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INTRODUCTION

RECENTLY, a trend in judicial opinions addressing mental health law issues has developed which authorizes the use of a psychiatrist as the neutral and independent decisionmaker mandated by due process requirements. The Supreme Court has been the prime mover behind this development,[1] and the lower courts have been quick to adopt it,[2] at least in some form. The use of a psychiatric decisionmaker raises many serious and interesting questions that have received scant attention by the commentators[3] and the courts. This Article will explore some of these questions.

In many respects, this approval of psychiatric decisionmakers need not be viewed as a radical departure from the past. In the first place, as the Court has recently made clear,[4] due process does not necessarily require that hearing officers be persons trained as attorneys.[5] Moreover, it generally has been recognized that psychiatric witnesses have a great influence on judicial decisions con-

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1. *See* Parham v. J.R., 442 U.S. 584, 606-16 (1979).

2. *See, e.g.*, Doe v. Gallinot, 657 F.2d 1017, 1023-24 (9th Cir. 1981); Boarding Home Advocacy Team, Inc. v. O'Bannon, 525 F. Supp. 1181, 1190-91 (E.D. Pa. 1981).

3. Of course, there have been numerous articles on the various specific issues that arise in these cases which address some of these questions within those specific contexts. *See, e.g.*, Garvey, *Children and the Idea of Liberty: A Comment on the Civil Commitment Cases*, 68 KY. L.J. 809, 826-30 (1980); Rhoden, *The Right to Refuse Psychotropic Drugs*, 15 HARV. C.R.-C.L. L. REV. 363, 406-08 (1980); Silverstein, *Civil Commitment of Minors: Due and Undue Process*, 58 N.C.L. REV. 1133, 1143-48 (1980); Zlotnick, *First Do No Harm: Least Restrictive Alternative Analysis and the Right of Mental Patients to Refuse Treatment*, 83 W. VA. L. REV. 375, 439-42 (1981).

4. Schweiker v. McClure, 456 U.S. 188, 199 n.14 (1982).

5. Goss v. Lopez, 419 U.S. 565, 583 (1975) (school official); Wolff v. McDonnell, 418 U.S. 539, 546, 571 (1974) (prison official); Goldberg v. Kelly, 397 U.S. 254, 271 (1970) (welfare official).

cerning mental health issues, almost to the point that the psychiatrists are de facto decisionmakers.[6] Still, the current judicial delegation of authority to psychiatric decisionmakers raises special issues that should be considered separately. Unlike most other non-attorney "hearing" officers, psychiatrists bring with them their own professional mode of decisionmaking, one that is quite different from the one found in the adversarial judicial process. The explicit use of psychiatrists as decisionmakers entails a decisionmaking process which is procedurally and substantively distinct from that entailed by the use of psychiatrists as mere witnesses, regardless of how influential the psychiatrists' testimony may be. Although many of the same questions arise, albeit in a different form, additional questions surface when the psychiatrist explicitly assumes the decisionmaker role. How is the psychiatrist expected to act in this role? How is the expertise to be employed? Which profession's standards of decisionmaking will govern the conduct of the psychiatric decisionmaker—those of the law or those of medicine? What form of adversary proceeding, if any, must be used? What are the essential minimal requirements to be met by a due process decisionmaker and how should these be applied to the pyschiatric expert? These questions themselves are but part of the broader considerations concerning the division of decisionmaking responsibility among different professions and the manner in which specialized expertise can and should be used in the decisionmaking process.

This Article's discussion of these issues begins with an analysis of the various cases that have sanctioned employing a psychiatrist as a due process decisionmaker. The different contexts in which these courts explicitly or implicity authorize the use of the psychiatric decisionmaker, especially in the adversarial context, are examined. The broader question of the alternative ways in which psychiatric expertise might be used in the decisionmaking process is then explored. It is shown that serious problems arise whichever role the psychiatric decisionmaker takes, whether it be the tradi-

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6. *See* Albers, Pasewark & Meyer, *Involuntary Hospitalization and Psychiatric Testimony: The Fallibility of the Doctrine of Immaculate Perception*, 6 CAP. U.L. REV. 11 (1977); Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 536 n.16 (1978), and numerous sources cited therein. *But see* Miller & Fiddleman, *Involuntary Civil Commitment in North Carolina: The Results of the 1979 Statutory Changes*, 60 N.C.L. REV. 985, 1004 n.89 (1982).

tional passive decisionmaker in an adversary context, the decisionmaker who is completely outside of the adversary context, or some compromise role between these two.

Next, the Article considers whether the psychiatric decisionmaker acting in any or all of these different roles satisfies the essential minimum requirements of due process. This necessitates a brief discussion of the ultimate purposes of the traditional due process protections, wherein two major values—broadly stated as accuracy and participation—are identified as those which due process provisions try to enhance. Against this general framework, the more specific requirements placed on adjudicatory-type decisionmakers are measured. These requirements—basically neutrality and independence—are the embodiment of the formal concept of the minimum essential attributes of a proper decisionmaker. As such, they are an appropriate set of guidelines for the assessment of the varying uses of the psychiatric decisionmaker. With respect to each of these various specific requirements, the following issues are discussed: whether the particular requirement needs to be applied to the different situation of the psychiatric decisionmaker; whether a psychiatric decisionmaker can meet this requirement; and whether the psychiatric profession provides a sufficient alternative means of accomplishing the goal of the provision. The conclusion reached is that psychiatrists meet the presently recognized due process requirements for neutral and independent decisionmakers, despite the fact that the use of psychiatric decisionmakers raises questions about neutrality and independence, especially as these provisions relate to passivity.

In the final Section, this Article addresses the appropriate role of expertise in the decisionmaking process and whether there are issues beyond neutrality and independence that should cause one to be wary of using psychiatrists as decisionmakers. The contention that psychiatrists do not possess sufficient expertise on the issues to be decided in these proceedings is considered, but it is recognized that the profession with the most expertise on these matters is psychiatry and therefore psychiatrists must play some role in the process. Still, it is argued that there is a real need to place some restrictions on the use of this expertise. This leads to a discussion of possible external controls on decisionmakers. In this context, various standards of "accuracy," including those of the "scientific expert" and of the "reasonable man," are considered.

It is concluded that, in many cases, there is a need for an external check on the psychiatric expert because the very expertise of that profession is also a type of bias. Finally, it is suggested that the form that this external control on psychiatric expertise should take is to have the psychiatrist testify as a witness and have the actual decisionmaker be the non-specialist judge.

I. The Use of Psychiatric Decisionmakers

A. *Judicial Formulations*

The prime example and seminal instance of using a psychiatrist to act as a due process decisionmaker is the Supreme Court's opinion in *Parham v. J.R.*[7] In *Parham,* the Court was faced with a due process challenge to state procedures whereby juveniles could be "voluntarily" committed to public mental hospitals by their parents.[8] The plaintiffs were children who contended that they had a right to have the question of whether they required hospitalization determined in an adversary proceeding. The majority concluded that these minors do have a constitutionally protected liberty interest under the due process clause.[9]

The real significance of the opinion for present purposes is its discussion of what minimum process is due. Some "inquiry" by a "neutral fact-finder" was deemed necessary, but the majority held that an independent medical evaluation of the child's need for hospitalization by a staff physician of the admitting hospital would be sufficient:

> Due process has never been thought to require that the neutral and detached trier of fact be law trained or a judicial or administrative officer. Surely, this is the case as to medical decisions, for 'neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments.' Thus, a staff physician will suffice, so long as he or she is free to evaluate independently the child's mental and emotional condition and need for treatment.[10]

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7. 442 U.S. 584 (1978).

8. *See generally* Garvey, *supra* note 3; Silverstein, *supra* note 3; Szasz, *The Child as Involuntary Mental Patient: The Threat of Child Therapy to the Child's Dignity, Privacy, and Self-Esteem,* 14 San Diego L. Rev. 1005 (1977).

9. *Parham,* 442 U.S. at 600-01.

10. *Id.* at 607 (citations omitted) (citing Goldberg v. Kelly, 397 U.S. 254, 271 (1970)). *See* Morrissey v. Brewer, 408 U.S. 471, 489 (1972); *In re* Roger S., 19 Cal. 3d 921, 942, 569 P.2d 1286, 1299, 141 Cal. Rptr. 298, 311 (1977) (Clark, J., dissenting)).

In addition, the Court decided that this inquiry need not take the form of any type of judicial-style hearing.

> It is not necessary that the deciding physician conduct a formal or quasi-formal hearing. A state is free to require such a hearing, but due process is not violated by use of informal traditional medical investigative techniques. Since well-established medical procedures already exist, we do not undertake to outline with specificity precisely what this investigation must involve. The mode and procedure of medical diagnostic procedures is not the business of judges. What is best for a child is an individual medical decision that must be left to the judgment of physicians in each case. We do no more than emphasize that the decision should represent an independent judgment of what the child requires and that all sources of information that are traditionally relied on by physicians and behavioral specialists should be consulted.[11]

Two aspects of this unusual approach to minimal due process safeguards should be recognized. First, the Court sanctioned the use of an expert decisionmaker in place of a judicial or administrative hearing official. Second, the Court indicated that an adjudicative-type adversary hearing is not the only form of decisionmaking that is encompassed within the concept of due process. Not surprisingly, these two aspects overlap and reinforce each other to a considerable degree. If the decision is made solely on the basis of medical diagnostic procedures, it should be made by a trained physician. Conversely, if the decision is to be made by a trained physician, it should be done in accordance with the methods for which the physician is trained.

Despite the obvious connection between these two concepts, they should be carefully distinguished. The psychiatric decisionmaker need not always be used completely outside of the adversary process. *Parham*, for example, presented a special situation necessitating restrictions on the use of an adversary hearing prior to hospitalization because of the danger of significant harm to the parent-child relationship resulting from the parents and child being opponents in an adversary hearing.[12] Even the dissenters agreed on that point,[13] although they believed a post-admission hearing should be required because the doctors would then be the child's adversaries.[14]

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11. 422 U.S. at 607-08.

12. *Id.* at 610.

13. *Id.* at 633. The dissenters only agreed regarding commitments by parents rather than juvenile authorities. *Id.* at 637-38.

14. *Id.* at 633-37. The evidence at this post-admission hearing presumably would in

Both aspects of *Parham* have been adopted by at least one court where there were no special dangers that might result from the requested adversary hearing itself.[15] However, other cases which have followed *Parham* have split these two aspects. They raise even more distinctly the questions of whether the psychiatric decisionmaker should be seen as meeting traditional notions of neutrality and independence and how the psychiatric decisionmaker is to operate. Indeed, the Supreme Court itself appears to have approved the use of an expert psychiatric decisionmaker in a far different type of proceeding. In *Vitek v. Jones*,[16] the Court agreed with a district court's conclusion that due process required an adversary hearing before a prisoner could be transferred to a mental hospital. Numerous elements of the adversary process, including the right to present testimony and cross-examine witnesses, were mandated.[17] The Court was careful to note, however, that the district court's order did not require that the independent decisionmaker come from outside the prison or hospital administration.[18] Presumably this envisions the possibility of using a psychiatrist as the decisionmaker.[19]

More explicit on this point is *Doe v. Gallinot*,[20] which held that a mandatory probable cause hearing was required by the due process clause for persons involuntarily committed under California's "gravely disabled" statutory scheme. These California provisions allowed a person to be declared "gravely disabled" due to mental disease and "committed to a mental institution for 72 hours on an emergency basis, and up to 14 more days for involuntary treatment, with no requirement that the state initiate a hearing before an independent tribunal to determine whether adequate cause for commitment exists."[21] The Ninth Circuit held that there must be

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most cases involve little more than testimony by mental health professionals.

15. Boarding Home Advocacy Team, Inc. v. O'Bannon, 525 F. Supp. 1181 (E.D. Pa. 1981) (fourteenth amendment deprivation was assumed to exist for purposes of discussion only).

16. 445 U.S. 480 (1980).

17. *Id.* at 494-95.

18. *Id.* at 496.

19. The district judge did state that the "examining or treating physician should not be permitted to vote on the commitment decision." Miller v. Vitek, 437 F. Supp. 569, 574 (D. Neb. 1977). This shows a recognition of the use of a psychiatric decisionmaker, but one not involved in the initial decision. *See* discussion *infra* notes 116-24.

20. 657 F.2d 1017 (9th Cir. 1981).

21. *Id.* at 1019.

