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Rights Within the Therapeutic Relationship

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RIGHTS WITHIN THE THERAPEUTIC RELATIONSHIP

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I. INTRODUCTION

In the last two decades, persons with mental illness have experienced an enormous expansion of their positive and negative rights. While this recognition of the autonomy and individuality of persons with mental illness is essential and long overdue, the result of this recognition has not been the empowerment of persons with mental illness nor, in general, the improvement of their care and treatment. Rather it has resulted in persons with mental illness becoming more isolated and disconnected from both the therapeutic community and the social community.

My thesis is that the failure of these rights to be implemented in any meaningful way for persons with mental illness is the result of a narrow image of rights which emphasizes the individual, valuing autonomy independent of care, and sacrifices relationship and the connection to the community. By conceiving of rights in such a way, we strengthen the individual but do not address the reality of the context or relationship within which persons with mental illness will actualize these rights. This failure to recognize and account for the disequilibrium within therapeutic relationships and the necessity of caring within such relationships makes implementation of rights, as expressed in this individual autonomous model, impossible.

In this paper I intend to explore the development of the rights afforded to persons with mental illness through the germinal cases in which those

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rights were articulated.[1] I will then describe a current effort to articulate a new image of rights which attempts to account for the necessary balancing of individual rights and the need for relationship and connection to a community to fully realize those rights. Finally, I will apply the new image to the context of persons with mental illness and describe how the new image might be the basis for a fuller implementation of the rights afforded to persons with mental illness.

Prior to the advent of consumerism in medicine, the paternalistic or philanthropic image of the therapeutic relationship served the interests of both the physician and the patient. Throughout the second half of this century, the central task of the judiciary and legislature has been the enumeration and articulation of the individual rights which for so long had been subsumed by the collective needs of the community and the paternalistic model for all relationships. In the second half of the twentieth century, more and more rights were articulated for those classes of persons who were most vulnerable to the tyranny of the majority because they were outside the circles of power, restricted from educational and employment opportunities, and limited in the political power they could wield.[2] This same tide of rights swept through all relationships within society, including the therapeutic relationship between physician and patient.

Prior to the surge of rights and the increasing efforts to establish equality as the basis for relationships, whether political, personal, educational, economic or therapeutic, the paternalistic therapeutic relationship reflected the general societal perception that relationships which reflected an inherent inequality were best experienced with the benevolence of the more powerful party protecting the interests of the less powerful, more

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[1] My focus in this paper is the federal and state cases which addressed the issue of rights for persons with mental illness from a constitutional perspective. I do not intend to look at the legislative or regulatory efforts to define the therapeutic relationship. Therefore, when I refer to 'the courts' I am referring only to those courts before whom the issue was presented and whose holdings articulated either explicitly or implicitly an image of the therapeutic relationship. The judiciary, characterized as 'the least dangerous branch', relies on the moral force of it holdings to compel acquiescence, even in the face of strong disagreement. The moral force of court decisions is supported by a number of factors, including the decision-making process, the image of justice, and the right which the decision creates and authenticates. It is this judicial imagery with which I am concerned.

[2] John Stuart Mill's writings have been the basis for much of the reasoning about the nature and legitimacy of rights. In *On Liberty*, Mills states that "the only purpose for which power can rightfully be exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. . . . Over himself, over his own body and mind, the individual is sovereign. . . . This doctrine is meant to apply only to human beings in the maturity of their faculties. . . . Those who are still in a state to require being taken care of by others must be protected against their own actions as well as against external injury." JOHN STUART MILL, THE PHILOSOPHY OF JOHN STUART MILL 197 (M. Cohen ed., 1961).

vulnerable party. With the growing emphasis on equality which accompanied the justification for the increasing enumerated rights, the inherent inequality in the therapeutic relationship could no longer be deemed sufficiently protected by a belief in the benevolence of the more powerful party. Furthermore, those who were committed to equality no longer believed in the benevolence of the physician. Since benevolence could no longer be relied upon to protect the rights of the more vulnerable patient and the inherent inequality of the relationship could not otherwise be redressed, the only available protections for the patient in the therapeutic relationship were procedural protections which made it more difficult for the physician to exercise her power without the complete consent of the patient. These procedural protections or impediments were installed in order to shift some power to the patient side of the therapeutic relationship. In doing this, it was hoped that, out of such power shifting, the therapeutic relationship would change and the principles of autonomy and individuality, so central to the growing body of rights, would become the principles which governed the therapeutic relationship as well.

What such an assertion failed to recognize is that the inherent inequality within the therapeutic relationship is not altered by either the articulation of rights or the imposition of procedural protections for those rights. Additionally, the emphasis on separation and autonomy inherent in the move toward equality makes it difficult to value the essential interdependence of the therapeutic relationship with its inherent asymmetry. This asymmetry in relationship is conceived as inequality with its accompanying unfairness, rather than as complementarity.[3] Furthermore, the courts, in their holdings, generally evidenced an antipathy and a distrust toward psychiatry, a narrow deconstructionist understanding of mental illness, and a skewed perception of the therapies available to treat persons with mental illness.[4]

Central to the transformation of the therapeutic relationship is not only the principle of rights, but also the principle of care.[5] Reconceiving the perception of the physician and patient as equals, armed with different weapons of power, did not result in more or better care for the patient. What in fact resulted was an increasing distancing and alienation of the patient from the physician, a pseudo-equal relationship constructed at the price of the therapeutic bond in which the benevolence essential to fiduciary relationships is rooted.

The case of persons with mental illness is especially poignant. Not only did the increasing emphasis on equality through procedural protections result in the rupture of the therapeutic relationship, rather than in its transformation, but the emphasis on equality and rights for persons with mental illness also distanced these patients from communities, like the family, which were often a source of protection and care. The procedural

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[3] MARY CATHERINE BATESON, COMPOSING A LIFE 104 (1990).
[4] *See infra* notes 9-72.
[5] MILTON MAYEROFF, ON CARING (1971).

protections and rights, conceived of as a way to protect patients from the exploitative and harmful experience of unconsented treatment or abandonment in hospital-backwards or uncaring families,[6] ignored the reality of the inherent disability of persons with mental illness in asserting those rights. The presumption behind the articulation of rights is a soundness of mind, a rational ability.[7] Yet mental illness is an assault on the very faculty which must be presumed for the rights to make any sense. The failure to recognize the reality of the disability of persons with mental illness has led to a series of cases upholding increasingly peculiar and disturbing expressions of rights, expressions of rights which result in increasing alienation and abandonment of the mentally ill, not in hospitals but on our streets and in our parks.[8]

II. THE CASES

Because my focus is looking at rights within the context of the therapeutic relationship, I am limiting my consideration to those cases which articulated rights for persons with mental illness in the civil context. Clearly there have been cases in the criminal context which deal with the same issues of right to treatment and right to refuse treatment,[9] as well as issues specific to the criminal context such as those related to the insanity defense[10] and the relationship of treatment to punishment like the death penalty.[11] I am not considering those cases because of the additional issues which the criminal context imposes on my principal concern with the articulation of rights within the therapeutic relationship. The criminal context itself shapes and colors the therapeutic relationship in ways that are important.[12] However, because of the other specific rights

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[6] The terrible revelations about the conditions at Willowbrook State Hospital in New York, Bridgewater State Hospital in Massachusetts, Bryce Hospital in Alabama and countless other institutions, provided an undeniable basis for the litigation which was brought before the courts. The courts, which addressed the issues presented by the abysmal conditions within which the patients lived and the staff worked, responded to the legitimate horror everyone should feel in those circumstances. My thesis does not deny the violence of the conditions nor the need for there to be intervention. Rather, my thesis is that the interventions, shaped by an image of relationships which prized autonomy and devalued connectedness and interdependence, are inadequate to address the issues at a level which can result in real empowering of persons with mental illness or transformation of institutions and people.

[7] John Stuart Mill also asserted that liberty itself is circumscribed when individuals are not capable "of being improved by free and equal discussion." MILL, *supra* note 2, at 198.

[8] Matter of Boggs, 522 N.Y.S.2d 407, *rev'd* 523 N.Y.S.2d 71 (N.Y. App. Div. 1987). In May 1990, the U.S. Court of Appeals for the Second Circuit overturned a lower court decision which recognized begging in the New York subways as protected activity under the First Amendment.

[9] Washington v. Harper, 429 U.S. 210 (1990).

[10] Jones v. United States, 463 U.S. 354 (1983).

[11] State v. Perry, 502 So.2d 543 (La. 1986), *cert. denied*, 484 U.S. 872 (1987), *reh'g denied*, 484 U.S. 992 (1987); Ford v. Wainwright, 477 U.S. 399 (1986).

