Maryland Law Review

Volume 32 | Issue 1 Article 5

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LAWYERS AND PSYCHIATRISTS IN THE COURT: ISSUES ON CIVIL COMMITMENT*

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Complete agreement in any dialogue between psychiatrists and lawyers can hardly be expected, even if they are successful in communicating their viewpoints to each other. In any issue on civil commitment of the mentally ill, the price of disrupted communication, or a lack of communication, between lawyers and psychiatrists which results in unnecessary confrontation or premature compromise, is paid by the patient whose needs might otherwise have been handled differently. What is needed for better communication is a recognition and an understanding by each of the modes of thinking and analysis of the other.

In September, 1965, revisions of the Mental Hygiene Law concerning hospitalization of the mentally ill[1] went into effect in New York. Since then, a group of lawyers specializing in the psychiatric field has been formed in that state. These lawyers, full-time employees of the Mental Health Information Service (MHIS) of the Supreme Court of the State of New York, are assigned to psychiatric hospitals in New York City and surrounding areas. They render free legal services to patients faced with hospitalization.[2] The staff attorneys of the MHIS of the First Judicial Department also represent these civil patients at any court hearings held concerning hospitalization.[3] In the First Department, seven or eight attorneys from the MHIS are always

* This work was supported by Public Health Service Grant MH 16485 from the National Institute of Mental Health. The materials on which this article is based (*see* note 10 *infra*) are on file under this grant number at the National Institute of Mental Health, Bethesda, Maryland.

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1. N.Y. MENTAL HYGIENE LAW §§ 70–88 (McKinney 1971).

2. For administrative purposes the State of New York is divided into four judicial departments. N.Y. JUDICIARY LAW § 70 (McKinney 1968). The Mental Health Information Service (MHIS), established pursuant to N.Y. MENTAL HYGIENE LAW § 88 (McKinney 1971), is similarly divided into four judicial departments. Only in its First and Second Departments is the MHIS staffed by lawyers. In the Third and Fourth Departments, the MHIS is staffed primarily by social workers.

3. *See* REPORT OF THE NEW YORK JUDICIAL CONFERENCE 60–61 (1967). In the other departments, the courts appoint public counsel for indigent patients. N.Y. JUDICIARY LAW §§ 35(1)(a), (2) (McKinney 1968). *See* N.Y. COURT RULES § 606.1(a)(2) (McKinney 1971).

present at the Psychiatric Division of Bellevue Hospital in Manhattan. At Bellevue, *all* patients who request a court hearing to contest the recommendation of two Bellevue psychiatrists for further hospitalization[4] are either represented or assisted by these "specialized" lawyers in the mental health field. The encounters between lawyers and psychiatrists at Bellevue court hearings provided the authors with a natural "experimental" setting in which to examine the basic issues of conflict and differences in reasoning between lawyers and psychiatrists dealing with hospitalization of the mentally ill, with special reference to the issue of "dangerousness."

METHOD OF STUDY

The authors obtained the court records for all civil commitment hearings held over a period of nine months at the courtroom in Bellevue Psychiatric Hospital. During this period, sixty hearings, involving fifty-five patients, were held. The court record for each of these cases consisted of the hearing transcript, a two-physician certificate (two-PC)[5] and the written report to the court by MHIS lawyers.[6]

The two-PC contains a brief description of events leading to hospitalization, mental status, diagnosis and limited demographic information, such as age, sex, race and religion. The form filled out by the physicians also seeks answers to the questions of whether a patient had demonstrated a "tendency to injure himself" and "to injure others." In practically all cases, the answer is a routine "possibly" or "probably." Psychiatrists themselves frequently disregard these answers in their testimony in later hearings.

In contrast to the medical certificate, the MHIS report gives a fairly detailed description of events leading to hospitalization and other background facts, relying partly on hospital records and partly on independent inquiries. The report specifically deals with the issue of "dangerousness," but usually employs a similar stock answer: "There

4. The extended hospitalization is almost always at a state hospital.

5. The two-PC is a certification by two examining physicians which accompanies any application filed by a family or a hospital administrator for the admission of a person alleged to be mentally ill. The certificate states that the person sought to be hospitalized is mentally ill and "suitable for care and treatment" in a hospital. N.Y. MENTAL HYGIENE LAW § 72(1) (McKinney 1971).

6. Under the rules promulgated by the Presiding Justice of the Appellate Division of the First Judicial Department, the Director of the MHIS is required to submit such reports to the court in every case. The report contains a summary of the patient's hospital record and results of interviews by the MHIS with the patient and others having information relevant to the patient's case. 22 N.Y. CODE, RULES AND REGULATIONS § 622.2(a).

is no indication in the hospital record nor is there any evidence that the patient is assaultive or suicidal."