"an independent evaluation, by a neutral decisionmaker," but stated that a decisionmaker within the institution could be used,[22] and that this person need not be a judicial officer.[23] On remand, the district court clarified the context in which the psychiatric decisionmaker could be employed. The probable cause hearing must provide all of the due process procedures required at a hearing on a petition for a writ of habeas corpus,[24] and the decisionmaker must "give a written statement as to the evidence relied on and the reasons for the involuntary detention for mental health treatment."[25] The independent decisionmaker who would conduct this hearing and give this statement could be a medical doctor, a judicial officer, or an administrative law judge.[26]

There are also uses of the psychiatric decisionmaker that fall somewhere between those of *Parham* and *Doe*. An illustration of this is provided by the current and often confusing judicial debate over the method of dealing with a patient's right to refuse psychotropic medication in non-emergency situations.[27] One of the first courts to address this issue was the federal district court in *Rennie v. Klein*.[28] This case relied upon *Parham* but created its own procedure for using a psychiatric decisionmaker.[29] The issue was whether an involuntarily hospitalized patient had a right to refuse to receive psychotropic medication. The court found that such a right exists as an aspect of the right to privacy, but that the right to refuse can be overcome by considerations of whether the refusal is a result of the underlying mental illness and whether less

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22. *Id.* at 1024.

23. *Id.* at 1025.

24. These appear to be the full rights of a formal adversary legal proceeding. *See generally* CAL. WELF. & INST. CODE §§ 5275-5276 (West 1984).

25. Doe v. Gallinot, No. CU76-107-F, slip op. (C.D. Cal Jan. 20, 1982).

26. A "court appointed commissioner or referee" was a fourth possibility. Interestingly, the court also approved using "a licensed clinical social worker with a minimum of 10 years' experience in mental health." January 20, 1982, order at 2. This is an extension of the "psychiatric decisionmaker" concept to another mental health profession and shows a recognition of the reality of mental health care especially in state hospitals. One wonders, however, how the licensed clinical psychologists managed to be left off the list.

27. *See generally* Brooks, *The Constitutional Right to Refuse Antipsychotic Medications*, 8 BULL. AM. ACAD. PSYCHOLOGY & L. 179 (1980); Rhoden, *supra* note 3; Zlotnick, *supra* note 3.

28. 462 F. Supp. 1131 (D.N.J. 1978) (motion for preliminary injunction denied), 476 F. Supp. 1294 (D.N.J. 1979) (complaint amended to add class action on behalf of all persons hospitalized).

29. *See Rennie*, 476 F. Supp. at 1307-08.

intensive forms of therapy can be used instead.[30] The court held that this qualified right constitutes "a sufficient liberty interest so that due process attaches"[31] and that an independent psychiatrist should be the ultimate decisionmaker on the issue of whether the right to refuse should be recognized and upheld.[32] This psychiatrist was required to conduct a hearing, but only "an informal hearing which can readily be conducted by a medical person."[33] In this context, a patient must be provided with a non-attorney patient-advocate to serve as "informal counsel" at the "informal hearing."[34] These procedural aspects of the district court decision were overturned by the Third Circuit, however, which found that the only process necessary is a series of informal consultations followed by a review of the treatment decision by the hospital's medical director.[35] This decision is still to be made by the psychiatrist, but presumably only by whatever procedural means the psychiatrist deems appropriate.[36] The First Circuit, in contrast, has required that there be some formal finding of incompetency, apparently by a judicial decisionmaker, before medication can be involuntarily administered; thus, this court has not endorsed any use of a psychiatric decisionmaker to resolve the general question of whether a particular patient has the capacity to exercise a right to refuse medication.[37]

These cases raise many interesting questions about the use of psychiatric decisionmakers. Perhaps the most fundamental one is how the courts decide in the first place that a particular decision is one that should be made by a psychiatrist. The short and simple answer found in the judicial opinions is that the decision is a medical one and thus should be made by doctors.[38] The simplicity of

30. *Rennie*, 462 F. Supp. at 1144-47.

31. *Id.* at 1147.

32. *Rennie*, 476 F. Supp. at 1312.

33. *Id.*

34. *Id.* at 1311.

35. Rennie v. Klein, 653 F.2d 836, 848-51 (3d Cir. 1981) (en banc).

36. *See id.* at 851.

37. Rogers v. Okin, 634 F.2d 650, 660 (1st Cir. 1980), *vacated and remanded sub nom.* Mills v. Rogers, 457 U.S. 291 (1982). A rather unusual decisionmaking role for the psychiatrist was envisioned in *Rogers*: nontreating physicians would review "the full treatment history of [incompetent] patients to ensure that the treating physicians are in fact attempting to make treatment decisions as the patients would were they competent." 634 F.2d at 661. This is a rather strange use of expert decisionmaking. *See* discussion *infra* at note 179.

38. *E.g.*, Parham v. J.R., 442 U.S. 584, 609 (1979).

this answer has some appeal. But its inadequacy lies in that same simplicity. One cannot abstractly say that a decision is a medical one or a legal one without begging the question. Labeling a decision "medical" in this context is no more than a short-hand way of saying that the decisionmaker should be a medical expert who will, to some degree, use the methods of the medical profession to arrive at the decision. Even if one were to agree that the expertise of doctors must enter the decisionmaking process at some point, this does not demonstrate that a decision should be labeled a medical one. Numerous decisions that are labeled "legal" require the use of medical expertise for their resolution.[39] The underlying questions remain the same no matter which label they are given. Should this child be placed in a mental hospital? Should this person be hospitalized as "gravely disabled"? Should this patient receive medication over his objections? These questions must be decided in the most accurate way possible,[40] but there is no abstract notion of accuracy to be consulted. The question is whether accuracy is to be viewed from the perspective of the medical profession, the legal profession, or neither.[41] The labels placed upon these decisions are themselves derived from determining whether psychiatrists or lawyer/judges are "best" able to decide what should be done with this child or patient.

A better way to approach these matters is to ask how expertise should be used in the decisionmaking process. Medical exper-

39. In a case involving injuries sustained from a dog bite, the judgment was reversed for insufficient expert medical testimony, the court stating that "where injuries complained of are of such character as to require skilled and professional persons to determine cause and extent thereof, the question is one of science and must necessarily be determined by testimony of skilled, professional persons." Spivey v. Atteberry, 205 Okla. 493, 494, 238 P.2d 814, 816 (1951). *See also* Hart v. State Accident Ins. Fund, 31 Or. App. 181, 184, 570 P.2d 92, 93-94 (1977) (workmen's compensation).

40. Although under an ideal adjudicatory system each particular case would be decided "accurately," people often are willing to settle for a system that results in some inaccuracy provided that the system provides safeguards against inaccurate decisions in specific types of cases. For instance, if one thinks preventing hospitalization of those who do not require it is more important than getting hospitalization for those who do, or vice versa, one might establish a system that has more overall inaccuracy than an alternative system because it errs on the side of preventing the type of wrong decision one finds more troubling. Indeed, psychiatrists are trained to err on the side of finding illness, as opposed to rejecting it. *See* Livermore, Malmquist & Mehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75, 77 (1968).

41. *See infra* notes 171-72 and accompanying text.

tise is relevant to and must inform the decision in such cases,[42] but certain questions remain. What form of proceeding and decisionmaking should be used? What are the possible uses of the expertise? What difficulties, if any, arise from these uses? These questions are addressed in the following Sections.

B. *Psychiatric Expertise in the Decisionmaking Process*

Unlike the role of the psychiatrist being discussed here, the psychiatric expert is used normally as an expert witness in the formal decisionmaking process.[43] The psychiatrist offers an opinion on the medical questions relevant to the issue at hand in order to assist the actual decisionmaker. Normally, this is done within the context of an adversary hearing. Although the psychiatrist is only a witness, this expert opinion is so crucial and so related to the "ultimate issue" that in many cases the psychiatrist can be seen as actually sharing in the decisionmaking process.[44] Moreover, the psychiatric expert's degree of participation in the adversary aspect of the proceeding can vary.

At one extreme are systems whereby the expert testifies solely on behalf of one of the parties and is forced to testify in the unnatural stylized manner of expert testimony developed by the legal system.[45] At the other end of the spectrum are the possibilities provided by more modern evidentiary rules wherein psychiatrists testify as court-appointed experts in a manner comfortable to them, basing their opinions on information normally relied upon in their profession.[46] Although this testimony occurs within the context of an adversary hearing with the parties being given an opportunity to cross-examine the expert,[47] there is a qualitative difference in the adversary nature of the expert's participation. As court-appointed experts, psychiatrists are not even identified with

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42. *See infra* text accompanying note 169.

43. There are, of course, other possible ways of using expertise in the decisionmaking process. *See* Boyer, *Alternatives to Administrative Trial-type Hearings for Resolving Complex Scientific, Economic and Social Issues*, 71 MICH. L. REV. 111, 126-27 (1972); Leventhal, *Environmental Decisionmaking and the Role of the Courts*, 122 U. PA. L. REV. 509, 546-59 (1974).

44. *See supra* note 6.

45. *See* C. MCCORMICK, HANDBOOK OF THE LAW OF EVIDENCE §§ 14, 15 (2d ed. 1972).

46. *See, e.g.*, FED. R. EVID. 703, 704, 705, 706.

47. FED. R. EVID. 706 provides for cross-examination, as do most states, although Alaska apparently makes it discretionary. ALASKA R. EVID. 706. *See* D. LOUISELL & C. MUELLER, FEDERAL EVIDENCE § 404, at 725-26 & Supp. at 250-51.

one particular party. They take on much more of the perceived neutrality and independence associated with the actual decisionmaker and, in effect, have an even larger share of the decisionmaking role than experts testifying on behalf of a particular party. This is probably a mixed blessing. When allowed to rely more upon the language and accepted practices of one's own profession, an expert not only is more removed from the adversary nature of the legal system, but is even further removed from the strictures imposed by this system.[48]

A similar but even more dramatic difference exists when the psychiatrist is actually used as the decisionmaker. One possibility is allowing the psychiatrist to come to decisions solely on the basis of his or her own observations and expertise. None of the primary characteristics of the adversary system would be used. The decision would be reached only by using those methods normally employed by the psychiatric profession to arrive at such a decision. This is apparently the situation envisioned by the majority in *Parham.*

Alternatively, there is a possibility that the expert could simply be used as a decisionmaker in the context of a complete adversary hearing. The parties would have the right to be represented by counsel, to call witnesses, and to cross-examine each other's witnesses. The psychiatrist would have to prepare a written statement of the evidence relied upon and the reasons for the decision. Thus, while a psychiatrist would be the decisionmaker, the formal process the decisionmaker would employ would be that of the legal system. This is the situation created by the district court in *Doe v. Gallinot.*

Falling somewhere between these two possibilities is the psychiatric decisionmaker envisioned by the district court in *Rennie.* Rather than allowing the expert to use only the methodology of the psychiatric profession, a hearing requirement would be added, albeit an "informal hearing" with only "informal counsel." The psychiatric decisionmaker would have to act in a somewhat strange professional role, but would not have to rely solely upon a

48. For criticisms of the use of impartial experts, see Diamond, *The Fallacy of the Impartial Expert,* 3 ARCHIVES CRIM. PSYCHODYNAMICS 221 (1959); Goldstein, *The Psychiatrist and the Legal Process: The Proposals for an Impartial Expert and for Preventive Detention,* 33 AM. J. ORTHOPSYCHIATRY 123, 123-28 (1963); Levy, *Impartial Medical Testimony—Revisited,* 34 TEMPLE L.Q. 416 (1961); Morse, *supra* note 6, at 609 n.172.

completely foreign process.

Serious issues arise with regard to each of these different ways of using psychiatric decisionmakers. In many respects, the placement of the psychiatrist as decisionmaker within the complete adversary process as done in *Doe* creates the most troubling situation. In what way is the expertise to be used? Would the psychiatrist simply act as the traditional passive decisionmaker who does no independent investigation? Alternatively, would the psychiatrist hear the parties and their witnesses, but then make an investigation (examination) "outside of the record"?

If the psychiatrist remains a passive decisionmaker, why should an expert even be used as the decisionmaker? Of course, expert decisionmakers who remain relatively passive are used in adversary proceedings in other contexts.[49] But unlike the possible use of such decisionmakers in a patent case concerning a technically confusing matter[50] or even an environmental case involving a complex engineering process,[51] psychiatric expertise is not needed in order for the decisionmaker to be able to comprehend adequately the basic issues in the case—that is, the arguments presented to support the claim for the need to hospitalize a minor. How, then, is the expertise useful if the psychiatrists do not make their own examination? Perhaps the psychiatrists are expected simply to draw upon their own expert knowledge and information about people and mental illnesses in general. Given the extent to which psychiatric diagnosis and prognosis is based on clinical evaluation[52] rather than on "objective" test findings,[53] this

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49. For a recent discussion of various specialized courts, see Jordan, *Specialized Courts: A Choice?*, 76 Nw. U.L. Rev. 745 (1981). *See also* Posner, *Will the Federal Courts of Appeals Survive Until 1984? An Essay on Delegation and Specialization of the Judicial Function*, 56 S. Cal. L. Rev. 761, 775-91 (1983).

50. *See* Marovitz, *Patent Cases in the District Courts—Who Should Hear Them?*, 51 Ind. L.J. 374 (1976); Gelfand, *Expanding the Role of the Patent Office in Determining Patent Validity: A Proposal*, 65 Cornell L. Rev. 75, 103 (1979).

