When Doctors Disagree: Differing Views on Competency

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Who shall decide when doctors disagree?

— Alexander Pope[1]

Nowhere is the power and influence of psychiatry more evident in the psycho-legal arena than when the psychiatrist is called upon to advise the Court as to who is competent to stand trial and who shall be deprived of personal liberty until such time as he becomes competent. The import of psychiatric hegemony in this aspect of the criminal justice system is clear when one realizes that "the majority of persons now held in institutions for the criminally insane are there not because they have been found not guilty by reason of insanity, but rather because they were judged incompetent to participate in a trial and therefore have never been tried on the question of their guilt or innocence."[2] The potential abuses and misuses of these politicized psychiatric powers have been outlined and the imperative needs for clear and meaningful standards for psychiatric competency examinations and for clear and meaningful communication of these findings to the Court have been emphasized.[3]

In an attempt further to scrutinize and dissect the psychiatric competency examination, we have undertaken a study of cases wherein the evaluating psychiatrists disagree in their interpretation of the findings and in their conclusions. Our aim is to expose and examine the inner workings of the decision-making process itself in a complex and controversial psycho-legal operation.

Method

The Forensic Psychiatry Clinic of the New York City Criminal Court has the primary responsibility for evaluating the competency of criminal defendants before the Court in Manhattan whenever the issue of competency is raised. The Court has jurisdiction over the full range of criminal offenses from misdemeanors to felonies, and thus the competency issue may arise with charges as diverse as loitering and homicide. Although the number of annual arraignments before the Court is well over 100,000 cases, the number

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of competency examinations requested represents a miniscule proportion of this figure (less than 1%).[4]

The psychiatrists at the Clinic are closely attuned to the Competency issue and sophisticated in regard to its ramifications. They favor the return of the mentally ill offender to Court whenever feasible, convinced that this serves the best interests of the patient-defendant and of justice in the broadest sense.

For the twelve-month period July 1, 1975 through June 30, 1976, a total of 1,404 patient-defendants were evaluated to determine their competency. (Table 1) Under the current Criminal Procedure Law, each defendant referred for a competency examination is interviewed by two psychiatrists who submit separate reports of their findings and conclusions. Despite the frightening image of institutional psychiatry as a monolithic threat to individual freedom that is propagandized by Szasz and others,[5,6,7] the intention of the statute clearly encourages independent evaluations in order to give patient-defendants an all-important *second opinion* in a matter bearing so crucially on their liberty. Also, rather than inferring that the examiners should or must agree, the statute makes specific provision for disagreement:

> If the psychiatric examiners are not unanimous in their opinion as to whether the defendant is or is not an incapacitated person [provision is made] . . . for another qualified psychiatrist to examine the defendant to determine if he is an incapacitated person.[8]

Whenever such disagreement occurs (in the Clinic during the period under study there were disagreements in 35 cases, or 2.5% of the total case load), after a third psychiatric examination is completed, a Court hearing is mandated in order to subject the controversial findings to judicial scrutiny and final decision-making. The provision for (and expectation of) such disagreements implies a tolerance for less than absolute scientific precision in the determination of competency by the examiners. Judge Bazelon puts it well: "It is argued that Psychiatry is a scientific discipline. Laying aside the question of whether medicine or psychiatry is solely an art or solely a science, I have always understood each to be in large part an art – an art that applies scientific information and expertise to the care of patients. Is it a putdown to suggest that most of what psychiatrists do is an art? I would consider that a compliment."[9]

Whatever the cause of such disagreement may be, differing clinical judgment, fluctuating clinical states, misguided paternalism, covert punitiveness, *etcetera, etcetera,* the safeguards of a second opinion which are built into the law are designed to protect the patient-defendant from the excesses of a unilateral psychiatric *pronunciamento.*

Our study involves ten consecutive cases referred to the Clinic for Competency examination wherein there was a disagreement between the two psychiatric examiners and a third had to be called in. Demographic data is contained in Table 2.

