CHAPTER 15

Involuntary Psychiatric Commitment

The Case of Joyce Brown

This chapter describes a homeless woman living on the Upper East Side of Manhattan who was committed against her will for treatment for schizophrenia. Defended by the ACLU, her cases raised ethical issues about paternalism, political uses of psychiatry, rights of mental patients, and compassion.

THE CASE OF JOYCE BROWN

In the 1980s, mentally unstable, homeless people overwhelmed Manhattan; mental health professionals and the public wanted something done. In 1987, New York City started Project Help, but the people it tried to help resisted. Could insane homeless people just be left to "die with their rights on?" Or could Project Help seize them for psychiatric evaluation and involuntary commitment?

Controversially, Project Help broadened its standards for involuntary commitment beyond the legal requirements of mental illness and dangerousness. It added two new criteria: "self-neglect" and a "need to be treated for mental illness."

The first person picked up was Joyce Brown, a 40-year-old African-American woman. For 18 months, she slept outside a Swensen's ice cream parlor on Second Avenue and 65th Street, not too far from Gracie Mansion, where Mayor Ed Koch lived. During the day, she panhandled for money to buy food, cigarettes, and toilet paper. Brown was chosen as a test case by Project Help and Mayor Koch, who saw her sometimes and spoke to her on the street.

Her physical appearance suggested mental illness. Her teeth were unclean; her hair was matted underneath a bulky white knit cap. She had a glazed look, muttered as she panhandled, and often talked to herself. She sometimes sang "How Much Is That Doggie in the Window?" Once, when a resident of the block gave her money, she tossed it back while screaming angrily at an invisible man. One neighbor described her in a letter to the *New York Times* as "full of rage." She cursed at black men she encountered, although she liked babies. She sometimes defecated and urinated in the gutter. On bitterly cold nights, the police tried to take her to a shelter, but she resisted.

When Project Help forcibly brought her to the emergency room of Bellevue Hospital, she was injected against her will with five mg. of Haldol, an antipsychotic drug and two mg. of Ativan, a fast-acting short-term tranquilizer, and then taken to a new 28-bed, locked psychiatric unit on the 19th floor.

The Legal Conflict

After Joyce Brown was evaluated at Bellevue, Mayor Koch was informed that she was neither sufficiently insane nor sufficiently dangerous for involuntary commitment. Although diagnosed as schizophrenic, Brown was not dangerous to herself or others. Bellevue psychiatrists did agree however that Brown was "in need of treatment for mental illness," so Joyce met one of the new criteria for commitment.

Once a person is brought to a psychiatric facility, release is unlikely until a commitment hearing occurs before a judge. New York state law allowed involuntary injections only in emergency rooms; and in the psychiatric unit at Bellevue, Joyce Brown exercised her right to refuse further drugs.

Prior to her hearing before Judge Robert Lippman, she called the American Civil Liberties Union (ACLU). It agreed to represent her if she would waive confidentiality and would agree to publicity about her case to help other homeless people, which she did.

At the hearing, her three sisters from New Jersey arrived. Married, working, and middle class, they said they had been searching for Joyce for the last 18 months. They said their family was from Elizabeth, New Jersey, and their father was a Methodist minister; all the children had gone to church.

Brown had been a "bright, attractive, and happy-go-lucky child." She had graduated from both high school and business school, and had held several jobs at Bell Laboratories. During these years, her sisters said, she had been a "big, healthy girl" who wore nice clothes and jewelry and "always drove around in a new Cadillac."

They said that Brown had started taking heroin in her 20s, and later cocaine. She worked for 10 years as a secretary for the New Jersey Human Rights Commission. In 1982, her mental health and her job performance plummeted. In 1985, at age 38, she was fired because of absenteeism and use of drugs. She was living with her sisters and her parents, but she left them and went to a shelter in Newark. There, she was expelled for assaulting someone.

Her sisters admit that they then tricked her into a voluntary commitment in the psychiatric ward of East Orange General Hospital in New Jersey. There she was diagnosed as psychotic and given antipsychotic drugs. She resisted these injections. She was locked up for two weeks, during which attendants restrained her in an isolation room. After these two weeks, she was released.

She then fled New Jersey and starting living under various aliases on East 62nd Street. She avoided shelters for the homeless, considering them dangerous for unattached women. She did not contact her sisters, fearing they would commit her.

At her hearing, Brown was articulate, called herself a "professional street person," and answered probing questions:

Q: Why had she torn up paper money given to her? A: "I only need $7 a day to live on. I tore up additional money given to me to prevent being robbed of it at night."[1]

Q: Why did she defecate on herself? "I never did," she replied, although she had used the streets because no local restaurant would let her use its restroom. "I offered to buy something and they still refused."

Four psychiatrists testified for the city that Brown suffered from schizophrenia, should be treated in an institution, and, if left on the street, would deteriorate. They denied that this was "political psychiatry" and stated that Joyce Brown's "self-neglect" was "so severe" that she should be helped against her will. They noted that schizophrenics are often bright and have periods of rationality.