51. *See* Wald, *Making "Informed" Decisions on the District of Columbia Circuit*, 50 Geo. Wash. L. Rev. 135, 143-49 (1982).

52. Indeed, it has been suggested that psychiatrists' expertise is simply that of observation. *See infra* note 163.

53. "Mental disorder is thus diagnosed by observing the person's behavior. There are no physical tests for the presence or absence of mental disorder. . . . Behavior is the only data in mental health diagnosis that all diagnosticians would agree is relevant." Morse, *supra* note 6 at 546 (footnotes omitted). *See also* Am. Medical Ass'n, Current Medical Information and Terminology 366-67 (B. Gordon 4th ed. 1971).

is a very strange position in which to place expert decisionmakers. Moreover, it is not even clear to what extent psychiatric decisionmakers operating within the traditional adversary system would be allowed to use their expertise in this very general way. Such use might be viewed as going outside of the record in an impermissible manner. In a somewhat analogous situation, an Oregon court has indicated that it would be improper for an expert to do so.[54] This seems an unnecessarily restrictive standard which, if applied, would leave virtually no role for the expertise of the decisionmaker.

One way in which one might envision this hybrid psychiatric decisionmaker (that is, one who operates in the adversary context but is not passive) is to try to differentiate fact-finding from disposition. Under this view, the psychiatrist would use the adversary process to determine the relevant "facts" and would then apply expert knowledge to these "facts" to arrive at a decision.[55] Usually, however, there are not many "facts" that can be used apart from the examination of the patient. Normally, the psychiatrist will use his or her own methods for deciding whether to accept outside reports concerning a patient's prior behavior, and the examination and diagnosis of the patient are usually seen as important in making these factual determinations.[56] Thus, although a process which splits fact-finding from the application of the expert knowledge to these facts may have some theoretical appeal, it is incompatible with normal psychiatric decisionmaking.

> [Since] the opinion of the psychiatrist is derived from his own highly subjective, total impression of the patient, it is impossible for him to divide his opinion into fragments. He cannot claim that a particular portion of his opinion was derived from direct observations of the patient while another portion comes from third parties. He cannot even confidently say that in the absence of such and such information he might have reached a different conclusion. If the psychiatrist is well trained and experienced, he will resist

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54. Rolfe v. Psychiatric Sec. Rev. Bd., 53 Or. App. 941, 633 P.2d 846 (1981) (en banc).

55. On the question of the factual element of expertise used in legal settings, see Korn, *Law, Fact, and Science in the Courts*, 66 COLUM. L. REV. 1080 (1966). For a consideration of some use of the adversary process in scientific research in general, see Levine, *Scientific Method and the Adversary Model*, 29 AM. PSYCHOLOGIST 661 (1974).

56. *See generally* THE COMPREHENSIVE TEXTBOOK OF PSYCHIATRY—III 904 (H. Kaplan, A. Freedman & B. Sadack eds. 1980) [hereinafter cited as COMPREHENSIVE TEXTBOOK OF PSYCHIATRY]; H. SULLIVAN, THE PSYCHIATRIC INTERVIEW 66 (1954).

with all his powers such attempts to particularize and fragment.[57]

Indeed, no decisionmaker is really able to divorce the fact-finding process from the overall decisionmaking process.[58]

Whereas the use of the totally passive psychiatric decisionmaker within an adversary proceeding produces some questionable situations, there are also difficulties with the other uses of psychiatric decisionmakers. The decisionmaker role created by the *Rennie* district judge is somewhat a compromise between the full use of the adversary process and its virtual abandonment. But can decisionmakers operating in an adversary context conduct their own investigation without undercutting the very purpose of the adversary proceeding? Would the parties' presentations be anything more than a sham? Are there any significant problems inherent in the lack of passivity of the decisionmaker?

Similar questions occur at the *Parham* end of the spectrum. What type of "due process of law" is being provided when there is no hint of the adversary system or the type of decisionmaker traditionally associated with due process? Concerns naturally arise about whether this psychiatric decisionmaker can ever be an appropriate due process decisionmaker and what "outside" requirements need to be added to make such a decisionmaker minimally adequate. The key question, however, is whether such concerns are justified. Not all important decisions in our society are appropriate for nor made by an adjudicative hearing process.[59] Does the difference in mode of investigation and type and role of decisionmaker matter for what ultimately is being sought in these situations?

In order to try to address the issues raised above, it is necessary first to explore, at least briefly, the broader purposes of the due process requirement, particularly in the area of mental health law. Also, it is necessary to examine the dynamics between these purposes and the more specific rules for judicial decisionmakers. Only then can one examine whether psychiatric decisionmakers, particularly those using only their own profession's method of in-

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57. Diamond & Louisell, *The Psychiatrist as an Expert Witness: Some Ruminations and Speculations*, 63 MICH. L. REV. 1335, 1350-51 (1965).

58. *See* Damaska, *Presentation of Evidence and Factfinding Precision*, 123 U. PA. L. REV. 1083, 1087 (1975).

59. *See generally* Parham v. J.R., 442 U.S. 584, 608 (1979); Boyer, *supra* note 43, at 120-22.

vestigation, can meet these specific rules and whether they *should* be subject to them.

II. The Neutral and Independent Psychiatric Decisionmaker

A. *Overview of Due Process*

Before considering the goals traditionally seen as served by due process requirements, an even more preliminary inquiry is appropriate: What, at a minimum, does it mean to say that some procedures are required by the fourteenth amendment because a deprivation is occurring? Must these be procedures that would not be mandated by other legal requirements? Specifically, does it mean anything to say that due process requires only that the professional who makes the initial decision do so in accordance with that decisionmaker's own professional standards?[60] The person who is subject to that professional's decision already has that "right" and a remedy in a tort suit for the professional's negligent or bad-faith decision. Presumably, when a fourteenth amendment due process right is found to exist, something additional is required—something more than just the possibility of a federal court forum for the post-deprivation suit.[61] At the very least, the fourteenth amendment requires that the decisionmaker and the decisionmaking procedure used be subjected to some sort of legal scrutiny that will ensure that certain minimal standards are met. This might entail grafting certain aspects of the traditional due process decisionmaking procedure onto the procedure used by the profession which has the initial responsibility for the decision. Thus, the issue becomes one of determining which aspects, if any, need be imposed upon the psychiatric decisionmaker.

The appropriateness of applying specific criteria cannot be intelligently considered without some concept of the ultimate goal

60. Admittedly, *Parham* is an example of the psychiatric decisionmaker checking the initial decision of another, the child's parent. But the principle can be carried to the point of saying that there is a deprivation subject to due process protection, but the initial decision by the medical professional satisfies any due process requirement. Boarding Home Advocacy Team, Inc. v. O'Bannon, 525 F. Supp. 1181 (E.D. Pa. 1981), in effect adopts this view, although a fourteenth amendment deprivation is only assumed for purposes of discussion.

61. *See generally* Parratt v. Taylor, 451 U.S. 527 (1981).

sought to be achieved by requiring adequate due process. At its most general level, the due process requirement prevents the government from taking certain actions without doing so in a manner that aims to ensure two things: first, that serious consideration be given to whether the action is correct—that is, whether the factual assumptions are accurate and the result that flows from these facts is in accordance with the prescribed standards; second, that the person subject to the action have some input into the decision-making process so that his or her view of the matter has been considered and some explanation for the action has been received. Stated differently, the two main values due process seeks to enhance are accuracy and participation.[62] Accuracy has been described as an "instrumental" value,[63] while participation has been termed an "intrinsic" or "dignitary"[64] value.

These values are not always viewed as equal aspects of the due process ideal; the Supreme Court, in particular, appears much more concerned with ensuring only the instrumental values.[65] Still, it is important that the intrinsic values be recognized, especially because some of the procedures discussed in this Article eliminate the adversary system, which provides a means of ensuring these values. Participation in the process helps to legitimate the result reached, though some would claim that it merely sublimates conflict by redirecting affected persons' energies.[66] More importantly, the intrinsic aspects of due process can be of great psychological value to the affected person: they can assist in developing a concept of self and a feeling of contribution to important decisions about one's own life.[67] This is a particularly vital concern where mental health issues are concerned, since such decisions relate to fundamental aspects of the individuals' control over their own lives.

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62. Marshall v. Jerico, Inc., 446 U.S. 238, 242 (1980).

63. L. TRIBE, AMERICAN CONSTITUTIONAL LAW § 10-7 (1978).

64. Mashaw, *The Supreme Court's Due Process Calculus for Administrative Adjudication in Mathews v. Eldridge: Three Factors in Search of a Theory of Value*, 44 U. CHI. L. REV. 28, 49-52 (1976).

65. *See* Mathews v. Eldridge, 424 U.S. 319 (1976); L. TRIBE, at note 63, § 10-7; Mashaw, *supra* note 64. *But see* Marshall v. Jerico, Inc., 446 U.S. 242.

66. Simon, *The Ideology of Advocacy: Procedural Justice and Professional Ethics*, 1978 WIS. L. REV. 29, 125-26 (1978).

67. Michelman, *Formal and Associational Aims In Procedural Due Process*, 18 NOMOS 126, 127-28 (1977).

The various particular requirements developed under the rubric of due process exist to protect either or, in most cases, both of these values.[68] In their most formal development, these requirements can be broadly stated to be that the affected person be given an opportunity to be heard before the final decision is made;[69] that the hearing proceed in a special manner (traditionally, in accordance with the adversary system);[70] and that a particular type of decisionmaker (neutral,[71] independent[72] and passive[73]) make the decision.[74]

The opportunity to be heard obviously ensures participation, but it also promotes accuracy.[75] Usually the affected person has

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68. This is not to suggest that other procedures could not be used and still satisfy some abstract requirement of being "fair." "Uniquely in the United States, adversarial due process and fundamental fairness have become virtually synonymous." Kirp, *Proceduralism and Bureaucracy: Due Process in the School Setting*, 28 STAN. L. REV. 841, 871 (1976). Indeed, although the judicial adversary system is the traditional model for due process, there are other deviations from it besides those involving the psychiatric decisionmaker. *See id.* at 871-72. Still, as the traditional model, it is appropriate to use the judicial adversary system for comparison as is done below in section II(B). *See infra* notes 85-157 and accompanying text.

69. Goldberg v. Kelly, 397 U.S. 254, 267 (1970); Mullane v. Central Hanover Bank & Trust Co., 339 U.S. 306, 314 (1950).

70. At least there will usually be some of the fundamentals of what have been viewed as the essential attributes of the adversary process: specifically, confrontation and cross-examination. Goldberg v. Kelly, 397 U.S. at 269-70. *See* Landsman, *The Decline of the Adversary System: How the Rhetoric of Swift and Certain Justice Has Affected Adjudication in American Courts*, 29 BUFFALO L. REV. 487, 490 (1980). *But see* Goss v. Lopez, 419 U.S. 565, 584 (1975).

71. Schweiker v. McClure, 456 U.S. 188, 196 (1982) ("impartiality"); Marshall v. Jerico Inc., 446 U.S. 238, 242 (1980) ("neutrality"); Goldberg v. Kelly, 397 U.S. at 271 ("impartial decisionmaker").

72. The nature and scope of this independence requirement, *see infra* notes 87-90 and accompanying text, casts some doubt on the degree to which there is such a general due process requirement. Nevertheless, it is fair to consider it a requirement in the due process context as well as the general judicial context. *See, e.g.*, Ward v. Village of Monroeville, 409 U.S. 57 (1972), where the due process violation actually was caused by the decisionmaker's lack of independence from an interested entity. The Supreme Court used the phrase "neutral and *detached* judge." *Id.* at 62 (emphasis added). The Supreme Court has also recognized the possibility of a due process violation through "derivative bias." Schweiker v. McClure, 456 U.S. at 197. *See infra* note 85.

73. Although the amount of passivity will certainly vary, even more than in the judicial context, *see infra* note 126, a requirement of some degree of passivity is implicit in the authorization of some type of adversary proceedings. *See* Landsman, *supra* note 70, at 490-91.

74. Another requirement often mandated is that reasons be given for the decision. Goldberg v. Kelly, 397 U.S. at 271.

75. Tribe sees this requirement as "ultimately more understandable as inherent in de-

information or a viewpoint on the action that should be considered in order to ensure accuracy. This is a part of the underlying basis for the form of the hearing used in the adversary system.[76] With regard to mental health law, it is particularly important that the affected party be seen and heard because a crucial consideration in the decision involves that particular party: the party's views and wishes and the "rationality" of those views and wishes. There is also the substantial issue of determining which are the best means to be used by the decisionmaker to learn about and evaluate the character and desires of this person.