[12] Estelle v. Smith, 451 U.S. 454 (1981).

and procedural protections which are extant in the criminal context, it presents a much less clear forum for the analysis of the impact of the articulation of rights on the therapeutic relationship. Therefore, I will consider only those cases which arose within the civil context.

A. Civil Commitment

Lessard v Schmidt,[13] a challenge to the civil commitment procedures in Wisconsin, was decided in 1972. This case represented the first major successful challenge to a state's commitment procedures.[14] The plaintiff, Alberta Lessard, had been picked up by the police because of a reported suicide attempt. Under the statute then in force, Ms. Lessard was involuntarily committed. With the assistance of the Milwaukee Legal Services, she filed a class action suit under 42 U.S.C. 1983 seeking declaratory and injunctive relief against the enforcement of certain provisions of the Wisconsin involuntary commitment statute.[15] The plaintiffs alleged that the civil commitment procedures were constitutionally defective because they denied to the plaintiffs the same protections that were afforded a criminal suspect.[16] The court's analysis begins with a consideration of what distinguishes the protections afforded the criminal suspect from those which operate in the civil commitment context. According to the court:

> The power of the state to deprive a person of the fundamental liberty to go unimpeded about in his or her affairs must rest on a consideration that society has a compelling interest in such deprivation. . . . State commitment procedures have not, however, traditionally assured the due process safeguards against unjustified deprivation of liberty that are accorded those accused of crime. This has been justified on the premise that the state is acting in the role of *parens patriae*, and thus depriving an individual of liberty not to punish him but to treat him. . . . [Persons may also be deprived of liberty under this doctrine] because of society's need to protect itself against the potential dangerous acts of persons who, because of mental illness are likely to act irrationally . . . and [because] involuntary incarceration carries with it a constitutional right to treatment.[17]

The court then goes on to undermine the force of these distinctions by finding that, while commitment may carry with it a constitutional right to treatment, individuals should not be subject to treatment against their

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[13] Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wisc. 1972).

[14] RAEL ISAAC & VIRGINIA ARMAT, MADNESS IN THE STREETS: HOW PSYCHIATRY AND THE LAW ABANDONED THE MENTALLY ILL (1990).

[15] *Lessard*, 359 F. Supp. at 1081-82.

[16] *Id.* at 1082.

[17] *Id.* at 1084, 1086 (footnotes omitted).

will.[18] The court further analogizes the situation of the civilly committed person with that of the criminal suspect when it uses *In re Gault*,[19] a case dealing with the distinctions between the safeguards afforded juveniles and adults within the criminal justice system.[20] The court thus constructs an analysis in which persons subject to civil commitment are analogized to persons subject to criminal prosecution. Both classes of persons are seen as deprived of significant liberty interests, but the court rejects the *parens patriae* doctrine as justification for the absence of protections for persons with mental illness. The rationale which the court offers for its rejection, however, reflects not only a legitimate concern with the arbitrariness of the Wisconsin civil commitment statute, but also an absence of understanding of the benefits of treatment and the pain of mental illness. The court does not include the potential benefits afforded the person with mental illness by hospitalization and treatment in its comparison of the criminal suspect and the person with mental illness. Rather, the court focuses on the risks of hospitalization and the possibility that no treatment is available.[21]

The result of this analogic analysis is a holding requiring the implementation of procedural protections for civil commitment much like those afforded to criminal suspects. The court required

> (1) effective and timely notice of "charges" justifying detention;
> (2) notice of rights including right to jury trial;
> (3) probable cause hearing within 48 hours of detention;
> (4) full hearing on necessity for commitment within two weeks of detention;
> (5) representation by counsel of the person at the hearing to determine commitment;
> (6) prohibition of hearsay evidence;
> (7) that the patient be given the benefit of privilege against self-incrimination;
> (8) proof of mental illness and dangerousness beyond a reasonable doubt;
> (9) that those seeking commitment [must] consider less restrictive alternatives.[22];

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[18] *Id.* at 1087.
[19] 387 U.S. 1 (1967).
[20] *Lessard*, 359 F. Supp. at 1081.
[21] *Id.* at 1087.
[22] *Id.* at 1090-1103. In Addington v Texas, 441 U.S. 418 (1979), the U.S. Supreme Court held that a "clear and convincing" standard of proof was required by the Fourteenth Amendment in a civil commitment proceeding brought under state law. The Court held that the "beyond a reasonable doubt" standard has historically been reserved for criminal cases and refused to equate the risk of error in a criminal context to that in the civil commitment context. The Court further distinguished the juvenile criminal context from that of civil commitment by addressing the uncertainty and fallibility of psychiatric diagnosis. The Court's purpose in asserting this distinction was to support what it viewed as legitimate efforts by the states to commit persons. Paradoxically, this distinction would be the basis in future cases for further narrowing the criteria under which persons could be civilly committed.

B. The Right to Treatment

One of the first judicial articulations of the right to treatment was in a criminal case, *Rouse v. Cameron*.[23] Following *Rouse*, the Mental Health Law Project brought suit in Alabama challenging the conditions in the state's mental hospitals.[24] It was brought as a class action case and on behalf of patients who had been civilly committed. In his holding, Judge Frank Johnson stated a clear constitutional basis for the right to treatment.

> To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane and therapeutic reasons, and then fail to provide adequate treatment violates the very fundamentals of due process. . . . [W]e hold that where a nondangerous patient is involuntarily civilly committed to a state mental hospital, the only constitutionally permissible purpose of confinement is to provide treatment, and that such a patient has a constitutional right to such treatment as will help him to be cured or to improve his mental condition.[25]

While this court did recognize the relationship of confinement to treatment, the court defined the right to treatment in objective terms, i.e. staff ratios, proportion of psychiatrists, nurses, etc. to patients, and even how often linen had to be changed and how often patients should shower.[26] It made no effort to articulate a right to treatment related to the therapeutic relationship and process or effectiveness but simply calculated the right in terms of tangible entities like staff and surroundings. Furthermore, it limited the right to treatment to those patients who had been involuntarily committed.

The result of the court's articulation of the right to treatment was not the improvement of care and treatment but rather a contribution to the accelerated pace of deinstitutionalization of patients with mental illness

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[23] 373 F.2d 451 (D.C. Cir. 1966). Rouse, who had been arrested for carrying a dangerous weapon, was found not guilty by reason of insanity. He was committed to St. Elizabeth's Hospital where he remained for a term longer than he would have been imprisoned for, had he been found guilty. Rouse petitioned for his release alleging that he had been given no treatment. Judge Bazelon, basing his holding on the revised District of Columbia Mental Health Code, found that a statutory right to treatment existed and that a patient could not be held indefinitely if he was not receiving treatment.

[24] Wyatt v. Stickney, 344 F. Supp. 387 (M.D. Ala. 1972). This case originated not primarily with a concern over patient welfare, but as an effort to circumvent layoffs of professional staff by the Alabama Department of Mental Health. The right of the department to layoff employees was upheld and only that part of the suit dealing with patient grievances was heard.

[25] Wyatt v. Stickney, 325 F. Supp. 781, 785 (M.D. Ala. 1971).

[26] Isaac & Armat, *supra* note 14, at 42-43, 135-39, quoting STUART GOLANN & WILLIAM J. FREMOUW, THE RIGHT TO TREATMENT FOR MENTAL PATIENTS (1976).

and a further restriction on the process of involuntary civil commitment, since only then were the states obligated to provide the constitutionally mandated treatment. It was less expensive to discharge patients to a community inadequately prepared to receive them than to hire more professionals to meet the court ordered staffing ratios.

At about the same time that *Wyatt* was being litigated, another case came before the courts, brought by a patient in the Florida State Hospital, Kenneth Donaldson.[27] Mr. Donaldson had been involuntarily committed to the Florida State Hospital on a petition by his father in January 1957.[28] Mr. Donaldson had a previous hospitalization in New York in 1943, during which he received electroconvulsive therapy and recovered sufficiently to return to his family and his work.[29] In 1957 he was committed to the Florida State Hospital where he received a diagnosis of paranoid schizophrenia. He remained confined to the hospital for fifteen years. Throughout his confinement, Mr. Donaldson refused to take any medication or to submit to electroconvulsive therapy, and he repeatedly requested his release.[30]

The trial court's verdict, based on the conditions of Donaldson's confinement and the physicians' behavior toward him,[31] awarded Donaldson both compensatory and punitive damages against both his physicians. This verdict was appealed to the Fifth Circuit Court of Appeals,[32] where it was upheld, and, ultimately, to the U.S. Supreme Court.[33]

The Court of Appeals dealt with this case as if it presented the issue of the constitutional basis for the right to treatment. As in *Wyatt*, this court also grounded the constitutional right to treatment in the context of an involuntarily committed person.

