

Living With Your Rights Off

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Perhaps in response to civil libertarians, to stricter commitment laws or to a professional paranoia that we are being persecuted by our legal colleagues, it has become fashionable for some psychiatrists to protest that certain patients are being allowed, legally, to "die with their rights on." Such allegations are presented in anecdotes which presumably illustrate the harms which resulted when seriously ill patients, deemed legally or otherwise uncommittable, were thereby "denied" treatment. In support of this position, the authors postulate that tragedies which followed decisions not to commit patients could have been prevented by their expedient hospitalization. In essence, they assert that a social preference for the patient's right to be free amounts to an unfortunate endorsement of his/her right to remain sick and to die as well.

If true, these allegations present a serious indictment of laws and legal practices, and portray a callous disregard of the fatal costs of providing physical freedom at the price of expedient treatment for certain critically ill psychiatric patients. Upon closer analysis, however, the available evidence may suggest that the allegations are unfounded or overly simplistic in explaining the tragedies which occurred. In either case, the analysis is merely one means to the desired end of clarifying ways in which psychiatrists, other mental health professionals, judges, lawyers, legislators and even friends and family members of patients can strike a fair balance between the patient's right to receive adequate treatment and his/her right to refuse that treatment in the interests of preserving other rights of freedom and privacy. Patients should not die with their rights on. But they should not live with their rights off, either.

Dying With Your Rights On: A Case of "Wrongful Death"?

The serious consequences of allowing some psychiatric patients a right to remain free despite their desperate need for hospitalization *via* civil commitment first became evident to many persons during the 1974 Annual Meeting of the American Psychiatric Association. At that time, Treffert¹ and Rachlin² addressed the possibility that a patient's right to treatment might, momentarily at least, properly supercede his/her right to remain free. Their sentiments were later echoed by Peele *et al.*³

Treffert published evidence to support his position in February, 1974,⁴

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and again the following year.⁵ Offering three anecdotes, and alluding to a fourth, he postulated that the involved patients, or members of their families, had died because their rights to freedom had prevailed despite their need for immediate psychiatric hospitalization. In the first case, two women (Angela and Rene) had been observed to stare “mutely” at one another on a busy street corner “for hours” as if in a “trance.” Police, upon consulting local attorneys, were informed that neither woman met the relevant criteria for civil commitment (imminent dangerousness). Some thirty hours later police found both women ablaze in their apartment, apparently the result of a mutual suicide pact. Rene allegedly “died with her rights on”; Angela lived. In the second case, a forty-nine-year-old woman suffering from “anorexia nervosa” was allowed to leave the hospital against medical advice because a court had not found her civilly committable at that time; three weeks later she died of “starvation.” A nineteen-year-old coed who attempted suicide by a “massive” overdose was the third case. Following detoxification, she was released from the hospital against medical advice, only to hang herself the following day. Apparently the woman’s parents had been advised by their attorney that she was not committable at the time of her AMA discharge. Treffert’s fourth case, drawn from California, involved a young man who, “by law,” had been refused “necessary hospitalization” only later to kill his wife, his children and himself. In each of these cases, Treffert concluded that the outcomes were “doubly tragic since early [psychiatric] intervention” could have “lessened” or “prevented” their occurrence.

Peele, *et al.*, presented three additional cases.⁶ In the first, a woman in her twenties seemed to support herself solely by the handouts which she solicited in public. “Everyone” concerned about her situation agreed that she was “mentally ill,” but apparently not sufficiently so for hospitalization to occur (probably *via* commitment, although this is not clear). Soon thereafter the woman was murdered. Peele also cites the case of a delusional divorcee and mother of three who claimed that she was Cleopatra. She refused voluntary hospitalization and was later found not committable. Apparently she survived despite her decision not to accept treatment in the hospital. The third (hypothetical) case involved a young manic-depressive male who stood to lose his “financial resources,” his family’s “security,” and even his “dignity” if denied treatment in the form of civil commitment during an attack of mania. In each of these cases the authors advocated psychiatric hospitalization, if necessary *via* civil commitment, in order to avoid what they felt to be the predictably tragic consequences of no treatment. They justified civil commitment upon the patient’s treatability, suggesting that treatability as well as dangerousness should be a relevant criterion for involuntary hospitalization.*

Committability: High Priority, Low Visibility Decision-making

In reviewing Treffert’s and Peele’s cases, one cannot escape the

*The authors propose seven categories of patients who might be expected to meet a treatability requirement for civil commitment purposes. Interestingly, they would exclude persons likely to commit suicide as a “rational act” or an “existential protest”; nor do they specifically include mentally retarded persons.

implication that critical and often fatal decisions were made by non-mental health professionals. Ultimately, the opinions of police, attorneys, family members, and, rarely, judges prevailed to deny hospitalization to patients whom the authors believed, in retrospect, were eligible for civil commitment. There is an aura of blame in these accounts. Repeatedly the authors speculate that predictable harms might have been avoided had only the decision-makers been more attentive to human suffering and less scrupulous about legal technicalities.

