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PSYCHIATRY AND THE LAW

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treatment position of the van der Hoeven Kliniek as follows (1965):

> To make the criminal realize his responsibility for his deeds, it is necessary to make him bear his responsibility throughout the whole criminal procedure. He should participate in the discussion and evaluation of his criminal behavior, and the harm he has caused—not only material but also psychological—through not having acted in consonance with the expectations of society as regards respect for human rights and fundamental freedom. He should also participate in the discussion of the consequences of his deeds and what he could do to alleviate them. Last, but not least, he should be involved in consideration of how to prevent recidivism and what he could do now towards a reconciliation with the victim or his family or other person affected. He should then have the opportunity to make himself as worthy as possible of that reconciliation.

M. Prison Grendon Underwood (Parker, 1970) was opened in 1962 in England under the direction of a full-time psychiatrist, W. J. Gray, as the long-delayed outcome of The 1939 East-Hubert Report, *The Psychological Treatment of Crime.* Housing 200 males, one half of whom are juveniles, it provides for a therapeutic community with intense and frequent large and small group meetings. The staff of approximately sixty-five (including guards) is responsible for treatment, with a staff-prisoner ratio of 1:3.5. Stays last approximately eighteen months. For political reasons the prison, although recommended to be built in London, is a long trip of one and a half hours away. This poor location makes prison industries poor and graduated release difficult.

None of these three prisons has any clinically controlled evaluation.

There are no base-expectancy failure rates to support belief that felons, as a result of these prison experiences, live better and less criminal lives in which less harm is done to themselves and others. Yet certain facts are inescapable. These prisons allow difficult prisoners to live in a humane setting in which less harm is done to themselves and others and in which an opportunity for change is available. Many do seem to change. Compared to institutions with similar purposes in the United States, they seem to be philosophically, politically, and practically far ahead of us.

The Patuxent Institution was established in 1955 in Maryland as an institution to treat, under indeterminate sentence, convicted offenders designated as "defective delinquents" under a 1951 Maryland law. The defective delinquent was defined as "an individual who by the demonstration of persistent aggravated antisocial or criminal behavior evidences a propensity toward criminal activity and is found to have either some intellectual deficiency or emotional imbalance or both as to clearly demonstrate an actual danger to society" (The Annotated Code of the Public Generals Laws of Maryland, 1951). The institution, built to hold 600, has a prisoner population of approximately 500. Besides the director, a psychiatrist, there are approximately thirty-five mental health professionals (psychiatrists, psychologists, and social workers). Inmates remain an average of four and a half years. Treatment consists of small groups and a "graded tier" system that uses the behavioral hypothesis of operant conditioning.

Although broad categories of offenders are eligible for examination at Patuxent, the trend over time has been toward the referral of predominantly violent offenders (from 41 percent in 1955 to 71 percent in 1972). Controversy (Hodges, 1971) has increased regarding the usefulness of indeterminate sentencing and the methods and efficacy of treatment at Patuxent. In a report (Department of Public Safety and Corrective Services) dated January 9, 1973, recidivism rates were reported of a sample of prisoners who passed through the institution. It should be added that this report of the Department of Public Safety and Correctional Services of Maryland resulted in the withdrawal of a Maryland House Bill that called for the abolishment of Patuxent Institution. The report discusses recidivism rates of 577 patients referred for diagnosis (see Table 44-1). If these statistics are correct, it is clear there is a direct relationship between the amount of treatment a patient receives at Patuxent and his recidivism rate on release. One problem in assessing the statistics is that the recidivism rates for each category include convictions for all sorts of crimes. When compared with the careful study by Kozol (1972, p. 392), in which a general recidivism of 32 percent was reported, the 7 percent rate at Patuxent is remarkable. In examining the data, however, the patient who receives full treatment receives in-care for an average of four years and parole delinquency status for another three years. Only then is he finally released. If a patient commits a crime at any time during his parole status, he does not appear on the recidivism

statistics of the fourth category. After three years of unviolated parole, when the patient is released from delinquency status, the odds that he will enter the last category as a success rather than a recidivist are greatly increased. This is supported by the statistics for the period 1959-1969, which show that 45 percent of the parolees violated their parole—26 percent by committing a new crime. If we add the 26 percent to the 7 percent rate shown, we arrive at 33 percent, a figure approximately that of the Bridgewater Study by Kozol. Lastly, it has been reported in support of indeterminate sentencing that only 3 percent of the first 638 patients have not experienced some form of release. Actually, Schreiber (1970) reports that of 348 inmates presently committed, 151 are beyond their original terms. Because the effects of treatment are not as broad or clear-cut as represented in the report, serious questions arise as to the propriety of indefinitely sentencing an offender, given the limited predictive ability of the psychiatrist and the questionable success of the treatment.

