In our zeal to protect basic, human freedoms, this psychiatrist points out, we have created a legal climate in which mentally ill patients, and sometimes the people around them, are . . .

Dying with Their Rights On

by DAROLD A. TREFFERT, M.D.

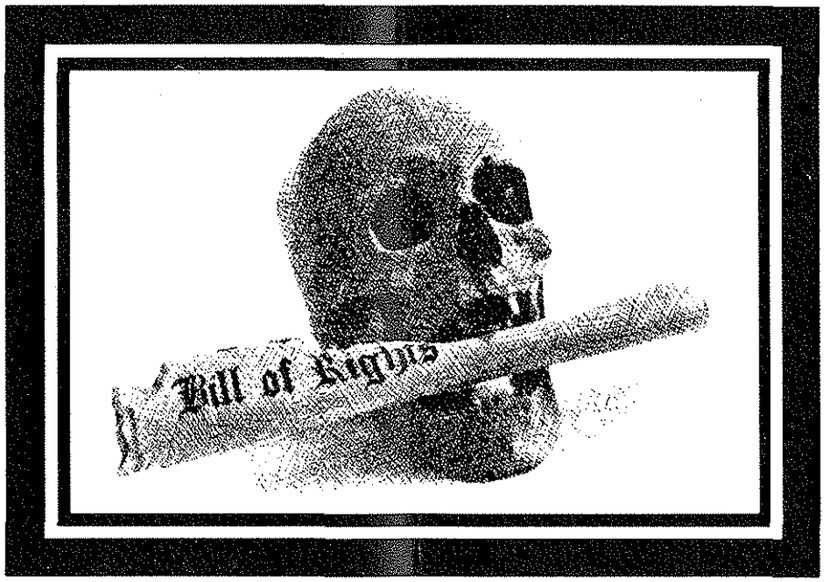
On November 10, 1971, in a midwestern university community, a 26-year-old woman named Rene and her 20-year-old companion Angela stood for several hours on a busy street corner near the campus benignly and mutely staring at each other—"as if in a trance," police records said.

There is, of course, no law against people staring at each other, but because the girls' strange behavior continued for so long, a crowd gathered, creating considerable confusion on that busy corner. The police arrived to investigate and took Angela and Rene to a nearby station for questioning.

But the two women refused to speak. They simply sat and stared at each other. The police were quite naturally concerned about the bizarre behavior of the two and eventually decided that some kind of psychiatric observation was called for.

Police contacted the city and prosecuting attorneys' offices for advice. The opinion of both offices was the same: State law allows people to be held for observation *only* if they appear obviously dangerous to themselves or others. While the behavior of Angela and Rene was admittedly bizarre, they were, after all, merely staring at each other and not verbalizing any threats against themselves or others. Since neither homicidal nor suicidal tendencies were obviously apparent, the attorneys agreed that the girls did not *legally* "qualify" for psychiatric observation.

The police reluctantly, but necessarily, released the women that night. But they were to soon meet Angela and Rene again, and under tragic circumstances. Called to a campus apartment some 30 hours later, they found the two women on the kitchen floor, writhing and screaming in a



self-made flaming pyre of butcher paper they had obligingly lit for each other in a suicide pact. Both were taken to the university hospital in critical condition.

Although more than 20 percent of her body was burned, including her chest, upper arms, and upper legs, Angela lived.

Rene died. But she died with her rights on.

To me, this case is reminiscent of the old medical school saw about "dying in electrolytic balance." Each of us can remember the compulsive chemoclinician who solemnly occupied himself with the patient's sodium, calcium, magnesium, and potassium levels, but scarcely noticed that the patient was slowly slipping away. Even though death came, the fact that it occurred with the patient's body in perfect electrolyte balance was somehow a morbid chemoclinical triumph.

Such extraordinarily limited vision is now affecting psychiatry, and in the zeal to impeccably protect a patient's civil liberties, an increasing number of troubled and psychotic patients are, as I choose to refer to the situation, "dying with their rights on"—as in the case of Rene—a morbid clinical-legal triumph.