Three psychiatrists testified for ACLU that she was not psychotic, not dangerous, not unreasonable in her answers, and not incapable of caring for herself on the streets. In his summation, an ACLU attorney said the city had not proved that Brown was dangerous to herself or others: "The only evidence the city had is that she goes to the bathroom in the streets. I see that in New York City every day, because there's a lack of public restroom facilities."

In her rebuttal, the attorney for the city replied: "Decency and the law and common sense do not require us to wait until something happens to her. It is our duty to act before it is too late."[2]

In November, Judge Lippman ordered Joyce Brown freed. He had found her "rational, logical, and coherent" throughout her testimony;[3] he said that she "displayed a sense of humor, pride, a fierce independence of spirit, [and] quick mental reflexes"; and he noted that she met none of the conditions set forth in *O'Connor* v. *Donaldson*.

He stressed that even if all the psychiatrists had diagnosed her as psychotic, the city had still not proved Brown was dangerous to others or herself:

> I am aware that her mode of existence does not conform to conventional standards, that it is an offense to aesthetic sense. [Nevertheless] she copes, she is fit, she survives. . . . [s]he refuses to be housed in a shelter. That may reveal more about conditions in shelters than about Joyce Brown's mental state. It might, in fact, prove she's quite sane. [Also] there must be some civilized alternatives other than involuntary hospitalization or the street.[4]

After the hearing, Brown's sisters called the judge's decision "racist" and "sexist." They argued that if his own wife or mother were sleeping on the streets, "he would not stand for it." They insisted that she needed treatment.

The sisters then revealed that after Brown had been hospitalized, they had gotten her declared mentally disabled and she had accordingly received $500 a month in social security disability payments, which they had been holding for her. Brown had refused the money, rejecting the "lie" that she was mentally disabled.

After her victory, Brown and her ACLU lawyers held a press conference, where she said, "I didn't want to play the game before, but now I am. . . . I am going to get an apartment, go back to work, and get my life together." She criticized the city for spending $600 a day on her care: "I could be living at Trump Tower."[5]

Why did Brown appear so different at her hearing than on the streets? Her psychiatrists claimed she had improved rapidly in the hospital. She dismissed their claim, asserting she had never been crazy. She resented being taken into Bellevue like "cattle" and affirmed that living on the street was a rational choice. Her sisters dismissed this assertion: "You might be able to survive one winter, or even two, but you can't survive that way forever."

Mayor Koch blasted Judge Lippman's decision: "If anything happens to that woman, God forbid, the blood of that woman is on that judge's hands." Reminded by a reporter that Lippman had found Brown lucid, Koch replied, "This woman is at risk. When she lay on the ground in the rain, in the snow, uncovered—was that lucid?"[6] When asked if Brown's commitment was "political psychiatry," Koch asked, "*Who* would claim that?" When told that it had been Brown herself, he replied, "That alone proves she's crazy."[7]

The city and Koch appealed to a five-member New York State Appellate Court, before which the ACLU argued that Brown would not return to the streets but would live in a supportive residence for the homeless. The city argued that where she would live was irrelevant: "She was not hospitalized because she was living on the streets [but because] three psychiatrists said she needed medical and psychiatric help."

The appellate court reviewed the testimony of a social worker who said she had observed "fecal matter" on the sheets in which Brown wrapped herself. The appellate court also reviewed the testimony of one psychiatrist who said that Brown had told him she often defecated and urinated on herself. It found that "the evidence presented in this case clearly and convincingly demonstrated her past history of assaultive and aggressive behavior."[8]

The appellate court overruled Judge Lippman, saying he had placed too much emphasis on Brown's testimony instead of the testimony of the psychiatrists who believed she would harm herself. Surprisingly, the majority noted that this case required the high standard of proof of "clear and convincing evidence" rather than the weaker "preponderance of evidence" standard, and that the city had met the higher standard.

After the appellate decision, Koch said, "Up until this moment, the only treatment has been a loving safe environment. Now we will seek to treat her medically." But New York state law required the city to get a court order to medicate her against her will. In 1988, a state judge ruled against forced medication. Bellevue Hospital then released her, saying there was no point in holding her there.

After being held for 84 days and then released, Brown said:

> I was incarcerated against my will. . . . [I was] a political prisoner. The only thing wrong with me was that I was homeless, not insane. You just can't go around picking everyone up and automatically label them schizophrenic. I'm angry at Mayor Koch, the city and Bellevue. They held me down and injected me . . . They took my blood against my will. . . .
>
> I need a place to live; I don't need an institution. . . .
>
> People are treated differently just because of your economic status, [because of] what you look like and where you live. . . .
>
> I was mistreated, mentally abused, and I will never, ever, forget this.[9]

The Aftermath

Joyce Brown was released to live in a hotel for women run by a nonprofit agency. She received several job offers and worked temporarily as a secretary in the ACLU office. In early 1988, she became a celebrity. She received half a dozen movie and book offers and dined at Windows on the World, a restaurant atop the World Trade Center. She appeared on *The Donahue Show* and *60 Minutes*. She loved the attention.