In addition to the above questions, a federal and a Maryland state court challenged the institution's theoretical justification on practical grounds. First, a federal court22 ruled that a prisoner who was convicted of assault and sentenced to five years imprisonment, but who was sent instead to Patuxent indeterminately, refused psychiatric examination, and remained beyond his original sentence, *had* to be released, because: (1) continued confinement was unlawful in that the petitioner was no longer in the class eligible for

commitment; and (2) his refusal to submit to a psychiatric examination did not justify his continued confinement. Supreme Court Justice Douglas made much of the second point, supporting the petitioner's claim to a Fifth Amendment right against self-incrimination. Second, a lower two-judge court (McCray v. Maryland, 1971) ruled in favor of inmates concerning the terrible conditions of solitary confinement—in fact, some of the conditions were worse than those proscribed by the American Correctional Association for Prisons—the lack of rules governing conduct of prisoners and staff, the diet, the censorship of mail, and the number and training of the staff. The court concluded that the "maintenance of prisoners in cells in a prison-like setting with the offering of group therapy and limited rehabilitative vocation training is not a total rehabilitative effort" (McCray v. Maryland, 1971). This may account for the mostly poor response of the press (Stanford, 1972) to this prison.

*Table 44-1. Recidivism Rates—Comparing Four Groups of Patuxent Patients and the National Recidivism Rate**

	NUMBER	RECIDIVISM RATE, PERCENT
Patients recommended for commitment but not committed by the courts (not treated, subjected to regular correctional system programs)	156	81
Patients released at rehearing against staff advice, in-house treatment only	186	46
Patients released at rehearing against staff advice, in-house treatment, plus conditional release experience	100	39

Patients released at recommendation of staff of Institutional Board of Review, in-house and continued treatment for three years on parole	135	7

**Statistics are for 1955-1964 (Department of Public Safety and Corrective Services, 1973, p. 3).*

The Center for the Care and Treatment of Dangerous Persons at Bridgewater, Massachusetts, was established in 1959 to implement a 1958 state law providing for the indefinite detention and treatment of dangerous offenders. Dangerousness is narrowly defined as a potential for inflicting serious bodily harm on another person. A prerequisite for such a finding is a past history of violent acts. Those offenders remanded to the Center are given a most extensive and meticulous examination made independently by at least two psychiatrists, two psychologists, and a social worker. Each diagnostic study includes a clinical examination, psychological testing, and a reconstruction of the life history, elicited from many sources. Table 44-2 gives a statistical examination of a sample of offenders processed by the Center, for serious assaultive crimes committed by the total of 435 patients released (Kozol, 1972, p. 390). The mean age of all 435 patients released was 35.6 years, unlike the Baxstrom population, which was middle-aged at the time of transfer to civil hospitals. It then seems unlikely that the recidivism rate was affected by the aging process.

As the Table 44-2 indicates, the Center's success in predicting dangerousness was good as to offenders recommended for release both

before treatment and after commitment for treatment. Of 386 patients released upon the Center's recommendations, only thirty-one (8 percent) committed crimes. Since the number of patients (forty-nine) released against the Center's recommendations is rather small, the recidivism rate may not be generalizable to larger samples. Nevertheless, this group had a combined recidivism rate of 34.7 percent. Although this figure exceeds the rate of the group of patients recommended for release, what is striking is that the Center was only 34.7 percent successful in predicting dangerousness in this group. That is, 65.3 percent proved to be false positives, that is, found to be not dangerous after release, in spite of predictions to the contrary. What is distressing is that even with a very narrow definition of dangerousness, the Center massively over predicted dangerousness in the group it recommended against releasing.

