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Hospital Refusal to Release Mental Patient

Thomas S. Szasz, M.D.*

THE DOUBLE ROLE of the institutional psychiatrist—consisting on the one hand of being a therapist to his patient, and on the other of being a protector of society against the patient—is one of the major dilemmas facing contemporary psychiatry.¹ While these two roles need not conflict in the case of every patient, the possibility of ambiguity, conflict and attendant injury to the patient and to society is ever present in this arrangement. Once it is admitted that patient and mental hospital (or hospital authorities) *might* come into conflict with each other, it becomes necessary to try to avoid situations in which persons are placed in the position of simultaneously representing opposing interests.

It is a well-established principle of democratic forms of social administration that situations of conflicting interests must not be entrusted to single persons (or agencies). This precaution is based on the premise that such arrangements are conducive to surreptitious slighting of one or the other of the two interests. It is believed, too, that reconciliation of the conflict by means of an equitable *compromise* can be more readily achieved if each interest has its own, separate and well-defined, representation. There is much empirical evidence in jurisprudence, politics, psychiatry, sociology and everyday life to support this contention. It is also well known that should the conflicting interests of two (or more) persons or parties be placed in the hands of a single representative, some of those so represented very likely will feel that they have been betrayed. Should this occur, the injured party has no recourse for remedying the harm done to him. Indeed, a person injured in this way is worse off than if he had no representation at all, since in the latter case he could avail himself of the requisite legal or perhaps legislative aid. But this avenue is barred to those who, by official *fiat*, are said to have adequate legal (or other, e.g., psychiatric) representation, when in fact they do not. It was shown elsewhere that mentally ill persons, especially those involuntarily hospitalized, often find themselves exactly in this position.²

*Professor, Department of Psychiatry, State University of New York, Upstate Medical Center, Syracuse, New York.

¹ I have discussed this problem in several previous papers to which the interested reader is referred. E.g., see Szasz, Some Observations on the Relationship between Psychiatry and the Law, 75 A. M. A. Arch. Neurol. & Psychiat. 297 (March 1956); Psychiatric Expert Testimony: Its Covert Meaning and Social Function, 20 Psychiatry 313 (August 1957); Psychiatry, Ethics, and The Criminal Law, 58 Colum. L. Rev., 183 (1958).

² Szasz, Commitment of the Mentally Ill: "Treatment" or Social Restraint? 125 J. Nerv. & Ment. Dis. 293 (April-June 1957); Civil Rights and The Mentally Ill, to be published.

The purpose of this essay is to amplify and illustrate this thesis by means of a type of litigation characteristic of forensic psychiatry. I refer to the legal contests resulting from the patient's suit for release from the mental hospital against the wishes of the hospital authorities; and also to its corollary, namely, the hospital superintendent's suit against the patient when the latter has gained his release by the decision of a lower court and the former, seeking the continued retention of the patient, appeals this decision.

The mere fact that a patient seeking release from a hospital is denied his request should, I submit, be considered *prima facie* evidence of a conflict of interests between himself and the hospital authorities. To argue that the patient is "psychotic" (or insane, deranged, etc.) will not do, even if it might, in some theoretical-psychiatric sense, be correct. This argument must be expressly disallowed simply because it rests on the wholly unwarranted assumption that mentally ill persons (or some of them) have no genuine ("rational") interests of their own, or if they have, they do not know what they really are. It seems to me that we should assiduously guard against temptations to make such assumptions. *For what is involved here is the adjudication of the legitimacy of interests (or desires, wishes, etc.), rather than their acknowledgment or description.* So-called mentally ill persons, however deranged or different from those considered normal, obviously do have desires and interests to do some things, and to avoid doing some others. The same is true of children. Clearly, the most honest thing possible in these situations is to acknowledge what *their* interests are, and to state, equally explicitly, what *ours* are. Should the two sets of interests conflict, this, too, must be explicitly acknowledged and dealt with, rather than obscured or denied. It may be asked: How are we to ascertain the interests of others? Our answer is that we must ascertain them the same way as we determine our own. In both cases, at least as a base line for further study and discussion, we must accept *self-declared intentions* as phenomenologically valid and morally legitimate. To argue that "mentally ill" persons do not know what their "real interests" are—that is, "what is good for them"—makes the speaker the self-appointed guardian of the patient's alleged best interests, and thus puts an end to any inquiry into or discussion of this problem.³

