On The Distinction Between Medical and Legal Diagnosis

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The practitioner of either psychiatry or law has as his ultimate object the taking of a rationally appropriate action in dealing with a case at hand. The case is brought to his attention by some motivated individual or individuals, and the case ends when the motivations are resolved. There are two possible outcomes: the motivations are resolved in a way desired by those who brought the case, or the conclusion is reached that no further action can be taken which will lead to a desired end—that is, the situation is hopeless. Until one of those two points is reached, however, the practitioner faces the problem of taking action with respect to the case.

Insofar as it would be regarded as rational or appropriate, the action that the practitioner undertakes is based on a concept of diagnosis. A "diagnosis" is in the broad sense a category; that is, an important common characteristic shared by a group of individuals. The general logic of rational action is that for a given diagnostic group, there is some best treatment. The practitioner observes the case, appraises the "facts" of the case, and "determines" the case to be an example of a certain diagnostic group. Then he implements the appropriate action.

Lay people and beginners in a field tend to act as if there were concrete diagnostic entities, thinking that, as it were, the universe of cases comes in discrete units. They assume that diagnosis is a straightforward procedure and that implementation of proper action follows as a matter of course. As individuals enter the field more deeply, they realize that such a simple notion is misleading. The cases which they confront defy simple categorization. Diagnosis becomes much more an ambiguous and subjective phenomenon, and formulation of a rational management program is infused with uncertainty and a large element of subjective "judgment."

Only after deep penetration into a field, however, does the student become aware that the very bedrock concepts of "diagnosis," "rationality," and "management plan" are not based on an apprehension of clear-cut phenomena in nature, but are rather cognitive structures by means of which people can organize experience into manageable chunks. We impose upon nature our cognitions, and the classifications we use do not necessarily correspond with any "natural reality." They are heuristic categories which enable us to cope and survive. We establish medical and legal diagnostic concepts because they help us to handle cases that present themselves to us. Other classification schemes, if we had them, might be better, but we must work with the tools in hand. It is not desirable, however, to take available categories for more than the helpful tools they are. We must always consider revising and improving them, as a constant concern of our ambiguous field.

The first basic concepts encountered in forensic psychiatry are the psychiatric and therefore the medical concepts. Medical concepts are those which relate to issues and processes of life and death. For virtually all practical purposes the role of the physician is to prevent death, and medical categories are incorporated into the field if they are useful in furthering that goal.

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A second goal of the physician is to prevent or alleviate suffering, and similarly concepts which are useful to that end are preserved. The goals of preserving life and eliminating suffering are both forms of aiding people in their adaptation to their environment. Thus a basic goal of a psychiatrist in interacting with another person in a patient-doctor encounter is to aid that individual in his adaptation.

Note that medical concepts are future-oriented. A diagnosis is the ascription of a case to a certain category or "disease." The essence of the concept of disease is that of "natural history." To speak of natural history of disease is a shorthand way of saying that individuals classified in a specific disease category have a common fate over a time period. For example, the natural history of measles typically includes recovery, while the natural history of pneumococcal pneumonia includes crisis soon followed by recovery or death. The concept of natural history also includes, by implication, the fate of individuals in the given disease category when they are exposed to certain conditions in the environment. (For example, the natural history of gonorrhea, following administration of penicillin, is recovery.) The concept of diagnosis is thus a future-oriented concept based upon some probabilistic expectation of outcome, which is a function of 1) observed conditions in the patient at the time of diagnosis or before, and 2) projected treatment conditions imposed upon the patient. The notion is probabilistic because of the intrinsic uncertainty associated with medical prognosis. (Prognosis is implicit in diagnosis. Indeed the very foundation of the establishment of new diagnostic concepts is that a gain in prognostic effectiveness is thereby attained. For example, prior to the age of bacteriology, pneumonia was pneumonia and could be said to have a certain expected outcome. Subsequent developments enabled a more elaborate classification of pneumonias to be made. On the basis of the more advanced classification, a more precise estimate could be made of the expected outcome of a case under various conditions. Rather than having to say of any pneumonia case that the patient had, shall we say, a 50% chance of surviving and a 50% chance of succumbing, we might now say that cases of type I have a 80-20 chance, type II a 90-10 chance if they receive penicillin, type N a 95-5 chance, etc. Even if antibiotics were not available, there would still be multiple diagnostic concepts of pneumonia because of improved prognostic capability and because improvement in prognostic ability paves the way for development and application of rational therapy.)