Table 44-2. Recidivism: A Comprehensive Study of All Patients Released

		RECIDIVISTS	
	NUMBER	NUMBER	PERCENT
Recommended for Release			
At time of initial diagnostic study	304	26	8.6
After commitment and treatment	82	5	6.1
Total	386	31	8.0
Not Recommended for Release			

At time of initial diagnostic study	31	12	38.7
After commitment and treatment	18	5	27.8
Total	49	17	34.7
Total of all patients released	435	48	11.0

There are a few other American institutions that try to treat the disturbed offender. Among these are Vacaville (California) and Springfield (Missouri) in the federal system. For the most part, they are said (Goldfarb, 1973) to range from a cheap version of Patuxent to just plain awful.

The role of the psychiatrist in the "treatment" of the chronic and/or dangerous offender is still being defined, as are the determinants of criminal behavior. As with the mentally ill, labeling of the offender (mentally ill or not) without some kind of resources for treatment or rehabilitation is a mockery at best and pernicious at worst. Certainly the psychiatrist has a role to play in the areas of prediction of dangerousness and the testing of the efficacy of various modes of intervention, if only to determine the narrowness of that role. The relationship between frustration and aggression, the genesis of violent behavior, the interaction between biological, psychological, and social variables in criminality with or without violence, and the role of prisons and extramural services in treatment and resocialization are still being developed. The psychological areas of poor self-image, genesis of aggression, and narcissistic rage show some promise of delineating certain motivational

factors that interdigitate with social situations in triggering violence toward other persons.

Most of the evidence points toward the necessity of developing small, specialized prisons for only the narrowest segment of convicted offenders. Such concepts as the use of space for developing optimal closeness and distance; stepwise increases of perimeter, stimulation, and responsibility; and the use of group supports and therapy can be tested there. It may well be that in such a setting the negative response to dangerous offenders can be minimized and less harm done to them (Goldfarb, 1973; Halleck, 1971; Lion, 1973). Ways of doing this can be gleaned from the methods used by the three European treatment prisons described above. Some of these methods are the prisons' small size, the importance of the first four to six weeks of a prisoner's stay, the use of intense group experiences (Jew, 1972), the sharing of responsibility by prisoners and staff with prisoners voluntarily (Barr, 1967) involved to a larger degree, and the use of graduated release. All of the prisons (Morris, 1965) that successfully treat offenders have these characteristics, and they also have an average stay of eighteen months. The failure of American experiments along the same line may result from not using those criteria noted, as well as from attempting to care for our entire class of offenders, once defined, rather than an optimal number. Thus the programs have been overwhelmed.

If, in addition, we can begin to predict dangerousness so that the truly dangerous can be segregated and given an opportunity to change, then the fear as well as the danger of harm to the ordinary citizen may be substantially reduced. The dangerous felon can return to the open community to live a better and less criminal life.

Psychiatric Reports and Testimony

In order to collect data effectively, make recommendations, and be of help to the client, patient, offender, prisoner, or parolee, or to the lawyer, court, or treatment staff, the following are areas that should generally be understood.

1. A psychiatric expert should be qualified and experienced in the diagnosis and treatment of persons with various mental disorders. He should have some knowledge of offender and normal populations. He should know the law pertaining to the area of difficulty being discussed and should confer with the lawyer, the court, or other persons asking for his expertise, to determine if he can play a role, and if so what kind.

2. The psychiatrist must clarify his role (as previously defined) with the person being examined, explaining such issues as confidentiality or the lack of it, possible consequences of the revelation of information, and how data will be used by the lawyer, court, or any agency involved.

3.A clinical examination should be carried out, usually in two to six hours in one half hour segments divided over days or weeks. An anamnestic history should be taken, with careful attention paid to facts and attitudes about alleged crimes and violence, attitudes about self and others, feelings about relationships to others (family and community), and prospects for the future. Unlike an examination of a person who seeks psychiatric help, these examinations should seek to establish facts as well as fantasy, which must be carefully differentiated.