She lectured to law students at Harvard on "The Homeless Crisis: A Street View." She observed, "It looks like I have been appointed the homeless spokesperson."

Then things worsened. Her roommate at the hotel said that Joyce had "a lot of anger inside" and frequently talked to herself. One day, while walking to work, she was heard muttering racial slurs and obscenities. In March 1988, Joyce was begging on a street in Times Square shouting obscenities at passersby. Asked how she was doing, she insisted, "I'm not insane."[10]

In September, she was charged with possession of a small amount of heroin and two hypodermic needles in a Harlem housing project.[11]

During 1989, Joyce lived in a supervised residence for formerly homeless women in Manhattan. Unconfirmed reports indicated that she was in and out of psychiatric hospitals between 1989 and 1994. After a decade of interventions, her physicians discovered that that her primary problem was addiction to drugs, not schizophrenia. At last report, she was drug-free and living on her own, and attended a daily support group for former drug-users.

Thus she never was a true schizophrenic, and hence did not meet the commitment standards of *O'Conner* v. *Donaldson*.

BACKGROUND TO THE CASE

Ideology and Insanity

Early humans believed that the voices characteristically heard by schizophrenics came from the gods. Julian Jaynes claims that the first humans to have identifiable thoughts experienced them as terrifying internal voices, and thinks the human brain evolved as bicameral to control them.[12]

Hippocrates held that mental disorders had natural causes. Plato thought insanity was an imbalance between parts of the mind. Roman physician Galen accepted Hippocrates' naturalistic concept.

The Middle Ages abandoned this naturalistic approach, substituting demonic possession and exorcism. The insane sometimes lived on a *ship of fools*, which sailed from port to port to take on food and water, but which never disembarked its human cargo.

From the 15th to the 18th century, the insane were seen as possessed by demons or as witches, and often killed.

Yet the 16th century saw the founding of Bethlehem Royal Hospital in London, based on naturalistic principles. It had more patients than it could handle. Its name is the origin of "bedlam."

The French physician Philippe Pinel (1745–1826), head of the Bicètre Hospital for the Insane in Paris, unchained his patients, used compassion, and looked for natural causes, all with therapeutic results.

In the 19th century, Quaker institutions practiced "moral treatment," allowing patients to roam the grounds, work in gardens, and to live in a homelike atmosphere.

In the 20th century, psychiatry embraced pharmacological treatments. Its two major ethical issues then were political diagnoses and patient rights against involuntary treatment.

Patients' Rights

If one accepts that the insane need therapeutic help rather than criminal justice, then they need no trial to commit them for treatment. In a benevolent system, committing psychiatrists act in the best interests of patients.

In the 1960s and 1970s, movies such as *King of Hearts* (1966) and the Oscar-winning *One Flew over the Cuckoo's Nest* (1975) attacked such commitment as unjust. Lawyers who defended patients' autonomy argued that psychiatric diagnoses were subjective, that large public mental institutions were coercive, and that checks and balances were needed. These lawyers would eventually batter down the locked doors of psychiatric wards.

On the other side, psychiatry saw itself as benevolent and held that the insane needed treatment. It emphasized that schizophrenia is biochemical and can be objectively identified and treated pharmacologically, but that schizophrenics must be made to take their medications.

Thomas Szasz, a famous gadfly to psychiatry, saw no problem with patients who voluntarily sought help, for the proper role of psychiatrists was to help them. He criticized situations where people like Joyce Brown had psychiatrists forced on them—people who did not see themselves as mentally ill and who resisted intervention. Szasz held that involuntary commitment rarely benefited patients and existed to rid society of strange people.

Szasz's basic position was this: A physical disease, such as AIDS or cancer, has a physical cause. Some mental illnesses have a physical cause in the brain, and these mental illnesses are real. But some so-called mental illnesses have no physical cause; they result from mere problems in living. A mental illness with no physical cause, Szasz famously held, is a *myth*, not a disease. (Note that Szasz did not claim that most mental illness is a myth.)

Szasz concluded that psychiatry could not be objective, or value-free in nonbiological cases. He held that it was "much more intimately related to problems of ethics than is medicine in general."[13] Consider that interpersonal relations—relationships between wife and husband, between the individual and the community, among colleagues, among neighbors—inevitably involve stress, conflict of interests, and strain. Much of this disharmony has to do with incompatible values, and to pretend that psychiatrists can offer value-free approaches is ludicrous: "Much of psychotherapy revolves around nothing other than the elucidation and weighing of goals and values—many of which may be mutually contradictory—and the means whereby they might best be harmonized, realized, or relinquished."

Szasz wonders who truly defines norms of "correct" and "psychotic" behavior. He opposed classification of personality disorders as mental illness. According to Szasz, psychiatry presumes that love, continued life, stable marriage, kindness, and meekness indicate mental health; and that hatred, homicide, suicide, repeated divorce, chronic hostility, and vengefulness indicate mental illness. These presumptions are evaluative, not factual.