Mental health law also raises other special problems with regard to the formal right to be heard. The person might be unable to participate in a very meaningful way, or, as it is sometimes argued,[77] the participation might be anti-therapeutic and thus actually contrary to the long-term interests of the person. Alternatively, the person might not have a strong desire to participate in the process. There are arguments for special considerations on both sides regarding the right to be heard in mental health cases that deserve recognition.[78]

Again, the adversarial determination and presentation of evidence is a means of ensuring participation rights as well as ensuring a more accurate result. Admittedly, the direct participation of the party is often limited when there is representation by counsel. Nevertheless, the adversary system's emphasis on the parties' control of the determination and presentation of the evidence and arguments does enhance the participation value, though at times perhaps at the expense of accuracy.[79] Indeed, proponents of the adversary system have advanced two arguments for the contention that it is actually the best vehicle for ensuring accuracy. The first argument is that the head-on clash of interested parties allows each party to expose the weaknesses or falsity of the assertions

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cent treatment than as optimally designed to minimize mistakes." L. TRIBE, *supra* note 64, § 10-15, at 554.

76. *See* Landsman, *supra* note 70, at 490.

77. *See, e.g.*, H. DAVIDSON, FORENSIC PSYCHIATRY 281-82 (1965); Weihofen, *Hospitalizing the Mentally Ill*, 50 MICH. L. REV. 837, 847-48 (1952).

78. For *Parham*, which concerned children, there was the additional special concern of the importance that should be afforded to the intrinsic aspects of participation. *See also* Garvey, *supra* note 3, at 842.

79. *See, e.g.*, Burger, *Agenda for 2000 A.D.—A Need for Systematic Anticipation*, 70 F.R.D. 83 (1976); Frankel, *The Search for Truth: An Umpireal View*, 123 U. PA. L. REV. 1031 (1975).

and evidence of the opposition.[80] The second argument, which focuses on the decisionmaker's role and thus is closely connected with some of the issues to be discussed below, is that the adversarial method of presentation of evidence and argument helps to guarantee that the decisionmaker maintains an open mind about the matter in controversy throughout the process.[81] The decisionmaker constantly will be exposed to the evidence and arguments that are contrary to any initial impression formed about the exact nature of the problem or dispute and what should be done about it.

The special attributes of the due process decisionmaker, in addition to serving to protect the accuracy aim of the decisionmaking process, also tend to help legitimate the process in the eyes of the participant in much the same way as does participation. While independence and neutrality are rather generalized attributes of any decisionmaker, passivity is more closely connected with the adversary system.[82] Yet, as noted above,[83] there is some claim that the adversary process also is specially connected with independence and neutrality.

How essential are these various criteria to the broad goals of due process when the decisionmaker is a psychiatrist? Does the psychiatrist satisfy these criteria? Are there equivalent procedures or protections that will in their own way achieve these broad goals? A comparison between the use of the psychiatric decisionmaker and the restrictions placed on the use of the most for-

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80. *E.g.*, "The interesting striving of two contending parties is, in the long run, an infinitely better agency for the ascertainment of truth than any species of paternalistic inquiry." Millar, *The Formative Principles of Civil Procedure I*, 18 ILL. L. REV. 1, 16 (1923); "[t]he resultant decision should be very comprehensively and creatively fashioned because of this adversarial input." Adams, *The Small Claims Court and the Adversary Process—More Problems of Function and Form*, 51 CAN. B. REV. 583, 593 (1973).

81. "'An adversary presentation seems the only effective means for combating this natural tendency to judge too swiftly in terms of the familiar that which is not yet fully known . . . .'" Fuller, *The Adversary System* in TALKS ON AMERICAN LAW 34, 44 (H. Berman ed. 1971) (quoting an American Bar Ass'n Comm. report). *See also* Thibaut, Walker & Lind, *Adversary Presentation and Bias in Legal Decisionmaking*, 86 HARV. L. REV. 386, 389-90 (1972); Lind, Thibaut & Walker, *A Cross-Cultural Comparison of the Effect of Adversary and Inquisitorial Processes on Bias in Legal Decisionmaking*, 62 VA. L. REV. 271, 272-73 (1976). *But see* Damaska, *supra* note 58. For a discussion and critique of this argument in the broader context of justifications for the adversary system, see Simon, *supra* note 66, at 69-76.

82. *See supra* note 73.

83. *See supra* note 81 and accompanying text.

mal model developed for a due process decisionmaker[84]—the judicial-type decisionmaker—will shed considerable light on these questions.

B. *Traditional Restrictions on Judicial-type Officers Applied to Psychiatric Decisionmakers*

1. *Neutrality and independence.* Although the concepts of "neutrality" and "independence" represent two quite different characteristics of the ideal decisionmaker, the difference is not always emphasized.[85] At times it appears that they are used interchangeably, simply to mean "fair." But they provide further meaning to the "fairness" ideal and should be separately identified. Independence, as applied to a decisionmaker, does not refer to the absence of any personal predisposition toward the decision as a result of a concern with the outcome or the parties. Rather, independence in this context refers to insulation from influences on the decisionmakers that are external to either their own personal predilections or the data and arguments upon which the decision is supposed to be based. The expressed ideal is to have decisionmakers be independent from factors outside of the process itself, such as the political system, the demands of the institution of which they are a part, or the press.[86]

As a general matter, the Supreme Court has not found that due process requires that a decisionmaker have no connection with the relevant institution or state bureaucracy.[87] This is true in the mental health context as well.[88] Some district courts have imposed a requirement that the decisionmaker be independent from

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84. *See supra* note 86.

85. The Supreme Court has used the term "derivative bias" in discussing the possible due process significance of Medicare hearing officers' connections with private insurance carriers, although no such bias was found. Schweiker v. McClure, 456 U.S. at 197. This alleged inadequacy of the decisionmaker more properly should be viewed as a possible lack of sufficient independence from an entity that might be interested in the outcome. *See also* McCormack, *The Purpose of Due Process: Fair Hearing or Vehicle for Judicial Review?*, 52 TEX. L. REV. 1257, 1262-72 (1974) (discussion of "institutional bias").

86. For a recent discussion of the concept of independence in its most usual context—judicial independence—see Kaufman, *The Essence of Judicial Independence*, 80 COLUM. L. REV. 671 (1980).

87. Wolff v. McDonnell, 418 U.S. 539, 570-71 (1974). *See also* Goldberg v. Kelly, 397 U.S. 254 (1970).

88. Vitek v. Jones, 445 U.S. 480, 496 (1980).

the institution[89]—that is, not a member of the hospital which seeks to take the action opposed by the patient—or even that that decisionmaker be independent from the entire mental health department.[90]

In the context of mental health issues, is it necessary to require independence from the institution itself? A hospital is generally not the type of "interested party" which would try to influence the psychiatric decisionmaker in these cases. There is no evidence to support the contention that, because the hospital is holding the person or wishes to admit the person, only a psychiatrist who is independent from the hospital should make the initial decision of whether to admit or medicate the patient. This situation should be carefully distinguished from the one, to be discussed later, in which the initial decision already has been made and now the hospital might have reason to support its earlier conclusion.[91] If the "due process hearing" is simply the initial examination by the staff psychiatrist, independence from the institution would need to be demanded only in certain circumstances.

Such independence should be required only if there is some reason to believe that the institution itself would likely be interested in the outcome of the decision. If, for instance, there were some basis for thinking that a hospital wished to increase its inpatient population, then perhaps the decisionmaker determining a question of admission of a patient should be independent of the hospital. Today, such a situation would be exceptional.[92] However, it is plausible to posit that a hospital and its employees might have an interest in a different type of decision, such as whether medication is to be administered. Safety and working conditions might well be affected by such a decision.[93] Thus, the issue of the independence of the decisionmaker from the institution should

89. Rennie v. Klein, 476 F. Supp. 1294, 1310-12 (D.N.J. 1979), *rev'd*, 653 F.2d 836 (3d Cir. 1981) (en banc).

90. Doe v. Gallinot, No. CV76-107-F, slip op. at 2 (C.D. Cal. Jan. 20, 1982). *But see* Doe v. Gallinot, 657 F.2d 1017, 1024 (9th Cir. 1981).

91. *See infra* notes 116-19 and accompanying text.

92. The movement in recent years has been toward deinstitutionalization of public mental hospitals and toward outpatient care rather than inpatient care. *See generally* G. MACLEOD & M. PERLMAN, HEALTH CARE CAPITAL: COMPETITION AND CONTROL (1976).

93. *See* Plotkin, *Limiting the Therapeutic Orgy: Mental Patient's Right to Refuse Treatment*, 72 NW. U.L. REV. 461, 478 (1978).

depend on the nature of the decision[94] as well as on its timing vis-à-vis a previous decision.

The discussion of independence has focused on being independent of others who are not totally neutral. Neutrality, of course, is a basic requirement for the decisionmakers themselves.[95] Neutrality refers to the personal desires of decisionmakers; decisionmakers are neutral when they personally have no desire, deemed improper, to have the case decided one way or another. The concept can be further broken down, as it is in the judicial context, to include personal interest and bias.[96] Judges are "interested" in a matter if they are likely to personally gain or lose some concrete thing depending on the outcome of the decision.[97] Judges are improperly "biased" if they have some specific and unacceptable reason to favor or disfavor one of the parties to the dispute even though the judge has nothing concrete to gain or lose from the decision.[98]

As a general matter, psychiatrists might be found to be "interested" decisionmakers if it can be shown that they have some personal stake in the outcome of a decision. Usually, there is no foundation for believing that psychiatrists would have a financial interest in institutionalization decisions, although in other contexts it has been argued that doctors may be seen as having a financial conflict of interest.[99] But non-monetary interests are sometimes seen as inherent in certain psychiatric decisionmaking. As previously mentioned, a psychiatrist who works with a patient might have a personal interest in whether the patient is involuntarily medicated because of the possible effects on the psychiatrist's

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94. *See, e.g.*, Goss v. Lopez, 419 U.S. 565, 584 (1975) (due process requires, at a minimum, "give-and-take" of notice to student of ground for suspension of up to 10 days and opportunity for student to explain actions).

95. *See supra* note 71.

96. *See* CODE OF JUDICIAL CONDUCT, Canon 3(C)(1)(a) & (c) (1980). *See generally* Frank, *Disqualification of Judges*, 56 YALE L.J. 605 (1947); Note, *Disqualification of Judges and Justices in the Federal Courts*, 86 HARV. L. REV. 736 (1973).

97. 3 K. DAVIS, ADMINISTRATIVE LAW TREATISE § 19:6 (2d ed. 1980). *See* Frank, *supra* note 96, at 613-18.

98. K. DAVIS, *supra* note 97, § 19:5. *See* Frank, *supra* note 96, at 618-26. Bias is actually a term that can have a much broader meaning. *See* K. DAVIS, *supra* note 97, § 19:1. *See also infra* notes 107-08 and accompanying text.

99. Bennett, *Allocation of Child Medical Care Decisionmaking Authority: A Suggested Interest Analysis*, 62 VA. L. REV. 285, 319-20 (1976).

own convenience and safety.[100] It might be argued that a psychiatrist who makes any type of hospitalization decision concerning a person who would then be a patient is interested, either because of a desire to work on this "interesting case,"[101] or, conversely, out of a desire not to have the person as a patient.[102] Nevertheless, the danger of interested decisionmaking in this context may well be too speculative to justify excluding "treating psychiatrists" from such decisionmaking.

Similarly, it is conceivable that a psychiatrist may be personally biased or prejudiced against a particular patient, but there is no reason to believe that most or even a significant percentage of psychiatrists harbor the type of personal bias that requires disqualification of a decisionmaker. Admittedly, there have been suggestions that psychiatrists' clinical judgments are biased against minorities and persons from lower social classes.[103] But even if this were true, the intensity of the bias would probably be about the same as that harbored by judges as a whole[104] and thus would provide no basis for excluding psychiatrists in particular from the decisionmaking process. Indeed, psychiatrists may be the professionals who are *most* conscious of their biases and therefore most able to compensate for them.[105] While we might question any person's ability to overcome his or her own biases, at least psychiatrists are more likely to be aware of the need for the effort than

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100. *See supra* note 93 and accompanying text. Judges, too, can be seen as having a type of interest in certain decisions that affect their professional working conditions which, although not a basis for disqualification, at least should dictate better scrutiny of these decisions by appellate courts. *See* Berger, *The Mandamus Power of the United States Courts of Appeals: A Complex and Confused Means of Appellate Control*, 31 BUFFALO L. REV. 37, 102-04 (1982).

101. *See* Bennett, *supra* note 99, at 320.

102. *See* Weihofen, *Detruding The Experts*, 1973 WASH. U.L.Q. 38, 53 (1973).

103. *See* Abramowitz & Dokecki, *The Politics of Clinical Judgment: Early Empirical Returns*, 84 PSYCHOLOGICAL BULL. 460 (1977); Adembimpe, *Overview: White Norms and Psychiatric Diagnosis of Black Patients*, 138 AM. J. PSYCHIATRY 279 (1981).

