(1990). While Pogue insisted that his only patient was the daughter, the documents Pogue released contained personal observations of the interaction between Mrozinski and his daughter, and included comments about Mrozinski's need for separate treatment and continued therapy for "his issues."

The court of appeals reversed the trial decision, finding sufficient factual dispute to overturn the summary judgment motion. Addressing the doctor's claim that participation in joint therapy was equivalent to a waiver of privilege, the court clarified that confidentiality is

> particularly important where the psychiatrist, in treating one person and knowing of another's deep concern . . . encourages him to participate in therapy with the original patient. The strongest public policy considerations militate against allowing a psychiatrist to encourage a person to participate in joint therapy, to obtain his trust and extract all confidences and place him in the most vulnerable position, and then abandon him on the trash heap of lost privilege.

The court also dismissed Pogue's claim that Mrozinski lacked standing to sue for the unauthorized release of his daughter's mental health records. Georgia law protects a patient's entire record from disclosure. The only permissible exception is a patient's release of information to the patient's own attorney. Despite the child's verbal consent at the time of release and a written consent upon reaching the age of majority, the court held that release of the records to the mother's, and not the child's attorney, was violative of law. As his daughter's guardian at the time of the unauthorized disclosure, Mrozinski was the only person who could sue for disclosures when she was 14, regardless of whether she approved the action after the fact.

Pogue was denied a reconsideration of the appellate court's decision, and the Georgia Supreme Court refused a petition to hear the case on appeal. The decision to allow Mrozinski's claim to proceed to trial was thus upheld.

. . . Morality of Coercion

(continued from page 27)

the proposition that decisionmakers should be willing to give prospective patients ample opportunity to express and explain themselves (often called "voice" in the literature on the social psychology of procedural justice (e.g., Tyler 1989, 1990)), and the proposition that decisionmakers should seriously consider whatever patients have to say in reaching a final decision regarding admission (often referred to as "validation" in the literature of patient advocacy (e.g., Campbell & Schraiber, 1989)). Not being permitted full participation in the hospitalization decision--or "having no say-so", a phrase which encompasses both voice and validation--was repeatedly cited as the most "coercive" aspect of the experience of entering the hospital. In the following excerpt, the patient complained about his therapist in a manner that illustrates the anger patients felt when they were not included in the admission decision:

P: I talked to him this morning. I said, "You...didn't even listen to me. You...call yourself a counselor...Why did you decide to do this instead of...try to listen to me and understand...what I was going through." And he said, "Well, it doesn't matter, you know, you're going away." ...He

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didn't listen to what I had to say...He didn't listen to the situation... He had decided before he ever got to the house...that I was coming up here. Either I come freely or the officers would have to subdue me and bring me in.

Later, the patient revealed that this lack of inclusion had moral significance to him. He compared what actually happened to him to his ideal of what a proper admission process should entail:

P: He [the therapist] had already made up his mind, you know, that I was coming one way or another, and I feel that...if you are to be a qualified counselor, you should be able to sit down and listen to your patients.

Similarly, another patient explained why he thought the hospital staff treated him unfairly:

P: 'Cause they were asking my mother yesterday...They were askin' her what she thought. They didn't ask me what I thought.

One context in which the issue of inclusion often arose was in discussion of "persuasion" by others to come into the hospital. In the structured part of our interview, questions were asked about four types of possible pressures: persuasion, inducements, threats and force. For persuasion, the question was "did anyone try to talk you into going to the hospital or being admitted?" If the answer to this was yes, four followup questions were asked on how hard the persuader was trying to get the patient into the hospital when he or she did that, whether the persuading made the patient want to come into the hospital more, how fair it was for the persuader to try to talk the patient into going to the hospital, and what it was that made it fair or unfair for the persuader to do that.

In answering these questions, not only did patients interpret persuasion positively, they not infrequently complained about its absence.[2] Indeed, efforts by others to persuade sometimes lead patients to report feeling more included or involved in the hospitalization decision by virtue of the fact that someone made the effort to try to persuade them. Attempts at persuasion had the effect of making some patients feel that their opinions and concerns actually mattered in the hospitalization process.

In the following two excerpts, patients were angry because no one tried to persuade them to be admitted to the hospital. Rather, the decisionmaker simply made it clear that the patients had no choice, implying that their internal agreement was irrelevant.

P:... Well, the police said, "Just go up there [to the hospital] and...listen to what they have to say." I wouldn't call that talking me into it, though.
I: You wouldn't?
P: I didn't have no choice.

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I: And that woman that you talked to in the jail...do you feel that she tried to talk you into being admitted into the hospital?
P: No, she just said you're going to the hospital. That's all she said.
I: She didn't try to talk you into it, she just said that this is going to happen?
P: Yeah, she said this was going to happen. She didn't try to give me any choices or any options or nothing. It was wham bam, you know.

