INSTITUTE OF CURRENT WORLD AFFAIRS

JLS-16 Psychiatry on the Stand

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Mr. Richard H. Nolte
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Dear Mr. Nolte:

Dr. Herbert Fine, the senior psychiatrist at St. Theresa's Hospital whom we met in JLS-14, once told me that most psychiatrists he knows dislike court appearances. Our testimony, he said, doesn't hold up well under cross-examination. I asked him why. Because, he replied, our opinions are in the nature of clinical judgments, developed over years of experience and difficult to justify on the basis of hard facts in brief courtroom testimony.

My impression is that, on the contrary, psychiatric conclusions are all too deferentially accepted by the judges at Bellevue and Manhattan State. These judges often seem to view the three statutory criteria for involuntary commitment discussed in JLS-15 as issues for medical judgment. They tend to ratify a psychiatrist's conclusions unless cross-examination succeeds in demonstrating them to be nearly baseless, placing a heavy burden of proof on the patient. In few of the involuntary commitment hearings I've attended over the past months has each of these criteria even been explicitly debated. And when, as the reader has observed in many of the hearings I've

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recounted, the judge runs quickly through the three criteria near the close of a psychiatrist's testimony and gets an affirmative answer on each from the doctor, the judge has already reached his decision, and is making sure that the court record contains a clear and unequivocal statement . But these things are rarely unequivocal.

Here is a nearly pure example of conclusory psychiatric testimony given at Manhattan State Hospital on February 27. I've reproduced only the doctor's statements and answers, eliminating the words of the lawyer and the judge. At the close of this testimony, the patient was retained at the hospital against her will.

> The patient is a 29-year-old black female on a 2-P.C. from Bellevue with a history of several previous admissions. I have not had a chance to review her previous history. My diagnosis is schizophrenic, paranoid type. The patient is threatening, accusative, shows loosening of associations and delusions of grandeur. She believes she is a princess with millions of dollars and hundreds of children. She shows inappropriate affect. She is in need of involuntary care and treatment in a hospital because she will not stay voluntarily. Her record shows that she got into a fight with another patient, but admittedly she may have been the victim. While in the hospital she has otherwise been only verbally abusive. But this does drive other people away from her. She is a dangerous person because her behavior is unpredictable and erratic. She is not ready for outpatient care because she won't take her medication. Why do I say this? It is a professional opinion.[1]

A professional opinion. The only elements in this testimony that look like facts are 1) the patient's speech is hostile and 2) she has false beliefs about herself. Everything else is either a circular statement (she is in need of involuntary commitment because she won't remain voluntarily), an illogical leap (she is dangerous because she is unpredictable) or an unsupported conclusion. The diagnosis, paranoid schizophrenia, is conclusory because not all paranoids are schizophrenic, and

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[1] As with all my other courtroom reports, I've changed the names of all participants and reconstructed the testimony from notes taken during the hearing.

the criteria for membership in the class of schizophrenics and the facts putting this patient into that class are not stated. The judgment that the patient won't continue taking her medication on the outside is a prediction without the barest factual support. It may be that under the standards of the Mental Hygiene Law, this patient belonged in a mental hospital against her will. But the psychiatrist's testimony gave us no way of knowing.

However well-motivated a psychiatrist's attempt to commit a patient may be, involuntary retention in a mental hospital is a deprivation of liberty, and there is no longer any doubt that, under a wide array of state and Federal judicial decisions, a patient is entitled to the Constitutional safeguards of due process and equal protection. While the applicable elements of due process vary from state to state, the minimum Constitutional requirements appear to include the right to a hearing and the right to be present and put on a defense. A decision to use the compulsory processes of law raises a question of value, a balancing of the traditional right to individual autonomy and society's interest in compelling a specified course of conduct. In our legal system the resolution of value conflicts is the responsibility of legislatures and courts; it is a moral and political task, not ultimately a question for medical expertise and judgment.

New York's Mental Hygiene Law contains elaborate procedures governing the involuntary hospitalization of an individual: notice to the patient of his rights, provision of legal counsel in certain instances, a speedy hearing before a state Supreme Court judge, periodic review of a patient's status, and so forth. The purpose of a hearing is to insure that the facts concerning a given patient put him in a class that the legislature considers appropriate for involuntary hospitalization. Medical testimony is indispensible to the accurate and uniform judicial application of legislative standards to individual cases.

But a hospital psychiatrist testifying in order to retain a patient against his will is not a disinterested technical expert, if such a thing ever exists. His conclusions are entirely predictable--otherwise he would not be in court. He is fully aware of the precise wording of the legislative criteria for involuntary commitment, and he phrases his conclusions to match these criteria. It is only the facts behind these conclusions that raise an issue for the judge to pass on.