104. There are some studies on sentencing that might suggest this. *See* Nagle, *Disparities in Criminal Procedure*, 14 UCLA L. REV. 1272 (1967); Tullock, *Does Punishment Deter Crime*, 36 PUB. INT. 103 (1974).

105. *See* A. FREEDMAN & M. KAPLAN, DIAGNOSING MENTAL ILLNESS 5-6 (1972); P. Mittler, THE PSYCHOLOGICAL ASSESSMENT OF MENTAL & PHYSICAL HANDICAPS 6-7 (1970).

Actually it is more likely that psychiatrists are more aware of their emotional responses to patients that could constitute biases, COMPREHENSIVE TEXTBOOK OF PSYCHIATRY, *supra* note 56, at 898, than they are conscious of actual class biases. *See* D. LIGHT, BECOMING PSYCHIATRISTS: THE PROFESSIONAL TRANSFORMATION OF SELF 185 (1980).

are most judges.

Indeed, bias is a far-reaching concept. A judge might wish to favor or disfavor a party because of an attitude toward the person which has no relationship to his particular status in the dispute. This is a "personal" bias and is normally one for which a judge is disqualifiable.[106] But we also speak of "bias" of judicial decisionmakers toward parties solely as a result of their position in the litigation—for example, being, in general, favorably disposed toward criminal defendants or defendants in product liability cases. Usually this stems from the judge's underlying political or jurisprudential outlook on life; it is actually a prejudgment about a question of law or policy. This latter type of predisposed favoritism is normally not deemed "bias" for purposes of disqualification.[107]

It is, of course, not always easy to differentiate disqualifiable personal bias from strong views on policy or legal questions.[108] This is particularly true when a judge is biased against a class of individuals,[109] such as selective-service offenders. In an extreme case, one court has found this to be a disqualifiable bias.[110] Psychiatrists, it has been claimed, have a tendency to overdiagnose mental illness—that is, to err on the side of finding that a person has such an illness.[111] One might argue, therefore, that they are improperly and personally biased against a class of people—those that are on the margin of being found to have a serious mental illness—if such a class could be identified. Yet this is really an indictment of the way in which they apply quite broad and amor-

106. Canon 3(C)(1)(a) of the CODE OF JUDICIAL CONDUCT uses the phrase "personal bias or prejudice concerning a party." *See* United States v. Thompson, 483 F.2d 527, 529 (3d Cir. 1973); K. DAVIS, *supra* note 97, § 19:5; Frank, *supra* note 96, at 618-26; Note, *supra* note 96, at 751-57.

107. *See, e.g.*, Deal v. Warner, 369 F. Supp. 174 (W.D. Mo. 1973). *See generally* Memorandum of Justice Rehnquist in Laird v. Tatum, 409 U.S. 824, 830-36 (1973); *In re* J. P. Linahan, Inc., 138 F.2d 650, 651-52 (2d Cir. 1943); K. DAVIS, *supra* note 97, § 19:2.

108. In the administrative context there is somewhat more willingness to find disqualification because of the decisionmaker's views about the parties resulting only from their position in the dispute. *See* K. DAVIS, *supra* note 97, § 19:5.

109. The classic case of a finding of disqualifiable bias against a class is Berger v. United States, 255 U.S. 22 (1921) (bias against Germans).

110. United States v. Thompson, 483 F.2d 527 (3d Cir. 1973).

111. "Mental health experts are a bit more inclined than the average person to declare that particular behaviors are abnormal and evidence mental disorder." Morse, *supra* note 6, at 556.

phous "standards." In other words, while psychiatrists might be more ready to find mental illness than they should be, this is more a general bias inherent in their expertise than a personal bias against a preexisting definable class.

It is true, though, that psychiatrists as decisionmakers possess a great deal of the general type of bias that normally is not a basis for disqualification. As a group they certainly have strong views on the matters that they would be deciding. These views are a function of their expertise. This same expertise that is the basis of using them as decisionmakers can also be viewed as a collection of biases. For all expertise is simply a collection of one or more "biases," if by this we mean viewpoints or outlooks on how the world and the people and things within it work.[112] Moreover, this is the type of "bias" that is the most difficult for anyone to recognize and overcome. One's professional training does not help to eliminate these "biases"; rather, it creates them.[113] Still, as indicated, these are not the types of biases that traditionally have been viewed as affecting neutrality of the decisionmaker sufficiently to require disqualification. As attempted below,[114] consideration must be given to whether these "biases" are a relevant factor in deciding who should be used as the actual due process decisionmaker and how expertise should be employed in the decisionmaking process.

There is, however, another standard due process requirement that seeks to ensure neutrality. This is the requirement that the due process decisionmaker have no substantial involvement in arriving at the original decision.[115] Although easily confused with the notion of being "independent" of the original decision,[116] this requirement actually is designed to prevent using an "interested" decisionmaker. Such a decisionmaker is "interested" in the out-

112. *See infra* notes 173-77 and accompanying text.

113. *See* Light, *supra* note 106, at 236-37, 252-57.

114. *See infra* notes 173-77 and accompanying text.

115. "In our view, due process requires that after the arrest, the determination that reasonable ground exists for revocation of parole should be made by someone not directly involved in the case." Morrissey v. Brewer, 408 U.S. 471, 485 (1972); *See also* Goldberg v. Kelly, 397 U.S. 254, 271 (1970). *But see generally* Withrow v. Larkin, 421 U.S. 35 (1975).

116. In Morrissey v. Brewer, the Court refers to the requirement in Goldberg v. Kelly, 397 U.S. 254, 271 (1970), that the due process decisionmaker should not "have participated in making the determination under review" as the "need for an independent decisionmaker . . . ." 408 U.S. 471, 482 (1972)

come because, already having made a decision in the matter, he or she has a personal stake in being proven right. Note that this is not the normal personal interest that exists prior to any formal presentation of the issue. Instead, it is a type of "professional" interest that arises solely because of involvement in the overall decisionmaking process regarding this matter. Once an individual has rendered a decision, it is doubtful that he or she could fairly be entrusted with further decisionmaking responsibility, even if different procedures would develop more and, hopefully, better information. Most people cannot truly keep an open mind about a specific question upon which they have previously announced a position because they become "psychologically wedded" to their initial position.[117] This might be even more pronounced for medical decisionmakers, who in general are quite sensitive to their reputations for professional competence.[118]

The manner in which this particular requirement should be applied to the psychiatric decisionmaker depends upon the circumstances in which the psychiatrist is used. In a situation like *Parham,* where the "hearing" is simply the initial examination by the staff psychiatrist, it is unlikely that the question will arise. The "formal hearing" and the initial decision by the institution will usually be one and the same. However, in situations in which the examining psychiatrist is the doctor who had originally suggested to the parents that the child should be hospitalized, it is questionable whether the physician can make a disinterested examination. Even if the suggestion were only a preliminary one based on a partial examination, the psychiatrist naturally would be somewhat "psychologically wedded" to his initial diagnosis. This type of predisposition, however, does not automatically constitute a basis for disqualification under the normal standards applied to adjudicators. The appropriate analogy might be that of the judge who has ruled on a preliminary injunction and is now conducting a full hearing for the final resolution of the case[119] or the administrative decisionmaker who had previously indicated there was probable

117. Withrow v. Larkin, 421 U.S. at 57; National Rifle Ass'n v. U.S. Postal Service, 407 F. Supp. 88, 93-94 (D.D.C. 1976).

118. Lowcher v. New York City Teachers Retirement Sys., 54 N.Y.2d 373, 378, 429 N.E.2d 1167, 1170, 445 N.Y.S.2d 696, 698 (1981).

119. *See* FED. R. CIV. P. 65.

cause for a complete investigation.[120]

A psychiatrist's complete medical examination of a patient before advising the patient's parents could qualify as the required due process hearing, assuming the psychiatrist is sufficiently independent of the parents. The psychiatrist could not bring a completely open mind to the issue at the time of the hospitalization, but that is not crucial. If due process required some type of appellate review (or, in the language of the medical profession, a second opinion), then there would be reason to have a new psychiatrist make the decision. But as a general matter, there is no constitutional right to appellate review,[121] and *Parham* does not appear to envision such a requirement in the particular context of institutionalization. Indeed, the psychiatric decisionmaker who previously had performed a complete medical examination is comparable to a judge who is considering a motion to reconsider his or her decision.

The question takes on added dimensions for the type of psychiatric decisionmaker envisioned by the district court in *Rennie*. Ignoring the serious issue of independence previously discussed,[122] should the psychiatrist who initially decided that the patient be given medication even over the patient's objections be qualified to be the decisionmaker when the "informal hearing" is held? The answer is dependent upon the nature of the hearing and the role of the psychiatric decisionmaker at that stage. Would the psychiatric decisionmaker at the "informal hearing" stage still conduct his or her own psychiatric examination of the patient? How much would the psychiatrist be restricted to relying only upon the "evidence" presented at the informal hearing?

The significance of these questions becomes clearer when one examines what seems to be a major part of the rationale for prohibiting any prior substantial involvement of the decisionmaker in the ordinary due process case. A decision is first made by an official operating on the basis of his or her own decisionmaking procedures. A traditional due process hearing is then necessary. The method by which the original decision was made is seen as procedurally inferior and inadequate to the due process

120. *See* Withrow v. Larkin, 412 U.S. 35 (1975); K. DAVIS, *supra* note 97, § 19:4.

121. Ortwein v. Schwab, 410 U.S. 656, 660 (1973); Griffin v. Illinois, 351 U.S. 12, 18 (1956). *Contra* Chaffin v. Stynchcombe, 412 U.S. 17, 24 n.11 (1973).

122. *See supra* notes 93, 100 and accompanying text.

hearing. Yet, the initial decisionmaker is already committed to a decision reached by using these inadequate and inferior procedures.[123] Thus, the psychiatric decisionmaker authorized in *Doe*, who would operate in an adversary context, could not be one who had previously made the initial diagnosis and decision to commit.

It might be a far different situation for the psychiatric decisionmaker at the informal hearing envisioned in *Rennie* if all the information gained from the original examination would be a proper aspect of this "informal hearing." The crucial question would be what else could be presented at this hearing. Would there be so much additional evidence and argument presented that the process should be seen as a whole new decisionmaking procedure, or would the judicial reconsideration analogy also be applicable here?

2. *Neutrality and passivity.* Another fundamental attribute of an adjudicator in an adversary system is passivity.[124] In the adversary model, the judge is not only neutral and independent, but is a passive arbiter as well: he or she does not take an active role in developing the information upon which the decision will be made. Instead, the opposing parties shoulder this responsibility and the judge decides solely on the basis of the information and arguments presented. Of course, strict adherence to this model varies greatly in practice[125] and there is considerable debate over the extent to which it should be the ideal toward which to strive.[126] Nevertheless, it is the general framework in which judges in this country act and is the model from which due process requirements are drawn.

As noted earlier, passivity is often seen as an adjunct to the other due process "rights," including those which allow parties an

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123. There is significance to the fact that an actual previous decision has been made to which the decisionmaker is now committed. *See supra* note 118; K. DAVIS, *supra* note 97, § 19:4.

124. *See* Resnick, *Managerial Judges*, 96 HARV. L. REV. 374, 380-86 (1982); Landsman, *supra* note 70, at 491 & n.11.

125. Judges, particularly federal judges, often have wide authority in such matters as commenting on evidence and questioning witnesss. *See, e.g.*, Ruiz v. Estelle, 679 F.2d 1115, 1129-31 (5th Cir. 1982), *cert. denied*, 460 U.S. 1042 (1983). There is also concern about the way in which federal judges have been abandoning passivity as they take on more responsibility for managing the pre-trial phases of cases. *See* Resnick, *supra* note 70.

126. *See* Frankel, *supra* note 79; Wyzanski, *A Trial Judge's Freedom and Responsibility*, 65 HARV. L. REV. 1281 (1952).

opportunity to be heard and present their case. Thus, one purpose of having the judge remain passive is to enhance the feelings of participation and control over one's own fate that have been identified as values being served by due process requirements.[127]

To what extent does the psychiatric decisionmaking process provide an equivalent means of ensuring participation and control? Although psychiatrists undoubtedly would find the inquiry strange, one can determine whether they afford their patients an equivalent of the right to be heard. The relationship between a psychiatrist and patient obviously is quite different than that between a judge and a party. In one sense, almost all that a psychiatrist does is "hear" the patient. But this is really just an observation of the patient's general thoughts and behavior rather than a "hearing" in which the patient's own view of relevant matters is presented. Certainly, good psychiatric practice is generally seen as taking the views and wishes of the patient into consideration.[128] One of the things that the psychiatrist must determine is whether these are the "true" wishes of the patients and whether the patients really understand what they claim to want. There is some reason to think psychiatrists are often skeptical of their patients' competence to participate in the process.[129] These same problems also can arise in a judicial setting; they are simply a part of the special aspects of the participation rights in mental health cases. Standard texts advise psychiatrists to consider their patients' desires and openly answer their patients' questions.[130] One significant current theory of the ideal therapy relationship stresses collaboration by "eliciting patient participation in their treatment and increasing their sense of being in charge of themselves

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127. *See* Landsman, *supra* note 70, at 492.