A famous study by D. Rosenhan, "On Being Sane in Insane Places," figured in the patients' rights movement. In this study, several sociologists, psychiatrists, and others voluntarily entered mental hospitals, saying that they were "hearing voices"—a major symptom of schizophrenia.[14] Once committed, they acted normally and no longer mentioned "voices." Because of the label "schizophrenic" in their medical charts, the staff continued to treat them as schizophrenic. Ironically, although the staff did not see through the sham, several of the genuine mental patients did.

Legal Victories for Psychiatric Patients

In 1972, in *Wyatt* v. *Stickney*, Alabama federal judge Frank Johnson ruled that a committed mental patient must either receive treatment or be released. Johnson's decision specified the institutional conditions necessary to ensure minimal treatment: at least two psychiatrists, 12 registered nurses, and 10 aides for every 250 patients. For years, most states had not met this minimal standard.

Johnson required state mental institutions to provide individualized treatment plans, to allow patients to refuse invasive electroconvulsive therapy and lobotomies, and to establish the least restrictive conditions necessary for treatment.

Johnson's ruling prefigured the *O'Conner* v. *Donaldson* decision by the United States Supreme Court in 1975.[15] In 1943, at age 34, Kenneth Donaldson got into a fight with coworkers over politics and was knocked out. His parents considered him crazy and petitioned a Florida judge to commit him. Committed, he underwent 11 weeks of electroshock treatment, and was then released.

In 1956, while he was visiting his parents in Florida, his father asked for a sanity hearing, saying that his son had a persecution complex. Donaldson was then committed to Florida State Mental Hospital, where he was held against his will for 15 years. During those years, he constantly petitioned the courts for a new hearing. All the while, he rarely saw a physician and never received treatment. Inside the institution, he was presumed insane and—like Rosenhan's impostors—could not prove otherwise. Finally, in 1971, when his case was about to be heard, he was released.

A lawyer then helped Donaldson sue for damages against the superintendent of the institution, J. B. O'Connor, and the case eventually reached the Supreme Court. The Supreme Court decided for Donaldson, ruling that he should not have been held against his will, even if he was mentally ill, unless he had been dangerous to himself or to others and had no means of existing outside the institution.

The *O'Connor* decision established two necessary conditions for involuntary commitment:

1. Suffering from mental illness (being "insane").
2. Being dangerous to others or being dangerous to oneself.

Note that both conditions, (1) insanity and (2) danger to oneself or others, must be met for involuntary commitment. Judges later interpreted dangerousness as imminent risk to life or imminent risk of bodily harm; "imminent" means within days or hours. The arbiters are two psychiatrists. Evidence of dangerousness to oneself would consist of:

(a) Threats of suicide.

(b) Gross neglect of basic needs.

With these legal changes, the courts moved from a medical model of civil commitment, which had been used in the early 1960s, to a patient's rights model in the 1970s.

In the 1990s, many states added a third requirement for involuntary commitment:

3. Provision of the least restrictive environment by the institution.

Conditions 1 (mental illness) and 2 (dangerousness) applied in all states, since the Supreme Court had established them; two-thirds of the states also applied condition 3 (least restrictive environment).[16]

In some states, the *O'Connor* criteria have been interpreted to mean that a person must commit an *overt act* in order to warrant a hearing for involuntary commitment. This interpretation is controversial and has been opposed by relatives, who can often perceive a pattern of threats and hostility and do not want to wait until someone is injured or killed before a hearing takes place. At present, courts and legislatures are struggling with the implications of this "overt act" requirement.

Deinstitutionalization

These legal decisions entailed the release of many mental patients from large state institutions, because such institutions often could not provide individualized treatment (as required by *Wyatt*) and were not the least restrictive environment.

Other factors also contributed to deinstitutionalization. New psychotropic medications allowed more outpatient treatment. The Kennedy administration had advocated small, community-integrated facilities rather than large, impersonal state institutions. In the words of President Kennedy, "Reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern."[17] Other factors included tight budgets, psychiatrists who sought lighter workloads, and a general distrust of authority in the early 1970s.

All these factors emptied American mental institutions. During the 1970s, 50 to 75 percent of the patients in state institutions were released. In 1955, nearly 560,000 patients lived in state mental institutions; in 1988, there were only 130,000, so over 30 years, nearly a half million mental patients were deinstitutionalized. All levels of government saved money, the ACLU was appeased, and mental patients flooded into communities.

But the "warmth of community concern" envisioned by John Kennedy did not appear. Communities rejected halfway houses, and few facilities were created. Mental patients "living in the community" scraped by on warm-air grates more

often than in group homes. More bag ladies appeared on city streets. Local charities set up soup kitchens for hungry street people. In the 1980s, Reaganites hailed soup kitchens as proof that government intervention was unneeded.

Deinstitutionalization failed to help people with mental illness. It failed because government funds were never allocated for community homes; because communities rejected such homes; because mental health services were fragmented between county, state, and federal agencies; because housing was scarce; and because the legal pendulum had swung toward patients' rights.[18]

During the month Joyce Brown was released from Bellevue, under the expanded criteria, Project Help helped 466 homeless mentally ill people. It estimated that 800 to 1,000 such people were still out on the city streets.

