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Patient Decisions and Psychiatric Hospitals: Quandaries of the Patient Self Determination Act

by Bethany Spielman, Ph.D., J.D.

The Patient Self Determination Act (PSDA)[1] went into effect on December 1,1991. The Act includes an informational requirement mandating that, upon admission to a hospital, nursing home, or hospice, or upon enrollment in a health maintenance organization receiving Medicare or Medicaid funds, patients must be informed of their right to refuse treatment and to formulate a living will or appoint a health care proxy. The Act's purpose, in part, was to increase the number of people who exercise their rights to execute an advance directive and refuse medical care.

Among those who may choose to exercise that right are the thirty-two million Americans who suffer each year from a diagnosable mental disorder. One and one-half million have a chronically disabling mental illness such as schizophrenia, other psychoses, or severe alcoholism.

The Patient Self Determination Act and Psychiatric Facilities

The threshold question regarding the PSDA in mental health contexts is: does it apply to them at all? The answer requires an examination of the Act's text and legislative history. The text of the PSDA says it is to be applied to hospitals, nursing facilities, home health or personal service providers, hospices, health maintenance organizations, and other prepaid agencies. Therefore it does apply to psychiatric facilities if the term "hospitals" (or "other eligible organizations") includes psychiatric facilities. Psychiatric facilities are not specifically mentioned anywhere in the text of the Act or in its legislative history. There is no indication that Congress intended psychiatric hospitals to be included, but no indication that it meant them to be excluded, either. It is reasonable to conclude psychiatric facilities are covered by the Act.

The Act states that a provider must give written information to each individual concerning rights under state law to make decisions concerning "medical care." The PSDA is intended to enhance "the right to accept or to refuse medical or surgical treatment," and that phrase appears both in the text and also regularly in the legislative history of the Act.

Senator Danforth, who sponsored the original bill, apparently had in mind Cruzan-like cases involving termination of life sustaining medical treatment. When he introduced the bill, Nancy Cruzan lay in a persistent vegetative state, supported by

Also in this issue:

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artificial nutrition and hydration in Senator Danforth's home state of Missouri. In his remarks to the Senate, Danforth included references to her family's dilemma.[2]

Because psychiatric treatment is a form of medical care, the text of the PSDA must be understood to require disclosure of information about the right to accept or refuse psychiatric treatment. Under the PSDA, psychiatric facilities would be required to inform patients of existing law regarding the right to refuse psychiatric treatment as well as the right to refuse nonpsychiatric treatment and to formulate advance directives. The Patient Self-Determination Act contains an antidiscrimination clause. It states that providers should not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. The antidiscrimination clause is not to be construed as requiring provision of care that conflicts with advance directives. But it will prevent psychiatric facilities from skirting the problems that advance directives create by simply avoiding the patients who have the directives. Facilities must accept a patient who already has an advance directive and inform those who don't of their right to formulate one.

This aspect of the PSDA may conflict with current law in several jurisdictions. For example, under Florida law,[3] a voluntary patient who refuses consent or revokes consent may be discharged from a psychiatric hospital within three days, or proceedings for involuntary placement may be instituted, or emergency treatment may be given in the least restrictive manner. If a facility exercises the first option -- discharge -- on a patient with an advance directive, that patient may under certain circumstances charge the facility with discrimination.

Psychiatric facilities cannot, therefore, avoid the problems associated with advance directives by transferring patients to another facility. The problems resulting from the formulation and implementation of advance directives will have to be faced by the facilities in which they arise.

What kinds of problems will most likely arise when the PSDA is applied in psychiatric settings? Some problems will not be unique to psychiatric settings: the difficulty of complying with the Act when patients are not decisionally capable upon admission; the lack of support within health care institutions for those patients who want to formulate an advance directive while in the hospital; and the potential for coercing patients into formulating an advance directive. Other problems may be unique to psychiatric settings, but are primarily problems of implementation. For example, a kind of cognitive dissonance may arise if psychiatric facilities comply with PSDA's public education requirement. No one expects a psychiatric hospital to be educating the public about the right to refuse life sustaining treatment.

Unanticipated legal and policy issues will also arise. The PSDA requires only the dissemination of information about state laws. It does not require that any new statutory rights be created, or that state law change in any way. However, the law that has developed around the right to refuse life sustaining care will now be "imported" into mental health facilities. PSDA brings together two bodies of law that previously rarely came together. Before the PSDA, the laws were separate; conflicts and difficult questions could be ignored. Now, intersections and conflicts need to be examined carefully.

Although the Act does not enlarge or constrict the scope of patients' rights in psychiatric settings, it raises three kinds of questions at the intersection of the law of refusal of treatment and the law of advance directives. The first questions arise from the suspect capacity of the patient at the time an advance directive is formulated. Second are questions regarding advance refusal of psychiatric care, and third are questions arising from concern for the differential effect of advance refusal of life sustaining treatment on patients with differing psychiatric histories.

In this paper, I will examine problems that arise in the context of each of those questions.

Advance Directives by a Patients with a Psychiatric History

Whenever an advance directive is adopted, it is fair to ask: how well can the potential patient imagine the circumstances under which her directive will be implemented? For example, can someone who has never been terminally ill, and has never been in an intensive care unit, and has never decided about forgoing life sustaining treatment possibly imagine what her decisions would be under those circumstances? When psychiatric care is involved, the difficulty of imagining future circumstances becomes even more complex. If someone has never been

mentally ill, how can she imagine what her decisions would be if she were? And if she has been seriously mentally ill, why should anyone trust her decisional capacity completely?

The cloud of suspicion that settles on those with a significant psychiatric history generates two major questions in relation to advance directives: 1) how probative can an advance directive by a patient with a significant psychiatric history be? and 2) how broad is the scope of decisional incapacity implied by involuntary commitment statues?

In its 1990 *Cruzan*[4] decision, the U.S. Supreme Court held that states may require clear and convincing evidence of an incompetent patient's wishes before permitting withdrawal of life sustaining care. Not all states do require clear and convincing evidence. But even in those states with a lower standard of proof, questions about the probity of an advance directive executed by someone with a psychiatric history will arise.

Many living will statutes require that one or more physicians certify that the individual formulating the directive is terminally ill. But durable powers of attorney for health care may be executed under more informal circumstances. Some states merely require that two witnesses sign a statement that the principal is of sound mind and not under duress. Those witnesses need not be mental health professionals; in fact, they could be fellow patients on a psychiatric unit. In some states, the conditions under which durable powers of attorney are executed may be considerably less formal than conditions under which a valid will must be executed. Where there are active grassroots "health decisions" movements, thousands of advance directives are executed in informal public meetings at which information about advance directives is disseminated, and participants formulate directives after breaking up into small groups. Neither psychiatrists nor lawyers are required for groups to do their work of completing directives.

There is no reported case in which the validity of an advance directive has been challenged because of the questionable capacity of the principal at the time of formulation. But a directive written by someone with a psychiatric history under extremely informal conditions could be challenged, and could fail to meet a state's "clear and convincing" standard.

Decisional Incapacity and Involuntary Commitment

A second question arises when the capacity of the principal at the time of formulation is suspect: what scope of incapacity to make health decisions do involuntary commitment statutes imply? This question is most important when two conditions are met: the first condition is that a state incorporates into its involuntary commitment statute criteria such as "patient lacks capacity to make informed decisions

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In the U. S. Supreme Court

Nevada defendant has constitutional right to unmedicated court appearance

Riggins v. Nevada, 112 S. Ct. 1810 (U.S.Nev., May 18, 1992).

The Supreme Court overruled a Nevada decision that allowed the administration of anti-psychotic medication to a criminal defendant without his consent. In a 7-2 decision authored by Justice Sandra Day O'Connor, the Court held that the defendant had been deprived of his right to refuse anti-psychotic medication.

David Riggins was charged with murder and robbery in 1987. Shortly after he was taken into custody, Riggins reported hearing voices and complained of sleeplessness. Dr. Edward Quass, a private psychiatrist who treated patients at the prison in Clark County, Nevada, prescribed a daily dose of 800 milligrams of Mellaril, an anti-psychotic drug that Riggins had taken previously. Riggins was also given Dilantin, an anticonvulsant drug.

In 1988, Riggins was examined by three court-appointed psychiatrists and found competent to stand trial in the Clark County District Court. Later that year, Riggins filed a motion to suspend the administration of Mellaril and Dilantin until the conclusion of his criminal trial so that he could appear in court unmedicated to offer an insanity defense. The motion was denied and Riggins was tried, convicted, and sentenced to death. The Nevada Supreme Court affirmed the decision on the ground that testimony from experts at trial was sufficient to alert the jury to Mellaril's effect on the defendant's demeanor and testimony.

The Supreme Court restricted its review to the issue of whether the involuntary administration of Mellaril denied Riggins a "Full and Fair Trial," as guaranteed under the Sixth and Fourteenth Amendments. In *Washington v. Harper,* 494 U.S. 210 (1990)(See 10 *Developments in Mental Health Law* 15, 1990) the Court found that a prisoner retained a liberty interest in avoiding involuntary medication, particularly when the medication significantly interferes with the patient's personality. The State's penological interests may outweigh this right, however, if it can demonstrate that the drugs are both necessary and either medically appropriate or the least intrusive method of protecting the safety of the patient or of others. Once Riggins asked to terminate Mellaril, the State became obligated to show the drug's necessity. No such evidence was presented by the State, and, as a result, Riggins' liberty interests were never evaluated by the lower courts. The Court found that this error may have impaired Riggins' right to a full and fair trial, and that the use of expert testimony could not repair the potentially damaging effect that Riggins' drug-induced demeanor may have had on the jury. Without any evidence from the State showing the necessity of Mellaril, the Court would not sustain the verdict.

In a concurring opinion, Justice Kennedy presented a dramatic condemnation of anti-psychotic medication. He equated involuntary medication to the fabrication of material evidence about a person's personality. Justice Kennedy's opinion emphasized that no defendant should be involuntarily medicated during a trial if his or her behavior will be affected in any substantial manner.

Current mental illness required to hold insanity acquittee in psychiatric facility

Foucha v. Louisiana, 112 S. Ct. 1780 (U.S. La., May 18, 1992).

The Supreme Court ruled that an insanity acquittee found to be dangerous but not mentally ill must be released from a mental institution. The Court's decision invalidated a Louisiana law that provided for confinement of insanity acquittees in psychiatric facilities based on dangerousness alone.

Initially, Terry Foucha was found incompetent to stand trial on charges of aggravated burglary and illegal discharge of a firearm. Four months later, a court hearing concluded that Foucha's competency was restored. After a full trial, in 1984 Foucha was found not guilty by reason of insanity. Consistent with state law for the disposition of insanity acquittees, he was committed to the East Feliciana (Louisiana) Forensic Facility.

In 1988, the facility recommended that he be released because doctors had seen no evidence of mental illness since his commitment. Testimony at a sanity hearing revealed that Foucha had recovered

from the drug induced psychosis from which he previously suffered, but that he could still be dangerous. This conclusion was based on his behavior in the institution and his diagnosis as an antisocial personality. Although "antisocial personality" is a diagnosable disorder, it is not included as a mental illness that would justify commitment. The court nevertheless ordered Foucha returned to the institution.

The Court of Appeals and the Louisiana Supreme Court refused to reverse the trial court's ruling. Foucha argued that the Louisiana provision which provided for his continued confinement based on dangerousness alone without mental illness denied him due process and equal protection in violation of the Fourteenth Amendment.

In an opinion by Justice White, the Supreme Court restated the requirement that confinement of insanity aquittees be based on current mental illness as well as dangerousness. A connection between the purpose of confinement (treatment for mental illness) and the type of confinement (in a psychiatric hospital) is necessary to satisfy due process. [*Jones v. United States*, 463 U.S. 354 (1983).]

Justice White went on to specify that the Louisiana scheme for confinement of dangerous insanity aquittees should be more narrowly tailored to serve state purposes and provide appropriate procedural safeguards to protect those to whom it would be applied. Only three other justices joined in a separate section of the opinion in which Justice White added that the Louisiana statute denied Foucha equal protection. Pointing out that convicted criminals are not required to show they are not dangerous before they are released, White stated that freedom from confinement is a fundamental right which the state must show a very convincing reason for denying to any particular group.

In the Federal Courts

Past absenteeism due to alcoholism triggers Rehabilitation Act analysis

Teahan v. Metro-North Commuter R.R., 951 F.2d 511 (2nd Cir (N.Y.)) (1991).

John Teahan worked for the Metro-North Commuter Railroad from 1983 to 1988 in telecommunications maintenance; he suffers from alchoholism. His job tenure was marked by routine and unexcused absences from work. The absences were related to and a consequence of his substance abuse. Following a course of discipline including warnings and suspensions, Teahan notified his employer of his abuse problem. He subsequently had additional unexcused absences and was so informed via letter from his employer in 1987. He entered a thirty-day rehabilitation program which he completed, then as allowed under his union contract, returned to work. His employer, continuing the progressive discipline required under a collective bargaining agreement, eventually fired Teahan.

Teahan's challenge to his termination, relying upon language in section 504 of the Rehabilitation Act, was dismissed at trial. The trial court reasoned that although the problematic absences were related to alcoholism, and even though alcoholism is a handicap under the Act, Teahan was fired because of attendance, not handicap.

The appellate court determined that dismissal of Teahan's case by the trial court on a motion for summary judgment was premature, stating that "whether or not absenteeism is `caused' by alcoholism is a question of fact" that should be left for a jury to decide. The burden-shifting procedural rules in section 504 suits require that Teahan be given the opportunity to prove he is "otherwise qualified" for the job despite behavior--unexcused absences--the employer relied on as justification for termination even while it admitted the absences were linked to the handicapping condition of alcoholism.

A second issue that surfaced on appeal involved characterizing Teahan's alcoholism as the "current" abuse of drugs. Recent amendments to the Rehabilitation Act do not require employers to accomodate current drug or alcohol abuse as a handicap. In other words, while a history of substance abuse may not form the basis for descriminatory treatment of employees who have overcome the effects of their addictions, ongoing abuse need not be tolerated. Since Teahan had entered a rehabilitation program before he received notice of termination, a question arose whether his employer relied on past or current abuse as a motive for the termination. The policy behind this distinction is to encourage employees to seek rehabilitation, thus the temporal sequence of abuse, rehabilitation and termination is critical.

The employer argued that the delay in firing was a result of a lengthy time lag between initial notice and eventual termination required by union contract. But for the contract, Teahan would not have been able to enter and complete his rehabilitation program. The appellate court nevertheless concluded that the relevant time for determining whether alcohol abuse is "current" or "past" is the actual time of firing, regardless of the effect of union agreements that may actually delay the day of termination.

Qualified immunity protects police for wrongful psychiatric detention

Gooden v. Howard County, Maryland, 954 F.2d 960 (4th Cir. (Md.)) (1991).

The officers involved and Theresa Gooden differ on their accounts of what happened March 2, 1987. The police first met Gooden, who is black, when they responded two weeks earlier to a call from Denise Beck, her white downstairs neighbor. Beck reported hearing screaming and yelling in the apartment above her, Gooden's apartment. The police left after questioning Gooden who stated that she had been asleep and heard nothing.

The officers returned to the apartment complex to respond to another call from Beck. The officers claim to have heard "long, blood-chilling screams" that convinced them that someone was being hurt. The went to Gooden's apartment where they stated they heard another scream coming from within the apartment.