The other day a young chief psychiatric resident at St. Theresa's Hospital asked me, in the course of a lively discussion about involuntary commitment proceedings,"What gives lawyers the idea that they're qualified to cross-examine psychiatrists?" And another, more experienced clinician at a state hospital who telephoned to discuss JLS-12, wondered, "Wouldn't it be better for everyone if the decision to keep a patient were left up to the doctors? The way you describe the hearings at Bellevue, they're like hospital case conferences with most of the participants, the judges and the lawyer, unqualified for the job." My reply was that if judges and lawyers are not knowledgeable enough--and this certainly is sometimes the case--then they should be further educated to do their job more conscientiously. But the views of both these psychiatrists reflect, I think, a misunderstanding of the purposes of our legal order. Only a judge can weigh medical recommendations against the inevitable detriments of confinements, and in JLS-15 I described the breadth and detail of psychiatric testimony he needs to do this. Conclusory testimony phrased in part-medical, part-legal language preempts the judge's function. And psychiatric conclusions are at their best (at St. Theresa's, for example) delicate judgments founded on years of clinical experience with a wide range of patients and on intimate familiarity with one specific patient. At worst, and they are often at their worst in large public mental hospitals, the bare conclusions of a testifying psychiatrist may sometimes be little more than an amalgam of cultural attitudes, circular reasoning, and hasty subjective impression. Only a rigorous cross-examination

by a lawyer for the patient will disclose whether the witness's conclusions are well-founded.

Expert psychiatric testimony may share the defects of any kind of expert testimony, and some others peculiar to institutional psychiatry:

a. inadequate familiarity with underlying facts (the patient, his history and current mental, emotional, and behavioral state under varying conditions. At Bellevue, the testifying psychiatrist is frequently not the doctor in charge of the patient's care.)

b. questionable investigatory procedures (the conditions under which interviews were held, the use of unverified stories from other hospital staff, the unreliability of certain testing procedures).

c. illogical leaps from observed facts to ultimate conclusions and predictions.(Studies reviewed in JLS-9 show diagnosis to vary with the doctor's personality and the patient's sex, social class, political beliefs, etc; most kinds of clinical predictions are notoriously inaccurate.)

d. testimony molded to make possible a legal disposition that the witness considers most beneficial to the public, the patient, the hospital, or the doctor himself. (A staff member at a prestigious New York psychiatric hospital that provides long-term psychoanalytic treatment at nominal fees to carefully selected, voluntary patients once told me that the hospital goes to court to retain patients who want to quit treatment after a year but in whom the hospital feels it has a heavy investment in time and money.)

e. personal bias (or, in psychoanalytic language, counter-transferrence.)

Two weeks ago I attended a hearing at Bellevue that illustrates an awesome array of the defects that may afflict psychiatric judgment formulated for the purpose of testimony at a judicial hearing. Otherwise it was an ordinary case among ordinary cases. Richard Pulaski was arrested by the New York City police because, apparently drunk, he was found kicking some trash cans around Columbus Circle. Instead of booking him and having him spend a night or two in jail--in which case, incidentally, Pulaski would have been guaranteed the full range of Constitutional rights for the criminally accused--the police decided to bring him to nearby Roosevelt Hospital, from which

he was transferred to Bellevue. Pulaski immediately requested a hearing.

The testifying psychiatrist from Bellevue was Jacob Greenfield, M.D., an old hand in the courtroom. Richard Pulaski is 27, single, tall and muscular, blond--an unemployed movie-house usher--and wore a pale-blue Western-style shirt decorated with a galaxy of five-pointed stars, the sun and the moon, and a spiral nebula.

> Dr. Greenfield: The patient was transferred from Roosevelt Hospital on March 13 because he appeared agitated and manifested destructive behavior. Also paranoid. His mental status is angry, hostile, inappropriate, potentially dangerous. The patient is bizarre, suspicious, paranoid, potentially assaultive, and guarded. He is labile, his affect inappropriate and blunted. He is well-oriented [time, place, and person] but difficult to manage. The nurse's chart from March 20 reported that the patient became angry, ripped a steel canister from the wall, and threatened to cut someone with its jagged edge. His medication was increased. Now he sleeps better and is more tractable.

A lawyer from the Mental Health Information Service cross-examined.

MHIS: Doctor, you said that Mr. Pulaski is fully oriented?

Dr.: Yes.

MHIS: There was a reference in your report to a suicide attempt?

Dr.: Yes, well, when I examined the patient the morning he was admitted, he claimed he had committed suicide the night before, and that I was the Devil and this hospital, Hell.