> We hold that a person involuntarily civilly committed to a state mental hospital has a constitutional right to receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition.[34]

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[27] Donaldson v. O'Connor, 493 F.2d 507 (5th Cir. 1974), *vacated*, 422 U.S. 563 (1975).

[28] *Id.* at 510.

[29] Isaac & Armat, *supra* note 14, at 66-67, quoting KENNETH DONALDSON, INSANITY INSIDE OUT (1976).

[30] *Donaldson*, 493 F.2d at 511-12.

[31] *Id.* at 511-18. When Donaldson refused treatment based on his Christian Science beliefs and, more centrally, his belief that he was not in need of treatment, no other treatments were offered to him. The ward he was kept on housed criminal patients, and the operation of the ward was geared to their requirements. He received subsistence level custodial care. The physicians responsible for Donaldson's care, Drs. O'Connor and Gumanis, repeatedly denied him privileges consistent with standard psychiatric practice and blocked efforts by responsible friends to have Donaldson released to their custody.

[32] *Id.* at 507.

[33] O'Connor v. Donaldson, 422 U.S. 563 (1975).

[34] *Donaldson*, 493 F.2d at 520.

The court analyzed the *parens patriae* theory as the basis for permitting involuntary civil commitment, drawing support from the Supreme Court's decision in *Jackson v. Indiana*,[35] in which the Court established the rule that

> [a]t the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purposes for which the individual is committed.[36]

This court reasoned that the provision of rehabilitative treatment is the *quid pro quo* offered for the loss of liberty of the involuntarily civilly committed patient, absent the procedural safeguards afforded to criminal suspects.[37] The court further refused to concede that it was beyond the competence of the judiciary to determine what constitutes adequate treatment. The opinion refers to the success achieved by the *Wyatt* court in reaching agreement among the parties on "almost all of the minimum standards for adequate treatment."[38]

The Supreme Court rejected the lower court's concern with the constitutional dimensions of the right to treatment and dealt with the case as if it presented a question of the basis for involuntary civil commitment.[39] The Court rejected a finding of mental illness alone as a justification for involuntary commitment absent a finding of dangerousness to self or others.[40] The Court vacated the Court of Appeals decision and remanded the case. On remand, the lower court was ordered to consider only the question of the physicians' liability for violating Donaldson's constitutional right to liberty. The effect of the remand order was to remove any precedential effect of the Court of Appeals decision regarding a constitutionally based right to treatment.[41]

In 1982, the Supreme Court again dealt with the issue of a right to treatment for an involuntarily committed patient. In *Romeo v. Youngberg*,[42] Nicholas Romeo was a profoundly retarded man who had been committed to the Pennhurst State School and Hospital pursuant to the involuntary commitment provision of the Pennsylvania Mental Health and Mental Retardation Act of 1966.[43] The plaintiff claimed liberty interests in having safe living conditions and in freedom from bodily restraint. The Court easily found that these interests survived involun-

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[35] 406 U.S. 715 (1972). *Jackson* involved the commitment of a retarded deaf mute who was found incompetent to stand trial for the crime of purse-snatching. The court held that the state could confine Jackson only long enough to determine if he would attain competence in the near future. Only if confinement would enable him to become competent would continued commitment be justified.

[36] *Id.* at 738.

[37] *Donaldson*, 493 F.2d at 522.

[38] *Id.* at 525-27.

[39] *O'Connor*, 422 U.S. at 573.

[40] *Id.* at 575.

[41] *Id.* at 577 n.12, 580-89 (Burger, J., concurring).

[42] 644 F.2d 147 (3rd Cir. 1980), *vacated and remanded*, 457 U.S. 307 (1982).

[43] PA. STAT. ANN. tit. 50, § 4406 (Purdon 1969).

tary commitment.[44] More difficult for the court was Romeo's claim to a constitutional right to minimally adequate habilitation, i.e. training and development of needed skills.[45] On this question the Court agreed that the plaintiff's "liberty interests require the State to provide minimally adequate or reasonable training to ensure safety and freedom from undue restraint."[46] The Court did not include a necessity for the state to provide "training and development of needed skills" other than those required to ensure safety and freedom from bodily restraint. Furthermore, the Court set the standard for liability to require "such a substantial departure from accepted professional judgment, practice or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment."[47] The Court also permitted budgetary constraints to be a basis for good faith immunity to liability.[48]

The Court's decision gave hollow recognition to the necessity of protecting the patient's liberty interests in safety and undue restraint, but refused to recognize as a distinct constitutionally required right what Justice Blackmun calls "minimally adequate training . . . as is reasonably necessary to prevent a person's pre-existing self-care skills from deteriorating because of his commitment."[49] Chief Justice Burger's concurrence explicitly denied a constitutional right to training or habilitation.[50]

C. The Right to Refuse Treatment

As changes in commitment laws began to be implemented in many states, the association of commitment and treatment were questioned. In place of a 'need for treatment' criteria, a 'dangerousness to self or others' criteria was substituted. This shift led to the questioning of the legitimacy of forced treatment on those persons who had been committed under the dangerousness criteria and resulted in the increasing judicial focus on the right of patients to refuse treatment. Since the U.S. Supreme Court has not explicitly addressed the constitutional basis for the patient's right to refuse treatment, numerous lower courts have fashioned their own models for the right to refuse treatment.

In his study of the effect of the right to refuse treatment on the treatment received by persons with mental illness, Dr. Appelbaum found that, while refusal is not uncommon, refusing patients appear almost always to receive treatment in the end. "No court considering a right to refuse treatment case has failed to find some substantial patient interest present."[51] He attributes this to the essential illogic of allowing committed

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[44] *Romeo*, 547 U.S. at 315-16.
[45] *Id.* at 316.
[46] *Id.* at 319.
[47] *Id.* at 323.
[48] *Id.*
[49] *Id.* at 326.
[50] *Id.* at 329.
[51] Paul S. Appelbaum, M.D., *The Right to Refuse Treatment With Antipsychotic Medications: Retrospect and Prospect*, AM. J. OF PSYCHIATRY 413, 414 (April 1988).

persons to refuse treatment that would permit their freedom to be restored and the difficulty both psychiatrists and the courts and their surrogates have in withholding help from someone in distress.[52]

The reasoning behind the articulation of this right of persons with mental illness is grounded in a decision about the right of a medical patient to refuse treatment to which she had not consented.[53] The case uses a battery model to analogize the meaning of the unconsented touching of the patient by the physician. Cardozo's opinion states that the right to determine what shall be done with an individual's body inheres in every person of adult years and sound mind.[54] The theory as subsequently applied to persons with mental illness was also influenced by the case law on the right to die.[55]

In *Rennie v. Klein*,[56] the court recognized the patient's right to refuse treatment and provided an optional review by an independent psychiatrist when the patient refused treatment. The *Rennie* case transformed the right to refuse treatment into a right to ensure proper and necessary treatment. It represented an effort to balance rights against therapeutic needs.[57]

The court in *Rogers v. Okin*[58] faced the issue of the right to refuse treatment in the context of a large, understaffed state hospital. The court found that patients had a constitutionally based right to refuse psychotropic medication grounded in their right to privacy.[59] The court held "[t]hat committed mental patients are presumed competent to make decisions with respect to their treatment in non-emergencies. Given an adjudication of incompetence, a guardian may exercise for and on behalf of a committed mental patient any rights he may have to make treatment decisions in a non-emergency."[60] The role of guardian is not merely as a third party but is a means for protecting the patient's right to be free from unwarranted government intrusion.[61] The court also held that voluntary patients also have a right to refuse treatment in a non-emergency, citing leaving the hospital as one available remedy.[62] The court emphasized that the desire to help the patient, though a laudable goal, is insufficient to override the patient's right to privacy.[63]

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[52] *Id.* at 413, 418.

[53] Schloendorff v. Society of New York Hosp., 105 N.E. 92 (N.Y. 1914).

[54] *Id.* at 129.

[55] Matter of Quinlan, 355 A.2d 647 (N.J. 1976); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977); Eichner v. Dillon, 73 A.D.2d 431 (N.Y. 1980).

[56] 462 F. Supp 1131 (D.N.J. 1978).

[57] Alan A. Stone, *The Right to Refuse Treatment*, 38 ARCH. OF GEN. PSYCHIATRY 360 (March 1981).

