LETTERS

Letters from readers are welcome. They will be published at the editor's discretion as space permits and will be subject to editing. They should not exceed 500 words with no more than three authors and five references and should include the writer's telephone and fax numbers and e-mail address. Letters related to material published in *Psychiatric Services* will be sent to the authors for possible reply. Send letters to John A. Talbott, M.D., Editor, *Psychiatric Services*, American Psychiatric Association, 1400 K Street, N.W., Washington, D.C. 20005; fax, 202-682-6189; e-mail, psjournal@psych.org.

Remembering a Life

To the Editor: My brother, two and a half years older, was a remarkable man. I hardly know how to describe his entire person. He embodied the true spirit of life and love. I can only speak of him from a little sister's point of view when I say that his greatest desire was to share knowledge with everyone with whom he came into contact. He wanted to help them better themselves as he continued on his personal journey of knowledge.

Tony's work on earth was great and his accomplishments enormous—so large that I believe even after his death the works he left behind will have an impact on others for years to come. His gift of genius came with a high price—that of being different. Being mentally ill was a concept that was very difficult for my brother to bear over the past 11 years. I watched him as he endured the task of explaining his odd behavior to others. His need to fit in was great, and because I was aware of his desperate desire, I would often pray that his greatest success would be to "be normal, like everyone else." I now realize that if that were to have come to pass, he—and the rest of us—would have missed out on his true calling: his marvelous, compassionate desire to help others.

Editor's Note: Tony Hays, whose contribution to the Personal Accounts column in the August 2002 issue movingly described his struggle with bipolar illness, was killed in July during an encounter with police in Hopewell, Virginia. When his sister informed the journal's staff of his death and asked us how we might help her carry on her brother's desire to help others, we suggested that she express her thoughts in a letter to the editor.

Tony lost his life and suffered a tragic death at the hands of the local police department. Losing Tony is so heart wrenching for those of us who knew him and on whose lives he had a direct impact. As a student of mental and physical health, I realize now, even more than before Tony's death, just how ignorant the public is with regard to people with mental illness. They are so afraid, maybe of their own shortcomings, when approached or confronted with mental illness. My brother, in a manic state, confronted the police officers as they approached him. Fearing hospitalization and suffering the debilitating side effects of medication, he lashed out—to get away from them and their fear. They struck back with brute force—out of fear, out of anger, and out of ignorance, and my brother's spirit was released from his earth walk, from his continual service to others, and from his suffering the label of "bipolar-manic."

The legacy that Tony left behind in volumes of writing needs to be shared with the mental health community, because Tony's words give us a poignant picture of the mind and heart of a person with mental illness. More important, his writings need to be shared with the public, with judges, and with law enforcement agencies. We need to educate them about interacting with people who have mental illness and tell them that senseless violence that ends in death is such a waste.

Tony is free now. Thus far, that is the only good that has come from his death. It is our responsibility to ensure that more good will come from my brother's life.

Rachael Hays

Ms. Hays lives in Lorton, Virginia.

An Ethically Complex Scenario

To the Editor: In the August Taking Issue column, Dr. Christensen (1) emphasized the ethical problem of sacrificing patient care to cost issues. In his example, such a sacrifice meant the apparent inappropriateness of referring a seriously ill inpatient to a primary care clinic for psychiatric follow-up.

Few would disagree with his point. However, the ethical considerations seem much more complex than presented, and several questions arise: Why was the patient referred to the primary care clinic? Was the patient doing quite well, even with a complicated medication profile? If not, the ethical question for the primary care clinic is: Why accept this patient? A call to the referring psychiatrist could have helped.

Why did the physician assistant make a drastic change in the medication, and who was supervising this sort of decision? Was this individual functioning beyond his or her capability? What did Dr. Christensen do to address the perceived ethical problem?

Perhaps Dr. Christensen could not fully describe the situation because of space limitations. If so, that leaves the reader with an inadequate presentation of and conclusion for an ethically complex scenario.

H. Steven Moffic, M.D.

Dr. Moffic is with the department of psychiatry at the Medical College of Wisconsin in Milwaukee.

Reference

1. Christensen RC: The ethics of cost shifting in community psychiatry. Psychiatric Services 53:921, 2002

In Reply: It is generally recognized that editorial pieces lack the completeness and specificity of a traditional case study in ethics. I believe Dr. Moffic would have to acknowledge that a measured response to his many questions, most of which are on the level of factual clarification rather than ethical disagreement, would have extended well beyond the constraints of an editorial format.

Nonetheless, I found a number of Dr. Moffic's questions to reflect a certain intellectual hastiness in their formulation. For instance, a careful reading of the Taking Issue made it abundantly clear that the patient was not doing well on her discharge medication regimen and the reason she was referred to the primary care clinic was that she had no insurance for mental health care. As I have noted elsewhere (1,2), it is not uncommon for the poor and uninsured who have serious mental illnesses to seek care from public health departments, city-funded primary care clinics, and emergency departments, because they are unable to pay their way in the community mental health care system. In answer to Dr. Moffic's question, the patient was "accepted" by the primary care clinic because it was the only health care system she was able to access.

Although questions about why the physician assistant made such a "drastic change in the medication" and "who was supervising this sort of decision" may be relevant for pursuing a more complete clinical discussion of this case, they have very little ethical bearing on the decisions that resulted in her being sent to a primary care provider in the first place. The prior and more fundamental moral issue, which I underscored in my editorial, was related to why her case was not followed up by those who initiated psychiatric care and who have the most expertise and training to treat her severe mental illness. Because the editorials in *Psychiatric Services* are intended to reach community mental health providers, I chose to focus on the profession-specific obligations that are most relevant to our clinical practices. I would argue that Dr. Moffic's questions raise an entirely different set of issues and stray from the central, albeit limited, ethical issues outlined in the article.

In closing, I would like to comment on Dr. Moffic's query, "What did Dr. Christensen do to address the perceived ethical problem?" I think I did what the vast majority of my colleagues in community psychiatry would have done when confronted with a similar situation. First, I treated the person before me to the best of my ability. I then petitioned the community mental health center for additional wraparound services and care for this young woman, which led to her subsequent treatment by the agency's assertive community treatment team. Finally, I wrote an editorial piece intended for community mental health providers that highlighted profession-specific ethical obligations not to "abandon by referral" those who expect from us compassionate care and competent treatment for their devastating mental illnesses.

Although this clinical scenario may be complex, deriving from it the ethical connection between what "is" and what "ought to be" requires little more than basic moral reasoning.

Richard C. Christensen, M.D., M.A.

References

1. Christensen RC: Ethical issues in community mental health: cases and conflicts. Community Mental Health Journal 33:5–11, 1997

2. Christensen RC: Managed care and the poor: examining the ethical life of community mental health organizations. American Association of Psychiatric Administrators, Winter 1998, pp 15–18, 1998