Reasonable Medical Certainty, Diagnostic Thresholds, and Definitions of Mental Illness in the Legal Context

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Dr. Seymour Pollack frequently used the phrase "reasonable medical certainty" in his forensic reports and in his expert testimony. In at least two articles, he discussed at some length what he meant by that phrase and his rationale for its use:[1,2]

> I also believe that the forensic psychiatrist should be held to a higher level of proof in his psychiatric-legal opinion-making than is customarily required. We need more certainty in determining a mental state or psychopathological condition for legal purposes than we do in identifying it for treatment purposes.[3]

Pollack justified the necessity of this higher level of proof in forensic psychiatry:

> The treating psychiatrist can change his initial clinical impression as a result of his ongoing relationship with the patient and his evaluation of response to treatment. Such monitoring is difficult, if not impossible, in the usual practice of forensic psychiatry. Also, the legal consequences of judicial decisions based on psychiatric opinion may be quite serious. If the psychiatric opinion is to be influential in determining the final decision, it should be offered with as high a level of confidence as possible.[4]

Pollack accepted as valid differences between clinical, social, and legal definitions of mental illness. He stated:

> To some extent all forensic psychiatrists experience conflict in being required to use legal definitions and concepts of mental illness that differ from those definitions and concepts traditionally used for treatment purposes.[5]

Pollack also accepted a differential threshold for the diagnosis of mental illness for treatment purposes and for legal purposes. Recognizing the problem of false positives, he agreed that the risk of overinclusion and overprediction is more desirable than overlooking mental illness. However, he adds:

> By contrast, however, the threshold for legal definition of mental illness is considerably higher than that for treatment definition. In other words, fewer people are identified as mentally ill for legal purposes than mentally ill for treatment purposes.[6]

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Pollack's position is bolstered by the assertion of some appellate courts that have adopted a similar distinction between clinical and legal definitions of mental illness. For example, the Court of Appeals for the District of Columbia Circuit, in *McDonald v. United States*, stated:

> What psychiatrists may consider a "mental disease or defect" for clinical purposes, where their concern is treatment, may or may not be the same as mental disease or defect for the jury's purpose in determining criminal responsibility. Consequently, for that purpose the jury should be told that a mental disease or defect includes any abnormal condition of the mind which substantially affects mental or emotional processes and substantially impairs behavior controls.[7]

The original Model Penal Code of the American Law Institute test of insanity also includes a legal definition of mental disease in its second paragraph, the caveat, which states:

> . . . the terms "mental disease or defect" do not include an abnormality manifested only by repeated criminal or otherwise anti-social conduct.[8]

In this article I intend to discuss the following questions: (1) What is meant by the phrase "reasonable medical certainty" and should there be a higher level of proof for psychiatric diagnoses in the legal context than in the clinical context? (2) Should the threshold for the diagnosis of psychiatric illness be higher and the definition and diagnostic criteria be different in the legal context than in the clinical context?

Reasonable Medical Certainty

I believe Pollack's concept of reasonable medical certainty is valuable because without such an expression of the level of confidence of the psychiatric expert witness, it is difficult, if not impossible, to relate the medical testimony to the traditional levels of evidentiary proof.

These traditional levels of proof are (1) probable cause, the lowest level; (2) preponderance of evidence, meaning 51 percent; (3) clear and convincing evidence, meaning more than preponderance, but less than beyond a reasonable doubt; and (4) proof beyond a reasonable doubt, meaning at least 90 to 95 percent.

Each legal process that calls for expert psychiatric testimony has its own requirement for level of proof. For example, very short-term commitments usually require only probable cause; longer commitments are required by the United States Supreme Court to be proven by clear and convincing evidence.[9] The California Supreme Court requires proof beyond a reasonable doubt for conservatorship proceedings and long-term commitment.[10] Criminal convictions always require proof beyond a reasonable doubt, yet a criminal defendant in most jurisdictions can be exculpated by proof of insanity by a preponderance of evidence.