During questioning, Gooden admitted that she "yelped" once because she burned herself with an iron and that she was on the phone with a friend when the police knocked. The police described

Gooden as "evasive and vague."

The police left Gooden's apartment and returned to Beck's apartment where they heard more noises and voices of both a man and a woman. They later reported that the noises were coming from Gooden's apartment. When they again confronted Gooden she reported that she had been on the phone while they were downstairs. The officers conferred with one another and decided that Ms. Gooden was mentally disordered and a threat to herself.

In the absence of other plausible explanations for the disturbance, they concluded that Gooden could be suffering from multiple personality disorder, throwing herself against the apartment walls and speaking alternately in male and female voices.

Following their return to Gooden's apartment, the police took her into custody, handcuffed her, and transported her to a local hospital for a psychiatric evaluation. The examining doctor found no signs of mental illness and released Ms. Gooden.

Before they had left for the hospital another apartment complex resident, Mr. Cummings, told the police that the noises were coming from the apartment below Beck's where a couple had been arguing, and that they had taken the wrong person. Although in court the officers did not recall the conversation, their report showed they did investigate a domestic dispute and file a report on the couple living below Ms. Beck.

As a result of the her detention, Ms. Gooden sued the county, the chief of police and the individual officers under the civil rights statutes 42 U.S.C. § 1983 and 42 U.S.C. § 1985(3), claiming a racially motivated deprivation of civil rights. The district court dismissed the actions against the county and the chief of police but denied the officers' claims that they were entitled to qualified immunity. The officers appealed the district court's decision. Meeting as a three judge panel, the Fourth Circuit Court of Appeals upheld the lower court. The officers requested a rehearing before the entire court meeting *en bank* (a total of eleven judges) and it was granted.

In certain instances a police officer is protected from civil liability and can invoke a right to qualified immunity for official actions. Gooden argued that in this case the officers should not be immune from suit because: (1) the facts of the case are disputed, (2) the judgment of the police was wrong, and (3) the officers violated clearly established principles for detention and psychiatric evaluations.

Admitting that the facts were in dispute, the court stated that the relevant inquiry was the reasonableness of the officers' perceptions. Since the court found no evidence that the officers' mistaken perceptions were unreasonable, it held that it was proper to determine qualified immunity without the need for a trial.

That the police were in error was not dispositive for the court. The court reasoned that if every officer's mistake can lead to a claim for damages, police would be overdeterred and frozen from fear of personal liability.

The final issue concerned whether the officers had violated a clearly established law when they detained Gooden. Despite the fact that the Fourth Amendment prohibits detentions for psychiatric evaluations without probable cause, that term has rarely been defined in the context of psychiatric detention. The court also emphasized that the determination of dangerousness is far more difficult than determining probable cause. This difficulty allows the police greater latitude in detaining individuals for psychiatric evaluations than for arrests in criminal cases. Under the circumstances, the court concluded that the police did not have "adequate legal guidance" to know that their conduct might violate Gooden's constitutional rights.

In effect, the court's ruling allows Maryland police to detain citizens for psychiatric evaluations as long as they can articulate some plausible subjective impressions that would justify their actions, and no specific precedent exists that would prohibit the detention.

Recovering addicts are "handicapped" under the Fair Housing Act

U.S. v. Southern Management Corp., 955 F.2nd 914 (4th Cir. (Va.)) (1992).

The United States Fourth Circuit Court of Appeals has decided that recovering drug addicts are entitled to protection from discrimination under the Fair Housing Act. The court upheld a trial court judgment against Southern Management Corporation (SMC) which had refused to rent apartments to clients of the Fairfax-Falls Church Community Services Board (CSB) Crossroads drug and alcohol abuse program. However, the court vacated the award of monetary damages and penalties against SMC.

The Community Services Board's drug and alco-

hol abuse program in Alexandria, Virginia includes a re-entry phase in which clients who have been drug-free for a year live in CSB rented apartments while CSB employees continue to monitor their progress. In July 1989, after contact by CSB employees, SMC refused to lease any apartments for the re-entry phase of the program. In response to SMC's refusal to rent the apartments, Justice Department attorneys brought an action under the Fair Housing Act, 42 U.S.C. § 3601 et seq. (1990), claiming that SMC's actions discriminated against handicapped individuals.

The trial court ruled that the clients of the CSB were "handicapped" within the meaning of the Fair Housing Act. The jury found that SMC had discriminated against the clients and awarded $10,000 in compensatory damages and $ 26,280 in punitive damages. The court also assessed a $50,000 penalty and issued an injunction ordering SMC to rent apartments to the CSB. SMC appealed the judgment claiming that even if the CSB clients were handicapped, they fell within an exception which excludes drug users and addicts from the protection of the Act.

The Court of Appeals upheld the trial court, agreeing that both the statute and regulations of the Department of Housing and Urban Development defining handicap apply to recovering addicts.

Although former substance abusers are within the definition of "handicapped", the Fair Housing Act contains an exclusion that SMC invoked to bar CSB clients from the Act's protection. That exclusion bars persons with a "current, illegal use of or addiction to a controlled substance...." 42 U.S.C. § 3602(h).

Those who sought to rent the apartments had been drug-free for one year, and were not currently using a controlled substance. SMC, however, argued that "addiction" includes persons addicted to, but no longer using, controlled substances. SMC asserted that medically, addiction is a chronic disease, without cure, despite recovery.

The court rejected that argument after reviewing the Congressional report submitted with the proposed amendments to the Fair Housing Act. The committee report recognized two categories of addicts--current addicts and former addicts. Because the intent of Congress was not to exclude former, or recovered, addicts, the court concluded that clients in the re-entry phase were not excluded from protection as handicapped individuals.

Finally, the court noted that the Americans with Disabilities Act of 1990 (ADA), though not in effect at the time of the SMC refusal to rent, clarified any ambiguity. The ADA provides that an individual who has "successfully completed a supervised drug rehabilitation program and is no longer engaging in the illegal use of drugs..." is handicapped and is not within the exclusion barring drug addicts.

Although the court affirmed the trial court's injunction ordering SMC to rent apartments to the CSB, the court vacated damages and the penalty; it stated that monetary relief was inequitable in light of the ambiguity in the statute excluding addicts. Given the clarity of the ADA, in future cases of discrimination in housing against former addicts damages may be available.

VA cannot terminate benefits to mentally incompetent

Disabled Am. Veterans v. U.S. Dept. of Veterans Affairs, 962 F.2nd 136 (2nd Cir. (N.Y.)) (1992).

The Disabled American Veterans brought a class action challenging the constitutionality of Section 8001 of the Omnibus Budget Reconciliation Act of 1990, 38 U.S.C. § 3205. Section 3205 is a form of workers' compensation for veterans and terminates compensation for veterans who the Department of Veterans Affairs (VA) deems mentally incompetent, and who (1) have no spouse, minor children, or dependent parent; (2) are not institutionalized at public expense; and (3) who have estates in excess of $ 25,000. Compensation resumes only when the estate reaches $ 10,000. The section affects only those individuals whom the VA classifies as mentally incompetent. Thus, an individual who is mentally competent, with an estate greater that $ 25,000, and without dependents will get compensation while a mentally incompetent individual will not.

In challenging the constitutionality of the statute under the equal protection clause of the fifth amendment, the plaintiffs sought an injunction which would bar the VA from enforcing the law. The district court granted the injunction finding that discrimination against mentally incompetent claimants was not rationally related to the goals of the statute such as deficit reduction or inhibiting fiduciary misconduct. The injunction will prohibit the VA from terminating benefits to mentally incompetent veterans solely because of their mental conditions.

Cases From Other States

Criminal contempt not available to deter refusal of medication by Indiana mental patient

Matter of Tarpley, 581 N.E.2d 1251 (Ind. 1991).

Timothy Tarpley has been diagnosed with chronic paranoid schizophrenia, and civilly committed to treatment at a community mental health center since 1987. Outpatient civil commitment is available under Indiana law to patients who otherwise would be involuntarily confined within psychiatric institutions, but may live successfully in the community if they cooperate with specific conditions of a treatment plan administered by mental health professionals. Tarpley's commitment was conditioned upon continuance of all prescribed medications, attendance at mental health center therapy sessions, and abstinence from drugs and alcohol.

Following reports that Tarpley was missing therapy sessions and was in need of medication, a court hearing was held. Since he continued to refuse his medication, the court found Tarpley in contempt of court and he was taken to jail, where he remained for twenty-nine days in early 1990.

The Indiana Court of Appeals heard the first challenge to the contempt order and concurred with the trial court. Outpatient commitment was the constitutionally mandated "least restrictive alternative" available, but required an acceptance of medication in order to be effective, the court found. Tarpley's refusal occured in light of the possibility of a finding of contempt, and was thus "willful, voluntary and knowing." He was represented by counsel at the contempt hearing, and therefore no violation of due process occurred. (*In re* Tarpley, 566 N.E.2d 71 (Ind. Ct. App. 1991). (See 11 *Developments in Mental Health Law* 13, 1991)

At the next level of review, the Indiana Supreme Court reversed the contempt citation, concluding that state law did not allow for forcible medication of an outpatient. It ruled that courts may, however, invoke the status of outpatient commitment for mental patients who meet four criteria. Patients must be: 1) mentally ill and dangerous or gravely disabled; 2) likely to respond to therapy as an outpatient; 3) not likely to be dangerous or gravely disabled if they comply with therapy; and 4) likely to cooperate with therapy.

Since the evidence was "overwhelming" that Tarpley did not meet the fourth criterion, he was not a true candidate for outpatient commitment. The lower court should have proceeded with inpatient commitment to an appropriate psychiatric facility. "Placing a mentally ill person in jail for contempt of a court order, as opposed to commiting such a person to a mental institution where his medical needs would be properly monitored " was inconsistent with Indiana law, according to the Indiana Court.

Psychopathy plus HIV fails as grounds for indeterminate commitment in Minnesota

In Re Robert Stilinovich, *479 N.W.2d 731, (Minn. App. 1992).*

Minnesota law allows for the indeterminate civil commitment of individuals diagnosed as "psychopathic personalities" and includes under this rubric people who, because of emotional instability or impulsivity of behavior, are "irresponsible for personal conduct with regard to sexual matters and thereby dangerous to others." (Minn.Stat. s 526.09 (1990)).

Following voluntary presentation for admission to a mental health center, Robert Stilinovich threatened to kill a physician and police officers. He was taken to a hospital from which he escaped, and to a second hospital where he refused medication. The efforts of 15 people were necessary to restrain him. While he was in custody pending a petition to commit him as mentally ill, he propositioned and touched men and women sexually at least nine times. He also told a social worker that although he was HIV positive, he wished to have sex with people and did not intend to tell them of his medical condition.

Testimony concerning this behavior was heard at the commitment hearing, along with a psychiatrist's report that though Stilinovich was free from mental illness and understood his behavior, he had no desire to control it. He was consequently committed under Minnesota law as a "psychopathic personality" for an observation period of 60 days, pending review by psychiatric facility staff.

The hospital staff reported numerous threats, belligerence, and other conduct consistent with an "antisocial personality", but not statutorily defined "psychopathy", and did not recommend continued commitment for an indeterminate term. At a second hearing, the court focused upon Stilinovich's repeated desire to engage in sex with others who would not know his condition. It declared that despite the hospital's recommendation, the criminal justice system could not accomodate his dangerousness. Stilinovich was committed as a psychopathic personality for an indeterminate term.

Rejecting the reasoning of the committing court, the Minnesota Court of Appeals instead referred to the 1987 Health Threat Procedures Act, written specifically to deal with "recalcitrant carriers of the HIV virus." The appellate court faulted the committing court for attempting "to stretch the psychopathic personality law to address the health problems presented by [Stilinovich]." Since it was not mental illness that led to a concern about dangerousness, but threats related to sex and HIV status, civil commitment was inappropriate.

Evidence of Munchausen's Syndrome admissible in medical malpractice suit

Cohen v. Albert Einstein Medical Center, Northern Division, 592 A.2d 720, 405 Pa.Super. 392 (1991).

A Pennsylvania appellate court overruled a trial court decision to exclude evidence of a patient's diagnosis with Munchausen's Syndrome in a medical malpractice case. The appellate court found that evidence of Munchausen's Syndrome, a mental disorder in which a person fabricates illness, was relevant in helping a jury assess the credibility of the plaintiff. The court also held that the trial court erred in charging the jury to rely on their "common knowledge as to hospital costs" in assessing damages.

Sara Cohen sued Albert Einstein Medical Center for nerve damage to her arm allegedly resulting from an improper intramuscular injection. Hospital records did not show that the injection of which Cohen complained ever occurred.

At trial, the hospital attempted to introduce evidence that Cohen suffered from Munchausen's Syndrome. Munchausen's Syndrome "is a mental disorder in which an individual voluntarily produces or simulates illness for no apparent purpose other than to assume the sick role, i.e., to be a patient.'" In offering the evidence, the hospital hoped to show that Cohen either feigned her injury or produced it herself by leaning on her arm while she was in a drug-induced stupor. The trial court held that the evidence was irrelevent and therefore inadmissible.

In reversing the trial court, the appellate court reasoned that evidence of mental illness was relevant to the assessment of Cohen's credibility. Because the presence of Munchausen's Syndrome "impacted directly on [Cohen's] ability to report truthfully the events and subjective symptoms," the court granted a new trial.

The court concluded Cohen's addiction to Demerol was also relevant to determining the cause of her injuries. The hospital had argued that Cohen caused her injury during a drug-induced stupor.

The court also determined that the trial court erred on the issue of damages by instructing the jury to use their common knowledge of hospital costs in determining future hospital expenses. At trial, the jury awarded Cohen $1,300,000. Because testimony on future hospital costs was vague--the expert testified that costs would be "astronomical"--the court found that insufficient evidence may have resulted in an excessive verdict.

Plea of guilty but mentally ill yields death sentence in South Carolina

South Carolina v. Wilson, 413 S.E. 2d 19 (S.C. 1992).

In September of 1988, during the lunch recess period at the Oakwood Elementary School in Greenwood, South Carolina, James Wilson fired a dozen bullets into children and their teachers. Wilson had stolen the gun he used from his grandmother, and loaded it with explosive hollow-point bullets. Bystanders reported a look of "hatred and rage" on his face during the shooting. Wilson discarded his empty gun, and remained outside the school until he was taken into custody by the police. He was charged with nine instances of assault with intent to kill and the murder of two eight-year old girls.

South Carolina is one of only three states (the others are Pennsysvania and Delaware) that allow a qualified guilty plea of "guilty but mentally ill" (GBMI) in criminal trials. Defendants who invoke this plea are not relieved of their culpability for crime, but may receive treatment for their illness during a period of incarceration. The GBMI Plea is distinct from what is usually known as an "insanity

plea."

In order to be found "not guilty by reason of insanity" (NGRI) in South Carolina, a criminal defendant must meet the traditional M'Naghten test. The M'Naghten formulation specifices that criminals may escape blame for their actions only if, at the time of the crime, they could not tell the difference between right and wrong, or could not appreciate the nature or consequences of their actions. The South Carolina version of M'Naghten does not allow a defendant to argue that his actions were uncontrollable as a result or mental illness, nor that he was subject to an "irresistible impulse" that was produced by mental illness or extreme emotional distress.

