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Involuntary Commitment and Treatment of Persons Diagnosed as Mentally Ill

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Introduction

The ethical issues involved in the practices of committing and treating persons diagnosed as mentally ill against their wills are extraordinarily complex, and strike at the very center of Kantian conceptions of personhood. This article seeks to lay out these issues systematically, report on current scientific understanding of, legal precedents for, and the state of philosophical assessment of these practices, and to indicate the directions in which additional philosophical work needs to be done. Much of what I say will apply, with little alteration, to the ethical issues involved in our practices regarding retarded and multiply-handicapped individuals.

A survey of the literature on the ethics of involuntary commitment and treatment suggests that there are four broad groupings of issues:

1. Issues involving the very concept of mental illness, theories of mental illness, and diagnostic application of terms such as "paranoid," "schizophrenic," "manic-depressive," and the like.
2. Issues involving the involuntary commitment of individuals to whom such terms have been applied to institutions, hospitals, or other restrictive environments.
3. Issues involving the treatment of such individuals, through psychotherapy, introduction of pharmacologic agents, surgery on the brain or other body parts, electroconvulsive ther-
apy and other therapies involving subjecting the body to unusual stimuli.

(4) Issues involving the release of persons classified as mentally ill.

That the first group of issues involves important ethical dimensions should be evident from the fact that psychiatric labels operate in a variety of ways to classify behavior in contexts where questions of responsibility, competence, and culpability are at issue. That the second group involves important ethical considerations is evident from the fact that, given that involuntary commitment entails a restriction on liberty, questions of whether such restrictions can be adequately justified are at issue. That the third group involves ethical questions is evident because we know that virtually all of the current and historical treatments for mental illness involve some potential for harm to the individual, and that the usual means of defusing such potential for harm of its ethically (and legally) onerous qualities is voluntary consent by a competent individual—putatively absent in cases of involuntary treatment.

That the last group of issues involves ethical concerns is clear because we see how inevitably the question of protection of both released individuals and others from harm arises out of our scepticism that those released are cured of the conditions that merited their involuntary commitment and treatment in the first place.

**Ethical Issues Involved in Diagnosis of Individuals as Mentally Ill**

Thomas Szasz, a psychiatrist, has been the chief critic of the concepts of mental illness and mental disease. In a series of articles and books, he has argued the following theses: (1) the concept of mental disease is a metaphor; (2) when analyzed, applications of the term either apply to bodily disease "for example, to individuals intoxicated with alcohol or other drugs, or to elderly people suffering from degenerative disease of the brain," or to objectionable behavior of persons who "are socially deviant or inept, or in conflict with individuals, groups, or institutions"; (3) for those in the former group, the ethical principles of ordinary medical decision-making are appropriate; (4) for those in the latter group, the normal social, moral, and criminal sanctions of society are appropriate; (5) there is no class of individuals whose behaviors are not properly classified as either normal, consequent upon bodily disease, or properly dealt with through social, moral, or criminal sanc-
(6) therefore, mental illness is an empty category, for the phenomenon does not exist in the field of human behavior. Szasz and others, on the basis of these theses, argue for the abolition of involuntary commitment.

Not surprisingly, there has been a large number of psychiatrists and others who have disagreed with one or more of Szasz's theses. They note that there are broader conceptions of illness than those involving "the demonstration of unequivocal organic pathology." For example, Talcott Parsons, a sociologist, extends the medical model to include "certain forms of social deviance as well as biological disorders," namely, ones characterized "by being negatively valued by society, by 'nonvoluntariness,' thus exempting its exemplars from blame."

However, the more philosophical issues lie in the first two theses. Can it be established by analysis of the concept of mental disease that its applications are either to bodily diseases or to socially objectionable behavior for which criminal sanctions are appropriate? At stake here is an account of the cause or causes of some particular item of behavior. Only by tacitly appealing to some physicalistic account can it seem that "mental disease" involves a metaphor, that there could not literally be a mental cause of some objectionable pattern of (bodily) behavior. Even if one accepts that the thesis of psychophysical correlation is shown to be highly likely by increasingly sophisticated psychophysiological research, it is the research, rather than any sort of conceptual or linguistic analysis, that establishes it.