Reasonable medical certainty, in my opinion, should express the psychiatrist's highest level of confidence in the validity and reliability of his opinion. This level of confidence must, necessarily, be formulated within the matrix of clinical experience and scientific knowledge. It cannot be directly translated into the legal scale of levels of proof. It is the obligation of the trier of fact, rather than the expert witness, to make that translation in its decision of the ultimate issue, the verdict.

Confidence in the validity of a clinical opinion rests upon a dual foundation: the validity of the underlying scientific knowledge about the issue in question and the validity and reliability of the application of that scientific knowledge to the particular case.

To illustrate, for a psychiatrist to express an opinion with reasonable medical certainty that a given individual is suffering from schizophrenia requires that there be a fund of knowledge about the condition known as schizophrenia. This fund of knowledge must not be idiosyncratic to the particular expert, but must be knowledge generally shared by the relevant scientific community. There must be generally agreed upon definitions of schizophrenia and the parameters of the condition must be reasonably well defined. There must be minimal conditions (i.e., symptoms and manifestations) which must be present to warrant the diagnosis and also criteria which permit one to distinguish schizophrenia from other conditions.

Without this underlying fund of scientific knowledge, there can be no reasonable medical certainty. But this underlying knowledge is not in itself sufficient. There must be the application of this knowledge to the particular individual. Thus, the psychiatric expert must express his confidence in the existence of a condition known as schizophrenia and the known effects of that condition upon human behavior. He must then claim a high probability that the individual in question actually has that condition and that the inferences which he has made concerning the effects that condition has had on the behavior of that individual are clinically justified. Only then can he claim reasonable medical certainty for his opinion.

I emphasize that an expert opinion, expressed in such terms is, of necessity, a clinical and scientific judgment, not a legal judgment, and that no concessions should have to be made to legal standards or definitions. The legal standards and definitions come into play when the clinical opinion, expressed with its appropriate level of clinical probability, is interpolated into the ultimate issue. Thus, in a criminal trial, the psychiatrist may express his opinion that a defendant is mentally ill, that he is suffering from chronic paranoid schizophrenia, that his illness existed throughout a particular period of time, and that it affected the defendant's thinking, feeling, judgment, control, and behavior in certain ways. By using strictly clinical and scientific criteria, the expert forms his opinion to the highest

possible level of probability—hopefully, to the level of reasonable medical certainty.

To make legal inferences from this clinical information requires knowledge and use of appropriate legal definitions and criteria. The type of legal inference permitted to the expert witness will vary and if it reaches the ultimate question, and depending upon the legal issue and the particular jurisdiction, it may be prohibited. For example, in a criminal trial on the issue of insanity as defined by the ALI rule, the psychiatrist may properly express his opinion of existence and nature of the defendant's mental illness, how the mental illness affected his ability to appreciate the criminality of his conduct or his ability to conform his behavior to the requirements of the law, but he may not, in many jurisdictions, express an opinion that the defendant is either sane or insane. Note that while the existence and nature of the mental illness are determined by clinical psychiatric criteria, concepts such as "appreciate the criminality of his conduct" or "ability to conform his behavior to the requirements of the law" are legal issues, and the expert must accept the legal constraints on their meanings.

Some authorities would contend that all components of an ultimate issue are themselves ultimate issues and thus denied to the expert witness. They say that because "mental disease or defect" is a component of the ultimate issue of insanity, it is, itself, an ultimate issue which can only be decided by the jury. In this view, the psychiatrist should not be allowed to state whether the defendant does or does not suffer from a mental illness nor give an opinion about any other component of the legal issue before the jury. He would be permitted, however, to describe the psychopathology demonstrated by the defendant and the jury (or judge) would decide whether a mental disease or defect existed.

