SOCIALLY JUST HEALTH CARE IN MENTAL HEALTH POLICY

by

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ABSTRACT

Americans idealize personal freedom. Every citizen recognizes the cries for "life, liberty, and the pursuit of happiness" demanding individual choice be upheld in the United States. Our ideals are ingrained in our culture and manifest in our national documents, governances, and traditions. Our health care system is no exception.

For years, medical schools have taught bioethics courses to student physicians. Schools design courses to train providers in biomedical ethics. Despite developing more patient centered treatments, mental health care—a major component of health care—lags behind in socially just care. Throughout my thesis I will discuss the discrepancy between somatic health care and mental health care, as well as the risks of compromising basic personal autonomy. In order for physicians to provide socially just health care, they must respect the principle of autonomy and abstain from treating a patient against their will.

For the purposes of this paper, I am not writing an anti- nor a pro-suicide position. I do not suggest we stand idly by while watching someone gravely injure themselves or suffocate within their pain. What I am saying is that suicidal ideation is not mitigated by confinement and social isolation. Even if you believe suicide is wrong, overreacting to suicidal ideation is an ineffective and potentially harmful way to combat suicide. In this paper, I am questioning the policies of involuntary-psychiatric hospitalization.

Chapter I – Prioritizing Autonomy

To begin, I refer to Tom Beauchamp's and James Childress's *Principles of Biomedical Ethics* which identifies four pillars of moral reasoning for health care professionals.[1] These pillars are respect for autonomy, non-maleficence, beneficence, and justice. For the purposes of this paper, I focus on the principle of autonomy as it applies to a patient's self-governance. Per *Biomedical Ethics*, autonomy is a philosophical concept of self-governance that requires both liberty and agency. *Liberty* is a state of independence free from imposed authority or coercive influences. For example, an individual has the liberty to act contrary to medical advisement regarding their personal medical care. *Agency* is a person's faculty for intentional action, specifically, the action of decision-making. How *intentional* an action is falls on the spectrum from capricious to conscientious, depending on age, attention, and lucidity.

I claim autonomy is an inalienable right, and as a right, physicians have the responsibility to respect patient autonomy. Although a physician may specialize in recognizing disease, patients *experience* disease. As such, ethical medicine requires an equitable partnership between healer and those who *desire* to be healed.

Before I broach who has the right to choose for the patient, namely the patient herself, I claim that when a person's capacity is not in question, we must empower autonomous choice. The infamous case of Donald "Dax" Cowart describes a 25-year-old patient in 1973 who sustained severe burns over 65% of his body following a gas explosion.[2] At the time of the injury Cowart presented to Parkland Hospital in Dallas, Texas. Despite Cowart's countless pleas for

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[1] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 4th ed. (New York: Oxford University Press, 1994), 120-170.

[2] *Dax Cowart*, Directed by Michael Brims, Jerome Crowder, Fabian Brims, and Donald Cowart (Houston, TX: Cosmic Light Productions, 2013).

treatment cessation, providers continued to extensively treat him. Cowart reported his experience in the documentary *Please Let Me Die.* When discharged from the hospital, he was unable to perform basic functions for himself, and was completely dependent on the aid of others.

In this case, medical providers considered what the pathophysiology of his injuries "indicated" as medically necessary, to the neglect of what the *patient* indicated as medically desirable. Physicians failed to obtain informed consent from Cowart. They instead presumed all life saving measures were indicated. Pertinent pathophysiology, such as the severity and likely lethality of his burns compelled clinicians to continue their work, but those same factors convinced Cowart that he wanted to discontinue care.

Although, according to the case report, Cowart was deemed capable of decision-making by psychiatric consult, physicians acted paternalistically and disregarded the patient's wishes. Therefore, the providers acted unjustly by forcing treatment on an unwilling patient. Had autonomy, or his autonomous decision, been respected, Cowart would have received socially just care.[3] Since Cowart's hospital discharge and rehabilitation he has become an advocate for patient autonomy, going so far as to earn his law degree from Texas Tech University. He has stated,

> The right to control your own body is a right you're born with, not something that you have to ask anyone else for, not the government, not your treating physician, not your next-of-kin. No one has the right to amputate your arms or your legs without your consent. No one has the right to remove your internal organs without your consent. No one has the right to force other kinds of medical treatment upon you without your consent. There is no legitimate law, there is no legitimate authority, there is no legitimate power anywhere on the face of this earth that can take the right away from a mentally competent human being and give it to a state, to a federal government, or to any other person. [4]

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[3] From the transcript made of the initial videotape and published as an appendix to Robert Burt, *Taking Care of Strangers: The Rule of Law in Doctor-Patient Relations* (New York: The Free Press, 1979), 174-80.

[4] "Confronting Death: Who Chooses, Who Controls? A Dialogue between Dax Cowart and Robert Burt," *Hastings Center Report* 28, no. 1 (1998): 14-24.

In the statement, Cowart exemplifies why the principle of autonomy is a corner stone of health care ethics. As persons, we have the inherent right to control our body; thus, we have the right to refuse medical interventions performed *to our body*.

By referencing Cowart, I not only demonstrate the egregious nature of compulsory care, I also allude to the idea of capacity. Capacity is a patient's *ability* to decide their own health care. Philosophers, Charland writes,

> In assessing claims about capacity, it is important to distinguish between descriptive and factual aspects of capacity on the one hand, and prescriptive and normative aspects on the other. As one commentator explains: 'a psychiatrist may give expert testimony, in his capacity as a trained observer, about a person's competence seen as a factual matter, and the judge may or may not give this testimony practical effect in deciding how we ought to treat that person' (Freedman 1981, 55). In this example, the first claim addresses the issue whether the individual *is* decisionally capable. The second claim addresses the issue whether the individual *should be* considered decisionally capable.[5]

Despite the fact that Cowart was deemed capable of decision-making by a psychiatrist, physicians acted in Cowart's supposed best interests, ignoring the psychiatric consult. I make this point not to question what qualifies a patient as "capable," but to illustrate the often-arbitrary role a patient's capacity plays when their wishes are contrary to a physician's goal.

Neither the concept of agency nor of liberty fully clarifies autonomy; therefore, I further argue that patient autonomy is a right, as opposed to a subjective capacity. A capacity is not a right, but a testable ability. If autonomy is a skill or a set of skills it does not mandate respect. Since skills are testable, they are therefore *certifiable.* A driver must be licensed to drive, implying the capability to drive under the law is a privilege to be *earned*, not freely awarded. In this case the burden of proof resides with the driver to show that she can drive. But in the

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[5] Louis Charland, "Decision-Making Capacity", *The Stanford Encyclopedia of Philosophy* (Fall 2015 Edition), Edward N. Zalta (ed.), <https://plato.stanford.edu/archives/fall2015/entries/decision-capacity/>.

framework of healthcare, if autonomy were a capacity then the patient would have to demonstrate their capacity to refuse care. While this is not the current model for somatic healthcare (SHC), it is a model which influences mental healthcare (MHC). Interpreting autonomy as a capacity in MHC but not SHC poses an unethical discrepancy in protocol.

Rather than being regarded as a capacity, autonomy must be regarded as a right. To do so, we must respect an individual's right to decide in line with her personal beliefs and values. For example, a Catholic defers to the authority of the Church following the conception of an unplanned pregnancy. The principle of autonomy obliges providers to respectful action which may require clinical inaction. In order to respect this ethical principle, not only must a patient's freedom to decide supersede a physician's will to intervene, but a provider must also enable informed decision-making by allaying concerns of choosing either action or inaction.