Yet it is interesting to note who made the critical decisions in several of the cases cited. The forty-nine-year-old woman with anorexia nervosa died *three weeks* after her discharge from the hospital; why did not members of her family or her physicians again seek to commit her during this precipitous decline? Surely their decisions *not* to act related to her untimely death. Similarly, if the nineteen-year-old coed's family and treating psychiatrist felt so strongly that she would commit suicide absent further hospitalization, why did they rely upon the mere advice of an attorney rather than the ruling of a judge during a formal commitment hearing? The stakes seem high enough to justify such a minor inconvenience. Is it not also strange that police consulted attorneys and not psychiatrists in their concern for Angela and Rene? Were psychiatrists and other mental health professionals "unavailable" to the police, or uninterested in their cause?

If blame is to be assigned – and I seriously doubt the wisdom of that endeavor – I submit that mental health professionals, by their actions as well as their inactions, were as responsible as others here. Nor can one blame civil commitment statutes and their criteria for committability; these are merely legislative guidelines, subject to judicial interpretation based upon the evidence presented. In order to bring about involuntary hospitalization, one must first get the case before a judge and then present the available evidence. A mere commitment statute prevents neither endeavor.

If laws and lawyers, or family members, or mental health professionals are not unilaterally responsible for patients "dying with their rights on," perhaps there are other factors *intrinsic* to the commitment decision-making process to explain such phenomena. Both the current literature and personal experiences suggest that such cases arise infrequently, although possibly more often than we admit. Most often, the "close" case seems to involve the patient who did not seek hospitalization initially, and who actively opposed it once suggested. Moreover, the historical evidence in such cases often amounts to hearsay technically, and may itself be conflicting. The psychiatric findings are likely to be incomplete as well, given the brevity (and even the urgency) of observation; clinical data, even properly obtained, may be poorly presented. To the extent that committability decisions are, for these reasons, of "low visibility," the solution would appear to lie in better – perhaps longer – evidence-gathering, plus learning to communicate more effectively across interdisciplinary (psychiatry-law) boundaries. Placing blame upon one party or another for errors in human judgment does not eliminate past mistakes, and may even undermine efforts to avoid future ones.

More Problems: Predictability and Containability

The cases under consideration imply a rather rigid cause-and-effect

relationship between no psychiatric hospitalization (lack of civil committability) on the one hand, and a patient's suicidal or homicidal behavior on the other. It is as if the decision against involuntary hospitalization were, *ipso facto*, permission to kill, die or be killed. Thus, in the California homicide-suicide case we are led to believe that the patient's exclusion from psychiatric hospitalization inexorably compromised his wife's and his children's rights to life: "*they* died with *his* rights on."⁷ * The case of the "mentally ill" beggar, existing solely on the public dole, who was murdered after being denied hospitalization, is construed to suggest either that she solicited her fate as well as her livelihood, or that treatment (asylum?) denied was homicide permitted.

In relating the absence of immediate hospitalization causally to the subsequent occurrence of homicidal or suicidal behavior, the authors seem to assume that a high predictability of dangerousness is possible, at least in the cases cited. Without digressing into endless debate, I submit that our current capacity to predict dangerousness, even imminent dangerousness, is far from well-established.⁹ At least we are not able to assert that persons whom we deem dangerous, but whom society does not restrain in some fashion thereafter, always harm themselves or others. Not everyone who seems to qualify psychiatrically, but not legally, for civil commitment dies or kills when denied hospitalization. Nor, as Professor Dix noted during a recent debate,¹⁰ are we, as psychiatrists, really so comfortable with predicting dangerousness, given our vociferous concern with the legal duty imposed by *Tarasoff*¹¹ to take action when treating patients whom we believe to be dangerous to others.

There are other problems as well. Even if one assumes a high degree of predictability, there must follow an assumption that hospitalization *per se* offers some guarantee of safe conduct on the part of the patient. Yet suicides and murders have occurred within psychiatric hospitals; moreover, for most patients at least, controls exerted within the hospital setting do not eliminate dangerous behavior following discharge. At best, hospitalization of the patients noted earlier would have offered containment and the intent to control imminent dangerousness. Beyond that, the patient's treatability within a given institutional setting *might* have offered some further protection. But more about that possibility later.