Rather than face a trial and a jury sentence, Wilson pled GBMI to assault and murder. He chose to have the penalty determined by the judge, and offered evidence in mitigation at the sentencing hearing. He asserted that he had no significant history of violent crime; was under the influence of an emotional and mental disturbance at the time of the crime; and that his capacity to appreciate the criminality of his conduct or conform it to the requirements of the law was substantially impaired. Accepting all these statutorily permissible factors in mitigation, the judge nevertheless sentenced Wilson to death.

Wilson appealed his sentence to the South Carolina Supreme Court. He argued that the death penalty statute gave no specific guidance to trial judges for sentencing a defendant to death, that death was an inappropriately "cruel and unusual punishment" under the Eighth Amendment when applied to a guilty but admittedly mentally ill defendant, and that the court had failed to properly consider all factors offered as mitigating circumstances for the crime.

Ruling that the so called "irresistible impulse" test had been rejected by the South Carolina legislature and several other states, the Court turned aside Wilson's objections. The state GBMI law clearly allows for imposition of the death penalty in proper cases, the Court noted, even though no particular instructions are included to guide courts in determining which cases are proper. Dismissing the argument that a GBMI defendant is, by definition, lacking in the blame necessary to justify execution, the Court followed earlier South Carolina precedent stating that the critical inquiry is whether the defendant can distinguish right from wrong. "When this power exists in a defendant . . . he must answer for his acts," regardless of his asserted inability to control them. The GBMI defense was enacted specifically "to narrow the field of defendants who could successfully claim a lack of culpability via the insanity defense."

Finally, the Court pointed out that the record was clear on the issue of mitigation. The sentencing judge had heard and admitted all evidence of mitigating factors. The law only required him to **consider** them, not to change his disposition of the case because of them. Additionally, the Court reminded Wilson that on two previous occasions the death penalty had been affirmed for defendants who were able to claim the identical three factors in mitigation. The "heinous nature of his crime easily compares with" those other cases in which the penalty was upheld. Two justices of the court joined with Chief Justice Gregory in affirming the death penalty.

Justice Finney, however, commented in dissent that

> [t]his may be the only instance in South Carolina and indeed, according to my research, in the entire nation where the death penalty has been imposed after a factual determination that mental illness deprived the offender of sufficient capacity to conform his conduct to the standard required by law. . . .The natural abhorence civilized societies feel at killing one who has no capacity to come to grips with his own conscience or deity is still valid today.

Wrongful confinement actionable in Texas

Texas Dept. of Mental Health and Mental Retardation v. Petty, 817 S.W.2d 707 (Tx. Ct. Apps. 1991)

Opal Petty's father petitioned for her commitment to the Austin State Hospital in 1934, when she was sixteen. Her diagnosis at admission was "hebephrenic scizophrenic." Petty remained at the Texas hospital until 1971. According to her testimony, the only "therapy" she received was thirty-five years of work in the hospital laundry at a salary of two dollars per week. During that time, the staff wavered on her diagnosis; she went from mentally ill to not mentally ill, and from mildly mentally retarded to moderately mentally retarded to not mentally retarded.

In 1971 Petty was transferred to the San Angelo State School, an institution for the mentally retarded. A report made by a social worker in 1978 noted that Petty's 1934 mental health commitment did not constitute "a legal commitment to the San Angelo State School." In 1985, the state released Petty, and she began living with her niece and nephew.

Petty filed suit against the state of Texas alleging "that she was wrongfully confined because she was neither mentally ill nor mentally deficient and did not receive any meaningful hearings on her continued commitment." The jury found that state agency employees were negligent in using treatment/habilitation plans, mental status exams, tests, evaluations, diagnoses, staffing reports, and progress notes. The jury awarded Ms. Petty $505,000, but the award was reduced to $ 250,000 in accordance with Texas damages limitations.

In affirming the trial court, the court of appeals ruled that the negligent use of tests to evaluate Ms. Petty was sufficient to establish government liability and that reducing the damages to $250,000 was proper. The state of Texas is liable for personal injuries only if they involve a condition or use of tangible personal property. Therefore, a plaintiff in a case against the state of Texas or its employees must show not only negligence, but also the use of personal property. The court held that the standardized tests measuring I.Q. and achievement fit within the meaning of personal property. The result of the decision is that patients in Texas facilities will be able to sue the state for wrongful confinement if the negligent use of such standardized tests contribute to the patient's wrongful confinement.

FORENSIC REPORT AVAILABLE

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New Jersey court reverses ruling to remove life support from retarded resident of state hospital

In the Matter of Marie Moorhouse, 593 A.2d 1256, 250 N.J. Super. 307 (1991).

Marie Moorhouse is fifty-two years old. She has suffered from Down's Syndrome since birth and lived in a state facility for the mentally retarded since age seven. In spring of 1990, Marie was found in her room, showing neither pulse nor respiration. She was taken to the intensive care unit, resuscitated, and attached to a respirator. At the time this case was decided in late summer of 1991, she had not regained consciousness.

In August of 1990, the Bureau of Guardianship Services began proceedings to have Marie's sister, Barbara Horan, named legal guardian with power to make medical decisions for Marie. Alerted to the possibility of removal of life-support from Moorhouse without judicial review, New Jersey's office of Public Advocacy requested a temporary restraining order to prohibit disconnection of the respirator. A *guardian ad litem* was appointed by the court, and directed to report with recommendations for legal standards and procedures to be put in place prior to any decision to discontinue artificial support for Moorhouse.

A trial was held in November of 1990. The court reviewed the report of the *guardian ad litem*, the briefs of the state Attorney General and the Public Advocate and determined that Barbara Horan was a proper guardian to make medical decisions for her sister. Though medical testimony on Marie's prognosis was available, the court did not elect to hear it, and relied instead on interviews done by the *guardian ad litem*, concluding: "I am satisfied that the record itself today is clear and convincing respecting the medical condition of this patient...." With the exception of the testimony of Barbara Horan, no witnesses spoke either at the trial or at the hearing on the restraining order. The trial judge authorized removal of life-support, and denied the request by the Public Advocate for a stay of the order for authorization until an appeal could be filed. The judge also failed to file written papers until more than three weeks following his ruling, thus compounding the difficulty of filing an appeal of his decision.

The Public Advocate petitioned the Superior

Court of New Jersey Appellate Division for an emergency order to prohibit removal of life support. That petition was granted, and Moorhouse remained on artificial life support while the case was reconsidered.

The appellate opinion that followed labeled the trial court's refusal to take direct medical evidence on Marie Moorhouse's prognosis and tardiness in issuing a written ruling "clearly improper." It criticized the lower court, noting that

> ...but for the Public Advocate's intervention on a matter of such grave importance as this life and death issue, Moorhouse would most likely have died before the court had entered its decision on the matter and thus, prior to appellate review . . . of the trial judge's decision.

The New Jersey Supreme Court has significant experience in cases involving the "right to die" and medical decisionmaking for those who are unable to decide for themselves. The appellate court reviewed each of these in turn, from the watershed Karen Ann Quinlan case (70 N.J. 10 (1976)), involving a comatose twenty-one year old whose family wished to remove her from a respirator, to the Conroy case (98 N.J. 321 (1985)), concerning an incompetent nursing home patient who was awake and conscious, but whose guardian wished to remove an artificial feeding tube, to several recent cases involving elderly nursing home patients who lapsed into a persistent vegetative state, and whose family or guardians wished to discontinue treatment.

Surveying the legal standards for "substituted judgment" in medical decisionmaking, and emphasizing the imperative for procedural prudence when deciding to terminate treatment or support for institutionalized people, the appellate court noted that this case was its first involving a person who, retarded since birth, has never been legally competent and is a resident of a state hospital. Unlike some previous cases in which the court counseled an avoidance of judicial review as "impossibly cumbersome" and often unnecessary, this case of a mentally retarded ward of the state called for "an enhanced degree of protection." In contrast to other populations, for Moorhouse the state acts *in parens patriae* with heightened interest in protecting her rights.

The court then established an exhaustive procedure for insulating mentally retarded patients in state institutions from abrupt discontinuance of treatment. A decision of family or friends to withdraw life support must be met with concurrence by the attending physician. Two independent physicians, knowledgeable in neurology, and the hospital's prognosis committee must concur that the patient is in a persistent vegetative state "with no reasonable possibility of recovering to a cognitive, sapient state." Review by the Public Advocate must follow this determination, and the Advocate is empowered to interview the physicians and the family and visit the patient, review all records, and seek an independent medical opinion if necessary. If the Advocate agrees with the decision, no judicial review is necessary.

If, however, any of the involved parties or the Advocate disagrees with the decision to terminate care, there must be judicial review and the decision cannot be implemented without a court order. A *guardian ad litem* will be appointed to review the case, and report to the court whether clear and convincing evidence exists to demonstrate: 1) that the patient is in fact in a persistent vegetative state as defined above; 2) that the patient's interests have been protected sufficiently; and 3) that the family member or friend is a proper guardian. If the evidence supports the decision, the judge may order that life support be removed.

Since the record of the trial in the matter of Marie Moorhouse contained insufficient evidence to demonstrate that a similarly thorough inquiry had taken place, the decision of the trial judge was reversed.

Emotional distress damages awarded for fear of contracting AIDS.

Johnson v. West Virginia Hospitals Inc., 413 S.E.2d 889 W.Va., (1991).

The Supreme Court of Appeals of West Virginia recently held that a plaintiff may recover damages for emotional distress against a hospital based upon the plaintiff's fear of contracting AIDS.

On June 2, 1988, an abusive, combative patient entered West Virginia University Hospital emergency room. During treatment, the patient stated that he was infected with AIDS. Contravening regular procedure, the hospital failed to notify personnel in contact with the patient of the patient's disease.

Due to the patient's unruly behavior, the hospital called university police officer Lofton Johnson for

assistance. After observing the patient's bed overturned, Johnson assisted in returning the patient to his bed. As Johnson lifted him the patient bit himself and, with his own blood still in his mouth, bit Johnson on the forearm. One-half hour after the attack, a paramedic informed Johnson that the patient carried the AIDS virus. After learning of the incident, Johnson's wife refused to sleep with him and subsequently divorced him. Johnson's children and grandchildren also refused to have contact with him for fear of contracting the disease.

Johnson sued the hospital for negligence in failing to advise him that the patient had AIDS. As a result of the exposure, Johnson claimed that he suffered emotional distress. Supporting this assertion, experts testified that Johnson exhibited post-traumatic stress disorder, aggravated by rejection by his family, friends and co-workers. The trial court found in favor of Johnson and awarded $1.9 million.

On appeal, the Supreme Court of Appeals considered whether emotional distress damages were recoverable under the circumstances of the case. The court noted that emotional distress damages are awarded when actual physical injury and exposure to the disease occurs, and when the fear is reasonable. Here the bite and subsequent post-traumatic stress disorder constituted actual physical injury. Expert testimony also indicated that actual exposure to the virus occurred. Under these circumstances, Johnson's fear was reasonable and the court upheld the damage award.

In its opinion, the court determined that damages for emotional distress may be recovered by a plaintiff against a hospital based upon the plaintiff's fear of contracting AIDS if: 1) the plaintiff is not an employee of the hospital but has a duty to assist hospital personnel in dealing with a patient infected with AIDS; 2) the plaintiff's fear is reasonable; 3) the AIDS infected patient physically injured the plaintiff and such physical injury causes the plaintiff to be exposed to AIDS; and 4) the hospital failed to follow regulations which required it to give a timely warning to the plaintiff that the patient had AIDS.

Nonadversary guardian ad litem not adequate in minor's sterilization hearing

In the Matter of the Guardianship of K.M., 816 P.2d 71, 62 Wash. App. 811 (1991).

At age fifteen, K.M. was diagnosed with congenital aphasia resulting from static encephalopathy. This condition had, since birth, limited her ability to communicate. Her functional age is six or seven, and her IQ is 40.

K.M.'s parents asked to be appointed guardians and authorized to consent for her to sexual sterilization. The trial court appointed an attorney as *guardian ad litem* to represent K.M.'s interests at the sterilization hearing, as directed under Washington law. The *guardian ad litem* recommended, prior to the hearing, that no attorney be appointed to represent K.M. as counsel, and that the parent's request for authority to consent to sterilization be granted.

At the hearing, the *guardian ad litem* was asked by the court to act as an independent examiner of witnesses, since no parties adversary to K.M.'s parents had appeared. She was also asked to clarify her conclusion that sterilization was in K.M.'s best interest.

Testimony was heard from K.M.'s mother, a counselor, a psychiatrist and a neurologist, all of whom concurred with the *guardian ad litem* that sterilization was indicated for K.M., due to her naivete and lack of judgment, the emotional risk to her of pregnancy, and her seeming desire not to have children. Only the counselor was cross-examined by the *guardian ad litem*. Ruling in favor of the petition for sterilization, the trial judge nevertheless delayed the procedure until an attorney could be appointed to evaluate the potential for appeal on K.M.'s behalf.

Several errors of the trial court were analyzed on appeal. Noting that "the parent's interest cannot be presumed to be identical to the child's" in a sterilization hearing, the court criticized the *guardian ad litem* for recommending against independent counsel, failing to cross-examine witnesses, waiving K.M.'s right to be present for portions of the hearing, and herself being absent during critical parts of the testimony. The court stated that when fundamental rights of incompetents are not observed, appointment of *guardians ad litem* may become a "mere formality." The appellate court remanded the matter for a new hearing during which appointed counsel would represent K.M., concluding that "[t]he nonadversarial guardian ad litem necessarily [denies] constitutional and statutory guarantees in regard to assistance of counsel."

. . . Patient Self Determination Act

- continued from page 3 -

about health care." This language is suggested by the American Psychiatric Association in its model code.[5] The second condition is that state law distinguish between incompetency and involuntary commitment, so that an individual who has been involuntarily committed has not lost significant legal rights. When these two conditions are met, involuntarily committed individuals are legally incapable of making contemporaneous decisions about health care, yet have the legal right to execute advance directives, and therefore, to make advance decisions about health care.

When both conditions are met, how broadly should the incapacity language of the commitment statute be construed? The trend has been to construe incapacity more and more narrowly. Incapacity to manage one's financial affairs no longer automatically implies incapacity to make health care decisions.

But the question here is a narrower one still, concerning how broadly or narrowly the time frame in which health care decisions cannot be made should be construed. Is the incapacity decision-specific, applying only to the initial decision to admit oneself to a psychiatric facility? Does it apply to the admission decision along with treatment immediately after admission? Or, does the incapacity extend to decisions about future health care? If it does extend to future health care decisions, then executing advance directives should be precluded by involuntary commitment. If it does not, then execution of advance directives by involuntarily committed individuals should be permitted, though perhaps not actively encouraged.

For example, New York's health care proxy law does permit it, but makes special provisions for formulation of advance directives by residents of mental hygiene facilities.[6] The District of Columbia health care proxy statute also permits it; it specifies that involuntary hospitalization is not a bar to execution of a directive.[7]

The question is less easily resolved in other states with statutes containing language referring to the "obviously ill." "Obviously ill" is defined in Hawaii as "a condition in which a person's behavior and previous history of mental illness, if known, indicate a disabling mental illness, and the person is incapable of understanding that there are serious and highly probable risks to health and safety involved in refusing treatment, the advantages of accepting treatment, or of understanding the advantages of accepting treatment and the alternatives to the particular treatment offered."[8] The law of other states presents the same dilemma.