Moreover, Szasz does not have a category for bizarre behavior that cannot be definitively categorized either as resulting from known organic pathology or as from within the individual's proper domain of responsibility. There is not even the notion of a temporary category for behavior that is involuntary but due to no known physical disorder. It is important to remember that categorization of behavior is not merely an intellectual exercise consequent upon acceptance or rejection of a theory; categorization serves some very important functions of both a pragmatic and procedural character.

One might imagine the system of justice that would be predicated on Szasz's two-fold classification system. If a *prima facie* socially incept, morally otiose, or criminal act could be ascribed to a bodily disease, then a case might well be made for excusing the act from social, moral, and criminal sanctions; but if no such known bodily disease is implicated, the only recourse would be the route of sanctions. Were our science of human behavior complete, our diagnostic powers efficient, and our attitudes enlightened, Szasz's proposals might prove to
be the truth of the matter. Until so, though, they strike one as theoretically speculative and as mistakenly taking empirical issues to be conceptual ones.

Having said that, one should add that much of Szasz's criticism of the system of involuntary institutionalization is fair and points to grave injustices that merit swift and drastic redress. One of the most objectionable practices in his view has been that of involuntary commitment of those diagnosed as mentally ill.

**Ethical Issues in Involuntary Commitment**

Involuntary commitment essentially involves the unwilling loss of liberty, as well as the contingent loss of many other rights. Since liberty is widely regarded as a human right that underlies the political, social, and moral orders, the first task is to inquire into the possible justifications for depriving individuals of liberty on the grounds that they are diagnosed as mentally ill.

Six such grounds have been adduced in justifying civil commitment: (A) the need for protection of property; (B) the need for custodial care (protection from the consequences of unsupervised contact with the natural or social environment); (C) the need of family, neighbors, or general society for relief from the burden of care or contact with the mentally ill person; (D) the need for treatment; (E) the need for protection from self-inflicted harm; (F) the need for protection of others from harm. The second, fourth, and fifth grounds are sometimes subsumed under a common rubric of dangerousness, but since the possible grounds of dangerousness to self and dangerousness to others are not congruent, it is advisable to address these separately. Each of these grounds is discussed *seriatim* in the following sections.

**Protection of Property**

Recognition of this justification as independently valid for civil commitment elevates protection of property to a position higher than that of protection of liberty. When this is a factor in a psychiatrist's recommendation of commitment, it is usually combined with some other factor such as protection of persons, as in commitment of children for pathologic incendiariam. The lack of normal criminal punishment options in the case of minors may well be a factor in the relatively high incidence of property-related commitment of adolescents. Walker sensibly suggests that simple property offenses be excluded from consideration as grounds for commitment, arguing that (a) measures such
as detention should be used only to "prevent serious and lasting hardships to other individuals, of a kind, which, once caused, cannot be remedied"; and that (b) most loss or damage to property can be remedied by recompensation.

Custodial Care and Protection from Harm
Although a mentally ill person's behavior may pose no threat to others, the loss of touch with reality may be sufficient to render the afflicted individual unsafe in the normal environmental setting. With this rationale, involuntary commitment is seen as justified under the principle of beneficence as preventing harm to oneself. However, this involves a fundamentally different subordinate principle, that of paternalism. "According to this position, paternalism could be justified only if the evils prevented from occurring to the person are greater than the evils caused by interference with his liberty and only if it is universally justified under relevantly similar circumstances to treat persons in this way."

Although it is obvious that an alternative to involuntary civil commitment of individuals who are vulnerable prey for others is restriction of those who would prey on them, not all "environmental" risk dwell in the exploiters of the weak; mental illness may manifest itself in a lack of ordinary caution with respect to such daily hazards as traffic and household dangers, and inattention to normal dietary and hygienic needs or to special pharmacological regimens. Protective custodial care is often seen as the only effective measure to preserve the health and welfare of the mentally ill person. It still might be argued that such custodial care can be provided in a manner consistent with the principle of liberty, through the ministrations of family or friends. Such support systems are not always available, however; in addition, there is a question about the obligatoriness of serving in such a role—one that entails such a considerable burden and compromise of lifestyle as to constitute an unjust burden that other individuals cannot fairly be required to undertake. (Important societal differences are involved here; this option of custodial care within the family may well appear to be a more reasonable one in a social setting where there is a strong tradition of multigenerational families with various members not pursuing independent careers outside the home available to fill the supervisory role.)