In Wisconsin, where I practice, a federal court decision in the class action suit of *Lessard* vs *Schmidt* (349 F. Supp. 1078) has stiffened the state's commitment laws. In that decision, the new—and sole—definition of commitability became *"extreme likelihood* that if the person is not confined he will do *immediate harm* to himself or others." (My italics.) Other states, including Michigan where Angela and Rene lived, have recently enacted or updated similar laws, and this was surely done by well-meaning lawmakers, judges, and doctors.

I submit, however, that in championing a cause they deeply believed in, their zeal may have exceeded their judgment. For there surely must be some reasonable middle ground between protecting the right of the psychiatric patient to remain free—a precious and important right—and protecting the right of both that patient and those around him or her from tragic and untoward effects of the patient's illness. The latter right has been overshadowed recently by our preoccupation with the former, but physicians and society must be equally concerned about both.

Since the Wisconsin law went into

The Author: Darold A. Treffert, M.D., is director of the Mental Health Institute—Winnebago, Winnebago, Wisconsin, and is in private practice as a psychiatrist in Fond du Lac, Wisconsin. His articles have appeared in the *American Journal of Psychiatry, Archives of General Psychiatry, Hospital and Community Psychiatry, Contemporary Drug Problems—A Law Quarterly,* and the *Wisconsin Medical Journal.*

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effect, a number of cases in which patients died with their rights on have been brought to my attention. I am in the process of collecting such cases from throughout the country so that they can be properly weighed by the psychiatric community in the always delicate task of balancing humane clinical and societal concerns against legal concerns in the commitment process.

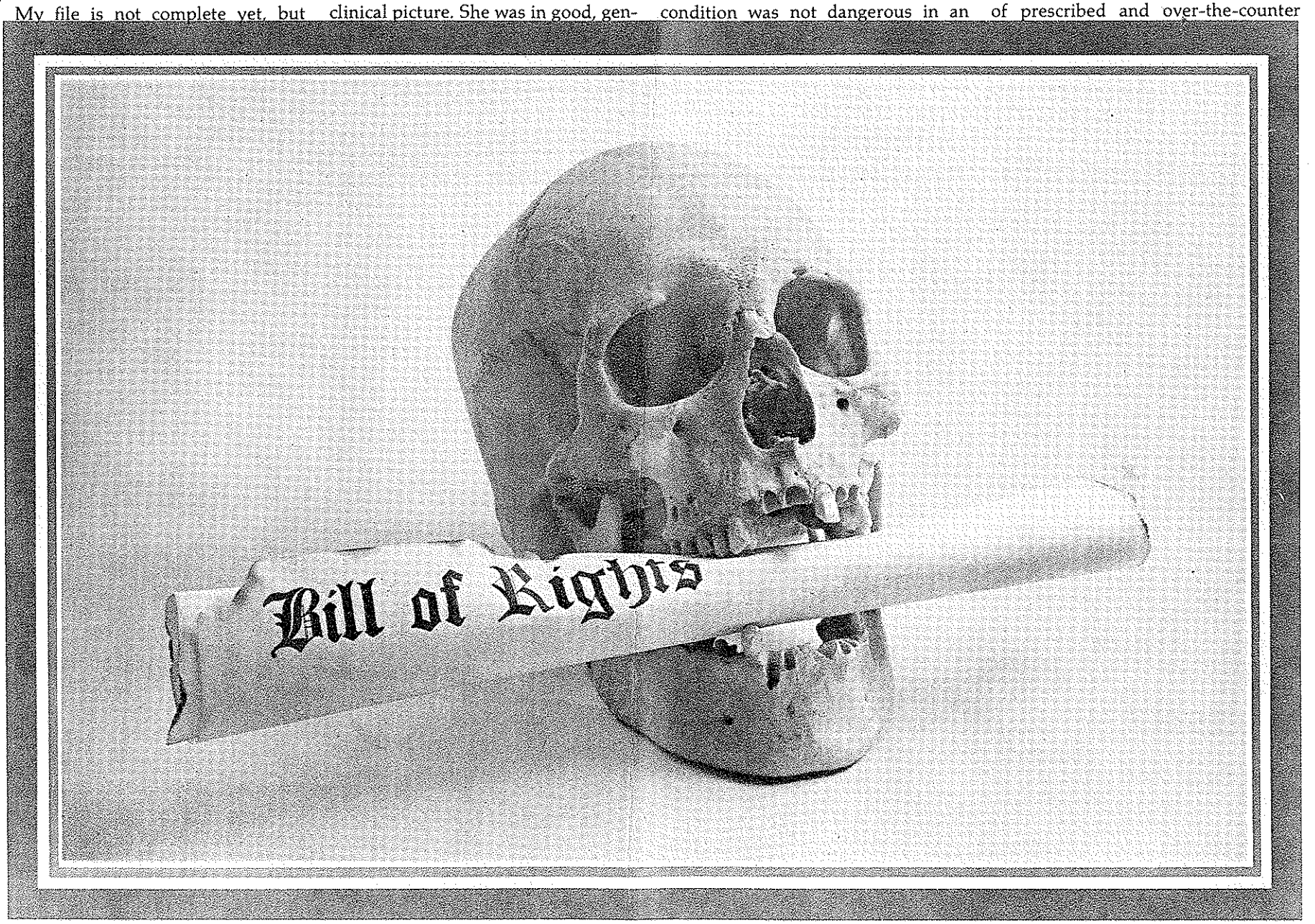
My file is not complete yet, but consider these Wisconsin cases:

