Legal Conceptualizations, Legal Fictions, and the Manipulation of Reality:

Conflict between models of decision making in psychiatry and law

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(T)he diversity of our opinions does not proceed from some men being more rational than others, but solely from the fact that our thoughts pass through diverse channels and the same objects are not considered by all.
Descartes, "Discourse on Method"

But experience is that the law is predictable in only one respect, that being that you can always be sure that you cannot reliably predict what a given judge will do in a given case. The judge will do as he damned pleases.
Higgins, "*Amicus Curiae*," Boston Globe

When epistemologic problems arise at junctures in relation to the interface between psychiatry and law, the conflicts between these disciplines are commonly based on a fundamental difference in conceptualization, at times, even a clash of models of the world. This article discusses legal and psychiatric models in conflict around scientific data, modes of clinical practice, and the manipulation of reality. An understanding of these models and their conflict may aid in reconciling the two disparate views. Recent judicial decisions and legal opinions will serve as examples.

One important difference to note at the outset is that the legal model lacks the empirical investigative tradition inherent in the scientific model; legal and clinical research seek markedly different data in different ways, producing quite different views of human nature and behavior. Put another way, the legal/judicial system is theory-driven, since the material of that system is best analyzable in theoretical terms. As a consequence, the manner or reasoning employed therein is primarily *inductive* in nature. In this way the evolution of law proceeds from gradual additions to past law; this method has served as the justly valued core of the American common law system.

In contrast, the clinical/scientific system is driven by largely empirical approaches. Consequently this model draws largely on *deductive* reasoning to reach its conclusions. We may anticipate that conceptualizations of what constitute valid data could well be a locus of possible conflict between the disciplines.

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This characterization of deductive vs. inductive approach was chosen to dramatize the different philosophic perspectives from which law and medicine operate. Exceptions to this framework certainly exist. Medicine, at times, uses an inductive approach to problem solving. For example, the only commonly accepted way in which several people can simultaneously develop similar symptoms on a large scale is through the operation of an infectious or toxic agent. This is the general rule that was reached inductively in the case of Legionnaire's Disease to suggest that the causative agent was either infectious or toxic. (It proved to be infectious: Legionella pneumophila.) That is, in thousands of previously known cases this rule had been validated, even though no definitive proof existed for it. Conversely, an example in the legal arena where deductive reasoning is operative was in the judicial creation of the new right for financial support: palimony. The general rule had been that where a couple lived together and supported one another, albeit in different fashions, the spouse with the larger income, especially if male, would provide for the other spouse in the event of marital dissolution. The unexpected conclusion deduced from this general rule was that such support should be provided even when the couple had not formally married.

Modes of Reality

It is important first to distinguish two major forms of reality, often confused, that are germane to our discussion. One is the reality of the outcome of a legal case, the reality of the verdict. The judicial decision in a case represents a reality that does not exist until that moment and could not be discovered before the decision: the verdict *makes* the reality. This legal reality has an inchoate aspect, since a number of developments can alter a verdict once rendered. For example, it may be reversed or vacated on appeal, and later decisions may invalidate the principles underlying the ruling.

Scientific reality differs in crucial respects from legal reality. For example, the properties of a new chemical may be empirically discovered, but they were inherent in the substance to begin with: they are in no way created by the discovery process. Only the precision of the measurement can change. Clinical reality is related to scientific reality through a common empirical basis; the inescapable inclusion of imponderables in clinical matters affects only the degree of precision involved. For example, a study may reveal that one of two cancer treatments is superior in matched populations; and this finding may well serve as a durable guide to practitioners for a number of years, despite the fact that many of the population and treatment variables are unknown or misunderstood at a given point in time.

Thus, it becomes clearer how some judicial opinions are problematic insofar as they confound these modes of reality. Another example to clarify the point is the attempt many decades ago of the Tennessee legislature to pass a law that *pi* (the ratio of circumference to diameter) be set equal to 3,

ostensibly because 3.14159 etc. was too difficult a number to use readily. This is a clear example of confusion between legislative reality (the reality of what is legal in that state) and scientific reality (a mathematical absolute).