4.Special tests should be run, including: (a) other medical examinations, e.g., neurological, endocrine, and so forth; (b) electroencephalograms; and (c) psychological tests to corroborate clinical findings, including organicity, and to reveal any less apparent psychopathology.

5.Data from other sources should be included. Information from family, friends, employers, police, witnesses, arrest records, and hospital or correctional records should be used, when available, to produce a composite picture of the individual's personality, alleged offense(s), and possible responses to punishment and treatment.

The data are then summarized and used to answer questions concerning illness, dangerousness, competence, accountability, and treatability in the form of correspondence, reports, depositions, or testimony.

In 1967 the Federal Appeals Court, District of Columbia, in attempting to help psychiatrists understand their role there, developed instructions40 to

ensure the collection of adequate information in cases involving insanity defenses. As stated below, these instructions provide an excellent description of what is expected of a psychiatrist in court:

Court's Instruction to Expert Witness in Case Involving the "Insanity Defense"

Dr. _____, this instruction is being given to you in advance of your testimony as an expert witness, in order to avoid confusion or misunderstanding. The instruction is not only for your guidance, but also for the guidance of counsel and the jury.

Because you have qualified as an expert witness your testimony is governed by special rules. Under ordinary rules, witnesses are allowed to testify about what they have seen or heard, but are not always allowed to express opinions and conclusions based on these observations. Due to your training and experience, you are allowed to draw conclusions and give opinions in the area of your special qualifications. However, you may not state conclusions or opinions as an expert unless you also tell the jury what investigations, observations, reasoning, and medical theory led to your opinion.

As an expert witness you may, if you wish and if you feel you can, give your opinion about whether the defendant suffered from a mental disease or defect. You may then explain how defendant's disease or defect relates to his alleged offense, that is, how the development, adaptation and functioning of defendant's behavioral processes may have influenced his conduct. This explanation should be so complete that the jury will have a basis for an informed judgment on whether the alleged crime was a "product" of his mental disease or defect. But it will not be necessary for you to express an opinion on whether the alleged crime was a "product" of a mental disease or defect and you will not be asked to do so.

It must be emphasized that you are to give your expert diagnosis of the defendant's mental condition. This word of caution is especially important if you given an opinion as to whether or not the defendant suffered from a

"mental disease or defect" because the clinical diagnostic meaning of this term may be different from its legal meaning. You should not be concerned with its legal meaning. Neither should you consider whether you think this defendant should be found guilty or responsible for the alleged crime. These are questions for the court and jury. Further, there are considerations which may be relevant in other proceedings or in other contexts which are not relevant here; for example, how the defendant's condition might change, or whether there are adequate hospital facilities, or whether commitment in the courtroom is the kind of opinion you would give to a family which brought one of its members to your clinic and asked for your diagnosis of his mental condition and a description of how his condition would be likely to influence his conduct. Insofar as counsel's questions permit, you should testify in this manner.

When you are asked questions which fall within the scope of your special training and experience, you may answer them if you feel competent to do so; otherwise you should not answer them. If the answer depends upon knowledge and experience generally possessed by ordinary citizens, for example questions of morality as distinguished from medical knowledge, you should not answer. You should try to separate expert medical judgments from what we may call "lay judgments." If you cannot make a separation and if you do answer the question nonetheless, you should state clearly that your answer is not based solely upon your special knowledge. It would be misleading for the jury to think that your testimony is based on your special knowledge concerning the nature and diagnosis of mental conditions if in fact it is not.

In order that the jury may understand exactly what you mean, you should try to explain things in simple language. Avoid technical terms whenever possible. Where medical terms are useful or unavoidable, make sure you explain these terms clearly. If possible, the explanation should not be merely general or abstract but should be related to this defendant, his behavior, and his condition. Where words or phrases used by counsel are unclear, or may have more than one meaning, you should ask for clarification before answering. You should then explain your answer so that your understanding of the question is clear. You need not give "yes or no" answers. In this way any confusion may be cleared up before the

questioning goes on.