Were Advance Directives Meant for This?

When we think of advance directives, we usually think about decisions to reject life sustaining care, not decisions to refuse psychiatric care. In some states, however, advance refusal of mental health care can be accomplished through an advance directive. In North Carolina, for example, the proxy statute specifically states that it applies to mental health care, although few details about any conditions or restraints on that right are provided.[9] The same is true of Rhode Island's Health Care Power of Attorney Statute.[10]

In Massachusetts, a Health Care Proxy Task Force, comprised of representatives of fifteen statewide organizations of health care providers, the Massachusetts Bar Association and key state agencies, was formed to ensure a coordinated approach to the dissemination of information about the Health Care Proxy Act which became law in December 1990.[11] The Task Force's Interim Consensus Report was amended in July 1991 to advise those who have been treated for emotional or mental health problems that other laws could affect their choice of certain mental health treatments and that they should draft proxy documents accordingly. The commentary stated that the relation between these laws and the Health Care proxy Act was "uncertain". In many states, the relationship between advance directive statutes and mental health law is even less clear than it is in North Carolina or Massachusetts.

What may concern mental health professionals more than the intent of legislators when they drafted advance directive statutes is the potential clinical consequence of the statutes, especially widespread refusal of mental health care. Mental health professionals may worry about the specter of psychiatric patients immunizing themselves from involuntary hospitalization by means of a "do not hospitalize" directive, or about being transformed from health care professionals into jailers by patients within

psychiatric facilities who refuse medication.

These problems, although potentially serious in some jurisdictions, are not likely to be exacerbated by the PSDA. Although individuals are theoretically capable when they execute an advance directive, and at that moment could not be involuntarily hospitalized, they lack the authority to override the state's *parens patriae* or police powers, even in advance. An individual can't delegate to a proxy more authority than he or she has. So an agent could never have the power to refuse when a principal did not. Where state law currently permits contemporaneous refusal of psychotropic medication, for example, individuals would also be able to refuse it in advance. But where state law currently prohibits contemporaneous refusal, advance refusal would be prohibited as well.

Refusal of life Sustaining Treatment: Different Effects for Different Patients

Another type of problem arises when an advance directive refusing life sustaining treatment is formulated by someone with a significant psychiatric history. The effect of being able to control her medical care in advance may be closely linked to the nature of her mental illness. Two examples illustrate two extremes in effect: a chronically and severely depressed individual who has repeatedly attempted suicide and a chronically anorexic person.

Imagine the following scenario: A chronically depressed individual has repeatedly attempted suicide. After having been informed upon admission to a general hospital of the right to do so, he executes an advance directive refusing life sustaining treatment. He later intentionally overdoses, and receives emergency treatment at a general hospital. So far the fact that he has executed an advance directive makes little difference; it is unlikely that the emergency treatment team would learn about the existence or contents of the advance directive before initiating treatment. Even if they did, they might decide that an "emergency exception' applied to the treatment, or that, because the patient had attempted suicide, his wishes should be overridden. However, if afterward, the treatment team learns of the advance directive and the patient develops complications, the question will arise whether to withhold or withdraw a life sustaining intervention. The situation has now become more complex.

It would be considerably more difficult to override an advance directive in this situation, particularly in states with advance directive statutes stating that "forgoing life sustaining treatment pursuant to an advance directive is not considered suicide." Health care workers could be backed into a corner in which their only choice was complicity with a suicide attempt. The professionals' moral dilemma is one problem; but the effect on a suicidal person of knowing that an advance directive is an option is the more important problem for my purposes. Awareness of his power to constrain professionals' lifesaving efforts could have a significant effect on a suicidal individual. An advance directive could increase the probability that a suicide attempt will be successful. Mentally ill individuals will know that is the case, and presumably act upon that knowledge in a way that is inconsistent with therapeutic goals.

In contrast to the effect on a suicidal patient, the effect of an advance directive on a patient with anorexia nervosa could be therapeutic. Although a range of conflicting explanatory theories about anorexia nervosa exists, there seems to be a fairly strong consensus that a sense of lack of control over one's life is an important part of the anorexic patient's problem. One commentator has argued that, partly because of that sense of lack of control, some anorexic patients' contemporaneous refusals, even of life sustaining treatment, should not be overridden.[12] The argument for honoring refusals may be even stronger when the refusal is done in advance. Advance refusal could give an anorexic patient a sense of control over her future medical care, and that in itself might have therapeutic value.

> ***An advance directive could increase the probability that a suicide attempt will be successful***

The point is not to predict what the effect of advance refusal of life sustaining care on any particular patient might be. Rather, it is to suggest that the effect might be linked to mental illness in ways that should concern both advocates of advance directives and mental health professionals. David Wexler has argued that mental health law should help people get well, or at least not present significant obstacles to their recovery.[13] From that perspective, an illness-specific approach, or perhaps a case-by-case approach, rather than a blanket approach to

advance directives might be appropriate, at least when individuals have had a serious mental illness.

Options for Psychiatric Facilities

How might psychiatric facilities and state legislatures prevent or minimize the likely harmful effects of increased use of advance directives in psychiatric settings? Psychiatric facilities could consider three kinds of options: ignoring the PSDA, requesting exemptions from the PSDA, or muddling through.

For reasons I have already outlined, ignoring the PSDA is not a legally viable option. Although the Act's legislative history makes no reference at all to psychiatric patients or facilities, one cannot make much of an argument from silence. The text of the PSDA uses language that seems to include all hospitals and medical treatments; psychiatric facilities and treatments are implicitly included.

Additionally, there currently is no mechanism for requesting exemption from the PSDA. Even if there were, the kinds of problems outlined earlier in this paper would not be resolved simply by exempting psychiatric facilities from its disclosure requirements. The incidence of these problems will increase as more people execute directives, regardless of whether they learn about their right to do so upon admission to a psychiatric facility, upon enrollment in an HMO, or from a newspaper or television program.

Psychiatric facilities could try to muddle through. They could comply minimally with PSDA, or make it difficult for involuntarily committed patients to actually formulate an advance directive. These are not viable solutions, and have the potential to create liability and lead to litigation unless several underlying policy issues are addressed by legislatures.

A Proposed Legislative Agenda

State legislatures have their work cut out for them. Four tasks require their attention: making a general statement about the relationship of health care proxy statutes to mental health statutes; considering a higher level of formality for formulating advance directives; stipulating the scope of the incapacity that attaches to involuntary commitment; and considering the conditions under which advance directives for psychiatric care should be recognized.

First, state legislatures should put into law a general statement about the relationship of health care proxy statements to mental health law. Such a statement could prevent litigation if it simply said, for example, that an advance directive could or could not be applied to refusal of mental health care.

Second, state legislatures could consider requiring a higher level of formality to make advance directives. That higher level of formality could be considered both in relation to the principal's capacity and in relation to informed consent requirements. Legislatures might consider requiring principals to indicate whether they have ever been seriously mentally ill, and, if they have, to require certification by a psychiatrist that they are in remission. Whether such a requirement might be found in conflict with Federal disability law (such as the Americans with Disabilities Act) would have to be resolved.

> ***State legislatures should put into law a general statement about the relationship of health care proxy statements to mental health law***

Legislatures might also consider requiring disclosure of more information before an individual can formulate a directive that refuses mental health care. There are two reasons for this requirement. First, the public generally is less aware of what mental health care is like, and what its potential benefits are, than it is aware of general medical care. The media have placed high technology medicine, to which advance directives are most frequently directed, in the public eye; but the same is not true of mental health treatments.

Additionally, the consequences of refusal of life sustaining treatment are more obvious than are the consequences of refusal of psychiatric care. Nearly everyone understands that if they refuse life sustaining treatment, they will die. But relatively few may understand that refusal of psychiatric care could result in disqualification for disability entitlements, extended psychiatric hospitalization, or loss of legal rights if they were subsequently adjudicated incompetent.

States that meet two conditions -- incorporation of "incapacity" language in the involuntary commitment statute and the legal distinction between involuntary commitment and incompetence -- can expect

litigation if they try to prevent in-hospital execution of advance directives by psychiatric patients. Such litigation could be avoided by permitting in-hospital execution; but if the resulting directives are challenged because of the principals' questionable capacity, the overall amount of litigation may actually increase. If legislatures spelled out clearly whether the "incapacity" associated with involuntary commitment referred only to the decision to hospitalize oneself, or to a broader ranger of decisions, including decisions in advance, litigation might be prevented.

Legislatures that wish to recognize advance directives for psychiatric care might also consider two options that have been discussed in the literature, but that have not yet been incorporated into law. The first is recognizing the Ulysses contract, or advance "consent" to "involuntary" treatment, and the second is specifying the qualifications psychiatric patients should meet before they can execute an advance directive either consenting to or refusing psychiatric care.

In the early 1980's, there was some discussion of Ulysses contracts which would enable a manic depressive, for example, to consent in advance to hospitalization, so that his contemporaneous but illness-induced refusal could be overridden.[14] Advocates of the Ulysses contract argued that such patients were likely to refuse treatment when in a manic phase, but were also likely to regret their refusal once they were in remission. Rather than bring advance directives for mental health care in through the "back door" of the PSDA, legislatures might give full consideration to the advantages and disadvantages of both advance consent to and advance refusal of mental health care.

The Ulysses contract debate generated several useful suggestions about which classes of psychiatric patients might benefit most from advance directives. Included among the suggestions were the following: that only patients who have already experienced involuntary hospitalization be permitted to make advance decisions about it; that advance directives would be most useful for those with chronic, cyclical diseases such as manic depression and schizophrenia; and that such patients be certified in remission before they were permitted to execute a directive. Legislatures might consider whether those suggestions should apply to advance refusals as well.

These legislative choices should be shaped by consideration of two questions. The first is whether there should be a double standard for refusing care -- one for psychiatric care, another for general medical care. The second is, "What are the purposes of advance directives?"

A Double Standard for Refusing Care?

How state legislators stand on the issues outlined above will depend in part on whether they believe a double standard for refusal exists, and whether they believe it ought to exist. The descriptive question has to be addressed at four levels: Constitutional law, state statutes, common law, and practice.

Constitutionally, neither patients receiving general medical treatment nor patients receiving psychiatric treatment have an absolute right to refuse treatment. The U.S. Supreme Court's decisions in *Cruzan*[15] and in *Washington v. Harper* [16] recognize only liberty interests -- not privacy rights -- that must be balanced against the relevant state interests to determine whether the refusal will be overridden. If both patients receiving general medical care and patients receiving psychiatric treatment have only liberty interests, it is difficult to argue that a double standard exists at the federal constitutional level.

At the level of state statutes and common law, however, the picture is far more complex. One commentator has observed, "It is difficult to understand why the two questions are dealt with so differently when they both concern a constitutional right to refuse highly intrusive medical intervention. The result has been that the right to die is often less regulated than the right to control one's mind."[17]

> ***". . . the right to die is often less regulated than the right to control one's mind"***

The double standard is evident in states such as Louisiana, where mental patients' refusals can be ignored (in the case of medication and treatment) or overridden (in the case of electroconvulsive therapy or major surgery) until they become terminally ill. Then and only then can patients execute an advance directive that will assure that their refusals are respected.[18] In states such as North Carolina, how-

ever, individuals have the right to refuse both mental health care and general medical treatment by means of a health care proxy.[19]

There is little empirical data demonstrating what has happened in the past when patients refuse general medical treatment. But the Patient Self-Determination Act requires that providers must ensure compliance with both common law and statutory state law respecting advance directives. It is meant to insure that the right to refuse general medical treatment will not be empty.

Conclusion

Legislative efforts will also be shaped by lawmakers' understandings of the purposes of advance directives. If legislators believe that the only purpose of advance directives is to avoid pain during the last stages of a terminal illness, their approach to advance directives for mental health care will be markedly different than if they believe that the primary purpose of advance directives is to enhance self determination. Advance directives can, in fact, fulfill several goals, including reducing pain, avoiding suffering, enhancing self determination, and reducing the cost of health care.

Psychiatric facilities may have few satisfactory options for addressing the PSDA at this point, but state legislators can and should act on several policy questions. The PSDA will exacerbate certain problems, but it also provides the opportunity for a second look at the issues of decisional capacity, refusal of mental health care, and the development of advance directives. The ultimate impact of the Patient Self-Determination Act will depend as much on how legislators and judges clarify laws that are already in place as on the content of the Act itself.

NOTES

[1] Omnibus Budget Reconciliation Act, Pub. L. No. 101-508, 104 Stat. 1388 (1990).

[2]"Most Americans are not aware, however, of their right to refuse medical treatment or of their right to execute an advance directive. In light of the *Cruzan* decision, it is the Committee's view that such information should be made available to adult Americans so that they can be best prepared to exercise those rights. Section 4481 is designed to help meet that objective". H.Rep. No. 101-881,101st Cong. 1st Sess. 291 WL (1990).

[3] Fla. Stat. Ann. Sec. 394-459 (West 1983).

[4]*Cruzan v. Director, Missouri Department of Health*, 110 S.Ct. 2841 (1990).

[5]See Stromberg & Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 Harv.J. on Legis. 275 (1983).

[6]N.Y.[Pub. Health] Code Sec. 2981 (1991) states: "[E]very adult shall be presumed competent to appoint a health care agent unless such person has been adjudged incompetent or otherwise adjudged not competent to appoint a health care agent, or unless a committee or guardian of the person has been appointed for the adult...."

[7]D.C. Code Ann. Sec. 21-2203 (1989) states: "An individual should be presumed capable of making health-care decisions unless certified otherwise .... Mental incapacity to make a health-care decision shall not be inferred from the fact that an individual: 1)Has been voluntarily or involuntarily hospitalized for mental illness...."

[8]Haw. Rev. Stat. Sec. 334.1 (1990).

[9]1991 N.C. Sess. Laws 639 (1991).

[10]R.I. Gen. Laws Sec. 23-4.10-2 (1989).

[11]Mass. Gen. L. Ann. ch. 201 Sec. D (West 1991).

[12]Dresser, *Feeding the Hunger Artists: Legal Issues in Treating Anorexia Nervosa*, 1984 U.Wis.L.Rev. 297 (1984).

[13] D. Wexler, *Therapeutic Jurisprudence* (1990).

[14] See Gert & Culver, *The Morality of Involuntary Hospitalization in The Law-Medicine Relation: A Philosophical Critique* (Englehardt & Spicker eds.1979): Reinert, *A Living Will for a Commitment Hearing*, 31 Hospital and Community Psychiatry 857 (1980); Szasz, *The Psychiatric Will--A New Mechanism for Protecting Persons Against 'Psychosis' and Psychiatry*, 37 American Psychologist 767 (1982); Chodoff & Peele, *The Psychiatric Will of Dr. Szasz* 13 Hastings Center Report 11 (1983).

[15] "A competent person has a liberty interest under the due Process Clause in refusing unwanted medical treatment. Cf., e.g. *Jacobson v. Massachusetts*, 197 U.S. 11, 24-30. However, the question whether that constitutional right has been violated must be determined by balancing the liberty interest against relevant state interests. For purposes of this case, it is assumed that a competent person would have a constitutionally protected right to refuse lifesaving hydration and nutrition. This does not mean that an incompetent person should possess the same right, since such a person is unable to make an informed an voluntary choice to exercise that hypothetical right or any other right." *Cruzan v. Director, Missouri Dep't of Health*, 110 S.Ct. 2841, 2843 (1990).