I believe this position is incorrect and that it caricatures, rather than expresses, the intent of the law. The ultimate issue, in this example, is expressed in the verdict: guilty, not guilty, or not guilty by reason of insanity. The components of this ultimate issue are issues, but not ultimate issues. To deny the expert an expression of opinion about these component issues is to so seriously limit his role that one may question whether it might not be wiser to eliminate him altogether from the legal process.

The assertion has also been made that the psychiatrist has no expertise outside of strictly clinical issues and that he should not be permitted to testify on any legal issues even though they are not the ultimate issues. He should, therefore, describe in his testimony the mental condition of the subject and leave all inferences and legal issues to others. This may well be so in the case of the psychiatrist practitioner who has had no experience outside of the clinical realm. But the designation "forensic psychiatrist" implies a knowledge, skill, and expertise which includes the kinds of

inferences which are required to make a rational legal decision, and most certainly he should possess a knowledge in depth of the legal definitions, standards, and procedures relevant to the case.

Many legal terms have specialized meanings which differ from their ordinary meaning. For example, "malice aforethought" does not necessarily denote anything resembling the ordinary meaning of malice or malicious nor does it necessarily imply premeditation. Many legal terms have been modified by judicial decisions or statutes which apply only to certain jurisdictions. If the psychiatrist is not familiar with the proper meaning of these terms and uses them incorrectly, his expertise as a forensic psychiatrist should certainly be questioned.

The expert witness may not be able at all times, on all issues, to reach the level of confidence implied by reasonable medical certainty. He may testify, for example, that schizophrenia is, with reasonable medical certainty, an illness which is manifested by delusions and hallucinations, impaired judgment, and distorted affect. But he may also qualify his opinion by stating that it has not been possible to determine with that level of confidence whether the defendant is actually suffering from that condition. If the clinical facts warrant, he could testify that the defendant has many of the symptoms usually associated with schizophrenia, but that certain symptoms are those found in manic-depressive psychosis and that it is not possible to give more than a probability answer (say, two to one odds) that the defendant is schizophrenic. He may also properly state that, regardless of the uncertainties of the diagnosis, he is of the opinion, with reasonable medical certainty, that there existed at the time in question an impairment of judgment and self-control which made it impossible for the defendant to control his behavior as would a normal person. One can conceive of all possible mixtures of varying levels of probability and uncertainty with some difficult, complex cases. Yet, for each significant element of the expert's testimony, he communicates to the trier of fact, his level of confidence.

I do not think that the law requires a higher level of proof from the psychiatric expert than he would normally use in clinical practice. The expert can only express the levels of proof which his clinical observations and his scientific knowledge allow, but it is exceedingly important that he accurately communicate to the trier of fact the levels that do realistically exist for each component of his testimony.

This is, I believe, what Seymour Pollack was striving for in developing his concept of reasonable medical certainty. However, I believe it was an error for him to link this with other issues such as a legal or social threshold for diagnosis of mental illness which differs from the clinical threshold, or that the definition of mental illness can differ in the legal context from that which has been accepted in the clinical context.

The Threshold and Definition of Mental Illness

I believe it is wrong to concede any threshold definition of mental illness other than that determined by scientific and clinical knowledge. We may agree that the present state of our knowledge does not allow us to precisely define that threshold in many cases. We may even agree that with some forms of emotional and psychologic disorders it is likely that no threshold exists. There is much valid clinical information which suggests that many psychopathologic conditions exist on a spectrum which extends from the normal, on the one hand, to the seriously disturbed, on the other, with no clear delineation of the normal from the abnormal. But other conditions, and I believe the major psychoses to be such, can be, or ought to be, clearly differentiated from the normal, with a diagnostic threshold established by appropriate clinical experience.

DSM-III represents a good start in this direction and the diagnostic criteria which are there set forth can represent, *for the time being*, the diagnostic thresholds with reasonable medical certainty. Obviously, they are not the final word, for as for all scientific knowledge, constant revision and refinement are required.