> Some final words of caution. Because we have an adversary system, counsel may deem it is his duty to attack your testimony. You should not construe this as an attack upon your integrity. More specifically, counsel may try to undermine your opinions as lacking certainty or adequate basis. We recognize that an opinion may be merely a balance of probabilities and that we cannot demand absolute certainty. Thus you may testify to opinions that are within the zone of reasonable medical certainty. The crucial point is that the jury should know how your opinion may be affected by limitations of time or facilities in the examination of this defendant or by limitations in present psychiatric knowledge. The underlying facts you have obtained may be so scanty or the state of professional knowledge so unsure that you cannot fairly venture any opinion. If so, you should not hesitate to say so. And again, if you do give an opinion, you should explain what these facts are, how they led to the opinion, and what if any, are the uncertainties in the opinion.

In an earlier report on psychiatric testimony, the Group for the Advancement of Psychiatry (1954) noted the limitations of the psychiatrist as expert witness:

1. He cannot fit any scientifically validated entity of psychopathology into present legal formulae of insanity. He cannot determine by scientific method the existence of "knowledge" as explained in legal tests, excepting in cases of disturbed consciousness or profound mental deficit.

2. He cannot testify in any manner in terms of moral judgment.

3. He cannot within the framework of present court requirements determine degree of legal responsibility calibrated to medical degrees of psychopathology.

As for competence, it was stated (1954):

1.He can predict behavior of the mass statistically and determine with fair accuracy the classes of undeterrable persons. He can predict the tendency of behavior in the individual and with fair accuracy determine his deterrability.

2.He can with fair accuracy determine the degree of disorder of the accused relating to: (a) the present mental state of the accused as it is relevant to his capacity to appreciate the significance of the charge and to cooperate in the preparation of his defense; and (b) the causal connection of the mental state and the act charged.

3.He can make advisory recommendations for suitable disposition of the convicted.

Twenty years later it would appear that the competence of the psychiatrist was exaggerated. Only now are the problems beginning to be understood, as the legal and psychiatric professions examine the questions together.

Rights of Patients

During the Age of Reason, two principles were articulated that expressed the sentiments of society regarding the treatment of persons designated as patients. The first, the right to be treated humanely, was applicable to the physically as well as the mentally ill and, in psychiatry, was

expressed in the work of a group of men known as “moral” psychiatrists: Pinel, Tuke, and Chiarugi. Since “moral psychiatry” argued that the location of the problem and its possible correction lay in the higher (moral) faculties, the second principle supported the right of a patient to participate—that is, share responsibility—in the treatment.

These two rights slowly evolved into the patient’s right to be treated as responsible and, as circumstances permitted, free. Public health laws, including mental health codes, shifted from concern for the protection of society to concern for the rights of individuals. This resulted in a gradual lessening of the doctor’s power over a patient’s body and mind. The rights of patients have been increasingly broadened and clarified, while the rights of physicians have been narrowed to agreements for specified interventions at agreed-upon times. Civil and criminal charges relating to breach of contract, false imprisonment, invasion of privacy, assault and battery, and negligence, can be brought against the psychiatrist. Freud (1964) emphasized that the psychoanalyst must not take advantage of the transference. Undue influence and advantage taken by the psychiatrist in relation to the patient’s transference has been perceived in two cases (Hammer v. Rosen, 1960; Landau v. Werner, 1961), with findings for the plaintiff in both. Prudence is required to be certain that suggestions are suggestions and prescriptions only prescriptions.

Lastly, the patient's conduct outside of the physician's office, if criminal, should raise questions concerning the physician's involvement. Certainly, should the patient indicate the possibility of future dangerous behavior, (and if he is not certifiable as legally mentally ill), then serious questions of the doctor's posture vis-a-vis privilege and public policy, can be raised. This allocation of a greater share of responsibility to the individual for his destiny in regard to behavior, illness, and death has put a larger burden on the physician in terms of accountability. It has also demanded of the physician a greater concern with ethics and public policy as regards the nature and extent of his interventions with other citizens. As developing technology allows attempts to be made to prolong life and to modify and control behavior, serious discussions of the implications for the limiting of liberty and choice ought to be continuing. And psychiatrists, lawyers, and jurists should be leading the way.

Privilege

Four criteria are universally accepted for judging any privilege's appropriateness:

1. The communication must originate in a confidence that they will not be disclosed.

2. The element of confidentiality must be essential to the full and satisfactory maintenance of the relationship to the parties.