Returning briefly to Treffert's California case, his assertion that "*they* [the patient's family] died with *his* rights on" is puzzling. If we assume that the patient's right to physical freedom was in direct conflict with his family's right to live, how does one justify, from the stance of psychiatry, waiving the former to insure the latter right? This last is, of course, put too bluntly. But over time would not the decision to restrain the patient within the hospital in order to protect his family amount to a decision *not* to subject the family (and perhaps society) to the risk of his potential dangerousness, but instead to expose him to the risks of continued hospitalization? At what point do we balance the patient's rights with those of others such that the patient is allowed the chance to demonstrate, empirically, whether he remains

⁷As of 1975, Treffert comments that "72 murders, suicides, and unfortunate accidents" involved former patients or patients who tried unsuccessfully to obtain psychiatric care in California, but who were excluded from involuntary hospitalization under terms of the Lanterman-Petris-Short Act.⁸

dangerous in society or not? It would appear that we seek to protect conflicting rights simultaneously at times. Yet the ultimate decisions in such cases are not always made openly or perhaps even consistently.

Treatability: The Elusive Promise

If mere containment – preventive detention – of dangerous and mentally ill persons is not the appropriate goal of psychiatric hospitalization, *O'Connor v. Donaldson*¹² notwithstanding, what does justify civil commitment? Peele, *et al.*, Treffert and Rachlin seem in accord that treatability, in addition to dangerousness, is a critical consideration in making civil commitment decisions. Treatment thus becomes the *quid pro quo* for involuntary confinement and, at the same time, provides an unstated promise of future safe behavior by the patient upon discharge from the hospital.*

Peele *et al.*¹³ believe that treatability is largely an empirical question, that is, one to be decided by the patient's response to an adequate trial of treatment. They would be willing to assess treatability *via* periodic reviews of a patient's progress in therapy. It is not clear what criteria they would use in conducting such reviews, but perhaps they and other mental health professionals would agree upon the merits of such criteria if elaborated. Having laid that groundwork, however, the authors offer their basic working hypothesis: "...three out of four patients who are involuntarily hospitalized in the District of Columbia have improved in one way or another in their ability to live in the community as a result of their hospital experience."¹⁴ Without doubt, their estimate is sincere. But there seems to be a remarkable disparity between predicting patients' treatability upon empirical trials of therapy on one hand, and assuming it in advance of such trials and their evaluations for approximately three-fourths of committed patients on the other hand.

Rachlin *et al.* approach the determination of treatability in somewhat different fashion. In 1975 they reported the results of treating 50 "treatment failures" – patients who had repeatedly eloped from the hospital, were considered "dangerous" to themselves and/or others, or had otherwise demonstrated "severely disturbed behavior."¹⁵ These cases do not seem markedly different compared to cases cited earlier. The authors selected fifty consecutive admissions to their closed ward, comparing pre- and post-index hospitalization, one-year periods for each patient in terms of (1) numbers of hospitalizations, (2) intervals between hospitalizations and (3) total inpatient time. Finding no statistically significant differences between the two time periods in terms of these variables, the authors then examined the incidence of patient behaviors which directly led to hospitalizations during either period. Again they were unable to demonstrate that the index hospitalization was followed by any marked reduction in the frequency of such behaviors. They then elected to rate each patient

*Before examining the means by which these authors wish to determine treatability, we might well wonder whether the *quid equals the quo*, whether the adequacy of treatment given justifies the patient's loss of liberty. Or whether society is really so willing, upon discharge, to forego earlier concerns about the patient's potential dangerousness.

“globally” to determine the effects of hospitalization and thereby achieved “nearly perfect agreement by consensus [among raters] after reviewing all available patient records.” By this analysis, 28% of the patients were considered “improved” following hospitalization, while 46% showed “little change in symptoms” and 12% were actually considered “worse.” Unfortunately 14% of the patients in their sample were lost to follow-up and could not be placed in any group.

While there is no definition of the precise “global” criteria by which Rachlin and his associates rated their patients’ response to treatment and thereby determined, in retrospect, their treatability, it is interesting to note that the stated criteria of their initial two analyses did not reveal statistically significant differences in “treatability.” Nor is it particularly convincing during a civil commitment hearing, for example, to argue that the potential patient has approximately a 28% chance of improvement versus a 12% chance of deterioration following hospitalization, about a two to one chance of benefitting versus suffering from treatment.* Other statistics might be cited to sway the decision one way or the other. But the point, I believe, is clear. One cannot assume treatability in many cases without resort to adequate trials of treatment for empirical determinations of that variable. Nor can one assume automatic credibility for offhand estimates of treatability absent hard data. Even with that information, psychiatric techniques of analysis may be open to question by those who seek to base commitment in large part upon statistical predictions of a patient’s potential treatability.

