1. Write a thesis statement for this article.

Power-of-attorney and patient-privacy laws governing patients with psychotic and schizoaffective disorders are unacceptably lenient and require modernization to reflect a progressive approach to mental illness.

2. Does Aviv have a strong position? How does this relate to her subtitle and her conclusion?

Aviv, as the omnipresent narrator, does not take an apparent stance on Linda’s case beyond the narrative she presents. The facts she chooses to include in her retelling of Linda’s demise cast a damning shadow on the protocols that led to Linda’s release, especially in the context of Joan’s and Caitlin’s prior involvement in Linda’s care. When Aviv writes that ”hospital staff continued to express concern about Linda’s belief in ”the 'plot,'” she illustrates the acknowledgement and subsequent lack of action (by medical professionals) in response to a legitimate threat Linda posed to herself. Later, she compounds this sentiment with a quote from Caitlin: ”Ask the daughter! I could have told them that every time the structure is gone she goes straight down the tubes.” The perspective and content of her narration inform the reader that she desires an improvement to the system, with Linda as a case-study; because Linda – because anyone – was so thoroughly failed by the current protocols, changes to avoid similar outcomes must be implemented.

Her implied position is an answer to the question posed in the subtitle: What should happen when patients reject their diagnosis? It’s not a definitive answer and offers no solutions to the specific issues that contributed to Linda’s death; instead, she objects to the potential for such a lethal consequence of following protocol. In doing so, she calls on the empathy of the audience – Linda could have been saved, and there are people who can be still, with the right adjustments to current procedures. Her conclusion resurrects this emotional appeal in Caitlin’s apathetic response to the news of her mother’s death; the trauma propagating from the emotional epicenter of Linda’s wasted life was completely unnecessary.

Aviv’s detached prose discreetly guides the reader to her position. In presenting the simple facts of the case (medical professionals knew Linda posed a threat to herself
but were obstructed by legislation from intervening or seeking assistance from her family, who, in hindsight, could have provided care for Linda and prevented her death), she illuminates the necessity for revision in the oversight and treatment of mental health patients.

3. Discuss Aviv’s use of details. How does she use details to engage the reader and tell Linda’s story? Why is this piece considered nonfiction? What is creative nonfiction?

The use of descriptive writing and sensory language in ”God Knows Where I Am” communicates Linda’s harrowing death on a visceral level; the Cronenberg-esque body horror of her gradual starvation otherwise would not reach the audience. Aviv employs disquieting imagery as Linda becomes malnourished: ”So much hair fell out each time she combed it that she realized she might need a temporary wig” is the stuff of nightmares, a quintessential fear of every child as they pull a comb through their knotted hair. Invoking this kind of disturbing material serves Aviv’s underlying motivations – scaring the audience with visions of Linda’s misfortune (and resultantly garnering sympathy for her) encourages the reader to object to Linda’s circumstances and desire improvement in the system that allowed such a horrific fate to befall her.

This piece is considered creative nonfiction: a narrative rooted in factual accuracy that focuses on literary style and technique instead of the simple data presentation of other academic literature or journalism (creative nonfiction bears many similarities to the ”New Journalism” genre, exemplified by John Hersey’s Hiroshima, also originally published in the New Yorker). Aviv’s rich descriptions and well-developed characters stimulate the reader’s imagination in ways that purely academic writing does not. Despite this distinction in creative approach, both styles are based on verifiable fact; Linda’s meticulous note-taking, coupled with Aviv’s own interviews, made the posthumous account possible.

4. Aviv uses narrative to educate her readers about ethical and medical issues. What do you think are the strong points and limitations of narrative medicine?

”God Knows Where I Am” benefits tremendously from having a relatable central patient in Linda. Her characterization as sometimes-humorous, quirky, fanciful,
naïve but overwhelmingly benevolent and curious allows the audience to easily relate and sympathize with her – if Linda’s episodes of psychosis were more violent and less absurd (e.g. when Linda claims to have purposely caused a car accident intentionally to somehow prove that ”police officers are ’illegal’”), empathizing would be far more difficult. Narrative medicine presents cases on a human level that is unattainable through other styles; this piece is fortunate to have a likable case study, especially when many schizoaffective disorders completely obfuscate the patient’s motivations from a non-affected perspective (and thusly detract from the human element of narrative medicine).

An often-ignored limitation of narrative medicine is the toll it takes on the author: As previously discussed, narrative medicine requires a tremendous amount of empathy since the author (if they desire to be effective) must capture ”the person behind the disease.” In doing so, they move away from the less emotional, more objective perspective of a clinician and towards the more empathetic perspective of a friend. Obviously, negative outcomes for friends are more affecting than negative outcomes for patients, leaving the authors of narrative medicine open to continual emotional hardship.

5. What do you think should have happened to Linda? What are the ethical considerations and where do you stand on this issue?

Linda’s case is mired in ethical quandaries: Because of her lack of insight, Linda unknowingly and unintentionally did exactly the wrong things in terms of existing protocol for psychotic patients. When she was initially institutionalized, antipsychotics and meetings with a psychiatrist seemed to improve her insight and return her to a level of semi-normality. After her releases, however, Linda’s insight evaporated and her fantasies grew, weed-like, into her day-to-day life. Only her family members, her primary caretakers, could see the degree to which Linda’s detachment with reality had progressed; worse still were her moments of lucidity in which she could defend herself to a judge, dismissing her psychotic episodes as other people mistaking her ”permanently pissed off” attitude and having ”a lot of energy” as insanity.

The ethics surrounding Linda’s care originate from the concept of insight and its problematic role in the mental health community – like Yossarian before her, Linda
faced an irreconcilable (perhaps unsolvable) problem: to assure caretakers of her
improving sanity, she had to validate her insanity. Contributing further to Linda’s
woes was the “ethical imperative” of insight; Linda could only consent to her care
if she understood why the care was required. The importance of medical consent
cannot be understated, but compromises – compromises that were not made for
Linda – must be made, for the protection of the patient. Linda unquestionably
posed a threat to herself and her situation compelled intervention, which was
ultimately insufficient.

When Linda was able to “explain” her psychotic behavior to a judge to gain self-
guardianship (and subsequently freedom), the system failed. Medical professionals
expressed concerns over her fantastical thinking but were unable to act; Linda was
free to refuse her antipsychotic medications. Beyond her medical team’s court-
mandated-impotence, Linda’s family was left uninformed as a result of patient-
privacy laws. From the outcome (Linda’s body was not found until May – she
had found the house in October and died in January), a revision to protocols is
imperative.

Psychotic and schizoaffective patients (who do not have living wills) should not be
allowed power-of-attorney until they have met requirements set by their psychiatric
care team, not a judge. Those patients who do not meet these requirements,
a category that would likely include Linda, should be treated at the discretion
of their guardian, who could implement mandatory medication regimens. These
modifications alleviate the immediate threat the patients pose to themselves, and
additional steps to return to normal life could be taken.

While this solution presents inherent ethical issues – treating patients who may
have moments of lucidity in which they coherently refuse care is unsettling for a
clinician (especially in the current malpractice climate) – it also would provide
demonstrable results in cases like Linda’s. Patients who refuse treatment on the
basis of not admitting (or even being unable to recognize, as Xavier Amador pro-
poses) their illness should not be allowed to cause lethal harm to themselves; the
resulting damage in the lives of their family and friends, as demonstrated by Caitlin
and Joan, is completely avoidable and unnecessary. To adopt a more protective
stance towards psychiatric patients, changes of this kind must be made to prevent
tragedies like Linda’s.