INSTITUTE OF CURRENT WORLD AFFAIRS

JLS-15 The Essentials of Hospitalization:
Helga Andersen, Sylvia Goldstein, and Others

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Mr. Richard H. Nolte
Institute of Current World Affairs
535 Fifth Avenue
New York, New York 10017

Dear Mr. Nolte:

Three months of court sessions at Bellevue and Manhattan State. Six different State Supreme Court justices on the mental hospital circuit. Twenty involuntary commitment hearings: in three the patient won, in seventeen the patient lost. Attending these hearings, I've become increasingly puzzled about what the law in New York intends, whether judges follow the law, and whether psychiatric testimony assists in its application. I was puzzled, for instance, by Helga Andersen's hearing.

Bellevue, February 11. The courtroom door opened and a young black woman in street clothes stood at it for awhile. Then she called back into the hallway, "This way, sweetheart," and the patient, a small gray-haired woman in an old-fashioned red dress shuffled into the room. Her opaque white stockings flapped loosely about her ankles.

A few weeks earlier Miss Andersen had telephoned the New York City police to report a murder in progress on the floor above her room in the modest hotel where she lives. The police

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Jeffrey Steingarten is an Institute Fellow interested in the relationship among psychiatry, psychoanalysis, and law.

responded with six squad cars, only to discover that nothing at all was happening upstairs; the room above Miss Andersen's was not even rented. The police brought her to Bellevue.

Dr. Vicente Nuces was sworn in, a large, nervous man with a compassionate face. His long white hospital coat was buttoned up almost to the knot of his tie, even though the coat was several sizes too small for him and pulled open around the buttons and the vent in the back. Speaking in a heavy accent, he told the judge that he had been a psychiatrist at Bellevue for 12 years, at another hospital for 5.

He said that Miss Andersen, a 67-year-old naturalized American, was friendly and rambling, with a paranoid flavor to her thinking, especially regarding her sister. When he interviewed her, she was oriented to time, place, and person, but showed lapses in memory, which she had tried to cover up. Miss Andersen has a long history of false beliefs, he said, and thinks some of the people around her are F.B.I. agents, spies, and Communists. And she told him that her niece was in prison, which was not true. According to her family, she has been mentally ill for the past 10 years. She is not a violent person, he said, but she bothers people.

Throughout his testimony, Dr. Nuces fumbled with a disheveled two-inch thick folder in his lap. With so large a hospital record, Miss Andersen must have been a guest at Bellevue before. But Dr. Nuces seemed unfamiliar with the record and was unable to produce further facts.

Diagnosis? asked the judge. Schizophrenic, paranoid type, with some organicity [senility]. Is this a mental illness? asked the judge with his mind's eye on the statutory requirements and the need to make a clear record. Yes. Is her disease progressive? Yes, because Miss Andersen refuses medi-

cation--she says it makes her mouth dry [a common side-effect of thorazine that causes some patients great difficulty in speaking]. Does she have hallucinations? Not to my knowledge, answered Dr. Nuces, but she does have extensive delusions. Are care and treatment essential? Yes.

Every so often Miss Andersen piped up: "Don't say that! I know what's going on!"

"This is a difficult case," said the judge, "Miss Andersen looks like a very intelligent lady."

A Mental Health Information Service lawyer cross-examined. Is Miss Andersen suicidal? No. Violent? No. How will commitment to a state hospital on an open ward prevent her from making nuisance phone calls? First, she'll be on medication, and second, maybe she'll realize that something's wrong with her. Will the medication make her well? the lawyer continued. Dr. Nuces answered softly and quickly as if to keep the patient from hearing. No.

The judge asked Miss Andersen whether she can take care of herself. "Sure I can. I know what's going on," she replied. Then she told the story of the man upstairs who goes under two names, one of which is Sam, and has police protection around the clock.

Miss Andersen's niece was sworn in. Sleeveless white jersey and black upswept eyeglasses. The police had telephoned her after bringing her aunt to Bellevue. She explained that Sam does not exist--her aunt always dreams up stories like this. It was apparent that the niece wanted her aunt kept in a hospital.

The judge said quietly, "I find that Miss Andersen is

mentally ill, that care and treatment are essential, and that her judgment is impaired." Next case.

