

# “The Wrong Handle”: Flawed Fixes of Medicolegal Problems in Psychiatry and the Law

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The practice of psychiatry, the severity of some mental illnesses, the rights of mental patients, and the available resources for evaluation and treatment of mentally ill persons all pose significant challenges for the involved parties, including patients, practitioners, institutions, legislatures, and social systems. Making the system work at all inescapably creates many problems of access to and delivery of care, balancing needs for treatment, needs for autonomy, and so on. The legal system may be invoked to solve some of these problems that emerge from the complex interaction of several forces at multiple levels.

Problems are best solved when they are approached from the most effective vantage point. The failure to accomplish this goal may be termed, “grabbing the problem by the wrong handle.” A number of legal approaches to problem-solving unfortunately fit this description. They have in common one or more of the following: a lack of clinical input, expert testimony, or consultation; a lack of due process and the failure to use the kinds of balancing tests that emerge from many courts; and the fact that most legislative initiatives are the product of compromise among interested parties, but not necessarily the best solution to the problem at hand. In other cases, ju-

dicially imposed standards are applied arbitrarily without necessary correlation with clinical realities, and committees spawn abstract statutes designed to remedy some perceived problem. Of course, all these forces are intensified by political pressures, imminence of elections, and other familiar factors.

We will attempt to illustrate the secondary problems created by grabbing the original problems by the wrong handle, and to suggest solutions.

## The Problem of Inadequate Care for Inpatients

The care of mentally ill patients, especially inpatients, has historically been a stigmatized, underfunded, and undersupplied element of society's health care system. The last century's construction of giant state hospitals in the rural countryside represented, among other goals, an attempt to move the mentally ill out of public view. Tight-fisted legislatures were always slow to honor, and quick to question, fiscal outlays for this population.

In the early 1970s, legal advocates, whose mandate was to support patients at the Boston State Hospital, failed to act through practical efforts to improve funding, staffing, training, and personnel. Instead, they responded to the requests of some, but not all, patients for permission to refuse to take their anti-psychotic medications. The advocates' class-action response was the important right-to-refuse-treatment case ultimately known as *Rogers v. Commissioner, Dept. Of Mental Health*.<sup>1</sup> Patients were sub-

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jected to a full hearing on whether they were competent to accept or refuse antipsychotic medications, and then they were treated, if at all, by judicial order. The issues are discussed at length elsewhere,<sup>1-11</sup> but the disruptive effect of this ruling and its attendant procedures was to delay treatment in almost every case,<sup>5</sup> and treatment delayed in major psychotic contexts is often treatment denied.

Although Appelbaum<sup>8</sup> has pointed out why this ruling did not cause a complete disaster (in essence, because of inertia and hidden balances within the actual practice of law), the effect of the ruling in causing delay of treatment was considerable for that fraction of patients who were covered by this rubric.<sup>2-5</sup>

Thus, grabbing the “quality of care” problem by the “right to refuse anti-psychotic medication” handle—by rendering more difficult the treatment of psychotic patients with antipsychotic drugs—actually worsened the treatment for those patients, prolonged their hospitalizations,<sup>5</sup> increased the costs,<sup>6</sup> paralyzed and discouraged treatment staff, and—perhaps most important—disrupted the care of other, treatment-compliant patients on the same wards.<sup>4</sup>

### The Problem of Involuntary Commitment

Involuntary commitment of the mentally ill has always been a theoretically and morally problematic exchange of liberty for protection of self and others. Yet almost any careful study of the issue has noted that the need for commitment for some patients cannot be wished away. Some persons require commitment, “case after case, law after law.”<sup>8</sup> A commitment procedure in some form will be necessary in the foreseeable future, since no society has been so libertarian as to tolerate unchecked dangerousness by its members. Yet commitment, like all other procedures, can be misused, overused, or used in an inappropriate setting.

Advocates observing this problem attempted to address it by raising the standards or threshold for commitment; their attempts took several forms. In the case of *Lessard v. Schmidt*,<sup>12</sup> the approach using “criminal” standards of procedure was to create an extremely high threshold for commitment through those multiple procedural requirements, such that, as one source noted, if all the criteria set forth were honored, no one would ever be committed.<sup>13</sup>

A second approach might be styled the “overt-act” requirement.<sup>14</sup> In some jurisdictions, even a palpably dangerous patient cannot be committed unless he or she has performed some overtly dangerous act against self or others within a certain time frame. In effect, this protocol sets aside the clinical assessment of the patient, removing the clinician from the equation, as it were, in exchange for what may be seriously harmful behavior as a condition for commitment. These two approaches, when coupled with clinicians’ natural reluctance to go to court, create an increase in the dangerousness of the outpatient population and become elements in the deinstitutionalization of a large number of mentally ill persons.