Altered Perceptions of Clinical Events

A previously cited case[1] involved a psychotic patient whose father had kept the patient on an idiosyncratic diet emphasizing organic and natural features. Both parents had been involved in intense struggles over this diet and had once taken this matter to court. The father, resisting the idea of antipsychotic medication for the patient during a hospitalization, reluctantly conceded that he might be willing to "compromise" by allowing the patient to receive medication every third day. His apparent intent was to limit the amounts of "unnatural" substance in the patient's system.

This regimen would, of course, be medically ineffective and worthless as treatment. The medication was here clearly being viewed as a purely nutritional event, limited as one might limit intake of dietary substances to every third day. This case of a perception of medication as nonmedical event adumbrates three other altered legal perceptions of clinical events.

The first derives from the Boston State Hospital case, *Rogers v. Okin.*[2] At that time attempts were made to redesign the regulations of the Department of Mental Health regarding involuntary medication, with the intent that the regulations conform with the *Rogers* ruling, yet make safe care of patients possible. Acrimonious debate ensued between clinical and legal parties to the case over the matter of "chemical restraints." This now-obsolete term was then used to describe involuntary medications given in narrowly defined emergency situations, specifically, at the presence or risk of serious self-destructive or assaultive behavior. The legal perspective was that a single dose of medication involuntarily administered was a single *legal* event, which represented the total permissible response authorized by the emergency situation. Clinicians met with legal resistance when they pointed out that medication effect depends on an adequate blood level of the drug in question; thus, an isolated dose of the usual antipsychotic medications did not treat the underlying disorder that was producing the emergency in the first place. Attempts by physicians to extend the permitted course of treatment to medically effective and meaningful lengths met additional legal resistance.

This inappropriate treatment strategy became known as the "one punch, one shot" theory of treatment: a violent, acting-out patient would punch someone and then could receive a single dose of medication involuntarily, perhaps resulting in transient calming. When this dose wore off, the essentially unchanged patient might again assault someone, thus "permitting" a second dose of medication, and the cycle might repeat. This situation bestows on the hapless patient all the risks and none of the benefits of psychopharmacology. The likelihood of tardive dyskinesia may even be increased under this regimen. What is more, some of the comments sent to the DMH by legal associations seemed even to suggest that the medications

should be allowed "by law" to act *physiologically* only for that amount of time prescribed in the regulations!

The issue here is clearly the violation of physiologic reality that can occur when one treats some *medical* interventions, representing points on a continuum of ongoing treatment, as if they were discrete *legal* events: the individual doses are viewed in an insular fashion, rather than as components of a cumulative, hence effective, treatment.

A second example of misperception of the clinical realities of treatment has been elucidated in the *Rogers* case.[3] In this instance, the first five days of an extended period of seclusion were found to be constitutional and the last 25, not so, despite the clinical success of the regimen in preventing serious assault and injury from the very dangerous patient involved. As clinicians know, the careful termination of a seclusion period must take place in a graduated, step-wise fashion to assess the patient's capacity to reacclimatize to the open ward.[4] Once again in this instance the issue is one of a discontinuity of view that fails to reckon with the continuous nature of all human behavior. For the clinician the notion of a constitutional threshold at the fifth (but apparently not the fourth or sixth) day of an uninterrupted, continuous course of treatment is a difficult one to fathom.

The third example is more complex, involving the Massachusetts Supreme Judicial Court case, *In the matter of guardianship of Richard Roe III*[5] (hereafter *Roe*), discussed in detail elsewhere.[6]

In that case the SJC notes:

> We have in the past stated our preference for judicial resolution of certain legal issues arising from proposed extraordinary treatment.