Afterwards the judge asked me what I thought about the procedings. I wondered about his disposition of Miss Andersen's case and asked what he'd have done if the hospital's application had been for 2 years' commitment instead of the 60 days to which it is limited on its first application for involuntary retention. He said he probably would have let her go home. "But we have no other way to deal with people like her." Whether or not this is true, I don't think the judge was following the law.

Apart from provisions for the short-term emergency hospitalization of imminently suicidal or violent mentally ill individuals, the New York legislature has defined in the following three sections of the Mental Hygiene Law the class of patients a judge may order retained involuntarily:

> Sec. 31.27(a). The director of a hospital may receive and retain therein any person alleged to be mentally ill and in need of involuntary care and treatment upon the certificates of two examining physicians....
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> Sec. 31.01 ..."in need of involuntary care and treatment" means that a person has a mental illness for which care and treatment in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment.
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> Sec. 1.05(17). "mental illness" means an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feelings, thinking, or judgment to such an extent that the person afflicted requires care and treatment.

All three requirements in section 31.01--mental illness, hospitalization essential to the person's welfare, impaired judgment--must be satisfied before a patient may be involuntarily hospitalized. When these sections were written into law in 1973,

the previous statutory definition of mental illness had included the words "for his own welfare or the welfare of others, or of the community..." and this was changed in the current law, which looks only to the patient's condition, welfare, and judgment. The legislature thereby decided that except for violent persons, society has no interest in hospitalization an individual other than to protect his own welfare.

Our laws generally do not require a man with a heart condition or a blood disease to seek medical treatment for his illness, even if it will further his welfare. They generally do not authorize hospitals to administer treatment against a patient's will, and hospitals are liable in damages for false imprisonment or assault and battery if they do. How is "mental illness" different? It is thought that mental illness affects a person's judgment to such an extent that he cannot understand he is ill and lacks the requisite rationality to decide for himself whether to seek care and treatment. But since this is by no means true of all mental illnesses (as the list of disturbances in section 1.05(17) implies--behavior, feelings, thinking, or judgment), the New York statute requires a determination by the judge that in the case before him, the individual's judgment is sufficiently impaired to justify taking the decision away from him; if the statute did not require such a finding, it might be vulnerable to challenge on the Constitutional grounds that treating men classified as mentally ill differently from those who are physically ill violates the equal protection clause of the 14th Amendment, which prohibits arbitrary distinctions between classes of people who are essentially alike. The requirement that a patient's judgment be impaired expresses the view that any person, whether or not he is found to be mentally ill, may still be the best judge of his own welfare. It affirms that unless there is proof to the contrary, men are thought to be responsible actors, whatever their predicament.

Now it is always the case in involuntary commitment hearings that the patient disputes the psychiatrist's judgment that care and treatment in a hospital are essential to his welfare--otherwise the patient would not be in court. But contrary to the intent of the statute, hospital psychiatrists and judges appear to assume that unless there are very good reasons to think otherwise, the patient's judgment must by definition be impaired--otherwise, why would he disagree with the psychiatrist, who has only the patient's best interests at heart? In just one hearing I've attended at Bellevue or Manhattan State has the patient's lawyer argued that his client in fact understood the reasons for hospitalization but decided on his own that he nonetheless wished to be released--perhaps because he might lose his job or his wife if he stayed, or perhaps because hospitals make him nervous. In practice, then, the requirement that a patient's judgment be impaired may as well be stricken from the Mental Hygiene Law. But a lawyer should be able to raise it as a separate issue in a wide range of cases, and the judge may rely, as he does in the adjudication of incompetency, on psychological tests of cognition, orientation, and memory, as well as his own conversation with the patient.[1]

Passing on to another of the three statutory requirements in section 31.01, that the patient have a mental illness: In no hearing I've attended has the issue whether the patient really has a mental illness even been raised. One reason for this is the confusion within the psychiatric professional and outside it about where the line between normality and abnormality, between health and illness, should be drawn. Who is to decide where to draw it? Referring to the official nomenclature of the

[1] I do not mean to minimize the difficulties of assessing objectively an individual's judgment. Cultural differences may cause special problems: how, for example, will a judge evaluate the Spiritist beliefs of Spanish-speaking patients?