Discussion

What factors led to divergent conclusions among the psychiatric examiners

in these cases? Rosenberg and McGarry observed that ". . . expertise should be real and not assumed, and special forensic training or experience is required" in order to assess competency in a meaningful and accurate fashion. In their study it was apparent that many examining psychiatrists were confused about the issues and in their reports demonstrated a lack of understanding of the question put to them, *viz.* is the patient-defendant competent? Inappropriate format of reports, irrelevant substance in reports, and a glaring failure to attempt to substantiate conclusions with available data reflected an inadequate concern for the purposes of the report and an inability to link up data with conclusions in such a way that the psychiatric decision-making process could be scrutinized and appreciated.[10] This lack of concern for the decision-making process itself, deliberate or unintentional concealment of what goes on between *input* and *output* (what Jonas and Jonas term *throughput*[11]), has been severely criticized by Bazelon and others, although one questions whether this indiscretion is a phenomenon peculiar to psychiatric terrain.[12]

Critical review of the psychiatric competency reports on the ten cases under study by the authors would tend to eliminate confusion about the nature of competency *per se* or woolly reporting as sources of differing determinations. The reports are brisk and lucid in their arguments, the reporters well versed in the mysteries of legal psychiatry and especially conversant with the niceties of competency.

Analysis of the clinical and legal records of the patient-defendants allowed us to formulate a number of categories of discordance that would account for the differing impressions and conclusions of the examiners:

Categories of Discordance

I. Fluctuating Psychosis: Schizophrenics, just like their "normal" counterparts, are not frozen and fixed into a microscopic slidelike section of pathology, but exhibit a dynamic and living picture of fluctuation and change. One of the serious disadvantages of the nosological efforts has been the reification of mental illness, the viewing of these pathological conditions of the mind as everpresent, fixed and unchanging. In our study, disagreement arose in cases 1 and 2 based on such fluctuation in the clinical picture. In case 1, a week elapsed between the first and second examination, enough time to permit sufficient improvement of the patient-defendant's psychotic disorganization so that the second examiner could not agree with a finding of Incompetent. In case 2, the two examinations took place on the same day. As the day wore on the patient-defendant seemed to become fatigued, inattentive, and finally increasingly disorganized and autistic. The second examiner found him unfit* although, just a few hours earlier, the first examiner had concluded he was Competent. The crucial factor in this case was the point in time at which the examiner observed the patient-defendant. Temporal variation in clinical phenomena elicited decided the issue and accounted for the disagreement.

*Throughout the paper the terms Competent, Fit, and Having Capacity will be used interchangeably as will their opposites Incompetent, Unfit, and Lacking Capacity. New York State favors the Fit-Unfit designation at this time.

CLINICAL EXAMPLE

The patient-defendant is a 26-year-old Black man charged with Grand Larceny and Jostling. The first examiner described a patient displaying pressured speech, loosening of associations, neologisms, blocking, and other evidence consistent with a schizophrenic thought disorder. He was agitated, silly, and inattentive. Auditory hallucinations were a frequent distraction. He was unable to discuss the charges or the proceedings in a rational fashion due to the degree of personality disorganization. Seven days later, the second examiner reported him to be "relaxed, affable, and cooperative. His replies are logical and relevant. He provides a detailed account of the charges, the circumstances surrounding them, and his role in the proceedings. He appears able to collaborate with counsel effectively." A set of replies to specific questions regarding courtroom procedure indicated an acceptable degree of reality testing and ability to act rationally in his own behalf. He had been receiving Thioradazine 300 mg daily since his arrest one day before the first examination.

II. Acting Out, Impulsiveness and Negativism in the Interview Situation: Cases 3 and 4 displayed definite signs and symptoms of psychosis, but were marginally intact and seemingly able to communicate rationally and to maintain an adequate level of reality testing to function as a defendant in the courtroom. These patient-defendants *did something* in one interview but not in the other, something dramatic, florid and inescapable that focussed the attention of that one examiner on the psychopathology (which was certainly present anyway) that now fit easily into a gestalt of incompetence. In case 3, the patient-defendant started to masturbate during the interview, which confirmed the first examiner's impression that "a lack of ego strength and poor impulse control will militate against his effective participation in the proceedings." The masturbation episode seemed to clinch it for the examiner who witnessed it. The second examiner, unexposed (literally) to the same incident, decided that the patient-defendant, although obviously impaired, would function adequately with good legal assistance and do well if returned to Court. In case 4, an explosive outburst of anger during one of the interviews followed by a general demeanor of hostility and suspicion led the examiner to conclude that the patient's "paranoid preoccupations and antagonism preclude meaningful participation in the criminal proceedings at this time." The other examiner, while acknowledging the presence of paranoid symptomatology and describing the patient-defendant as "labile," felt he could nonetheless be returned to Court. Without the benefit of direct exposure to the paranoid outburst of rage and negativism, the second examiner was able to feel more tolerant and optimistic about pathology that both observed and otherwise described in more or less the same terms. These cases must certainly represent, among other considerations, *counter-transference* phenomena that are perhaps a more pervasive element in competency evaluations than heretofore realized.