In my following argument, I highlight Immanuel Kant, John Stuart Mill, and John Rawls's influences as interpreters of the principle of autonomy. I reference their works to establish a standard lexicon in my argument. Kant purports that all persons are owed the right to determine the influences of their destiny because all persons have inherent and unconditional worth.[6] Mill defends the "harm principle," which claims that as long as a person's actions do not harm or endanger another, then she should be free to act as she wishes.[7] A peer may have a conviction that homosexuality is wrong, and I may have a conviction that it is permissible, resulting in a conflict of convictions. But Mill says that as long as my actions do not physically harm or endanger my peer, then my convictions do not unduly impose on hers.

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[6] Tom Beauchamp, "The Principle of Beneficence in Applied Ethics", *The Stanford Encyclopedia of Philosophy* (Spring 2019 Edition), Edward N. Zalta (ed.), URL = <https://plato.stanford.edu/archives/spr2019/entries/principle-beneficence/>.

[7] John Stuart Mill, *On Liberty* (original pub info; John W. Parker and Son, West Strand. London, 1859), 134-168.

Within the field of healthcare, the harm principle allows physicians to persuade a patient of her best interest, but not to coerce her to receive treatment she decides against. Mill advocates both non-interference and the active protection of choice and subsequent action. Finally, Rawls theorizes that people are "self-authenticating sources of valid claims." [8] He asserts that a person's wants or needs matter simply because *she wants or needs it*. The role of justice is to adjudicate between conflicting needs of individuals, because not all needs are mutually attainable. Regardless of attainability, every person's claims matter because every person has the right to want or need.

In Cowart's case, autonomy was treated as a capacity. A consultation was required to verify his "capacity" as a decision maker in his personal care. Defining autonomy as a capacity, as opposed to a right, risks manipulating, or worse exploiting, the patient. Autonomy as a right upholds patients' decisions whether or not to undergo medical treatments. Thus, when autonomy is viewed as a right the patient retains agency over their body, and the physician is not morally nor legally liable for the decision reached by the patient's chosen care.

The greatest concerns expressed by health care providers when discussing treatment options typically do not concern legal liability so much as moral responsibility.[9] A doctor may say, "I can't sleep at night if I didn't do something" or "I can't just let them die, that's not what we do. We help people. We *save* people." These expressions do not concern questions of medical malpractice *legally*, but rather questions of compassion. The hardest action for a person trained to act is inaction. Doctors express their frustration, knowing they could help someone but are

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[8] John Rawls. *A Theory of Justice*. Cambridge, Mass: Belknap Press of Harvard University Press, 1971.

[9] Eldo Frezza, "Moral Injury: The Pandemic for Physicians," *Texas Medicine* (March 2019): 4-7.

legally withheld from doing so. I sympathize with the provider's sentiment, but their sentiment is paternalistic, not patient centered.

I understand that doctors intervene to *help*. In fact, if they are legally held from medically intervening, that too creates a sense of helplessness. Eldo E. Frezza argues that moral distress for a physician is having the knowledge and means to act ethically, but being legally or fiscally restrained from doing so.[10] Frezza further writes, "A key component of moral distress is a sense of powerlessness. . .one can distinguish between a moral dilemma—in which there are multiple choices to make and the correct path may not be clear—and moral distress in which the way is clear, but the ability to implement a solution is somehow blocked."[11] But even within the article, "moral injury" is induced by corporations constraining physicians, not the patients themselves.

The difference between the powerlessness of a physician and the powerlessness of a patient is multifold. When a physician is powerless, they are withheld from providing. When a patient is powerless, their corporal and mental boundaries are violated. As helpless as a clinician may feel, they still hold greater power than the patient; therefore, the physician must be cognizant of the power imbalance when suggesting versus requiring care. Compulsory treatment, even in the best interests of a patient, is not justified. A physician may have limited power, but a patient being compulsorily treated has no power at all. In the next chapter I will address compulsory vaccinations, and the risk unvaccinated persons pose to the greater community.

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[10] Eldo Frezza, "Moral Injury: The Pandemic for Physicians," *Texas Medicine* (March 2019): 4-7.
[11] Eldo Frezza, "Moral Injury: The Pandemic for Physicians," *Texas Medicine* (March 2019): 4-7.

Chapter II – Competency

As written previously, the principle of autonomy must be respected in order to practice ethical medicine. That being said, I support exemptions or nuances for demographic groups such as minors, inebriates, people with concussions, the elderly, and several others. But it is not the focus of my paper to address these groups of patients. Not because these groups are unimportant, or regulation has been perfected, but because I generally agree with the protocol in place and promoted by the American Medical Association (AMA). In equitable medicine, if a patient is entitled to refuse SHC, then she is equally entitled to refuse MHC.

If we treat autonomy as capacity, we imply an individual must "earn" autonomy by meeting certain qualifications that determine one's ability to rule over oneself. Qualifications include a competent understanding of pertinent information offered by providers in lay-person terms. A patient should not be considered incompetent simply because the provider disagrees with her decision. The burden of proof must be on the one attempting to revoke agency from another. Patients have the right to refuse life-saving treatment.

A skeptic may claim, "there are situations where incompetency matters." There are situations which justify limitations to a person's individual freedom. These include cases of public threat, and violence to others. For the purposes of this paper, and the sake of time, I am choosing not to address clinical decision making from threatening persons, but rather, focus on those who pose a potential threat-to-self, and their right to refuse psychiatric hospitalization.

Ironically, for a country claiming unmatched policies of personal freedom, we are willing to sacrifice that freedom in order to restrict an individual deemed as a threat-to-self. It is as though the medical community protects the interests of a future patient over the interests of the present patient, violating the principle of autonomy and disregarding personal freedom.

Those involved with Cowart's case abused their authority by disregarding his personal autonomy and consequently failing to provide socially just medical care. Providers must respect patient autonomy in the form of treatment preferences. If autonomy is considered a capacity as opposed to a right, I claim injustices are more likely to occur because a patient is not guaranteed the same leniency in decision making. The liability rests in the agent who chooses. The agent must bear the weight of the medical, emotional, and fiscal risks of the treatment enacted regardless of their ability to assume these risks; therefore, a patient must be the agent of her own care.

Physicians must be advocates for the patient, aiding decision-making by offering choices and executing the patient's will from those choices, but not *deciding* for the patient. Patients have the right to make informed choices about which treatments to undergo, and which to decline uninhibited by a physician's paternalistic impulses. A critic may say, a physician ethically administers CPR when the will of the patient is unknown or unknowable, such as when a person is unconscious. The key nuance to this scenario is that the patient's will is either unknown or unknowable. Although the action of CPR is a life-saving measure when medically indicated, CPR performed on a patient who is both conscious and unwilling is unjust, unethical, and terrifying. Moreover, when a patient has an expressed and known DNR (Do Not Resuscitate), providers are legally bound to not perform CPR. To do so would not only break the law but would also assault a patient. The provider would not only act without consent but also act directly contrary to dissent.

Similarly, treatment of patients with mental disorders must also abide by the principle of autonomy. Mental healthcare is not relevantly different from somatic healthcare, or "typical healthcare," as it may be recognized in the general population. The case of Dax Cowart exemplifies the tragic outcomes of violating the principle of autonomy in medicine. Performing CPR on an unwilling patient spawns tragedy. So too does involuntary commitment of a person to a psychiatric inpatient facility.

While I acknowledge the legitimate concern that individual rights must be contextualized within the rights of many, the scenario of involuntary psychiatric commitment will be further explored in following Chapters. All persons have a right to safety, which should not be compromised by an individual person's autonomous choice. The idea of personal choice within the confines of public safety is in line with John Stuart Mill's idea of the harm principle and will be addressed below.