When New York City officials planned Project Help, they assumed that people such as Joyce Brown would stay for a few weeks in psychiatric hospitals and would then be moved into community facilities, where they could live under supervised conditions. When Project Help picked up these people, however, they were far sicker than had been expected. Many more places were needed in psychiatric hospitals than had been planned for.

Violence and the Mentally Ill Homeless in the Cities

In 1977, Juan Gonzalez, a homeless man suffering from symptoms like Joyce Brown's, went berserk on the Staten Island Ferry and killed two people with a sword. As a result, the public clamored for incarceration of *potentially dangerous* mentally ill people. The concept of potential danger soon came to be used to justify holding someone temporarily for a "cool-down" observational period. Gonzalez had been picked up for just such a period and diagnosed as a paranoid schizophrenic just before the killings, but he had not been considered imminently dangerous to others, so he had been discharged.

In 1991, Keven McKiever, a homeless man who had gone to Bellevue Hospital seeking care and had been turned away, stabbed to death Alexis Walsh, a former Radio City Rockette. In 1993, Christopher Battiste, a homeless mentally ill drug abuser, allegedly murdered an elderly woman in the Bronx on a Sunday morning as she came home from church.

Larry Hogue, a homeless, mentally ill, African-American, Vietnam veteran, sometimes lived peacefully on a street corner in the upper west side of Manhattan, but when he took illegal drugs, he became hostile, violent, and what *60 Minutes* called the "wild man of 96th Street." A state judge ruled that he could be involuntarily committed against his will for detoxification, but that he would have to be released "as soon as he decides to seek outpatient care."[19] In 1994, shortly before he was due to be released from Creedmore Hospital, he escaped, committed a robbery for small change, and was soon picked up. He was then returned to Creedmore.

In 1999, two schizophrenic men not taking their prescribed medications pushed innocent people in front of oncoming subway trains in New York City, killing a young woman named Kendra Webdale and leaving the other victim without legs. Both men had a history of violence. In previous years, similar events had occurred:

> Reuben Harris, who suffered from paranoid schizophrenia, had 12 hospitalizations and a history of violent behavior, pushed Song Sin to her death in the same manner in 1995. Jaheem Grayton, who also had a history of violence and severe mental illness, pushed Naeeham Lee to her death after struggling to steal her earrings in 1996. Mary Ventura pushed Catherine Costello into the path of a subway train in 1985, three weeks after being discharged from a psychiatric hospital.[20]

These cases resulted in passage in New York in 1999 of *Kendra's law,* where a psychiatrist or relative can force hospitalization for a mentally ill person who has been hospitalized within the last three years, who has a history of violence, and who will not take his medication. At least 41 states passed laws implementing such Assisted Outpatient Treatment programs, where outpatients can be forced to take medications and remain under supervision (California, Maine, Maryland, Massachusetts, New Jersey, Pennsylvania, and Rhode Island have not).[21]

The courts and the general public have come to expect psychiatrists to be able to predict dangerousness among the mentally ill, but can they? To assess the potential for violent behavior, emergency-room psychiatrists simply ask patients about their own tendencies toward violence and their own past acts of violence.[22] This is not a sophisticated tool, although in practice it seems to work better than anything else.

The famous legal decision *Tarasoff* should be noted here.[23] In this case, Prosenjit Poddarin 1969 confided to his psychotherapist at the University of California that he planned to kill Tatiana Tarasoff, which he did. Tarasoff's parents sued the therapist and university saying they should have broken confidentiality and warned the girl and parents of Poddarin's threat. The actual decision has been misinterpreted to say that therapists must breach confidentiality and warn potential victims when life is at stake. In fact the 1976 decision merely said that, in such situations, therapists have a duty to take "reasonable steps" to protect potential victims, such as notifying police or seeking involuntary commitment.

ETHICAL ISSUES

Paternalism, Autonomy, and Diminished Competence

Paternalism in medicine is treatment of adult patients as incompetents who do not know their own best interests. Under which conditions might paternalism be justified? One condition is *temporary incompetence,* followed by a return of competence. In these situations, paternalism would be justified if patients later agreed with it (for example, people prevented from committing suicide who later agree that they are glad to be alive).

Questions about patients' competence are important in any discussion of paternalism. In this regard, one question has to do with the basic concept of competence. The American legal system tends to treat mental patients as if they were either totally competent and autonomous, or totally dysfunctional and subject to mandatory treatment. Many observers argue that this is a false dichotomy that harms patients. Competence is not an either-or capacity, but a matter of degrees on a gradient.

Another question has to do with what constitutes proof of competence and incompetence. This issue is not necessarily clear-cut: the psychiatrist Virginia Abernethy argues, for instance, that "disorientation, mental illness, irrationality, [and] commitment to a mental institution are not conclusive proof of incompetence."[24]

Abernethy describes the case of "Ms. A," a highly intelligent, independent woman who lived alone in a large house with six cats, in an unheated garbage-strewn room.[25] After a fire in her house, Ms. A was hospitalized but found competent and released. As winter came, a concerned social worker investigated; he found her with her feet black, ulcerated, and bleeding. When he tried to get her to go with him to a hospital, she chased him away with a shotgun. The police later came and forcibly hospitalized her. At the hospital, her feet were diagnosed as gangrenous, and surgeons wanted to amputate; when she refused, psychiatrists began to evaluate her.

