Psychiatrists, State Hospitals, and Civil Rights

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One aspect of the court order that tends to produce fear in the hearts and minds of administrators everywhere is the human rights committee . . . . There has never been a disagreement over the ultimate goal—the best possible treatment for residents. At no time has the present hospital administration considered the human rights committee an adversary.[1]

The advent of civil rights in large mental health establishments has been long in coming. For nearly a century these institutions have flourished as a law unto themselves, their inmates subject to the vagaries of changing treatment philosophy, entrenched personnel, and broad-based social climates of unconcern.[8] Recent alterations in financing, federal encroachment on traditional state prerogatives, optimism generated by new treatment modalities, especially psychoactive chemicals, new and pivotal legal decisions, and enhanced public concern for the civil rights of disestablished social strata have all resulted in substantial attitudinal and programmatic change designed to uphold previously abrogated patient rights.[3,4]

However, in the last half of the 1970s, some reactionary forces have combined to undermine progress in this area. A decrease in financial commitment by the federal government, along with curtailed state revenues, recognition of the liabilities of professional/chemical modulation of behavior, disparity between constitutional law and local court practice, as well as the de facto disappearance of the civil rights movement, have all combined with substantial public backlash to imperil gains yet insecurely established.[6]

In this setting, large state hospitals serving both rural and urban populations constitute a useful barometer of the current "state of the art," and a delineation of some of the actual procedures and processes may serve to emphasize both the problems and potential solutions previously ignored. One such hospital is "Uplands" (Utica Psychiatric Center, Utica, New York), with over 100 years of continuous service and an inpatient population of 700, down from the thousands of only 30 years ago. I had the opportunity recently to work on an "acute" care unit with an average census of 25 inpatients and an average stay of over 60 days; 50 percent of the patients are formally committed, by DCS (director of community services, 3-day commitment), by 2PC (2-physician certification, 60 days), or by CRO (court retention order, 6, 12, or 24 months).

A number of problems in this area have previously been addressed, including distribution of psychiatrists and manpower ratios,[6,7] as well as legal standards and implications of court rulings on both general standards of qualification and treatment necessity in the hospital setting,[4,8] and specific issues relating to standards of psychiatric practice regarding legal liability.[9] Other more general issues, such as different methods in the provision of health-care delivery, are also relevant.[10] My intention in this report is to focus on the attitudes, and the reason for the attitudes, that permit and encourage the destruction of civil rights in the hospital setting.

Gap In care

The attraction of psychiatrists to major medical centers and private urban practice is well known. The result has been a qualitative and quantitative gap in the provision of mental health services to those in circumstances of poverty, multiple handicap, rural isolation, or minority status. Since the nineteenth century, first county, and then state, institutions have attempted to fill this gap.[11] The development of a more precise psychologic and pharmacologic technology, aimed at emotional and behavioral disturbance, augmented demands for a treatment function as distinct from mere custodial care for the populations both underserved and at risk. Because of these demands and the nature of the institutions' work setting, the state sought to fulfill its mandate through the employment of underqualified, semiretired, aging, and foreign physicians. In harmony with the well-established principle of "downward drift" in patient populations, there has been an established downward drift in the physician-psychiatric population. The point has now been reached where the state hospitals are a sanctuary, not just for the welfare patient, but also for the welfare physician; these are physicians who frequently are unable to gain employment elsewhere, who have failed in private practice, who are unemployable as a result of national barriers or state restrictions on the free commerce of physicians (both foreign nationals and intrastate "psychiatrists"), who are looking for less responsibility, more security, a pension retirement plan, and any of a number of state-related job and fringe benefits that rule out the highly motivated and

competent physician in favor of those already in a holding pattern or with downward mobility.