[16]"[Prisoners possess] a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs." *Washington v. Harper* 110 S.Ct. 1028, 1036, (1990).

[17] Parry, *The Court's Role in Decisions Involving Incompetent Refusals of Life-Sustaining Care and Psychiatric Medication*, 14 Mental and Physical Disability Law Reporter 468 at 472 (1990).

[18]La. Rev. Stat. Ann.Sec.28:52 (1979); 28:171 (1978);40:1299 (1975);52:40 (1975):1299:58 (1990).

[19] 1991 N. C. Sess. Laws 639.

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Turning Back the Clock on Sexual Abuse of Children: Amending Virginia's Statute of Limitations

by Paul A. Lombardo, Ph.D., J.D.

Numerous verified reports of child sexual abuse have combined with the growing literature on that topic to call into question a well-worn Freudian myth. Women's reports of childhood sexual activity with their fathers or other men are no longer assumed to be the products of fantasy nor artifacts of wish-fulfillment and over-active feminine imaginations. Concrete evidence of the incidence of child sexual abuse--of males and females--no longer permits such charges to be dismissed without serious investigation. [1]

Increasing popular and professional attention has forced the sexual abuse of children out of the psychic closet and into public view. With increased attention has come vigorous advocacy for "survivors" of abuse. Step-by-step guides for bringing lawsuits against sexual abuse perpetrators have been published. [2] Proposals have appeared to hypnotize witnesses and unearth childhood memories for use as evidence in civil trials. [3]

Advocates for the accused have also spoken out. Some, concerned about the potential for unsubstantiated claims, focus upon the rights of those charged with being abusers. Fabrication of an abuse charge for "leverage" during a child custody case has been explored in the legal literature. [4] A number of prominent mental health professionals have formed the False Memory Syndrome Foundation. The foundation's mission includes efforts to study and combat what is described as "enormous family suffering" caused by misguided programs of therapy during which patients "come to believe that they suffer from 'repressed memories' of incest and sexual abuse." [5] The potential for false accusation remains a serious consideration both for the therapeutic community and for those who would fashion legal policy.

Thus, adult survivors of the trauma of sexual abuse who choose to reveal the secrets of a lifetime may confront not only professionals who doubt them but also a skeptical public, whose attitudes concerning intrafamilial privacy and publicized shame have changed slowly, if at all. Equally troublesome for those bold enough to unmask their assailants is a legal system unprepared to address allegations of harms long past, accus-

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tomed instead to a counsel of indifference toward claims so difficult to substantiate.

The first announced survivors of childhood sexual abuse transcended the traditional reticence to report past victimization. They coupled public accusations with claims for financial damages to compensate for years of shame, guilt, emotional pain and the cost of therapy to treat those feelings. But lawsuits between survivors of childhood sexual abuse and their abusers were blocked by legal, as well as attitudinal hurdles. For many adults who had suffered abuse decades earlier, the time frame in which suits could be brought had already passed. Their claims were barred from court by statutes of limitation.

Prior to 1991, Virginia's law reflected a common limitation period for personal injury litigation. People claiming damages had to initiate lawsuits within two years after an injury was sustained.[6] If the victim was a child at the time of the injury, the statute of limitations was "tolled" or held in abeyance until the child became an adult. Since the age of majority in Virginia is eighteen, a victim of personal injury (including sexual abuse) could wait no longer than the twentieth birthday to pursue a claim in court. Those who delayed forfeited the right to sue.

Statutes of Limitation

A statute of limitation forms chronological brackets around an injury that could lead to a lawsuit and the time when the suit must be filed. The injury gives rise to a legal "cause of action" and marks the first temporal point when a victim has a claim for damages, and thus the first time a suit would be justified. In most personal injury lawsuits, the cause of action is said to "accrue" when an intentional or negligent and wrongful act has occurred and an injury is sustained. The lawsuit for damages is the remedy for the injury. The purpose of the limitation period is to rule out "stale" legal claims, and bring some finality to interpersonal transactions.[7] Litigants who fail to pursue legal remedies within the limitation period are said to have "slept on their rights."

Statutes of limitation aid social stability by foreclosing disputes about events in the distant past. They also reflect the recognition that even if time does not heal all wounds, it does dull most memories. Witnesses die or move to other places, recollections fade, and physical evidence that might be necessary to prove a case in court tends to disappear. The possibility of reliably proving fault, causation or even damage diminishes with each passing year.

Therefore, limitation periods vary in length to accommodate evidentiary needs. Limitation periods also protect those who might be falsely accused from being required to counter allegations that reach far into the past and are impossible to disprove. A typical limitation period for bringing suit for breach of a written contract, for example, is four years from the date of breach. In contrast, personal injury actions for slander (oral defamation), must be pursued more quickly, often within one year. The different time limit takes into account the common sense conclusion that recollections about unrecorded conversations are often less reliable than written documents describing commercial transactions.

Statutes of limitation developed long before mental health experts began to study the dynamics of sexual abuse. It should not be surprising that until very recently the law did not address the unique circumstances of victims of childhood abuse, and the relationship between relatively short limitation periods and the difficulty of filing a timely lawsuit. Commentaries by therapists who regularly treat adults still suffering the effects of childhood trauma describe several predictable behavioral patterns that make that difficulty understandable.

Statutes of limitation developed long before mental health experts began to study the dynamics of sexual abuse.

The psychic wounds that result from sexual abuse are not easily healed. They persist into adulthood, and often manifest themselves in a range of symptoms and disorders, including recurrent or long-term depression and severe anxiety. Adult survivors unable to escape the legacy of childhood sexual abuse are also characterized by an inability to develop

socially and a wide variety of other interpersonal problems. Because of intense feelings of shame or to avoid consequences threatened by the abuser for disclosing secret events, children do not report abuse that has occurred. The process of repression and denial may become so habitual that as years pass, amnesia may develop.

Survivors bury childhood memories, psychologically disassociating themselves from the terrifying events. Conscious or not the memories remain and while causal relationships are still unclear, victims of sexual abuse do seem to be at heightened risk of mental illness or substance abuse.

While mental health therapy may yield insight into the roots of emotional pain and behavioral dysfunction, making the connection between the apparent failure to develop a satisfying adult life and the buried horror of childhood abuse can take years. Long hidden recollections of abuse may emerge from patients in therapy well into middle age. Dealing with the shock of newly unearthed, painful memories takes time; gathering the courage to seek a legal remedy takes more time yet. The impediments to disclosure of injuries suffered by victims of child abuse were, until very recently, not recognized in the laws of most states. More importantly, little attention was paid to the injustice of shielding abusers from potentially meritorious lawsuits simply because they had waited out limitation periods.

1990 Amendments to Virginia Law

Following the lead of states such as California, which in 1990 passed legislation dramatically extending the statute of limitations in childhood sexual abuse cases,[8] the normally conservative Virginia legislature passed a bill in 1991 allowing lawsuits to begin a full ten years after a victim comes of age. It explicitly recognized the potential role of mental health professionals who assist patients to uncover memories of past abuse. The law permitted all personal injury suits based on sexual abuse of an underage or incompetent person to be brought from the time

> . . . when the fact of the injury and its causal connection to the sexual abuse is first communicated [to the patient] by a licensed physician, psychologist, or clinical psychologist. However, no such action may be brought more than ten years after the later of (i) the last act by the same perpetrator which was part of a common scheme or plan of abuse or (ii) removal of the disability of infancy or incompetency.[9]

The effect of this amendment to existing law was to extend the limitation period for many adults who had endured sexual abuse as children, from a

— *continued on page 39* —

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In the Virginia Courts

State and Federal Courts Agree that Suicide Rules Out Wrongful Death Claim in Virginia

Wackwitz v. Roy, 244 Va. 60, 418 S. E. 2d 861 (1992).

Hill v. Nicodemus, ___F.2d___, 1992 WL 332206 (4th Cir.).

Both the Virginia Supreme Court and the federal 4th Circuit Court of Appeals have recently considered wrongful death claims in which the suicide of the decedent played a prominent part in the defendants' arguments against recovery. The federal court conclusion echoed the conclusion of Virginia's high court, refusing to compensate survivors when the cause of death is suicide, a crime under the common law.

In the state case, representatives of the estate of Byron Wackwitz sued Dr. Gaston Roy and Potomac Hospital for negligent care and treatment leading to Wackwitz's death. Wackwitz had been diagnosed with "major depression with agitation and paranoia" at another hospital from which he had "eloped" only days before his admission to the psychiatric unit at Potomac. Upon admission to Potomac he was treated for lacerations to his wrists. He had threatened to kill himself rather than face the prospect of thirty years of psychiatric hospitalization, the fate he believed was in store for him. The diagnosis at Potomac was "severely paranoid, delusional, anxious and afraid of relating to his peers."

Dr. Gaston Roy was Wackwitz's psychiatrist during the twenty-four days he remained in the psychiatric unit. The plaintiffs argued that "insufficient attention was paid to the depressive and suicidal components of [Wackwitz's] illness" by Dr. Roy. The patient's psychiatric history and past suicidal tendencies were not taken into account during treatment planning, they said. The consequences of this neglect, according to the plaintiffs, were that inadequate instruction was given to Wackwitz about potential depressive effects of medication prescribed for him and he was discharged prematurely. The plaintiffs linked the alleged neglect to Wackwitz's suicide.

The defendants asked the trial court to dismiss the suit. They argued that suicide is both an immoral and illegal act that should bar recovery by Wackwitz's survivors. The principle invoked by the defense--that a participant in a wrongful act may not profit from it--became the basis for the trial court's dismissal of the case.

On appeal, the Virginia Supreme Court reviewed the history of suicide. At common law, suicide was punished as a crime, and the estate of a person dying of suicide was forfeited to the crown. Crimes at English common law remain crimes in Virginia unless they are abolished legislatively. Forfeiture of a suicide's estate has been rescinded through legislation. While no punishment is prescribed for suicide, Virginia law still proscribes the act. Survivors who seek to make "wrongful death" claims stand in the place of the deceased -- no recovery is allowed for the result of the illegal act.

Killing oneself does not constitute suicide unless the person taking his own life is "of years of discretion and of sound mind." Since the plaintiffs in *Wackwitz* had affirmatively alleged that Byron Wackwitz was "of unsound mind" at the time of his death, the trial court erred in dismissing the case without further exploring the factual issues related to his mental state. The Supreme Court reversed the dismissal and remanded the case to the trial court.

Justice Lacy filed a dissent focusing the court's attention not on the illegality of the act of suicide, but on the definition of suicide as an "act subversive of sound morality." This language from a 1906 Virginia decision [*Plunkett v. Supreme Conclave,* 105 Va. 643, 55 S.E. 9] was the sole ground upon which the plaintiff's appeal was filed. Justice Lacy faulted her colleagues for not addressing the morality issue directly. She would have declared suicide not to constitute an immoral act, and would not allow a court to dismiss a lawsuit "solely because it seeks recovery for injuries resulting from an act the court considers immoral."

The Wackwitz decision was delivered while a similar case was pending before the 4th Circuit Court of Appeals. That case followed the death of Tanya Hill in the jail of Clarke County, Virginia. Hill was observed crying and sobbing at the time she was taken into custody. The matron who completed her initial intake and medical screening form noted a history of suicide attempts and psychiatric hospitalizations as well as Hill's report that she had taken cocaine and PCP the previous day and wished to "talk to someone."

About one hour after she was jailed, Hill was observed attempting to cut her wrists with a plastic spoon. An hour later, the jailer called the local mental health center to request clinical assistance in light of Hill's behavior and suicide threat. Less than two hours later, and before mental health personnel had arrived at the jail, Hill was found dead, hanging from the cell bars by a bedsheet. Her family subsequently filed a wrongful death claim against the jail, sheriff Albert Nicodemus and various members of the jail staff.

A major question in the Hill case was whether a person held in jail prior to trial has different due process rights with regard to medical care than a convicted prisoner. If so, Hill's federal claim alleging a violation of civil rights by jail officials would have to be reheard. At trial, the federal district court had instructed the jury to assess liability according to the constitutional standard of "deliberate indifference" established by the U.S. Supreme Court. Because Hill had not been convicted, the eighth amendment standard forbidding deliberate indifference to serious medical needs as a kind of "cruel and unusual punishment" was inappropriate, Hill's family argued. On appeal they urged a higher standard for pretrial detainees, based in the fourteenth amendment due process clause rather than the eighth amendment. In effect, they wanted to measure the actions of jail officials by a more demanding test, similar to the "gross negligence" or "recklessness" standard common to some tort actions. The appellate court, however, declined to adopt language that would require a heightened level of medical care to be available in jails to those under arrest for, rather than convicted of, crimes.

The federal court was required to interpret Virginia state law to dispose of the wrongful death claim. The district court had ruled that since suicide is considered "an immoral or unlawful act" under Virginia law, the claim must fail. The appellate court, citing the recent decision in *Wackwitz*, agreed. The court also refused to hear new evidence of Hill's mental state at the time of her death. Hill's potential mental impairment was specifically disclaimed at trial by Hill's representatives as a possible counter to the defendant's reliance on the suicide defense, and no claim of "unsound mind" was raised prior to the appeal. The court followed the presumption that a person is sane, in the absence of specific evidence to the contrary. In that light Tanya Hill's death as suicide ruled out recovery on her behalf.

Both the *Wackwitz* and the *Hill* cases relied upon previous Virginia cases that endorsed criminalization of socially disfavored behavior. The older case, *Miller v. Bennett*, 190 Va. 162, 56 S.E. 2d 217 (1949), involved a wrongful death claim brought on behalf of a woman who died following an attempted abortion. Her estate sued the abortionist who had by then been convicted under a now defunct statute criminalizing abortion. (See *Coffman v. Commonwealth*, 188 Va. 553, 50 S.E. 2d 431 (1948)). The case was weighted with significant moral overtones, since the deceased woman had contacted the abortionist to avoid revealing a pregnancy by a man other than her husband. The *Miller* court denied recovery on the wrongful death claim because "a mature married woman was guilty of moral turpitude" in the procuring of an illegal abortion. Her estate could not benefit from her wrong-doing.

This principle was again recited in the case of *Zysk v. Zysk*, 239 Va. 32, 404 S.E. 2d 721 (1990), the second case that formed a precedent for both *Wackwitz* and *Hill*. Mrs. Zysk sued her husband for infecting her with herpes. The infection took place as the result of sexual intimacy that occurred prior to their marriage. Fornication was then, as it is now, illegal in Virginia. The Virginia Supreme Court declared that "the very illegal act to which the plaintiff consented and in which she participated produced the injuries and damages of which she complains." Mrs. Zysk was therefore forbidden from recovering.

Thus suicide in Virginia today evokes the same response formerly applied to illicit sex and clandestine abortions, and the precedent is preserved wherein no claim is honored that arises from an illegal act.

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Cases from Other States

Disruption to Family Life Inadequate to Justify Commitment in New Jersey

In the Matter of the Commitment of A.A., 252 N.J. Super. 170, 599 A. 2d 573 (1991).

In early 1991, A.A. was taken by family members to an acute care psychiatric facility. During the assessment that followed he exhibited paranoia and emotional volatility and reported auditory and visual hallucinations. Voices were commanding him, he said, to hurt himself and others in his family and he had threatened his wife and daughter with knives. The hospitalization occurred only three weeks after a week-long stay at the hospital and was A.A.'s sixth hospitalization in six months.

