Analysis and Commentary

Do Juries Listen to Jury Instructions?

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The author reports the case in which he was sued for medical malpractice. A nonunanimous jury found in favor of the plaintiff. Interviews of two of the jurors revealed that the jury discounted the expert testimony on both sides, the evidence, and the jury instructions. The author, finding that the jury decided the case based upon it's perception of the physician's "bedside manner," concludes that juries expect psychiatrists to behave more like friendly family doctors than objective psychoanalysts.

The patient was first treated psychiatrically at age 20 when he was admitted to the county psychiatric hospital in Grand Rapids, MI. He was again admitted to the same hospital at age 21. Schizoaffective psychosis was his discharge diagnosis for both hospitalizations. At the time of the second admission, the patient banged on the hospital windows, saying that he wanted to be admitted. He was told to go to the general hospital emergency room and get certified, which he cooperatively did. He then came back to the psychiatric hospital and was admitted.

The patient's third hospitalization, at age 29, was to a private, for-profit hospital in Grand Rapids, the Forest View Psychiatric Hospital. Upon admission, his behavior was bizarre. He walked out a fire escape door and came back in the front door. He put his arm around the neck of another patient's visitor, behavior that was described in the hospital chart as disruptive but not violent. Other than this incident, the patient had no history of violent behavior in his lifetime. He was then transferred by sheriff's deputies to the county psychiatric hospital where he had previously been treated. This time, his discharge diagnosis was bipolar disorder, manic.

In 1986, his treating psychiatrist retired, and the patient asked me to be his psychiatrist. I saw the patient seven times when the patient was age 30 to 33 years. The first of these appointments was a 45-minute diagnostic evaluation. The other six appointments were 20-minute semiannual medication management appointments. During that three and one-half year period, the patient became gradually less compliant about taking his lithium as directed, being seen every six months, and getting his serum lithium level measured every six months. How-

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ever, the patient was symptom free. His mood was never manic or depressed.

The patient's seventh appointment was in January 1990. On Thursday, October 18, 1990, the patient's wife called my office at 5:40 PM. I returned her call at 6:00 PM. She said the patient (age 35) was having a flare-up of mania, that he was cooperative, and asked if he should be hospitalized. I assessed the urgency of the situation and replied that hospitalization did not seem indicated at the moment. I recommend that she bring him to my office for the first appointment the next day at 9:45 AM. She agreed to this suggested plan. No untoward events occurred during that night.

On the next morning, Friday, October 19, 1990, the patient and his wife were seen by me in my office. The patient was cooperative, but his behavior was unusual. He followed instructions for about 15 minutes, until I told him I would bring his wife in so I could gather more information. At that point, he walked out, not responding to my verbal instructions to stay in the examining room. He walked out of my office, out of the building, and down the road to the private psychiatric hospital where he had been admitted previously for less than a day. That hospital was two buildings away, about 100 yards. He smashed his way in, through the receptionist's window. He began smashing windows and trashing offices in the business area of the hospital. He did not threaten or harm any other person. He sustained mild lacerations and bruises from breaking windows.

The hospital personnel, not knowing who this was, called the sheriff. Ten deputies responded. When the deputies approached him, the patient challenged them to try to subdue him. He was a large man of much greater than average strength. They finally subdued him with night sticks, including blows to his head. Seven deputies were treated for injuries at the general hospital emergency room. The patient was treated at the general hospital emergency room for lacerations and a fractured hand. He was then committed to the state hospital in Kalamazoo, MI.

The patient had been charged with malicious destruction of property, resisting arrest, and obstructing justice. In July 1992, the patient's plea of not guilty by reason of insanity was accepted by the court.[1]

On October 16, 1992, I was sued in state court for malpractice by the patient and his wife (Case No. 92-78900 NH, Circuit Court, Kent County, MI).[2]

The patient also brought a separate suit in federal court against the sheriff's department for deprivation of his constitutional civil rights (police brutality). At some time in 1994, that suit was thrown out of court by the judge, even before going to trial. The judge determined that any interpretation of the facts was insufficient to show "excessive force." The judge therefore determined that the patient was not entitled to try the case before a jury. The county then settled with the plaintiff for a nuisance amount in order to stop the plaintiff from appealing that decision. (It should be noted that federal judges are more likely than state judges to dismiss cases without a jury trial.)[3]

The Trial

On February 26, 1996, my malpractice trial began.

The factual dispute focused on the October 18, 1990, phone call. The plaintiff, now age 41, claimed that I should have performed an assessment at the time of that call, which would have prevented the events of the following day, including the beating by the sheriff's deputies. The defense expert claimed that only the urgency of the situation needed to be assessed that evening, not the clinical condition of the patient. The plaintiff's expert agreed that evaluating the urgency may have been sufficient, depending on the circumstances.

Regarding damages, the plaintiff claimed that his headaches have robbed him of the enjoyment of life, and he now socializes less. He denied any decrease in sexual frequency with his wife. He claimed that his character was defamed because the news media let all his friends and fellow factory workers know that he has a mental illness. He was described by the news as "The Incredible Hulk."[4]

The jury consisted of four men and three women, all middle age, all white, all middle class, all employed except for two women who were homemakers. During it's deliberations, the jury came back twice to ask questions: (1) was the jury to use the standard of ordinary negligence or those of professional negligence? (2) What does consortium mean?

The Verdict

After 11 days of testimony and 3 days of deliberations, the jury found in favor of the plaintiff, awarding $157,250, based on the following breakdown: $64,000 for the patient's past noneconomic damages (pain and suffering); $35,000 for the patient's past economic damages (primarily medical expenses); $10,000 for the wife's past loss of consortium; $30,000 for the patient's future noneconomic damages; $15,250 for the patient's future economic damages; and $3,000 for the wife's future loss of consortium.