The second technique the government monopoly has used to fill its mandate has been the continuous fissioning of roles. Not only have therapeutic responsibilities been diffused by the creation of a whole new generation of nonmedically trained therapists—and this is in an era when the development of the science and technology of mental restructuring has reached new heights of sophistication—but also the social responsibility of the state physician has been attenuated by the development of a separate group of health professionals who are essentially administrators or are systems management personnel. Thus, hiring, firing, insight into the therapeutic effects of the team, and so forth, are all delegated to an administrative branch. The goal of therapy then, of treatment and of cure, is thus necessarily subordinate to that of smooth institutional function and of administrative priority. In view of the burgeoning mental-health bureaucracy, this may justly be termed the "politicization" of psychiatry; of course, this is now an issue precisely because (A) mental-disturbance illness is out of the closet, in the public eye, and (B) the science of behavioral alteration is groping for maturity.

In this circumstance of the employment of marginal "psychiatrists" as treatment captains, and the subordination of treatment to administration the civil rights of patients are at the mercy of those persons least likely to reflect on or be responsive to the crucial issues of individual liberty versus social power at stake. The following cases are some instances in point.

Case reports

Case 1. A 36-year-old white male, an ex-alcoholic, on the night prior to hospital admission ingested 20 tablets (200 mg.) of diazepam (Valium), called his family, and was taken to a general hospital, from whence he was sent, on a DCS, to the State hospital. On examination the following day, he had no thought disorder or psychosis, and expressed disbelief and consternation over his involuntary hospitalization. He denied insomnia, but said he had been losing weight for over one year due to separation from his wife and children. On the previous evening, his wife had refused to let him see their children (ages 2 to 12), and he felt hopeless and suicidal. He wanted to return to his job immediately; this was his first hospital admission.

Case 2. A 35-year-old white woman, of Irish extraction and modest intelligence, had a 10-year history of multiple hospital admissions, usually after a marital dispute with a known alcoholic husband. On occasion she admitted experiencing voices and visions. She came in on a DCS with an allegation, which she denied, that she had threatened to kill her husband by turning on all the gas burners. She snorted at this story, saying "I should have called the cops myself; that no good drunken bastard, he railroaded me in here, why didn't they take him?" Mental-status examination revealed no thought disorder, no voices or visions, or no marked mood alteration. She was admitted for observation because of lack of adequate placement and past history.

Case 3. **A** 21-year-old black male was discharged from "Uplands" three weeks prior to this current admission. He had come in on a 2PC, with allegations of delusions and homicidal threats. On examination, he said "That's (the threats) none of your business. Everybody has to let off some steam. You can't just hold it all in." He became angry at further questioning, and his thoughts became disordered and lacked direction. He admitted to no delusions or hallucinations, and claimed "I have papers to prove I'm not crazy." He said that everybody had lied to him about being committed, to which the staff who brought him in agreed; they had stated "It's for your own good."

Case 4. A 19-year-old white male in treatment for schizophrenia had entered "Uplands" voluntarily for three days and then wanted to be released. He displayed some hostility toward "captors," continued his repetitious demands (obsessional?), but no overt delusions or hallucinations were apparent. Past threats toward his mother and lack of a currently available secure/acceptable "placement" were part of the story. He was first told that he must petition in writing for discharge (that gives the director of the hospital 72 hours to accede or to move for retention). The next day he was told his request would result in retention; he withdrew the request, preferring "voluntary" status.

Case 5. A 42-year-old white male had been hospitalized for three months with a diagnosis of "schizophrenia, undifferentiated." He originally had been committed on a 2PC because of weight loss, refusal to eat, and hyperirritability. Neurologic examination revealed no disorders. I received a note in my mailbox, "Dictate a CRO on your patient." Examination of the patient found him motivated to stay in the hospital and willing to sign voluntary papers. No thought disorder or psychosis was evident, although he appeared, but did not admit to being, depressed.

Comment

Each of these five cases serves to exemplify one most significant principle, that is, the ease of involuntary commitment. Additionally, they shed light on the factors that support this facility.