The usual participants in a hearing are the judge, the MHIS lawyer, a Bellevue staff psychiatrist, who is usually one of the two certifying psychiatrists on the two-PC, and the patient. Other participants may be family members, friends, private lawyers and independent psychiatrists appointed by the court to give independent medical opinions.[7] Hearings are generally informal and vary in length depending on the problems presented.[8] The dialogue between a lawyer and a psychiatrist usually follows the psychiatrist's direct testimony and takes the form of cross-examination. Therefore, in order to ascertain the opinions and views of the lawyers, one would have to analyze their questions to the psychiatrists and the direction of their cross-examination. The lawyers occasionally reveal themselves as well either spontaneously or upon questioning by the judge.

The authors submitted the court records for each of the fifty-five cases to two independent analysts. Our goal was to determine the issues — the points of conflict — between the professional participants

7. In the hearings that formed the basis for this study, sixty-three professionals participated: twenty-five judges, eight MHIS lawyers, four private attorneys, twenty-four Bellevue staff psychiatrists and two independent psychiatrists.

8. Previous studies on court hearings pertaining to the civil commitment of the mentally ill have indicated that the hearings rarely take place, and when they do, they are usually of very short duration. R. ROCK, HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL 154 (1968) (5 minutes on the average); Scheff, *Social Condition for Rationality: How Urban and Rural Courts Deal with the Mentally Ill,* AM. BEHAVIORAL SCIENTIST, Mar., 1964, at 22 (1.6 minutes); Wenger & Fletcher, *The Effect of Legal Counsel and Admissions to a State Mental Hospital: A Confrontation of Professions,* 10 J. HEALTH & SOCIAL BEHAVIOR 66 (1969) (8.13 minutes). Furthermore, they tend to be routine and ritualistic, and are "merely a review of the decision of the hospital staff." Rock, *supra,* at 198.

When the New York legislature revised the Mental Hygiene Law, it did not really intend to increase the number of court hearings but to make them more meaningful. However, implementation of the new law has differed from hospital to hospital. Most state hospitals designate the psychiatrist who is to testify; the hospital is represented by an attorney from the State Attorney General's office. On the patient's side, the MHIS lawyers or non-lawyer officers in all four judicial departments routinely submit their written reports to the courts, but do not always represent patients at hearings. Except in the First Department, where the MHIS lawyers also represent the patients in court, a court-appointed lawyer represents the patient unless he has a private lawyer. *See* Gupta, *New York's Mental Health Information Service: An Experiment in Due Process,* 25 RUTGERS L. REV. 405 (1971); Zitrin, Herman & Kumasaka, *New York's Mental Hygiene Law — A Preliminary Evaluation,* 54 MENTAL HYGIENE 28 (1970).

At Bellevue, hearings last an average of 16.4 minutes. One of the two certifying psychiatrists on the two-PC usually testifies in the court, the hospital is not represented by a lawyer and the psychiatrist is cross-examined by the MHIS lawyer who represents the patient.

at the hearings, and to abstract the nature of their reasoning from the content of their written and oral testimony. Since the process involved judgment, we realized that our findings might potentially be influenced by the personal and professional orientation of the analysts. We nevertheless chose analysts familiar with the matter of civil commitment of the mentally ill, who had sufficient knowledge in the field that they would concentrate on the basic problems and not emphasize peripheral ones. The analysts chosen were a lawyer and a psychiatrist, both of whom maintain an academic interest in the field and are impartial insofar as the court hearings at Bellevue are concerned.[9] Both the lawyer-analyst and the psychiatrist-analyst were asked to review the fifty-five casebooks[10] *independently,* and to answer a prepared questionnaire for each case, containing both structured alternating and open-ended questions.

One question asked of the analysts was: "Are there any issues in this case between professional participants, including the judge?" If they answered "yes," the analysts were then requested to enumerate the issues, describing the positions taken by the participants.

Following the general open question on issues, both analysts were asked to focus on: "Is there any disagreement among professional participants regarding the dangerousness of this patient?" An affirmative answer raised the open-ended question "In what way?" If the answer was negative, the analyst was asked: "Were the participants agreed that the case is: dangerous, not dangerous, other?" The analyst was asked to be specific if he chose "other." However, since the primary question permitted only an unqualified "yes" or "no" answer, the "other" response was used by our analysts to express reservations, qualifications or their inability to make a choice between different answers. For example, one analyst answered that the participants agreed the patient was dangerous and qualified the answer by adding "if not treated." The difficulties in making a choice were expressed by such an answer as "cannot say whether there is agreement or disagreement" (in that event the analyst refrained from choosing between

9. The lawyer-analyst was Dr. Malachy Mahon, Professor of Law and Dean of Hofstra Law School, and former Staff Director of the Special Committee of the New York City Bar Association on the study of commitment procedures and the law relating to incompetents. The psychiatrist-analyst was Dr. Henry Pinsker, M.D., Associate Clinical Professor of Psychiatry, Mt. Sinai School of Medicine and Psychiatrist in Charge of In-Patient Psychiatric Service, Beth Israel Medical Center.