3.The relation must be one which, in the opinion of the community, ought to be sedulously fostered; and

4.The injury that would inure to the relation by the disclosure of the communication must be greater than the benefit thereby gained for the correct disposal of the litigation (Wigmore, 1961, Sect. 2285).

Such privilege has been granted the attorney-client, physician-patient, and clergyman-penitent relationships. But all professional-client privileges contain exceptions, usually in relation to criminal rather than civil laws. The exceptions usually relate to the fourth item above—that is, when the "benefit gained for the correct disposal of the litigation" outweighs the "injury that would inure to the relationship by the disclosure." The attorney-client privilege covers all civil actions and criminal actions *except* where the attorney has knowledge (or ground to believe) that his client (1) was contemplating the commission of a crime (future crime exception) or (2) was attempting to suppress the discovery of a crime already committed (Wigmore, 1961, Sect. 2298).

The physician-patient privilege is only applicable to civil actions. However, the clergy-penitent covers all communications in all kinds of actions. The nature of the psychiatrist-patient relationship—because of the intense, probing character of the communication, the desirability of expressing things not acceptable to society at large, and the concern for

feelings and fantasy as well as facts—seems to make it closer to the clergy-penitent relationship, which alone remains unhampered. Historically, however, psychiatrists, as physicians, have used the physician-patient privileges when available. Only California (People v. Scheer, 1969) has sought to distinguish between physician-patient and psychiatrist-patient. A probable mistake was the proposal (1960) of a model statute by the Group for the Advancement of Psychiatry, which in 1960 stated, "The confidential relationship and communication between psychiatrist and patient shall be placed on the same basis as regards privilege as provided by law between attorney and client." Neither the physician-patient nor lawyer-client privilege can provide the protection needed for a full psychotherapeutic relationship. An Illinois trial court recognized that a psychotherapist-patient relationship was worthy of more extensive privilege than a physician-patient relationship. The reasons are worth noting (Binder v. Ruvell, 1952):

1. A thorough examination for mental illness and more important, a thorough cure, cannot take place unless the patient reveal his thoughts. A therapist cannot ferret out secrets of the mind in the way a physician can ferret out secrets of the body.

2. Whereas an organic illness can be treated without trust between a physician and patient, a mental illness cannot.

3. If the patient feels betrayed by one analyst, chances are that he will mistrust the whole profession—and thus negate his chances for future treatment. On the other hand, patients frequently seek out

new doctors.

In criminal actions, the conflict between injury and benefit is more of concern to the accused and to society as a whole. It is not helpful to say that psychiatrists do not treat criminals, as they may, and it cannot be ignored in relation to the entire area of the treatment of offenders, dangerous or not. Such persons are more in need of privilege—to talk without fear that their therapist will testify against them in court—than is the civil litigant (MacCormick, 1959; Slovenko, 1960; Slovenko, 1966).

Informed Consent

The physician's duty to inform his patients is derived from his duty to obtain the patient's consent to the proposed treatment. Consent consists of awareness and assent. Battery was the older theory of recovery in relation to this concept, but since the late 1950s a second ground—negligence—has been developing. The classic case where consent is not required is an emergency situation where the life and health of the person is in immediate danger. Consent is held to be implied.

Consent can be imposed by the law—for example, inoculations. Upon application of a physician or hospital, a few courts have ordered medical treatment for a nonconsenting adult on the grounds that the state, as *parens patriae,* has an interest in protecting the patient's life. This is especially true if

the patient has children who would become wards of the state on his incapacity or death.2 A few cases appear to condone the withholding of information when a disclosure of collateral risks to a treatment may unduly alarm an already apprehensive patient. Arguments tend to be paternalistic, usually based neither on law nor logic. The problem of innovative treatment, the results of which are not fully known or explored, is informing the patient and getting his consent. In response to this, Waltz (1970) states:

> If a physician acted improperly by going ahead with an innovative technique as to which there were too many unplumbed questions involving its potential risks, liability will flow from the physician's unreasonable consent. If, on the other hand, lie acted reasonably in going forward on the basis of existing knowledge, the patient's consent even to the possibility of unanticipated risks is again irrelevant, since the physician had no legal duty to disclose risks about which he neither knew nor should have known, and for that reason alone he is immune from liability.