The American medical community outlines exceptions to autonomous choice. Exceptions include: an unconscious patient in life-threatening emergencies, a patient with waived consent, the cognitively declined, and those considered *incapable* of decision-making.[12] By using the word "incapable," the American Medical Association (AMA) frees providers to act coercively, or even directly, in patients' supposed best interest.[13] But by using a non-ubiquitous term such as "incapable" which must be further interpreted, the AMA allows a legal loophole. Providers are both judge and are judged for accessing a patient capable or incapable. Of course, while there are protections in place that may protect patients from the most overtly nefarious acts, the protections do little to protect a patient from being psychologically committed for their supposed own good.

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[12] AMA American Medical Association, Council on Ethical and Judicial Affairs and American Medical Association, *Code of Medical Ethics of the American Medical Association* (Chicago: American Medical Association, 2017), n.p.

[13] Ibid.

What a provider may consider as an "easy" medical decision may not seem easy to a non-professional. These same "easy" or "clear" decisions are coercive in nature when patients feel powerless; thus, the vulnerable are neglected. Consent is not a hoop to protect doctors from liability, but rather the means to ensure patient participation. A patient may decide against the obvious or medically indicated procedure, but disagreement with a professional does not indicate one's inability to decide.

I argue the principle of autonomy can be overruled by the need to protect public safety. If we define justice as "giving to each their due," as proposed by Aristotle, safety must be fairly distributed.[14] Patients have the right to be safe from compulsory care, and providers have the right to be safe from personal endangerment. In other words, persons with compromised decision-making do not have the right to endanger public safety.

That being said, individuals with an inability to make informed decisions do not inherently pose public threats. Compromised decision making occurs with cognitive decline, loss of agency, and decisions made under duress, that is, coercive "decisions." An altered state of cognition can present acutely, as in the case of a concussion, chronically, as in the case of dementia, or episodically as in recurrent psychosis. Additionally, an individual who is drunk, or otherwise under the influence of mind-altering substances, presents with cognitive inhibition. We hold inebriated persons culpable of violent action. So too, must we hold other states of acute altered cognition culpable for violence. Acting dangerously in a drunken stupor may be understandable, but it certainly does not make actions excusable.

Posing an active public threat does not always correlate with compromised decision-making. Violence and incoherence may appear simultaneously but are not mutually entwined. A

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[14] Plato, *The Republic* (CITY: Lerner Publishing Group, 2015), 17-29.

violent person may be sane, and a sane person may be incapable. Cognitive decline does not singularly pose a public threat. Sanctioning compulsory medicines and procedures to prevent violence is unwarranted and unjustified. Public threats are rightfully addressed by legal system for the protection of the community, but for the purposes of this paper I am only focusing on violence against self in legal adults. I will further address this claim in my argument below.

Considerations of mental illness should be kept separate from considerations of violence. Autonomy, as a right, should be assumed and overruled only in specific circumstances where the actions of the patient infringe on the rights of others, as described by Mill's harm principle. The harm principle states that individual liberties should only be limited in order to protect others from harm. Therefore, an individual's own wellbeing is not grounds enough for restricting her behavior.

Chapter III – Agency

Healthcare providers risk projecting their own personal biases, beliefs, and values as reasons to limit a patient's freedom. Another reason to value personal autonomy is to protect the rights of the individual despite a provider's cultural bias. A common point of conflict between providers' and patients' cultural preferences is religious differences.

For example, Jehovah's Witnesses believe accepting blood transfusions is immoral regardless of life-threatening circumstances. Most surgical consent forms in non-emergency interventions include a clause regarding transfusions. These clauses explain the risks of not accepting blood transfusions, and the patient then must express verbal and written consent wishing either to proceed or elect not to proceed with surgical intervention. A patient must *make* an informed choice, but a doctor must *offer* informed choice in order to meet the standard of biomedicine for ethical treatment.

The question of blood transfusions in treating Jehovah's Witnesses exemplifies quintessential respect for religious preference in patient care. Many clinicians would be upset if a patient died in the operating room because she refused necessary blood transfusions. The provider's personal morality and the patient's autonomous choice do not align, and yet the physician is legally and ethically bound not to perform transfusions. When providers respect the requests of a Jehovah's Witness, they respect the principle of autonomy, a major component of ethical medicine because the Jehovah's witness does not pose a threat to others. I will also say that children (minors under the law) pose unique ethical questions beyond the scope of this paper.

The medical community agrees that socially just healthcare protects the patient. As an essential component of socially just healthcare exceptions or exclusions to the principle of autonomy should be rare and scrupulously reviewed. Fundamentally, health decisions are not made in a vacuum, so policies and protocols must have the latitude to accommodate for individual variance. Clinicians must be cautious of coercion, power discrepancy, and cultural preferences.

A physician should be legally and ethically bound to not impose their own views and preferred treatment on a patient who presents to the ER with self-inflicted injury. The mental healthcare system fails to respect the principle of autonomy in any case when a provider deems a patient "an immediate danger to themselves" and consequentially orders commitment. Physicians who align treatment with their personal morality, in this case an adversity to self-injury, ensnare rather than liberate patients. The only justification for limiting an individual's freedom is to prevent harm towards others, not oneself; therefore, I claim mentally ill patients who pose a threat to themselves must not be forced to undergo treatment.[15]

A skeptic may purport "there are, of course, cases where a person should not be allowed to decide for themselves. When they might not be cognizant or *capable* of decisions." The skeptic's question highlights the dual understanding of "capacity." Referring back the Charland and Zalta, "[t]here are two ways to interpret the claims that are at odds in this dispute. First, there is the descriptive claim that the subjects *are* capable. Second, there is the normative claim that, notwithstanding this descriptive fact of the matter, the subjects nonetheless probably *should not* be declared capable."[16] Cognizance or capability are not the best measures of who has the right to decide. Instead, we should question whether or not a patient has the mental faculty to *reason* through a decision. A patient without higher ordered

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[15] Mill, *On Liberty*, 134-168.

[16] Louis Charland, "Decision-Making Capacity", *The Stanford Encyclopedia of Philosophy* (Fall 2015 Edition), Edward N. Zalta (ed.), <https://plato.stanford.edu/archives/fall2015/entries/decision-capacity/>.

thinking does not have the facility to interpret information so she cannot understand and weigh the risks and benefits of medical consent.[17]

A patient's ability to reason addresses many of the exceptions in full patient autonomy. Patients with dementia or high on mind altering substances do not have the mental faculty to reason. In this paper, I focus on mental illness specifically, a patient's right to refuse care. Some mental illnesses do hinder mental faculty, such as a state of delusion or extreme paranoia, symptoms secondary to uncommon mental disorders. That being said, a patient unable to reason, or a severely comprised ability to reason, does justify limitations to their medical autonomy. At least, until the patient regains the ability to reason.

My greater ethical concern is the case of individuals with suicidal ideation (SI), self-harm behaviors (SH), or depression. The idea that a person who is either suicidal or deeply depressed is therefore unable to decide for themselves is misguided at best. Just because a supposedly neurotypical person finds self-injurious behaviors disturbing does not justify restrictions to the self-injurer's autonomy. The same is true for an individual with suicidal ideation. Many clinicians are skeptical of a depressed patient's ability to make medical decision because of the patients depressed state, despite the patient's uncompromised cognitive reasoning.[18]

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[17] Tom Grisso & Paul Appelbaum, *The Assessment of Decision-Making Capacity: A Guide for Physicians And Other Health Professionals*,(Oxford: Oxford University Press.), 1998, 52–58.; Tom Grisso & Paul Appelbaum, "The MacArthur Treatment Competence Study. III. Abilities of Patient's to Consent to Psychiatric and Medical Treatment," *Law and Human Behavior*, 19: 149–174.; Tom Grisso & Paul Appelbaum, E.P. Mulvey, and K. Fletcher, 1995. "The MacArthur Treatment Competence Study. II. Measures and Abilities Related to Competence to Consent to Treatment," *Law and Human Behavior*, 19:126–148.; Buchanan & Brock 1989, 24–25; Brock, Dan, 1991. "Decision Making Competence and Risk,"*Bioethics*, 5(2): 105–112. Buchanan, Alec, 2004. "Mental Capacity, Legal Competence and Consent," *Journal of the Royal Society of Medicine*, 920: 415–420. Buchanan, Allen E., and Dan W. Brock, 1989. *Deciding for Others: The Ethics of Surrogate Decision Making*, Cambridge: Cambridge University Press.

