18 months that O'Connor was in direct charge of his case, Mr. Donaldson spent no more than one hour talking to him. During his first 10 years at the hospital, progress reports on Mr. Donaldson's condition were irregularly entered in his patient record at intervals averaging one entry every two and a half months.

In the original complaint, Mr. Donaldson, guided by my father, attempted to bring a class action suit on behalf of all of the patients on his ward. In addition to damages to Mr. Donaldson and to the class, the complaint sought *habeas corpus* relief directing the release of Mr. Donaldson and of the entire class and sought broad declaratory and injunctive relief requiring the hospital to provide adequate psychiatric treatment. My father would exclaim in disbelief in later years that for 14 years, on 18 separate occasions before every Florida and federal court having jurisdiction over granting the writ of *habeas corpus* and before more than 30 different state, federal, and U.S. Supreme Court judges, he was unable to obtain a fundamental writ of *habeas corpus* for Mr. Donaldson.

Both sides in subsequent trial testimony agreed that Mr. Donaldson presented no danger to himself or to others, that he had never committed any dangerous acts, and that he had never been suicidal. O'Connor claimed that Mr. Donaldson was never released because he was concerned that Mr. Donaldson would be unable to make a "successful adjustment outside of the institution."

After 12 claims before state and federal courts and after 4 claims before the U.S. Supreme Court, Mr. Donaldson was finally granted an unconditional release by the hospital in 1971, at the age of 62. After discharge from the hospital, Donaldson returned to his hometown in Syracuse, New York, and worked there as a night clerk in a hotel while he wrote a book about his experiences titled *Insanity Inside Out*.¹⁰

From a legal perspective, the U.S. Supreme Court had the opportunity to rule on the constitutional right to treatment in the *Donaldson* case. Most legal scholars would agree that the court evaded deciding whether the U.S. Constitution provides a right to treatment, although it did not explicitly reject the possibility of such a right. In *O'Connor v. Donaldson* (1975), Justice Stewart, writing for the majority, indicated that “There is no reason now to decide whether mentally ill persons dangerous to themselves or to others have a right to treatment. This case raises a single, relatively simple but nonetheless important question concerning every man’s constitutional right to liberty.”¹¹ Essentially then, the Supreme Court transferred the emphasis from a *prima facie* rights issue to a liberty issue.

The Supreme Court found that “a state cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.” The Court was ambiguous however in defining “without more” and legal debate regarding its meaning has ensued. It has been interpreted by some to mean that nondangerous individuals cannot be involuntarily hospitalized without treatment.

It is notable that in the *Donaldson* case, the lower courts did find a basis for a constitutional right to treatment. In contrast to the Supreme Court, the U.S. Court of Appeals utilized a two-part theory: the first part, in accordance with the principle embodied in the Fourteenth Amendment that “liberty” shall not be denied without due process of law and the second part, a *quid pro quo* argument.¹²

My father remained in contact with Mr. Donaldson subsequent to his release from the Florida State Hospital. He traveled to New York City several times to visit my father in his medical office, and they stayed in correspondence via letters and occasional phone calls. My father continued encouraging him to tell his story, especially as he authored an autobiography.

The letters between my father and Mr. Donaldson during the years that he was at the Florida State Hospital, which his daughter saved at her father’s request, are remarkably inspiring.¹³ Some excerpts of the correspondence below, give authentic voice to the heart of the struggle and to the sheer joint determination of my father and Mr. Donaldson to overturn a nefarious system.

July 1967 (in a letter from my father to Mr. Donaldson):

First, please tell me how many doctors are taking care of the 950 men in your section. It seems to me that now there is only one half-time doctor for the 950 inmates. Please send me this reply by air-mail, special delivery.

November 1969 (my father to Mr. Donaldson):

I believe that the only way that you can correct all the injustices of the past—at least in part—is to continue your appeal up to the U.S. Supreme Court. . . . By the way if you proceed in the U.S. Supreme Court, I shall again ask various groups to appear as *amicus curiae*. I am hoping that it may influence the Court.

July 19, 1970 (my father to Mr. Donaldson):

I am enclosing a copy of the book *Gideon’s Trumpet* that I read a few days before I came over to see you. I thought that you might get some ideas from it for your book.

July 22, 1970 (Mr. Donaldson to my father):

From the first chapter of *Gideon’s Trumpet* it seems to be the style that I shall try to emulate.