10. For each case a casebook was prepared comprised of the three sets of court materials: the hearing transcript, the two-PC and the MHIS report. Minor editing was done in order to conceal the identities of the participants in the hearings. In this article, each of the cases is identified by its casebook number.

a "yes" or a "no" answer). The "other" response also contained a finding by one analyst that the question of dangerousness was "not alluded to during the hearing." A response such as "dangerous if not treated" was re-coded by us as "dangerous" and the rest of the responses were categorized into "not clear" and "question is not raised."

FINDINGS

As noted before, our two analysts went over the same material independently. We surmised that if both analysts indicated the existence of a certain "dispute" from the same data, we would have objective findings, free from possible professional bias. Otherwise, differences in their judgment would furnish us with clues to explore differences in approach inherent in their respective professions.

In Table 1, issues pointed out by both the analysts or by either analyst alone are listed. In categorizing issues, we concentrated on summarizing findings of our analysts in brief but concrete terms. Admittedly, descriptions of some issues, especially those listed at M through R, are less concrete than the rest, but we could not subdivide them further without losing the theme common to several "disputes." These "disputes" involved conceptual, definitional and attitudinal differences between lawyers and psychiatrists.

A first glance at Table 1 reveals considerable judgmental discrepancies between our two analysts. Our lawyer-analyst alone tended to see issues among the professional participants on legal matters and "abnormal" behavior aspects, whereas our psychiatrist-analyst alone tended to see issues in the therapeutic area. It is possible that these discrepancies were largely the result of differences in professional training of the analysts (for instance, it is natural that a lawyer would be more sensitive to legal rules of evidence). This aspect, however, will be further examined in the course of this article.

Dangerousness

Even though the stated statutory criterion for civil commitment in New York is merely that the mentally ill person be "suitable for care and treatment"[11] in an institution, the dangerousness of that person to

11. *See, e.g.*, N.Y. MENTAL HYGIENE LAW § 72(1) (McKinney 1971). Although the statute does not directly make "dangerousness" of the mentally ill person a criterion for commitment, it does state that a "harmless" patient may be released by the court to the care and custody of his relatives or a committee of his person. *Id.* § 72(3). Also, if a judge refuses to authorize continued confinement of a mentally ill person proven to be "dangerous" to himself or others, any person aggrieved thereby may obtain a rehearing and review of such refusal. *Id.* § 74.

TABLE 1

ISSUES AMONG PARTICIPATING PROFESSIONALS IN EACH OF THE FIFTY-FIVE COURT-HEARING CASES AS JUDGED TO EXIST BY BOTH PSYCHIATRIST-ANALYST AND LAWYER-ANALYST, AND BY EACH ANALYST SEPARATELY[1]

(unless otherwise indicated, issue is between psychiatrist and lawyer)[2]

ISSUES	JUDGMENT BY		
	Both Analysts (Consensus)	*Psychiatrist-Analyst alone*	*Lawyer-Analyst alone*
A. criteria of voluntary hospitalization	1		
B. weight of hearsay			8
C. legality of first admission			34
D. weight of written records			30
E. needed length of hospitalization		24, 33	
F. choice of hospital	27, 51 (j vs p)[3]		
G. further benefit of hospitalization	1 (p vs p),[4] 43 (p vs p)		
H. need of medication			10
I. suitability of nursing home admission	36	6, 37	
J. suitability of out-patient treatment	53	38, 42	
K. adequacy of private care at home	19		
L. diagnosis			34
M. "abnormal" behavior	51	46 (j vs p)	3 (j vs p), 3, 8, 13, 14, 44 (j vs p)
N. dangerousness		10 (j vs p), 47	14
O. functioning or "too sick" to live outside	10, 11, 13, 14	8, 39, 40, 52	
P. purpose of hospitalization	30, 31	2, 5	55
Q. benefit of doubt			14 (j vs p)
R. "better off" in hospital than on street			30

[1] Cases in which both analysts found "no issue" among the participating professionals were 4, 7, 9, 12, 15, 16, 17, 18, 20, 21, 22, 23, 25, 26, 28, 29, 32, 35, 41, 45, 48, 49, 50, 54.