Case 1 shows that the possibility of suicide, even in the absence of other criteria that might validate a diagnosis of a treatable mental illness, is sufficient to provoke a commitment. Even granting that the potential risk for suicide is substantial, based on such other factors as age, marital status, history of alcoholism, recent separation, and so forth, the lack of independent evidence for mental illness that would include a finding that the suicide potential is the result of mental illness or that the illness is one treatable only in the hospital, would appear to vitiate the use of a mental hospital for this singular purpose of incarceration. This is a point that Szasz[12] has repeatedly made.

Case 2 makes the point that disparities in social power may frequently be the focus for decision making. Thus, it is not the placement of the drunken (?) husband that is at issue, but, rather, the

wife. This is a repeat of the scenario that led to the famous "Packard Case" of over one century ago, and is continued evidence of the vulnerability of minority or low-status groups, that is, in this case, women. Beyond that, the history of prior multiple hospitalizations was an additional weighted factor in her commitment The abuse had happened so frequently that it had become a commonplace; even the patient could muster only a slight indignation at the injustice.

Case 3 illustrates the difficulty that faces the examining officer in an attempt to separate lie and fraud from truth, and legitimate anger at being tricked, from a general excess of anger in conjunction with a disorder of thought, such as paranoid schizophrenia. Furthermore, in what is a trial without jury where deprivation of civil liberty is at stake, there appear to be no rules of evidence applicable in standard form. This constitutes an arbitrary proceeding and one in clear conflict with standards of due process and equal protection of the law, in effect, a preventive detention in a system coordinate, but not in accord, with standards operative in a criminal jurisdiction. Furthermore, the indisputable evidence of prior hospitalizations should suggest that the patient is "not treatable," since no prior "treatment," including the most recent hospitalization, has managed to cure him of his threatening behavior, if indeed it is present. Is hospitalization under this added circumstance lawful?

Case 4 illustrates the involuntary status of a "voluntary" patient.

Case 5 illustrates a most morbid propensity on the part of the institution. Whereas the first four cases exemplify a legitimate confusion regarding the mental state of the patient, or ambivalent or hypocritical legal standards surrounding questions of due process—in effect failures in the rule of law to provide a necessary, if arbitrary, resolution of borderline issues—Case 5 makes a different point. The institutional dehumanization of the psychiatrist goes on apace. The psychiatrist here was expected to conduct not an objective examination but a ritual disenfranchisement. This is not uncommon with respect to the fulfillment of job duties that seem to bear little relationship to the therapeutic task. In the preparation of progress notes, the dictation of summaries, and so forth, the psychiatrist may be asked to perform without benefit of examination, solely on the basis of notes made by others. I do not know whether or not this is legal, but I do know it is standard operating practice. It is part of the existing balance of power in favor of administration as compared to treatment goals. In this case, however, the psychiatrist is asked to become a team player whose judgment is subordinate to another (a psychiatrist?); this is clearly contrary to both medical ethics and law regarding medical responsibility. Such cases may be uncommon, but in this particular institution they bespeak an attitude that is prevalent Furthermore, discussion of this particular issue with the supervising psychiatrist of the unit suggested that this attitude had the highest administrative sanction.

At this point one might well ask, where is the mental-health rights worker, that person designated by the state to ascertain that the civil rights of patients are respected? On the one hand, a disorder of communication, such as schizophrenia, may make this job well nigh impossible, unless the protector is also a psychiatrist, or trained in the vagaries of disordered communication; to protect rights at the individual level, one must first identify what a person desires as well as what is right In no small way is the decoding of psychotic communication one of the first tasks of the psychiatrist. On the other hand, the mental-health rights worker may be handicapped by logistic problems. One patient on our unit refused to discuss his own rights with the worker, during the limited time allotted. A further difficulty is that the procedure for gaining civil rights may require skills, such as reading and writing, that are not possessed by the hospitalized victim. Finally there are the catch 22s, the ambiguities in procedure, and the attitude of staff to the exercise of legitimate rights that may make their exercise within the hospital setting , impossible or intensely frustrating, even to the well-adapted and highly functioning individual The securing of rights in a highly complexified society is in itself a mark of both talent and ambition, and there are many among us, both inside and outside those hospital or prison walls, who prefer an erosion of these rights to the hassle involved in their personal or individual maintainance.