The matter in question is the use of standard neuroleptic (that is, antipsychotic) medication for the treatment of schizophrenia, hardly an "extraordinary" treatment. The context indicates clearly that the term "extraordinary" is used in the sense of the phrase, "extraordinary measures to prolong life."[7]

The significance of the quote is that at a single semantic stroke, the usual is made unusual, thus simultaneously allowing the court to turn to its own precedents in claiming jurisdiction for the matter, as well as making appropriate the invocation of special sanctions for this quite ordinary treatment. The confusion of realities earlier noted may well be at work, in the following manner.

It should be clear that the only realistic way to determine what is an "ordinary" type of treatment is to perform what is essentially an empirical survey of actual, clinical practice. Such an investigation should precisely distinguish what is, in fact, the "usual" form of treatment. Yet it appears that the SJC, eschewing an empirical approach, is here *defining* what is usual as if that were a verdict capable of being rendered by judicial fiat. This "finding of fact" does not result from a study of the facts of outside reality (where the truth of "the usual" must lie) but from a study of the facts chosen by the Court to examine, as will be discussed below.

The court extends this point by stating:[5]

> (antipsychotic) drugs are powerful enough to immobilize mind and body. Because of both the profound effect these drugs have on the thought processes of an individual and the well-established likelihood [*sic*] of severe and irreversible side effects... we treat these drugs in the same manner we would treat psychosurgery or electroconvulsive therapy.

This last remark poses a dilemma in terms of our thesis. The fact that the Court has distorted the best current psychopharmacologic information does not, in one sense, make a difference; the Court may categorize freely and rule accordingly. But it is difficult to avoid the sense that in the above example the Court is committing the rational error parodied by Lincoln, who supposedly asked how many legs a sheep had if you called the tail a leg, and rejected the answer "Five," by retorting, "Four! Because calling a tail a leg does not make it one!" The Court's ruling above appears to lose sight of the profound differences in effect, side effect, indications, and reversibility of the three very different modalities thus grouped together. Consequently, it remains unclear to what degree the Court is functioning within its definitional compass and to what degree it has simply misinformed itself. This result appears to derive from the Court's turning inward, to theory, for its data, rather than outward, empirically, as would seem to be called for, and as the clinician would do.

The three examples above show how differing conceptualizations of certain clinical realities may lead to confusion and disagreement between psychiatry and law as to what constitutes the true state of affairs in the clinical setting. We turn now to interactive problems between those disciplines.

Communicative Difficulties between Legal and Clinical Models

The following dialogue between a judge and a psychiatric expert witness occurred during the *Rogers* trial; it captures the disparities between legal and clinical perspectives in a particularly explicit way. Of special interest is the apparently unnoticed continual shift of models and of clinical and legal conceptualizations of the patient while the conversation is transpiring in court. To highlight these points, the text will be presented verbatim from the trial transcript with periodic interlinear commentary.[8]

To place the excerpt in context, note that the judge is attempting to ascertain why guardianships were not sought for the incompetent, medication-refusing patients who were the plaintiffs in the suit, *Rogers v. Okin*. For perspective we must recall that, although the use of guardians was required by one of the provisions of the opinion in this case, such a procedure was almost unknown previously and was extremely rare; in addition, the case occurred at a time when involuntary commitment was considered inherently to permit, if not actually require, involuntary treatment, as described, for instance, in "Developments in the Law."[9]

Trial Excerpt

DOCTOR: In my opinion, it's acceptable medical practice to intervene with forcible medication prior to seclusion.

JUDGE: Let me ask you this, going back to the depressed patient who is sitting in the corner: you think the patient should take the medication. The patient says, "I don't want to take it." Now, the patient is not threatening anyone, not threatening suicide, just withdrawn. There is no apparent danger to himself or anyone else, at least nothing immediate. Now, at this point, why isn't it a more reasonable, less restrictive alternative to impose on a staff, even an understaffed institution like Boston State Hospital, to have a petition for guardianship taken out? (The judge here proposes hypothetically the very patient most vulnerable to currently conceived right-to-refuse-treatment legislation: the patient in need of treatment, of doubtful competence, yet in no acute emergency. These are the patients who may "rot with their rights on."[10] Note also how the patient is portrayed as quite harmless, clearly not an emergency.)

