texas research institute of mental sciences houston march 1981

# legal issues in treatment

New mental health-legal issues of concern have been raised recently: the extent of our duty and liability in treating dangerous patients, and the right of the patient to refuse treatment and that of the therapist to refuse to render it.

### dangerous patients

Two recent court decisions dealt with the physician's duty in caring for dangerous patients. The courts defined this duty and imposed liability when that duty was breached.

The first case, *Simmel* v. *Psychiatric Institute of Washington, D.C.*, 538 F. 2d 121 (1976), was filed by the parents of a girl murdered by a patient of the institute. The patient had been on probation and committed for treatment. After a course of inpatient treatment he was transferred to day hospital status with the knowledge and permission of the court. During both his stay in the hospital and day treatment center he received weekend passes. After four months in day treatment, the patient was transferred to full outpatient status without the knowledge and consent of the court, although the probation officer had agreed to the transfer. It was during this period, when the patient had only twice-weekly contact with the Psychiatric Institute staff, that the Simmel child was killed.

The plaintiff alleged that the Psychiatric Institute had a general duty to protect the public and that the failure of the staff to obtain the court's permission to change the frequency and duration of the patient's treatment was a breach of that duty. In its opinion the court emphasized the patient's change in status.

To most mental health professionals such a change in status is part of the natural course of events in treatment. The fact that the probation officer had agreed to the change did not relieve the Psychiatric Institute or the physician of liability for not notifying the court.

The second case was also a murder case. *Neal* v. *Donahue,* 611 P. 2d 1125 (Okla. 1980), was a suit against the Oklahoma Central State Hospital, its superintendent, Dr. Donahue, and the treating physician, Dr. Sullivan. The court found that protection of the public through involuntary hospitalization was a proper governmental function and that the hospital was immune from liability. The court dealt with the failure of the hospital superintendent to establish policies to resolve a situation such as the one in this case. The court found that Dr. Donahue had acted in good faith in not promulgating standards and was thus immune from liability.

The court took a different approach to the conduct of the treating physician. The court stated that if it could be shown that Dr. Sullivan *knew or should have known* that his patient had a propensity to murder small children, then his conduct in releasing the patient without notifying the court "could fairly be construed to amount to willful, wanton acts on the part of Dr. Sullivan" and take him outside the scope of protection offered by governmental immunity. The Oklahoma Supreme Court thus sent the case back to the lower court for trial against Dr. Sullivan.

The message of these cases is clear: If we are to treat dangerous individuals who are under court order, we have a burden not found in other treatment programs, and that is the duty to keep the court informed of the patient's treatment course. Failure in this duty may result in institutional or personal liability by the staff for the patient's acts.

### patients' and therapists' right to refuse treatment

Recent court decisions have focused on the right of patients to refuse treatment. Most widely known is *Donaldson* v. *O'Connor* in which the United States Supreme Court set forth the principle that a nondangerous person may not be confined against his will. Kenneth Donaldson maintained during his entire incarceration that he did not require any treatment and refused some treatment that was offered. His refusal was interpreted as evidence of his paranoid condition; hence, the more he protested his sanity, the more convinced were his doctors of his need for treatment. A Catch-22 worthy of Joseph Heller.

What then of the patient's right to refuse treatment when the patient is properly committed involuntarily (in Texas defined as mentally ill, dangerous to self or others, and able to benefit from hospitalization)? Clearly the patient has the right to refuse such invasive procedures as psychosurgery and electroconvulsive therapy. But what of generally medically accepted

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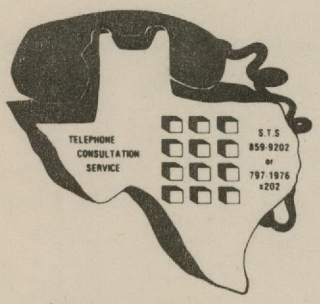
TRIMS therapy notes

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psychotropic medication? Can an involuntarily committed patient under nonemergency conditions refuse to take it?

Based on recent court decisions, I believe that the patient has the right to refuse *any* proffered treatment, but that such a refusal has certain logical consequences which the patient should understand. Therapists and public institutions are obligated to serve patients who seek treatment. One consequence of refusal by a patient may be the patient's discharge from treatment.

In the case of an imminently dangerous patient, the institution has an obligation to society *not* to discharge the patient; however, more than the minimum of food, clothing, and housing necessary to maintain the patient must be provided.

Patients may be uncooperative because of their mental condition or because of their personality. Before such a patient is discharged from treatment, clinical decisions must be made about the patient's condition and the need for referral and follow-up.

*—J. Ray Hays, Ph.D., J.D.*