It turned out that Ms. A's feet had blackened once before, a few years earlier, and she had recovered. She now hoped for another recovery, but the psychiatrists interpreted this as "psychotic denial" and tried to get her to say that she wanted to live, so that they could amputate. She refused, avoiding their questions. Ms. A was faced with a dilemma: either she had to let the surgeons amputate, or she had to let the psychiatrists conclude that she was in denial and therefore psychotic. It might seem unfair to present a patient with such a choice, and trying to avoid the choice would seem to be reasonable. Amazingly, according to Abernethy, "Her rejection of the two-choice model became the grounds, finally, for concluding that Ms. A was not competent to refuse amputation."

Abernethy analyzed the psychodynamics of this process. First, a false aura of medical emergency "pervaded the psychiatric consultations and judicial process." Second, "Ms. A herself was quick to anger and regarded most interactions with medical personnel as adversarial." Third, Ms. A's anger created anger in those evaluating her competence: "Professionals who think of themselves as altruistic, or at least benevolently motivated, may be particularly sensitive to hostility because they feel deserving of gratitude." Abernethy says that psychiatrists are outcome-oriented and cannot tolerate a patient's self-destructiveness, even in the name of autonomy and even when self-destruction results from an underlying disease that they ultimately cannot stop. Abernethy notes, moreover, that "hope is not a criterion of psychotic denial."

In some ways, Joyce Brown resembled Ms. A. Like Ms. A, she rejected her diagnosis, hoped that she was sane, and thought she could take care of herself. Like Ms. A, she saw psychiatrists as enemies. Acknowledged to be generally competent, both women were claimed to have a *focal incompetence,* a specific incompetence to make decisions about their own treatment. Abernethy notes, "The criterion of a focal delusion is dangerously liable to error because a patient can easily be seen as delusional in an emotionally charged interchange, when in other circumstances he addresses the same issue appropriately." Abernethy sums up: "Competence is presumed and does not have to proved. Incompetence has to be proved."

Homelessness and Commitment

What was the issue in the Joyce Brown case—insanity or homelessness? Mayor Koch and New York City were accused of wanting Brown committed because she was a public nuisance and homeless. Her neighbors were accused of wanting her out of their sight because she offended their affluent sensibilities.

The ACLU, noting that Joyce Brown did not want to leave the street and had never been proven dangerous, argued that her presence embarrassed the rich people in the neighborhood. New York City had thousands of people like her, so why was there no outcry about others? Why did no one write letters to the *New York Times* about the Joyce Browns in the Bronx? Once Brown was gone, how many of her former neighbors on the upper east side inquired about her?

Norman Siegel, executive director of ACLU, extended this argument to Koch and the city as well: "In sweeping up the homeless, the Mayor is attempting to place these people out of sight and out of mind and hide the crisis from the public consciousness." Siegel claimed that Project Help targeted areas seen by tourists and inhabited by the rich.

Even though Koch and the city cared about quality of life in public places, they emphasized that homeless people were picked up for treatment, not to remove them from public places. Homeless people gravitated to rich areas because they were safer there and such places offered them better opportunities for begging.

City officials claimed that Brown's insanity was the true issue and her homelessness merely a side issue. Her ACLU lawyers disagreed: "The Joyce Brown story has captured the issue of the homeless that a lot of people have been trying to deal with for years."[26] The city's goal, the ACLU implied, was how to get homeless people off the streets, not how to treat the mentally ill; city officials didn't seem worried about schizophrenics who camped out in bad neighborhoods.

The ACLU suggested reinstituting public baths (which had been widely available in the city during the depression and earlier) and using condemned housing as temporary shelters. Incarcerating the homeless "for their own good" was a cheap solution; building homes for street people was much more expensive.

No one could deny that the housing situation in New York City was bad: affordable housing was rare. The problem of creating permanent housing for the city's homeless had frustrated many good minds. The city maintained thousands of families in squalid welfare hotels at exorbitant rates. Critics feared that providing rented housing would encourage more people to depend on government handouts; they also pointed out that the city was one of the most expensive places in the United States in which to subsidize public housing.

Psychiatry and Commitment

During this case, ACLU lawyer Robert Levy and psychiatrist Robert Gould, who testified for Brown, emphasized the political dangers of involuntary roundups, handcuffing, forcible injections of medication, and confinement in locked wards. Levy and Gould said that Brown had been examined at least five times previously and had been found "not to require involuntary hospitalization." They claimed that nearly half of the 215 people brought to emergency rooms by Project Help did "not require involuntary hospitalization." Gould and Levy argued that to allow "preventive detention based solely on nebulous predictions of 'future self-destructive behavior'" would invite abuse. They warned of "totalitarian regimes" using psychiatry for control of dissidents.[27]

When confronted with arguments like this, Mayor Koch replied, "This is not political psychiatry! This is not Russia! We're trying to help this woman!"