[2] Of the fifty-five patients, only thirteen were discharged. The other forty-two were all committed to state hospitals by the court. Of the thirteen discharged, patients in cases numbered 8, 13, 14, 21, 31, 46 and 49 were ordered released by the court. In cases numbered 5, 6, 16, 30, 35 and 44, the patients were discharged by the hospital psychiatrists during adjournments.

[3] Judge versus psychiatrist.

[4] Independent psychiatrist versus Bellevue psychiatrist.

himself or others plays an important role in the hearings on civil commitment.[12]

Surprisingly, there was not a single case among the fifty-five in which both the analysts agreed upon the existence of an issue on dangerousness among professionals (Table 1). This phenomenon was also evident in the apparent paucity of agreement between the analysts on the issue of dangerousness even after their attention was focused on that problem by our second question (Table 2). Even here, there were only two cases in which both analysts agreed that an issue on dangerousness existed among the professional participants. However, we note that even the agreement on the existence of a dispute on dangerousness in two cases by both analysts was based on a conflicting pattern of judgment. In Table 2, our psychiatrist-analyst alone saw far more disputes among participants than did our lawyer-analyst alone, while the latter placed more cases in the columns "not clear" and "question is not raised." Our lawyer-analyst alone placed nine cases in the column headed "question is not raised." In eight of these nine cases, the psychiatrist-analyst reported agreement among professional participants that the patient was "not dangerous," and, in the ninth case, that the patient was "dangerous." This raised the obvious question, how did our psychiatrist-analyst judge that the participants agreed whether the patient was "dangerous" or "not dangerous" in cases in which the lawyer-analyst believed the question was not even raised. For an answer we took a close look at the casebooks.

In case 22, our psychiatrist-analyst found an agreement among the participants that the patient was "dangerous," while according to our lawyer-analyst the "question [was] not raised." In both the two-PC and the MHIS report on the case, there were allegations that the patient had fought with his brother with a *knife* on the day of his admission. Other than the lawyer's question, "Has he assaulted anyone on the ward?" and the psychiatrist's answer "no," there was no dialogue at the court hearing between the participants on the matter of "dangerousness." In view of this, our lawyer-analyst reported that the question was "not specifically alluded to during hearing."

That our lawyer-analyst relied only on the testimony presented at the hearings became clearer in other cases. For instance, in case 45, page 4 of the MHIS report read "the doctor states that while she is not dangerous, she would not be able to care for herself." The hearing transcript for this case was brief and the question of danger-

12. *See* Kumasaka, Stokes & Gupta, *Criteria of Involuntary Hospitalization*, 26 ARCHIVES OF GENERAL PSYCHIATRY 399 (1972).

TABLE 2

JUDGED PRESENCE OR ABSENCE OF THE ISSUE ON "DANGEROUSNESS" AMONG PARTICIPATING PROFESSIONALS IN EACH OF THE FIFTY-FIVE COURT-HEARING CASES

	JUDGMENT				
			No issue because participants agreed the patient is:		
Analyst	*Issue exists*	*Not clear*	*dangerous*	*not dangerous*	*Question is not raised*
Both analysts (Consensus)	14, 53		41, 42, 49	4, 5, 6, 8, 9, 11, 13, 16, 20, 26, 31, 33, 37, 40, 44, 46, 50	7, 28
Psychiatrist-Analyst alone	1, 2, 3, 10, 12, 21, 27, 30, 34, 36, 38, 39, 43, 47, 51, 54	19	22, 23, 24, 48, 55	15, 17, 18, 25, 29, 32, 35, 45, 52	
Lawyer-Analyst alone	19	21, 23, 24, 25, 47, 48	1, 2, 3, 12, 27, 43	10, 30, 34, 36, 38, 39, 51, 54, 55	15, 17, 18, 22, 29, 32, 35, 45, 52

ousness was never raised or touched upon by either participant. While our psychiatrist-analyst *deduced* from this that the participants agreed the patient was "not dangerous," our lawyer-analyst reported the question "not discussed at hearing (but see MHIS report p. 4)."

Similarly in case 29, the two-PC states: "On the day of admission, she started a fire in her apartment." The two-PC does not reveal the source of this information. But the MHIS report relates: "The patient stated that on the day she was admitted to the hospital, fire accidentally broke out in her apartment, which she attempted to put out by filling the bathroom hamper with water and throwing it on the floor, until the firemen arrived." Again, there was no attempt by either participant to clarify the incident during the hearing. Based on this, our psychiatrist-analyst felt that the participants agreed that the patient was "not dangerous," while our lawyer-analyst reported that the question was not raised.