This leaves the position of consent intact, and does not thwart the development of new ideas for medicine. Three court decisions in California (Cobbs v. Grant, 1972), the District of Columbia (Cantebury v. Spence, 1972), and Rhode Island (Wilkenson v. Vesey, 1972) in the 1970s together more clearly define the legal position in relation to informed consent in medical malpractice. That position is (Breckler, 1973):

> Respect for the patient's rights of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves. Unlimited discretion of the physician is irreconcilable with the basic right of the patient to make

> the ultimate informed decision regarding the course of treatment to which he knowledgeably consents to be subjected.

In Cobbs versus Grant (1972), the court indicated that the patient had an abject dependence upon and trust in his physician for education in regard to his condition. That is, the relationship between physician and patient was a fiduciary one. It was further stated that "adults of sound mind have a right to determine whether to submit to lawful medical treatment." And in Cantebury versus Spence (1972), it was emphasized that ". . . the decision whether or not to undertake treatment is vested in the party most directly affected: the patient." There were no exceptions except for emergency or incompetency. The most important element in obtaining informed consent is discussion of death, bodily harm, recovery and recuperation, and the possible complications. The patient should know all his options.

In the area of mental illness, how may consent be properly obtained when the mental illness of the patient is severe enough to render the patient incapable of consent? The standard used by the courts is the same as that for competency to stand trial—that is, to be able to understand the seriousness of the information that the doctor is required to give him and to make a decision based on that knowledge. If a patient is not competent to give consent, it can be given by the person *legally* responsible for the patient (Faber v. Olkon, 1953). In a pair of decisions the U.S. district court in Alabama held as unconstitutional a statute which allowed sterilization of mentally retarded

inmates at the behest of the superintendent and assistant superintendent of the institution, and set down guidelines for informed consent in such a situation, and for the review of that consent.[10]

Medicine, Psychiatry, and Liberty

Progress in the physical sciences and medicine has resulted in increased freedom, due to technological innovations, that make the quality of life less harmful and more enjoyable with the decline in sickness and premature death. Equally serious dangers have become more apparent in recent years, with resulting concern about overpopulation, pollution, surveillance, and behavior control.

Participation in Medical Research

Such studies fall into two categories: (1) therapeutic experiments conducted in the context of the traditional doctor-patient relationship; and (2) experiments that are aimed at acquiring knowledge of potential value to others but of no benefit to the research subjects themselves. The first category is covered by malpractice and contract law, as noted above. The second category of research, carried out to serve the scientific interests of the investigator, raises more difficult problems, with many uncertain ethical and legal questions. In 1971 the Public Health Service produced new guidelines (Department of Health, Education, and Welfare, 1971), including a

sophisticated discussion of the types of risk that may occur (such as physical, psychological, and social dangers), and it lucidly defined the differences between therapy and experimentation. Detailed criteria for informed consent were provided and exculpatory clauses were expressly prohibited.

Yet a number of problems about research remain unresolved. One is that of research on civil prisoners. Inmates often are enthusiastic about participation because they get paid, it relieves monotony, and it implies earlier release. It is doubtful whether truly noncoerced consent can be obtained from prisoners. A prisoner in Michigan, diagnosed as dangerous and chosen as a subject for psychosurgery, was *not* allowed to be a subject although he himself was strongly in favor of it. In this case, a panel of experts and the state agreed that there could be no true consent to this procedure for this prisoner (Rawls, 1971). One argument for research on prisoners is that society needs to understand and control dangerous and/or repetitive criminal behavior. Many and at times extreme approaches have been suggested, including lithium therapy (Sheard, 1971), in-depth electrode placement, and ablation of parts of the brain (Maletsky, 1973; Mark, 1970; Rawls, 1971). This is all being proposed on the basis of a behavioral complex characterized by episodic "violent" behavior (Maletsky, 1973; Mark, 1970; Monroe, 1970). As discussed above, it remains theoretically possible and practically valid to have therapeutic experiments aimed at controlling violent behavior so that offenders might lead more free and satisfying lives.