Once the patient brings suit against the hospital superintendent (in his capacity as representative of the hospital), their respective roles become legally defined as those of *adversaries*. It is hard to see how anyone can maintain, in the face of such evidence, that they could, nevertheless, be *partners* in working toward the therapeutic rehabilitation of the patient. Yet this is generally what the psychiatrists in these situations have claimed and continue to claim. In a previous discussion of the civil rights

³ Szasz, *Moral Conflict and Psychiatry*. Yale Review, in press.

of involuntarily hospitalized mental patients,⁴ I suggested that the relationship of these patients to their psychiatrists is of an adversary character and urged that this fact be more openly recognized and implemented. How such recognition and implementation might operate could probably be described better by using actual case illustrations, rather than by stating it only in general terms. To accomplish this, we shall briefly consider some examples.

The typical form of the type of litigation which we are considering is "John Doe (patient) v. John Smith (superintendent)," when the patient sues for release; and its reverse, when the mental hospital superintendent sues to reverse the decision of a lower court ordering the patient's release. The literature on forensic psychiatry is replete with such cases. The examples which follow are condensed from Lebensohn's essay, *Contributions of St. Elizabeth's Hospital To a Century of Medicolegal Progress*.⁵

Let us begin with the case of Barry v. White.⁶ The patient, Paul duV. Barry, sued William Alanson White, the superintendent of St. Elizabeth's Hospital, for his release. Barry had been *acquitted* of a murder charge on the grounds of insanity and was subsequently committed to St. Elizabeth's Hospital. He filed three writs of habeas corpus, and when all of these were denied, he appealed the last ruling to a higher court.⁷ In their decision, the appeal court ruled:

It seems clear that the natural assumption of fact follows that such condition of insanity has continued to the present time. The effect of such presumption is to cast upon the prisoner here the burden of proving that since the commission of the homicide he has become sane to the degree that it is reasonably certain that his enlargement will now be without menace to the public peace or safety. Where insanity has gone so far as actually to take human life, no

⁴ Szasz, *Civil Rights and The Mentally Ill*, to be published.

⁵ Lebensohn, *Contributions of St. Elizabeth's Hospital to a Century of Medicolegal Progress*, 24 *Med. Ann. Dist. Columbia* 469, 542 (Sept. and Oct. 1955).

⁶ 62 U. S. App. D. C. 69 (1933).

⁷ It is important to note that often this type of litigation is complicated and confused by the fact that the "patient" committed an unlawful act. Thus, when he asks for release from the "hospital," the superintendent of that institution tends naturally to assume the role of prison-warden (i.e., the role of being entrusted to keep the "patient" safely locked up). But if this is so, surely he has asked to be so defined! Moreover, these quasi-criminal cases have also served as models for the lawsuits of other mental patients who have never committed an unlawful act. In *their* suits for release, too, the superintendent is apt to take the role of warden. The concepts of criminality and mental illness thus remain persistently confused and equated in the management of the (involuntarily) hospitalized mental patient.

sensible person will be satisfied with evidence of recovery which does not attain to the degree of reasonable certainty.⁸

Lebensohn added: "It will be noted that the burden of proving his recovery in such cases rests squarely on the shoulders of the petitioner."⁹

This situation deserves critical scrutiny. I shall limit myself to only a few brief remarks.

1. How can a plaintiff-patient, in such a situation, prove his so-called sanity, or recovery (from an alleged mental illness), when the precise criteria of what constitutes mental illness has never been clearly defined? This is an utterly Kafkaesque situation, requiring the defendant (as it were) to prove that he is innocent, without specifying the crime of which he is alleged to be guilty.

2. If "insanity" was inferred directly from homicide, as seems to have been the case here, "sanity" could be *proved* (logically) only by guaranteeing the non-commission of future homicide. But how can anyone prove a *future* occurrence? Surely, this is a good example of a requirement which it is logically impossible to fulfill.