III. Language Barrier: In case 5, a Spanish-speaking patient-defendant was interviewed in English during the first examination and in Spanish during the second. Both examinations took place on the same day. The

English examination resulted in a finding of Unfit. The patient-defendant was described as "vague, inattentive, displaying a limited attention span and at times uncooperative." In summing up, the examiner concluded "he is unable to collaborate with his lawyer because of a pervasive Schizophrenic thought disorder that precludes a reasonable degree of concentration, ability to focus on specifics, and *ability to communicate effectively* [italics ours]." The Spanish-speaking psychiatrist experienced only minor communication problems and found the patient-defendant Competent.

Previous studies have indicated that Spanish speaking Schizophrenic patients when interviewed in English are often rated by experienced psychiatrists as significantly more disturbed than when interviewed in Spanish. "Patients interviewed in English demonstrated more content indicative of psychopathology, more frequent misunderstandings of the interviewer, briefer responses, and a significantly higher frequency of speech disturbances . . . . They tended to speak more slowly and with longer silent periods . . . . Unless he is aware of these features, the clinician may interpret them as reflecting increased psychopathology."[13] It may be that the language barrier, as well as contributing to other multiple problems for the Hispanic defendant in the New York City Criminal Justice System, also leads to unwarranted findings of Incompetency in selected cases.

IV. Weighting the Symptoms According to Psychiatric Philosophy and Style: In cases 6, 7, 8, 9, and 10 (fifty per cent of our sample) the examiners saw the same clinical picture, described the same symptomatology, were not differentially exposed to traumatic outbursts, and both interviewed the patient-defendants in English; yet they reached different conclusions as to Competency. This may well be the category that reflects most accurately Judge Bazelon's observation that medicine and psychiatry are in large part an art that applies scientific information and expertise to the care of patients. Here we see the examiners perceiving and reporting identical clinical data, unanimous in their diagnostic impressions, yet at odds when asked to assess what influence these symptoms and their underlying psychopathological processes will have on the patient-defendants' future ability to function in a prescribed specific role with its own probabilistic demands and stresses.

The five cases involved chronic brain syndrome (associated with habitual excessive drinking) with mild confusion and memory impairment of a spotty nature; mental deficiency (mild to moderate) with a degree of inconsistency and ingenuousness; and three cases of paranoid schizophrenia with circumscribed delusions and a general attitude of suspiciousness and evasion. The disagreeing examiners described and labelled these patients in parallel but assessed the *degree* of impairment and *weighted* the symptoms in what appears to be a distinct expression of their psychiatric philosophies and styles. These seemed to be split into two camps: the Guardians and the Green-Lighters. The Guardians tended to be protective, "on the safe side," worried that the worst might happen and must be averted. Their reports contained phrases such as "the defendant does not appreciate the seriousness of his situation and will not be able to assist the defense counsel to his best advantage" . . . or "the defendant is too preoccupied with delusional material to attend to reality demands of a stressful Courtroom situation." . . . . or finally "the defendant already displays abundant evidence of