After a temporary commitment, a hearing was held in an attempt to commit A.A. to a long term psychiatric facility. A report offered by the consulting psychiatrist at the hearing noted that A.A. had no history of physical assault nor had he been threatening or assaultive during his temporary hospitalization. The psychiatrist testified that A.A. was cooperative and posed no danger to himself, but that he might be dangerous to children living in his home. Upon cross examination, the doctor clarified that in addition to three children of his own, A.A. and his wife were raising three small children--ages one, two, and three-- whom they had taken in after the death of a relative. The "danger" to the children might result from A.A.'s inability to supervise them properly, the doctor said.

A.A.'s wife also testified, noting that though he was not violent, his disruptive behavior caused "aggravation" and hurt the children mentally. The judge presiding over the commitment hearing concluded that A.A.

> was suffering from a psychiatric disability and that he does present a danger to others in that his actions . . . create a serious bodily harm, though it may not be a physical harm, to others.

A.A. was subsequently committed to the Camden County Psychiatric Hospital. He petitioned the court in appeal of his commitment.

The appeal called into question the sufficiency of the evidence presented at the commitment hearing. U.S. Supreme Court precedents require that mental illness must be accompanied by danger to self or others as a prerequisite to civil commitment. New Jersey law defines "danger" to include

> a substantial likelihood that the person will inflict bodily harm upon another person or cause serious property damage within the reasonably foreseeable future.

The committing court did not find that physical harm of any kind was predicted. The only evidence of anticipated "psychological harm" was the testimony of A.A.'s wife. She recited instances when he had shouted at her and engaged in erratic behavior such as cooking a family meal at 3:00 a.m.--then discarding it before it could be eaten. While these episodes and the regular need for hospitalization no doubt made A.A. difficult to live with and posed a burden to his family, the appellate court found them insufficient to justify involuntary commitment under a standard calling for "serious bodily harm" to another person. The court did not rule out the possibility that some case might exist in which long term hospitalization could be the proper remedy to a threat of psychological harm. But the court added that proof of psychological harm that might lead to bodily injury would probably require the testimony of a mental health professional before it would add up to the "clear and convincing" evidence necessary to justify commitment.

Transfer of Controlled Substance from Mother to Child after Birth through the Umbilical Cord Is Not "Delivery" under Florida Law

Johnson v. Florida, 602 So. 2d 1288 (Fla. 1992).

Jennifer Johnson gave birth to a daughter on January 23, 1989. Johnson told her doctor that she had used rock cocaine that morning while she was in labor. She later told an investigator from the Department of Health and Rehabilitative Services that she had smoked marijuana and crack cocaine three to four times every other day during her pregnancy.

The state filed criminal charges against Johnson for violating Florida law prohibiting delivery of controlled substances to a minor. The "delivery" allegedly took place in the sixty to ninety seconds between the infant's birth and the severing of the umbilical cord. Johnson's doctor testified that metabolized cocaine derivatives in the mother's blood diffuse from the womb to the placenta and reach the baby through the umbilical cord. In the brief time between birth and the severing of the umbilical cord, the transfer occurs from mother to child.

Johnson's conviction was appealed to the Florida Supreme Court. The question for that court was whether the ingestion of a controlled substance by a mother who knows the substance will pass to her child after birth is a violation of Florida law. The Supreme Court refused to criminalize Johnson's behavior, citing the insufficiency of the evidence against her and the legislature's intent in crafting specific laws dealing with controlled substances.

No evidence was presented at trial that any cocaine derivatives passed from the womb to the placenta during the period before the umbilical cord was severed. The state also failed to prove that Johnson intentionally timed her dosage of cocaine in order to transmit cocaine derivatives to her child after birth. The court reasoned that "delivery" cannot be based on involuntary acts such as diffusion and blood flow.

During the 1987 session of the Florida legislature, a specific statutory provision authorizing criminal penalties against mothers who give birth to drug-affected children was rejected. Part of the reasoning behind that vote was that allowing the criminal prosecution of mothers would undermine Florida's express policy of keeping families together and make it less likely that drug addicted women would seek prenatal care. Criminalizing mothers would have the perverse effect of denying prenatal care to the most fragile and sick newborns.

The court added that when the language of a statute is open to several interpretations, the statute should be construed most favorably to the accused. Noting that no other jurisdiction has upheld charges such as those made against Johnson and calling her prosecution a "radical incursion upon existing law" requiring "strained construction" of statutory language, the court reversed the conviction.

In a related case dealing with a substance abusing parent, the Supreme Court of Connecticut rejected an attempt to terminate parental rights because of a mother's conduct during pregnancy. The court refused to interpret state law to include prenatal substance abuse as "a denial of care necessary for the well being of a child" that would justify permanent, rather than temporary loss of custody. [*In re Valerie D.*, 223 Conn. 492, 613 A.2d 748 (1992)].

California Supreme Court Clarifies the Limits of the "Dangerous Patient" Exception to the Psychotherapist-Patient Privilege

Menendez v. Superior Court of Los Angeles County, 11 Cal. Rptr. 2d 92, 834 P.2d 786 (1992).

On August 20, 1989, Jose and Mary Louise Menendez were killed in their home. The deaths were reported by their sons, Erik and Lyle, then eighteen and twenty-one. As part of the police investigation, a warrant was obtained to search the records of Dr. Oziel, the psychotherapist for both Lyle and Erik. The police seized several audio tapes that they believed were related to the killings. Dr. Oziel cooperated with the police, but asserted the psychotherapist-patient privilege on behalf of the Menendez brothers.

The tapes contained a recording of a therapeutic session as well as taped notes pertaining to four other sessions. At the two earliest sessions, the brothers

threatened the lives of Dr. Oziel, his wife and his girlfriend. After those sessions, Dr. Oziel warned the two women of the threats.

The Menendez brothers were allowed to intervene in a proceeding to determine whether the tapes were privileged. The trial court found that the tapes were not protected because of the "dangerous patient" exception to the California privilege statute. This state law codified the California Tarasoff rule (*Tarasoff v. Regents of the University of California*, 17 Cal. 3d 425, 551 P.2d 334 (1976)), allowing an exception to the expected confidentiality between patients and therapists when a patient threatens to harm an identifiable person. The lower court ruled that notes of the second two sessions were not privileged either because they dealt with the same information as had the session tapes.

Arguments on admissibility of the tapes and the application of psychotherapeutic privilege were complicated by several details. First, after his initial meeting with the Menendez brothers, Dr. Oziel disclosed to his wife Laurel and to his assistant and lover, Judalon Smith, that they were in danger. At the lower court as well as the California Court of Appeals these disclosures gave rise to the assertion that the privilege for the entire sessions had been waived by Oziel. Second, Smith had been present to eavesdrop on at least one of the sessions with the brothers. According to an affidavit she later released to the media, she overheard them confess to the murder of their parents. Third, questions were raised during several hearings concerning whether the latter two psychotherapeutic sessions had been arranged by Dr. Oziel merely to monitor the dangerousness of the patients and/or whether the Menendez brothers arranged the sessions not for therapeutic motives but merely trying to create evidence concerning their mental state at the time of the killings. Arguments were heard suggesting that each of these factors-- the warnings, the eavesdropping and the motives for scheduling time with the therapist--had destroyed the therapeutic privilege that might have otherwise protected the seized tapes.

Upon final review, the California Supreme Court held that the taped notes of the first two sessions were not privileged because of the dangerous patient exception: the psychotherapist reasonably believed that the patients were dangerous and that disclosure of the threats was necessary to prevent harm. With regard to the taped notes of the third session and the tape of the fourth session (both of which occurred after Dr. Oziel warned the two women), the court found that disclosure was not necessary to prevent harm. Therefore, the taped notes of the third session and the tape of the fourth session were still protected by the psychotherapist-patient privilege.

The supreme court emphasized that disclosures of the content of therapeutic encounters did not defeat the exercise of privilege by the patients themselves. The law gives the privilege primarily for the benefit of patients and the furtherance of the therapeutic relationship. Thus unjustified disclosures of therapists (such as may occur when the "dangerous patient" conditions are not met) or eavesdropping by others do not rule out the patient's right to invoke the privilege in court. Additionally, the law need not analyze the content of each communication between therapist and patient nor the motives that each brought to it to determine whether the privilege applies. As the court put it, "the dispositive fact is what the participants do, not why." The expectation of confidentiality during a therapeutic session was present, therefore the privilege attaches.

Finally, the California court determined that the statutory privilege for psychotherapy applies even in the context of a criminal trial. While California law specifically excludes the invocation of a physician-patient privilege during criminal proceedings, no such exception applies to the psychotherapeutic privilege which the court describes as "paramount" to the claims of the criminal justice system.

Full Due Process Preferred by Ohio Supreme Court for Involuntarily Committed Patients

In re Miller, Alleged to be Mentally Ill, 63 Ohio St. 3d 99, 585 N.E.2d 396 (1992).

The Supreme Court of Ohio recently reviewed that state's law on civil commitment of the mentally

ill and privileged communications between patients and psychiatrists. It affirmed a patient's rights to extensive due process protections before involuntary custody may be undertaken and reasserted the expectation of confidentiality that applies to information exchanged as part of the Doctor/Patient relationship.

Kenneth Miller was taken from his home by police at the request of his family and delivered to the psychiatric ward of the Mansfield Ohio General Hospital in 1989. There he was held for four days, at which time commitment proceedings were initiated by a hospital social worker who filed an affidavit containing this statement:

> Mr. Kenneth Miller is a 38 year old [C]aucasian, married male, admitted on an emergency basis on November 18, 1989. The patient has been progressively confused, delusional, and paranoid. His sense of reality is altered, grandiouse [sic] and at times, out of touch with reality.

The affidavit was accompanied by a certificate of examination, executed by a Dr. Fernandez, Miller's personal psychiatrist. The certificate contained the identical language found in the social worker's affidavit.

After twenty-six days in custody, Miller's hearing occurred. Testimony was taken from members of his family, two of the police officers who had detained him, a psychiatrist retained by Miller, and from Dr. Fernandez. The court allowed Fernandez's testimony despite objections from Miller that it would violate the physician-patient relationship. The court concluded that Miller should be committed to the hospital and he remained there for an additional twenty-five days.

Following his discharge, Miller brought suit alleging violation of his rights to due process of law and appealing his order of commitment. The court of appeals affirmed the commitment order and the appeal proceeded to the state's highest court.

Ohio law allows civil commitment of the mentally ill via two distinct procedures. The first is available for emergency situations and applies only to people who represent a "substantial risk of physical harm" to themselves or others. Police may take people into custody whom they have reason to believe are mentally ill and subject to hospitalization by court order. Police must first file a written statement describing the circumstances that led them to believe the person should be committed and deliver it to the hospital at the time of admission. An examination by hospital staff must occur within twenty-four hours, and the chief clinical officer must either file an affidavit within the third day of custody to initiate commitment proceedings or discharge the patient. The "chief clinical officer" is defined as the medical director of the facility or another licensed physician responsible for treatment in the facility. The statute allows her to delegate certain duties to other physicians or licensed clinical psychologists.

The second procedure is more elaborate, calling for notice to the potential patient of rights to counsel, to an independent expert assessment (at state expense, if necessary), and to a full hearing before a judicial officer before custody may be undertaken or a court order for hospital commitment may be issued.

The supreme court struck down the original commitment order as deficient under both the emergency custody statute and the involuntary commitment law. In the first instance, by failing to file the required written statement of facts with the hospital as part of the emergency custody procedure, the police neglected to provide evidence of "probable cause" that could justify their detention of Miller. The emergency commitment was faulty on due process grounds.

The second error occurred when the court accepted the affidavit of a social worker to begin the formal commitment process. The court pointed out that the statute did not contemplate delegation of the chief clinical officer's duty to prepare the affidavit to anyone other than another physician or perhaps a clinical psychologist.

The third error concerned the content of the affidavit. Affidavits contain assertions of fact, the court noted. They must relate things that have happened or events that have taken place. In the Ohio statutory scheme, they provide the raw material that can be interpreted in the psychiatrist's clinical opinion, and without them such opinions have no foundation. Since the social worker's affidavit failed to provide any information that rose to the level of concrete fact, it failed to comply with the statute and

probable cause was not present. The court thus had no jurisdiction to continue with commitment.

Since Miller's initial custody and also his commitment hearing followed flawed procedures, the court concluded that he should have been released immediately upon his arrival at the hospital or, at the latest, by the court that accepted the faulty affidavit.

The Ohio Court also judged the acceptance of testimony from Miller's personal psychiatrist a fatal error in the commitment proceeding. Ohio law, unlike several other states, does not list commitment proceedings as exceptions to the usual rule prohibiting compelled testimony concerning confidential physician-patient transactions. Additionally, the testimony of Dr. Fernandez was not limited to facts he may have observed while examining Miller for the commitment hearing, but included observations based on his ten-year treatment history. Repetition of this information unnecessarily breached the confidence that should have been upheld between Miller and Fernandez, and further corrupted an already faulty commitment proceeding.

Criminal Conviction for Pedophilic Acts Does not Qualify Defendant for Total Disability Under Insurance Policy

Massachusetts Mutual Life Ins. Co. v. Ouellette, ___A.2d___, 1992 WL 354994 (Vt.).

James Ouellette practiced optometry for more than ten years. During this period he was also suffering from the mental disorder of atypical paraphilia. He surrendered his license to practice optometry and was imprisoned following a conviction of lewd and lascivious conduct with a minor. He subsequently filed a claim with his professional insurer seeking disability benefits.

Ouellette claimed to suffer from atypical paraphilia, primarily pedophilia, a recognized mental disorder. Insurance policy terms define "totally disabled" as a condition resulting from an illness preventing the insured from performing substantially all of the duties of his usual occupation. Because pedophilia led to incarceration and loss of his professional license, Ouellette claimed he fit the definition of totally disabled.

The Vermont court ruled that Ouellette's inability to practice was caused by the legal consequences of his behavior--not his disability. The court cited a long line of federal cases that bar Social Security disability benefits to criminals whose incarceration results from behavior caused by a mental disorder. Claimants in those cases were unable to show that disability, rather than voluntary behavior, caused their incarceration. Vermont relied upon a federal precedent drawing a line between an impairment that results in the inability to perform the physical or mental functions of gainful employment, and antisocial behavior that results in confinement.

Ouellette was able to practice optometry for ten years after his disorder manifested itself. The court found that imposing liability on the insurer would be contrary to the public interest in discouraging insurance coverage for an insured's intentional criminal conduct.

In the Federal Courts

Second Circuit Discovers Psychotherapist/ Patient Privilege

U.S. v. Diamond (In re Doe), 964 F.2d 1325 (2nd Cir. 1992).

Forty-nine states have adopted some form of evidentiary privilege that allows patients and psychotherapists to avoid compelled revelations of the content of their therapeutic encounters. In those states, the importance of fostering uninhibited dialogue between therapists and their patients is considered more important, in many instances, than disclosing the details of therapy in court to assist the resolution of a lawsuit.