Despite adjudication and review by courts, entreaties by civil rights groups and mental .patient liberation organizations, widespread publicity of abuses of power through film/television and newspaper commentary, and the clear commitment of the State Office of Mental Health to the firm support of the civil rights of mental patients, the abuse continues.[13] What is needed, what is imperative, is an institution devoted to both civil rights and therapeutic service, as well as personnel who will understand and uphold the basic tenents of the Constitution and the Bill of Rights. From a professional perspective this cannot be done by persons untrained, inexperienced, and uncommitted to the traditions or specifics of a government of law, a limited government. Nor can it be done when the insulating power of an institution allows persons of designated responsibility to escape the consequences of their behavior, either through role fragmentations or the subtle and shared delusions of group responsibility and institutional loyalty.

Some groups seek to fortify existing laws and press for further separation of therapeutic and legal concerns.[4] Others believe this approach is misguided and futile, based itself on an incorrect analysis of mental disorder and behavioral disruption.[12] From this has arisen an attitude that enhancing the punitive effects of wrongful decisions (for example, civil suits) will strike the psychiatrist where it hurts most,

in the purse. This approach, besides requiring extensive time, effort, and expense, will predictably result in higher malpractice rates and will drive practitioners into the womb of richer and more secure institutions. It is easier to collect from the individual psychiatrist than it is from the state. The traditional approach, to further separate the roles of those who treat versus those who protect, suggests a further schizoid dichotomization ("that's not my role") among those most capable of protecting the interests of patients, that is, psychiatrists. Furthermore, interpenetration of legal and mental health systems then occurs on the next, or administrative, level, resulting in the co-opting of one system by the other.[12,14]

A third possible approach has not received adequate trial. Claims to civil rights may be placed within the context of treatment by reference to effects on such attitudes as self-esteem and enhanced status within the social milieu; we know too little about these potentially therapeutic effects on patients,[16] and almost nothing about the effects on psychiatrists. Historically, however, we can note that the invalidation of the social human being comes about through the dehumanization of the captor, turning them from responsible moral agents into cog-in-the wheel parts of the machine. Although it may seem paradoxical to look for the therapeutic effects of upholding values of rule by law and civil rights, -it is certainly tenable.as a strategy in the struggle. Furthermore, an open mind on the issue may suggest that both parties to the dispute have a partial claim to truth. If this is indeed the case, the level of dispute may be advanced from the ongoing and frequently implicit and anecdotal claims now in currency. In those areas that continue to be problematic, the law may clarify its expectations regarding psychiatric behavior, and those legitimate personal concerns that make us "poor lawyers at the expense of good doctors" may be laid to rest.

Recommendations

Following are suggestions to correct these inequities:

1. Fortification of forensic training of psychiatrists.
2. Elevation of standards for psychiatrists within state hospitals.
3. Civil rights caseworkers present on admission, ex-roental-patient rights workers present, if agreed to by patient.
4. Abandonment of DCS commitment. The social workers and others who are exercising this power are subject to insufficient scrutiny and lack of expertise. The DCS is clearly preventive detention (danger to self/others) and should be effected, if at all, by the police powers of the state. The police can hire their own psychiatrist for treatment, if necessary, in analogy with other illnesses. If this DCS system is not eliminated, abuse will continue, for this is the easiest, most facile voluntary commitment, and, once committed, it is much harder for the patient to get out. Alternatively, only forensic psychiatrists, with a strong commitment to the Bill of Rights should exercise judicial power, and they should be appointed or elected as judges for this purpose.
5. No voluntary patients should ever be placed in a locked ward, and they should retain all rights retained by all voluntary patients everywhere regarding consent to treatment, restraints, and so forth. Conversely, committed patients should be subjected to any humane treatment that is acceptable as part of a regimen designed to effect a curative change with respect to that condition and only that condition that necessitated their commitment, and no treatment regarded as "experimental" and in need of any extraordinary consent procedure should be permitted. This change should do away with the dual hypocrisy of imprisoning voluntary patients, and of treating involuntary patients as if they were the physicians in charge of their own treatment
6. Psychiatrists should be responsible for the hiring and firing of treatment staff and the delegation of administrative power. The current orthodoxy permits blatant political abuses of treatment, as well as the deterioration of an atmosphere designed to advance treatment as the first priority of the hospital

