The Role of the Psychiatrist in the Criminal Justice System*

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Psychiatry, institutional psychiatry in particular, stands today on the verge of a crisis of public confidence. Society's inflated expectations of psychiatry, fed in part by the profession itself, are being punctured on several fronts. Where once we believed in and institutionalized the psychiatrist's ability to predict and prevent the anti-social conduct of disordered offenders, we are now told that prediction (APA, 1974) and, in most instances, effective treatment (Stone, 1976) are beyond present abilities and/or resources. Where once we were told that large numbers of marginally functioning persons, elderly persons in particular, were proper candidates for full psychiatric hospitalization, we are now told that many if not most are not helped by hospitalization and indeed would be better served in other, less liberty-restrictive settings (*Dixon v. Weinberger,* 1975). Where once we were told psychiatrists could assist our determinations of criminal responsibility, we now hear distinguished psychiatrists calling for wholesale retreat from the fray (Stone, 1976).

Total retreat, to my mind, is neither a desirable nor a viable option. Psychiatry today, more than ever before, offers critical insights for our understanding of the mind and human behavior. Society has understandably, if somewhat naively, involved psychiatric expertise in an increasingly broad range of decisional processes. From criminal and correctional matters, from juvenile courts and involuntary hospitalization proceedings, psychiatric participation has spread to matters of employment in industry and government, to schools, and to preventive medicine in the community. Unquestionably, inclusion of the psychiatric perspective often enhances the sophistication with which such public and private decisions may be reached.

The danger, however, is that psychiatric participation in these decisional processes may slide by imperceptible degrees into psychiatric assumption of responsibility for the ultimate decisions themselves. Rather than confining themselves to those aspects of a problem for which they have expertise, psychiatrists may be seduced into taking responsibility for making judgments or assessing facts about which they have no special competence. As a result, not only does psychiatry become over-extended, but society is deluded into believing that scientific, "medical" answers exist to a problem and that

*The material for this article is a portion of an essay prepared for *Controversy in Psychiatry,* to be published by Saunders & Company in 1978.

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social, moral, and other determinants of the problem may therefore be ignored.

The critical point at which such dangers arise occurs when psychiatrists step beyond the traditional medical model of doctor and patient. When the doctor's employer is someone or some institution other than the individual whose mental functioning is at issue, the doctor must confront the effects his new masters have on the performance of his professional skills.

The issue, in essence, is one of candor and of the mechanisms we might devise to see that candor is assured. If public decision-making is in fact to be benefitted by psychiatric input, then psychiatrists must be willing and able to state not only what they know, but more importantly what they do not know. They must be attentive to biases arising from their professional theoretical orientation and from their personal values and beliefs. Finally, they must begin to recognize, and divulge, the conflicting interests they serve when they step beyond the traditional relationship of doctor and patient. Although these biases and conflicts of interests – these hidden agendas – must in the first instance be addressed by the profession itself, psychiatrists must also be willing to lay bare their contributions to the scrutiny of the ultimate decision-maker through such mechanisms as the adversary process.

Who's Calling the Tune?

The problem of hidden agendas can be seen most clearly in their extreme form. In 1967, I had occasion to visit the Soviet Union as a member of the First U.S. Mission on Mental Health. Although the seven-member mission was concerned with a broad overview of Soviet mental health services, my own particular concern as the only legally oriented member was with forensic psychiatry. As an outgrowth of that mission, I later made a study of case reports furnished by the Soviets of the psychiatric commitment of political dissidents. Assuming that the case reports were authentic, they revealed obviously improper uses of psychiatry. The evidence supporting findings of psychopathology in the reports was tenuous at best, there were no behavioral manifestations of the alleged pathology to justify a conclusion of "social danger," and the facilities to which the dissidents were committed belied the asserted goal of treatment. In short, the medical label of "sick" had been used by Soviet psychiatrists to serve the political purposes of the state.

It occurred to me that the abuses I had encountered differed from American practice in motive and degree but perhaps not in kind. In case after case before my court I had seen the error of the Soviet psychiatrists benignly repeated: psychiatrists had, to one degree or another, abandoned their role as ally of the patient to serve institutional interests. The fact that these American psychiatrists lacked the more sinister motives of their Soviet counterparts offers me little consolation. For as Justice Louis Brandeis once wrote:

> Experience should teach us to be most on our guard to protect liberty when the Government's purposes are beneficient. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers. The greatest dangers to liberty lurk in insidious encroachment by

men of zeal, well-meaning but without understanding. (*Olmstead v. United States*, 1928)

I do not suggest that American psychiatry is on the verge of participation in wholesale repression of political dissent. But my reasons for this conclusion have more to do with the political climate of the United States than with any confidence in our profession's recognition of the conflicting interests it serves. Isolated incidents in our history suggest the possibility of similar abuses in other, more politically heated times.