Hence, the protection of an individual from the distortions of his or her own mental disorders through civil commitment comes to be regarded as legitimate by virtue of a complex application of both the principle of beneficence and the harm principle, preventing harm to the individual (beneficence) and to others who would be unduly burdened by the duties of care (harm).
Relief from the Burden of Care

In Wyatt v. Aderholt, Governor George Wallace argued that “the principal justification for commitment lies in the inability of the mentally ill and mentally retarded to care for themselves. The essence of this argument is that the primary function of civil commitment is to relieve the burden imposed upon the families and friends of the mentally disabled. The families and friends of the disabled, the Governor asserts, are the ‘true clients’ of the institutionalization system.” Wallace concluded that “(T)he providing of custodial care alone is a tremendously important consideration to patients, their families, and the public-at-large.” Presumably, the appeal here is to the harm principle; it is difficult to understand what the moral force of relief of the burden of care would be if that were not the implicit rationale. But such an implicit justification raises the question of what degree of harm is necessary to offset the loss of liberty suffered by the committed individual. It also raises the question of whether the psychiatrist has his or her chief obligation to serve the interests of the family and the state, or to serve those of the patient.

Governor Wallace’s arguments were rejected; and in the series of cases beginning with Donaldson v. O’Connor and ending with Wyatt v. Aderholt, federal courts have held that (1) nothing justifies the state in involuntarily hospitalizing a mentally ill person through civil commitment procedures except need for treatment or protection of self or others from a clear danger posed by the individual; (2) for an individual who has been subjected to civil commitment, the 14th Amendment’s due process clause provides a constitutional right to treatment for the mental disorder that offers the chance for eventual restoration of liberty; (3) only if the disorder is such (as in severe mental retardation or chronic, unremitting psychosis) that treatment would be inappropriate because ineffectual, can mere custodial care be provided, and that only if certain standards of care are met. The ability of psychiatrists or other social scientists to predict dangerousness to self or others thus becomes increasingly important to the commitment process as the courts have limited the grounds on which commitment may be predicated and underscored the potential for serious abridgment of constitutional rights inherent in such proceedings.

Need for Treatment

The need for treatment is a tempting ground for involuntary hospitalization. Under the supposition that various behaviors or states of individuals are attributable to disease (whether physiological or mental), the protective, efficient, equipped wards of the psychiatric institution
appear to many to constitute the only appropriate site for treatment. Further, those perceived to be in need of such treatment may well deny their need, either as a further delusional product of their disorders, or in the (perhaps legitimate) belief that their needs would not be well served in an institutional setting.

Generally, the courts have swung about on this as a ground for commitment. The current trend seems to be that the rights of privacy and self-determination from which arise the right to refuse medical treatment also yield a right to refuse treatment in a psychiatric institution in all but critical, emergency situations. Certain treatments cannot ever be given in some jurisdictions, without consent, because of their risks or aversive character. This, together with the nondangerous patient's right to refuse any treatment, and the historical dearth of adequate treatment facilities, effectively undercuts the need-for-treatment rationale. As Judge Bazelon observed, "Absent treatment the hospital is 'transform(ed) . . . into a penitentiary where one could be held indefinitely. . . ."

These issues also relate to insanity defenses. "Conceptually an acquittal by reason of insanity should lead to release, and if deprivation of liberty can be justified by all, it can only rest on a need for treatment. . . ." If the right to treatment is granted or activated only for those who wish to exercise it, then there is no faulting the logic of one who, acquitted on an insanity plea and committed for treatment purposes, refuses treatment and demands release. On the other hand, at least one commentator suggests that there may well devolve on such an individual a duty to be treated, such that it is clear that involved in a successful insanity plea is an obligation to accept whatever treatment is currently available. It is unclear whether this suggestion also entails a duty to be cured as a condition of restoration of liberty, and a duty to remain confined until a treatment can be developed in case one is not currently available. It may well be that, absent treatment, it is better to go with Szasz's suggestions (also, cf Humber) and turn to the criminal process; some courts have elected this rationale.