Consider alcoholism from the lens of the harm principle an alcoholic is free to drink to his own detriment, but he has no right to neglect his responsibilities to others. If he neglects or abuses those under his care then his behavior is criminal, regardless of disease. Likewise, if in an inebriated state he drives and consequentially kills, then that too is a criminal act. We should hold the willingly unmedicated to the same standard as the willingly inebriated. The standard being: one of full culpability.

My point is action and behavior are distinct from disease: one does not guarantee the other. It would be ridiculous to think that just because someone presents with liver cirrhosis and vocalizes a desire for drink, we would lock him away for a week because he is an "immediate risk to self or others." But that is exactly what we do when a person with self-injurious behaviors presents to a health facility with a laceration and a vocalized desire for the pain to abate. Far more individuals die every day from complications of drinking than from attempted suicide, what's more, from unintentionally lethal, self-injurious behaviors.

Additionally, we do not attend to alcoholics or inebriation with the same fervor or forced pharmaceutical intervention which we do in mental health care (MHC). We have medications to aid in withdrawal symptoms and cravings addiction, but not only do we not force medication, many patients cannot attain these medications even when requested.

Mill acknowledges personal freedom and personal safety cannot always be simultaneously respected.[19] For example, a person does not have the freedom to endanger other persons. The iconic *Schenck v United States* (1919) court ruling contends the right of free speech

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[18] Elliott, Carl, 1991. "Competence as Accountability," *Journal of Clinical Ethics*, 2(3): 167–171.
–––, 1997. "Caring About Risks: Are Severely Depressed Patients Competent to Consent to Research?" *Archives of General Psychiatry*, 54(22): 113–116.; Abraham Rudnick 2002, "Depression and Competence to Refuse Treatment," *Journal of Medical Ethics*, 28: 151.

[19] Mill, John Stuart and ProQuest Academic Complete. *On Liberty*. Luton: Andrews UK, 2011.

does not extend to the fearmonger crying fire in a crowded theater.[20] Just so, a person behaving violently towards others must be isolated from those he threatens to injure. In this case a person is removed from society so his violent actions cannot be enacted, not so the public may be free from mentally ill persons.

That being said, diagnosis of a mental disorder is irrelevant to the consequences of violent action. Regardless of disorder, a person is culpable for the harm they cause. A person's mental disorder neither excuses harm inflicted nor justifies commitment by the community. *Insanity* is not a medical term, but an exclusively *legal* term. A diagnosis of schizophrenia does not excuse or condemn a person, just as heart disease does not justify violent action. A court may deem a defendant legally insane, but no such diagnosis exists in the medical community.[21] I am not suggesting that violent offenders are not influenced by a mental disorder, but rather, from a legal perspective, persons who behave violently towards others, regardless of etiology, should be prevented from violently injuring others. My point is in line with the harm principle. An individual does not have the right to harm others but does have the right to harm themselves.

For example, a 1999 New York law known as Kendra's Law proposes to "help serve loved ones while simultaneously keeping society safe" by enforcing assisted outpatient treatment (AOT) on persons deemed a threat to society based on mental illnesses. Similar to court-ordered rehab, Kendra's law authorizes judges to commit residents of the state of New York to AOT.[22] In mental health care outpatient treatment, or OT, is considered optional care. As a term *outpatient* widely ranges from intensive out-patient (IOP) to sporadic sessions of talk therapy. Any form of

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[20] *Schenck v. United States*, 249 U.S. 47 (1919).

[21] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Arlington, VA: Publisher, 2013), n.p.

[22] Ali Watkins, "A Horrific Crime on the Subway Led to Kendra's Law. Years Later, has it Helped?" *New York Times*, September 11th , 2018.

mental health treatment that excludes overnight hospital stays generally falls under OT. The "assisted" component of AOT requires the state provide means for patients to receive OT care. This also means patients are *ordered* to receive OT care. This may include compulsory antipsychotics and forced sedative injections.

The compulsory treatment functions as a condition for reintegration into society. Supporters of the law claim the statute prevents dangerous behavior rather than requires it. Kendra's Law originated from a tragic incident in New York City when a young woman encountered a violent man on the subway system. The perpetrator pushed Kendra in front of an oncoming train, leading to her untimely death. The aggressor happened to experience symptoms of schizophrenia, but his schizophrenia did not cause his murderous act.

Kendra's Law developed as a means to protect the susceptible from the violent. In reality, the resulting litigation served to stigmatize and ostracize mentally ill persons who may have no history nor inclination towards violence. The man's diagnosis not only prejudiced the law but offered a societally palatable reason for an unreasonable act. Kendra's Law demonizes an illness, not a murderer. Failing to distinguish the act from the actor's *incidental* neuropathology perpetuates discrimination against mental illness. I reference Kendra's Law to draw attention to an injustice. By applying the harm principle, I agree the man's violent actions justify restrictions from society, but I disagree that his diagnosis justifies forced pharmaceuticals or undesirable medical procedures.

A diagnosis alone does not warrant compulsory medical practice. For example, homosexuality has historically been considered sexually deviant and mentally disordered. As a result, many individuals suffered forced castration, medical sterilization, and gay conversion therapies. When queerness was medicalized, queer people were treated against their will. Abuses they endured were justified by similar caveats utilized in contemporary mental health care. A diagnosis categorizes, distinguishes the like from the unlike, and separates the "us" from "them." Separating a group based on alternative thought processing, social oddities or general otherness parallels historical internments based on culture race, and religion.

Ron Amundson claims disability to "be similar to the traditional concept of race. . . Like the concept of race, the concept of biological normality is invoked to explain [social variance].'"[23] But when the persons in power distinguish themselves as an "us" incomparable to "them", the persons without, they enable atrocities. For authorities to perform duties for "a higher purpose," "a greater good," or "the patient's best interests" is not only imprudent, it is totalitarian. Whether groups are distinguished by race or the concept of normality the majority must also respect the rights of the minority.

Human rights are universal, but capacity can only be understood through a social lens. An individual's capacity varies not only by person, but also by time, environment, and social engagement. Basing application of personal autonomy on idealized faculty does cannot accurately measure competency, but instead, measures ability from the framework of authority. Autonomy *must* be upheld as a fundamental human right, otherwise "best interests" empower *unjustified* actions.

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[23] Ron Amundson *Stud. Hist. Phil. Biol. & Biomed. Sci.*, Vol. 31, No. 1, pp. 33–53, (2000), p. 2.

Chapter IV – Diagnostic Bias

The art of patient care, especially psychiatric care, cycles between progressive highs and regressive lows. Take for example, Mary Couts Burnett, the patron of Texas Christian University's library. Mary was a Fort Worth native who married a wealthy cattle and oilman in Weatherford, Burk Burnett. When their only child died, Mary was certain her husband was trying to kill her. As a result, Mary's husband had her declared insane and restricted to a private house, isolated from her friends and family. Once Burk died, Mary escaped imprisonment and successfully sued for half of his estate. She then willed her estate, a sum greater than 3 million dollars, to TCU following her death. Through Mary's financial contribution and endowment, the University survived the Great Depression. At Mary's funeral in 1924, over a hundred female TCU students celebrated her life. The life "of a woman who refused to be held down and kept her own counsel about the distribution of her fortune."[24]

Mary's story is one of sorrow and ultimate triumph. It is unlikely for such a set of events to occur these days. This is progress. Nevertheless, contemporary psychiatric commitment has also regressed ethically. I refer to the story of Mary Couts Burnett to draw parallels to the injustices she suffered and injustices today. Not only are mental health care (MHC) and somatic health care (SHC) treated distinctly, as opposed to holistically, but the principle of autonomy is not equitably applied across health care.