Summary

Because of the immoderate use of involuntary hospitalization, large state hospitals retain their historic identity as repositories of the halt, the lame, the infirm, the debtor, the impoverished, the intellectually disabled, the lazy, the multiply disabled, the elderly handicapped, and the criminal. They continue to function as nineteenth century asylums and as charity institutions for the custodial care of those whom society prefers to label "sick" rather than "needy," and "insane" rather than "criminal." One of the primary'mechanisms supporting this historic role is involuntary hospitalization. In this sense, the arguments of civil libertarians have a firm basis in fact The abuses of present standards of civil liberty continue, owing in large part to the designation of the psychiatrist as either the instrument responsible for the maintenance of civil rights or the leading instrumentality in the treatment and cure of the patient. Several solutions are presented to reverse this trend.

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letters to the Editor

Psychiatrists, state hospitals, and civil rights

To the Editor The article, "Psychiatrists, State Hospitals, and Civil Rights"* in your November, 1980, issue raises significant questions, I believe, about responsibility of medical journals toward flagrantly unsupported content of published articles. In this instance, Dr. Many, in the midst of an uninformed, if well-intentioned support of mental patients' civil rights, goes on to describe our State Hospitals as...

> a sanctuary, not just for the welfare patient, but also for the welfare physician; these are physicians who frequently are unable to gain employment elsewhere, who have failed in private practice, who are unemployable as a result of national barriers or state restrictions on the free commerce of physicians (both foreign nationals and intrastate "psychiatrists"), who are looking for less responsibility, more security, a pension retirement plan, and any of a number of state-related job and fringe benefits that rule out the highly motivated and competent physician in favor of those already in a holding pattern or with downward mobility.

The physicians which Dr. Many describes are, in fact, licensed by New York State (only approximately 150 of 865 have limited permits). Of the 715 who have full licenses, approximately 350 are certified by the American Board of Psychiatry and Neurology. Many are nationally distinguished physicians, some of international renown.

Most alarming is the arbitrary designation of public service physicians as inherently inferior to their privately-oriented, ostensibly more socially acceptable colleagues. I deny and deplore this designation, and request that your Journal communicate the data I have supplied.

There is no longer any need to exhort physicians concerning their responsibility to the underserved populations in our society. There is a need, however, to begin bestowing some commendation on those physicians who have already chosen to fully accept that responsibility.

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Psychiatrists, State hospitals, and civil rights*

To the Editor: The article by Setb E. Many, M.D., in the November, 1980, issue of your journal entitled "Psychiatrists, State hospitals, and civil rights," does a disservice to the State hospitals, the psychiatrists working in them, and to the patients.

Dr. Many states that the physicians in the State hospitals have failed in private practice, are unemployable, look for less responsibility and more security, and that highly motivated and competent physicians are ruled out. This demeans the physicians in the State system, many of whom are members of our Association. These psychiatrists have my admiration for working in difficult circumstances, with generally the most disturbed group of patients. This article might make it more difficult to recruit and retain physicians for the State system.

Information which I have obtained from the New York State Office of Mental Health—which presumably was available to Dr. Many—is that over one half of the psychiatrists employed are Board certified. This compares well with the national average. Of the 865 psychiatrists in the State system, 715 are fully licensed by the State of New York and the other 150 have limited licenses. This surely does not correspond to the picture of the State hospital psychiatrist as described by Dr. Many.