On the other hand, how broadly should standards of commitment sweep? In cases like Brown's, how many people might be forced into mental hospitals by uncaring or even malevolent relatives? (Isn't this what Barbara Streisand portrayed in *Nuts*?) How many psychiatrists might use medication, time-out rooms, restraints, and continued commitment not as treatment but as punishment for patients who thwart their will?

Part of the debate about Brown's case concerned the ability of psychiatry to help schizophrenics. Judge Lippman noted that the four city and three ACLU psychiatrists had disagreed dramatically, and concluded, "It is evident that psychiatry is not a science amenable to the exactness of mathematics or the predictability of physical laws."

Most psychiatrists objected to this view. They point to schizophrenics who were dysfunctional but who gained years of ability after being forced to take medication. They say that such patients stabilize and become free from delusions and that many patients, if they take their medication regularly, can even return to life outside institutions. The psychiatrist Paul Chodoff defended limited involuntary commitment as follows:

> Is freedom defined only by absence of external constraints? Internal physiological or psychological processes can contribute to a throttling of the spirit that is as painful as any applied from the outside. The "wild" manic individual without his lithium, the panicky hallucinator without his injection of fluphenazine hydrochloride and the understanding support of a concerned staff, the sodden alcoholic—are they free? Sometimes, as Woody Guthrie said, "Freedom means no place to go."[28]

In fact, many people suffering from paranoid schizophrenia can be improved by treatment. All psychiatrists today believe that schizophrenia is a biological disease caused by chemical imbalance, so it makes sense that chemical treatments can help such people.

Suffering and Commitment: Benefit and Harm

Columnist Ellen Goodman argued that the ethical questions in this case boiled down not to whether people like Joyce Brown were likely to harm themselves, but whether they were suffering. Brown should be taken off the streets before she dies there "with her rights on."[29]

But was the matter really so straightforward? To say that commitment is justified to end suffering assumes first that a person is really suffering, and second that involuntary psychiatric commitment can ease his or her suffering.

Consider the first assumption, that the person is suffering. When someone like Joyce Brown protests that she does not need or want help, it can be asked—as Thomas Szasz asked—who can determine that she is "suffering" enough to be locked inside a psychiatric ward? Who bears the onus of proof, the patient or the psychiatrist?

With regard to the second assumption, that involuntary commitment can help, it is important to consider the nature of involuntary commitment. What Brown feared most was another commitment to an inpatient unit like the one at East Orange Hospital. Would she really be helped by involuntary psychiatry, involuntary medication, and involuntary therapy in a locked unit within a large public institution?

Brown's court-appointed psychiatrist had found that she suffered from "serious mental illness" and would benefit from medication—but that she would suffer more from forced treatment than from the mental illness itself. In such a situation, she might harm herself while trying to resist the administration of antipsychotic medications and tranquilizers. Also, commitment might destroy her fierce independence; and if it did not—if she continued to resist—she might end up a zombie, like McMurphy in *One Flew over the Cuckoo's Nest*.

Moreover, the long-term side effects of antipsychotics and tranquilizers can be as bad as the original disorder: antipsychotic drugs, such as neuroleptics, administered over years create tardive dyskinesia in 10–25 percent of patients. This condition impairs voluntary movement, is untreatable, and persists in two-thirds of affected patients when medication is stopped.

It can also be argued that the potential benefits of involuntary treatment cannot be defined objectively. Most psychiatrists, of course, tend to think that people such as Brown benefit from living on medication and thereby losing their inner voices and delusions. But aren't benefit and harm, above the level of basic needs, defined by each person's own self-concept and life plans? As three lawyers write,

> When faced with an obviously aberrant person, we know, or we think we know, that he would be "happier" if he were as we are. We believe that no one would want to be a misfit in society. From the very best of motives, then, we wish to fix him. It is difficult to deal with this feeling since it rests on the unverifiable assumption that the aberrant person, if he saw himself as we see him, would choose to be different than he is. But since he cannot be as we, and we cannot be as he, there is simply no way to judge the predicate for the assertion.[30]

Isn't it a rather shaky application of paternalism to say that Joyce Brown had to be treated so that she could obtain someone else's idea of a benefit? Psychiatrists imply that mentally ill patients suffer internal pain; but if that is so, why don't all patients want to get rid of it? Isn't it illogical—isn't it begging the question—for psychiatrists to explain that patients don't want to get rid of this pain "because they're crazy"?

Housing for the Mentally Ill as an Ethical Issue

Recently, the term "homeless" has been attacked by a new wave of critics as inappropriate for the wandering mentally ill; instead, these critics emphasize substance abuse. They have challenged the ACLU's view that people like Joyce Brown are primarily victims of a greedy or indifferent society which failed to provide affordable housing; they say there is evidence that as many as 85 percent of panhandlers are alcoholics, substance abusers, or mentally ill—and that all of these need treatment.[31] These new critics advocate mandatory treatment and police intervention to prevent panhandling. They urge people not to give money to beggars, saying that those who do give money are "enablers of addiction."