128. *See* Hoyt, *Therapist and Patient Actions in Good Psychotherapy Sessions*, 37 ARCH. GEN. PSYCHIATRY 159 (1980); Orlinsky & Howard, *The Good Therapy Hour: Experiential Correlates of Patients' and Therapists' Evaluation of Therapy Sessions*, 16 ARCH. GEN. PSYCHIATRY 621 (1967). One must be wary, however, of any attempt to generalize about psychiatric practice given the vastly different "schools" of psychiatry that exist. *See generally* A. HOLLINGSHEAD & F. REDLICH, SOCIAL CLASS AND MENTAL ILLNESS, 155-61 (1958).

129. There is some evidence of this attitude in regard to consent to treatment, especially by hospitalized patients. *See* Kaufmann & Roth, *Psychiatric Evaluation of Patient Decision-making: Informed Consent to ECT*, 16 SOC. PSYCHIATRY 11 (1981); Stone, *Informed Consent: Special Problems for Psychiatry*, 30 HOSP. & COMMUNITY PSYCHIATRY 321 (1979).

130. THE HARVARD GUIDE TO MODERN PSYCHIATRY 8 (A. Nicoli ed. 1978); COMPREHENSIVE TEXTBOOK OF PSYCHIATRY, *supra* note 56, at 902.

. . . ."[131] Of course, the realities of the quality and number of psychiatrists at state mental hospitals casts serious doubt on the degree to which the psychiatrists who would generally be used as due process decisionmakers would or could fit this ideal.[132]

Nevertheless, whereas some degree of participation probably occurs in most situations, it is likely that very little actual control of the process by the patient exists. The relationship is often built upon the patient having confidence in the psychiatrist, who actually directs matters, hopefully leading to solutions to the problems.[133] The participation/legitimation value of the party-controlled adversary proceeding is not necessarily something that psychiatrists are trying to foster. For many, their legitimation may come from more of a notion of desire for and acceptance of controls by the psychiatrist.[134]

This difference in approach, whatever its exact dimensions, is not one that automatically should disqualify psychiatric decisionmaking. In the first place, as mentioned earlier,[135] the intrinsic aspects of due process recently have been downplayed somewhat by the Court. Moreover, it is very questionable whether parties themselves, as opposed to their counsel, achieve much control over the actual determination of the matter in an adversary hearing. Finally, though the adversary system uses process as a means of legitimation, it does not follow that a completely different mode of decisionmaking, which seeks its legitimation by other means, should not be recognized.

Concern about the complete abandonment of passivity re-

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131. COMPREHENSIVE TEXTBOOK OF PSYCHIATRY, *supra* note 56, at 2366. In the hospital setting, this is supposed to be the relationship between staff and patient. Of course, there are actually various different models of the doctor-patient relationship. *See* Szasz & Hollender, *The Basic Models of the Doctor-Patient Relationship*, 97 ARCH. INTERN. MED. 585 (1956).

132. *See* Koz, *Catch-22: The Psychiatrist in the State Hospital*, 9 PSYCHIATRY ANN. 47 (1979); Gralnick, Schact & Kempster, *The Psychiatric Hospital as a Therapeutic Instrument*, 8 AM. J. PSYCHOTHERAPY 312 (Apr. 1954), *reprinted in* THE PSYCHIATRIC HOSPITAL AS A THERAPEUTIC INSTRUMENT 3 (A. Gralnick ed. 1969); THE PATIENT AND THE MENTAL HOSPITAL 44 (M. Greenblatt, P. Levinson & R. Williams eds. 1957).

133. Thus, the psychiatrist decides when to acquiesce to a patient's request. *See* COMPREHENSIVE TEXTBOOK OF PSYCHIATRY, *supra* note 56, at 898.

134. *See* D. LIGHT, *supra* note 105, at 224-26. For a strong statement of the necessity for control, see L. LINN, A HANDBOOK OF HOSPITAL PSYCHIATRY 11 (1955): "Patients who are sick enough to require admission to a mental hospital are without exception regressed to an emotional state of helpless infantile dependency."

135. *See supra* note 65.

mains. Does passivity exist only to fulfill these participation values of the adversary-process model, or is it also an essential adjunct to neutrality and thus accuracy in a more generalized context? In considering this, it is important to differentiate between passivity as an assurance of actual neutrality and passivity as the maintenance of the appearance of neutrality. In the adversary context, a judge's active involvement in developing evidence will almost never result in approximately equal amounts of favorable and unfavorable evidence for both sides. Thus, the judge may be perceived by a jury or one of the parties as being biased, as "helping" one side, even though the judge is supposed to be neutral and passive.[136] Notice, however, that this appearance of unfairness results to a great extent only because the judge's active participation is contrary to the adversary-system model's assumption that all parties should sink or swim on their own. Although such participation may sometimes lead to an appearance of impropriety in other systems, the likelihood of its doing so is minimized once it is recognized that the decisionmaker's involvement helps elicit the necessary information to ensure the most accurate decision possible.

The relationship between neutrality and passivity is best explored through discussion of a specific limitation on judicial decisionmakers: judges are not allowed to hear any case about which they have personal knowledge of disputed facts relevant to the matter at issue.[137] If a particular judge saw an automobile accident, for example, that judge could not sit on a case arising from that accident. Why should that be so? Arguably, decisionmakers who have personal knowledge of disputed facts might reach a more accurate decision than those who do not, provided both hear the evidence and testimony of others. Still, there are legitimate reasons to be wary of decisionmakers with their own "knowledge." Such decisionmakers can be considered neither passive nor neutral. They would lack passivity because they would base their

136. *See* Landsman, *supra* note 70, at 491; People v. Mees, 47 N.Y.2d 997, 394 N.E.2d 283, 420 N.Y.S.2d 214 (1979) (reversal of conviction because judge's unusually active participation in questioning witnesses created unfair trial).

137. CODE OF JUDICIAL CONDUCT, Canon 3(C)(1)(a) (1980). *See In re* Murchison, 349 U.S. 133 (1955). In the administrative law area, the rule is different and some combination of investigatory and adjudicatory authority is allowed. *See* K. DAVIS, *supra* note 97, § 19:4. This is still quite different, however, from the full use of the psychiatric decisionmaker. *See infra* text accompanying note 154.

decisions partly upon information that they gathered themselves rather than heard through the presentation of the parties. To state it in a more formalistic way, such information might be considered matter outside the record. Similarly, they would lack neutrality because they presumably would have some preconceived view of what happened based on their own observations outside the adversary context, and these observations might well be incorrect.[138] As has been noted,[139] it would be very difficult for judges to be able to determine impartially the veracity of their own knowledge.

The question is, then, whether this type of neutrality problem always arises when the passivity requirement is abandoned.[140] For instance, the psychiatric decisionmakers envisioned in *Parham* who would rely upon their own examination would certainly not be passive decisionmakers. They would be actively making their own "investigation" (examination) and developing their information based on their own observations. But whether or not they should be viewed as lacking neutrality because they would have their own knowledge of disputed facts is another matter.

Three aspects to this question should be recognized and considered separately. The first does not even concern neutrality directly, but naturally arises in the consideration of it: the contention that the psychiatrist, needing to determine whether certain things actually occurred in the past, will make these determinations in a manner less accurate than that which would result from a full judicial proceeding.[141] Such a contention posits that the lack of passivity directly causes inaccuracy (rather than doing so indirectly) by creating a situation in which the decisionmaker would not be neutral. The argument is based on a faith in the accuracy of the adversary system's method of determining facts rather than a belief in the inherent superiority of the decisionmaker.

The weaknesses of this contention are manifold. In the first place, some situations exist, such as that in *Parham*, in which it is

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138. There is psychological literature concerning the general problem of preconceptions. *See* R. NISBETT & L. ROSS, HUMAN INFERENCE: STATEGIES AND SHORTCOMINGS OF SOCIAL JUDGMENT 66-71 (1980).

139. *In re* Continental Vending Machine Corp., 543 F.2d 986, 995 (2d Cir. 1976).

140. For the view that this restriction on judges is a function of the adversary system, see Damaska, *supra* note 58, at 1105.

141. *See* Hiday, *The Attorney's Role in Involuntary Civil Commitment*, 60 N.C.L. REV. 1027, 1046 (1982).

not merely impractical and expensive to decide factual issues in an adversary setting, but arguably harmful to the ultimate objective of the proceeding.[142] Thus, some alternative form of fact-finding may have to be employed. Whereas the breadth of the claims of injury resulting from the use of the adversary system in mental health cases may be overstated,[143] there are definite problems with its use and perhaps some instances in which it should not be employed. Moreover, there is reason to question whether the legal system's adversary method of resolving evidentiary disputes definitely ensures greater accuracy than the methods relied upon by other professions. The claims of the superiority of adversary hearings have been called "assertions, which constitute a kind of 'folk-wisdom.' "[144] In fact, modern evidentiary rules recognize this doubt, to some extent, by allowing experts to testify upon the basis of information relied upon in their profession even if it is inadmissible under the prevailing evidentiary rules.[145] Admittedly, other professionals may make important decisions on the basis of evidence of questionable reliability, but judges, too, often do the same. Furthermore, an argument can be made that psychiatrists are better than non-experts in resolving credibility disputes in mental health cases because they are able to determine if outside reports are consistent with their own evaluation of the patient.[146]

The second important aspect of the relationship between a psychiatric decisionmaker's lack of passivity and neutrality stems from a claim on behalf of the adversary system briefly mentioned earlier.[147] This is the contention that the tendency to rely upon premature conclusions is lessened, and hence the continued neutrality of a decisionmaker is better ensured, when a passive decisionmaker is forced to be constantly exposed to the opposing evidence and arguments presented by the adverse party. Presumably psychiatrists reach tentative conclusions as their own examination and investigation proceeds. Can they keep an open mind on the

142. For examples of this problem in other contexts, see Boyer, *supra* note 43, at 121.

143. *See* Wexler & Scovile, *The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 69-72 (1971).

144. Kirp, *supra* note 68, at 873.

145. *See, e.g.*, FED. R. EVID. 703. *But see* Note, *Hearsay Bases of Psychiatric Opinion Testimony: A Critique of Federal Rule of Evidence 703*, 51 S. CAL. L. REV. 129 (1977).

146. But it is also claimed that, as a general matter, psychiatrists have no special expertise in making credibility determinations. Morse, *supra* note 6, at 614-15.

147. *See supra* note 81.

question until the investigations are completed? The seriousness of this issue is illustrated by the famous Rosenhan study,[148] which, among other things, seemed to indicate that once a person has been labeled as mentally ill, mental health professionals are prone to interpret all actions of the person in a manner consistent with that initial diagnosis. It is logical to assume that a tendency for this same type of error is likely to exist at even earlier stages of the yet to be completed diagnostic process. Indeed, one observer of psychiatric residents claims that they are, in effect, taught "to get the patient to produce some material which could be used to support one's prior interpretation."[149] Perhaps passive decisionmakers acting in an adversary setting are less susceptible to this problem; the empirical evidence said to support this proposition is, however, quite questionable.[150] I believe common sense gives some weight to this claim but that may simply be a function of my own legal training. Psychiatric decisionmakers act in their role as trained professional decisionmakers, and any preliminary observations they make occur only in the context of the official decisionmaking process. Unlike judges, admittedly, their training may encourage rather than discourage the early formulation of hypotheses or conclusions.[151] Nevertheless, psychiatrists always have to deal with this problem and are well aware of it.[152] Moreover, as a general rule, judges cannot be disqualified for bias as a result of any facts or information learned while formally presiding over a case even though they may develop some degree of partiality that ideally should not exist.[153] Similarly, psychiatric deci-

148. Rosenhan, *On Being Sane in Insane Places*, 179 SCI. 250, 252-54 (1973). The study has received much criticism, at least partly on the basis that the study merely showed examples of poor psychiatric practice. Wideman, *Psychiatric Disease: Fiction or Reality?*, 37 BULL. MENNINGER CLINIC 519 (1973); Schectman, *On Being Misinformed By Misleading Arguments*, 37 BULL. MENNINGER CLINIC 523 (1973). For a general criticism, see Spitzer, *On Pseudoscience in Science, Logic in Remission and Psychiatric Diagnosis: A Critique of Rosenhan's "On Being Sane in Insane Places,"* 84 J. ABNORMAL PSYCHIATRY 442 (1975), and the reply in Rosenhan, *The Contextual Nature of Psychiatric Diagnosis*, 84 J. ABNORMAL PSYCHIATRY 462 (1975).

149. D. LIGHT, *supra* note 106, at 224-26.

150. *See* Damaska, *supra* note 58, at 1095-1103, criticizing the main empirical study of Thibaut, Walker & Lind, *supra* note 81.