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I:...you're saying she really didn't persuade you, she just told you this was happening?
P: That's right...there was no persuading, no talking about it, no nothing; you're going to go, period. And I said, "Are you serious?" and she said, "Yes I am, you're going."

While inclusion was morally important for the patients in our sample, it never became an issue for some of them. Some patients wanted a particular outcome, and it did not seem to matter how the decision was made, as long as that outcome resulted. The degree of involvement desired seemed to depend partly on what the situation demanded.

I:... How much did you want to be the one to choose whether to be admitted?
P: It didn't have to be me. But I definitely wanted to be admitted...So that's...I don't know how to answer you.
I: Okay. So you didn't care who chose, as long as you got the right answer?
P: As long as I got in. Just wanted to get in. (pause) You know, I just wanted them to realize, "Yeah, I need help."

Occasionally, a patient actively did *not* want to be included in the decisionmaking process regarding hospitalization. These patients felt that they were not "up to" making the decision about whether they should be hospitalized, and wanted to depend on someone else to make the decision. Making a decision of any sort was more of a responsibility than the patient wished to accept.[3]

I: How much did you want to be the one to choose whether to be admitted?
P: A little. I didn't want the decision on me (laughing).
I: How come?
P: Because if I'd screwed up like at work or something...If I'd lost my job, then I wouldn't have to say, "Oh, it's all my fault." You know, I'll say, "Dr. X made me come in the hospital."...That was mainly the reason why. I was afraid of losing my job.
I:...How is that related to who makes the decision?
P: Well, if the decision isn't on me, then I don't have to pay for the consequences of that...I know it's very immature, but ...

II. Theme Two: Motivation

A second theme to emerge from our interviews was that patients' perceptions of the coerciveness of others' behavior seemed to be strongly influenced by the patient's interpretation of the others' motives. Of particular importance was whether others' involvement was judged to be motivated by an appropriate degree of concern for the patient.

Patients have different expectations of concern for different people, depending upon the role relationship between the patient and the other person.[4] The same behavior, therefore, could be evaluated and responded to quite differently depending upon who the actor was. The transcripts reveal both the patients' expectations for different categories of actors, and how the evaluation of whether those expectations were met affects patients' perceptions further.

A. Evaluation of Others' Motives

One of the most frequently mentioned ways in which others were expected to show their concern was through their willingness to become involved in the process of deciding whether the

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patient should come into the hospital, particularly for people whom patients trusted and were close to. Patients might have had different reasons for wanting their family or friends' involvement, such as needing assistance in figuring out how to get help, needing emotional support, or needing approval before being able to ask for help, but whatever form the involvement of these trusted individuals took, it was taken as a sign of caring and was therefore appreciated. Two examples are:

> *I: How did you feel when your friend...said that he thought it would be a good idea for you to come in today?*
> *P: I thought it was good, I thought he was being concerned.*
>
> ***
>
> *I: How did you feel about that? [a friend becoming involved in the hospitalization decision when the patient threatened to hurt herself]*
> *P: I was happy. Because nobody ever cared enough about me to do that...Because he heard what I had to say. He wasn't all right with me attempting to do what I had to do. He told me my life was worth something.*

Conversely, when a family member or friend whom a patient thought should be involved in the decision to be hospitalized failed to become so, or did not do so soon enough, patients were often disappointed and angered. Since involvement was taken as a sign of caring, when someone whom the patient expected to care seemed not to, it was interpreted as a breach of moral duty.

> *P. Sometimes she [the patient's wife] takes it too casually. Like when I'm telling her I'm hearing voices really bad and that, she'll say, "Well, just take your medication and you'll get better in a couple days." Like she don't care.*
>
> ***
>
> *I: How seriously did she [a family member] consider what you had to say?*
> *P: Well, I guess if she didn't really do anything, she didn't take it very seriously at all.*
> *I:...Okay. How about your sister? How seriously did she consider what you had to say?*
> *P: Oh, she must have been awful serious...She must have cared, because she went and talked to the counselor.*

Involvement *per se* was less of an issue with mental health professionals, as their involvement was partially determined by their role and therefore not taken entirely as a sign of caring. But they were still expected to be motivated by what was in the patient's best interest, with perhaps a lesser degree of emotional investment being acceptable than with friends or family members.

> *I:...And how did being admitted to the hospital make you feel? Did it make you feel angry?*
> *P: It made me feel like somebody cared.*
> *I: What made you feel like that?*
> *P: "Cause somebody cared enough to listen and want to help me. I thank the staff...Just for caring.*

Indeed, it was difficult for some patients to believe that a professional who did not help them get the care they thought they needed was motivated by an appropriate degree of concern for their welfare.

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P: ...I needed to be in the hospital. How come she [a counselor] couldn't make arrangements for me to come to a hospital?...I thought that's what she was there for, you know.