[58] 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part, rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *vacated*, Mills v. Rogers, 457 U.S. 291 (1982).

[59] *Id.* at 1365-66.

[60] *Id.* at 1364.

[61] *Id.* at 1362.

[62] *Id.* at 1368.

[63] *Id.* at 1369.

The opinion also referred to anti-psychotic drugs as "mind-altering" because their purpose is to reduce the level of psychotic thinking.[64] The court recognized that "[t]he capacity to think and decide is a fundamental element of freedom" but seemed, thereby, to afford First Amendment protection to the psychotic thinking which the anti-psychotic drugs are designed to control. "The fact that mind control takes place in a mental institution in the form of medically sound treatment of mental disease is not, itself, an extraordinary circumstance warranting an unsanctioned intrusion on the integrity of a human being." Therefore, despite the state's "obligation to make treatment available and a legitimate interest in providing such treatment, a competent patient has a fundamental right (to refuse that treatment)."[65]

In *In the Matter of Guardianship of Richard Roe, III*,[66] the court used the reasoning of the *Rogers* court in holding that competent mental patients had the right to refuse treatment. The court further held that the guardian of a mentally ill person could not consent to the "[f]orcible administration of antipsychotic medication to his noninstitutionalized ward in the absence of an emergency."[67] Such administration can only be ordered by a judge using the principles of 'substituted judgment' as articulated in *Saikewicz*.[68] The court found that the decision to refuse or to accept treatment for a person with mental illness adjudged to be incompetent required "the process of detached but passionate investigation and decision that form the ideal on which the judicial branch of government was created."[69] The principle of 'substituted judgment' was stated by the court in *Saikewicz*. "[T]he decision in cases such as this should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person."[70] The decision did not necessarily have to reflect what might be in the patient's best interests, and it minimized the impact on the patient's family of his refusal to accept treatment.

> [F]ew parents could make this substituted judgment determination - by its nature a self-centered determination in which the decisionmaker is called upon to ignore all but the implementation of the values and preferences of the ward . . . [even] when the ward, in his present condition, is living at home with other children.[71]

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[64] *Id.* at 1360.
[65] *Id.* at 1367.
[66] 421 N.E.2d 40 (Mass. 1981).
[67] *Id.* at 61.
[68] *Id.* at 51.
[69] *Id.* at 51 (quoting Superintendent of Belchertown State Sch. v. Saikewicz, 373 Mass. 750, 759 (1977)).
[70] *Id.* at 56 (quoting *Saikewicz*, 373 Mass. at 752-53).
[71] *Id.* at 56.

The court did include in the relevant factors in the substituted judgment determination the impact upon the ward's family, but only if it was believed by the court to be part of the ward's values or interests regardless of the preferences of any other persons.[72]

In summary, in three areas, civil commitment, right to treatment and the right to refuse treatment, state and federal courts began, in response to genuine abuses within the mental health system, to construct an image of relationship between persons with mental illness and care-givers which focused on the values of individual autonomy and ignored or denigrated the interconnectedness and vulnerability of the therapeutic relationship. Not only did this focus not empower persons with mental illness to receive appropriate care, it also resulted in an accelerated pace of deinstitutionalization, a limiting of the population to whom a right to treatment was owed, a narrower definition of the right to treatment, and an incomprehensible procedural approach to the right to refuse treatment.

III. WEST'S MODEL

Robin West critically analyzes the rights theory from at least two perspectives. In "Jurisprudence and Gender,"[73] West analyzes the rights theory as articulated by liberal jurisprudence, critical legal studies, and cultural and radical feminist jurisprudence. Her perspective in this analysis is a gendered perspective, but her effort is to transform the gendered limitations of the jurisprudential traditions into an integrated perspective on the understanding of rights.

In "Jurisprudence as Narrative: An Aesthetic Analysis of Modern Legal Theory,"[74] West analyzes jurisprudential traditions in terms of their narrative vision and method. These two analytic approaches, gendered and aesthetic, provide a basis for understanding the role that rights play in the judicial approach to the concerns of persons with mental illness and the failure of rights to empower persons with mental illness to address those concerns creatively or adequately.

A. Gendered Analysis

In her gendered approach, West begins her analysis of the four jurisprudential perspectives by an analysis of their effort to answer the question, 'what does it mean to be a human being?"[75] This question is central to her analysis since West believes that the Rule of Law, whatever one conceives it to be, is derived from the understanding one has about what

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[72] *Roe*, 421 N.E.2d at 58.

[73] Robin West, *Jurisprudence and Gender*, 55 U. CHI. L. REV. 1 (1988).

[74] Robin West, *Jurisprudence as Narrative: An Aesthetic Analysis of Modern Legal Theory*, 60 N.Y.U. L. REV. 145 (1985).

[75] West, *supra* note 73, at 1-42.

it means to be a human being. Furthermore, envisioning true human nature and living fully that vision enables the transformation of such visions into reality.[76]

West finds that liberal theorists and critical legal theorists view the essential separation of human beings from each other as paradigmatic and central to the origin of law.[77] Yet the meanings which liberal theorists and critical legal theorists ascribe to the experience of separation is quite different. Liberal theory views this separation from the "other" as a valuable and desirable experience necessary for the central experience of freedom.[78] As a consequence of this experience, not only are human beings free, they are also inherently equal with respect to that freedom. That equality is experienced as a legitimate claim to autonomy which must be respected and protected.[79]

However, this autonomy is threatened by the very otherness which defines it. Conflict, or at least its potential, is inherent in a world of equally free autonomous beings. Therefore, one remains always vulnerable to the conflicting claims of others to ends which may frustrate one's own, or result in one's annihilation. This vulnerability, this potential to be annihilated is the threat to autonomy inherent in separation.[80] West calls this "liberal legalist phenomenological narrative" the 'official story'.[81] From this story, the creation of the state is necessary to insure the safeguarding of individual autonomy from the risk of annihilation.[82]

Critical legal theorists ascribe a different meaning to the experience of human beings as separate autonomous individuals. Critical theorists find meaning in the continual effort of the individual to bridge the separation, to construct community as a balm for the "alienation, loneliness, and existential isolation that his material separation from the other imposes upon him."[83] This "longing for connection persists . . . because of [the value that the dominant culture places on autonomy]."[84]

West views both of these understandings of the nature of human beings, and their connection to, or dread of, the community connection, to be a narrative description of an essentially male experience of growth and development which shapes the law and the legal system.[85] She goes on to describe two feminist theories, cultural feminism and radical feminism, in contrast to the male narratives of liberal and critical legal jurisprudence.[86]

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[76] West, *supra* note 74, at 202.
[77] West, *supra* note 73, at 5.
[78] *Id.*
[79] *Id.* at 6-7.
[80] *Id.* at 7-9.
[81] *Id.* at 9.
[82] *Id.*
[83] *Id.* at 9-10.
[84] *Id.* at 10-11.
[85] *Id.* at 2.
[86] *Id* at 13-42.

West distinguishes cultural feminist theory from radical theory in a way analogous to her characterization of the difference of liberal from critical theory. While liberal and critical theory are based in an understanding of human beings as essentially separate from the other, cultural and radical feminist theory are grounded in an understanding of women as potentially connected to each other. "The potential for material connection with the other defines women's subjective, phenomenological and existential state, just as surely as the inevitability of material separation from the other defines men's existential state." Just as liberal and critical theorists are divided by the meaning each ascribes to what they believe to be the inherent separation of persons, cultural and radical feminist theory are divided by the different meaning each ascribes to this inherent potential for connectedness.[87] Cultural and radical feminist theory both appreciate the distinctive potential of women for material connection to others, but cultural theory celebrates this capacity for connectedness as the basis for the development of an ethic of care. Radical theory, in contrast, sees the capacity for connectedness as "[inviting] invasion into the physical integrity of our bodies, and intrusion into the existential integrity of our lives."[88]

Cultural theory in large measure adopts the articulation of their experience by a psychological description found in Carol Gilligan's writings.[89] Gilligan distinguishes the male and female perspectives on responsibility to others, and rights and autonomy of others:

> The moral imperative . . . [for] women is an injunction to care, a responsibility to discern and alleviate the "real and recognizable trouble" of this world. For men, the moral imperative appears rather as an injunction to respect the rights of others and thus to protect from interference the rights to life and self fulfillment.[90]

Cultural theory adopts and celebrates these differences. These differences become the basis for valuing connectedness to others just as separation becomes the basis of the liberal theorist's valuing of autonomy. The cultural theory fears separation from the other while the liberal theorist fears annihilation by the other.[91]