**Dangerousness to Self**

Feinberg has distinguished between strong and weak paternalism: the former involves liberty-limiting interventions in genuinely rational, relevantly informed actions that would tend to result in physical harm to the agent; the latter involves restrictions imposed in the face of evidence that the agent's actions are not voluntary, are not relevantly informed, are in the grip of unreasonable fears, or are being influenced by toxic substances or by severe depression. The principle of liberty
conflicts with the harm principle here in that, if we follow Mill (and, arguably, Kant) in allowing unrestricted self-regarding autonomous behavior irrespective of personal consequences, our only justification for intervening will consist either in our need to determine whether an irreversible decision is genuinely autonomous, or in our well-founded belief that it is not.

A decision that is autonomous, in the sense of being free from coercion, knowledgeable of alternatives and of relevant consequences, and accepting of potential risks, is one in which possible negative consequences to the agent do not acquire the character of harms, but rather that of losses. As such, it is plausible to exempt such anticipated, autonomously accepted consequences from the harm principle and to regard as morally indefensible paternalistic interventions in such cases. That is, since the harm principle justifies restriction of liberty only when doing so prevents harm, if the only negative consequences that can be foreseen accrue just to the agent, and the agent has accepted their possibility, those consequences would not be harms whose possibility could serve as the basis for invoking the harm principle. Just as knowledgeable consent is the chief difference between conscription and legitimate military service, charity and theft, sexual relations and rape, so it is the difference between harm and loss.

However, such an application of the principle of autonomy has the character of a limiting case. At the other extreme falls behavior with negative consequences of individuals who wholly lack the capacity to consent. In these cases, the harm principle justifies (indeed, requires) limitation of liberty on behalf of the welfare of the infant, the profoundly and severely retarded, and so on. The ethically troublesome cases lie between; and, as argued by Wear, competence and autonomy are not all-or-none capacities, but manifest degrees and ranges. Hence, the harm principle may justify some restriction of liberty that falls short of that appropriate for absolutely nonautonomous individuals, such as required periodic attendance at an out-patient facility.

Other subtleties compound these issues. One of the most difficult is the iatrogenic character of the loss of autonomy experienced by individuals who undergo institutionalization. That is, commitment, whether voluntary or involuntary, often in and of itself produces or exacerbates incompetence and diminishment of autonomy, increases bizarre and potentially harmful behavior, and the like. Often, such perceptions appear to be a function of the perceptual set of the staff of the institution; studies abound showing that frequently the perceptions of inmates about the mental condition of a person shamming psychotic
symptoms are more accurate than those of staff. Another is that the potential for harm to self may be a function of one’s external situation, rather than to an internal disorder of the psyche.

But the chief ethical concern over the dangerousness ground for commitment lies with the ability of psychiatrists and social scientists to predict dangerousness with sufficient reliability both to reduce instances of harm to self (or others) and to minimize the number of false positives—persons identified as at risk who, if left unconfined, would not perpetrate harmful acts. As the need for treatment declines as a rationale for non-emergency confinement, one can note two trends in involuntary commitment: the limitation of such hospitalization for periods greater than a couple of weeks “to persons who present an imminent threat of taking their own lives or an imminent threat of substantial physical harm to others”; and limiting the criteria for involuntary commitment to dangerousness to self or others. One effort at studying patients hospitalized following suicide attempts in order to devise predictive devices to identify impending suicides produced measures that would have yielded over one-half false positives; another, which identified a high-risk recidivist group in a 10-year followup study of attempted suicides, gave 67% false positives for subsequent successful suicides, and 46% false positives for subsequent suicide attempts (whether successful or not). Other predictive devices appear both to miss a substantial portion of suicides and to involve some significant number of false positives; the studies were additionally flawed in that they involved only voluntarily committed patients.

