Using a Moot Court Experience in the Education of Psychiatric Residents

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Introduction

This paper describes an educational experience for psychiatric residents that can serve both as an introduction to the interface of law and psychiatry and to issues related to assuming a professional role. This experience centers on participation with law students in a moot court or similar exercise. For the past three years, psychiatric residents and law students have been participating in such exercises as part of the Community Clinical Law Project, a clinical law seminar at Columbia University Law School, taught in conjunction with psychiatric services affiliated with the university's medical school.**

This kind of experience is rare in psychiatric training. In a recent survey of forensic psychiatric education, Sadoff does not report any programs utilizing participation by residents in a moot court and reports little or no contact between law students and medical students or residents in interdisciplinary educational efforts.[1]

Teaching about the relationship between law and psychiatry presents special problems during psychiatric training. Unlike clinical decision making, residents' legal decision making is rarely examined in rounds, conferences, or supervision. Residents may often not be aware of the full legal significance of discussing a case with a relative or filling out commitment papers. Few ever become involved in a legal proceeding where they could get first hand experience with the legal process, so that whatever didactic exposure they get is not grounded in experience.

Consideration of how the legal viewpoint differs from that of psychiatrists can generate heat as well as light. The two professions are committed to systems of values which can be conflicting and often appear to be in opposition when put into practice. This clash in values can lead to confrontation and polarization, particularly when the practical outcome of an interaction between the two professions can result in one or the other giving up a measure of control in a situation as, for instance, in the addition of numerous legal procedures to commitment proceedings.

Whatever exposure to law is going to take place in a residency training

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program must do so in the atmosphere created by recent interactions of the two professions. This climate is reflected in published responses of candidates for major offices in the APA to a question on the patients' rights issue.[2,3] These comments indicate worry about the practical consequences of legal interventions for psychiatric treatment, distrust of the legal system by some, a sense that psychiatry has lost ground, and no assurance that the profession is getting its point of view across in the courts.

Getting residents to recognize the legal implications of their decisions could also complicate their daily work. It is simpler and often appropriate to see a medication refusal or sign out letter as essentially a clinical issue.[4] The law and legal principles involved in these situations are complicated, and their specific applications are not always clear.

These educational problems are difficult to overcome by most traditional educational approaches. The apprenticeship model, effective for teaching clinical skills, suffers from most practitioners' lack of legal sophistication. Didactic teaching or seminars based on case material do not offer the opportunity for the examination of the lawyers' and psychiatrists' actual behavior under the pressure of human problems and institutional processes. The kind of experience described here has promise of overcoming some of these obstacles.

By using exercises that highlight the differences in approach of psychiatrists and lawyers, residents can be helped to see that where they, as psychiatrists, make decisions in complex human situations, they are imposing a value system as well as introducing objective, scientific considerations. This value system tends to emphasize the usefulness of the disease model applied to behavior and thinking, the value of treatment, the need sometimes to protect people from themselves, and other values that are sometimes in conflict with those espoused by other groups and individuals in society. It has been one of the tenets of those teaching in this program that it is important for both lawyers and psychiatrists to confront this issue as part of professional training. Doing this as part of training may limit the anger, feelings of misunderstanding, and other defensive reactions by professionals that often seem to accompany challenges to their role by other segments of society.

Course Methodology

The moot court experience was developed as part of a clinical law seminar for second and third year law students. The course is based on experiential learning by the law students with the focus as much on examining the professional role of lawyers as on the substance of mental health law or legal procedure. The law students are assigned to psychiatric services (the in-patient service, day hospital, clinics, etc.). They do not deal principally with commitment issues (for which legal counsel is provided in New York State through the Mental Health Information Service), but rather provide patients a range of legal assistance, with landlord-tenant, domestic and criminal law problems. The seminar part of the course is used to prepare for and examine this experience.

The law students get to know psychiatric residents through their placements, as many of their clients are also patients of residents. About six

weeks into the semester, residents are asked if they would be interested in participating with the law students in a moot court exercise. The residents are given some review articles and court decisions as background, but the

and one-half hours and is videotaped, for later review. The use of videotape equipment is important as a convincing record of what went on for later discussions and as direct feed-back to participants on their participation.

Case Example

For the moot court exercise described below, we created as our patient a 51-year-old woman widowed for two years and unemployed for the past six months. She lives alone. Three months prior to her admission she becomes depressed. She moves in with her married daughter for support and six weeks prior to admission begins seeing a private psychiatrist for drug treatment and psychotherapy, which have little effect. On the evening of her admission, her daughter brings the patient to the hospital because some statements the patient made that day seem to have suicidal implications.

The patient's history and examination are typical for a severe agitated depression. She is vague about suicidal intent. There are no organic mental signs, hallucinations, or somatic or other specific delusional ideas. The patient says that 24 years ago she received ECT for an illness following the birth of her son, but she remembers few details.