It should also be noted that the basis of classification in prognosis leads in practice to a classification based on therapeutic modalities. Thus there are cases for which aspirin is the treatment of choice, those in which chlorpromazine is the treatment of choice, or those in which gastrectomy followed by radium is the treatment of choice. The practitioner, faced by an array of cases which do not fit neatly into any of the diagnostic categories, has to weigh and choose his observations to evaluate cases according to their similarity to previously formulated categories, and on that basis guess which therapeutic modality is likely to be most effective and least harmful.

Alas, we are in the field of psychiatry. We have not been able to keep pace with the bacteriologists and laboratory scientists in formulating our nosological categories. We have categories, but they are primitive; they are based excessively upon phenomenology manifest at the time of examination, and they are of low prognostic precision. Although some grossly rational therapeutic decisions can be made respecting certain psychiatric cases, on the whole those tend to involve certain drastic conditions which have proved amenable to physical or chemical therapy. They tend to be based on "macrodiagnostic" observations such as presence of unusual affect, hallucinations, delusions, and disorganized thinking patterns.

Forensic psychiatrists, at least those who work in out-patient court settings, seldom are involved with these macrodiagnostic phenomena. The patient population in such settings tends not to deviate from the general population so grossly, for example, as those who are admitted as psychotic to a state hospital. The majority of the forensic psychiatric population tends to be classified differently, and in a somewhat negative manner, as

"character disorders." There are not sharp differentiations among categories based upon prognostic expectation related to clinical phenomenology. Rather the group tends to be a non-specific one with imprecise prognosis.

In approaching such cases for purposes of management, we incline toward a "minidiagnostic" approach based more upon specific details of the individual's environment and of his history than upon the grosser aspects of what we observe. Such things as the details of his offenses, the kind of parental responsiveness he faced or faces, his insight into his behavior, and his thoughts about and his reactions to specific events in his experiential environment take on importance. However, though those are in the broad sense diagnostic items, they are not so in the usual sense. That is, they are based not upon experience with the specific historical or observational item, but rather upon some experience with a more general and abstract class of observations, of which class the instant case is presumed to be a member. Thus, for example, there is a general impression that stress at times motivates people to act inappropriately. We may observe a person who is having difficulty fulfilling his job duties and who is drinking excessively, and we may conclude that that behavior represents an example of a stress reaction. The predictive power generated by that kind of non-specific diagnosis is, of course, not high. Yet in the field of forensic psychiatry, perhaps in the whole area of psychiatry encompassing the non-grossly-disabling disorders, which are presumed to be contributed to etiologically by the interaction between the individual and his environment, there does not seem to be a real alternative to that loose diagnostic approach. (We have not touched on the issue of "microdiagnostics" in psychotherapy, *i.e.* deciding how to proceed on a minute-to-minute basis. Not only can there not be more than a vague impressionistic set of concepts pertaining there, but also the practitioner is subject to the constraint of having to make immediate decisions under pressure. Those conditions make psychotherapy primarily an "art" rather than a systematic method, and negate efforts to perform effectiveness evaluation of that method as a treatment approach.)

It need not be said that such diagnostic imprecision leads to a corresponding handicap in implementing a therapy rationally. Such cases are the ones that psychiatrists try to help with conversation. Small wonder that it hasn't been established whether the right kind of conversation does any good or not.

The second aspect of forensic psychiatry is the legal one. Diagnosis in the sense of formulating a rational basis for legal decisions is in principle similar to the notion of medical decisions. However, there are some important differences.

Perhaps the most important distinction lies in relation to the ultimate goal of the activity. In medicine the goal is the adaptation of the patient. Indeed, the goal is set by the patient, and basically the doctor agrees with the patient about the goal. In the criminal legal system, the situation is different. Not only is there not a patient who can respond quickly and leave if the outcome of the legal interaction seems to be heading in an undesired direction, but also there are not even explicit goals for the activity agreed upon by the decision-maker and the object of the decision. At essentially any stage in a criminal proceeding there are various options which are available to a decision-maker; yet there is no simple goal which can be used by the decider as a criterion for his actions, and those actions may be completely independent of the wish of the individual whose fate is decided.

The legal decision-maker knows that he has inherited a place in a legal system which has evolved over centuries. Thus it obviously fulfills some functions in society. Yet precisely what those functions are or how the action of an individual within the system can contribute to the system's functions is not certain. The functions of a criminal justice system are often regarded as deterrence of crime, satisfying society's wish for vengeance, rehabilitating criminals, giving the populace a sense of security and predictability in areas of their lives, and so on. Yet these are concepts which are very general, highly influenced by individual interpretation, and above all, not formally and officially arranged in any

priority. There are often conflicts among the several possible functions of the criminal legal system, and there is no *a priori* hierarchy to which decision-makers may appeal to determine which ostensible function ought to take precedence and which ought to give way in cases of conflict. One set of priorities is as "legitimate" as any other set of priorities.