DOCTOR: That seems to be a very reasonable alternative.

JUDGE: Having this reasonable alternative available, how can you take the position that the patient . . . doesn't have a right to refuse the treatment so long as he or she is not bothering anyone else? (The issue is here couched as a police powers, or dangerousness issue, rather than as a *parens patriae* or need-for-treatment issue. Non-dangerousness is again implied for the hypothetical patient.)

DOCTOR: What I'm thinking specifically of . . . (is) where the individual can't be reached to understand the consequences of not taking medication. (The doctor here introduces the notion of competence, which actually shifts the focus of conversation to that topic and away from the topic of grounds for authority to treat, that is, police powers vs. *parens patriae*; his comment amounts to making and applying a medical determination of incompetence.)

JUDGE: But there's no violence.

DOCTOR: No violence. (Back to the dangerousness mode! The patient is again being characterized as non-dangerous.)

JUDGE: You and I aren't discussing a situation where you make a medical judgment that if this medication isn't taken that this person is going to smack Charlie in the chops: we're not talking about that (Again, emphatically, *not* dangerous) . . . what I'm talking about is the person just sitting in a corner withdrawn, eats meals, not starving to death, just withdrawn, doesn't want to be bothered, and you have reached the point, you say, to yourself, "She's not going to get better unless we give her some medication and bring her out of it;" she says, "I don't want to." At that point, how can you force her to take it? Don't you have to, first of all, go to a court and establish her incompetency, and then deal with somebody you can talk to and who will make decisions for her? (This, of course, was one of the rulings at the outcome of this case; as noted, however, it was not the usual procedure at the time. Note how specifically the judge has delineated both the need for treatment and the nondangerousness of this patient.)

DOCTOR: I find it difficult to try and think about that in general, because . . . the usual practice was if a patient refused medication, under those

circumstances, to sit with the patient and attempt to somehow persuade the patient. If a patient says, "I love you, but I'm not going to take the medications," and he is eating three meals a day, I think it would occur to the hospital to say to the patient, "If you don't want to be treated you are free to leave." (In other words, if the alliance effort fails, and the patient, as repeatedly portrayed by the judge, is *not* dangerous, then the hospital is being used as a hotel or as a custodial setting; it is not at all unimaginable or inappropriate, under those circumstances, that the patient might be asked to leave. This very point was brought out by the Circuit Court's ruling on appeal.)[11]

JUDGE: That is a voluntary patient. I think that's a reasonable reaction: "If you don't want to take my advice, go someplace else." What about the involuntary patient? (In point of fact, the judge's invocation of voluntarity at this point is quite irrelevant; strikingly, the judge in his final opinion reversed his own reasoning as expressed here, holding finally that the voluntary patient could stay and be offered his choice of treatments, a view reversed in turn by the appeals court. The more important point is this: the patient has been repeatedly characterized by the judge as non-dangerous, that is, she would not be commitable if an immediate hearing took place. Thus, even in the event of a previous involuntary commitment, the patient's current clinical condition of safety has been so clearly established by the judge's hypothetical example that it would make no practical difference whether the patient were "voluntary" or "involuntary" on paper, as it were. For example, such a patient might sign out of the hospital unopposed, according to Massachusetts statute.)[12]

DOCTOR: Who was committed for treatment? (The doctor is stumbling over this very point: the judge just reminded him that the patient is now involuntary in the hypothetical, ergo, by definition, dangerous or commitable—but wasn't this patient depicted just a few moments ago as non-dangerous? The sudden apparent shift leaves the doctor understandably confused. In addition we infer that the doctor is, in effect, building a bit of a case for *treating* this patient, in the teeth of the judge's implicit pressure against this course.)