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[24] *Handbook of Texas Online*, Debbie Mauldin Cottrell, "BURNETT, MARY COUTS," (accessed May 01, 2019), **http://www.tshaonline.org/handbook/online/articles/fbuad**.; Rebecca Sharpless, "Mary Couts Burnett", WITH Women in Texas History, (accessed May 01, 2019), https://www.womenintexashistory.org/audio/mary-couts-burnett/#

MHC is devalued in contemporary medicine. In this chapter, I return to the question of psychiatric commitment. I argue the principle of autonomy must be respected as a civil liberty, even in cases of mental illness. What's more, physicians cannot not ethically commit a person who poses a harm to self, but not others, which I will discuss further in the following chapter. In the following paragraphs I will discuss the distinction between SHC and MHC to demonstrate the arbitrary nature of these distinctions.

Mental health care is often minimized within the broader discipline of medicine. But there are no categorical differences between mental illness and somatic illness. Robert Kendell argues that both mental illness and somatic illness have somatic, mental and behavioral elements; so mental and somatic illnesses cannot be distinguished by their symptoms.[25] Nor are mental illness and somatic illness distinguishable by causation. Both have anatomical, physiological, and environmental causes. To summarize, mental illnesses and somatic illnesses do not have distinct qualities, so they are therefore indistinguishable.

That is not to suggest that mental health care and somatic health care are the same, but rather, the distinction between MHC and SHC is socially derived. The tendency to separate MHC and SHC demonstrates a lack of scientific reckoning. In this paper I refer to MHC and SHC to clarify which set of protocols I am referring to; that is, the protocols used in MHC or protocols used in SHC. Without a change in symptoms, a change in diagnosis shifts both how a patient is heard and how her care is administered. Somatic illness and mental illness are not definably distinct, but MHC and SHC have distinct policies and procedures.

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[25] Robert Kendall, "The Distinction Between Mental and Physical Illness," *British Journal of Psychiatry,* June (2001), 178:490-3.

I refer to the discrepancy between somatic and mental health to further clarify questions of patient autonomy. One may express concern about patient autonomy in individuals with cognitive decline, altered cognition, psychosis, or intellectual disability. I understand these concerns and recognize their legitimacy, but these are the same concerns for any patient consenting to medical care. That is why I say, if a patient is entitled to refuse SHC, then she is equally entitled to refuse MHC.

Despite the overlap in qualities, neurology is recognized as a somatic discipline with "organic pathology," but psychotherapy is not. In biomedicine, a patient with chronic and idiopathic nerve pain can be treated by both (or either) a neurologist or psychotherapist. A neurologist would likely prescribe the drugs Gabapentin or Topamax. A psychologist would likely treat with Cognitive Behavioral Therapy (CBT) or other non-pharmacotherapy such as meditation. While I am not drawing the parallel to promote one approach over the other, nor suggest the approaches contradict, I am emphasizing that the same symptom, chronic idiopathic pain, is treated in both neurology and psychotherapy.

I underline the commonality because a neurological diagnosis is often considered socially "legitimate" while a psychotherapeutic diagnosis is not. As a result, despite an undetectable difference between the source of pain, a neurological diagnosis elicits more sympathy than a psychotherapeutic one. The distinction highlights how public opinion gives greater credence to SHC than MHC**.** While public opinion does not have the power to alter the legitimacy of a patient's experience of illness, it can worsen a patient's experience of *being* ill. What I mean is, regardless of organic symptomology, public opinion can support and validate, or oppress and invalidate an ill patient.

Another, and perhaps more concrete, example of the medical dialectic is our understanding of hallucinations. If the patient presents at a clinic that is unfamiliar with her hallucinatory symptoms, she is likely to be prescribed atypical antipsychotics, sedatives, or transferred to a higher level of care. But if the patient goes to say, an Otolaryngologist, they are more likely to perform hearing tests and medical imaging. A tumor in the petrous apex can cause auditory hallucinations. An uncovertebral tumor can cause olfactory hallucinations. Lesions and tumors of the optic nerve cause major changes in vision. The medical specialties differ only in the tests that choose to conduct, but the stigma of hallucinations, deters many patients from seeking care.

Returning to the focus of this chapter, psychiatric commitment, a patient presenting to an ER with a self-inflicted wound, may legally be committed to a psychiatric unit, but when forced or coerced they are not ethically committed. By comparison, when a patient presents to an ER as non-responsive and needing intubation, the clinical providers cannot ethically, nor legally, intubate her when she has a DNR. Federal law protects patients from unwanted intubation even though, in many cases, this means the patient will die.

A DNR must be preemptively written by a person determined to be legally competent because a DNR only becomes relevant when a patient can no longer contemporaneously advocate for themselves. In contrast, a patient who self-injures has no need for a written DNR because they are lucid while resisting advised medical care. Once again, this demonstrates the divergence between SHC and MHC protocols.

I described the parallels in mental health care and somatic health care to highlight the injustice of differently applying the principles of patient autonomy to sub-disciplines of health care. The varied application is not only misguided it is unjust. No one, absolutely no one, ever deserves forced medical procedures or pharmaceutical treatment which alters the person physically or mentally. There are other ways to address those who harm others without sentencing him to unwanted medications or surgeries.

Science has a long history of failing to comply with basic human decency for the sake of progress. Although, in this paper I do not focus on the unique ramifications experienced by marginalized peoples. It is important to note that inequalities in medicine have disproportionately affected minorities throughout history. Medical Journalist Harriet Washington coined the term 'Medical Apartheid' to refer to racial discrepancies in medicine. The United States in particular has a long history of exploiting marginalized communities in pursuit of scientific innovation.[26] Within the last century asylums and prisons practiced medical treatments that were considered beneficent at the time, but ultimately proved detrimental

One such procedure is the frontal lobotomy, depicted in *One Flew Over the Cuckoo's Nest* written by Ken Kesey.[27] Another, equally heinous procedure, pneumoencephalography (PEG) was used to image patients presenting with neuropsychiatric illnesses. The procedure consisted of removing a patient's cerebrospinal fluid (CSF)—the aqueous matter which cushions and protects the brain and nervous system in mammals—replacing the CSF with air or other gases, and then using x-ray to image the brain. This procedure allowed for clearer imaging of in vivo brain morphology, that is, the procedure allowed clinicians to see the brain of a living patient to the detriment of the same patient.[28]

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[26] Harriet Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*. New York: Doubleday, 2006.

[27] Ken Kesey, *One Flew Over the Cuckoo's Nest*. New York: Penguin Books, 1999.

[28] Rebecca Skloot, *The Immortal Life Of Henrietta Lacks*, New York : Crown Publishers, 2010, Print.

Studies of patients with schizophrenia and epilepsy often utilized PEG imaging. Elsie Lacks the daughter of Henrietta Lacks whose harvested cancer cells continue to be invaluable in today's scientific research, was one such patient.[29] Elsie was committed to the Crownsville State Hospital under the diagnosis of "idiocy," but Elsie most likely suffered from epilepsy. Rebecca Skloot details great injustices which occurred to the Lacks family in her book *The Immortal Life of Henrietta Lacks.* In the excerpt below, Rebecca recounts learning about what happened to the ill-fated Elsie after she was institutionalized.