Given the absence of definable goals to legal action, the notion of rationality applied to legal decisions is seriously crippled. (That is to say nothing of the problem that even if there were a set of agreed-upon priorities, there is no body of knowledge that enables satisfactory prediction of the impact of potential actions upon the legal system and upon society. Even with all the methodological and state-of-the-art problems in psychiatry, which make it virtually impossible to assess adequately the impact of various factors on the patient, psychiatric decisions involve a much smaller scope of subject matter than do societal ones.)

The criminal justice system does involve some diagnostic concepts which, once invoked, do limit the latitude of the decision-maker's options in disposing of a case. These are mainly the definitions of "crime" and "guilt" and the notions of "competency" and "insanity." In some jurisdictions, concepts like "dangerous," "drug-addicted" and "alcoholic" enter into the legal dispositions of cases and also involve forensic psychiatrists. (Concepts like "arrest" do not much involve forensic psychiatry.)

The notion of a crime as applied to an individual involves, from the standpoint of development of such a concept, a relationship to time just as does the notion of a disease. However, unlike the disease notion, which is based on homogeneous expectation of outcome for those individuals so categorized, the placement of an individual within a given crime category merely gives guidelines and sanction for legal authorities to make a disposition. Establishing whether the diagnosis applies to an individual demands historical information which is in practice often ambiguous. It also requires some interpretation regarding the breadth of application of the diagnostic criteria, as well as making decisions about the method of determination whether the individual falls into the specific diagnostic category. Also—completely unlike the patient undergoing medical diagnosis—the individual has some influence, as does the legal authority, in determining what the diagnosis may be. Perhaps the critical difference here is the fundamental one of conflict of interest. Except perhaps in the area of fees, the doctor and the patient have common medical interests. They may disagree as to whether the patient should have an operation immediately or whether he should wait, but that conflict is usually based on the patient's value system and his attitude toward gambling with his body. It is unthinkable, however, that a doctor would say to a patient, "Well, I think you have either cancer or ulcers, but in order to avoid the trouble of a diagnostic investigation, if you agree, I'll let you have a diagnosis of ulcers and treat you on that basis."

In criminal situations, however, the prosecutor, who wishes to obtain a "Guilty" diagnosis, is often willing to negotiate in order to establish the diagnosis. Although in criminal law as in medicine the diagnosis makes the difference in the way the case is handled, the legal decision-makers obviously have much more latitude in the task of assigning diagnosis. Thus "plea-bargaining" can occur. The existence and the extent of that latitude occur because of the ambiguities related to the goals of the criminal justice system. In practice, therefore, the discretion of the decision-maker is a factor as important as or even predominating over formal and abstract legal considerations in the actual implementation of legal decisions, though, of course, only uncommonly do such decisions take place in a complete vacuum. Purely local, perhaps idiosyncratic influences thus dominate the scene of the administration of criminal justice. Statutes and decisions of supreme courts are in the background for interpretation (and possible challenge), but practically, the diagnoses made by the people on the spot are the ones that count.

(The interpretation of statutes and decisions, or determining the appropriate precedent in the case, is another important aspect of legal diagnosis which has no counterpart in

medicine. Many cases can be interpreted as falling under the rubric of different legal categories. The potential dispositions of a case may be fundamentally different depending on which category encompasses the case. That kind of decision, which is the crucial one in deciding a "point of law," calls for "judgment" on the part of the judges and attorneys who make them. It is an area of law which can call for a great deal of creativity and initiative. In cases like these, in which the ambiguities in explicit law are themselves made explicit, the saying applies that "the law is what the judges say it is." There is no completely analogous situation in medicine, though perhaps defining a new syndrome and suggesting a treatment is similar, for it establishes a kind of precedent for a physician newly approaching such a case.)

The legal determination is the first task of the judge. That decision, however, though of course it goes hand in hand with dispositional decisions, really provides the limits for the more discretionary aspects of the judge's handling of a case. The ultimate decision, such as the sentence, insofar as it impinges on the individual, has the major impact both on the individual and on society.