MHIS: But didn't Mr. Pulaski also tell you that someone had slipped LSD into his drink at a bar?

Dr.: That's what he says.

MHIS: Doctor, can Mr. Pulaski take care of himself, feed himself, and so forth?

Dr.: Yes.

MHIS: Could he take care of himself outside the hospital?

Dr.: Yes.

Judge: Couldn't the LSD he said was dropped into his drink account for his behavior.

Dr.: There's always that possibility. But his record shows that he had a first break two years ago, spent one week at Marlboro State and a week in Florida on thorazine.

MHIS: Doctor, you say that hospitalization would be beneficial to Mr. Pulaski, but is it essential?

Dr.: The patient's behavior was hostile and belligerant when I examined him. With medication, he has become less hostile, has better contact with reality.

The doctor was excused. The judge asked whether the patient's family, New Jersey residents, were present and Pulaski said no. A friend Pulaski had met in Florida six months ago testified that he could get Pulaski a job. He told the court that Pulaski had never been violent in his presence. Then Pulaski himself was sworn in. The judge asked if he were willing to seek outpatient treatment and whether he could support himself. Yes, Pulaski answered.

"Why not live with your family," the judge suggested, or close relatives, next of kin. I would be prone to let this thing go," the judge told the MHIS lawyer, "if he'll stay with his family, get a little rest, three square meals. He could get in trouble at the YMCA. I will sign a conditional discharge if his family comes and takes him home."

After the hearing, I followed Dr. Greenfield into the hallway to ask him a few questions. I wondered why he had decided to seek Pulaski's retention on so little firm evidence.

"Look," he said, "you can take a hard line or a soft line in the courtroom. I took a soft line."

"Sure, but why did you want to keep him here in the first place?"

"This guy is sick," Greenfield said.

"You mean he has a thought disorder?"

"Yes, yes."

"Then you administered tests to him, proverbs, serial sevens, like that?"

"No, we don't need to do that. When you've been in this field as long as I have, you can just tell. He's been hospitalized before. He shows looseness of associations. And his reality testing is very poor?"

"How do you mean ?" I asked.

"He misperceived my role, for one thing."

"You mean when he said you were the Devil and this is Hell? I thought Pulaski said he was on LSD."

"It wasn't just that one statement. His reality testing was bad generally. We're here to help him, but he was suspicious. We asked him to take medicine, and he refused. This is already a distortion of reality."

"But you testified that he is psychotic."

"Look, all I can say is, his distortion of my role is a sign of his disturbance."

I changed the subject. "You testified that Pulaski is a violent guy, assaultive. But he only threatened violence on the ward. Maybe he just didn't like it there."

"No, no. You can tell he's violent. A man can communicate violence in many ways. When I examined him, he constantly tried to tower over me." Dr. Greenfield stands just over five feet tall.

"Was it your decision alone to go to court," I asked, "or was it a hospital decision arrived at after a case conference?"

"No, we didn't have a conference on him. I interviewed him, spoke to the social worker on his ward. Then I found another doctor to sign the 2-P.C. papers." I was about to ask who the other doctor was and whether he had also examined Pulaski as the law requires when Dr. Greenfield interrupted the conversation and hurried down the hall.

Dr. Greenfield's court appearance is an extreme instance of the dangers of conclusory testimony. The judge, who as I've observed in other hearings appears to have a firmer view than most about the laws of evidence and the burden of proof, did not buy Greenfield's opinions and commit Pulaski. (He still did, of course, restrict Pulaski's freedom by ordering a conditional release.) But other judges I've observed might have gone along with the psychiatrist.

The only proof Dr. Greenfield offered of Pulaski's lack of "reality testing" was the familiar reasoning that a patient who will not swallow the notion that the doctor who is trying to commit him involuntarily is only trying to help him is out of touch with reality. If one accepted this logic, which can be applied to any patient who disagrees with the hospital psychiatrist about the need for commitment, one may as well eliminate the patient's right to a meaningful hearing. (It is hard to see how a psychiatrist with a bottle of thorazine in one hand and a law book in the other can gain the confidence of all but the most docile of patients.) Nor can one evaluate the significance of Pulaski's previous hospitalization and the

medication he had been given in Florida without knowing how he came to be hospitalized and what the usual custom is in Florida hospitals. Dr. Greenfield's notion that a patient's violent disposition can be communicated other than with overt acts or words may be valid in the abstract, but in Pulaski's case, one wonders whether the diminutive Dr. Greenfield didn't read too much into his patient's swagger. Mother Nature in her wisdom spared me also from the affliction of excessive height, and I can sympathize with Dr. Greenfield's reaction; another psychiatrist might have understood that Pulaski is inarticulate, proud of his physique, and swaggers when he feels trapped. It is no wonder that Greenfield didn't offer in court the facts he believed supported his conclusions, taking refuge instead in medical terminology. Whatever may have been Pulaski's problem, it was lost in the swamp between Pulaski's posturing and Greenfield's projections.