delusional material and may well come to include the entire proceedings in his delusional system if placed under further stress." These Guardians of the defendant-patients' welfare applied their "scientific information and expertise" in a solicitous and paternalistic fashion which some may find ill-founded but which, for all that, still remains open to judicial scrutiny and adversarial review. The Green-Lighters were more inclined toward a "benefit of the doubt" approach. They responded to the same clinical data with statements like "despite the presence of some recent memory loss, this defendant seems sufficiently alert and aware of the circumstances involved in his case (at least in an overall way) to be declared Fit to Proceed and to return to Court" . . . or "the delusional process seems sufficiently circumscribed so that the patient's reality-testing still allows for an understanding of the charges and an ability to assist counsel effectively" . . . or finally "while his view of the crime is colored by ideas that can only be described as delusional, yet he understands the charges, the nature of the proceedings, and knows that he may be found guilty of a criminal offense, *viz.* that the Judge and Jury may well disagree with his view of things and find him guilty of a crime. He is therefore able to function in Court as intended and should be returned." These examiners were more *laissez-faire,* more optimistic about patient-defendants' future performance, less concerned about a reversal that might discredit their powers of prediction, and inclined to let the chips fall where they may. One of these examiners put it well in a report: "I cannot declare with certainty that this man may not decompensate under the stresses that surely await him in a trial situation. Still I feel this course is more desirable than the alternative delay which has its own stresses. Continuing tranquillizing medication will assist in maintaining healthy personality functioning. At this point I feel he should go on. If at some future time he is unable to function, he can always be returned to the Hospital for further treatment and re-evaluation."

Conclusion

A discussion of ten consecutive cases referred for competency examination by the Court wherein the psychiatric examiners disagreed is presented. Over a twelve-month period, such a disagreement arose in 2.5% of the cases referred by the Court. Factors leading to discordant conclusions were (1) fluctuating psychosis, (2) acting out, impulsiveness, and negativism in the interview situation, (3) language barrier, and (4) weighting the symptoms according to psychiatric philosophy and style. Especially in an area where psychiatry interfaces with the law, a clear and candid acknowledgement of the limits of medical expertise, an openness about the mechanics and "throughput" of psychiatric decision-making, and a scrutiny of areas of controversy are both essential and instructive. In this article, we have attempted to air the issues and discuss the bases of conflict: we do not believe that any study is likely to decisively demolish one side or the other.

We concur most enthusiastically with Ingelfinger:

> The glorious promise of Truth rising from the flames of Controversy is thus probably more visionary than real, but controversy has its own

lessons, whether or not it is headed anywhere. Controversy, moreover, is a fact of medical life – wholesome medical life in our opinion.[14]

TABLE 1

Total Number of Patients Examined for Fitness	1404
Total Found Fit	1001
Percentage	71%
Total Found Unfit	70
Percentage	5%
Total Referred to Hospital to Examine Equivocal Cases	333*
Percentage	24%

TABLE 2

Case No.	Sex	Age	Race	Highest Grade Completed	Charge	Diagnosis
1	M	26	Black	9th	Grand Larceny Jostling	Schizophrenia Chronic Undiff.
2	M	21	Hispanic	5th	Robbery Grand Larceny	Schizophrenia Unspec. Type
3	M	33	Hispanic	9th	Robbery	Reactive Psychosis
4	M	21	Black	9th	Armed Robbery	Schizophrenia Unspec. Type
5	F	37	White	5th	Assault	Schizophrenia Unspec. Type
6	M	70	White	8th	Homicide	Schizophrenia Paranoid Type
7	M	25	Black	12th	Possession Dangerous Weapon	Schizophrenia Paranoid Type
8	M	28	Black	12th	Assault	Schizophrenia Paranoid Type
9	M	25	Black	6th	Rape	Mental Deficiency (mild to moderate)
10	M	47	White	12th	Manslaughter	Chronic Brain Synd. Chronic Alcoholic

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5 Szasz TS: Law, Liberty and Psychiatry. Macmillan Co., 1963
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*These cases were sent on to the Hospital (for further observation and more comprehensive examination to assess their competency) by the first psychiatric examiner in the Clinic. These were cases in which the first psychiatrist felt he could reach no opinion (competent or incompetent) because of the equivocal nature of the patient-defendant's condition, the possibility of malingering which could not be ruled out on the basis of an interview situation alone, a judgment that brief hospitalization (and treatment) might substantially alter the current clinical picture, etc. In any case, these Hospital referrals were seen by only one psychiatrist and do not represent cases of disagreement between the two psychiatric examiners.

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