In the hospital, the patient is continued on antidepressant and phenothiazine at increasing doses. She complains of side effects, and on the thirteenth day refuses the medication. She then agrees to ECT, but changes her mind the morning of the first treatment. The hospital files papers to have her status reverted to involuntary and ECT given by court order. In a few days, the patient agrees to go back on the medications and the court order is not pursued. Finally, after some more problems with the medications, including a fall, she again refuses medication. At the end of the hospital records, the patient is willing to stay in the hospital but refusing all treatment.

The facsimile hospital record contains a very large amount of information about her past history, her clinical status, her family relationships, the course of her treatment and her reactions to it, and other material one would expect to find in a record. Unlike an actual patient, however, the details of this patient's history were selected to serve our educational purposes, although they are consistent with actual case histories.

For instance, we did not want to focus on whether the patient's treatment represented an attempt to control deviance more than relieve suffering. This reason helped us decide on a depressed patient. We also wanted tension over whether the patient's refusal of treatment was competent or whether it was influenced by her illness. Depression seemed preferable as the patient's condition can be serious while her refusal to accept treatment is neither obviously a product of psychotic thinking nor free from influence by the illness. We did not want our patient to be a simple case, either for involuntary retention or release. In particular, we were careful to include ambiguous expressions of suicidal intent in her record.

The patient's refusal of further treatment is intended in the chart to have multiple possible causes. The treatment she has received has not done her much good, and there have been side effects. The struggle over treatment can be related to other struggles in the patient's life – with her daughter and late husband. Also, refusing treatment can be seen as part of a depressed patient's

need to suffer.

Similarly, the case indicates how a psychiatrist's actions may serve to relieve others of responsibilities. A possible disposition for the patient is to return to her daughter. It is the daughter, however, who brought her to the hospital, and throughout expresses her reluctance to have her mother return to her if she is not cured of her symptoms.

As a final point, the case deliberately allows speculation as to whether the existence of the power of commitment almost automatically brings an adversarial quality to the doctor-patient relationship. Long before he has any intention of doing so, the patient's doctor mentions involuntary transfer to a state hospital as a possible outcome of her refusal of medication. Later, the patient gives her fear of forced treatment as one of her reasons for not returning from a pass. At the end of the record, the doctor tries to be more supportive of the patient's need to feel in control, but is unable to repair the alliance.

Legal Status

Along with the hospital record, a status of the case memorandum outlining the legal situation of our patient as of the last day in the record was distributed to the participants. This memorandum details the various ways the case could end up in court based on what has happened so far to the patient. The memorandum also indicates other legal issues raised by the case that may call for hearings or other steps besides a court hearing. In addition to detailing the legal issues, the memorandum specifies the proper procedures to follow according to New York State law and regulations.

The legal situation presented by the case was summarized for the participants under three major issues. First, at one point in the patient's hospitalization, the hospital filed court papers to have her status converted to involuntary, necessary under New York law for any forced treatment, and to request permission to give ECT without her consent, which can only be done pursuant to court order.[5,6] The request to give ECT is considered to be part of the moot court hearing unless withdrawn by the hospital. Second, the patient may request that her conversion to involuntary status be considered at our moot court hearing as well. The third major legal question is the use of forced medication. If the patient's doctor and the unit chief want to give the patient medication against her will, they are instructed to communicate this decision to the patient's counsel. The patient's side may then under New York regulations request a review by the hospital director (not a participant in the case) which we would arrange.[7] Should the hospital director decide to allow forced medication, the patient's side could seek an injunction, and a hearing on that request would then become part of the moot court.[8]

Pre-Court Deliberations

The participants were given the hospital record and status of the case memorandum several weeks before the date set for any eventual court hearing. Depending on their decisions, there could be no court hearing or one on several issues as well as other proceedings. We hoped we had presented them with a situation with problems close enough to the

experience of both law students and residents to engage their serious attention and identification.

As we lacked a real patient for the residents and law students to work with, we tried to compensate by allowing them to direct inquiries to us that they would like to direct to the patient. We responded either directly or through additions to the patient's chart. To keep things from being too hectic, we set a date several days before the court date as a cut-off point after which there could be no further communication with the patient or changes in position.

Both sides began by trying to refine elements in the situation of special interest. The patient's attorneys attempt to learn under what conditions the patient would be willing to stay in the hospital, possibly accept medications, etc. Similarly, the hospital team wanted to know exactly how suicidal the patient is and what her plans would be if released.