This clinical threshold is the only threshold for the definition of mental illness that I am prepared to recognize. I do accept, however, that there are other thresholds for social and legal intervention in the lives of mentally ill persons, and that those thresholds can be much higher (or conceivably lower) than are customary for clinical interventions. Thus, I insist that the diagnosis of mental illness is strictly a clinical matter to be determined in all instances by clinical criteria and definitions. But the point at which society determines a mentally ill person is sufficiently disabled to warrant invoking a *parens patriae* intervention is a social and legal decision whose threshold can be much higher than that required to establish a diagnosis of mental illness. Similarly, it is not up to the law to establish the threshold for the existence of mental illness in a criminal defendant. But it is up to the law to determine what particular forms and degree of psychopathology it will recognize as exculpatory.

The three distinguished psychiatrists who participated in the drafting of the ALI rule of insanity in the Model Penal Code emphatically opposed the caveat paragraph, maintaining that it is not the business of the law to decide what is or is not a mental disease.[11] They were quite right; it is no more within the province of the law to define mental illness than it is within the province of medicine to define exculpatory insanity.

It was the intention of the committee which drafted the ALI rule to exclude from the insanity defense persons suffering from sociopathic personality disorders and who were not otherwise mentally ill. This could have

been accomplished without intruding upon clinical territory by directly specifying those conditions, mental illness, or not, which do not exculpate even if they meet other criteria, such as causing the defendant to lack the ability to appreciate the wrongfulness of his conduct. One may challenge the wisdom of such a restriction, but not the right of the law to so restrict the application of the insanity defense or any other legal intervention it so chooses.

Because the net effect is the same, one might question whether this is only a trivial distinction from the actual draft of the ALI rule. However, it is precisely this failure to distinguish territories that has led to so much confusion and lack of understanding of the proper role and function of the expert witness. The law has usurped medical functions and psychiatry tends to usurp legal functions, to the disadvantage and mutual recriminations of both disciplines.

Conclusions

The phrase reasonable medical certainty is a valid and valuable expression of the level of confidence maintained by the psychiatric expert witness for his opinions. It is a clinical concept with its roots in both the relevant fund of scientific knowledge and the specific clinical observations of the psychiatrist. Although consideration by the trier of fact of this clinical level of confidence is relevant to the legal standard of proof, it is not synonymous or contiguous with any of these legal standards. The definitions of mental illness and the criteria for diagnosis should be determined solely by scientific and clinical standards, and the law should not encroach upon scientific territory by creating its own definitions of mental illness and its own threshold levels.

The ultimate issue to be decided by the trier of fact contains a variety of component issues. Some of these component issues are strictly matters of science and clinical knowledge, others are purely legal, some are, perhaps, hybrid. Even though the psychiatric expert may be prohibited from expressing an opinion about the ultimate issue, he should not be prevented from expressing opinions about the component issues, providing he does, in truth, possess the requisite expertise.

Addendum

California appellate courts have increasingly indicated that, at least in medical negligence cases, the proper word is "probability" rather than "certainty" (*Barton v. Owen*, 71 Cal. App.3d 484; 139 Cal. Rptr. 494). I favor dropping the phrase "reasonable medical certainty" altogether and have the expert testify only as to "reasonable medical probability." This

would be more in accordance with scientific reality. However, the issues discussed in this article would not change; they would be equally relevant to reasonable medical probability.

References

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3. Pollack, note 1, *supra*, at p. 195
4. Pollack, note 1, *supra*, at pp. 195–196
5. Pollack, note 1, *supra*, at p. 197
6. Pollack, note 1, *supra*, at p. 196
7. *McDonald v. United States*, 312 F.2d 847, 851 (D.C. Cir. 1962)
8. See *Wade v. United States*, 426 F.2d 64, 72 (9th Cir. 1970) for discussion of this caveat and reasons for its rejection
9. *Addington v. Texas*, 441 U.S. 418, 99 S.Ct. 1804, 60 L.Ed. 323 (1979)
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