Data on pure clinical judgment accuracy have not been gathered and studied in much detail, but the few studies that have included such data indicate varying degrees of accuracy, often reflecting differences between impressions gained through extensive contact with a patient (relatively more accurate) and those gained in the brief contacts preceding a commitment decision. Hence, commitment for evaluative, predictive efforts may require extensive revision of our sense of what is just in the pursuit of data pertaining to long-term commitment justifications.

**Dangerousness to Others**

With respect to the question of how dangerousness to others justifies deprivation of liberty, the basic arguments turn on what is called the harm principle. Though John Stuart Mill has given the principle its classic articulation, the following statement of it will suffice for our purposes: "It is morally justified to prevent harm to (other) persons when the harm is caused or would be caused by those whose liberty is
This principle, in turn, rests on the principle of beneficence, understood as a duty to produce good, prevent harm, and remove harm. In light of the phrasing of the harm principle ("when the harm is caused or would be caused"), this issue may seem to be divisible into the question of justifying commitment in light of harmful acts already committed, and the question of justifying commitment in order to prevent harm that would otherwise be expected. However, the two questions reduce to the latter.

Deprivation of liberty after a harmful act has been committed is generally subsumed under the concept of punishment, and punishment is appropriate only where guilt is appropriate. The development of the insanity defense has permitted those for whom that defense is successfully raised to escape criminal commitment for the purpose of punishment by virtue of escaping the finding of guilt. Of course, individuals who are found innocent by reason of insanity are very frequently subjected to involuntary civil commitment, but the justification is not simply because of the fact that they have committed harmful acts (where that may well be sufficient for involuntary criminal commitment); rather, the justification is either to obtain treatment for a continuing disorder, or to protect others from further harm because of continuing dangerousness. This view is further reinforced by the occasional case in which innocence by reason of temporary insanity is successfully pleaded, followed by a recognition that the individual in question no longer suffers from the temporary disorder and thus neither constitutes a continuing danger to others nor stands in need of treatment, and this results in neither civil nor criminal commitment. [In State of New Jersey vs. Lester Zygmanik, the latter was successfully defended against the charge of first degree murder on the grounds that sleep deprivation and other long-standing stresses had placed the defendant in a temporary psychotic state in which he did not know the quality of his act (the harmfulness of shooting a paralyzed brother while in the intensive care unit of the hospital) and did not know that what he was doing was wrong. Zygmanik was found innocent; since there was no evidence of persistent psychosis, no effort was made to obtain commitment for either treatment or protection of others from future harmful acts.]

Having committed a harmful act, together with a diagnosis of mental illness, is often sufficient for civil commitment under the harm principle, but it has not historically been a necessary condition as well. Prospective dangerousness to others is often predicated on evidence weaker than retrospective dangerousness. The chief source of such predictive evidence is the same as the source of evidence of mental illness—expert testimony of psychiatrists or psychologists. However,
courts have often accepted testimony of family, friends, and neighbors. Considerable doubt has been cast upon both types of judgment. These doubts concern both substantive and procedural components.

The substantive issues are similar to those involved in predicting dangerousness to self. False positives as high as 72% are reported, although some studies comparing the judgment of the courts with that of clinical staff suggest the relative superiority of the latter. Procedurally, the use of counsel and of the right to jury evaluation, together with cross-examination and other rules of evidence, would go far toward protecting the potential patient. Some would hold that adherence to such standards would result in the release of virtually everyone involuntarily confined on dangerousness grounds, since prediction of dangerousness is not well-validated on any known measure. Others would maintain that such measures are too extreme, involving implicit appeals to standard of proof appropriate only in criminal proceedings. There is a serious question, however, whether anything short of the most stringent procedural standards is appropriate, since in fact such confinements may have the character of imprisonment without realistic hope of release, because of the poor treatment situations still existing in many state hospitals.