West recognizes that in some ways this distinction is an artificial one since both women and men have had the experience of connectedness before and after birth. Yet it is the feminist voice which has articulated and asserted the value of connectedness in the face of dominant legal theories which denigrate and fear connection. The outcome of this assertion is, according to West, not a new rule of law but, rather, "a new vision of human nature, reality, and sociopolitical arrangement."[92] West con-

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[87] *Id.* at 14.
[88] *Id.* at 15.
[89] *Id.* at 15-18.
[90] *Id.* at 18 (quoting CAROL GILLIGAN, IN A DIFFERENT VOICE 100 (1982)).
[91] *Id.* at 18-19.
[92] *Id.* at 25-26.

trasts cultural theory with liberal theory and finds within cultural theory "the creation of value [which] depend[s] upon relational, contextual . . . responses to the needs of those who are dependent and weak."[93] Within liberal theory, West finds the creation of value dependent "upon the ability to respect the rights of independent co-equals."[94]

Just as critical theory sees separation, the essential experience, as something to be overcome by striving for connection to a community, radical feminist theory sees connectedness, the essential experience, as inherently destructive and invasive.[95] Quoting Andrea Dworkin, West describes the experience of inherent violability of women because of their material connectedness to the other. Out of this experience comes powerlessness and self-annihilation.[96]

According to West's analysis, the different experiences which ground masculine legal theory (separation) and feminist legal theory (connectedness) and the different meanings each theory ascribes to its essential experience create what she calls the "fundamental contradictions" of each theory.[97] Of the three efforts she describes to explain the contradictions, the third is the most grounded in experience. This explanation, offered by the critical legal theorists, is that the fundamental contradiction "is an experiential contradiction, not a logical contradiction."[98] Because the contradiction is inherent in our experience it is reflected in the rule of law.

> The Rule of Law is a product of our dread of alienation from the other and our longing for connection with him, no less that it is a product of love of autonomy and fear of annihilation by him. As a consequence, it can be used and occasionally is used to ameliorate the sorrow we feel as a consequence of our alienation, as well as to protect the autonomy we value against the very real threat of annihilation.[99]

West concludes that the experience of connectedness carries within it the potential for intimacy and invasion, and the experience of separation carries the potential for both intimacy and alienation. Therefore, each of the legal theories articulates some dimension of human experience.[100] Yet only liberal theory finds articulation in the courts.[101]

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[93] *Id.* at 28.
[94] *Id.*
[95] *Id.* at 29.
[96] *Id.* at 33-36.
[97] *Id.* at 42-58.
[98] *Id.* at 50-58.
[99] *Id.* at 51-52.
[100] *Id.* at 53.
[101] See text accompanying footnotes 9-72.
[102] West, *supra* note 74, at 145-48, *citing* NORTHROP FRYE, ANATOMY OF CRITICISM (1957).

B. Aesthetic Analysis

West further analyzes the major jurisprudential traditions by use of an aesthetic analysis.[102] Using Frye's "aesthetic myths," West examines the liberal methods and visions of law as examples of Frye's romantic and ironic narrative methods and instances of comic and tragic narrative visions.[103]

Liberalism attempts to address issues about "history, human nature, and human societies."[104] Liberal theory finds in history support for its belief "that legal systems and the societies they control tend to improve morally, not degenerate, over time."[105] The liberal vision, analogous to the comic vision, assumes that laws, as a natural and positive element of human nature, express in both the present and the future a humane community promoting human welfare.[106]

Using Frye's categories of method and vision, West describes the overlapping application of method and vision and the schools of jurisprudence which result. A comic (liberal) vision coupled with a romantic method results in the romantic "optimism of liberal and progressive theorists . . . [like] the American legal realists" with a focus on individualism and constitutionalism. Liberal vision which uses a romantic method "results in a reactionary acceptance of the status quo, . . . a celebration of the moral virtue of the dominant social group."[107] West describes the modern version of this as the story of the constitutionally mandated procedures which legitimize the constitutional authority.[108]

The liberal vision coupled with an ironic method results in the ironic sense of "isolation and alienation . . . [resulting from the] changeable and perverse present institutions" which characterize the dark irony of the critical legal studies movement or the social pragmatist.[109]

Liberalism, which adopts an ironic method, "yields an acceptance of our social world based upon changing facts of experience."[110] This liberal view sees such an acceptance as providing either an opportunity for liberation and empowerment of the governed or the risk of majoritarian oppression.[111] West also describes a liberalism "poised delicately between these jurisprudential methods of innocence (romance) and experience (irony)."[112] This experience of liberalism maintains both an optimistic faith in experience and the experiential assertion "that communities exist and will progress" through a faith in human nature.[113]

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[103] *Id.* at 147.
[104] *Id.* at 153.
[105] *Id.* at 154 (footnote omitted).
[106] *Id.* at 154.
[107] *Id.* at 155-156, 159.
[108] *Id.* at 165.
[109] *Id.* at 155.
[110] *Id.* at 156 (footnote omitted).
[111] *Id.* at 178 (footnote omitted).
[112] *Id.* at 194.
[113] *Id.* at 194-195.

West concludes from this aesthetic analysis of jurisprudential narrative that jurisprudence is "part history, part vision, and part method"[114] and that to transform reality "[w]e must envision our true, ideal nature, and then prove the viability as well as the beauty of those visions, by living the lives we profess."[115] Most relevant to my task is West's conclusion that understanding the "story", which the liberal jurisprudence tells, can clarify the substantive debates within the jurisprudential traditions.[116] Such an understanding of the debates as one of conflicting visions and methods within the jurisprudential narratives permits greater insight into the successes and failures of these narratives in implementing their visions in the specific area of rights for persons with mental illness.

Both of West's methods of analysis, gendered and aesthetic, are useful in understanding the cases which have articulated the rights afforded to persons with mental illness and Unger's alternative right's image. Though she proposes no alternative image for articulating a system of rights which would empower and improve the status of persons with mental illness, her analytic framework provides a means of understanding the case law generated image and other images, as well as providing a context in which an alternative image can be developed.

West's gendered and aesthetic analyses are helpful in understanding the conceptions of reality which ground the enumeration of rights and the procedural protections. Her analyses are also helpful in understanding the misperception of such central features of the therapeutic relationship as vulnerability, power, caring, interdependence and rights which explain the failure of the rights revolution to positively effect the care and treatment of persons with mental illness. Her analyses and Unger's image offer alternative conceptions of reality and rights. These conceptions might more appropriately address the issues faced by persons with mental illness in securing care and treatment, not at the expense of their autonomy, but in such ways as that autonomy can have an authentic reality for the individual. This autonomy is in contrast to a theoretical ideal which in fact leaves the person with mental illness more isolated, with less possibility of recovery and regaining the resources to experience her life as a meaningful, rich, connected life of possibility and care.

IV. UNGER'S MODEL

Roberto Unger, in *False Necessity*,[117] describes a prescriptive redefinition of a system of rights as part of his program of empowered democracy.[118] Unger first describes what he believes to be the trouble with the

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[114] *Id.* at 203 (footnote omitted).
[115] *Id.* at 202.
[116] *Id.* at 203.
[117] ROBERTO UNGER, FALSE NECESSITY (1987).
[118] *Id.* at 508-539.

established system of legal rights.[119] Unger states that the model of rights exemplified by the consolidated property right influences the conceptions of rights in areas "far removed from the methods for economic decentralization."[120] The real problem with abstracting this form and applying it to other matters is "to force large areas of existing social practice into incongruous legal forms."[121] This results in a failure of imagination about other forms of relationship which might be more appropriate to relationships of mutual interdependence, "the idolatry of the actual" in its insistence on the preservation of the established social order and its rejection of "diversity in the form and substance of legal rights."[122]

As the basis for his reconstruction of a system of rights, Unger chooses two principles. The first principle assures the security of the individual and avoids an unchallengeable social hierarchy and the risk of personal subjugation.[123] The second principle "is the effort to affirm legal rights that, by their form and content, suit the obligations of interdependence that characterize communal life."[124] The basis for this effort is a prescription for communal relationships in which it is possible to diminish the tension between the assertion of autonomous individual rights and the claims of community connectedness. Unger argues that the "supposed antipathy between rights and community reflects both a rigid view of rights and an impoverished conception of community" and leaves the community more vulnerable to domination by self-interested assertion of individual rights. This artificial dichotomy between the individual and the community is inappropriate to communal and collaborative relationships and denies an "acknowledgement of obligations that arise from half-articulate and half-deliberate relations of interdependence."[125]