The jury found 0 percent comparative negligence on the part of the plaintiff.

Jury Interviews

Two jurors were interviewed by the defense attorney after the verdict; one was the only dissenting juror. The jurors reported the following:

1. Initially, four jurors favored the plaintiff, one favored the defendant, and two were undecided. Six jurors supported the final verdict and one dissented. Unanimous verdicts are not required in Michigan.

2. The concurring juror felt that the phone call on the evening before the incident should have received more attention than it did, because it was the only such phone call in the four years that I treated the patient.

3. The jury felt that my testimony presentation at the trial was distant and lacked warmth. They found my office notes were dry and did not reflect interaction with the patient on a personal level. The jury sensed that I was dispassionate and technical with the patient.

4. The jury felt that I was too method-

ical in handling the patient's crisis and that this patient's crisis should not have been handled in a methodical manner.

5. The issue of my negligence was hotly contested. The jury struggled with its instructions to use the definition of professional negligence (what a psychiatrist of ordinary learning, judgment, or skill would do). Instead, they seemed to use the definition of ordinary negligence (what a person of ordinary learning, judgment, or skill would do in the same or similar circumstances).

6. The jury analyzed the case on an interpersonal level more than on a professional level. (I interpret this to mean that my "bedside manner" was on trial, not my professional judgment.)

7. The jury's discussion was exhausting and extremely emotional. Their deliberations included yelling. They fought over the question of the plaintiff's comparative negligence. My lawyer said this was one of the longest deliberations (three days) of which he is aware in a civil case.

8. The jury felt that I should have made a preparatory phone call to the hospital saying that the patient might be admitted.

9. The jury felt that if the doctor (i.e., the defendant) had wanted to get the patient into the hospital quickly, he could have done so. (I had explained to the jury that the year of this incident was the first year that the patient's insurance, Blue Cross and Blue Shield of Michigan, required doctor-to-doctor phone contact to obtain certification for admission before the insurance would cover the admission. At that time, I could not call a Blue Cross doctor directly, however. I had to leave a message for the Blue Cross doctor and wait for the doctor to call me back.)

10. The jury felt that the plaintiff's behavior was somehow foreseeable, like an explosion is foreseeable to a fireman who is fighting a brush fire.

11. The jury was troubled by my lack of action when the patient walked out of my office. The jury felt I should have followed the patient into the parking lot or called the hospital. (I had explained to the jury that I assumed the patient was going to his car to wait while I talked to the wife; I explained this to the wife at the time; she did not follow the patient to the parking lot either.) None of the experts testified that my failure to follow the patient was a violation of the standard of care.

12. After the wife and I talked and we then saw the police cars going down the street, we knew that something was happening, but we did not know that the patient was involved. The police cars could have been going to a different building on the street. I asked the wife to remain in the waiting room until we learned from the hospital whether the patient was there. Because, in the past, the patient had neglected my office policy of payment at the time of service, I asked the wife to pay his bill for that day's appointment while she was waiting. The jury was bothered by my asking her to pay the bill.

13. In the factual dispute over whether the patient was taking his lithium as directed or not, the jury concluded that he was taking it, and that he was not negligent.

14. The deliberations over the issue of the patient's comparative negligence focused on his failing to keep his appointments every six months as directed. (The incident in question occurred nine months after the patient's last semiannual appointment.) The jury concluded that the patient was not negligent.

15. The jury was not swayed by any expert witness, plaintiff, or defense.

16. The members of the jury felt no anger at me, and their verdict did not represent any personal feelings about me.

Conclusions

1. My attorney concluded that no jury misconduct warranting an appeal or post-trial motion had occurred.

2. My attorney was selected and paid by my malpractice carrier, the American Psychiatric Association-sponsored coverage. I felt that he was very competent and that he handled the case appropriately.

3. I feel that the jury made the wrong decision, the same as in the O.J. Simpson criminal trial jury.

4. My attorney, however, feels that this case is different from the O.J. Simpson case, because the jury in this case did struggle in its deliberations, and "The case just came out the wrong way." He feels that this case does not illustrate that the jury system is a bad system. He feels that this case was a factual dispute that was well fought, but lost.

5. My conclusion is that the patient did not listen to my instructions, and the jury did not listen to the judge's instructions. Thus, the jury identified with the patient and disregarded the facts and instructions.

Lessons to be Learned from This Case

1. Juries do not always understand the jury instructions.

2. Juries do not always follow the jury instructions.

3. The issue on which a jury decides a case is not necessarily the issue they are specifically instructed to consider. The jury decides which issue it will use as the basis for its decision.

Discussion

My residency training, (1968 to 1972) was psychoanalytically oriented. I was taught to be objective and not personally involved with patients. Because this case did not focus on technical issues such as diagnosis or pharmacotherapy, personality issues emerged. The jury seemed to judge this case on the basis of—more than anything else—how warm a person (not how warm a physician) I seemed to be compared with the patient. It found me cold, and rendered a verdict against me.

In the short time since the verdict (two weeks), I have found myself being less formal with patients, joking more with patients, calling patients more often just to check on them, and even being more lenient with the beginning and ending times of appointments. I find myself behaving as a warmer person and less as a formal physician. However, being warmer and less formal has its risks also. Greater informality increases the risk of blurred boundaries for both the patient and the doctor.[5]

The challenge presented to the treating

psychiatrist is to be warm and casual enough to be recognized as caring and concerned, but not so informal as to appear to breach doctor-patient boundaries. Formality in treating patients, record keeping, and testimony to a jury can be seen as cold and uncaring. In this age of managed care, when psychiatrists are more likely to be medication managers than psychotherapists,[6] patients and jurors seem to expect psychiatrists to act more like family doctors and less like psychoanalysts.

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