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P: Well, some people I think should...set there and say, "Yeah, you should go in the hospital." Like the psychiatrist, the counselors, and things like that. But they're just the opposite.
I: You wanted them to say you should come to the hospital?
P. Uh-hum (yes).

B. Effects of Evaluation of Others' Motives

Attributing the cause of another's actions to concern or caring had a powerful impact on the patients' moral evaluation of those acts. But patients' evaluations of whether others' involvement was motivated by an appropriate degree of concern also affected both patients' perceptions of the fairness of those others' behavior, and the degree to which those behaviors were likely to influence the patient's point of view regarding admission.

It was almost universally true that when a patient evaluated a family member or friend as acting "fairly," the reason given for that evaluation was that the family member or friend cared about the patient or had the patient's best interests at heart.[5]

I: And could you tell me why you think it's fair for her [the patient's mother] to try to talk you into going [into the hospital]?
P: I guess it's because she cared for me and helped me get out of the trouble I'm in.
I:...Could you tell me how come you think it [the patient's sisters' persuasion] was mostly fair?
P: 'Cause they were all there. And they were all... tryin' to get me to go. They was all tellin' me, "I love you."

The fact that the degree of concern patients expected of mental health professionals was less than that expected of people in close personal relationships with them was demonstrated by patients' apparent willingness to forgive professionals' behavior because it was "just their job." Some patients knew that mental health professionals were morally--and legally--obligated to intervene when a patient might otherwise harm him or herself or someone else, and this awareness allowed the patient to accept whatever the professionals found necessary to do to fulfill that obligation.

I: Did you feel that the [commitment] was pressure?
P: Well,...It's hard to explain because she [the doctor evaluating patient] was concerned for my safety. And I was puttin' her on the spot because if I would've left and...maybe did go out and hurt myself, she would've felt, you know, responsible...So, I...understand where she's comin' from.

Once a patient came to evaluate another's actions as motivated by an appropriate degree of concern, those actions also appeared to be more likely to influence the patient's point of view.

I: And did that [the patient's mother's suggestion] make you want to go to the hospital?
P: Yeah. Because when my mom says it's time for me to get help, then it's definitely time.

***

P: That one little nurse, she come in, she even brought me somethin' to eat in the room.

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I: Did that make you want to come into the hospital more?
P: Yeah, 'cause they was real nice to me, you know...Seemed like they wanted to help.

***

[On why a particular doctor succeeded in influencing the patient:]
P: 'Cause...I was real mean and...I didn't hear nothin' they had to say neither, but...Somethin' about her [the doctor] just...She just like...It's like she felt what I was feelin', some kind of way. I don't know, but she did.

III. Theme Three: Good Faith

The final theme to be revealed in our interviews was that patients' perceptions of coercion appeared to be heavily influenced by their beliefs about whether others acted toward them in "good faith." Good faith was not a term used by the patients, but it seems to capture three related moral notions that were of great importance to the patients: that those who try to exert influence be qualified to do so, that they not be deceitful, and that they treat the patient with equality and respect.

A. Qualifications: Formal and Informal

Patients seemed less likely to find another's actions coercive if they believed that the others were qualified to do what they did. This held true whether the other was a family member or friend who was personally qualified by character and experience to exert influence, or was a mental health professional who was qualified by expertise. When a patient perceived another as unqualified to participate in the process of hospitalization, the patient often felt angry and coerced: someone who is unqualified should not be involved in making decisions about his or her life.

I: Okay. How about your dad? Same question. [What made it unfair for him to make you go?]
P: 'Cause he has a problem himself. He needs a counselor...It's like the pot calling the kettle black.

***

P:...(He) [patient's father] actually doesn't help me, even though I probably wouldn't let him. But I just feel like, you know, since he didn't help me...I don't think he should have that right to decide...Because I don't think he fully understands how I feel.

On the other hand, the actions of people who were perceived as qualified to offer help were often accepted. In particular, recognizing a problem that others had not recognized seemed evidence enough that person was qualified to offer help and should be involved in the hospitalization process.

I: Why...do you think it [a sister's involvement] was fair?
P: Oh, she was concerned, I mean, she seen things, you know, that I didn't see.

***

P:...after I had tried to do the pills, he [the patient's father]...just snatched me up, threw my clothes on the bed and said, "Come on, you're going to Western Psych." And brought me here...
I: You didn't perceive that as force?
P: Hm-mm (no).
I: What if you wouldn't have wanted to come?
P: He probably would'a drug me here.
I: How fair do you think it was for your dad to do that though?
P: Very fair (laughing). Instead of me killing myself.
I: Okay, and why do you think it was very fair?
P: "Cause I didn't really want to die. I'm glad...that he did. You know. I could'a had brain damage or anything. I mean, you know if I'd'a took those pills.