American Psychiatric Association (see JLS-9 for an extract of disorders from DSM-II), we discover that even a slight neurotic disturbance and an emotionally unstable personality are characterized as disorders. For the purposes of the Mental Hygiene Law, does disorder include only the severe neuroses and the psychoses and exclude the less severe neuroses and character disorders? Does it include the psychopathies, kleptomania, homosexuality, or prostitution?

The definition of mental illness in section 1.05(17) is no help in answering these questions. The definition is essentially circular: a patient is in need of involuntary care and treatment if, among other things, he has a mental illness; and a person is considered to have a mental illness if he requires care and treatment. Since section 1.05(17) appears at the beginning of the Mental Hygiene Law, most of which is devoted to the administration of the Department of Mental Hygiene, including hospitals, community mental health facilities and research programs, it was written to establish the purview of the Department and not with involuntary patients primarily in mind. Section 1.05(17) serves to distinguish mental afflictions from physical ones, and differentiates the prospective clients of the mental health care system from clients of the state prison system, for whom care and treatment are not the primary objectives even though their conduct may qualify as a "disturbance in behavior." In practice, once a judge has determined that an individual's judgment is impaired and that care and treatment in a mental hospital are essential to his welfare, a finding of mental illness adds nothing.

Consequently, the central criterion for involuntary hospitalization in section 31.01 is a finding by the court that hospitalization is "essential to such person's welfare." As with the other two criteria discussed above, there are no appeals court decisions defining this phrase, and what follows is my

view of what a sensible reading of section 31.01 implies. While psychiatric testimony may be indispensible to determine whether involuntary care and treatment are essential to the patient's welfare, the ultimate decision is not one of medical expertise and judgment but requires the judge to strike a balance between competing values in each case before him. On one side is the expected benefit of hospitalization, and on the other are the loss of freedom, the separation from family and job, the inevitably unpleasant aspects of life in a hospital, and so forth. Even if your judgment and mine are reasonably sound, we still may differ in how we balance the advantages and disadvantages of commiting ourselves to a mental hospital; as with all difficult decisions we make, the intensities of our preference for and aversion to the various consequences of hospitalization may be quite different--yet without being irrational. If our judgment is so impaired that a judge is authorized to strike this balance for us, however, he cannot in practice divine what each of us would have decided if our judgment were sound. Consequently the judge will fall back on that most popular of legal personae, the "reasonable man", and ask what a reasonable man in the position of this unreasonable patient would do in this particular predicament.

In asking this question, the judge may wish to distinguish two somewhat artificial categories of benefit that an individual can expert to derive from hospitalization: the alleviation of his suffering from mental anguish, depression, or confusion and from physical disease or injury; and the improvement in his ability to lead a more satisfying life. As to the first of these, it seems justifiable for society to intervene in a man's life to spare him from the degree of suffering that any reasonable man would choose to avoid, for how can a man enjoy his freedom and autonomy when he is plagued by great psychic or physical pain? Still this is a question of value: how much pain, what probability of death, what degree of disease or injury

outweighs the value of freedom? One might decide, for example, that a man continuously tormented by hallucinations or suicidal thoughts qualifies for hospitalization, as does one who cannot take care of himself and may die from exposure, malnutrition, or pneumonia if left on his own, but that a man who is terrified of heights or has an annoying problem with anxiety does not. With lines like these roughly drawn, the medical witness will be asked to testify about the patient's mental and emotional processes, his functioning outside the hospital, the proposed treatment plan and its likely duration, and what degree of alleviation of his pain may follow from either outpatient treatment or hospitalization.

The second category of benefit from hospitalization, an improvement in the individual's chances to lead a more fruitful, satisfying life, even though his suffering is not by itself sufficient to authorize society's intercession, is quite a bit trickier. Any of us may benefit from psychiatric treatment. But while it is safe to say that no reasonable man would put up with intense suffering if he had the choice, it is more difficult to define what kind and degree of improvement in his life a reasonable man would exchange, even temporarily, for his freedom. Should we hospitalize for long-term psychoanalytic treatment the neurotic office worker who refuses to acknowedge that his chances for advancement are curtailed because he cannot get along with others? Probably not. Or the manic-depressive businessman who, during his "high" phases makes reckless commercial decisions endangering his fortune and his family's welfare and who, after two weeks of hospitalization to begin treatment with lithium (widely thought to help 80% of accurately diagnosed manic-depressives), will return to his family and his business, grateful that his fortune and his name have been saved? Perhaps. What of the hostile woman who lives in the solitude of her own anger, without friends or family or work, and whose brief en-