Unger describes four areas of rights: market rights, immunity rights, destabilization rights and solidarity rights.[126] Market rights deal with issues of economic exchange and advantage within a reconstructed economy with inherent economic decentralization and plasticity.[127]

Immunity rights "protect the individual against oppression by concentrations of public or private power, against exclusion from the important collective decisions that influence her life and against the extremes of economic and cultural deprivation."[128] This right, in part, resembles the image for individual autonomous rights which dominates the current rights discourse. It also differs significantly in relying not only on "freedom from violence, coercion, subjugation and poverty" as components of individual security, but also on the "intangible sense of being accepted

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[119] *Id.* at 511-513.
[120] *Id.* at 512.
[121] *Id.*
[122] *Id.* at 513.
[123] *Id.* at 513-515.
[124] *Id.* at 517.
[125] *Id.* at 518.
[126] *Id.* at 520-539.
[127] *Id.* at 520.
[128] *Id.* at 524.

by other people as a person, with a place in the world."[129] Immunity rights differ even further because they not only insure against government or private oppression, they also guarantee access to the resources necessary to make a life.[130] Immunity rights find their source in the relationship of the individual to the society, not in rigid role hierarchy. These rights provide safeguards with which the individual enters whatever relationships she chooses, insuring freedom of independent experimentation with relationships without fear of subjugation.[131]

Destabilization rights protect the citizen's interest in attacking the rigid social hierarchy and institutions currently immune from such attack.[132] The right denies protection to institutions or relationships which result in domination and dependence of those who do not have a privileged hold over the resources of society by those who do.[133] Inherent in the right is also a transformative capacity which results in the creation of new institutions or relationships which must themselves remain subject to further destabilization.[134]

Solidarity rights are communally based rights giving "legal form to social relations of reliance and trust."[135] Their intention is not only the transformation of institutional goals but also the transformation of personal relations inherent in an empowered democracy.[136] The idea of community inherent in this right does not exclude conflict. Rather it provides an arena for experimentation with ways to reconcile and sustain the tension between self-interest and communal relations of trust and reliance.[137] The legal form these rights take is the protection afforded to "claims to abide by implicit obligations to take other people's situations and expectations into account."[138] Solidarity rights prevent individuals from claiming, either through immunity or market rights, that others can make no claim upon them.[139] The source of solidarity rights is neither the fully bargained agreement nor the state imposed duty. Rather the source is in the not fully articulated relationships of interdependence, whether in equal or unequal relation.[140] Further, solidarity rights are not rigidly defined apart from the relationship between the persons by whom and against whom the right is asserted.[141] Unger concedes that many

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[129] *Id.* at 524.
[130] *Id.* at 528.
[131] *Id.* at 529-530.
[132] *Id.* at 530.
[133] *Id.* at 531.
[134] *Id.* at 531-532.
[135] *Id.* at 535.
[136] *Id.* at 535.
[137] *Id.* at 536.
[138] *Id.* at 537.
[139] *Id.* at 537.
[140] *Id.* at 537-538.
[141] *Id.* at 538.

solidarity rights may remain unenforceable, as coercively enforcing them might harm the reciprocal trust inherent within the rights. Yet, though unenforced, such rights may remain a symbol of "the ideals embodied in other, enforceable parts of the system of rights."[142]

Unger's image of empowerment contributes to an understanding of each of these rights and to the notion of solidarity. Empowerment contains both a prophetic and a priestly function. The prophetic function challenges the rigid social hierarchy and institutions. The priestly function compels continual reconstruction of social relationships and institutions.[143] Together they make possible the individual and the community imagination and transformative vision of new forms and acceptance of the unconditional as inherent in the transformative vision.[144] Empowerment further strengthens the individual enabling her to forgive the harms done to her and thereby "imagine [herself] related to others in untried ways - especially in ways that diminish the conflict between attachment and independent selfassertion."[145]

V. IMAGES OF THE THERAPEUTIC RELATIONSHIP

Central to an understanding of how the articulation of rights for persons with mental illness has changed the therapeutic relationship is an appreciation for the images of the physician which are part of the visions of the rights' theorists. An appreciation of the images of the physician also includes an understanding of the different images of the patient which correspond to the physician images. If the physician is imagined as parent, then the patient becomes the child. If the physician is seen as the benevolent philanthropist, then the patient is the passive recipient. If the physician is seen as covenantor, then the patient is "a bonded partner is the pursuit of health."[146] Because the image of the physician is multi-dimensional, containing elements of inarticulate religious or mythic experience, it remains a powerful force in a person's unconscious. This force exists whether or not the person assumes the role of patient.

The assertion of rights for persons with mental illness has been at least partly a response to the oppressiveness of the images of physician as parent and philanthropist. "Traditionally, the adversarial image domi-

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[142] *Id.* at 538-539.

[143] The priestly [work] is each individual's and each group's renewed sacrifice of the acceptance of any one situation as a permanent element in the definition of its identity. The priestly, sacrifical emptying out is just the reverse side of the prophetic iconoclasm.

This priestly and prophetic activity makes possible the emergence of fuller forms of self-assertion and attachment, and enables people to hold themselves open to the signs of the unconditional or the less conditional.

Id. at 575.

[144] *Id.* at 574-575.

[145] *Id.* at 593.

[146] WILLIAM F. MAY, THE PHYSICIAN'S COVENANT: IMAGES OF THE HEALER IN MEDICAL ETHICS (1983).

nated the practice of the law; the parental [image], the practice of medicine."[147] The image rested on the physician's willingness to extend himself or herself to meet the needs of the family with compassion, to avoid exploitation of the patient. Both patient and physician derived a portion of their identity from the relationship. The image has been altered, though not destroyed, not only by the changing nature of modern families and life, but also by the specialized delivery of care and increased emphasis on medical technology. The transience of modern families and the changing roles and construction of the family have undermined the image, resulting in a move toward contractualism.[148] Nevertheless, the parental image persists in a negative form, as physicians "continue to diminish the patient's freedom for the patient's benefit."[149] The relationship is now defined by management rather than care.

In contrast to the parental image, the image of the physician as philanthropist represents a relationship defined solely by the giving of the physician. It is a relationship without empathy or reciprocity. Unlike the parental image, "the philanthropist may sympathize, but . . . he or she does not suffer with the beneficiary."[150] The giving is from the philanthropist's abundance, a wholly gratuitous rather than responsive act. It denies the debt that the physician owes to the community and fails to acknowledge the reciprocity of need in the physician-patient relationship.[151] While the notion of gift is a valuable one in the physician-patient relationship, an objection should be raised to "the moral pretension of professionals who see themselves as givers alone."[152]

The image offered by the rights theorists, the physician as contractor, fails to unseat the deeply rooted expectations of both those who provide care and those who receive it. This contractual approach identifies an agreement external to the parties involved and presumes an exhaustive predictive listing of rights and duties. It further "tends to reduce professional obligation to self-interested minimalism, *quid pro quo* . . . and a peculiar kind of maximalism, 'defensive medicine'"[153] and "fails to judge the more powerful of the two parties (the physician) by transcendent standards."[154] Because of the contract image's emphasis on self-interest, external restraints like procedural protections are heavily relied upon.[155]

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[147] *Id.* at 37.
[148] *Id.* at 45.
[149] *Id.* at 39-45.
[150] *Id.* at 39.
[151] *Id.* at 112-15.
[152] *Id.* at 118.
[153] *Id.* at 118, 122. Self-interested minimalism likens the physician-patient relationship to a commercial contract for services - Do no more for your patients than what the contract calls for, i.e., specified services for established fees. Maximalism, on the other hand, suggests that physicians, with both reasonable and unreasonable fear of litigation, will order tests and procedures which can be medically justified only by reference to such fear and the nearly ubiquitous availability of advanced medical technologies. Physicians often yield to (or exploit) these fears because they fear malpractice suits. *Id.*
[154] *Id.* at 123.
[155] *Id.*

The image fails because it is "insufficiently communal," with its emphasis on autonomy and self-interest, the isolated self.[156]

The image of the physician as covenantor is a more central, whole image with antecedents in theological and political traditions.[157] The covenant is a promissory event, grounded in the gift which the physician received and assumed when he or she chose to practice medicine, a gift not wholly deserved but which one accepts gratefully. "The covenant details duties that give specific content to the future, while enjoining a comprehensive fidelity that extends beyond particulars to unforeseen and unforeseeable contingencies."[158] The duties run not only to the physician but also to the patient, who accepts, within the covenanted relationship, "an inclusive set of ritual and moral obligations by which they will live."[159] The covenantal image, in contrast to the contractual image, "obliges the more powerful to accept some responsibility for the more vulnerable and powerless of the two [parties]. . . . It does not permit a free rein to self-interest, subject only to the capacity of the weaker partner to protect himself or herself through knowledge, shrewdness, and purchasing power."[160] This image results in a physician-patient relationship characterized by "a pervasive fidelity that informs the performance of all duties."[161] This fidelity transforms the human context in which physician and patient relate. Fears of patients that they will be abandoned in their time of greatest need can be allayed if the physician promises not only technical proficiency, but also fidelity. In this way patients and physicians can be made whole, even in the face of untreatable or incurable disease.[162] This wholeness within the covenantal relationship is enabled by the physician also acting as teacher.