3. Furthermore, how could the patient prove that he is "mentally healthy" without powerful psychiatric assistance, powerful enough to counteract the prestige and authority of the hospital superintendent? Without supplying him with *psychiatric defense*—in addition to legal defense—he is, in fact, as good as unrepresented in his psychiatric battle with the experts. In support of this contention, consider Dr. White's much poorer showing in his forensic-psychiatric battle in the Leopold-Loeb case.¹⁰ In that case, finding himself in the other corner, as it were, from the power represented by the prosecution, he was unable to make his "diagnoses" of "insanity" stick. It is evident that mental hospital psychiatrists testifying *against* disenfranchised and feared mental patients have the power of the state (and of public opinion) on their side. If such matters are to be legally adjudicated, it is not enough to go through the formalities of a judicial proceeding. The ethic of democracy requires *equal representation* of the interests of the two parties.

There is an interesting postscript to the *Barry* case. After approximately eleven years of hospitalization, Barry managed to escape from St. Elizabeth's Hospital and make his way to St. Louis. Although picked up by the police there, he was not returned to the District of Columbia, and no more was heard of him. Mental hospitalization of this kind reminds one of the tales

⁸ Lebensohn, *op. cit.* *supra* note 5, at 543.

⁹ *Id.*

¹⁰ W. White, *The Autobiography of a Purpose* (1938).

of the Count of Monte Cristo: that is, of indefinite detention in jails without possibilities of legal reprieve, intelligently conceived and skillfully executed escape being the only means for gaining one's freedom. But should we not ask why psychiatrists wish to play wardens in such a system of unreasoning and unjust imprisonment? And if they really believe that Barry, or men like him, should be segregated from society for virtually unlimited periods of time, what training, skill or legal status do psychiatrists possess to implement such "sentences"?

Let us briefly review another celebrated case, that of *Overholser v. DeMarcos*.¹¹ DeMarcos was from Tennessee, and while living in Canada, was tried for murder and convicted of manslaughter. While serving his sentence for life imprisonment, he was found to be of "unsound mind." He was sent to a mental hospital in Canada, and then, in accordance with the "reciprocal trade agreement" (as Lebensohn put it) between that country and the United States, he was transferred to St. Elizabeth's Hospital. This was in 1939, at which time DeMarcos was already 71 years old. At St. Elizabeth's Hospital he was diagnosed "as one of the rare cases of true paranoia."¹² Between 1940 and 1944, he made several unsuccessful attempts to gain his freedom by filing four different writs of habeas corpus. In his fifth attempt, "Justice Goldsborough took the case out of the hands of a jury and summarily ordered him discharged . . . The apprehension of the District Attorney's office at having DeMarcos at large"—wrote Lebensohn—"was further evidenced by the unprecedented speed with which the appeal was drawn and filed . . . This was seen in some legal circles as an effort on the part of the District Attorney's office to 'get out from under' should anything untoward happen involving the released man. The appeals court ordered the arrest of DeMarcos, and this was interpreted as a direct rebuke to the presiding judge. The wheels of justice moved much too slowly in this instance, for by the time the order for arrest was issued, DeMarcos was already in Knoxville. After some delay, he was apprehended by the F. B. I. on an assault charge and returned to the District."¹³

In *Overholser v. DeMarcos*, the Court of Appeals announced the following decision (as abbreviated by Lebensohn):

It is not the function of the Judge in habeas corpus proceedings to determine the mental condition of a person who has been committed for insanity. . . *It should be remembered that persons committed . . . are presumed to be insane . . . There is also a presumption that the hospital staff are competent . . . and that their opinion is correct.* Their determination that a petitioner should not be at large should not be

¹¹ 80 U. S. App. D. C. 91 (1945).

¹² Lebensohn, *op. cit. supra* note 5, at 544.