counters with the people around her are inevitably unsuccessful?[1] A difficult moral decision to which a diagnostic label may be only barely relevant. The judge must know in detail the proposed treatment plan, its likely duration, the probabilities of success and the criteria of success; he must understand the patient's emotional processes, what his life is like on the outside, and the likely prognosis without hospitalization; and he will need to evaluate the credibility of professional reasoning and predictions regarding the relative benefits of hospitalization, outpatient treatment, and unconditional release. I have not attended a hearing so detailed as this. The professional time required would be ten or a hundred times what is currently expended. If it is not feasible to devote so much attention to an individual patient, then the statutory standard "essential to such person's welfare" should be interpreted narrowly and limited to cases where the alleviation of anguish or the prevention of physical harm will likely follow only upon hospitalization.

To return to Helga Andersen's case. Since she does not realize that she has delusions, a judge could conclude that her judgment is sufficiently impaired to authorize his intervention to protect her welfare. But is hospitalization essential to her welfare? There was no testimony that she cannot take care of herself, only that she is a bother to her relatives and to the police. She is cheery, alert, and apparently free from anguish, and does not seem likely to cause herself physical injury. Nor was Dr. Nuces optimistic about the prospect for real improvement in her mental state; the medication seemed intended solely to make her more manageable. Her life on the outside is probably as fruitful as it would be during and after a long stay in a state hospital. And she appears to value her freedom highly.

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[1] This is the case of Sylvia Goldstein, described at the conclusion of this newsletter.

It was not essential to Helga Anderson's welfare to be hospitalized against her will.

Even taking as true every fact Dr. Nuces reported, Miss Anderson is nothing worse than a paranoid nuisance. In a small town where the police may be more familiar with the citizenry than in New York, they wouldn't have sent six squad cars to Miss Andersen's hotel; an officer might have tried to calm her on the telephone or gone to her after awhile to make sure nothing was wrong. And that would have been that. In New York City a false murder report is a more serious nuisance. But being a nuisance is listed nowhere in the Mental Hygiene Law as a ground for involuntary hospitalization.[1] Federal Judge Frank M. Johnson, Jr., frequently in the news this past year for his decisions broadening the Constitutional rights of involuntary patients in Alabama mental hospitals, said in a recent speech to social workers, "No longer will Alabama mental hospitals be invisible depositories for the eccentric, those with aberrational behavior or those whose families would rather not be bothered."[2] If Helga Andersen's case is any indication, New York State hospitals are still depositories for eccentrics. No matter that their retention in a hospital is not essential to their own welfare or, for that matter, to ours. We simply do not want them among us.

The perfunctory character of much psychiatric testimony and an overly broad reading of the phrase "essential to such person's welfare" encourages each doctor, judge, and lawyer to have his own subjective standards for what kinds of patients need involuntary hospitalization. The result, as I reported in JLS-12, is a far less uniform disposition of patients than

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[1] Under section 240.60 of the New York State Penal Law, "falsely reporting an incident in the first degree is itself a class E felony punishable by up to four years in prison. But since Miss Andersen did not know that her report was false, and section 240.60 includes the words, "knowing the information ...to be false or baseless," she was innocent of the crime.

[2] New York Times, March 31, 1975, p. 11, col. 1.

should be the case and the retention of many patients who, according to a sensible reading of the present statute, should have been let go.

The subjective standards of individual hospital psychiatrists may be corrected to some extent by requiring them to testify to more than merely their "medical conclusions" (the subject of my next newsletter) and by relying on the testimony of independent psychiatric experts. In New York, an independent psychiatrist will be appointed by the judge in most cases on request from the patient's attorney. In a short guide to trial techniques in mental health cases, Bruce Ennis, a well-known and experienced patient's advocate, writes:

> Use expert witnesses whenever possible. Judges are excessively deferential to "expert opinion" on psychiatric issues. So it is important, whenever possible, to bring in an expert of your own to testify that your client is not mentally ill or dangerous, or that even if he is, hospitalization is not necessary. The existence of a dispute between experts forces the judge to use his own common sense, and to pay attention to your legal arguments....[1]

Yet in the twenty hearings I've attended, only once did an independent psychiatrist testify. Some patients want to avoid the two or three weeks' delay for an outside examination, but more often it is the lawyer's decision that his patient's case will not be helped by the additional testimony. Independent psychiatrists, who must be chosen from a short official list, are reluctant to devote too much of their time to court testimony, and lawyers naturally approach them only when they believe it is necessary.