Shortly after we had begun to issue supplements to the case record, the resident in the role of unit chief wrote to the patient's attorneys that he had decided it was necessary forcibly to medicate the patient. Attorneys for the patient sought a hearing with the hospital director on this issue. With a volunteer psychiatrist* acting as the hospital director, this meeting was attended by law students for both sides, the resident portraying the patient's doctor, and the resident portraying the unit chief. The meeting was videotaped for later review and discussion.

At this meeting, the hospital director seems to simplify the case. The patient's doctor presents the case as an obviously ill patient who retains some ability to make decisions. The director responds by emphasizing that the patient could commit suicide or decompensate further. He points out the need to suffer is part of depression and her refusal is to be expected. The director suggests the patient be told she cannot be released, that she must accept treatment, including perhaps ECT, or that she will be transferred to a (less desirable) state or city hospital. The transfer will be made because of the patient's limited insurance coverage, and resulting financial hardship, should she stay beyond that coverage in a voluntary institution. This strategy was openly intended to pressure the patient to accept treatment, but the director felt confident the hospital would win should the case go to court.

The resident portraying the patient's doctor seems to be in agreement with the hospital director's plan at their meeting, but despite the patient's continued refusal of treatment, he does not carry out the plan. Perhaps due to his own uneasiness about the patient's condition or the influence of the law students advising him, he withdraws the request for involuntary hospitalization and ECT and appears willing to have her just sit in the hospital.

If allowed to stand, this turn of events would have left no cause for a hearing. Therefore, we had the patient request release in a sign-out letter. We felt this was reasonable for the patient to do, threatened with the expiration of her insurance coverage, and with no statement from the hospital of their plans. The hospital team had said they would not release the patient and responded with a new request for a court order for retention and

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accompanying physicians' certificates. The court hearing, which took place a few days later, concerns this request.

The Moot Court

As the meeting with the hospital director was dominated by the psychiatric perspective, the moot court is dominated by the legal perspective. The majority of testimony centers on whether patient meets the standards of Article 31 of the New York Mental Hygiene Law, that she is mentally ill, is in need of hospital care and treatment, and that her judgment is so impaired she is unable to understand this need. On the issue of mental illness, both sides agree the patient is depressed. The patient's side argues her illness may not be as severe as implied by the hospital's diagnosis of involutional melancholia.

On the issue of whether or not hospital treatment is essential, there was disagreement. This disagreement was principally as to whether or not the patient was suicidal. The hospital's testimony that the patient was in a group at high risk for suicide was not disputed. What was disputed were the implications of certain statements alluding to suicide the patient had made. As discussed earlier, these statements were deliberately ambiguous. (In later discussions, one of the points made was the problems associated with psychiatrists' definitive testimony about these indefinite matters.)

The second area of disagreement is on the third criterion, the patient's judgment and understanding of her need for care and treatment. Both sides bring opposite interpretations to the same incident. Late in her hospitalization, the patient was given an overnight pass. She did not return to the hospital, but on her second night out, when she found herself nervous and unable to sleep, she called her doctor at home for advice and returned to the hospital at his insistence. The hospital views this as evidence of her inability to make decisions for herself. Witnesses for the patient see her calling the doctor and following his advice as evidence of her ability to understand and deal with her situation. Other testimony deals with the influence of the patient's depressed mental status on her ability to think and reason. Although both sides argue the patient's psychiatric status is readily translatable to a legal standard, they come to opposite conclusions.

As time for testimony was severely limited, many issues other than how suicidal the patient might be were not developed in the testimony on the need for hospitalization. How effective further treatment might be, how long it might take, how access to visitors and a telephone could minimize limits on liberty are not discussed. Witnesses for the patient do equally little on how outpatient treatment might proceed. In fact, at one point in the hearing, the law student acting as judge took it upon himself to question one of the patient's witnesses on how the patient could be treated if released.

In their opening and closing statements, both sides do put forth what values they want the judge to respect. The hospital stresses the patient's right to be treated and live free from illness; the patient's side stresses her right to determine her own fate and avoid further "imprisonment."

The judge decides to release the patient. He points out in his decision that aside from the patient's being mentally ill, the evidence was clearly in dispute between the two sides on the other two criteria, the essential nature

of hospital treatment and the patient's ability to understand her need for care and treatment. The judge reasons that to retain the patient would be to "completely disregard" the testimony on her side. In the absence of a clear demonstration of the need for hospitalization, he prefers to "err on the side of patient's rights to determine her own future" in his decision to release her, despite the risks.

Discussion

For psychiatric residents, this educational experience occurs in three phases. The first is interaction with the law students in preparation for the moot court, with some supplemental reading. Second is participation in the preliminaries and the moot court itself. Third is the group discussion of the experience which raised several of the issues discussed below.