Nevertheless, there should be absolute freedom from coercion. Methods by which acceptable research can be carried out in this area are still being devised.

More subtle are the ethical questions (Medical Tribune, 1973) raised concerning the use of long-acting medications or electrode implantation in the control of psychosis, epilepsy, and other behavior. Such medication, once injected, can affect the individuals for weeks and possibly months. How, and when and to what extent such medications should be used experimentally or therapeutically requires continuing discussions of public policy.

Another set of unresolved problems concerns research on subjects who are incapable of giving informed consent. This includes children and the mentally incompetent. Should any hazardous research be carried out on these groups? If so, who should provide consent and under what limitations? What standards should govern nonhazardous but painful studies? Still further, to what extent has the burden of research participation been lifted from the indigent hospitalized? What about mass testing of drugs by American companies in countries other than the United States?

Lastly, what threats to civil liberties are inherent in the medical process of organ transplantation? Serious questions regarding the definition of death, the choice of subjects, and the equitable distribution of scarce biological

resources are raised. The newest development in medicine is the possibility of producing human beings through a type of asexual reproduction known as "cloning." If it becomes feasible to produce such individuals, what are the consequences for them as well as for the rest of us?

Freedom to Be Wrong, Freedom to Die

As medical science progresses and its technological assets increase, there is an increasing illusion that the power of the physician over illness and death is absolute. Because of this the physician, when confronted with not knowing what to do, usually responds with a massive use of technological supports as a means of handling his own anxiety. This often results in a maintenance of metabolism but of little else that resembles life as we ordinarily experience it. Patients who do not wish to be treated or saved should have the right to make that decision. Each person should be able, when possible, to die in his own way and in his own place, as long as he brings no harm to others (Lerner, 1970). As populations live longer, physicians have an increasing proximity to death as a part of life (Barton, 173).

To insure a dignified death, the patient should have the right to know the truth, to experience human company and caring, to share in the decisions, and to be unmolested if that is his wish. Should the patient be incapable of communication, comatose, senile, or mute, it is suggested that the physician

act in a way that he believes would be consistent with the patient's wishes (Kass, 1972). Since euthanasia (Furlow, 1973), in relation to the hopeless and terminal patient, has become more of an issue as the number of such individuals increases, there have been renewed discussions of its ethical and moral implications. The more we know, the more difficult the questions become. In attempting to determine the possible limits of human behavior, concern with maintaining optimal freedom should be central. In that regard, the words of Supreme Court Justice Louis Brandeis are instructive (Olmstead v. United States):

> Experience should teach us to be most on guard to protect liberty when the government's purposes are beneficent. Men born to freedom are naturally alert to repel invasion of their liberties by evil-minded rulers. The greatest danger to liberty lurks in insidious encroachment by men of zeal, well-meaning hut without understanding.

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Notes

1 This Mental Health code has been modified since 1963. For comparison see 111. Rev. Stat. Chap. 91 1/2, Sects. 1-17, 1952.

2 See The Narcotics and Drug Abuse Task Force Report, in which civil commitment is tentatively recommended (President's Commission on Law Enforcement, 1967, p. 17).

3 Donaldson v. O'Conner, 493 F2d 507, (5th circuit), 1974

4 Wyatt v. Aderholt, 493 F2d 712, (5th circuit), 1974

5 See also "APA Favors ALI Test of Criminal Responsibility," Psychiatr. News, 6 (1971).

6 See also "APA Favors ALI Test of Criminal Responsibility," Psychiatr. News, 6 (19 7 1) .

7 See references 82 [pp. 347- 351], 129, 143 [pp. 84-88, 2 18], 154 [pp. 778-798], and 183 [p. 151].

8 As of early 1975: S 1-1975, Report by Committee on the Judiciary of the United States Senate. Federal Criminal Code, Chapt. 23, Sect. 2302 (b).

9 Murder, second degree; arson; forcible rape; robbery while armed with a deadly weapon; mayhem; bombing of an airplane, vehicle, vessel, or other structure.

10 Wyatt v. Aderholt, 368 F Supp. 1382, 1973 Wyatt v. Aderholt, 368 F Supp. 1383, 1974.