One judge who has done valiant battle against unsupported psychiatric conclusions is David L. Bazelon, now Chief Judge of the United States Court of Appeals in Washington, D.C. His efforts came to something of a culmination in the 1967 case of Washington v. U.S.[1] Thomas H. Washington, Jr. had been convicted in Federal District Court of rape, robbery, and assault with a deadly weapon. His chief defense was insanity, and his appeal was based on the theory that the psychiatric testimony at his trial had been too heavily dependent on conclusory labels. According to Washington's reply brief, his case would "settle once and for all the proper role of labels and conclusions in insanity cases." Although Judge Bazelon's opinion affirmed Washington's conviction, finding the testimony at his trial "a little better than that in most insanity cases," Bazelon's scholarly opinion sought to establish proper standards for future psychiatric testimony in trials under his court's jurisdiction.

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[1] 390 F.2d 444 (1967).

Bazelon reviewed previous attempts by the D.C. Court of Appeals to insure that medical terminology not preempt the judge's or jury's function by controlling the legal outcome. The 1954 Durham case[1] had promulgated a new standard for the insanity defense that, it was believed, would widen the range and specificity of psychiatric testimony and lessen the influence on the jury of expert conclusions. By 1958, the D.C. Court of Appeals found that Durham had not accomplished its purpose. In the case of Carter v. U.S.[2] the court reiterated its objectives in Durham: "Unexplained medical labels--schizophrenia, paranoia, psychosis, neurosis, psychopathy--are not enough. The chief value of an expert's testimony in this field, as in all other fields, rests on the material from which his opinion is fashioned and the reasoning by which he progresses to his conclusion; ...it does not lie in his mere expression of conclusion." But four years later, finding that the warning in Carter had gone unheeded, the Court of Appeals tried a different strategy. In Mc Donald v. U.S.[3] it sought to separate the legal question of criminal responsibility from the psychiatric concept of illness by giving to the Durham rule phrase "disease or defect" a legal definition that would be independent of how the words are understood medically. Psychiatric witnesses would then testify to their observations of "the development, adaptation, and functioning" of the defendant's emotional processes and behavior controls, and the judge or jury would itself apply the new definition to these observations. "We emphasize," wrote the court in a per curiam opinion, "that since the question of whether the defendant has a disease or defect is ultimately for the triers of fact, obviously its resolution cannot be controlled by expert opinion."

Again the injunction fell on deaf ears. The Mc Donald opinion had proved to be an empty exercise in semantics in which one set of conclusory labels was substituted for another; psychiatrists were still too free to supplant the court's judgment on criminal responsibility with their own. (Ironically, just one month

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1 214 F.2d 862 (1954).

2 252 F.2d 608 (1958).

3 312 F.2d 847 (1962) (en banc).

after the Mc Donald decision, the Court of Appeals upheld the conviction of one Dallas O. Williams on the grounds that even though nine of eleven testifying psychiatrists had labelled Williams a sociopathic personality or otherwise unbalanced, only six of them had characterized his condition as a "mental disease or defect".)

And so five years later in the Washington case, Judge Bazelon wrote a set of court instructions explaining to expert witnesses their function in the adversary system of justice and warning that "you may not state conclusions or opinions as an expert unless you also tell the jury what investigations, observations, reasoning and medical theory led to your opinion." These instructions were to be given to psychiatrists before they examined defendants, read in open court before the testimony of the first psychiatric witness of each trial, and included in trial judges' instructions to the jury. Judge Bazelon, speaking for himself in a footnote, wrote: "It may be that this instruction will not significantly improve the adjudication of criminal responsibility. Then we may be forced to consider an absolute prohibition on the use of conclusory legal labels.... For now the writer is content to join the court in this first step."

Was this first step effective? In the 1972 Brauner case, instituting a new standard for criminal insanity while retaining the required court instructions from Washington, Judge Bazelon observed in a concurring opinion that they had had "a significant salutary effect...on the adjudication of the responsibility issue in this jurisdiction." While the ultimate legal and moral questions in civil commitment hearings differ significantly from those in insanity defense cases, the danger that a judicial hearing will be controlled by expert opinion are no less threatening to the Constitutional due process guarantee of a meaningful hearing. It has been my experience that, while the procedures of New York's Mental Hygiene Law appear to work well enough, the substance of justice still awaits a first step.

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