> Teaching offers one of the few ways in which one can engage in transformation while respecting the patient's intelligence and power of self-determination. Good teaching depends not only upon a direct grasp of one's subject, a desire to share it, and some verbal facility, it also requires a kind of moral imagination that permits one to enter into the life circumstances of the learner: to reckon with the difficulties the learner faces in acquiring, assimilating, and acting on what he or she needs to know. Good teachers do not attempt to transform their students by bending them against their will, or by charming them out of their faculties, or by managing them behind their backs. Rather, they help them see their lives and their habits in a new light and thereby aid them in unlocking a freedom to perform in new ways.[163]

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[156] *Id.* at 125.
[157] *Id.* at 23.
[158] *Id.* at 107-108.
[159] *Id.* at 108-109.
[160] *Id.* at 124.
[161] *Id.* at 141.
[162] *Id.* at 141-44.
[163] *Id.* at 149-50.

There are dangers inherent in relying on an image of the physician-patient relationship which addresses the inequalities within the relationship, not through external constraints, but through a transformed image of how the physician and patient should relate. Nevertheless, the construction of such a relationship seems a more secure safeguard than the bare articulation of disempowering rights and procedural protections. Internal restraints grounded in a sense of giftedness, reciprocity and fidelity are a more sure protection against the use of the physician's power by the state to transgress the rights of individual patients than are procedural impediments to the formation of a physician-patient relationship. Without such a transformative image, patients are denied a powerful protective ally when procedural protections displace the physician-patient relationship.

VI. CONCLUSION

The germinal cases in the area of civil commitment, the right to treatment, and the right to refuse treatment are grounded in and create an image of the relationship within which rights are experienced and actualized. This image of relationship reflects the image of separation and alienation which liberal and critical theorists believe characterizes all relationships. The image, because it involves a relationship in which there is inherent inequality in what is perceived by the courts to be a power-centered relationship, also incorporates the radical feminist theorists' negative view of connectedness and vulnerability. What is missing from the image in which the rights are based is the cultural feminist perspective on the value of connectedness, the relationship of vulnerability to power, and the relationship of individual to community. Absent this element of meaning, the image of relationship in which the rights of persons with mental illness are expressed is itself disconnected from the reality of the relationship. This disconnection becomes disempowering for persons with mental illness, their families and the communities within which they live.

Each of the court opinions narrates a story. The parties have brought before the court the beginnings of a narrative, and they request that the court write the ending. Two assumptions are important. First, there is the shared belief that the court is the proper or, perhaps, the only place where the end can be written. This is so because of how each party has written his or her part of the story to this point. The story has been framed so that it poses a narrative question which the courts have said they will, and sometimes must, answer. The courts have further defined the narrative so that a judicial answer is the determinative answer. Second, there is the context which defines the narrative which the parties bring to the court, and there is the context within which the court writes its portion of the narrative. If the realists are right, then context, both recognized and unrecognized, determines the contours of the narrative answer which the court writes to each of the questions that the parties

bring before it. What courts must do is construct narrative endings, i.e., holdings, which recognize the tension between autonomy and interdependence which exists in the therapeutic relationship.

Beyond simple recognition, the holding must also sustain that tension through the court's articulation of a new image of rights, grounded in the covenantal imagery of the therapeutic relationship. Unger has attempted to articulate such an image by his description of immunity, destablization and solidarity rights. His assertion that solidarity rights might not be enforceable because of the effect that enforcement might have on the trust necessary for interdependent relationships is not completely accurate. The courts already enforce similarly conceived rights within recognized fiduciary relationships and such enforcement itself serves as a model for other fiduciary relationships. In those cases, however, the court has not attempted to sustain the tension between immunity/individual rights and solidarity rights. Rather the relationship has been conceived as so inherently unequal that the court, through enforcement of the fiduciary duties, has simply attempted to redress the imbalance rather than to articulate a new image of rights within an interdependent relationship.

If the courts could instead articulate a holding which sustains rather than resolves the tension, then solidarity rights would be enforceable, if grounded within an image of therapeutic relationships which recognizes the dialectic between autonomy and interdependence which is at the center of the therapeutic relationship. Absent such a dialectic, rights for persons with mental illness will continue to erode the very relationships which make possible a full elaboration of those rights. Alternatively, rights within the therapeutic relationship held in dialectical tension with interdependence and benevolence are transformative of both parties to the relationship and make possible the full flowering of individual autonomy within community.

West's gendered and aesthetic analysis of these judicial holdings understands that the court's response is shaped by the liberal belief in the inherence of separation as part of the human condition and an emphasis on the value of that separation rather than its dangers. The courts' holdings are further shaped by the aesthetic contours of the liberal vision, but in these cases that vision is itself shaped by the tragically ironic perspective on interdependence and vulnerability in relationship, and the comic romantic perspective on equality. The negative view of the therapeutic relationship reflects the courts' vision of relationships experienced through the tragic vision of the inherent violence and oppression of human relationships. Within this vision, the desire to care, even if rooted in good medical practice, is insufficient to overcome the dangers of a relationship characterized by vulnerability and interdependence.[164]

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[164] *See supra* notes 63-65 and accompanying text.

In contrast, the liberal vision, with its comic romantic perspective, presumes that the articulation of rights reflects the highest of individual values, autonomy, and necessarily results in a humane community promoting human welfare. This vision remains steadfastly committed to the status quo. This means a commitment to individual rights in a world of separate autonomous individuals, celebrating the dominance of rights even in the face of the countless individual tragedies which result from the isolation of persons with mental illness from their communities. The liberal vision would maintain the status quo even in the face of disempowerment and isolation of those whose rights are articulated, even as the very rights which the courts so carefully crafted in the context of separation and individuality resulted in less care and more abandonment.

Trapped as the courts are in the context in which separation and individual autonomy are viewed as the highest values, values which trump all others, and in which connection is seen as dangerous, the courts can only write one ending to the cases which are brought before them by persons with mental illness or by their families. The ending is always the same because, as Unger says, the courts are practitioners of the idolatry of the actual. The courts fail to imagine or implement a radical transformation of the therapeutic relationship within which autonomy and interdependence are maintained in creative tension. The courts' failure results in maintenance of the liberal status quo.

The liberal and the critical theories, which shape the courts' image, rest on a belief that separation is the essential experience of a human being. While liberals view this as a good thing to be protected, and critical theorists as an imposition to be overcome, neither recognizes the inherence of the connectedness which is central to the cultural and radical theorists. Likewise, the holdings represent what West calls the "official story,"[165] when they analogize the therapeutic relationship to the relationship between an accused criminal and the state.[166] The consequence of this analogic image of the therapeutic relationship is, in this case, the court's imposition of procedural protections on the therapeutic relationship, designed to safeguard this highly valued autonomy. But the autonomy is viewed through the lens of the liberal theorists' image of the value of separation. The court emphasizes the risks of hospitalization and the possibility that no treatment exists but makes no mention of the potential benefits of treatment and hospitalization to persons suffering from mental illness.[167] The liberal image, which paints a picture of the therapeutic relationship as dangerous, is similar to the image which the radical theorists would construct of the vulnerability of the connectedness inherent in the therapeutic relationship. Though the court does not explicitly discuss the vulnerability of the patient in a therapeutic relationship, its analogy of the patient to the criminal who has the full force of the state

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[165] *See supra* note 81 and accompanying text.
[166] *See supra* notes 13-22 and accompanying text.
[167] *See supra* note 21 and accompanying text.

brought to bear against her suggests the same inequality of power in the patient-physician relationship. Like the radical theorists, the court sees this vulnerability as a source of powerlessness and annihilation. The answer to this valuing of autonomy and this rejection of connectedness and vulnerability is the court's construction of procedural protections to define the relationship between patient and caregiver.