151. *See* D. LIGHT, *supra*, note 105, at 224-26.

152. Psychiatric texts do warn against failing to reconsider initial diagnoses. *See, e.g.* H. SULLIVAN, THE PSYCHIATRIC INTERVIEW 74, 121 (1958).

153. United States v. Grinnell Corp., 384 U.S. 583 (1966); Wolfson v. Palmieri, 396 F.2d 121, 124 (2d Cir. 1968). *But see* Reserve Mining Co. v. Lord, 529 F.2d 181, 185 (8th Cir. 1976) (recusal appropriate where district judge demonstrated great bias through overt

sionmakers probably cannot be viewed as lacking minimal requirements of neutrality even though another system might provide slightly better assurance of neutrality.

The third aspect of the psychiatric decisionmaker's active role that might be seen as causing a neutrality concern is that psychiatrists in their own practice base their decisions on their own examinations. Unlike cases in the administrative law context that have allowed adjudicators to be used who had been involved in the investigatory process,[154] psychiatric decisionmakers authorized by *Parham*, and perhaps *Rennie*, would not simply have heard the testimony of potential witnesses in an *ex parte* setting, but actually would have done their own examinations from which they would have drawn their own conclusions. Arguably, they would have the same problem evaluating the veracity of their own conclusions that the judge has in evaluating his or her own observations of the automobile accident.

Perhaps in some respects this criticism is true. Nevertheless, psychiatrists' neutrality should not be viewed as inherently tainted. The judge who saw the accident has no special abilities or training in viewing and remembering such occurrences.[155] The personal knowledge came from outside the judge's role as a trained decisionmaker and outside the context of the sanctioned decisionmaking process.[156] In contrast to this, psychiatrists' observations and conclusions will be made within the context of their professional decisionmaking ability and responsibility. A decision may not be an accurate one, but that would be a result of the inadequacy of the substantive capabilities of the decisionmaker rather than the result of lack of neutrality of the decisionmaker.

It is undoubtedly true that psychiatric decisionmakers are likely to rely on their own observations rather than on the opinions of others. This would occur even in a hybrid situation like that of the *Rennie* district court where psychiatrists would have to listen to the adversary presentations of the parties in addition to doing their own examination. This does not mean, however, that psychiatrists cannot be seen as *neutral* decisionmakers. That psy-

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acts and where he assumed role of advocate).

154. Withrow v. Larkin, 421 U.S. 35 (1975). *See* K. DAVIS, *supra* note 97, § 19:4.

155. *See* Tyler v. Swenson, 427 F.2d 412, 415 (8th Cir. 1970).

156. Admittedly, at one time jurors made their decision based on their own personal knowledge. *See* W. FORSYTH, HISTORY OF TRIAL BY JURY (1852).

chiatrists rely on their own observations is not a matter of neutrality but rather of the substantive manner in which the decision is to be made. They do not rely on the expert opinions of others because, unlike most judges, they possess their own expertise on the "scientific" aspects of the question and that is what they would use as the fundamental basis for making decisions. The ultimate question of what the decision should be is to be made solely by the decisionmaker. A judge permits no expert opinions on the essential question of how a case should be decided; that is the judge's function, for which he or she is trained. Similarly, the expert who makes a decision based on his own expertise need not necessarily entertain opinions from other experts. Such a model does not fit our conception of the passive arbiter in the adversarial decisionmaking process, but that does not prove that the particular decisionmaker cannot be neutral. It is simply an entirely different use of expertise in the decisionmaking process.

In summary, one finds that problems exist with the use of psychiatric decisionmakers, especially ones who would not remain passive. Still, the severity of these problems viewed solely in the context of judicially recognized concerns about due process is not so great that psychiatric decisionmakers as a class could not meet traditional minimal levels of independence and neutrality. These matters must be evaluated in particular cases, as with any decisionmaker; but there is no inherent reason to believe that the psychiatric decisionmaker (or pyschiatric decisionmaking process) lacks the normal minimal characteristics, or sufficient equivalents, of the basic requirements of due process as they are currently viewed by courts. Nevertheless, there are other relevant considerations that need to be explored in order to properly evaluate the importance of choosing a particular type of decisionmaker in any given instances.

III. The Appropriate Role of Expertise in the Decisionmaking Process

A. *The Nature of Psychiatric Expertise*

Even if, as argued above, the use of a psychiatric decisionmaker presents no inherent problems of independence or neutrality, as those terms are used in the due process context, this

should not end the inquiry. The question remains whether the psychiatrist's expertise should be used in this fashion in the decisionmaking process.

Implicit in this question is the assumption that the psychiatric profession has some expertise that can be used in the decisionmaking process. Confusion can result from the failure to differentiate between doubts about the expertise of a particular profession and doubts about using a member of that profession as an expert decisionmaker. Thus, the criticism, probably valid, that psychiatrists have a poor accuracy rate in diagnosing mental illness and predicting the utility of hospitalization[157] does not go directly to the issue of whether a psychiatrist can be a proper decisionmaker. Rather, it is relevant to the broader question of whether the type of issue that the psychiatrist is to decide is one that any decisionmaker is likely to decide with a high degree of accuracy.

Viewed from another perspective, however, this argument concerning the accuracy of psychiatric diagnosis challenges the presumption that psychiatrists possess any expertise at all on those matters that should enter the decisionmaking process. This is the contention presented by Stephen Morse.[158] His thesis is that psychiatrists are not experts on the legal questions of when one should be deemed "crazy," because these are social and moral questions rather than scientific ones.[159] This thesis is one which has much to offer.

Nevertheless, we cannot easily dismiss psychiatric expertise from the decisionmaking process. Even Morse does not do so. He argues, in effect, that psychiatrists should not play a role in the actual decisionmaking, but can aid in the fact-finding process.[160] They can do this by reporting to the triers of fact such information that may not be known to them. They can tell the judge or jury relevant things they observed the person had said or done

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157. *See* Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693, 697-719 (1974).

158. Morse, *supra* note 6. Morse's basic contention is challenged in Bonnie & Slobogin, *The Role of Mental Health Professionals in the Criminal Process: The Case for Informed Speculation*, 66 VA. L. REV. 427, 452-96 (1980). Morse's reply is Morse, *Failed Explanations and Criminal Responsibility: Experts and the Unconscious*, 68 VA. L. REV. 971 (1982).

159. Morse, *supra* note 6, at 560. *See also* J. ZISKIN, COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY (2d ed. 1975); Ennis & Litwack, *supra* note 157.

160. Morse, *supra* note 6, at 601-15.

that the lay trier would not have noticed.[161] Morse, however, wishes to prevent psychiatrists from drawing their own conclusions from this information. Morse recognizes that psychiatrists have some special expertise in observing people and gathering relevant data,[162] yet he finds no corresponding psychiatric expertise in reaching conclusions from this data.

As mentioned earlier,[163] however, these two functions are not easily split. Should the psychiatrists simply report on certain comments or behavior from their examinations when they view the matters as a whole? If psychiatrists have some expertise in conducting examinations of allegedly mentally ill persons, why should they be relegated to trying only to pass on the raw information?[164] Why can they not go the next step and offer their own conclusions, or in the present setting, actually be the decisionmakers?

Morse's only answer to the questions he was considering appears to be that these decisions must be made by "society's representatives."[165] Why can psychiatrists not play this role? One possible reason is that, unlike judges, psychiatrists are not specifically chosen to be decisionmakers for the public. This merely begs the question, however. The more sophisticated version of this argument is that judges are chosen by some type of political process, be it direct election or appointment by elected officials. Although this is true, one goal of making judges independent is to insulate them from politics, much as psychiatrists are so insulated. Moreover, not all due process decisionmakers are a direct product of the political system.[166] If political selection were really thought to be the crucial protection, psychiatrists conceivably could be elected to decisionmaking positions in the legal system.[167] Thus, the question of whether psychiatrists could be used as "society's representatives" requires further exploration.[168]

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161. *Id.* at 611-12.

162. *Id.* at 612.

163. *See supra* note 57 and accompanying text.

164. *See generally* Bonnie & Slobogin, *supra* note 158, at 468-69.

165. Morse, *supra* note 6, at 560.

166. For instance, many hearing officers such as federal administrative law judges are chosen in a non-partisan manner. 5 U.S.C. § 3105 (1982).

167. This suggestion may seem somewhat absurd perhaps, but consider that coroners are still elected in some places. *See* Sheehan, Phenneey, Bass & Green Professional Ass'n, *Death Investigation: An Analysis of Laws and Policies of U.S., Each State and Jurisdiction (as of Jan. 31, 1977)*, HEW No. 240-76-0021 (1978).

168. *See infra* notes 180-84 and accompanying text.

At this time it is sufficient to note that if we choose to try to make decisions regarding who should be hospitalized or given medication against his or her will, we must recognize that the group with the most expertise on matters relating to these questions is psychiatrists.[169] Thus, that psychiatrists are going to play some role in the decisionmaking process is inevitable. Still open is the question of what this role should be, or more particularly, who should actually be the formal decisionmaker. Though this question was explored above in the specific and somewhat narrow context of due process requirements, traditional considerations of independence and neutrality are not the only relevant considerations when comparing the psychiatric decisionmaker and the judicial decisionmaker. While these may constitute essential qualifications for a decisionmaker, there may be a need to provide additional controls if there is to be an effective check on the specialized biases of the profession as a whole.

B. *Necessity for an External Control on Psychiatric Decisionmakers*

The need for an external control on the psychiatric expert can be so crucial that it affects the determination of who should be the ultimate decisionmaker. Such control is necessary in many instances because some check upon the psychiatric profession itself is needed. The accepted principles of "neutrality" discussed above, which generally allow the use of a particular decisionmaker regardless of that person's "political" or "philosophical" views, should not necessarily apply where the question concerns using a member of a given profession. As was suggested above, the expertise of the members of the psychiatric profession regarding the issues involved in the decisions they are to make renders them too biased to make some decisions without an external control.[170] A

169. This does not mean that every psychiatrist should be allowed to testify, nor that other mental health professionals might not have sufficient expertise to qualify as expert witnesses. *See* Bonnie & Slobogin, *supra* note 158, at 455-61.

170. One may ask whether judges do not also constitute an entire profession with a particularlized knowledge over which there is a need for an external check. As a general matter, there is no such external control on judges. Appellate review exists, but this is not an external control for the profession itself. Admittedly, there is the significant recent phenomenon of the judicial conduct commission, *see* I. TESITOR & D. SINKS, JUDICIAL CONDUCT ORGANIZATIONS (2d ed. 1980), but these commissions do not constitute much of an external control. In the first place, it is probably inaccurate in this context to categorize these commissions as external controls on the judicial profession in light of the fact that ultimately

check on their views is often necessary. Indeed, the question of how to determine whether or not a particular type of decision should be termed a "medical" one actually should depend upon the degree and form of external control which is deemed necessary on the medical profession. This decision, in turn, necessitates a determination of the type of decisionmaking that should be used for a particular issue. Obviously an accurate decision is desired, but there are many possible definitions of accuracy, even where, as here, "individual" disputes rather than polycentric disputes are involved.[171] The substantive questions at issue here are fundamental ones concerning the way in which the affected person will be able to live, at least for the short term. Normally, that person, if an adult, is considered to be able to make the most accurate decision of how his or her life should be lived; the person's own views, in other words, set the standard of accuracy. If the person is incompetent, an effort is still made to make the decision on the basis of what the affected person would want by having a guardian be the decisionmaker. The guardian presumably tries to make the decision on the basis of a type of "expert knowledge" of what the affected person would choose to do if competent.[172] Even though

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the authority over the commissions rests with judges, usually those of a state's highest court. *See id.* at 3. Moreover, the commissions are not a check on any particular decision. *See* People *ex rel.* Harrod v. Illinois Courts Commission, 69 Ill. 2d 445, 372 N.E.2d 53 (1978). For purposes of this discussion it is sufficient to note that the overall conduct of a judge might be subject to some outside control, but not the decisionmaking authority in a specific instance. This is generally true of the other even less viable controls such as recall or impeachment. Even judges who must face the voters view re-election as a control on their individual decisionmaking in only the rarest of cases.

For some decisions, especially in criminal cases, the jury may be viewed as an external control. Admittedly, the judge exercises varying degrees of control over the jury even though the jury technically is the ultimate decisionmaker. *See, e.g.*, FED. R. CIV. P. 50. This constitutes a type of dual decisionmaking somewhat analogous to that suggested *infra* notes 174-77 and accompanying text. Yet for many other decisions, sentencing being a prime example, there may be no outside check on the judicial profession, although even for sentencing it has been argued that the judge is not an "expert" and that he shares this responsibility with experts such as probation officers and penologists. P. DEVLIN, THE JUDGE 22-34 (1979). There are, then, many decisions which, under the analysis here, would have to be viewed as involving issues appropriately considered internal to the particular knowledge of judges. *See infra* notes 178-82 and accompanying text. Whether and how one can justify assigning such a large number of decisions and issues to the domain of judges' special knowledge is a complex and intriguing question that is beyond the scope of this Article.