Despite this near unanimity of the states on the privilege question, federal law provides no parallel rule protecting confidential disclosures made during therapy. While the federal Rules of Evidence allow federal courts to review issues of privilege "governed by principles of the common law as they may be interpreted by the courts of the United States in light of reason and experience," [Rule 501] only one appellate court has recognized the privilege and three others have rejected it. The 2d Circuit Court of Appeals, which covers New York, Connecticut and Vermont became second to recognize the privilege with its decision in *U.S. v. Diamond.*

John Doe (whose identity has been concealed as the result of a protective order of court throughout this litigation) owns a vacant theatre. In 1990 he testified that Steven Diamond had attempted to extort $50,000 from him as payment for assistance in obtaining a zoning variance for the theatre. Doe's complaint of the extortion attempt to federal authorities gave rise to an investigation that resulted in the indictment of Diamond.

During the discovery portion of Diamond's criminal case, evidence of Doe's thirty year history of periodic clinical depression and psychiatric treatment surfaced. Because Doe was to be the government's star witness on the charge of extortion and his credibility would be critical, he agreed that the judge in the case and counsel for Diamond could review his psychiatric records privately. The records were, however, shielded from public disclosure by a court order.

Diamond's lawyers retained a psychiatrist to review the records and determine what information should be explored at trial. The psychiatrist's report noted that Doe had a long history of emotional illness, and at the time of the alleged extortion was "paranoid" and suffering from "narcissistic trends." The report suggested that Doe's perception of reality could be faulty and that his credibility as a witness should be questioned. The report also stated that all Doe's records were relevant to credibility and should be available to Diamond's lawyers during the trial.

Doe objected to the request to allow introduction of the confidential records or cross examination on their contents in court. During a pretrial hearing, he invoked the psychotherapist/patient privilege and refused to answer questions concerning the dates he received therapy or the identities of his doctors. The court issued a contempt order, denying the existence of such a privilege under federal law, and Doe took his case to the Court of Appeals.

The appellate court's opinion emphasized that "communications between a patient and a psychotherapist typically involve far more intensely personal information than communications to other kinds of doctors." This fact, it said, explains why the psychotherapist/patient privilege is recognized by more courts than the privilege that applies to physicians generally. In order to uphold the expectation of confidentiality that accompanies mental health treatment and encourage candor from those who seek it, the court interpreted Rule 501 to allow recognition of the privilege to refuse compelled testimony during litigation.

The court's recognition of the privilege was "highly qualified," however. It declared that the existence of the privilege

> amounts only to the requirement that a court give consideration to a witness's privacy interests as an im-

portant factor to be weighed in the balance in considering the admissibility of psychiatric histories or diagnoses.

Although it conceded that Doe's plea for confidentiality was supported by federal law, the court judged the evidentiary need for information on his mental state more compelling than Doe's interest in privacy. Doe won on the principle of law, but lost his privacy in this case.

Future applications of the privilege rule, at least in the 2d Circuit, will require a case by case assessment and call for delicate balancing by trial judges of the privacy interests of litigants and the impact of their silence on the fair resolution of disputes.

No Constitutional Guarantee of Independent Psychiatric Assistance In Federal Circuit

Goetz v. Crosson, 967 F.2d 29 (2d.Cir. 1992).

The Court of Appeals for the Second Circuit unanimously agreed that the Due Process Clause of the Fourteenth Amendment does not absolutely guarantee psychiatric assistance to indigent individuals subject to involuntary commitment or retention proceedings. However, the court reserved the possibility that such assistance may be constitutionally required in certain, fact-specific situations. On that basis, *Goetz v. Crosson* was remanded for further exploration of New York's civil commitment law.

Lyle Goetz, filing on his own behalf and on behalf of all others similarly situated, is an involuntary patient at the Dutchess County, New York Psychiatric Center. Goetz' complaint was two-fold: first, that the failure to provide a consulting psychiatrist in all commitment and retention hearings violates due process under the Fourteenth Amendment and 42 U.S.C. §1983; and second, that New York State's existing procedures for appointing an independent psychiatrist do not satisfy the prerequisites of due process. For the purposes of the appeal, a "consulting" psychiatrist is defined as one who would testify on behalf of the patient (only if he or she believed that the patient should not be committed or retained) and would assist counsel in the preparation of the patient's case (regardless of his or her beliefs). An "independent" psychiatrist is one appointed by the court, but unaffiliated with the state, who would examine the patient and testify about her findings.

Addressing the first complaint, the court differentiated between criminal and civil defendants and found that the current statutory procedures in New York's Mental Hygiene Law provided adequate due process for the civil psychiatric patient. Criminal defendants are guaranteed psychiatric assistance under *Ake v. Oklahoma*, 470 U.S. 68 (1985). (See 5 *Developments in Mental Health Law* 1, 1985). The court declined to extend that guarantee to civil commitment proceedings, relying on precedent differentiating the liberty interests implicated in civil cases from those in criminal cases. The court felt that its goal--to omit erroneous outcomes--could be sufficiently tested by the three-pronged due process test outlined in *Ake* and *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976).

The three-pronged test examines 1) the potential patient's interest in involuntary commitment; 2) the government's interest in implementing changes; and, 3) the risk of erroneous deprivation of the individual's interests without the procedural safeguards. The court examined each interest in turn, and concluded that the "role of the 'consulting' psychiatrist was not of sufficient import to implicate due process in every proceeding." In most New York cases, two psychiatrists must certify the necessity of commitment and a third must confirm the decision before a patient can be admitted. To require additional psychiatric assistance in all cases would be costly and often duplicative. Where further use of forensic psychiatrists is necessary, an "independent" doctor may be requested. In any case, hiring more psychiatrists would only introduce conflicting opinions, and would not necessarily lead to fewer erroneous outcomes.

Next, the court considered Goetz' claim that New York's existing procedures for appointing "independent" psychiatrists do not satisfy the prerequisites of due process. Goetz asserted that the existing procedures leave few psychiatrists willing to testify and those that do inadequately represent the patients' liberty interests. The court agreed that in certain

cases this claim may be true, and that an indigent individual should have the right to obtain the testimony of an independent psychiatrist. On this basis, the case was remanded to determine whether New York's procedure for appointing a psychiatrist were adequate under circumstances presented in the Goetz case.

The majority opinion emphasized the individual's liberty interest in being treated, stressing that erroneous non-commitments are as harmful as erroneous commitments, and equally burdensome to liberty. A concurring opinion disagreed with that equation, asserting that "it remains better to release a mentally ill person than to commit a mentally normal person. And that is how the balance of consequences must be struck." A dissent concluded that a judge's request for further psychiatric testimony should not translate into a constitutional requirement to provide it. The dissenter reasoned that the State's burden is to show, clearly and convincingly, the necessity of institutionalization. If the state cannot meet this burden within existing statutory provisions, the court should not be constitutionally obligated to provide more psychiatric testimony.

Pending in the U. S. Supreme Court

Family Ties and Due Process: Supreme Court to Review Kentucky's Law for Committing Mentally Retarded Adults

Heller v. Doe

Since the 1970s constitutionally mandated procedural safeguards have been available to all citizens detained in state psychiatric facilities. Several United States Supreme Court cases defined the contours of those protections against unwarranted confinement. *O'Connor v. Donaldson* [1] required both "mental illness" and "dangerousness" as standards that must be met before civil commitment of adults is justified. *Addington v. Texas* [2] established the need for at least "clear and convincing" evidence to prove those standards had been satisfied. *Parham v. J.R.* [3] recognized the interests of parents during their children's commitment process, and relaxed the procedural safeguards that are available to adults. At the same time, it judged minors' rights to liberty significant enough to demand a neutral, independent medical review prior to placement in a psychiatric hospital.

The rights of the adult mentally retarded or "persons with developmental disabilities" have been more difficult to define. The life-long deficits in comprehension or decision-making ability among this population confound the attempts of lawmakers to decide when the language of "voluntary" or "involuntary" choices should apply. An additional complexity arises because of the involvement of families in the lives of the mentally retarded. Legislators are hesitant to interfere with parents, guardians, or others who act as caretakers and representatives of people with mental disabilities.

Kentucky is just one of the states struggling to develop a process which acknowledges the role of families in planning for, monitoring, and assisting in their children's care. Despite its legislative efforts, according to the United States Court of Appeals for the Sixth Circuit, Kentucky has yet to find the balance between parental prerogatives and patient's rights. Kentucky's most recent legal difficulties resulted from the state's failure to provide residential placement choices to adults who were labeled "mentally retarded."

Samuel Doe, the pseudonymous plaintiff who initiated the suit that became *Doe v. Austin*[4], has been institutionalized since 1971. Until he filed suit in federal court, no independent review of the propriety his seventeen-year confinement had taken place. In 1986 a group of mentally retarded adults joined Doe to challenge Kentucky's administrative practices regulating admission to state residential care facilities. This class action resulted in several revisions to Kentucky law, and the abolition of facility admission practices that were declared unconstitutional.

> ***Legislators are hesitant to interfere with parents of people with mental disabilities.***

Prior to 1986 a comprehensive statutory scheme guaranteed all procedural rights to the mentally retarded that applied prior to any involuntary commitment to a mental health facility. The law prescribed a judicial hearing where any person subject to commitment could employ a lawyer, testify, and call witnesses. Despite these legal protections, an alternative procedure for admission to Kentucky's residential treatment centers (RTC) for the mentally retarded was established by the state Cabinet for Human Resources. This process was administered by the Record Review Committee (RRC) and gave parents and guardians almost complete discretion over facility placement.

For example, an adult child committed via

parent-initiated petition through the RRC was considered a "voluntary" patient even though he might wish to remain in the community. The four years this procedure was in effect (1982-1985), only one mentally retarded adult in the entire state of Kentucky was admitted through the "involuntary" process required by statute. A similar administrative policy governed the release of patients. It gave parents an absolute veto over any community placement suggested for their children. In effect, parents and guardians were in complete control of RTC admission and discharge, regardless of the apparent dictates of state law.

Changes in Kentucky law abolished any consideration for the wishes of the people most affected by residential placement.

The *Austin* case raised serious questions about Kentucky's commitment policies for the mentally retarded. The federal court's first decision in early 1986 granted the plaintiff's request for a preliminary injunction to prohibit the use of alternative, nonstatutory admission procedures. The Court also decreed the parental veto over discharges unconstitutional.

In response to these rulings, the Kentucky General Assembly revised state law during its 1986 session.[5] The section of the law that had granted equality of treatment for the mentally retarded in all commitment proceedings was deleted. Admission requirements for residential facilities were rewritten. Under the new law, any admission requested by a parent or guardian was defined as a voluntary admission. Authority to review all decisions concerning the potential resident was given to an "interdisciplinary team" consisting of mental health professionals. Teams could also include the resident and a member of his family.

These changes in Kentucky law abolished any consideration for the independent wishes of the people most affected by residential placement. As the court said when the *Austin* plaintiffs returned to court, "the 1986 amendments effectively eliminated the rights of mentally retarded persons to a judicial hearing prior to involuntary commitment."[6] The plaintiffs asked the court to enjoin the state from further commitments of mentally retarded adults unless judicial hearings prior to admission were guaranteed. They also demanded that all facility residents who turned eighteen after their initial confinement and wanted to challenge their placement should be given a similar hearing.

The district court decided that since a majority of severely and profoundly mentally retarded persons are incapable of determining whether being admitted into an RTC is in their best interest, all such admissions are to be considered involuntary. Additionally, since Kentucky law required the same procedures for admitting mentally ill or mentally retarded people to state facilities, refusal to treat these two groups similarly amounted to a denial of equal protection to the mentally retarded. An injunction was issued to prohibit the contested practices. Kentucky appealed.

Kentucky's argument in the 6th Circuit Court of Appeals relied on the *Parham* case, which prescribed deference to the traditional parent-child relationship, and required no adversary proceeding prior to commitment of minors. The state contended that parents of the mentally retarded should have to surmount no more obstacles to placing their children in a state facility than the Supreme Court had authorized for parents of mentally ill minors in *Parham*. But the *Parham* rule was crafted for children, the court countered, and regardless of their mental capabilities, adults are not the same as children.

Despite its unwillingness to apply the rule of *Parham*, the appellate court did not adopt the district court's conclusion that due process mandated a full judicial hearing. The 6th Circuit looked instead to *Vitek v. Jones*,[7] a case that provided a procedural model for transferring prison inmates to psychiatric hospitals.

Vitek required six separate features of due process to enable prisoners to oppose an order into psychiatric placement: the right to 1) written notice; 2) request a hearing; 3) call and cross examine witnesses; 4) give evidence and be heard; 5) receive a written statement of the conclusions of an impartial hearing officer; and, 6) receive qualified, independent assistance to oppose the transfer. While not requiring the involvement of a legally trained judicial officer, the *Austin* court affirmed the procedures

outlined in *Vitek*:

> If these basic safeguards are required before an inmate is transferred from a prison to a mental hospital, surely a person thought to be mentally retarded must be afforded at least the same level of protection before being removed from an ostensibly unfettered existence in society to the confines of an institution.[8]

The appeals court also confirmed the need for periodic review of commitment of the mentally retarded. Kentucky petitioned the U.S. Supreme Court to set aside the *Austin* decision, but the high court denied further review.

The lawmakers responded with amendments once again. Again, Samuel Doe and the plaintiff class returned to court. In *Doe v. Cowherd* [9] they argued that state law continued to violate their rights to equal protection and due process. The trial court concurred. When the state took the case to the appellate level, two major issues remained.

First, could Kentucky's new law require a lower standard of proof to commit a person who is mentally retarded than the standard applied to the mentally ill? *Addington* had established "clear and convincing" evidence as an acceptable level of proof for civil commitment. But the state had adopted a criminal law standard for the mentally ill, requiring proof "beyond a reasonable doubt" before commitment could take place. The "reasonable doubt" level of scrutiny actually exceeded constitutional requirements. It was, however, consistent with Kentucky law requiring that any proceeding leading to the loss of personal liberty must afford the defendant the same constitutional protections that are given to defendants in a criminal prosecution.

Kentucky advanced several arguments in favor of a lesser level of proof. The mentally retarded were not subject to treatment, the state argued. They were merely "habilitated." Services at mental retardation facilities were described as "less intrusive" than those for the mentally ill. Kentucky also contended that less stigma was associated with mental retardation than mental illness. The differences between the two classes of patients justified the lower "clear and convincing" standard for the mentally retarded, who benefitted from a less cumbersome procedure for admission to state institutions.

But a different standard was not warranted by the distinctions Kentucky emphasized, according to the court. The mentally ill and the mentally retarded have identical interests in freedom from involuntary confinement, and equal protection demands equal levels of proof. "Regardless of the asserted benefits of institutionalization," the court noted, "it nevertheless results in the loss of personal liberty."[10] The dual standard was unconstitutional.

The final issue before the court of appeals involved a new statutory provision that allowed parents and guardians to participate as parties during residential commitment proceedings of mentally retarded adults. As parties, parents had many of the same rights to present or refute evidence that an adult child would. Parents were also given the right to appeal placement decisions. This provision had the same flavor as the "parental veto" that was rejected in earlier litigation and it met a similar end. Because parents were not included during commitment hearings of the mentally ill, this part of the new law placed an unequal burden on the mentally retarded. It also failed to met the constitutional standard of equal protection. Kentucky challenged the circuit court's decision and the U.S. Supreme Court has granted a petition for certiorari,[11] agreeing to hear arguments this term on the standards for involuntary commitment of mentally retarded adults.

Kentucky also contended that less stigma was associated with mental retardation than mental illness.