Conclusion

Psychiatric patients who live with their rights off, no less than those who die with them on, represent errors in human judgment which may be partly unavoidable given our evolving sophistication about mentally ill persons and their needs. In response to these tragic realities, it is neither sufficient nor useful for psychiatrists and other mental health professionals to develop a paranoid suspiciousness toward those who seek accountability for psychiatric decision-making. In particular, little can be gained from placing blame wholesale upon the legal profession and the accommodations made for mentally ill persons by courts and legislatures.

The implications of dying with one’s rights on or living with them off lie in other directions. For psychiatry, at least, two major undertakings seem in order. First, we shall have to temper a sincere, but perhaps premature, optimism about the extent of our professional expertise in certain areas. This will require continuing efforts to upgrade clinical skills and methods in such a way that psychiatric judgments, in the areas of treatability and dangerousness, for example, are based upon the total experience of mental health professionals and not merely upon that of the individual practitioner. And

*Arguably one could conclude that a patient’s chances for deterioration versus improvement or remaining unchanged were roughly one in six (disregarding those patients lost to follow-up). To have meaning, however, this estimate should be compared to the results of no hospitalization. Although the populations studied may be dissimilar, reports by Pasamanick *et al.*¹⁶ and Langsley *et al.*¹⁷ would imply a not unfavorable result for many patients, possibly not all committable, who receive outpatient as opposed to inpatient care.

psychiatry must still decline some inquiries with the observation that not enough is yet known to answer them accurately. There is no loss of professional dignity or stature in such honesty; quite the opposite, I should think.

Psychiatry's second task is less obvious, but equally urgent. Psychiatrists must share with other decision-makers — other professionals, perhaps psychiatric patients and even their friends and families — the accumulation of psychiatric knowledge in such a way that past mistakes are not repeated and former successes are preserved in caring for the mentally ill. At a professional level it will be difficult to create and maintain the dialogue required for this essential exchange of information. Obviously, mental health professionals do not share a vocabulary or a conceptual approach with, for example, lawyers, judges, or even legislators. The mental health professional, and particularly the psychiatrist, must therefore cultivate a multi-disciplinary expertise, an ability to understand and appreciate the contributions of many disciplines if he or she is to address fairly the complex needs of mentally ill persons and their social alienation. The alternative of professional retrenchment and isolation is no longer tenable — for the professions or their patients and clients.

References

- 1 Treffert DA: Dying with your rights on. Presented at the 127th Annual Meeting of the American Psychiatric Association, Detroit, Michigan, May 6-10, 1974
- 2 Rachlin S, Pam A, Milton J: Civil liberties versus involuntary hospitalization. Presented at the 127th Annual Meeting of the American Psychiatric Association, Detroit, Michigan, May 6-10, 1974
- 3 Peele R, Chodoff P, Taub N: Involuntary hospitalization and treatability: Observations from the District of Columbia experience. *Catholic University Law Review* 23:744-753 (1974)
- 4 Treffert DA: Dying with their rights on. *Prism*, pp. 47-52, 1974
- 5 Treffert DA: The practical limits of patients' rights. *Psychiatric Annals* 5:91-96 (1975)
- 6 Peele *et al.*, *op. cit.*, n. 3
- 7 Treffert, *op. cit.*, n. 5, p. 93
- 8 Lanterman-Petris-Short Act, Cal. Welf. & Inst. Code, 5000 *et. seq.* (1974)
- 9 Amer. Psychiat. Assoc.: Clinical Aspects of the Violent Individual. Task Force Report 8, July, 1974, Washington, D.C. (See also Contract Research Corporation: The Evaluation of Patuxent Institution (Final Report), submitted to the Maryland Department of Public Safety and Correctional Services, Feb. 25, 1977.)
- 10 Dix GE: Dangerousness. Presented at the Conference on Aspects of Psychiatry and the Legal Process, St. Mary's School of Law, San Antonio, Texas, September 1, 1976
- 11 *Tarasoff v. Regents of the University of California*, 551 P. 2d 334 (1976)
- 12 *O'Connor v. Donaldson*, 422 U.S. 563 (1975)
- 13 Peele, *et al.*, *op. cit.*, n.3
- 14 *Ibid.*, p. 747
- 15 Rachlin S, Pam A, Milton J: Civil liberties versus involuntary hospitalization. *American Journal of Psychiatry* 132:189-192 (1975)
- 16 Pasamanick B, Scarpitti F, Dinitz S: Schizophrenics in the Community: An Experimental Study in the Prevention of Hospitalization. Appleton-Century-Crofts, 1967. See also, Davis A, Dinitz S, Pasamanick B: The prevention of hospitalization in schizophrenia: Five years after an experimental program. *Amer J. Orthopsychiat* 42:375-88 (1972)
- 17 Langsley D *et al.*: *The Treatment of Families in Crisis*. Grune & Stratton, 1968. See also Flomenhaft K and Langsley D: After the crisis. *Ment Hyg* 55:473-77 (1971)