The inherent logic of civil commitment in order to prevent harm to others dictates an indefinite period of commitment. In this justification, commitment should last as long as the committed individual constitutes a threat. However, the principle of liberty (viz., an individual has a right to the greatest amount of liberty consistent with an equal amount of liberty for each other individual) has suggested to some that an external limit on the power of civil commitment should be imposed so as to preserve some real content for the principle of liberty as it applies to the committed individual. The effort to balance the considerations of each principle in the commitment situation results in an acknowledgment of a right to such treatment as offers hope for restoration of liberty, and severely limits the contexts in which purely custodial, protective care may be offered to only those individuals in whom the mental illness that makes for dangerousness to others is chronic, or unable to be cured or controlled through any known mode of treatment.

**Ethical Issues in Involuntary Treatment of the Mentally Ill**

Two themes dominate the issues in this range of our concerns. The first concerns whether, under what conditions, and what sorts of treatment may be administered to an involuntarily committed patient. The sec-
ond has to do with the conditions under which an involuntarily committed patient may effectively refuse treatment for his or her illness.

It must be borne in mind that the courts have approached this question from the perspective of the preceding section's issues. The right to treatment for psychiatric illness has been asserted as a quid pro quo right, acquired in exchange for the right of liberty lost through involuntary commitment. And this right was articulated against the position that the state’s only obligation to the incarcerated mental patient was custodial care. Thus, the courts did not address, even in the narrowly proscribed area of mental illness, the question of whether there is a constitutional right to treatment enjoyed by all by virtue of humanity or citizenship. The questions raised in recent years concerning a right to health care that might be brought to bear on treatment of mental illness issues have not surfaced in the various decisions involving involuntarily committed persons.

What has been a matter of concern is whether the involuntary commitment of a mentally ill person, together with that person’s need for treatment, provides a sufficient justification for compulsory treatment. Chief Justice Burger held, in his concurring opinion to O’Connor v. Donaldson, that committed individuals do not lose their right to refuse treatment, and that there is no basis for compelling treatment since it is the case that the patient’s cooperation is essential for most forms of treatment to be effective. One may question whether this latter assertion is correct, particularly since there is an increasing medicalization of our understanding of psychiatric disorders as arising from such factors as neurotransmitter and receptor site disorders; his comment seems more appropriate to psychotherapy. A deeper issue, however, concerns the very possibility of ethically treating the mentally ill. If one held the position that involuntary commitment because of a psychiatric disorder leading to dangerousness entailed, or even was presumptive evidence for, incompetence to consent (as argued by the defendants in Rogers v. Orkin) and if one also holds that the mentally ill patient’s refusal of treatment is indefeasible, then only nondissenting mental patients who voluntarily accept treatment could be treated, and then only on the authorization of a proxy or the courts. It would seem that many of those most in need of treatment could not be provided with it. And, such individuals then become effectively imprisoned by their own illness, involuntarily confined and unable to obtain freedom because of a “refusal (that) may be symptomatic of their illness.”

The courts have generally avoided this logical trap. The informed consent doctrine has been dissociated from the state’s power to invol-
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untarily commit. This is partly because of the tendency in recent decisions to disallow the need for treatment justification as a sufficient basis for involuntary commitment. However, the right to make treatment decisions is not held to be indefeasible. Rather, competence to consent to treatment and/or to refuse treatment is treated as a separately determinable matter, on the grounds that “Mentally ill patients may or may not be competent to make any number of decisions, including the decision to accept or reject medications.”

Procedurally, courts have held that “(1) an involuntary mental patient may have a right to refuse medication in the absence of an emergency, founded on constitutional right of privacy, and (2) in the absence of an emergency, some due process hearing is required prior to the forced administration of drugs,” and the patient has the right to be represented by counsel.

Thus, the courts appear to have endorsed the view that competence should not be viewed as an all-or-none phenomenon, but rather in a domain-by-domain manner (e.g., competence to manage financial affairs, competence to decide on treatment questions, competence to vote, and so on). Although there have been efforts made by both psychiatrists and philosophers to clarify it, we seem short of a well-thought through, objective, operationalized concept of competence that would apply to each of these domains. In its absence, the borderline, “grayer” cases will continue to provoke controversy and dispute within and outside institutional settings.