Through eight years of litigation and at every level of federal court, Kentucky has insisted on treating all mentally retarded adults as if they are simply children. Regardless of their potential for making independent decisions or desire to live in the community, Kentucky's administrative policies have ignored the rights of mentally retarded citizens in defiance of both state law and constitutional principles. In an effort to insure parental control over

disabled adults, the state has itself exercised the most stifling kind of paternalism over the lives and choices of a vulnerable, but no longer voiceless segment of the population.

To date, it has been Kentucky's official habit to regard each person labeled "retarded" as if he shared the most severe limitations of any other person marked by that term. Whether the outmoded attitudes underlying that habit must change as a matter of constitutional law should be made clear in a Supreme Court decison within the next year.

Kentucky's administrative policies have ignored the rights of mentally retarded citizens in defiance of both state law and constitutional principles.

-by Paul A. Lombardo

NOTES

[1] 422 U.S. 563 (1975).

[2] 441 U.S. 418 (1979).

[3] 442 U.S. 584 (1979).

[4] 668 F. Supp. 597 (W.D. Ky. 1986).

[5] 1986 Ky. Acts ch. 79 at 163.

[6] 668 F. Supp. 597, at 598.

[7] 445 U.S. 480 (1980).

[8] 848 F.2d 1386 (6th Cir.), cert. denied, 288 U.S. 967 (1988).

[9] 770 F. Supp. 354 (W.D. Ky. 1991).

[10] *Doe v. Cowherd*, 965 F.2d 109 (6th Cir.1992).

[11] *Heller v. Doe*, cert. granted, 113 S.Ct 373, 61 U.S.L.W. 3297 (1992).

SPECIAL JUSTICE TRAINING

The Institute of Law, Psychiatry and Public Policy at the University of Virginia is planning a training program in civil commitment for special justices May 27 & 28, 1993. The schedule will begin at 1 pm on Thursday and end at noon on Friday in Charlottesville. Efforts are currently underway to develop a roster of all special justices in the state. Any special justice or individual working with a special justice is encouraged to contact the Institute. For more information, call or write: Irene Brenneman, Institute of Law, Psychiatry and Public Policy, Box 100, Blue Ridge Hospital, Charlottesville, VA 22908. Telephone 804-924-5435.

IF YOU ARE MOVING

Please let us know by sending any changes in your position, department, or address. Include both old and new information.

. . . Child Sexual Abuse

-continued from page 23 -

potential outside limit of two years after legal majority (age twenty) to ten years after majority (age twenty-eight). The basic provisions were to apply prospectively to all abuse cases. The final section of the law created a new opportunity even for those abuse victims whose right to sue had expired under the former statute of limitations. Suits could be filed for a full year after the new law went into effect regardless of when the alleged abuse was said to have occurred. Thus, for at least one year, *any* act of child abuse committed in the past could form the basis for litigation.

Questions for Mental Health Professionals

Even though Virginia's law was adopted by a nearly unanimous vote, serious questions remained about how it would be applied. For example, the statute assumes that a "licensed physician, psychologist, or clinical psychologist" will reveal the connection between mental or emotional distress and past sexual abuse. A communication from therapist to patient will start the legal clock ticking. But the language of the new statute was borrowed from another Virginia law[10] describing delayed discovery of asbestosis and other occupational diseases. In that context, where the origin of internal physical injury is rarely understood before a physician's diagnosis, marking the starting point for a claim at the time a diagnosis is communicated to the patient poses few difficulties. Patients consult with their doctors, who perform physical examinations and tests and report their conclusions. In the mental health context, such an approach is more problematic.

Many therapists treat patients without regard to whether the content of the therapeutic encounter yields legally relevant "facts" that can be discovered and reported to the patient. They believe that patients should go through the process of reaching psychological insights and clarifying memories with professional assistance, but they reject the idea that therapists must convince patients that past trauma is related to current distress.

Several legal questions follow from this point of view. Would a nondirective therapist incur malpractice liability for failing to explore the potential that sexual abuse preceded pathology? Would being unwilling to infer the occurrence of sexual abuse from a patient's life report lead to lawsuits against therapists? Do mental health professionals bear a legal "duty to discover" a history of sexual abuse, and thereby preserve timely legal claims for patients?

Designating specific professionals as the gatekeepers of sexual abuse litigation raises other issues. A variety of counselors and therapists work with patients to untangle life traumas and the problems that follow. Does the new law discount insights into childhood abuse if someone not mentioned in the statute trips the lever of memory? Would a communication from a social worker, for example, not be admissible to prove when the cause of action for abuse accrued? How would a person who first revealed details of abuse to a member of clergy fare under the new law? What about a survivor whose only confidant was the lawyer engaged to bring the suit?

Finally, and apart from the concerns that were voiced by mental health professionals, the last part of the Virginia statute appeared to contain a fatal flaw. It declared open season, for one year only, on anyone who ever committed child sexual abuse. Actual perpetrators were vulnerable to suit for one more year; anyone else, guilty or not, was subject to allegations destructive of family, friendships and reputation, but about which no concrete evidence might exist in defense. The retrospective feature of the law threatened to reopen matters that had once seemed officially forgotten.

Starnes v. Cayouette

With the new law in place, plaintiffs wasted no time getting to court. Marjorie Starnes was among the first adults to bring suit for childhood sexual abuse. In July of 1991, she sued Robert Cayouette,[11] alleging that for nine years--from age five to four-

teen--she had endured multiple acts of abuse. Cayouette, the father of Starnes' childhood best friend, had often "threatened her with the alienation of her family" if she revealed the abusive events. His threats, she claimed, had caused her "to fear for her safety." Starnes catalogued injuries that included eating disorders, sleep disturbances, depression and anxiety attacks. She specifically charged Cayouette with "assault, battery, sexual battery, rape, sodomy, false imprisonment and intentional infliction of emotional distress."

Starnes was born in 1964 and the last alleged act of abuse occurred in 1978. She turned eighteen, the age of majority, in 1982. Relying on this chronology, Cayouette responded to the allegations by invoking the usual Virginia statute of limitations. It would have required a claim for personal injury to be filed within two years of legal adulthood, in this case by 1984. Starnes relied on the new Virginia law extending the limitation period for childhood sexual abuse. The question for the trial court was whether the new law could, consistent with the Virginia Constitution, be applied retroactively to claims that had already expired under the old limitation period. Regardless of the truth of Starnes' charges, if the new law was unconstitutional, the suit would be dismissed.

The final order of the trial court was issued in October of 1991. That court ruled that the new law violated state constitutional due process guarantees in two ways. First, by extending the limitation period to ten years, it revived some claims that had already expired. Second, by creating a one year "window of opportunity," it stretched the limitation period for claims that had not yet expired, but for which the previous limitation period had already begun to run. Starnes' suit was dismissed, and she appealed to the Supreme Court of Virginia.

Virginia's highest court analyzed the case as a question of the defendant's rights. Did Cayouette, upon expiration of the statute of limitations in 1984, acquire a right that was protected by due process guarantees of the state constitution? The court began its review by noting that as early as 1887, Virginia had rejected the U.S. Supreme Court's ruling[12] (interpreting the federal constitution) allowing states retroactively to revive certain remedies that had already expired under statutes of limitation. In contrast, Virginia cases going back to 1876 had declared the defendant's right to rely on the finality of an expired limitation period to be a "vested right." Later Virginia cases clarified the rule that retroactive laws were only constitutional if they did not destroy such "vested rights."

On June 5, 1992, the court declared all retrospective applications of the law unconstitutional and invalid.

Though Starnes attempted to distinguish purely "procedural" rights to a defense from other "substantive" rights deserving of due process protection, the court rejected the distinction. Cayouette had, a "valuable property right" in being free of suit, the court declared.

> The immunity from suit that arises by operation of the statute of limitations is as valuable a right as the right to bring the suit itself. . . . If the legislature can infringe a constitutionally protected right of one class by retroactive legislation, it can infringe the rights of every class.[13]

While the provisions of the 1991 law that act prospectively were not disturbed, on June 5, 1992, the court declared all retrospective applications of the law unconstitutional and invalid.

Other states have reached different conclusions in applying statutes of limitation to sex abuse cases. Many states (twenty-one) follow the federal rule and allow retroactive application of new limitation periods. The Nevada Supreme Court reviewed the history of its state law and concluded it was formulated without concern for the issue of child sexual abuse. Because lawmakers never considered that social problem when they drafted statutes of limitations, current law should not be applied to sexual abuse claims, that court declared.[14] Proponents of extended limitation periods quote the conclusion of

the Nevada court, which said:

> To place the passage of time in a position of priority and importance over the plight of childhood sexual abuse victims would seem to be the ultimate exultation of form over substance, convenience over principle.[15]

Constitutional Amendment

Joseph Gartlan, the state senator who sponsored the 1991 change to Virginia's law on child sexual abuse, announced in the wake of the *Starnes* decision that he would introduce a constitutional amendment during the next session of the Virginia General Assembly that would allow expired sexual abuse claims to be revived. The proposed amendment simply states that

> [t]he General Assembly's power to define the accrual date for an action based on an intentional wrong shall include the power to provide for the retroactive application of a change in the accrual date. No person shall have a constitutionally protected property right to bar a wrong on the grounds that a change in the accrual date for the action has been applied retroactively.[16]

The constitutional amendment process is quite cumbersome.[17] It requires a majority vote in favor of the amendment by both legislative houses, then a second vote, taken at the next session of the legislature following a general election. If the amendment is carried both times, it must then be submitted to popular vote. A majority of the electorate must approve the constitutional change.

The earliest the proposed change and the legislative amendment could take effect is 1995. Despite this additional lengthy delay, advocates for a new law appear unfazed by their court setback. They wish to insure that those who abuse children, and by trauma and threats delay exposure of guilt, should not escape judgement simply because of the passage of time. The campaign for a new law embodies a principle announced by ancient courts of equity: a wrongdoer may not benefit from his own evil act. Whether that principle can be preserved without discarding the valuable public policies behind statutes of limitation or providing an avenue for unmerited allegations is a puzzle Virginia legislators will have to resolve.

NOTES

[1] See, for example, Bagley and King, *Child Sexual Abuse* (London: Tavistock/Routledge, 1990) p. 30, 70. Recent studies suggest that at least 15% of all girls are victims of serious sexual abuse; reported figures for boys are somewhat lower.

[2] Joseph and Kimberley Crnich, *Shifting the Burden of Truth: Suing Child Sexual Abusers--A Legal Guide for Survivors and Their Supporters* (Lake Oswego, Oregon: Recollex, 1992.)

[3] Kanovitz, "Hypnotic Memories and Civil Sexual Abuse Trials," 45 *Vanderbilt Law Review* 1185 (1992).

[4] Gordon, "False Allegations of Abuse in Child Custody Disputes," 135 *New L. J.* 687 (1985); Patterson, "The Other Victim: The Falsely Accused Parent in a Sexual Abuse Custody Case," 30 *Journal of Family Law* 919 (1991-92); Wakefield and Vanderwager, "Recovered Memories of Alleged Sexual Abuse: Lawsuit Against Parents," 10 *Behavioral Science and the Law* 483 (1992).

[5] FMS Foundation Mission and Purpose pamphlet, Philadelphia, 1992.

[6] Va. Code Ann. § 8.01-243 (Michie 1950, 1992 cum. suppl.).

[7] As Justice Holmes commented, the purpose of these statutes is to "[prevent] surprises through the revival of claims that have been allowed to slumber until evidence has been lost." *Telegraphers v. Railway Express Agency, 321 U.S. 342 (1944).*

[8] Cal. Civ. Proc. Code § 340.1 (West 1990). The California law allows victims of any age to sue within three years after they "discover" the cause of their injuries, no matter how old they are, or eight years after they reach the age of majority, whichever comes later.

[9] 1991 Va. Acts ch. 674, Va. Code Ann. § 8.01-249 (1950).

[10] Va. Code Ann. § 65.2-406 (Michie 1950, 1992 cum. suppl.).

[11] *Starnes v. Cayouette*, 244 Va. 202, 419 S.E.2d 669 (1992).

[12] In *Campbell v. Holt*, 115 U.S. 620 (1885).

[13] 244 Va. 202, 212.

[14] *Peterson v. Bruen*, 792 P.2d 18, 106 Nev. 271 (1990).

[15] 792 P. 2d 18, at 24.

[16] The text of the proposed amendment is being circulated as part of a petition drive by Virginians Aligned Against Sexual Assault.

[17] Va. Constitution, Art. XII, sec. 1.

THE 16TH ANNUAL SYMPOSIUM ON MENTAL HEALTH AND THE LAW

Thursday, April 1

8:00 a.m. **Registration and Coffee**

9:00 **Welcoming Remarks**
King Davis, Ph.D.
R. Claire Guthrie, J.D.
Paul A. Lombardo, Ph.D., J.D.

9:30 **Recent Currents in Mental Health Law**
Richard J. Bonnie, LL.B.

MOTHERS, DRUGS AND REPRODUCTIVE RIGHTS

10:00 **Criminalizing the Pregnant Addict: The Policy Debate**
Moderator: Joan Volpe, Ph.D.
Discussants: Delegate Marian Van Landingham
David Melesco, Esq.

11:15 **The Impact of Prenatal Drug Use on Children: Clinical Realities**
Sidney Schnoll, M.D., Ph.D.

12:05 p.m. **Questions**

12:30 **Luncheon**

DEINSTITUTIONALIZATION, HOMELESSNESS AND JAILS

1:30 **Policing the Mentally Ill: Problems and Strategies**
Linda Teplin, Ph.D.

2:20 **Criminal Justice and Mental Health: An Analysis of Intersecting Systems**
Henry Steadman, Ph.D.

3:10 **BREAK**

3:25 **The Epidemiology of Homelessness**
Pamela Fischer, Ph.D.

4:15 **PANEL DISCUSSION**
Moderator: W. Lawrence Fitch, J.D.
Discussants: Pamela Fischer, Ph.D.
Patricia Griffin, Ph.D.
Henry Steadman, Ph.D.

5:00 **Adjourn**

APRIL 1 & 2, 1993 - HYATT RICHMOND HOTEL

RICHMOND, VIRGINIA

Friday April 2

8:15 a.m. **Continental Breakfast**

PARENTAL RIGHTS AND THE MENTALLY ILL

9:00 **Panel Discussion**
Moderator: Paul Lombardo, Ph.D., J.D.
Discussants: Richard T. Greer
John Oliver, Esq.
Dennis Wool, Ph.D.
Elizabeth A.Willeford, M.S., C.R.C.

10:15 **Coffee**

INSURANCE BENEFITS UNDER THE AMERICANS WITH DISABILITIES ACT

10:30 **The Federal Perspective**
Sharon Rennert, Esq.

11:15 **Mental Health Insurance: Virginia Legislative Trends**
Mark Rubin, Esq.

Noon **Adjourn**

UPDATES FOR VIRGINIA PRACTITIONERS

WORKSHOPS

1:30 - 3:00 **MENTAL HEALTH LAW UPDATE**
Evelyn Fleming, Esq.
Jane Hickey, Esq.
S. Ken Hoge, M.D.
Paul A. Lombardo, Ph.D., J.D.

3:15 - 5:00 **FORENSIC UPDATE**
W.Lawrence Fitch, J.D.
Patricia Griffin, Ph.D.
Jane Hickey, Esq.