Although, as noted before, no official priorities are enunciated for judges' dispositional decisions, jurists do tend to share certain common attitudes toward their approaches. They are interested in preventing recidivism and violence in order to protect the public; they wish to inculcate respect for law and authority; and particularly in the cases of youthful or first offenders, they are interested in habilitation and rehabilitation so that the offenders will become good citizens. They are more reluctant to commit an offender to prison than to assign a lesser punishment, but they feel they cannot be deterred by qualms of sentiment from dispensing a harsh punishment when necessary. By and large they try very hard to be fair and equitable. Their decisions are made upon some kind of mixed reasoning which is both legal and practical and attempts to take prognosis, as well as precedent, into consideration.

What does this mean to the forensic psychiatrist? Indeed, should there be such a person as a forensic psychiatrist? Given the lack of precision and predictability in psychiatry, and an essentially similar situation with respect to legal decisions, is there any real alternative to flipping coins to make decisions in either field?

Maybe there isn't. Surely there is no proof that human decision-making is better than Monte Carlo methods. Yet many people believe that human decisions are important in the administration of legal decision-making and that psychiatrists can make a contribution to the field. The writer agrees with that view.

The forensic psychiatrist, as a practitioner involved in both fields, must understand decision-making in relation to diagnosis in both the medical and the legal senses. His main concern must always be the adaptation and survival of his patient, and thus he must be aware that the patient's adaptation depends not only upon how the patient perceives and responds to his environment but also upon what the potential threats and rewards of the environment may themselves actually be. Since a psychiatrist enters a legal proceeding during a legal crisis, knowledge of the potential impacts of the legal system on the patient's life is critical to understanding the patient's environment and his place in it. The psychiatrist must also understand that conflict may arise between the interests of the legal system, as perceived by the court, and the interests of the patient. Focusing excessively upon the patient's interests, particularly his short-term interests, may render the psychiatrist ineffectual in approaching the court and minimize his contribution to the patient's adaptation.

On some occasions the forensic psychiatrist may know more about the relevant legal issues in a case than anyone else involved, defense counsel, prosecutor, or judge. Such a situation may arise because of the psychiatrist's greater expertise in such cases and their nuances, while the legal personnel may have only general knowledge of the area. On such occasions the psychiatrist is often looked to for guidance and can provide the most comprehensive and useful view of the case. (Sometimes, of course, legal personnel are

ignorant of the law and refuse to be educated. The psychiatrist can only try tactfully to apply his knowledge to accomplish that education and perhaps advise the patient to appeal to a higher court.) It is apparent that the earlier in his training the psychiatrist acquires this legal knowledge—*i.e.*, if he can obtain it by "training" rather than by "experience"—the earlier, and ultimately the greater, will be his effectiveness.

The situation in a court clinic setting is somewhat different from the usual psychiatrist-court encounter. In the local court, the same judges usually preside over cases. They become familiar with the clinic's psychiatrists and what they can do, while the psychiatrists become familiar with the judges and their approach to cases. (Perhaps the individual differences among psychiatrists and among judges are not the crucial issues. The more important factor, in this writer's experience, is for the judge to become cognizant of psychiatric thinking in approaching a case and for the psychiatrist to become cognizant of judicial thinking.) Once the general familiarity is established, the court comes to expect and anticipate certain approaches to the adaptation of the individual that will be made by the court clinic psychiatrist, and that expectation tends to become implied in the court's handling of its cases. In effect, the interaction between judge and psychiatrist may lead to the judge's using his discretionary case-dispositional latitude in a manner which, within the formal legal constraints of the case, gives major consideration to the adaptation of the individual. Indeed, the mere presence of a psychiatrist in the case helps to focus the court's attention on the adaptation of the individual, which might otherwise on occasion slip into the background. (We discount here those few cases in which the presence of the psychiatrist creates a counter-productive backlash effect.)

Two case vignettes may be illustrative. The first concerns a 28-year-old divorced man with a long history of drug and alcohol abuse associated with intermittent episodes of drug-free behavior. He had been briefly involved with various drug treatment clinics but had not found the treatment atmosphere there satisfactory. He was arrested after presenting a fraudulent prescription for narcotics, and charges were preferred against him in a court with which the psychiatrist was unfamiliar. Because of his past record and chronic drug usage, a prison sentence seemed likely. Defense counsel referred the defendant to the psychiatrist.