But lawyers, especially those who work on great numbers of similar cases, have their own standards for which patients

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[1] Bruce Ennis and Loren Siegel, The Rights of Mental Patients, New York: 1973, p. 285.

should be retained and which let go--based in part on their experience with judges and in part on their own views in the matter. The subjective criteria of judges and lawyers are difficult to expose and unify. A traditional legal method for achieving uniformity in the interpretation and application of a law is by appeal to a higher court. I've been able to discover no appellate court decisions aiming to clarify the statutory criteria for commitment, and in my months of hearing-watching, I've seen no case on which an appeal was taken.

Of course, patients too have their subjective criteria concerning who should be committed and who not, and sometimes the problem is resolved right there:

Bellevue, February 25. A dark-haired woman in her late thirties, wearing a gray tweed suit and heavy make-up, walked into the little room next to the Bellevue courtroom where I sat with a paper cup of coffee, waiting for the procedings to begin.

"Are you a lawyer?" she asked me. "I need a lawyer." She began to unfold a piece of paper with handwriting on it.

"Sort of," I answered, "but...."

"They won't let me see my lawyer, Marjorie Lipsky. She's in the courtroom, and they say I can't go in. I've gotta get out of this place. You think I should get a Legal Aid lawyer?"

I began to ask if she were accused of a crime when a very short, stocky old man in a white coat appeared in the doorway. "Come on, Sylvia, you know you're not supposed to come in here." He reached out towards her.

"Keep your filthy hands off me!" He left. A Legal Aid attorney walked into the room and sat down to review a

file, and Sylvia asked him to take her case.

"Look Sylvia, you get your ass thrown in jail, I'll take your case. Not until then." He left.

I asked her what the lawyer from the Mental Health Information Service was doing wrong. "Goddam this place. They tell me when I can take a shower. The food's lousy. They try to make me take their quote medication unquote. But I won't." I assured her that the MHIS lawyer would do a fine job with her case, and that it would be to her advantage to calm down a bit before seeing the judge.

A court officer put his head in the doorway to tell me that the day's session was about to begin, and I walked with him into the courtroom. "You'll get to see Sylvia Goldstein today," he said. "One of our favorite customers--ten or twelve times since I've been here." I had inadvertently brought my coffee with me, and he noticed it as I was settling into a chair in the second row of the courtroom. "Hey," he called out to me, "you can't bring that in here. We've sent people to Matteawan [State Hospital] for less. Back to your ward!" A favorite jest of his.

Sylvia's case was the first on the civil calendar. A psychiatrist testified that the police had brought Sylvia to Bellevue after a violent argument with a cab driver. Her mental status, he said, is bizarre, hostile, and uncooperative. Talks endlessly, psychotic productions, loose associations. Diagnosis: schizophrenia, undifferentiated type. Reality testing poor; disorganized. Long record of intermittent institutionalization since 1960.

The judge asked if Sylvia is mentally ill. Yes. Care and treatment essential? Yes. Judgment impaired? Yes. The

three statutory requirements for involuntary retention had been met.

MHIS lawyer Marjorie Lipsky cross-examined. Suicidal? No. Violent on the ward? No. Chronic? Yes. Has her stay in Bellevue improved her condition? Too early to tell. Is treatment essential? Helpful.

Uninvited, Sylvia spoke up to complain about the doctor and the hospital. She said she had been tied down and injected. She was becoming agitated, ruining her lawyer's case, and the judge advised her that it would be better for her to keep quiet. Sylvia persisted. She said she had been beaten up by a butch on the ward who held a lighted cigarette under the arch of her foot.

"Is the patient hallucinating?" the judge asked the doctor.

"Her judgment is poor," the doctor replied irrelevantly.

"Is there a record of these incidents?" The doctor did not answer. Sylvia interrupted to point out that there is no record in her file of what's normal about her, of her good points, her good moments. She said they won't give her dental floss, won't let her brush her teeth at night. She told the judge of an article she'd read in the Times reporting that eight out of ten patients diagnosed as schizophrenic weren't.