Dr. Many asked for the elevation of standards for psychiatrists working in the State hospitals. I wonder how this article leads to that desirable end.

On behalf of the New York State Psychiatric Association's 4,000 members, I would like to state that we strive constantly towards our primary goal—improving the care of all patients we serve. We welcome the conjoint efforts of our medical colleagues in this ongoing constructive endeavor.

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Dr. Many's reply

To the Editor: The topic of my paper (Psychiatrists, State hospitals, and civil rights) was clearly spelled out: "... a focus on the attitudes, and the reason for the attitudes, that permit and encourage the destruction of civil rights in the hospital setting." Notwithstanding, the factual issues raised by Dr. Bluestone deserve comment.

Bluettone: "Of the 865 psychiatrists in the (N.Y.) State system..."

Many: In fact there are 1,035 psychiatric positions. One hundred ninety-two are vacant That is, one place is vacant for each four psychiatrists employed. Given low median salary, poor morale, staggering paperwork, and so forth, what is the real payoff?
Answer: Steady State employment, pension plans, limited responsibility, malpractice protection, and "perks," and so forth.

Bluettone: "...715 (psychiatrists) are fully licensed by the State of N.Y. and the other 150 have limited licenses."

Many: A limited license is insufficient to permit psychiatric practice in the general population. Why is this experiment permitted on

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* Many, S. E.: Psychiatrists, stale hospitals, and civil rights, New York State J. Med. 80:1873 (Nov.) 198a

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patients in State mental hospitals?
Answer: "... the governmental license authorized limited practice in the institutional settings which are less appealing to U.S. medical graduates; in the last few years some of these institutions have come to depend heavily for their supply of physician manpower upon the growing population of foreign medical graduates."[1]

Bluettone: "Over one half of the psychiatrists employed are Board certified. This compares well with the national average."

Many: (1) Close to one half of the psychiatrists employed in New York State are *not even* Board Eligible (precise data not available from N.Y.S. Office of Mental Health). Board eligibility is a measure of the completion of an accredited psychiatric residency program. It is the crucial index of postmedical-graduate psychiatric training.
(2) A relationship between Board certification and competency in either general or forensic psychiatry has yet to be demonstrated.*
(3) National standards for the competent practice of forensic psychiatry have not been established. My experience in California, a state with the strongest pro forma patients' rights protections, suggests an erosion similar to but worse than that in New York.[9]

I have identified psychiatrist "downward drift" as one of the factors instrumental in an erosion of patient civil rights. Yet downward *clinical* drift may coexist with upward *administrative* drift Getting of the front (clinical) lines is rewarded in most states by higher pay, off-ward offices, secretarial support, and so forth. Administrative expedience appears to preempt patient rights in such circumstances.

I have suggested the fortification of psychiatric forensic training and the elevation of standards for state hospital psychiatrists. In their quasi judicial role, psychiatrists must have more than just a passing familiarity with standards of due process and constitutional safeguards against the abuse of authority. Competency based training and the elimination of limited licensure might be just such a first step. Beyond that, history suggests that patients at risk for the psychiatric abuse of authority need objective safeguards, such as those indicated in my report.

In all. Dr. Bluestone's comments help to underline my observations. His elaborated concerns are those of the representative of a professional interest group with a strong, state, bureaucratic affiliation.[4] He prefers to ignore the core issue, which is the disparity between a constitutional standard of law and the de facto psychiatric deprivation of patient civil rights. Hopefully, psychiatrists in N.Y. State employ are neither less competent nor more disturbed than those in other states or even in private practice. Yet arbitrary role requirements and professional drift patterns leading to State employment may play a special part in psychiatrist insensitivity and hostility to issues of social justice. Erosion of civil rights should not be concealed by appeals to psychiatric patriotism. We need to see what is actually happening in our State mental hospitals. Then we need to change it

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* Upward mobility may increase mental instability as measured by suicide among some physicians.[2]

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