The courts have rather consistently extended the dangerousness justification for involuntary commitment to involuntary treatment. If treatment is necessary to reduce a patient’s level of dangerousness to others or to self, it may be undertaken in an emergency situation where physical harm is imminent and physical restriction or isolation is impossible or ineffectual. However, outside the context of an emergency, the presumption of competence and the right of privacy impose various due process requirements.

Finally, right to treatment issues in the context of the mentally ill have been inconclusively addressed by the courts in several decisions involving in extremis treatment decisions. The courts have, in the Quinlan, Saikewicz and Brother Fox decisions, articulated conflicting procedures, at one time leaving prognosis issues up to families and physicians, at another requiring proof in court using a “clear and convincing” standard, in one case disallowing statements made by the patient in healthy contemplation of catastrophic medical possibilities, in another accepting a “living will” procedure. As Annas notes, judges are attempting to legislate termination of treatment issues, and to insert public and judicial review into matters that have been traditionally the purview of the physician, patient, and family. The net effect may
well be to encourage physicians not to seek recourse to the courts for
tough decisions, but to make them carefully and circumspectly with
the active contribution of patient and family when possible. The fre-
quently politically tinged role of the hospital administrator in such de-
cisions as involve involuntarily committed patients in extremis may
limit the growing aversion to court intervention in that context, how-
ever.

**Ethical Issues in Release and Resocialization of the Mentally Ill**

As indicated at the outset, scepticism exists about the efficacy of much
of the so-called treatment for mental illness, as well as its availability
to the involuntarily committed patient. One of the more interesting lev-
ers that has been used to obtain social reform, first by commentators
and later by the courts, is the argument that an involuntarily committed
patient has a quid pro quo right to treatment, from which it follows that
if such a right is not to be realized, that patient must be released. Both
commentators and courts have relied upon social pressure to force leg-
islatures to fund treatment measures, rather than to resort to wholesale
release of involuntarily committed individuals.

However, uncertainty as to what is required by the law has
prompted some to argue for abandonment of various treatment options
and modes that may be the only possible options for certain patients.
If treatment becomes thus impossible, and need for care and other jus-
tifications are lost, then either custodial care or release become the
only options. Added to this is the deinstitutionalization movement,
found both in the area of mental retardation and chronic mental illness,
which provides political pressure on legislatures to close institutional
facilities and fund half-way houses and home care as superior alterna-
tives. Further, we have the views of Szasz and others that the notion
of mental illness, and thus of treatment of mental illness, involves fic-
tions. On this view, no person may legitimately be involuntarily
committed because the constitutional requirement of treatment as a
quid pro quo right cannot be met. Finally, there are those who are
sceptical of the existence, or foreseeable likelihood, of effective treat-
ment facilities, and those who believe that individualized treatment
plans cannot be effective because of the state’s unwillingness to ade-
quately fund requisite staffing; they fear the ‘danger that after imple-
mentation of reform, the same abuses will emerge again in new,
though initially disguised, forms.’
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Such movements and scepticism about treatment realities, and accessibility to effective representation of counsel, together with the poor showing of both clinical impression and predictive measures of psychologists, all contribute to the institution's growing tendency to release individuals who have been involuntarily committed. Add to this the fact that such individuals often return to the environments in which their symptoms of dangerousness were initially elicited (a fact that can only be exacerbated by the decline in public funding of social services), cap it all off with increasing media coverage of instances of violent recidivism, and one may well anticipate a great public outcry against the liberalization of our practices towards the mentally ill.

"(L)argely unconscious feelings of apprehension, awe and anger toward the 'sick,' particularly if associated with 'criminality' . . . must be recognized [in our] enormous ambivalence toward the 'sick' reflected in conflicting wishes to exculpate and to blame; to sanction and not to sanction; to degrade and to elevate; to stigmatize and not to stigmatize; to care and to reject; to treat and to mistreat; to protect and to destroy. ' ' That ambivalence, together with the uncertainties of prediction, treatment, and indeed the very conceptions of mental disease, will continue to occupy law, social policy, and philosophical reflection for some time to come.

Notes and References


Rouse v. Cameron (373 F 2d 451), (DC Cir 1966).