An example is the effort in 1958 of the Rev. Clennon King, then pastor of a church in Gulfport, Mississippi, to become the first black student at the University of Mississippi, only to be hustled off by state troopers, on orders from the Governor's office, to a commitment proceeding to the state hospital. After all, reasoned the man on the street, what sane black man would attempt to enter the University in 1958? To their credit, the state hospital staff was able to persuade the Governor's office that King was "without psychosis" and should be released. After twelve days' confinement and diagnosis, King was discharged to the custody of family members from Georgia who returned with him to their home.

A second example arose out of federal efforts to keep the peace when James Meredith became the first black to enroll at the University of Mississippi. Former General Edwin Walker was arrested October 1, 1962, on federal charges for contributing to the resistance to the federal marshals. Within 24 hours, Gen. Walker had been transferred to the Medical Center for Federal Prisoners in Springfield, Missouri, and the Justice Department had obtained a court order to require him to submit to a psychiatric examination to determine his competence to stand trial. The order was based in part on the affidavit of a government psychiatrist who had never seen Gen. Walker but who suggested the need for an examination based on newspaper reports of his activities, a transcript of his testimony before a Senate subcommittee six months earlier, and some old Army medical records. The affidavit suggested the possible existence of paranoid mental disorder based in part on Gen. Walker's strongly anti-communist statements. On November 22, 1962, the court declared Gen. Walker competent to stand trial, and on January 21, 1963, the Grand Jury failed to indict and charges were dismissed. In the interim, Gen. Walker had been portrayed in the press as insane (Szasz, 1965).

To a limited extent, service of the political and social *status quo* is endemic to the concept of mental illness itself. Mental disease is a "cross-dimensional concept" reflecting, in addition to medical judgments, "moral, legal, actuarial, or political" judgments as well (Fingarette, 1972). One who drinks alcohol to excess over a long period of time may be judged sick or not sick, depending on who is judging and on the purpose for which the diagnosis is made. The fact that psychiatrists may have special skills in diagnosing and treating such conditions does not by itself render the decision as to illness a purely medical one. Similarly, in the well-known *Blocker* case, a weekend meeting of staff psychiatrists at St. Elizabeths Hospital, resulting in a decision to call psychopathy a mental illness for purposes of Blocker's insanity defense, related only marginally to the medical issue presented by the patient (*Blocker v. United States*). The degree to which Blocker and

many others are considered mentally ill is dependent upon the diagnostician's social, political and cultural reference points and the degree to which the patient's behavior and ideation depart from those norms.

Although the "cross-dimensional" nature of the mental illness concept creates some potential for abuse even in the traditional doctor-patient relationship, those dangers are minimized and made tolerable by the nature of that relationship. For there the patient has come to the doctor to engage the doctor as an ally or agent to help the patient deal with what the patient has at least tentatively identified as a medical problem. By the same token, if the patient ceases to believe the problem is medical or becomes dissatisfied with the doctor's approach in some way, the patient may terminate the relationship. To be sure, the patient may be so impressed with the mystique of the doctor's expertise that he may be swayed to a great degree by the doctor's assessment of mental illness, an assessment governed in part by the doctor's personal beliefs and professional orientation. Although such dangers are not to be taken lightly, they are held in check somewhat by the doctor's training in the traditions of the doctor-patient relationship and by the patient's ultimate power, if not actual ability, to control the relationship.

When the patient no longer controls the relationship and is no longer free to disregard the doctor's assessment of mental illness, however, the dangers of hidden agendas are greatly increased. Furthermore, there is an additional factor threatening distortion of diagnoses: the interests of the institutions seeking the doctor's services. Thus, for example, a psychiatrist employed by a state hospital for the "criminally insane" who conducts court-ordered examinations of persons raising the insanity defense in a criminal trial must deal with many masters. His professional theoretical orientation may dictate a broad or narrow view of mental illness; Soviet forensic psychiatrists, for example, at least in non-political cases, appear to take a narrow, largely organic view of mental illness (Bazelon, 1970). His personal values, especially his views on the causes of crime, are clearly implicated, whether he be of the law and order mentality or of the view that all crime is sick. Additionally, he must deal with the interests of his various constituencies – the hospital which employs him, the court which seeks to render a legal-moral decision on criminal responsibility, and society at large. The hospital is concerned with such matters as bed space, whether the defendant, if returned as a patient upon a finding of non-responsibility, will be the sort of patient the hospital can handle effectively, and the extent to which it can afford to expend its resources on the court-ordered examination, to name only a few (Pugh, 1973; Chambers, 1972). The court, although theoretically obligated to make its own determination of the moral issue, may be eager to have this thorny question resolved for it under the guise of a "medical" expert opinion (Pugh, 1973). Society may wish to keep the offender off the streets for as long as possible and may informally hold psychiatry partially accountable for any failures to achieve that goal.