171. For a discussion of similar issues in the context of polycentric disputes, see Boyer, *supra* note 43, at 124-30.

172. Actually, it may be quite difficult for anyone to make the decision on any basis other than what he himself thinks is best. *See* R. BURT, TAKING CARE OF STRANGERS (1979).

there is a surrogate decisionmaker, theoretically the standard of "accuracy" still is that of the affected person's own wishes.

Most of this Article, however, has addressed the decisionmaking process in instances in which the wishes of the affected person do not set the standard of accuracy. At this point, at least two other possible standards of "accuracy," or different criteria for making the decision, become relevant. Trying to base our decision on the "best" current scientific view of the issue is one possibility. Alternatively, a look toward the mythical "reasonable man," which in this context is probably the equivalent of a person possessing "common-sense," might be employed. Recognized experts, such as psychiatrists, base their decisions on what they believe the best currently accepted knowledge dictates, and thus incorporate the basic premises of their field into the process. Decisionmakers looking to the reasonable man standard try to reach their decisions on the basis of what, in their view, most "rational" members of our society would deem correct. It is a decision based on this latter standard of accuracy which, in effect, Morse is advocating. Indeed, this "common-sense" standard should play the dominant role for many decisions in the area of mental health law. But once one accepts that legal procedures raise issues which may exceed anyone's knowledge, it seems evident—more so than Morse would concede—that the "scientific" standard must play a necessary part in the decisionmaking process.

Still remaining, though, is the question of why a judge can apply the "reasonable man" standard and represent "society" while a psychiatrist cannot. In one sense, neither the psychiatric nor the judicial decisionmaker is representative of the "common man"—even if there were such a thing—as it might be argued a jury is. Both are by definition professionals. For the most part, they are "representative" of only a small socio-economic segment of our society. Whatever decisionmaking they both engage in on behalf of "society" is justified on the basis of their having some superior knowledge and training.

To a substantial degree, nevertheless, the judicial decisionmaker can effectuate the purpose of the "reasonable man" standard of "accuracy" whereas the psychiatric decisionmaker cannot. Ironically, the psychiatrist is unqualified for this role for much the same reason an expert is generally deemed qualified: his or her possession of special expertise. The judge is a non-specialist

on the technical or scientific dimensions of these issues, whereas the psychiatrist is a specialist. One might contend that this means we should be more doubtful about the judge's ability to understand and reach an accurate decision about a matter in which the judge has no particular scientific expertise. At one level this is true. Nevertheless, as a non-specialist the judge can better act as a representative of a broader segment of society's views on the matter. At the same time, the views of the expert will certainly play an important part in reaching the final decision. But there needs to be some check on that expertise, on that specialized bias, and it is not provided by due process requirements of neutrality. Indeed, it cannot be expected to come from within the profession because, although there are exceptions,[173] basically all members of the profession agree with the underlying principles to which the profession is rooted. This is an inherent part of their expertise, an inherent part of any science.[174] A part of the socialization of a new professional is the internalization of these basic premises.[175]

As the non-specialists on these matters, judges can represent a more varied spectrum of thoughts—less-informed thoughts, but certainly more varied. Judges can act as a check on psychiatric opinion by setting the outer limits of what the non-expert members of society will accept no matter what the technical experts believe. The control needed is some non-psychiatrist with the au-

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173. At present, the best known psychiatrist who would probably qualify as such an exception is Thomas Szasz. *See, e.g.*, T. SZASZ, THE MYTH OF MENTAL ILLNESS (1961).

174. "Paradigm formation is fundamental to science as a social process. Without the personal commitment of individual scientists to the same world picture, there could be no communication, no basis for criticism, no criteria for consensuality." J. ZIMAN, RELIABLE KNOWLEDGE 90 (1978). "Thus scientific knowledge in any era is what the scientists actively take as such, and the scientific knowledge of one era may be rejected as error in the next." H. BROWN, PERCEPTION, THEORY AND COMMITMENT 151 (1977). *See also* S. BUCHANAN, TRUTH IN THE SCIENCES (1972).

175. "The aim of a professional scientific education is to develop the ability to live at ease within the current scientific consensus—to 'think physically' (or 'chemically', or 'biologically') as we dons like to put it. Experience has shown that it is practically impossible to contribute to physics, or chemistry, or geology, or physiology until one has become a 'physicist', or a 'chemist', or a 'geologist', or a 'physiologist' by internalizing the paradigm of one's subject." J. ZIMAN, *supra* note 174, at 90.

"[S]ocialization involves becoming the values, language, behavior patterns, and beliefs of a social group which have a relatively enduring impact on how a person conducts him—or herself. . . . Socialization differs from learning, whether one is learning knowledge, skills or roles, because it indicates a personal involvement and absorption that 'learning' does not." D. LIGHT, *supra* note 105, at 326. Because of the nature of psychiatric training, this internalization is "unusually thorough." *Id.* at 256.

thority of society to say: "Wait a minute. That's not right. We're not going to do that no matter what people in your profession say." Psychiatrists as specialists cannot provide much of a check on each other at the broadest level. There can be bitter debate and disagreement within the profession, but the outside check provided by someone with an open perspective—even if an uninformed one—is still needed.[176] For, as recognized in a more general context, "[t]he expert—who ought to know better . . . is often more credulous than the layman concerning the foundation of his knowledge."[177]

We should be careful, however, not to be too glib about the efficacy of relying upon common sense, because "[c]ommon-sense conclusions, particularly about human nature, are not necessarily the embodiment of the wisdom of the ages."[178] It might be that in some situations we do not need or want the check of the person who lacks knowledge of and belief in the basic principles of the field. These are disputes that raise issues that should be left solely to the internal processes of expert knowledge. For our particular inquiry, they constitute the true "medical decisions."[179] Yet saying that there may be such instances is much easier than identifying which they are.

The question of who should be the decisionmaker when an involuntarily hospitalized patient refuses psychotropic medication presents one such hard case. On the one hand, even an independent psychiatrist is likely to share the approach, perspective, and biases of the treating doctor.[180] The utility and desirability of medicating patients is one of the deeply ingrained aspects of most

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176. "Each person [psychiatric resident] absorbs these common elements, yet crafts them in a way that suits his or her style. . . . From an inside perspective, this gives the impression of eclectic diversity, just as an outside perspective may perceive uniformity. By the nature of the process, both are right." D. LIGHT, *supra* note 105, at 237.

177. J. ZIMAN, *supra* note 174, at 91.

178. Diamond & Louisell, *supra* note 57, at 1343.

179. The Supreme Court has recently decided, in effect, that the question of what minimally adequate training is due involuntarily hospitalized mentally retarded patients should be a matter committed solely to the domain of the "experts," and thus held that professional decisions are "presumptively valid" and that "liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment." Youngberg v. Romeo, 457 U.S. 307, 323 (1982).

180. Brooks, *supra* note 27, at 199.

modern psychiatry, especially as practiced in public hospitals.[181] The use of such medication can have serious physical consequences and can infringe on basic notions of autonomy and privacy. On the other hand, this still may not be the type of decision for which we need the check of the non-specialist. The question of the person's mental illness will have already been determined. The question is reduced to the type and level of treatment that can be used against the patient's desires. Is this just a "technical" question—that is, one that should be resolved by an independent expert decisionmaker without an outside check on the profession? It is very hard to say. Perhaps Alexander Brooks is right when he comments that many of the concerns about the use of medication in state hospitals which might cause one to seek a check on the psychiatric profession on this issue (such as actual selection of medication by nurses or attendants) are, to a great extent, the result of the failure of of the psychiatric profession to regulate itself.[182] This suggests that the problem is not the inherent nature of the professional beliefs, but the lack of adherence to the dictates of the best of these beliefs. If this is true, it might be appropriate to have truly independent psychiatrists act as decisionmakers for disputes about refusals to accept medication.

C. *Form of the External Control*

Once the necessity of an outside control on psychiatrists is accepted, the issue becomes what form that control should take. Perhaps the psychiatrist should be left unconstrained as the initial decisionmaker, subject soley to the external check of judicial review. This is the general policy in the analogous situation of administrative-agency decisions.[183] Indeed, it has been argued that the due process requirement is primarily designed just to provide an adequate record for review.[184]

Such external control, however, would not be sufficient—particularly under the current standard of substantial evidence on the record as a whole. This Article has suggested that

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181. *Id.* at 182, 200; DuBose, *Of the Parens Patriae Commitment Power and Drug Treatment of Schizophrenia: Do the Benefits to the Patient Justify Involuntary Treatment?*, 60 MINN. L. REV. 1149, 1167-68 (1976).

182. Brooks, *supra* note 27, at 208, 214.

183. Administrative Procedure Act, 5 U.S.C. § 706(2) (1982).

184. McCormack, *supra* note 85.

the non-expert should question the expert's findings whenever they seem too distant from his or her own common sense. As has been noted,[185] however, one of the serious problems today is that many judges do not provide much of a check on the psychiatrist even when the judge is the actual decisionmaker. There is even less likelihood that they would do so when there is only a "cold record" to review rather than an ability to see, hear, and question the expert. It is therefore at the fact-finder stage where this type of societal "veto" power should be placed, the type of power exercised by the jury in criminal cases. Traditionally, the jury is seen as exercising a common-sense check by using its power of nullification and, in effect, rejecting the legal standard[186] whenever it believes that "the law" is inappropriate or simply wrong. This same function needs to be performed by the non-expert who could reject the "science" of the psychiatric expert.[187]

Finally, judicial review as a means of control would be insufficient in the quantity as well as the quality of control it would provide if used. The check needs to be more pervasive than one which would result in the relatively rare instances where some party would endure the time and expense of judicial review. The external control on the psychiatric expert should be a part of each decision and not just exist as a generalized control over a category or type of decision.[188] Thus, in those situations where the outside check is desired, the ultimate decisionmaker should be the non-specialist.[189] Even where only expert testimony is to be offered, there is a strong reason to prefer that the expert enter the process

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185. *See supra* note 6.

186. "The jury's fundamental function is not only to guard against official departures from the rules of law, but on proper occasions themselves to depart from unjust rules and their unjust application." M. KADISH & S. KADISH, DISCRETION TO DISOBEY 53-54 (1973).

187. In somewhat the same vein, Alan Stone has included in his thought-provoking suggested standard for civil commitment a provision requiring the determination that a "reasonable man" would choose hospitalization under the particular circumstances of the case at issue. A. STONE, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION 67 (1975).

188. Admittedly, it might be possible to have a joint tribunal consisting of an expert and legally trained (and/or) lay decisionmakers similar to that used for malpractice claims. *See* Friedman, *Arbitration in Medical Malpractice*, 13 TRIAL 49 (Aug. 1977). But that would mean there would still have to be the presentation of experts as witnesses and the added expense of a joint tribunal.

189. Perhaps the non-specialist decisionmaker should not hear only mental health cases for any long period of time in order to try to retain more of the common-sense check. *See* C. WARREN, THE COURT OF LAST RESORT 212-13 (1982).

in the form of a witness rather than a decisionmaker. As such, there is some sense to the solution suggested by Justice Brennan in *Parham* wherein a judicial proceeding would be held which, in effect, would resolve an issue based solely on hearing the opinions of psychiatrists.[190] Even in situations in which only an impartial court-appointed expert testifies, the non-specialist still should be the decisionmaker if an effective external control on psychiatric expertise is to be maintained, even when the parties are not allowed to cross-examine the expert. There is value in having the expert appear as witness rather than decisionmaker beyond the fact that it gives the parties an opportunity to explore and challenge the expert's views. This opportunity is undoubtedly important and aids whatever hope there is of having the non-specialist act as an effective check on that expert. But the actual check of the non-specialist decisionmaker is in fact an independent one that is not inherently connected to the adversary system. The adversary system provides many protections, but the protection of an adequate external control on psychiatric expertise can be provided only by having the actual decisionmaker be a non-expert.

CONCLUSION

It is important to recognize that the psychiatric expert is almost always a part of the decisionmaking process in cases involving mental health issues. Even when the expert is put in the role of witness with a limited ability to express an opinion on the "ultimate" issue, he or she, in reality, shares in the decisionmaking. This does not mean, however, that there is no significance to whether the psychiatrist participates as witness rather than decisionmaker. Whether psychiatrists can meet the most basic levels of independence and neutrality required of due process decisionmakers, even when using their own decisionmaking procedures, is not a legitimate concern. They can satisfy these requirements as they are currently formulated. Nevertheless, there is still a need for an outside check by a person who is not a specialist in this "science" who will better reflect the broader, societal interest on mental health issues. By making the psychiatrist the witness rather than the decisionmaker, there is hope that the needed con-

190. *See* Parham v. J.R., 442 U.S. 584, 637-38 (1979).

trol will be exerted on the views of this expert and on the psychiatric profession as a whole.