JUDGE: Was committed. He wasn't sentenced. This isn't punishment. (A gratuitous remark, considering that many important standards in mental health over the last decade have been "criminalized," including some standards set in this very jurisdiction (for example,[13]); to add to the confusion, the patient has undergone a pronomial sex-change from "she" to "he.")

DOCTOR: No. (There is not much else one can say.)

JUDGE: The involuntary patient was committed primarily to quarantine that patient from the outside world, hopefully going to be able to be treated and cured; you say an involuntary patient has no right to refuse treatment regardless of any situation, is *that* your premise? (This extraordinary notion of "quarantine" for mental as opposed to infectious illness has been critiqued elsewhere;[14] in the present instance, of course, the wording of this leading question appears prejudicial: if hospitalization equals no more than "quarantine," then treatment really is irrelevant or secondary at best.)

DOCTOR: In a non-psychiatric emergency? (The doctor, apparently still reeling from the last mercurial metamorphosis of this protean hypothetical

patient, seems now to be grasping desperately for some stable condition in the situation!)

JUDGE: Let's get back to our depressed person just sitting in the corner, does the involuntary patient have the right to refuse treatment? (This is the crux of the entire case. The doctor's answer to this question would be irrelevant because the judge must decide this very point. The crucial issue here, however, is that the judge clearly thinks that the second part of his question follows logically from the first; but consider what a complete *non-sequitur* this must seem to the clinician: the patient is quietly depressed and, as earlier portrayed, non-dangerous, yet involuntary, therefore committed for dangerousness: a non-dangerous dangerous patient!)

DOCTOR: I would, looking at the practice, say that the involuntary patient in that situation would have to accept treatment. (Perfectly true for that time.)

JUDGE: Would have to accept forced medication?

DOCTOR: Given a situation of the patient who was psychotic, out of touch, as opposed to someone who was simply saying, "I understand the medication will help me get better, but I don't want any." (Again the scene has shifted to "competent vs. incompetent," without a clear indication that the parties realize that they are addressing a different parameter.)

JUDGE: Take both instances, the patient who says, "Look, I like you, Doctor, I know that it will probably help me, but I just don't want the medication, I don't like the medication, I don't like what it does to me, I don't like what it makes me feel. Come up with something I like and someday I'll take it. Right now, I don't want it. I know that means I'm going to be involuntarily committed here for years." Now, that patient, do you have the right to forcibly medicate him? (This patient is now pictured essentially as competent, based on the way the patient's remarks are portrayed by the judge; the unperceived nuance is that, in real-life clinical situations, a patient who is *that* competent is usually not that sick, so that the doctor's next remark makes perfect sense, even though the judge misses this point.)

DOCTOR: No, I would think about discharging him. (Because the patient is non-dangerous and competent, thus probably not that sick and certainly not commitable; therefore, if that same patient is refusing treatment, one might well think about discharge.)

JUDGE: He's *involuntarily* committed. (Apparently, the judge seems to imply, the patient is now dangerous again, or, at least, was dangerous at the point of his recent "quarantine.")

DOCTOR: The involuntary commitment, as you know, can be broken by discharge (especially since, as depicted verbally by the judge, the patient is competent and not, or no longer, dangerous; the doctor apparently feels he is answering the judge, and does not see, as the judge also does not see, the impossible paradox that this dangerous nondangerous patient has become.) If the patient was in that good touch, was not dangerous to himself or others, and I'm just having a hard time . . . (The hard time appears to be the difficulty of imagining a noncommitable committed patient in a meaningful way.)

JUDGE: What makes him in good touch if he's refusing medication and you

think it necessary for him to get rid of whatever it is that caused the commitment in the first place? (The judge is apparently suggesting that a committed, treatment-refusing patient cannot be all *that* competent—forgetting or not realizing that his own depiction of the patient's comments about medication above portray the patient as essentially competent in clinical terms; both parties appear unable to hypothesize the same patient in the same consistent clinical condition at the same time—a most dramatic example of the incongruity of the two models.)