The psychiatrist concluded that with close supervision and interview therapy, the defendant, who was highly frightened by the prospect of incarceration, might be able to remain drug-free. It was also felt that the patient's tendency to alcohol abuse was undesirable. Disulfiram was offered to him with the rationale for its use in terms of the whole case, and the patient accepted the drug. The plan was suggested to defense counsel that treatment with certain stipulations was the best approach to the patient's adaptation which could be devised at that time. It was recommended that defense counsel be the intermediary between psychiatrist and court and that the psychiatrist should inform the attorney of any aberrations in the attendance or visible performance of the patient. The attorney contacted the court, requesting a continuance of the court proceedings with the understanding that if the defendant did not remain drug-free and attentive to treatment, the case could be brought forward at any time, and that the attorney would notify the court if such necessity arose. The court accepted the plan. Indeed after several months the court was so pleased that the charges were dismissed. (Defense counsel found himself then in a difficult position in that situation. It was obvious that fear of the court was the major motivating factor in the patient's doing well. It would have been better for the individual's overall adaptation had the legal case remained open. It would be unthinkable, however, for a defense attorney to go against his client's wishes and challenge a court's dismissal of charges. The client's short-term wishes must carry the day in such a conflict situation.) Of course, both the attorney and the psychiatrist lost contact with the individual after the charges were dismissed.

Both that case and the following one illustrate the necessity to consider primarily the individual's overall adaptation in formulating a treatment program. When the program is planned, features and safeguards can usually be incorporated so as to satisfy the requirements of the court. In this situation the legal considerations, which provided the

initial underpinnings for the psychiatric plan, subsequently removed those underpinnings. Perhaps if the law were different such situations might be avoided—but that is a discussion for a different forum.

The second case concerned a 58-year-old widower who was referred to a court clinic after having been disarmed one night. He had drunk an excessive amount of wine and had taken a loaded pistol out onto a public street, where he was waving it menacingly. It was his first offense. (The offense occurred before the Massachusetts Legislature passed a gun control law requiring a mandatory imprisonment of a year for a person convicted of violating it. The existence of that law could certainly have altered the management of the case.) He was convicted of possession of a dangerous weapon and of assault with a dangerous weapon. The court sought psychiatric evaluation for aid in sentencing. The diagnostic interview revealed an unresolved grief reaction of six years' duration, since the death of the patient's wife, to whom he had been extremely devoted. Prior to that time he had been a reliable, if somewhat eccentric, worker and had lived a stable life. Subsequently, his work performance had deteriorated in level, quality, and regularity; he drifted about and drank too much.

The recommendation to the court was a straightforward one calling for interview psychotherapy. He was not considered to be likely to repeat such a crime. (His gun had long since been confiscated by the police, and he was willing to allow them to retain it.)

The court sentenced him to the House of Correction for one year but suspended the sentence for two years. (As in most courts, in the court in which sentence was given, an individual who violates the terms of his suspended sentence may be ordered to serve it. A minor violation, however, does not usually result in the imposition of the sentence if the individual is otherwise doing reasonably well.) He has been seen in individual therapy over a period of a year and a half, and has done well. He is not drinking and he is again working. He participates readily in therapy interviews.

The latter case is not an atypical court clinic case. The evaluation probably did not alter the sentence, for the individual had had no prior record and did not appear to be an aggressive person. The judge generally feels more comfortable, however, when his opinions are buttressed by those of a psychiatrist with whom he can share some of the advisory responsibility for his decision. The psychiatrist also, by offering treatment, presents to the judge some hope that the situation will improve, another factor leading to a more confident decision on the part of the court.

In both cases the psychiatric recommendations were "rational" in that they were based on diagnostic considerations. The psychiatric diagnoses were mini-diagnoses based on the more specific aspects of the facts of the patients' cases within the broad rubric of their macrodiagnostic categories of drug-alcohol abuse and depression. The diagnoses and recommendations were not precise, but within the context of the state of the art, they were reasonably on target.

As psychiatric legal diagnoses, they took account of the diagnostic aspects of the situation and attempted to integrate the patient's adaptation with the requirements and constraints of the legal diagnosis and the local legal situation. The prescriptions based on those diagnoses appeared to be successful in aiming at that goal.

It appears to this writer to be necessary for a psychiatrist to receive some legal training if he is going to function harmoniously, and maybe even effectively, in a legal setting. Since more and more of psychiatric practice has legal overtones, the profession will perforce be required to face the issue of obtaining legal training. In essence the psychiatrist in such a situation must learn how to think like a lawyer. He need not learn to be a lawyer, for that seems to be a wasting of resources. But he must think along lines of legal diagnostic concepts and how they are employed within the framework of his activity, the legal system. When the psychiatrist learns to do that, he can function harmoniously and effectively within the legal system and serve both his patients' adaptation and the demands of the system. If he does not learn to think legally, he is likely to be ineffective in his role in working with legal personnel and to feel frustrated in his professional efforts.