In such a setting, the non-medical determinants of a diagnosis of mental illness increase in importance. Values of the political and social *status quo* as defined by the new institutional clients, as well as the physician's own internal values, contribute significantly to the definition of norms against which the patient's behavior is measured. Such values may not all be

irrelevant to the ultimate decision which is to be made – in this example, the decision of criminal responsibility. But they are values and factors beyond the medical expertise of the psychiatrist. The psychiatrist who conceals such factors in his expert opinion not only taints the decisional process by usurping the function of the appropriate decision-maker – in this example, the jury – but also undermines the credibility of his profession in the public arena. He allows his profession to be prostituted, just as Soviet psychiatrists have done, to achieve decisions for which other institutions in society should bear responsibility. And he allows society to deceive itself as to the true nature of the issues involved and to avoid facing the real and difficult questions of the state's power over the individual.

It is tempting for the psychiatrist in perfect good faith to insist that his professional attitude and his humanitarian concern for the welfare of the patient allow him to overcome bias and conflict of interest. But psychiatrists are also human, and the pressures of conflicting interests are often subtle and intense. Where we might be willing to trust the psychiatrist's professionalism in the context of a relationship which the patient is free to terminate, we (and the profession itself) cannot afford to extend that trust where the patient has no control and where, in fact, competing interests hold the real power.

If we are to facilitate the real contributions psychiatry can make to public decision-making, we must develop techniques for confronting and sorting out the institutional interests which intrude upon the psychiatrist's proper function. Some of those techniques can and should be instituted by the profession itself. As a first step, let me presume to offer the following suggestions.

First, the profession can begin by frankly confronting the existence of competing interests at work when psychiatric practice steps beyond the traditional doctor-patient relationship. Various types of conflict of interest settings – one example would be the handling of court-ordered examinations for the insanity defense – can be identified and analysed for the ethical dilemmas which they pose. Guidelines for professional conduct might be debated and instituted. In short, the first step must be recognition and acceptance of the problem so that solutions may ensue.

Second, psychiatrists working in conflict of interest settings should keep careful and detailed records of their conduct of a particular patient's case. Keeping records serves both to continually remind the psychiatrist of his obligations and to provide a basis upon which others may review his conduct.

Third, peer review mechanisms should be established by which professionals situated outside the conflict of interest setting can evaluate the performance of the psychiatrist.

Fourth, the patient must be forthrightly advised at the outset of particular conflicts of interest besetting the psychiatrist. For the psychiatrist to encourage a free flow of communication from the patient as though the traditional doctor-patient relationship existed is nothing short of fraud. If such disclosure inhibits the ability of the psychiatrist to obtain information for the institutional decision-maker, then it is for the decision-maker, not the psychiatrist, to bear the consequences.

Beyond these techniques which the profession itself can employ to refine its input into public decision-making, the decision-making bodies themselves must have mechanisms to assure that they are addressing the appropriate issues in their use of psychiatric expertise. It is here that the legal model of the adversary process provides some guidance for coping with these new uses of psychiatric skills.

Morality and the Decisional Process

Persuading the psychiatrist to learn to love the adversary process of the courts is like persuading the old Tories to appreciate self-determination. Yet I firmly believe psychiatry's aversion to the legal process to be in large part the result of misunderstanding of the nature and goals of that process. Courts are continually handling a wide range of complex and esoteric subjects, from the problems of nuclear power to environmental questions to the intricacies of economics. In so doing the courts are not attempting to substitute their own spurious expertise for that of the scientists and professionals. To do so would be to commit the same error I see many psychiatrists making in seeking to shoulder the moral responsibility question in criminal trials. Rather courts seek assurance that the contributions of the professionals on a particular issue are within the bounds of their expertise and are based on a rational consideration of all the information and alternatives available.

In my view the law is not a static order built on certitude, but a dynamic order built on process. Rather than providing wisdom, it offers a structure for seeking wisdom. Courts work through cases, actual conflicts which must be resolved whether or not all the information which we might wish to have is available. Policies may change as new cases and the passage of time bring more information to bear on a particular question. In this way the law grows, shedding old conceptions for new ones as new facts and values emerge.

Applying my model of law as process, I became deeply concerned in my first few years on the bench with our mechanistic application of the criminal laws. Time after time appeals by defendants from the lowest socio-economic-cultural strata of society were brought before my court without our ever seeking to understand the causes of their behavior or whether our punishment schemes were at all relevant to the problem. It seemed to me amoral, if not immoral, to be imposing moral blame in case after case when we neither knew nor were even attempting to know the roots of the behavior we condemned.