November 1970 (my father to Mr. Donaldson):

Last week I spoke to a member of the staff of the ACLU, and he informed me that they had decided to enter this matter as co-counsel with me. I think that this is very good news. . . . I am having a long meeting with members of the ACLU during the coming week and will discuss their participation in greater detail.

April 1971 (my father to Mr. Donaldson):

Enclosed find the order of the U.S. District Court of March 10, 1971 that denied the petition for a writ of *habeas corpus*, etc. It really came as a great surprise to me; however, I hope that the enclosed motion papers that I have prepared will help correct the Court’s error.

June 1971 (Mr. Donaldson to my father):

Every bit of news from you shows a little more velocity on the growing snowball. Things are working out better than I ever hoped for in my fondest dreams. I am extremely pleased that Mssrs. Ennis and Dean are fully committed to the case.

July 28, 1971 (Mr. Donaldson to my father):

I have thanked god for my dedicated and fighting counsel. Yesterday afternoon I spoke to the new clinical director. . . . At this end, I asked him if he understood my position after fifteen years of abuse, and he said that he did. I look forward to seeing my superb counsel next month.

September 1971 (my father to Mr. Donaldson, after his release from the Florida State Hospital):

Enclosed find a copy of the transcript of the depositions of you and Dr. Walls on August 13, 1971. . . . Isn’t this the first letter that I have written to you not addressed to you at the Florida State Hospital?

The Aftermath

The shift of the Court from my father's initial focus on a right to treatment to ensure improved patient care, to primarily a civil libertarian focus, as advocated by the ACLU lawyers who assumed the case at the Supreme Court level, represented a growing split that would only increase among legal advocates of the mentally ill.

Advocates with a predominant focus on services for the mentally ill, like my father, would continue to argue for "welfare rights." They would seek due process protection in the civil commitment process and would focus on improving conditions for the mentally ill. Advocates with a predominantly civil libertarian focus, like the lawyers of the ACLU, would argue for a right to liberty. In their cases and arguments, they would emphasize due process restrictions on civil commitment, stricter substantive standards for civil commitment, protection against long-term confinement, and rights against forcible treatment within institutions. They would in some cases favor the elimination of involuntary treatment altogether and support deinstitutionalization.¹⁴

In fact, even in the earlier *Wyatt* case there was an ideological split among the service-oriented advocates who straightforwardly desired improvement in hospital conditions and the ardent civil libertarians who feared that obtaining improvements could legitimize institutions and further involuntary confinement. The litigation proceeded based on a compromise in which the civil libertarians acknowledged that the United States was not ready to abandon the civil commitment process and decided that forcing states to provide more physical resources to institutionalized patients could be justified as creating a disincentive to unnecessary institutionalization. During the *Wyatt* case, my father, a service-oriented advocate, had sought to include a challenge to the Medicaid exclusion of the mentally ill on the theory that federal reimbursement would permit the right to treatment to be implemented effectively. However, according to my father, the other principal attorneys of the *Wyatt* case, who held a civil libertarian view, refused to include this challenge because they believed that the state hospital systems should be abolished.

So with characteristic indefatigability, after the *Wyatt* case, my father therefore decided to return to New York to focus his attention on ensuring ade-

quate funding of state mental hospitals, and hopefully thereby ensuring adequate care, by challenging Medicaid's refusal to reimburse states for the care of institutionalized patients under the age of sixty-five. In 1972, my father brought suit against the Medicaid exclusion in a test case, *Legion v. Richardson*.¹⁵

John Legion was a 30-year-old involuntarily civilly committed patient with paranoid schizophrenia at Brooklyn State Hospital, a New York state mental hospital. Before his institutionalization, he had been on welfare and received Medicaid benefits for both physical and mental illnesses, but because he was institutionalized at a state mental hospital, he lost his Medicaid benefits. He did not claim that he was entitled to Medicaid benefits for the custodial care received in the state hospital. Rather, he claimed that he was entitled to Medicaid benefits only if the state mental hospital provided active treatment. He argued that the Medicaid legislation resulted in arbitrary and invidious discrimination against public mental institution patients. He sued on his own behalf and on behalf of the more than 600,000 Americans under age 65 who were treated annually in state mental hospitals and asked that the Medicaid exclusion of state mental hospital patients be declared unconstitutional. The suit requested that benefits be extended to all state mental hospital patients then excluded, at a potential annual expenditure of \$1.5 billion of additional Medicaid funds.