A 49-year-old woman with anorexia nervosa was admitted to a medical unit in a general hospital. Largely because of anxiety over a family struggle in which she was deeply enmeshed, she had steadfastly refused to eat and lost a great amount of weight. The woman, like many anorectic patients, presented a life-threatening—though not immediate—clinical picture. She was in good, general contact with reality and was not flagrantly psychotic. But she refused to voluntarily submit to any psychiatric help in spite of her family's concern and encouragement. In fact, she insisted on leaving the hospital although her condition was frail and deteriorating.

Her family and physician asked the court to permit psychiatric observation. But the judge felt that her condition was not dangerous in an immediate or imminent sense, and therefore, she failed to qualify for admission to a psychiatric hospital. She was allowed to go home as she had wanted.

She died from starvation three weeks later—with her rights on.

A 19-year-old coed, with a lingering schizo-affective depression of major proportions, attempted suicide by swallowing a massive overdose of prescribed and over-the-counter



"There must be some reasonable middle ground between protecting the right of the psychiatric patient from external coercion and the right of both the patient and those around him to be protected from tragic and untoward effects of the patient's illness."

drugs. Only the unexpected arrival of friends, who found the girl unconscious and took her to a nearby emergency room, prevented successful suicide. After two days in intensive care, she regained consciousness and agreed to be transferred to the psychiatric ward in the same hospital.

"No Suicidal Intent"

Although only partially dissuaded from her wish to end her life, she voiced a feeling of well-being that was obviously superficial and insisted on being released in spite of her family's and her doctor's wishes that she remain for further treatment. The patient adamantly denied any suicidal intent and her family extracted a promise from her that she simply wouldn't try such a thing again. Her family considered commitment but was advised by lawyers that, in view of the girl's generally positive presentation of herself, she did not qualify for commitment under the new guidelines. Her situation lacked the element of *"extreme likelihood* of *immediate harm* to herself or others." The girl signed out of the hospital against medical advice.

The following day, she hanged herself. But like the others she died with her rights inviolably observed.

No doubt for every one of these cases there does exist somewhere a little old immigrant who, though perfectly sane, has been institutionalized for years because his broken, unintelligible English was mistaken for psychotic ramblings. Or somewhere an elderly woman, labeled retarded in 1920 and shuffled to a forgotten ward, may be found by an inquisitive psychology graduate student wandering the back wards to be, in fact, a genius. Or an eccentric who once delighted in storing pancakes will be turned up years later, after having been committed at a time when storing pancakes was unfashionable.

My intent is not to minimize the grievous harm done in such situations. In fact, the discovery of such cases has rightfully heightened our vigilance and concern that the commitment process should not be arbitrary, abused, or perfunctory. Yet we seem overly zealous with regard to the hazards of commitment. A public epidemic of "unicorn-in-the-garden" fear is sweeping society and the courts. I take the name for the epidemic from the late James Thurber's tongue-in-cheek tale of a woman who tries to have her husband committed after he speaks of feeding a lily to a unicorn in their garden. But when she informs the authorities, they take her away instead.