Attitudinal differences on the reliability of "evidence" and different levels of factual interpretation appeared to exist between the two analysts. The latter was clearly seen in case 18. In that case, there was no material in either the two-PC, the MHIS report or the hearing transcript relating to "dangerousness," but the patient was an eighty-one-year-old blind, incontinent and physically feeble man with a diagnosis of senile dementia. Even in the absence of any statement by either participant, our psychiatrist-analyst "assumed" that the participants agreed on the "harmlessness" of this old and feeble man. But the lawyer-analyst merely pointed out that the question was not raised.

However, if it appears that the psychiatrist-analyst was "assuming" more than the lawyer-analyst, it would be hard to account for the fact that the lawyer-analyst saw "agreement" among the participants (Table 2) in more cases than his psychiatrist colleague. Except in cases 21 and 47, the lawyer-analyst found agreement on dangerousness among participants, in various ways, in *all of the cases* [totalling sixteen] in which the psychiatrist-analyst had judged that the issue existed. If two persons, given the same material, report contradictory findings — one indicating agreement and the other disagreement — the obvious reason would seem to be that the one finding the agreement is trying to "read" between the lines in order to resolve an apparent dispute. However, in the instant case, a closer look at the casebooks revealed answers other than the obvious.

The dialogue between lawyer and psychiatrist took the form of the attorney cross-examining the doctor. The cross-examination was sometimes routine, undertaken to qualify the stated opinion or to con-

fine its implications; on the other hand, it was occasionally carried out to join an issue and establish different viewpoints. The following excerpts from the hearing transcripts of the cases illustrate the point.

Case 27

DOCTOR: . . . He was brought to Roosevelt [Hospital] because he felt that various people, including neighbors and his girlfriend, were members of the C.I.A., and he was threatening to assault the neighbors, and he did on occasion assault his girlfriend. When he arrived on the ward he was very angry, continually hostile, felt that everyone was against him, felt that there were agents of the C.I.A. all over the place; he used obscene language demanding immediate discharge, threatened to injure and kill various members of the personnel, including his own doctor, myself, the charge nurse and also before coming into the hospital he went into a bank demanding ten million dollars and threatened to kill the manager of the bank, which was denied by him. . . . I think there is very real possibility of his injuring or hurting somebody else, perhaps even killing them. . . .

JUDGE: Do you wish to ask the doctor any question?

LAWYER: Yes, I have a few questions. Doctor, has the patient actually assaulted anyone while on the ward to your knowledge?

DOCTOR: No, he hasn't.

LAWYER: In other words, as far as you know, his only potential danger has been limited to verbal threats?

DOCTOR: Yes, but could I elaborate on that?

JUDGE: We will give you a chance again. Just answer the question.

DOCTOR: All right. No, he hasn't.

Although the psychiatrist-analyst felt that the lawyer was challenging the opinion of the psychiatrist, the lawyer-analyst saw agreement among the parties on "dangerousness" of the patient. The MHIS lawyer intended in the cross-examination to qualify the extent of the patient's dangerousness, but not to deny it. Familiarity with lawyers' examination procedures would certainly enable our lawyer-analyst to "guess" with greater accuracy than the psychiatrist-analyst the intent of the MHIS lawyer. By the same token, in another situation, it is

possible that our psychiatrist-analyst was better able to "read" the testimony of psychiatrists than his lawyer-colleague.[13]

Generally, the lawyer began his cross-examination on the matter of "dangerousness" by asking the psychiatrist whether the patient was assaultive or not. And the psychiatrist usually replied with qualifications, such as: "While on the ward, no"; or with reservations, such as: "I don't think, in general, but in a general sense we are not using the word 'assaultive' in the sense that she wants to fight with people physically, but she will fight with them verbally. Unless she gets what she wants, what would she do next?" (Case 34). In case 51, definitional differences between the lawyer, the judge and the psychiatrist became much clearer.

Case 51

JUDGE: Well, she came in on April 27th. How many times approximately would you say you saw her since April 27th?

DOCTOR: Formally, I have seen her, I would say, sitting down in an interview with her, I would say I have seen her about five times. Informally, I see her all of the time. She walks into my office all the time, demands to be discharged. Otherwise, she would blow the place apart. She has threatened to harm me sometimes.

PATIENT: Doctor, you are full of baloney.

LAWYER: Has she been destructive on the ward?

DOCTOR: Because of her inappropriateness.

JUDGE: She has no record of her harming or injuring any human being, has she?

DOCTOR: No.

JUDGE: And she has no criminal record, there is no criminal record of any kind; any violations of law of any respect, violent or otherwise?

DOCTOR: Not that I know.