Sylvia's mother was sworn in. Pearl earrings, expensive blue ski jacket, hair set in a bouffant. She said she thought Sylvia should stay in the hospital. She reported that her daughter is confused, hallucinated, uncoordinated, hostile.

"My mother lies through her teeth," observed Sylvia.

"Keep quiet or we'll put you under restraint. The court finds the patient mentally ill...." began the judge, reciting the statutory formula.

"What do you think constitutes mental illness?" inquired Sylvia.

"...in need of care, and her judgment is so impaired that she doesn't appreciate the need...."

"Can I make a request?" Sylvia asked.

"Anything you want."

"I want a sandwich, bacon, lettuce and tomato with mayonnaise."

"And a cocktail too?"

"How long can they keep me here for?" Sylvia asked.

"48 days," replied the judge.

"48 hours?" Sylvia seemed relieved.

"Days." Sylvia was taken out, and as they led in the next patient, one could hear Sylvia's shriek from the hallway, "Don't touch me!"

"I thought we could help her," said the judge. "But she needs a structured environment. And that <u>was</u> her mother, after all."

Nine days later I saw Sylvia again, this time at Manhattan State Hospital where she had been transferred. Another MHIS lawyer was applying for the appointment of an independent psychiatrist to testify in another hearing Sylvia had requested, and Sylvia appeared briefly in the courtroom. She looked horrible. Her hair was disheveled and dirty, her skin was yellow and broken out. But she was calmer than the time before and requested only once and in a decorous voice that the judge assign her a lawyer from Legal Aid. "I don't exactly know how to phrase it, your honor," she said, her speech slightly slurred, "but I'm full of medication." The judge ignored her request.

After the court session had been adjourned and I sat outside the hospital waiting for the twice-hourly bus that plies between Wards Island in the East River where the hospital is located and Lexington Avenue at 125th Street where there is a subway connection, I saw Sylvia walk out through the hospital doors. I figured that she was about to elope, as mental health people call it, until I saw her attendant or social worker nearby. Sylvia walked over in my direction, her companion not far behind. "You're that lawyer," Sylvia said. I smiled and nodded. "I feel like hell," she continued. "They're taking me over to the Rehabilitation Building so I can wash my hair. I hate to look this way. I'm not a vain woman, but I hate to look this way. It's the medication."

"You seem to be in a better mood today than you were at Bellevue last week," I said. "Maybe it's the thorazine."

"I guess it <u>was</u> silly of me to ask the judge at Bellevue for a sandwich. Why do you come here, anyway?" I told her why.

"Research project? Who needs a lousy research project?

Everyone knows these places are lousy. You know what? There's no soap in the bathrooms. They're afraid people will steal the bars of soap. And maybe they will, but isn't that ridiculous? I've been in places where they gave me an IM [intra-muscular injection] just for asking the attendant for some some soap."

"I've heard that Manhattan State isn't so bad," I said.

"The ward I'm on now isn't bad. The people are nice. Last night I played 500 Rummy and Scrabble."

"I wouldn't have thought you could play Scrabble on thorazine. You need all your wits about you to play Scrabble."

"Yeah, well I lost," Sylvia said disgustedly. "I used to be a champ at Scrabble."

"I guess you ought to play Scrabble only with other people on thorazine."

Sylvia laughed. "Oooh, I could kill you." She gestured as if to strangle me.

The bus arrived. I folded my newspaper and stood up from the bench. Sylvia put out her hand. "My name's Sylvia," she said. "I hope I'll see you again."

As the bus crossed the Triboro Bridge, I wondered almost despite myself whether hospitalization and thorazine hadn't done Sylvia some good. It is true that she was looking bad, but her manner in the courtroom had been so much more "appropriate," as they say; perhaps "tractable" is more accurate. Yes, her speech was slurred, but she seemed to be in better humor now. She had liked my joke.

There I go, I mused, applying my own standards of appropriateness to judge whether hospitalization is essential for Sylvia.

Sylvia, however, had not incorporated my standards, or those of the judge or the hospital staff. She had her own ideas. Two days later she was reported A.W.P., "away from the hospital without permission." She must have taken the bus to 125th Street.

Sincerely,

Jeffrey Steingarten

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