Particularly in the relationship between psychiatry and law, but also generally in the relationship between psychiatry and society, there is the problem of how to get the action one wants (retention of the patient for treatment, a larger appropriation for mental health) without exceeding the profession's claims to knowledge or competence in ways that are self-defeating. In this exercise, the participants were able to see that each had tried to assure the outcome by presenting as definitive professional judgments what were possible conclusions based on ambiguous facts. When the circumstances of the proceeding, limits on time, procedural rules, and the strategies adopted by the two sides did not allow for the distillation of a generally accepted interpretation of the facts, the judge chose one interpretation over another. His choice is led by his own set of values, as well as rules of law.

When one profession is trying to achieve a desired result from some other social process, such as a court hearing, it may be a problem to be too impressed by the rules of that process. As already mentioned, much of what psychiatry might say about the need for further hospitalization for the patient or alternative outpatient care was not developed because of narrow adherence by both sides to the criteria of the mental hygiene law. For psychiatrists concerned about the narrowness of legal criteria for commitment, the problem of bringing other issues into the judge's decision-making process was reflected in this exercise.

The exercise also raised more personal professional issues for the residents that must be confronted by psychiatrists as expert witnesses. For instance, one resident appearing as an expert for the patient was glad she was not asked too directly her opinions on the patient's suicide potential, as she felt her truthful answer might harm the patient's chance for release. This resident mentioned the struggle she had gone through between her own clinical assessment of the situation and her acceptance of the role of patient's witness, defined as not necessarily presenting as testimony professional judgments not in keeping with the patient's stated desires.

The testimony of the patient's treating doctor at the court hearing when he is quite definite that the patient meets criteria for retention, and his presentation of the case at the hearing with the hospital director where he seems unsure, were both videotaped. These were then discussed in the context of whether or not the pressures of a legal proceeding or a formal

meeting with a professional superior can influence "objective" professional objectives. The resident portraying the treating doctor was himself aware of these shifts but tended to attribute them more to changes in the patient as reflected in the record than to the proceedings. We, of course, felt the patient had remained the same.

For psychiatrists increasingly forced to define and defend their professional identity, an experience such as this can help them understand that their profession has a value system not necessarily identical with that of other groups. Perhaps they can also learn to avoid self-defeat through exaggerated professional claims to interpret and understand reality. Finally, they can experience some of the pitfalls of trying to present one profession's point of view in courtrooms, legislatures, and other places which are dominated by another profession's rules and values.

This discussion has focused on how this particular exercise could be seen to raise issues of general relevance to educating psychiatric residents to practical and theoretical issues involved in the relationship between law and psychiatry. A fuller evaluation would require measurement of how effective the exercise actually has been with the participants involved and comparison with the results of others using similar and differing techniques.

Unfortunately, an evaluation design was not built into this experience, so no before and after conclusions are available. A questionnaire was circulated to psychiatric residents who participated in the course over several years. The questionnaire indicated general enthusiasm for the experience with the main value cited being the opportunity to work closely with law students. A few participants had had subsequent experience with the legal system as witnesses and generally found the preparation helpful. Data from these questionnaires is being more completely analyzed for possible future reporting.

An independent effort to introduce adult residents and fellows in child psychiatry to family law through seminars which culminated in a moot court experience has been reported.[9] In this effort, a series of six seminars were presented to introduce the mental health professionals to the legal system from an overview down to the workings of a court. The last two sessions were devoted to a moot court with practicing attorneys representing various parties to a fictional case and the mental health trainees appearing as expert witnesses. A questionnaire was administered before and after the experience to measure changes in knowledge of family law. Twelve of the first twenty and fifteen of the second twenty participants improved on the quesionnaire. In their report, Cohen and co-authors express enthusiasm for their efforts from trainees and others to whom the work was presented. They seem to indicate the moot court experience provided a dynamic focus for their didactic effort. They also specifically mention the usefulness of videotapes.

Definite defects must be balanced against the relatively simply logistics, dramatic value, and opportunity for direct experience provided by a moot court. The moot court can emphasize process at the expense of content and will necessarily deal with a few issues in some depth at the expense of many others. The content, if developed for pedagogical purpose as in the case reported here, may be far from the realities of most cases seen in court or settled by negotiation. Moreover, a moot court is not real and its outcome

will not affect real people. This, combined with the opportunities presented to manipulate circumstances in the source of dramatic tension, may combine to create an atmosphere that elevates the courtroom drama above the human dilemmas and conflicts that might be more accurately reflected were the parties to negotiate a settlement out of court.

The experience reported here was not part of a coherent educational strategy aimed at systematically meeting the educational needs of psychiatric residents in the area of law and psychiatry. It was, rather, the outgrowth of a seminar principally for law students. It is reported here because it did seem a practical and interesting addition to residency training that can introduce residents to forensic psychiatry issues. The combination of law students and psychiatric residents also provides the opportunity to raise issues concerning conflicts in the value system of different professions as they function in society.

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