> [W]hile Elsie was at Crownsville, scientists often conducted research on patients there without consent, including one study titled "Pneumoencephalographic and skull X-ray studies in 100 epileptics… Pneumoencephalography involved drilling holes into the skulls of research subjects. . . side effects--crippling headaches, dizziness, seizures, vomiting--lasted until the body naturally refilled the skull with spinal fluid, which usually took two to three months. Because pneumoencephalography could cause permanent brain damage and paralysis, it was abandoned in the 1970s.[30]

Whatever checks and measures set in place to protect patients condemned to Crownsville were utterly insufficient. That being said, a skeptic may counter, "Well, that was then, in 1957, not now" presuming that procedures for protecting patients have improved since the 1960s. I acknowledge, that the practices of PEG and frontal lobotomies have been phased out of popular practice, but I contend that other compulsory and potentially harmful treatments have replaced the aforementioned practices.

On March 7th, 2019 the *Chicago Tribune* published a front-page article on the world-renowned psychiatric treatment center Timberline Knolls. Timberline Knolls, or TK, has famously treated celebrities such as Kesha and Demi Lovato, but as revealed by reporter David Jackson, many women "instead of finding safe harbor, . . . reported being traumatized in new and horrible ways."

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[29] Ibid.
[30] Ibid.

Jackson's article details the horrors of sexual assaults committed by treatment facilitators alluding to systemic problems beyond individual counselors. An anonymous resident recounted,

> I have been trying to find the words to explain the horrors I saw there. It is hard for women to be believed; it is even harder when we are socially stigmatized for mental health concerns. The level of control we were placed under was utterly terrifying. The whole experience was like the Stanford Prison Experiment on a much larger scale. Since the treatment center offered a level of care referred to as 'residential' legally we were allowed to leave whenever we wished to. But once we arrived at the lodge, the narrative changed. We COULD NOT LEAVE. That is what they told us. They told us, until we had to believe them. We all attempted to run. It was called a code green. The code would be broadcast across the walkie system. And all employees were required to drop whatever they were doing and chase the poor soul trying to escape. One girl jumped from a window and broke her leg. She walked all the way to town on that leg.
>
> How are we to heal if we are held without bond and without hearing? Someone tried to run almost every day. Many days had many people running. When we were caught, they would call an ambulance. The campus was on lock-down. The EMT would roll a gurney into the common area of a lodge and we must submit. We were told if we did not get on the gurney, we would be arrested. We were strapped and siphoned to psychiatric inpatient, where we were "voluntarily" committed. To this day I refuse to publicly admit struggling with anorexia because admitting to having a mental illness risks giving someone power over me. I am unwilling to face that coercion, that abuse.[31]

The quoted resident describes loss of control, that is, loss of personal autonomy, worsening mental illness. When we force treatment on unwilling young women, trap them, and coerce them, we exacerbate the inherent power imbalance between treatment facilitators and treatment recipients. In the era of #MeToo, respect for consent must be applied broadly, including in healthcare. Ethical care requires consent for treatment. This includes mental health care. Treatment is tolerable only when one consents and believes if they revoke consent, their voice is respected.

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[31] anonymous, telephone conversation with author, April 6, 2019.

Chapter V - Coercion and Commitment

It is only natural that we do not want people to die, but our impulse to protect a patient from herself is paternalistic. So, in acting on the impulse, we fail to provide patient centered care and violate her free will. I argued previously, if a patient poses a threat to themselves alone, we have no right to separate her from her community. Just as Mary Burnett's husband had no right to imprison his wife and separate her from her community, physicians cannot ethically commit a person who singularly poses a harm to self, but not others.

We must treat autonomy as a right, not a capacity. Capacities are certifiable, but rights must be upheld by all persons, for all persons. The power structure of medicine fails to consistently protect the vulnerable. No practice in medicine better portrays the imbalance as the concept of informed consent in "voluntary" hospitalizations.

In his 2011 publication "Informed Consent: Its History, Meaning, and Present Challenges," bioethicist Beauchamp writes, "the whole point of the practice of informed consent is to protect and enable meaningful choice."[32] Appropriate informed consent includes the discussion of procedures, alternatives, and risks regarding a suggested treatment. If adequately prepared, a patient can choose free from controlling influence, and truly volunteer consent. If instead, a provider coerces, persuades, or manipulates a patient or the information given to the patient, then the provider fails to act ethically.

In Illinois, when a patient is legally, but involuntarily, committed she can be held against her will up to 5 days before being granted access to court proceedings and appointed representation.[33] If she refuses to consent to the suggested treatment, she is forced to receive the

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[32] Tom L. Beauchamp, "Informed Consent: Its History, Meaning, and Present Challenges", Camb. Quart. Healthcare Ethics 20:1-9 4 (2011).

treatment for up to 5 days until she will be seen by a judge who tries her case. Instead, if she "voluntarily" consents to treatment, she is likely to be released from the psychiatric unit within 7 days but will not incur legal fees. Commitment is only supposedly voluntary, because as is often the case the patient is told that by consenting they have a greater likelihood of being released sooner from confinement. But a consent obtained through coercion is no consent at all.

It is against the law in Illinois to threaten involuntary admission to a psychiatric unit without informing the patient she is "entitled to a court hearing to fight the involuntary admission, and the right to be represented by a lawyer at the hearing"[34] But even if a doctor states the rights of the mentally different, they may add that a facility has 5 business days to release the patient, but only after a request has been made in writing.

In short, the implication is that a patient will either be involuntarily admitted, and thus begin the legal process that extends beyond her prescribed commitment, or "voluntarily" admitted and waive their right to refuse care for 5 days until their written request for discharge must be followed. Facilities are allowed to continue hospitalization while the patient waits for her hearing. "Therefore a 'voluntarily admitted' patient can be hospitalized against their will for 2 or more weeks after requesting discharge."[35]

Additionally, the physician can pursue a court petition to hold you beyond five business days. So, within the time of requesting discharge and actually being discharged the therapeutic team has the opportunity to process an involuntary commitment. While it is unlikely that a

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[33] "Rules for Involuntary Admission Hearings and Discharge." Illinois Legal Aid Online. 2019. https://www.illinoislegalaid.org/legal-information/rules-involuntary-admission-hearings-and-discharge.; "Voluntary and informal admission mental health facility," Illinois Legal Aid Online, 2019. https://www.illinoislegalaid.org/legal-information/voluntary-and-informal-admission-mental-health-facility

[34] Ibid.

[35] Ibid.

physician would go to that much trouble to put a medical hold on a patient's discharge, that does not stop the clinician from alluding to their power to do so.

When facing commitment, the patient's options are not to refuse or to accept treatment. Her "options" are to pursue court proceedings while waiting in a psychiatric unit, or to "voluntarily" wait in a psychiatric unit. Both outcomes ignore whether or not she believes herself to be a threat to her own well-being. If a doctor believes inpatient hospitalization is in the best interests of the patient, even if the patient disagrees, she is forced into treatment and is consequentially injured by non-consensual treatment. There can be no informed consent without mitigating this power imbalance.

The patient's "consent" has the dynamic of a coerced plea bargain from a defendant charged with a crime they did not commit. The defendant is offered a more lenient sentence in exchange for waiving their right to plead "not guilty." If they do not take the plea bargain they risk a greater minimum sentence and greater accrual of legal fees. As a result, patients and defendants are socially quarantined without due process, and without protection of their individual rights.