Mr. Legion's claim was denied in 1973 by a U.S. District Court and ultimately by the U.S. Supreme Court, when Justice Blackmun concurred with the lower court's decision. Sixteen *amicus curiae* briefs were filed in the *Legion* appeal to the Supreme Court, including those submitted by the American Medical Association, the American Psychiatric Association, Black Psychiatrists of America, and the Association of Black Psychologists, but organizations with a predominantly civil libertarian orientation did not join in. All *amici* concluded that the Medicaid exclusion of the nation's state mental hospital patients was medically and sociologically irrational and that the motion to dismiss should not have been granted.

My father again faulted what he believed to be an underlying, recurrent sanism in the courts. In an editorial he spoke out harshly:

With all due respect to the Supreme Court from the viewpoint of the oppressed involuntarily civilly committed state mental hospital inmate, one can claim that the Court's

approval of a two-tier system of federal reimbursement for the institutionalization of our nation's mentally ill is only the latest illustration of the sanism of the Court. . . [Ref. 3, p 135].

In Later Years

My father gradually focused less on his *pro bono* legal battles and more on his medical practice in Brooklyn. He was fiercely dedicated to his own patients in Bedford-Stuyvesant. He wanted to be able to have time to spend with my growing siblings and me, and he wanted to be able to support us financially, at my mother's insistence. "I make my living as a doctor and throw it away as a lawyer" he would quip to family and friends.

When I was growing up, I am not sure that I understood what my father was really doing with all of his legal boxes and articles. As I look back, I understand now that he was continually trying to advance the right to treatment by litigating a series of actions in the federal courts in New York. Beginning with *Woe v. Matthews*¹⁶ and continuing through to *Foe v. Cuomo*,¹⁷ he brought suit against many state mental hospitals, including the Kingsboro Psychiatric Center and the Bronx Psychiatric Center, demanding that they halt admissions or close down, since in the face of continued overcrowding and understaffing, their patients were being deprived of their constitutional right to adequate care. It is noteworthy that he consistently avoided criticizing the staff of public mental hospitals; rather, he highly commended them for their work under extremely trying conditions, and he criticized the state legislatures for their inadequate appropriations as he engaged in legal reform.

In his later cases, he submitted a creative and novel extension of the right to treatment in his briefs, a proposal for state mental hospital inpatients to have a precommitment right to refuse inadequate treatment. He also continued arguing against the Medicaid exclusion of the mentally ill during the Clinton administration, when he brought suit again in federal court in *Doe v. Shalala*¹⁸ to attempt to end the exclusion.

I can't recall that my father explained to me straightforwardly why he adopted this cause of the mentally ill as his own cause. He just humbly stated when I asked him that it came naturally to him, and I very much agreed since he was so obviously impassioned about it. It seemed instinctual to him, I

thought, as instinctual as munching on a potato knish on the Coney Island Boardwalk. I didn't push him any further on his reasons. One of my brothers recalls that my father explained to him that he took on this burden of challenging the inadequate care of the mentally ill in the way that he did because he truly feared that no one else would, and he felt that someone had to assume this expensive, time-consuming, uphill battle.

My father felt that sanism pervaded all facets of society, even the courtrooms, and that it obstructed justice. Most of his lawsuits, which he felt rested on fundamental and defensible humanitarian concepts, inevitably evolved into years of protracted litigation. And most often, the rulings were not in his favor! He fully recognized the depth of the struggle of the indigent mentally ill, and he recognized that the suffering was still ongoing.

Even as a series of strokes reduced my father's cognitive and overall abilities, he expressed to me the sense that he would still like to submit one more brief or to be in the courtroom again arguing. I recall his discussing the overwhelming problems of deinstitutionalization, that the mentally ill were now in the prisons and on the streets, and he would hand me article after article citing the horrendous statistics. He would speak of our obligation to the mentally ill as we walked past the homeless on the streets in New York City. He was overwhelmed and infuriated by the lack of therapeutic community alternatives to inpatient facilities. He had presciently and repeatedly emphasized the need for a standard for quality of care of the mentally ill, whether in the community or in the hospital.

The state hospital inpatient conditions that initially provoked my father's campaign may no longer exist, but as I progress through my own residency training, and as I come to know my own patients' struggles intimately, I am recognizing other forms of sanism. I am still considering the evolution of the right to treatment and where the concept stands now. Perhaps that will be the topic of another article. I am still at an early and impressionable stage in my own route toward advocacy.

I am very sure that today, in our challenging the current *status quo* and in our calling for the ever more needed legal and legislative reform to better the care of disadvantaged mentally ill patients, my father's voice and legacy live on.

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