LAWYER: Doctor, has she been destructive on the ward?

DOCTOR: Yes, she has.

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13. Psychiatrists are, in general, uneasy with cross-examination, in part, perhaps, because of a lack of knowledge as to its purpose. One psychiatrist expressed her feeling in case 30 by saying ". . . I do resent this sort of questioning when the lawyer knows perfectly well what the answers to the questions are."

LAWYER: In what way?

DOCTOR: We are getting repetitious. She did throw off her own clothes, she has thrown books around, she has ripped books—

Cases 10 and 30 present a different situation in the matter of "dangerousness."

Case 10

LAWYER: Do you consider her dangerous to other people in an assaultive fashion? Has she ever assaulted patients in the ward?

DOCTOR: She did not. She had aggressive tendency in the ward. She is a very nice and peaceful person, but when you are dealing with a paranoid person you never know how she will react, when she is seventy-five years old, what would she do. In a case when we are dealing with a paranoid patient who fears that "some people are against me, and to prevent this I will attack them before they will be against me."

Case 30

LAWYER: I'm aware of that, Dr. X. The point is that you testified that the symptoms were irreversible, the disease is irreversible. Do you consider this man dangerous?

DOCTOR: To himself, yes, he is ruining himself. Didn't he come in just a month ago, an acute alcoholic toxic with gastritis and bleeding and in a very bad paranoid state when he was under his own care, and supervision implemented by very intensive coverage at the Fountain House, and he couldn't make it? If you want to take him home and take care of him, feel free. I am wondering about this case what would happen to him—

In cases 34, 51, 10 and 30, quoted above, the psychiatrist-analyst saw the existence of an issue but the lawyer-analyst saw agreement among participants that the patients were "not dangerous." In these cases, there seems to be a definitional and conceptual disagreement, if not a "dispute" among the professional participants on "dangerousness." However, our lawyer-analyst would be correct if all the participants, including the psychiatrists, shared a common definition of "dangerousness" as "directly and seriously assaultive or suicidal," the frame of reference evidently maintained by all participating lawyers and our lawyer-analyst. New York State's Mental Hygiene Law does

not define "dangerousness."[14] Therefore, any apparent agreement within the legal profession on the definition of "dangerousness" is not in conformity with any statutory definition but is a working definition. However, it is not correct to assume that lawyers accept "dangerousness" as encompassing only physical danger. For instance, our lawyer-analyst saw agreement that the patient was dangerous in case 27, mentioned above, in which the acknowledged problem was mere "verbal threats" although the patient had reportedly assaulted his girlfriend. Case 12 offered an even better example.

Case 12

LAWYER: Now, Doctor, in the absence of any actual injury to himself or others, on what basis — first of all, would you say that there is any likelihood of any dangerousness to himself or others?

DOCTOR: I would say that there would be a likelihood of both, although primarily injury to others would be what one would expect.

LAWYER: On what basis do you say that?

DOCTOR: The basis for this is that the ideas of persecution in this sort of patient, and in this patient's case particularly, are very strongly held and proved resistant to all argumentation. Clearly, the patient has already attempted to confront his supposed persecutor. It is only a small step from there to making the confrontation a violent one, and such things have very frequently happened in the course of such a disease as this where the idea of persecution is fixed as to theme and constant in its presentation. *So that I think the index of suspicion of potential violence here would be quite high.*

LAWYER: I have no further questions of the Doctor.

Our lawyer-analyst felt that the cross-examining lawyer agreed with the psychiatrist, whereas our psychiatrist-analyst felt that they

14. There is only one place in article 5 of the Mental Hygiene Law, relating to hospitalization of the mentally ill, where "dangerousness" is at all elaborately described. Section 85, dealing with proceedings for certification to Matteawan State Hospital of certain dangerous mentally ill patients of state hospitals, states: "Such physicians, if satisfied, after a personal examination, that such patient has committed or is liable to commit *an act or acts* which if committed by a sane person would constitute homicide or felonious assault, *or* is so *dangerously mentally ill* that his presence in such hospital is dangerous to the safety of other patients therein, the officers or employees thereof, or to the community, shall make a certificate to such effect." N.Y. MENTAL HYGIENE LAW § 85(1) (McKinney 1971) (emphasis added).

disagreed. The difference between psychiatric and legal professionals on the matter of "dangerousness," then, is not really so much a question of how one interprets "assaultiveness," but of how short one perceives the distance between thought and action or, as this testifying psychiatrist put it, how high *"the index of suspicion of potential violence"* is.

In cases 53 and 14, both analysts agreed upon the existence of the "issue."

Case 53

LAWYER: . . . Doctor, do you have any information which would lead you to believe that the patient has ever or would ever physically hurt himself or others?