DOCTOR: I'm thinking of the patient, who is so delusional, who thinks that he is the devil and he deserves to suffer. (In other words, the doctor is picturing an incompetent patient.)

JUDGE: Involuntary?

DOCTOR: Involuntary, yes. (An ephemeral moment of congruity! Unfortunately, this question of voluntarity again distracts both parties from the actual issue now before them, that is, competence.)

JUDGE: But he's not hurting anybody, not hurting himself? (Although committed, the patient is not now commitable—this point appears lost to both parties.)

DOCTOR: Yes.

JUDGE: Can he refuse treatment?

DOCTOR: I would be inclined to have him treated.

JUDGE: Forcibly?

DOCTOR: Forcibly.

JUDGE: Even though there is no emergency in terms of any danger to himself, any physical danger to himself or another?

DOCTOR: In my opinion, he would do well to be treated. (An attempt at temporizing . . .)

JUDGE: We know you feel that way. Can he refuse it? (. . . which fails.)

DOCTOR: I don't think so, Sir.

JUDGE: Do you think that patient might consider it to be punishment to have medication forced upon him when he's not doing anything anyway, just minding his own business, not hurting anybody? He gets a needle up his rear end. Do you think that patient might perceive this as punishment? (This sudden new line of inquiry about the patient's *subjective* perception is, of course, utterly irrelevant to the matter at hand. It is common clinical experience, for that matter, for a patient to interpret *not* being treated as not being cared for or cared about, and thus as being punitively abandoned. This unexpected excursion into punishment and subjectivity apparently throws the witness, with results as may be seen.)

DOCTOR: The problem, your Honor—

JUDGE: Do you understand the question?

DOCTOR: I just want to—yes, I think I understand the question.

JUDGE: Answer it.

DOCTOR: May I make a comment?

JUDGE: Answer the question.

DOCTOR: I don't think I can, Sir.

JUDGE: That's your answer.

As noted in the introductory segment above, the two speakers have vastly different perspectives. Allowances must be made, of course, for the stressful setting and the probable interpersonal tensions perhaps felt, especially by the doctor-witness. The patient in the example, however, refuses to "hold still," as it were, since, as noted in the interlinear discussion, both parties are rarely viewing comparable hypothetical individuals simultaneously.

But is this clearly a question of conflicting models, as opposed to the kind of misunderstanding that can develop as a consequence of the cross-examination process itself? We believe that we can describe the difficulty noted as, in fact, a problem resulting from a clash of models on the following grounds. The judge in this dialogue appears to feel free to create for discussion a patient possessed of *any* characteristics, freely coexisting and combined without regard for clinical consistency; the doctor appears to be trying to visualize a patient similar to some real, actual patient he has known, so that he may base meaningful responses and predictions on this hypothetical individual. Thus the judge's hypothetical model ("Anything may be considered for the sake of argument") and the doctor's clinically based model ("Who that I have seen in clinical practice fits this description?") are at cross-purposes.

Conclusion

An awareness of the difference between clinical and legal conceptualizations, as it affects the manipulation of realistic data, has always proved valuable in improving the interdisciplinary dialogue through increasing understanding of the origins and implications of the principles native to the "other view." More significantly and specifically, careful examination of the data utilized and conclusions drawn in legal decisions can reveal clinical, logical, or conceptual errors or flaws in reasoning. The detection of these may serve the practical purpose of shaping the basis of an appeal, a request for a rehearing, or an *amicus* brief.

While close examination of judicial decisions themselves may be important for the above reasons, the importance of empirical studies to obtain the clinical data cannot be overemphasized. In the adversary system, justice for the patient cannot be obtained without availability of the facts. As educable and receptive as some judges and attorneys may be, the data are irreplaceable. This fact should continue to inspire our close examination and documentation of the facts concerning our time-honored subject who commands our attention: the patient.

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