The patient accepted his father's actions, as his father's ability to recognize the dangerousness of the situation saved his life.

B. Deceit

Though deceit on the part of others was reported only rarely in our interviews, it evoked strong reactions when it was perceived to have occurred.[6] Deceit apparently fit into no schema for morally appropriate behavior by family members or friends, or by mental health professionals, and was therefore rarely forgiven or perceived as morally legitimate.

P:...So, today she [a hospital staff member] said I was a risk because I wanna kill my husband with a gun or a knife. And they just changed it all around, you know what I mean? That's not what I said...I could've lied and said...but if you...seek a professional's help, you expect...they don't lie to you and you won't lie to them, you know what I mean?

***

I: If he [the patient's father] could've...forced you in with the 302 [involuntary hospitalization] without lying, would it still be unfair?
P: Not...if he wasn't lying, no. It wouldn't...be unfair, if he was only trying to help.

A milder version of deceit can be found in cases in which others feign some activity on behalf of the patient, without being willing or able to carry through on what they suggest. In these cases, the actor was aware of the pretense and hoped, incorrectly, that the patient was not. In the first case, a staff member had gone through the motions of trying to talk the patient into coming into the hospital, but then did not wait to hear the patient's response. She immediately left the room to make arrangements for the patient's admission:

I: How fair was it for her to try to talk you into the hospital...?
P: I mean, all she said was her words and she left to make arrangements, you know.

In another case, a promise was made to the patient which was not within the power of the person making the promise to carry out. A father promised to get his son off probation if the son went into the hospital. But the son knew that was not a legitimate offer:

I: Okay. And how fair do you think that was...for him to make that offer?
P: It was...very unfair.

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I: And why do you say that?
P: I knew...and I think he even knows, that he couldn't make a promise like that, you know.
I: Okay. He couldn't keep his promise?
P: Right.

C. Respect

The simple notion that patients should be treated by others with respect and, as much as possible, as equals received wide endorsement in our interviews.[7] Patients believed in a version of the Golden Rule: they wanted to be treated by their family members and friends, and by the hospital staff, as these people would wish themselves to be treated in similar circumstances. This patient's complaint was about the evaluating staff:

P:...I think it should have been my decision. And I don't think...that they have to put an order on me like some kind of animal or something. Forced me to do something that I don't really need. I mean I don't think they'd appreciate it if it was forced on them. They would be a little upset too.

Another patient explained how he expected to be treated:

P:...I used to work with the mentally retarded and counselled people. When I'm working with people, I try to step on their level and look through their eyes and see their pain, and then I try to come up with an idea of how to help them. But I think...even the first time I came here, they are too cold, too impersonal, and they turn people off. So if it wasn't involuntary...commitment, I would walk out this door.

In short, patients expected the staff to recognize them, in a morally fundamental way, as being people *just like them*, albeit people in need of help. If staff are free to do otherwise--if disrespectful behavior is seemingly institutionalized--the whole process of hospitalization may be seen as immoral and coercive.

CONCLUSION

A qualitative analysis of the transcripts of interviews with patients shortly after admission to two mental hospitals reveals that patients tend to employ heavily moralized theories of coercion, much as Wertheimer (1989, 1993) urges philosophers to do. Patients believe that they should be included as much as they wish to be in the process of determining whether they will be admitted to the hospital. They believe that those involved in the admission process should be motivated by an appropriate degree of concern for their well-being, and they evaluate the legitimacy of involved persons' actions in light of the motivations they attribute to them. Finally, patients believe that others should act toward them in good faith. The others should be personally or professionally qualified to participate in the admission process, should act without deceit, and should treat the patient with equality and respect.

When the admission process violates these moral norms--when the patient is excluded from participation in the decision about whether he or she should be hospitalized, when the actions of others appear to be selfishly motivated, or when others lack the personal or professional qualifications to intervene, or lie to or disrespect the patient--coercion may be more likely to be perceived, and resented. When these moral norms are adhered to, many apparently coercive acts seem to be accepted by the patient as morally legitimate.

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NOTES

[1] See Barham and Hayward (1991) for more on inclusion and exclusion in the lives of psychiatric patients.

[2] Relatedly, Faden and Beauchamp (1986) posit that, in contrast to coercive influences, persuasion is completely compatible with substantially autonomous action. They place persuasion and coercion at opposite ends of a spectrum of pressures.

[3] See Taylor (1989) for similar findings in the area of accepting responsibility for making medical decisions.

[4] See Dakof and Taylor (1990) for similar findings in medical setting.

[5] See Lind, Kanfer, and Early (1990) on subjective evaluations underlying fairness judgments.

[6] See also Shannon (1976); Linn (1969).

[7] See Barham and Hayward (1991) for similar findings.

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