DOCTOR: Yes, I do.

LAWYER: What information is that?

DOCTOR: One day when I was talking to him about asking him what had happened to him in November, what had happened to him in Kings County, he became anxious and he stood up and he said, "No, I'm not going to talk about this. Something bad will happen, someone will get hurt if I talk about this."

LAWYER: But, do you have any information that he ever struck anybody or cut his wrists or made a suicidal gesture?

DOCTOR: No, but I think he was angry, and the reason that he was nervous was he was afraid he was going to hurt me.

JUDGE: He was, what?

DOCTOR: He was afraid he was going to hurt me.

JUDGE: Hurt you?

DOCTOR: Yes.

Case 14

JUDGE: Doctor, in your opinion, if she is released will she be a danger to herself or to the community?

DOCTOR: I think so, your Honor. That is my only reason for recommending this [hospitalization].

LAWYER: On what basis, Doctor?

DOCTOR: On the basis of this what I call chip on her shoulder, on the basis of her paranoia, and the fact that, you

know, she will tell you, for instance, that people were playing a rock record in an effort to kill her. And she will tell you that—

LAWYER: She never told me this.

DOCTOR: Well, she told me this.

LAWYER: It's not in the record.

DOCTOR: I have talked to her, I suspect, longer than you have.

LAWYER: Is it in the record?

DOCTOR: Not everything is in the record.

LAWYER: Is it in the record that she is dangerous to self and others?

DOCTOR: Well, I think the implication is in the record.

LAWYER: No, it is not in the record.

DOCTOR: Well, I think it is in the record. I guess it depends on how you read a record.

LAWYER: Will you give me an incident of the time that she either assaulted physically or in some other way injured another person?

DOCTOR: Here is something from the record that I think indicates some of the problems: she says that people are playing tricks on her with her money, her clothes, and so forth.

LAWYER: What date is that, Doctor?

DOCTOR: That is the [date]. I think that there isn't any question that the woman is a paranoid schizophrenic. I think that how dangerous she is is a matter of judgment, which the more you attempt to—

LAWYER: I am asking you for a strict judgment.

DOCTOR: But I say living with her — well, as strict as I know how — because I think sometimes the more literal you are, the more you escape essentials.

LAWYER: Dangerousness has a certain meaning before the Court.

DOCTOR: [To the patient] You tell me if this is true or not. If you had heard her screaming and marching up and down and threatening everyone on the ward, then you would begin to know that she is a risk in the community, that even when she

came back from this walk, or when she discusses this outing that you would have the impression that she is a risk.

LAWYER: Doctor, excuse me, but we discussed this at length. I didn't note either intense anger or any other intense emotional reaction. She described the situation to me, which happens in this city a thousand times a day. I am not able to, and I don't think you are able to, say it didn't happen.

DOCTOR: No, and I haven't said it. I have said that on the ward in my observation she has had intense anger expressed at times. Even yesterday. . . . [To the patient] Is that correct? When you were talking to me?

PATIENT: She insists that I need psychiatric treatment. I said to her: how can she know what's down here and what's up here. I have been with mental treatment when I went to the hospital—

Functioning

"Functioning" may be used to describe either mental or social behavior. Functioning on the mental level, in terms of intellectual performance, emotional stability and the like, may affect occupational and interpersonal performance. Poor performance, however, may equally well result from such non-psychiatric causes as the general employment situation, racial or social bias and so forth. The double meaning of functioning sometimes creates an issue in the court.

Although the testifying psychiatrist in case 14 indicated that dangerousness was her only reason for recommending hospitalization, her disagreement with the lawyer over "functioning" (Table 1) was also pointed out by both analysts.

Case 14

DOCTOR: It was on the basis of this that I finally had to draw the conclusion that she is not ready to function in the community on her own.

LAWYER: What is that conclusion based on?

DOCTOR: Well, I will give you one example. We have many. Even on the ward where the patient has a chip on her shoulder so large that it reaches quite across to anyone she comes in contact with. But on a pass, a recent pass, she was out with a group. They went to the Manhattan Zoo, and they were out in the street. And a man was walking with his wife, and the patient felt that he left his wife to brush against her.

LAWYER: Do you know if this was his wife?

DOCTOR: She tells me that. I don't know. The woman he was with.

LAWYER: She told you he was walking with a woman?

DOCTOR: Yes. In any case, that he left that woman to come and brush against her. She felt that it was deliberate. She felt where he touched her and how he touched her was rather a deliberate attempt to violate, or whatever she feels are the proprieties.

LAWYER: Do you know that this was not true?