What is dangerous about the imagery which the court chooses to use to explain and define the therapeutic relationship is that it tells only part of the truth of the human experience. As West points out about the images of separation and connectedness and their attendant risks of annihilation and intimacy, each articulates some dimension of human experience but no one articulates the wholeness of human experience. As the courts place more and more emphasis on the liberal image of autonomy as the singular value, with its inherent risk of annihilation, the disconnection which critical theorists fear and which is central to cultural theorists becomes the most certain outcome. This outcome can be seen in the accelerated deinstitutionalization which followed from the court's elaboration of rights for persons with mental illness. By using the same image of power and relationship for persons with mental illness which was used in articulating rights in the criminal context for persons whose cognitive abilities were not at issue, the courts assured the isolation which is the unacknowledged cost of unfettered autonomy.

The perspective taken by the court reflects a tragic vision of experience which presumes oppression to be inherent in human relationships, even those which purport to be therapeutic and caregiving. The court's vision focuses on the constitutionally mandated procedural protections which celebrate the value of the dominant individualism and reject communitarian notions of interdependence and inequality. Rather than resulting in an empowerment of persons with mental illness or protecting their autonomy, the court's vision resulted in a disconnection of persons with mental illness from the relationships within which their autonomy might flourish.

This disconnection from relationship can be seen in the series of cases in Alabama,[168] where the court focused on objective numerical criteria for its determination of the enforcement of the patients' right to treatment. While the court properly recognized that the *parens patriae* doctrine made sense as a basis for involuntary commitment only if it was accompanied by a right to treatment, the court addressed the externals of the environment in which treatment might take place, rather than grappling with the far more difficult but fundamental question of the relationships within which treatment would take place.[169]

The *Wyatt* court's definition of the physical environment for the involuntarily committed is analogous to the *Lessard* court's elaboration of the procedural environment in which care must be given.[170] In neither case

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[168] *See supra* notes 24-26 and accompanying test.
[169] *See supra* notes 24-25 and accompanying text.
[170] *See supra* notes 13-22 and accompanying text.

does the court focus on the relationship between patient and caregiver as anything other than a relationship between two autonomous individuals whose rights must be defined separately and protected within that separation. The court can focus on nothing else with its singular emphasis on the principle of autonomy and its tacit rejection of the value of connectedness.

In *Donaldson*, the Supreme Court further separated rights from relationship when it rejected mental illness absent dangerousness as a basis for commitment.[171] The Court further reconstructed the lower court case by its focus on the issue of liberty rather than treatment. The Court almost totally ignored the right to treatment, the basis of the lower court holding, which is inherent in the patient-caregiver relationship. The Court used this same reconstructive technique in *Romeo*, where it again refused to recognize the right to treatment.[172] In both *Donaldson* and *Romeo*, the Court focused exclusively on the image which liberal theorists articulate, one of individuals separate and equal. The Court extends that image beyond the relationship of individual patient and caregiver to the relationship of individual and community. The rights of individuals in relationships do not form the basis for a claim on the other party in the relationship nor on the community as a whole. The autonomy of individuals in isolation from each other and from the community is the paramount value. Once again the court constructs an image of rights which ignores the reality of the relatedness of extant and empowering rights. The image the court constructs focuses entirely on issues of power, i.e. safety and undue restraint, and presumes an equality belied by the reality of the vulnerability of persons with mental illness.

The natural result of the focus on images of power in relationship is the line of cases which developed around the right to refuse treatment. Once commitment was separated from the need for treatment and instead related only to dangerousness, the image used by the *Lessard* court in its analogy of the criminal to the prisoner became the reality. The court's singular emphasis on the liberal image of individual autonomy completely supplanted any image of the relationship within which autonomy and vulnerability, and separation and connection have a place. The sole focus of the right to refuse treatment is the issue of power within the therapeutic relationship. The court rejected entirely the desire to care for the patient as something against which the patient's right to refuse treatment could be weighed. The court states this right within the context of a competent patient, but does not distinguish legal competence from the disease process which, though not rendering the patient incompetent as defined by the courts, interferes with the patient's ability to choose in such a way that rights are enabling of a full connected life, rather than a life which reflects the isolation and anonymity of unfettered autonomy.

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[171] *See supra* notes 27-41 and accompanying text.
[172] *See supra* notes 42-50 and accompanying text.

Unger's articulation of solidarity rights offers an alternative ending for the tales brought before the court. Though Unger hedges and says that such rights may not be enforceable, he does acknowledge that the image which they represent is a powerful transformative image. Unger's reconstruction of rights is similar to the covenantal image of relationship. Both would assure the security of the individual by the imposition of responsibilities on both the stronger and the more vulnerable party. Both would challenge the social hierarchy by creating a relationship of mutual trust and respect born of fidelity to individuals rather than derived from power. Both would recognize the interdependence within relationships as inherent in the community necessary for a full flowering of individual lives.

The covenantal image and Unger's solidarity rights provide a means of truly balancing the tension between autonomy and connectedness. The covenantal image provides the richness of relational imagery which Unger finds lacking in the impoverished liberal conception of rights. Furthermore, it offers an alternative to the constructed antipathy of rights and community by the reality of relationship it creates, in which interdependence is primary and realized in collaboration between caregiver and patient. The therapeutic relationship, which has been reconceived by the courts as a contractual relationship, is a relationship of reliance and trust requiring a recognition that individuals can make a claim on each other and must take each other's situations and expectations into account. Solidarity rights find their source in the covenantal relationship, a relationship of interdependence, obligation, fidelity, giftedness and reciprocity.

The covenantal image of relationship should not be confined only to the relationship of caregiver to patient. For the image to be truly transformative, it must transform all the relationships within which there is a need for care and an inherent inequality. Not only must the physician-patient relationship be transformed, but the way in which the physician herself is viewed must be transformed. The way in which we view and talk about the foreign physicians who staff our state institutions must be infused with the same sense of care and fidelity with which we expect those physicians to treat their patients. Furthermore, the nurses, aides, maintenance people and whoever else has a role in the care of the patients and their environment must also be afforded the care and respect inherent in the covenantal image. Only in such a way can the powerlessness which those persons often feel be transformed, and the risk that they will mistreat patients more powerless than themselves be minimized. This is why Unger's model of immunity, destabilization and solidarity rights is so radical a vision. Unger's vision requires the transformation of all social relationships, not just those which are litigated in the courts. The covenantal image of relationship offers a transformative model for all relationships.

The effect of this transformative image on litigated cases would be important. In the area of civil commitment, the criteria for civil commitment would be expanded beyond the narrow "dangerousness to self

or others" standard which currently controls involuntary access to care for persons with mental illness.[173] In order to balance the other equally important immunity and destabilization rights, the courts, in implementing the covenantal image, should incorporate the "five-step procedure" described by Dr. Alan Stone.[174] The procedure would apply involuntary civil commitment to those persons who have a reliable diagnosis of a severe mental illness and are experiencing major distress. The court would also determine that treatment is available. Further, the persons subject to civil commitment must have an impaired ability to accept treatment which a reasonable person would accept.[175] Transgressions of immunity rights and destabilization rights are protected against by requiring that the illness be severe and that the impairment in the ability to accept treatment be a product of the illness. The grounding of this procedure in a compassionate recognition of human suffering, and the ability of treatment to address that suffering while balancing the competing values of autonomy and care, enables the covenantal relationship to empower persons with mental illness.

The right to refuse treatment would likewise be circumscribed by an examination of the basis of the person's refusal and a recognition that mental illness itself interferes with a person's ability to choose. Refusals based on grounds other than a disease-produced misperception of reality would be respected. However, refusals which are irrational and based in the mental illness would be subjected to further inquiry. Protection of immunity and destabilization rights requires a balancing test in which the loss of freedom by commitment is measured against the assurance of treatment known to produce results in similar cases and the alleviation of suffering. However, as Dr. Stone notes, these assurances would require a significant overhauling of the state and county hospital systems in which persons would receive care.[176]

Because of the changes which would be required in the mental health care system by a redefinition of the right to refuse treatment, the right to treatment would be enormously expanded. The covenantal model of relationship would impose on institutions outside the judiciary the responsibility to provide proper and necessary treatment for persons with mental illness. The impact of this covenantal image would be felt far beyond the patient-caregiver relationship. Its reality would have to be experienced in all relationships within the community. The covenantal image which is the basis for the transformation of the rights of persons with mental illness can fully assure a balancing of solidarity, immunity and destabilization rights only if it serves as the model for relationships between all members of the community.

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[173] ALAN A. STONE, MENTAL HEALTH AND LAW 45 (1979).
[174] *Id.* at 66-67.
[175] *Id.*
[176] *Id.* at 69.