The criminal trial seemed to me an ideal forum for raising such issues. Each case presented the opportunity to conduct a kind of post-mortem of a particular crime. The community, as represented by the jury, was involved as decision-maker to assess against its concept of moral blame the career and conduct of the defendant. With each new presentation of facts and values, the community through the jury could gain further insights into the problem of assessing blame. As a by-product, the community could learn more about the causes of crime and how those causes might be addressed, either through the application of criminal laws or through other social programs.

The most available avenue for conducting such an inquiry was the insanity

defense. In substituting the *Durham* rule (the accused is not responsible for his act if it "was the product of a mental disease or defect") (*Durham v. U.S.*, 1954) for the *M'Naghten* rule (the accused is not responsible for his act if he lacked understanding of the "nature and quality" of his act, or did not know that his act was wrong) (*M'Naghten Rule,* 1843), we sought to broaden the inquiry beyond cognitive functioning to encompass modern dynamic theories of personality. Our goal was simply to allow the jury a more complete picture of why the accused acted as he did in order to render the moral judgment of blame as well informed as current knowledge of human behavior would permit.

Although *Durham* broadened our trial inquiries somewhat, it soon accumulated in practice all the problems of its predecessor. Psychiatrists, often encouraged by trial judges, testified in conclusory terms which concealed many of the hidden agendas discussed above. Jurors knew little more about those they judged than they had before, and indeed were often deluded into thinking that the psychiatric conclusion foreclosed any further investigation on their part into the moral issue of criminal responsibility.

Nor has our experience with psychiatric testimony in other areas such as juvenile proceedings and civil commitment been any better. Different jargon and different labels are used with the same effect: concealment of the difficult issues of the state's power to deprive individuals of liberty.

I joined my court in discarding the *Durham* formula in 1972 (*United States v. Brawner,* 1972), but dissented from its adoption of the American Law Institute test for insanity. In its place, I suggested that we instruct the jury that the defendant be held not responsible "if at the time of his unlawful conduct his mental or emotional processes or behavior controls were impaired to such an extent that he cannot justly be held responsible." The value of such a test would be to focus the jury on the ultimate issue of moral responsibility while directing the psychiatric expert to provide information to the jury on the defendant's behavioral impairments. Whether the accused can be considered "mentally ill," from whatever frame of reference, is irrelevant to me. What the jury needs is raw information about the defendant's behavioral controls, be it psychiatric, social, or cultural information, upon which it might base its assessment of moral blame.

From the example of criminal responsibility, one can derive broader principles on the use of psychiatric testimony in the courtroom. First, it is imperative that psychiatric and other information from the behavioral sciences continue to flow into the decisional process when society attempts to decide what to do with persons whose ability to cope within social norms is impaired. A decisional process which ignores relevant, available information is not morally defensible. Although we have to decide how to resolve particular cases without waiting for all relevant information to be discovered, we are at least bound to investigate all avenues currently available.

Second, it is essential that the decision-maker not have the issues of state power and individual liberty obscured by testimony which overreaches the bounds of the witness' legitimate expertise.

Third, it is essential not only that the decision-maker confront what relevant information is known, but that it also be aware of what is unknown.

Only then will the process attain the humility which is critical to a just determination of the balance between individual and state. We cannot cope with uncertainty, and we cannot move forwards toward certainty, if we are deluded into thinking we have ultimate answers at hand.

Lastly, in evaluating the psychiatric and other information provided, the decision-maker must be able to see clearly the extent to which such information may be colored by individual and institutional bias. To preserve the legitimacy of its own process, the court must insist on the opportunity to probe witnesses' testimony for bias to determine the appropriate weighting of that information in the final decision.

To these ends, the process of cross-examination by adverse parties is the law's principal mechanism for sifting through the competing facts and values presented in court. Parties adversely affected by a particular witness' testimony carry the burden of testing that information for its completeness, its factual basis, and its coloration by personal, theoretical, and institutional values and beliefs. Psychiatric use of conclusory labels thwarts this process and leaves the decision-maker unable to weigh accurately the facts and values presented and to confront honestly the issues at hand.

If psychiatrists follow my advice to "let it all hang out," they will make our job in the courts immeasurably more difficult. We will be forced to face a number of difficult issues for which we have no ready solutions. What, for example, is society to do with a dangerous offender who cannot be held responsible for his past criminal conduct, yet who is not now "sick" and for whom no particular course of treatment or rehabilitation is available? I do not know. But I do know that courts and other public decision-making bodies cannot begin to resolve such questions, for which they are ultimately responsible, until they are provided with relevant and accurate data upon which to base the first tentative steps toward a wise and just solution. So long as psychiatrists presume to decide such questions for us by incorporating into their medical judgments factors beyond their medical expertise, they will be subject to the kinds of charges we currently levy against Soviet psychiatry. Their integrity as scientists and their public image will suffer, and their usefulness in helping those whom they are dedicated to helping will be diminished.

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