The sheltered or supervised group home remains an elusive ideal. Whether we are discussing severely physically disabled people like Larry McAfee, welfare reform, or the mentally ill homeless, the best living facility for many people is a supervised group home. Living in such a home is much better than being warehoused in a large institution or being left to fend for oneself. Supervised group homes in safe neighborhoods are the perfect compromise between institutionalization and independence.

Urban revitalization made new residents in old neighborhoods intolerant of homeless beggars. No one denied that lack of affordable housing caused homelessness, but few citizens felt government should raise taxes to build such housing. The problem, then, is not with group homes as a concept but with the practical matter of getting group homes for those who need them.

Funding has been one difficulty. In New York, for example, because of AIDS and years of limited funding to balance its gigantic medical budget, places in group homes are scarce; in fact, the shortage of homes has caused a crisis in the city since 1988. Budgets were cut for existing homes, so that some staff members had to be fired and some patients released. The funds saved by cutting group homes were used by legislators for other projects; and now no one seems to know how to get the funding—or the patients—back.

Meanwhile, deinstitutionalization has continued. In 1993, in New York, 2,400 new group home beds had been planned in preparation for the release of 1,000 more people with mental illness from large institutions in 1994, but the number of new beds was later cut to 800. When New York's highest court ruled in 1993 that the City must provide housing for homeless mentally ill patients discharged from city hospitals, the city estimated that it would cost $300 million to do so and disputed the ruling. Nine years later, a study by the *New York Times* exposed widespread failings in the city's adult homes for mentally ill people, "allowing some of its most vulnerable citizens to be exploited in a system plagued by inept, wasteful and fraudulent services."[32]

Many cities emulated New York City's mayor Rudolph Giuliani, who forced homeless people off the streets in the 1990s and into city-funded shelters away from tourists and the affluent. Cities such as Sacramento, Seattle, and Atlanta forced homeless people to move out and did not build new shelters.

When cities tried to build group homes, fights ensued. Residents on Earle Street in Greenville, SC, one of its oldest neighborhoods, sued in 1994 when charities tried to open a sixth group home there. In Alabama, Birmingham's Southside, Forest Park, and Avondale neighborhoods had too many group homes, while surrounding, affluent suburbs had none. All around the country, certain neighborhoods in each city became categorized as "the" area for group homes, where too many were built. Such identification made other neighborhoods passionately resist having even one such home, lest more such homes follow.

In the first decade of the 21st century, lack of housing remains a problem for mentally ill homeless people plagued by drugs, dysfunctional families, poverty, and often, all three.

FURTHER READING AND RESOURCES

Alice Baum and Donald Burnes, *A Nation in Denial: The Truth about Homelessness*, Westview, Boulder, Colo., 1993.

Paul Chodoff, "The Case for Involuntary Hospitalization of the Mentally Ill," *American Journal of Psychiatry*, vol. 133, no. 5, May 1976.

Saul Feldman, "Out of the Hospitals, onto the Streets: The Overselling of Benevolence," *Hastings Center Report*, 13, no. 3, June 1983.

Charles Krauthammer, "How to Save the Homeless Mentally Ill," *New Republic*, February 8, 1988.

J. Livermore, C. Malmquist, and P. Meehl, "On the Justification for Civil Commitment," *University of Pennsylvania Law Review*, 117, November 1968.

The video "Brown vs. Koch" from *60 Minutes* may be available for purchase for a reasonable fee.

Classic Cases in Medical Ethics

Accounts of the Cases and Issues that Define Medical Ethics

FIFTH EDITION

Gregory E. Pence
Professor of Philosophy
School of Medicine and Department of Philosophy
University of Alabama at Birmingham

Boston Burr Ridge, IL Dubuque, IA Madison, WI New York
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Preface

I first started writing this book for my students 20 years ago when I had already been teaching the emerging field of bioethics for 10 years. I wrote this book for them because existing texts failed to convey the excitement of real cases in bioethics. In this fifth edition, I tried to keep the good parts of past editions ("If it's not broke, don't fix it") and to add to, or improve, them.

Every reviewer used some chapters and not others, so it was difficult to cut any chapter. I decided to edit every chapter, sometimes reducing the number of words by a third, while retaining the essence of each. In addition, I added relevant cases and new issues to each chapter.

Like previous editions, this edition was tested on my undergraduates and medical students during 2006. As in the past, my students freely told me of mistakes and biases, improving the book.

If we date the start of modern bioethics to the 1962 God Committee, we're almost at half a century of bioethics. Professors today must both teach about new issues (face transplants) while showing how they build on previous cases (heart and hand transplants). And sometimes one issue ties them together: a desire to be first in surgery.

Personally, I believe that knowing about real cases and how they were resolved is real education in ethics for people who will one day make medical decisions. Like the spreading ripples of a stone in a pond, more and more cases build up spheres of knowledge that are as close as we can teach to what Aristotle called *phronesis* or practical wisdom.

As always, I would like to hear your comments and can be reached at my email address: pence@uab.edu.

Gregory E. Pence
pence@uab.edu