I have previously discussed the importance of patient autonomy. Now, I am focusing on the importance of patient autonomy in voluntary hospitalization. The greatest threat to informed consent in psychiatric care is misinformation, and misrepresentation of laws and protocols. When a person in authority, such as a provider or a technician, informs a patient of protocol it is unlikely the patient will be able to recognize mistakes or falsehoods, and what's more demand their rights.

A well-meaning clinician may still commit a patient with suicidal ideation or self-injurious behaviors against their will, declaring "better safe than sorry." But the options are not safe or sorry. The options are confinement or autonomy. While a doctor may view a psychiatric hospital as "safe" an unwillingly committed patient may *not* see a psychiatric hospital as the safe option. In this example, the "better safe than sorry" applies to the physician's conscience, not the freedom of a patient.

Not only is forced or coerced hospitalization contrary to a patient's will, it is ineffective. Despite increasing psychiatric commitments, suicide and suicidality rates have continued to rise, especially in adolescent females.[36] This suggests that our current measures for suicide risk are insufficient.[37]

Historically, expressing suicidal ideation (SI) has been considered prognostic of future suicide attempts.[38] However, a 2019 meta-analysis by Catherine McHugh and colleagues found suicidal ideation is a poor predictor of suicide attempt (SA), arguing there is a "high degree of uncertainty about the statistical strength of commonly used approaches to suicide risk assessment."[39] The McHugh study reviewed 320 publications ultimately compiling data from 70 papers reporting 71 studies from 1961 to 2017, with a median of 2006. Relevant studies collected the responses of people reporting SI or not reporting SI who later died by SA. Further review of the study reveals why the link between expressed SI and future SA has persisted.[40]

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[36] Jean Twenge, Thomas E. Joiner, Megan L. Rogers, and Gabrielle N. Martin. "Increases in Depressive Symptoms, Suicide-Related Outcomes, and Suicide Rates among U.S. Adolescents After 2010 and Links to Increased New Media Screen Time." *Clinical Psychological Science* 6, no. 1 (2018): 3-17.

[37] Louis Charland, "Decision-Making Capacity", *The Stanford Encyclopedia of Philosophy* (Fall 2015 Edition), Edward N. Zalta (ed.), URL = <https://plato.stanford.edu/archives/fall2015/entries/decision-capacity/>.

[38] Morgan, Stanton. "Suicide among psychiatric in-patients in a changing clinical scene," "Suicidal ideation as a paramount index of short-term risk," *Br J Psychiatry* 1997; 171: 561–3.; Boudreaux ED, Camargo Jr CA, Arias SA, Sullivan AF, Allen MH, Goldstein AB, et al. "Improving suicide risk screening and detection in the emergency department," *Am J Prev Med* 2016; 50: 445–53.; Horowitz, Snyder, LudiE, Rosenstein, Kohn-Godbout, Lee, et al. "Ask suicide-screening questions to everyone in medical settings: the ask'em Quality Improvement Project". *Psychosomatics* 2013; 54: 239–47.

[39] Catherine McHugh., Amy Corderoy, Christopher James Ryan, Ian B. Hickie, and Matthew Michael Large. "Association between Suicidal Ideation and Suicide: Meta-Analyses of Odds Ratios, Sensitivity, Specificity and Positive Predictive Value." *BJPsych Open* 5, no. 2 (2019), 9.

[40] Ibid, 1.

SI and SA are correlated but are not specifically correlated. That is, the test for SA is sensitive, but not specific. To use an analogy, mammals and goats are correlated. Mammal-ness is a sensitive test for goat-ness because all goats are mammals, but it is not a specific test for goat-ness because many mammals are not goats. A recent meta-analysis of individuals who have attempted suicide has found SI did not have a positive predictive value in psychiatric nor in non-psychiatric settings (PPV .3% psychiatric and 3.9% non-psychiatric). Which translates to both populations having similar odds of attempting suicide regardless of expression of suicidal ideation. The difference between psychiatric and non-psychiatric settings also is not significantly different having an odds ratio of 3.86 and 3.23 respectively. Therefore, SI is not an effective way to differentiate between who will or will not attempt suicide.

Similarly, 60% of individuals who died due to SA did not previously admit SI regardless of a psychiatric or non-psychiatric setting. But in exclusively non-psychiatric settings, 80% of individuals who died from suicide did not express SI.[41] The odds of an individual expressing SI and then committing suicide were not significantly different from the odds of an individual not expressing SI and still committing suicide. I argue SI is more likely an attempted communication of psychological distress, rather than a predictive sign of future suicide attempts. That is, suicidality is more likely an idiom of distress, communicating an unmet need.

An “idiom of distress” is a culturally relative “expression of emotional tension” which results from the intersection of somatic illness and compromised social support.[42] An “idiom of distress,” a phrase typically used in anthropology, complements the interpersonal theory of depression, which is a phrase typically used in psychology. To use an “idiom of distress” is to

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[41] Ibid. 9.

[42] Claire Parsons and P Wakeley. "idioms of Distress - Somatic Responses to Distress in Everyday Life." *Culture Medicine and Psychiatry* 15, no. 1 (1991): 111-132.

communicate the psychosomatic consequences of social isolation, interpersonal conflict, or cultural dissonance. As such, it is plausable that an admission of suicidality more accurately represents social marginalization and powerlessness between the individual and larger sociocultural group.[43]

That is not to say that expressed suicidality is an attention seeking behavior, but rather SI arises when social support is lacking or inaccessible or when life feels purposeless. If SI is an idiom of distress communicating an unmet need unlikely to be met by the social isolation of a psychiatric hospital, it follows that patients should not be forcibly hospitalized for SI, especially from the perspective of the Interpersonal Theory of depression.

The Interpersonal Theory of Depression purports that social isolation and feelings of burdensomeness precipitate and deepen depression.[44] If you consider the interpersonal theory of suicide, which posits the two greatest factors for depression as lack of social connectedness (i.e., alienation and loneliness), and feeling burdensome to others, then expressed suicidality is an

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[43] Paul Farmer. 1988 Bad Blood, Spoiled Milk: Bodily Fluids as Moral Barometers in Rural Haiti. American Ethnologist 15(1):62–83; Annamiek Richters 1991 Fighting Symbols and Structures: Postmodernism, Feminism, and Women's Health. *In* Constructing Knowledge: Authority and Critique in Social Science. Lor- raine Nencel and Peter Pels, eds. Pp. 123–144. London: Sage. 1991; Cancela de la, Victor, Peter Guarnaccia, and Emilio Carrillo 1986 Psychosocial Distress among Latinos: A Critical Analysis of Ataques de Nervios. Humanity and Society 10:431–447. Guarnaccia, Peter J., and Pablo Farias 1988 The Social Meaning of Nervios: A Case Study of a Central American Woman. Social Science and Medicine 26(12):1223–1231. Guarnaccia, Peter. J., Roberto Lewis Fernańdez, and Melissa R. Marano2003 Toward a Puerto Rican Popular Nosology: Nervios and Ataque de Nervios. Culture Medicine and Psychology 27(3):339–366. Guarnaccia, Peter J., and Melissa Rivera 1996 The Experience of Ataques de Nervios: Towards an Anthropology of Emotion in Puerto Rico. Culture, Medicine and Psychiatry 20(3):343–364.; Lock, Margaret 1989 Words of Fear, Words of Power: Nerves and the Awakening of Political Consciousness. Medical Anthropology 11:79–90.; Low, Setha M. 1985 Culturally Interpreted Symptoms or Culture-Bound Syndromes: A Cross-Cultural Review of Nerves. Social Science and Medicine 21(2):187–196.