Indeed, many fear that the sane rather than the sick will somehow be hospitalized without stricter laws and that commitment to the psychiatric hospital (white coats, nets, and all) will be used as a subterfuge for unsavory, convenient motives, be they personal, societal, or political.

The attention and empathy of the public and press lately have focused on this problem—that of keeping the sane or eccentric from mistaken commitment. But how do we console the grief-shattered mother in California who, appearing before a state legislative committee looking into the commitment turmoil there, told of actually seeing her mentally ill son kill his wife, children, and himself after he was refused—by law—necessary continued hospitalization.

Those poor people died, it seems to me, with *his* rights on. But what about *their* rights to be spared the tragic outcome of his illness?

The California mother charitably acknowledged that those who changed the commitment law (unwittingly making the tragedy possible) were well intentioned and "humanely inspired." Yet she argued, as I do, that however necessary, important, and noble the effort to protect the civil rights of patients, we must guard the rights of those close to the mentally ill just as carefully. For suicide and homicide are not the only untoward consequences of the new laws; morbidity also occurs in the form of unnecessary suffering for the patient and his family.

Some patients become increasingly disturbed and develop a poorer prognosis as time passes until they finally accumulate the proper mix of symptoms to meet the law's dubious qualification of "dangerous."

And sometimes the family of a psychotic mother may literally disintegrate while vainly trying to construct some form of routine family life around mother's bizarre and often psychologically destructive symptoms. Or the wife of a mentally ill man may finally abandon her struggle to keep the family going, wearied by fruitless attempts to patch together the semblance of a normal marriage. Such morbidity is doubly tragic since early intervention could lessen or even prevent destructive consequences.

Stifling Paternalism

There is another matter that should be considered in redefining qualifications for commitment. It is the abrupt reversal of social policymakers from an attitude of stifling paternalism toward the mentally ill to the outright abandonment of their needs. From Canada, England, and the United States come reports of a forced, mass exodus of dependent patients into a relatively unreceptive society with which they are ill equipped to cope.

This effort, also humanely inspired, has been carried to a grim extreme by politicians who are interested not in the mental health system, but in the economics of that system. The mass exodus has been chiefly an effort to solve fiscal problems, not the patients' human problems.

In New York, Suffolk County reports that 5,000 former mental patients are on the welfare rolls and have no family, no job, and no place in the community.

Balancing the complex equation of which of the mentally ill must be hospitalized is a difficult task at best and a treacherous one at worst. Somehow, however, all the elements of that equation need be given their proper weighting. These elements include not just the right to be free or the right to be sick, but also the right to be rescued; the right of the family and of society to be free from the serious untoward effects of such illness; the right of the patient to due process; and the right of the patient to dignity as a human being.

Man has never moved by plan. He

has always moved by crisis. The pendulum has been the vehicle. A swing forward and a swing backward. Having reached the upward limit of too liberally defining illness and commitment, the pendulum now threatens to reach the other extreme. We are struggling now to come to some reasonable middle ground between the right to be ill and the right to be rescued, just as we struggle in criminal law to somehow balance the criminal's rights with the rights of the victim.

The Pendulum of History

But the pendulum of history is a peculiar instrument. Like all pendulums, it swings to and fro. But somehow, almost imperceptibly, its forward excursions have always slightly exceeded the backward ones, and thus we as a people have managed to awkwardly inch forward. But we've moved backward recently, toward once again criminalizing the mentally ill, taking a stance I thought we had abandoned a century ago. In Wisconsin, for example, in an obviously adversary proceeding one can be found "guilty" of being mentally ill, for mental illness is defined only in terms of dangerousness. Family members testify "against" each other, and what should be a private predicament becomes a public record.

Perhaps the next time the pendulum swings forward it will propel us, gently, further than we have ever been before, so that we will reach a more sophisticated point of balance. It will be too late for Angela, Rene, the California mother, and the several others I have briefly cited here. But I hope that their predicament will at least aid us in soon finding that humane balance point that will mean a more humane attitude toward the mentally ill.