In sum, instead of improving commitment procedures, training advocates and judges in the realities of dangerousness among the mentally ill, or attempting other valid approaches, the matter of commitment was grasped by a handle perhaps expressed as, “just make commitment more difficult.”

### Deinstitutionalization Itself

In a closely related context, the problems of inpatients, noted earlier, prompted some social entities, including legislatures and advocates, to take the position: “if the institution has problems, solve them by getting the patients out of it.” Driven by clear economic incentives, as well as both the community psychiatry and the antipsychiatry movements, deinstitutionalization was a very popular trend during the 1960s and 1970s, with significant negative effects visible on every street corner.<sup>15,16</sup> Removing those in need of hospitalization from the hospital, instead of improving the lot of the hospital itself and of the aftercare system, constitutes a glaring example of grabbing a social problem by the wrong handle.

### The Problem of Venal Expert Witness Testimony

Within forensic psychiatric practice, the *bête noire* is the so-called “hired gun,” defined as an expert who sells testimony—that is, says what an attorney wants him or her to say—rather than simply charging for the time spent in doing the work objectively.<sup>17</sup> The problem is particularly acute in malpractice cases.<sup>17,18</sup> A variant is the so-called “carpetbagger expert,” a metaphor for the expert in malpractice cases who travels around from town to town opining on how

the local practitioners should have practiced as opposed to how they did. An element of this admitted stereotype is the fact that this expert does not do, or no longer does, the clinical practice he or she is criticizing.

The usual and most appropriate remedy for this problem is skilled cross-examination, which is not always available or provided. Some efforts to grab this problem by various “wrong handles” merit inclusion herein.

The American Medical Association (AMA) defines expert witness testimony as “the practice of medicine,”<sup>19</sup> despite the fact that there are clinical, legal, and ethics-related barriers, conflicts, and contradictions to that view.<sup>20,21</sup> The Association’s apparent goal is to permit complaint procedures to challenge venal testimony through the local medical licensure boards.<sup>22</sup> This sanction, embodying a threat to licensure, will serve, they apparently feel, as a deterrent to venal practice.

Some states, such as Kansas, grabbed the problem by a different handle.<sup>23</sup> In those states an expert is not qualified to testify on the standard of care if he or she spends less than 50 percent of the time in actual, current, direct care of patients. (Note in passing that other states allow experts to qualify for the 50% or 51% threshold through teaching activity.) The apparent reasoning is based on the theory that at least the expert witness would be experienced as a clinician in the field relevant to testimony, rather than being, say, a retired dilettante in that field. Thus, this rule attempts to exclude carpetbagger experts.

The flaw in this reasoning is that the “hired gun” role is most often driven by character pathology, venality, or ignorance, not by insufficient time spent in clinical practice. No rule precludes a full-time practitioner from selling out to an attorney, despite a full patient caseload (perhaps even because of a full caseload), nor do experts with predominantly teaching responsibilities necessarily know less about the field. Indeed, many senior, experienced forensic psychiatrists do not have large clinical practices; that fact is what allows them to go to trials on short notice, for example. They may also have extensive teaching responsibilities and, indeed, may be called on to perform many different functions in a work day.

Of interest, there is a paradoxical conflict between the AMA’s position and that of states that limit the definition of medical practice to face-to-face contact with patients. In reality, medical practice embraces

several activities that may well include teaching, consulting, supervising, record-keeping, and related matters. By limiting the definition, some states markedly constrain and constrict what constitutes medical practice, while the AMA claims that testimony is medical practice. In theory, a doctor who did nothing but testify would be engaged in the full-time practice of medicine per the AMA, but would have zero medical practice per the restrictive states.

For example, consider a hypothetical physician who has a 10-hour work week, of which 5 hours are spent in seeing patients and 5 hours are spent in forensic work. The remainder of this physician’s income might come from investments, gambling, or selling illegal drugs, say. This individual would qualify as an expert in Kansas (50% rule), while a senior, experienced forensic psychiatrist with an active teaching practice that takes 51 percent of his time would not. Moreover, it would not matter that the latter expert had published extensively in peer-reviewed, *Daubert*-qualified<sup>24</sup> sources on the exact topic in contention.

Thus, by grabbing the “corrupt forensic testimony” problem by the “clinical practice” handle,<sup>25</sup> Kansas and similar states exert in reality no effect on the likelihood of hired gun practice, but merely continue to decrease the pool of competent, ethical experts available. The authors clearly feel that teaching clinical psychiatry, as the name implies, as well as other professional activities, is clinical work. Opposing attorneys’ deposition strategy to eliminate an expert by painting teaching or other clinical activities as “not clinical” may or may not pass court muster. If providing expert testimony, acknowledge the truth about how time is divided.