¹³ *Id.* at 544-45.

lightly disregarded . . . The issue which must ultimately be decided is whether he has sufficiently recovered from a mental disease, so that he may be safely released. Lay judgment on such an issue is of little value. If, despite the judgment of the hospital staff that the petitioner has not recovered, there is a substantial doubt on the question, it becomes the duty of the court to see that a new judgment on the petitioner's sanity is made according to the procedure laid down in the District of Columbia code. This procedure requires an examination and report by the Commission on Mental Health (*italics added*).¹⁴

This, however, was not the end of the story. DeMarcos seemed to be indestructible and forever hopeful. This is Lebensohn's account of the denouement of this story:

The Commission did, indeed, examine him on two separate occasions and concurred with the Hospital findings. In spite of this, DeMarcos persisted, and in persisting he finally triumphed. In 1946, at the time of his eighth try, he was 78, and possibly the court was influenced by the mellowing effect of his advancing years. At any rate, the court disregarded the unanimous opinion of all Hospital and Commission psychiatrists and ordered his discharge. This time he went directly to Tennessee where, I am informed, he is engaged in teaching school. In this instance, the psychiatrists' dire predictions were happily, but surprisingly, unfulfilled. The DeMarcos case is the exception which proves the rule.¹⁵

In the light of my previous comments, this story, in a way, speaks for itself. Without belaboring some of the points made already, a few additional remarks will be offered.

1. Inasmuch as DeMarcos was sufficiently intact to persevere, as he did, in efforts to gain his release by appropriate legal methods, one may well be skeptical about what kind of "insanity" he had suffered from. Perhaps his was a "case of true paranoia," as claimed by the psychiatrists who saw him. But even if the validity of this "diagnosis" is granted, *it alone* could not explain or justify his interminable "hospitalization." This could only be justified as serving the purposes of preventive jailing, that is, imprisonment to prevent a *future crime*. I have discussed in detail elsewhere the moral and legal illegitimacy of putting psychiatric hospitalization to this use.¹⁶

¹⁴ *Id.* at 545.

¹⁵ *Id.*

¹⁶ Szasz, *Recent Books on the Relation of Psychiatry to Criminology*, 21 *Psychiatry* 307 (August 1958); *Politics and Mental Health: Some Remarks Apropos of the Case of Mr. Ezra Pound*, 115 *Am. J. Psychiat.* 508 (December 1958).

2. The present case also illustrates the extremely unequal distribution of both power and (claims to) expert knowledge characteristic of these legal contests. All the power and expert knowledge reside in the hands of the psychiatric authorities; the patient is virtually helpless, even though he has the right to file writs of habeas corpus and have legal representation. These are necessary but insufficient safeguards for the preservation of the rights of involuntary hospitalized mental patients.

3. Finally, I wish to call attention to a remark made by Lebensohn. Although his paper is exceedingly interesting and instructive, I feel it necessary to note that he considered De-Marcos' good conduct following his release from the hospital an "exception which proves the rule." I submit that there is no evidence for this statement and opinion. I am not implying that there is evidence for the opposite contention, namely, that everyone who wants to get out of a mental hospital can "safely" be released. The future is not easy to predict, and most of the time we simply do not know what patients might or might not do. In any case, my point is that it is *the principle*, and not merely the practice, of *preventive psychiatric jailing* that should be questioned.

This paper was intended as a contribution to the study of psychiatry, and especially institutional psychiatry, as a form of *social control*. More specifically, I have sought to present further evidence in support of the thesis that the relationship between the involuntarily hospitalized mental patient and his psychiatrist(s) is commonly antagonistic rather than cooperative in nature. This fact has received insufficient psychiatric, social and legal attention. The conception of a "mental illness," as essentially similar to a bodily disease, serves to obscure the many exceedingly significant socio-economic, legal and ethical aspects of forced mental hospitalization.

The patient's lawsuit for release, and the psychiatric superintendent's appeal that he be permitted to hold the patient despite a lower court's verdict to set him free, were examined as paradigmatic of many contemporary problems in forensic psychiatry. Two suggestions were offered: first, that the frequent adversary character of the physician-patient relationship in hospital psychiatry be more explicitly recognized; and second, that there is a pressing need for more adequate legal as well as psychiatric representation ("defense") for the involuntarily hospitalized mental patient.