[44] Claire Parsons and P Wakeley. "idioms of Distress - Somatic Responses to Distress in Everyday Life." *Culture Medicine and Psychiatry* 15, no. 1 (1991): 111-132.; Jean Twenge, Thomas E. Joiner, Megan L. Rogers, and Gabrielle N. Martin. "Increases in Depressive Symptoms, Suicide-Related Outcomes, and Suicide Rates among U.S. Adolescents After 2010 and Links to Increased New Media Screen Time." *Clinical Psychological Science* 6, no. 1 (2018): 3-17.

effectual “idiom of distress.”[45] When a person experiences suicidal ideation, they are likely experiencing feelings of social disconnect and unimportance. If she expresses her ideation thereby asking for help or comfort, she is more likely to be socially reengaged and consequentially have her self-importance reaffirmed.

In sum, expressed suicidality is not a good predictor of suicide attempts; therefore, we should be more reticent when involuntarily hospitalizing suicidal patients. Instead, we should consider community outreach programs which can serve as preventative factors from social isolation. Not only is hospitalization very expensive, intensifying perceived burden on others, but hospitalizing a suicidal person increases social isolation, and therefore may be counterproductive. While the etiology of SI cannot always be explained by the Interpersonal Theory of Depression, it is important to consider the impact of social isolation, either as an impetus or exacerbating factor for depression and SI.

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[45] Jean Twenge, Thomas E. Joiner, Megan L. Rogers, and Gabrielle N. Martin. "Increases in Depressive Symptoms, Suicide-Related Outcomes, and Suicide Rates among U.S. Adolescents After 2010 and Links to Increased New Media Screen Time." *Clinical Psychological Science* 6, no. 1 (2018): 3-17.

Chapter - A Dialectic

In the rest of the paper, I will address the difference between freedom from vaccination and freedom from psychiatric hospitalization. A skeptic of vaccinations might compare involuntary hospitalization to compulsory inoculation saying, “If we require vaccination of children then why should we not also require other preventative health measures?” Another and equally irksome skeptic may add, “current vaccinations may have low to no risk of adverse side effects, but what if a vaccine was developed that had greater risks? If we comply to mandatory vaccinations, how do we protect ourselves from more insidious medical treatments?” The final skeptic may question the justness of failing to commit a person with SI when the consequences of suicide affect many persons beyond the individual, thereby comparing the spread of preventable infectious disease to communal suffering after a suicide. In the following paragraphs I will respond to the three rebuttals posed by hypothetical skeptics.

The first skeptic confuses psychiatric hospitalization for preventative medicine. As discussed in the last chapter, hospitalization is not effective as a preventative for SI or suicide. The skeptic also fails to recognize the broader implications of not vaccinating a child. It is not a single unvaccinated child, but multiple unvaccinated children, which increases the risk of disease outbreak. With decline in the percentage of the population vaccinated, herd immunity decreases in effectiveness. Herd immunity is the idea that when a pathogen has fewer susceptible targets, it is more likely remain isolated and not spread epidemically or pandemically.[46] As a result, the “personal” choice to vaccinate or not vaccinate is not truly personal, but an action which

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[46] “Herd Immunity”, Oxford Vaccine Group, University of Oxford. 12 December 2017. Accessed 2 May 2019.

threatens members of the greater community. Refusing to vaccinate poses harm beyond one's personal sphere of influence, therefore not aligning with the harm principle.

I suppose that if a mother quarantines her non-vaccinated child from the general population indefinitely, then perhaps the comparison could be further debated. But this really is impossible to do. Besides the ethical and moral complications of a perfunctory quarantine, in the globalized world one cannot guarantee against exposure to infection. Furthermore, even after an individual is vaccinated, there are individuals who do not develop immunity for biological reasons, which is why herd immunity is so important for the eradication of communicable diseases. My point is, refusing to vaccinate cannot affect the individual alone.

While the first skeptic did not consider the larger picture, the second skeptic takes the analogy of compulsory vaccination to compulsory confinement too far. I agree that the medical field has a long history of misguided treatment protocol. For centuries, medical abuses have been inflicted on marginalized populations without sufficient oversight. But the vaccinations proposed, or rather, the vaccinations mandated by many school systems, are not comparable to neuropsychiatric surgeries like lobotomy, nor pain medications like Oxycontin. The vaccines suggested in pediatric medicine have been rigorously scrutinized and reviewed. Vaccinations do not pose an undue burden to the well-being of the person injected.

I appreciate the second skeptic's 'slippery-slope' fears that "if we let big-brother mandate vaccines, then we may not be able to refuse other medical treatments in the future" as a valid fear, especially considering the long history of marginalized communities being coerced into dangerous medical research. But vaccinations are *heavily* regulated and are clearly efficacious. It is unfair to compare mandatory vaccination to more egregious practices like forced sterilization, and then say that all mandatory medicine is dictatorial.

The ‘slippery-slope’ is controlled by a functional regulatory system which holds the confidence of the larger community. If the concern is failed regulation of a specific protocol, the answer is not anarchy or a medical coup, but rather, a directed call for reform, such as the practice of coerced hospitalization. What must be the greater consideration when fearful of government overreach is ensuring a well-functioning legislative process, more so than fearing a single mandate.

Now, the third skeptic reiterates that “mental illness not only affects the bearer. Other people are harmed as well.” This is a valid concern, but as mentioned previously, violence and mental illness separate. Horrific acts of aggression must not be rationalized as only the result of the aggressor’s mental illness.

Then again, perhaps the skeptic was not referring to overt violence, but rather harms which induce distress or grief in others, such as the distress or grief for someone who commits suicide. The skeptic’s reference to these less tangible harms poses a more relevant question: “what about the pain experienced by those who love the individual with suicidal ideation?” Those who surround a bearer of mental illness experience legitimate heart ache, and their distress must be sincerely considered. But their distress does not justify jurisdiction over the life and freedom of another person.

In sum, it is not justified to control a loved one “to protect them.” Nor is it justified to control a loved one to protect yourself. A person’s freedom from confinement supersedes another’s freedom to confine even for the sake of palliation. If the argument for personal freedom seems insufficient, refer back to previous chapters. SI has not shown to be an effective predictor for attempted suicide; therefore, overreacting to expressed SI will not effectively protect loved ones from grief.

Conclusion

Suicidal ideation alone is not reason enough for compulsory psychiatric hospitalization. Treating an unwilling patient disregards the principle of autonomy, and is therefore, unethical care. Since there is no substantive difference between mental illness and somatic illness it follows that the principle of autonomy should not be differently applied to MHC and SHC. There are many ethical dilemmas to be addressed in healthcare, but due to finite time and resources I have not touched upon all of them. Future analysis should consider the efficacy of current policies in place at the national, state, and regional levels. Epidemiological studies researching the successes and failures of in-patient hospitalization units will consider rates of recidivism, SA and SI, leading to better informed policy proposals.

I have claimed that coercive voluntary and involuntary psychiatric hospitalization for non-violent patients is unethical. It is both contemporaneously and historically relevant to reconsider the role of psychiatric hospitalization and the frequency of use. Concerns about efficacy of in-patient hospitalization are important to challenge in order to amend and reform ineffective—or even harmful—protocol. In the United States we have freedom of speech which allows us to petition reform. We have the right to life, Liberty, and property. That is, the we have the right to decide medical procedures enacted on our person. Psychiatric health care reform is imperative for a nation with rising cases of mental illness, suicidal ideation, and attempted suicides especially among adolescent populations.[47] With increasing risk we need more efficacious care. Only through critical analysis can the medical community distinguish between misinformed medicine and medicine that heals.

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[47] Jean Twenge, Thomas E. Joiner, Megan L. Rogers, and Gabrielle N. Martin. "Increases in Depressive Symptoms, Suicide-Related Outcomes, and Suicide Rates among U.S. Adolescents After 2010 and Links to Increased New Media Screen Time." *Clinical Psychological Science* 6, no. 1 (2018): 3-17.

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