### The Problem of Risk in Society

In the famous *Tarasoff* decision, a comment was made about our “risk infested society.”<sup>26</sup> This risk was erroneously linked to mentally ill individuals who actually represent a low risk pool.<sup>27</sup> In addition, advocates for the mentally ill were concerned that involuntary commitment, representing a significant liberty interest, was being overused or should not be used at all to deal with what some individuals at the time thought of as social dissent, not mental illness. That is, involuntary commitment was viewed as a form of social control of the majority over disenfranchised minorities.

A possible solution to both the dilemmas of risk and commitment (viewed as a negative event) was proposed in an article by two law students, Fleming and Maximov,<sup>28</sup> who suggested an alternative to commitment: having a therapist warn a potential victim of a threat posed to him by a mentally ill person. The potential victim could then presumably take responsibility for his or her own protection. Thus, it would no longer be necessary, so these advocates reasoned, to commit involuntarily this potentially dangerous patient.

The article, springing from libertarian influences of the 1960s and early 1970s, had one noteworthy impact on the legal system. In the *Tarasoff* decision<sup>26</sup> the Supreme Court of California created a duty, not to a therapist's patients, but through a therapist's patients to a patient's potential victim. This has been popularly known as a duty to third parties or duty to potential victims.

The *Tarasoff* decision, in its initial 1974 version,<sup>26</sup> created a duty that involved the need for clinicians to warn possible victims about the violent intent of mentally ill patients who express intent to harm while undergoing psychiatric treatment. Most scholars in this area<sup>29</sup> agree that warning the victim is an extremely problematic approach. For one thing, warning creates great anxiety but without an obvious solution to the underlying issue. Even more problematic, the individual warned may well take preemptive action into his or her own hands. Should that occur, the warning approach will have precipitated the violence that it was intended to avoid.

Even though the original *Tarasoff* decision was later modified<sup>30</sup> to permit a range of possible responses to patient dangerousness, warning remained one of them. Moreover, many clinicians find the idea of warning victims so nonclinical that it sticks in their minds, so that, even in cases in which warning should not be employed and commitment should be instituted, clinicians still attempt warnings, sometimes under markedly inappropriate circumstances.<sup>29</sup>

A senior forensic psychiatrist tells this illuminating story:

The senior forensic psychiatrist received a call from one of his former trainees now working in an institution, who reported that one of the inmates had threatened the senior psychiatrist's life and the inmate was due to be discharged in the near future. After having received this call with emotions that might well be imagined, the senior psychiatrist examined his options. The police, when called, indicated that, should anything actually be happening at the moment, they would "be right over." Inves-

tigation of the bodyguard situation revealed a price range clearly beyond his resources. Finally, he considered leaving town and changing his name; but, of course, he had tenure, a situation that made this approach unmanageable. In sum, the senior psychiatrist realized that—despite his expertise in the field of forensic assessment—the only effect of the "warning" was to make him more anxious, with no available remedy foreseeable.<sup>31</sup>

## Therapeutic Jurisprudence as a Solution

Some of the more sophisticated legal advocates have proposed the notion of therapeutic jurisprudence, by which they mean that the legal system can in some cases be used for clinically supportive goals and ends.<sup>32</sup> In the history of legislation, the case of *Wyatt v. Stickney*<sup>33</sup> demonstrates the concrete version of therapeutic jurisprudence. In that right-to-treatment case, Judge Frank Johnson indicated an explicit blueprint for how the Alabama State Hospital might be improved and brought within humane parameters of patient care. His ruling even went so far as to define the exact temperature of the water in the inmate showers. In other contexts, therapeutic jurisprudence, we suggest, will only occur when the proposing attorneys or legislatures are soundly anchored in clinical understanding. These conditions would counteract the general problems of lack of due process and lack of clinical input that we identified at the outset.

## Conclusions

Attempts to solve complex problems have at times led the legal system to grasp the problem by the "wrong handle." But the medicolegal problems described herein will not go away. We advise clinicians first to act clinically without attempting to second-guess a law or to interpret a statute. If a patient is thought to be at risk, petition for commitment, even if "hard" evidence is lacking or if courts in that jurisdiction have a low rate of granting such petitions. While clinicians' acts must be guided by the compass of the law, they must ultimately operate in the patient's interests, regardless of the expected legal outcomes.

Finally, recall that the duty to warn articulated in the first *Tarasoff* decision<sup>26</sup> was a legal, not a clinical, intervention. The professional duty to our patients is not merely statutorily defined or limited. We must keep this in mind.

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