DOCTOR: I know that the other members of the group felt this was not the case, yes. And I know that in contact after contact on the ward of the patient's starting with a small kernel of reality and building up a fantasy that is colossal.

LAWYER: You make these statements, Doctor, but you don't give me an adequate ground for them.

DOCTOR: Well, I am sorry.

LAWYER: The fact that she was with people, the man brushed against her, and that other people concluded that this was not meant to violate her, or it was not meant in any fashion whatsoever is arguable on either side.

DOCTOR: All right. I would say that in the daytime in New York City that if it happened just as she describes it, her response was still highly inappropriate. The excitement and the injury and the enormous anger that she felt would have been inappropriate had it truly occurred as she describes it.

LAWYER: I think this is a matter of conjecture and entirely subjective—

JUDGE: Counsel, please limit yourself to questions.

LAWYER: All right, Sir. . . . Doctor, is it true that this lady asked you if she could obtain a position and go out from the hospital?

DOCTOR: Yes.

LAWYER: And—

DOCTOR: I felt when I let her go out on pass, I was hoping she might be ready to start work. Several of our patients have from the ward. But after observing her behavior on the ward—

LAWYER: After this incident you mean?

DOCTOR: This one plus others. There are many on the ward, but this was out of the ward. But I felt that she wasn't ready to go back to work.

Case 10

LAWYER: Is there any limitation to this lady's psychosis, to what area is this confined? Could you give an example?

DOCTOR: Mainly preoccupied with paranoid ideas.

LAWYER: That's generally, but specifically what kind of idea?

DOCTOR: As I mentioned before, she thought she was being gassed here, she thought she was being gassed, that people are laughing at her, that people are watching her from the opposite side of the street.

LAWYER: When she tells you this and you have seen her and on interviews when she tells you this, does she look particularly frightened?

. . . .

DOCTOR: No.

LAWYER: And she doesn't get angry?

DOCTOR: No.

LAWYER: In other words, she has these ideas but goes on generally living her life pretty much the same, except that she has these ideas?

DOCTOR: Yes.

In both these cases, the judgment of the psychiatrists on the ability of the patient to function in social and occupational spheres was based on their evaluation that "illness" was present. In case 14, the lawyer disagreed with the conclusion of the psychiatrist because of the heavy reliance on "subjective" judgment by the latter, and in case 10, the lawyer insisted on the limited impact of the patient's "illness" on her daily life.

When a patient's difficulty manifests itself on the behavioral level or in such events in his daily life as becoming unemployed, which may be plausibly explained by situational or social circumstances, there is

a question as to what extent psychiatric illness is responsible for these difficulties.

Case 13

JUDGE: Well, that is the issue, whether he eats, or doesn't eat.

LAWYER: No, sir, not a question on that issue. It's a question of lassitude. If I may ask the doctor, does anemia result in lassitude?

DOCTOR: This is true. Now, he has anemia, nutritional anemia. Now, another circumstantial fact, he was living alone, and the sister says he stays home and doesn't even go out shopping,—

PATIENT: I go out shopping.

DOCTOR: He stays in the ward and does nothing, remains in seclusion. Now, one more thing, we call him schizophrenic. The basic thing of schizophrenia [is] autistic tendency.

LAWYER: Has any prior psychiatric disease anything to do—

DOCTOR: Well, there is something before psychiatric admission. I have added that I guess he has been out of work for two years and according to the sister, the information, that I suspect he has been this way at least in the last two years.

LAWYER: Do you have any idea of the date of onset of the anemia due to the inhalation of sulphur fumes of where he worked? Do you know how long that was?

DOCTOR: I have no idea. I can't make a guess about it.

LAWYER: You don't know that it was two years ago?

DOCTOR: No.

LAWYER: Well, it was two years ago.

JUDGE: You said he was out of work for two years?

LAWYER: Your Honor, this man was employed in a plant where they used some sort of chemicals.

JUDGE: Yes, I see that now in the report.

LAWYER: Which resulted in a blood disclosure [dyscrasia]. We are not claiming that his condition was due entirely to anemia but certainly his mother was informed that he was anemic . . .

In this case, the lawyer's position was clearly expressed in her closing remarks to the court: "We don't have any more questions. The only thing, we request the court to consider discharging this gentleman so there can be an attempt to live in the community and to function. If he cannot, the worst that can possibly happen to society is that he be returned."

The lawyer's attempt in case 11, which follows, to suggest reasons other than psychiatric "illness" that would explain the patient's situation and conduct, was in sharp conflict with the psychiatrist, who attributed those same facts to "illness." In this case, the patient left Chicago rather abruptly and came to New York City, where she was stranded and wandered around Grand Central Station for three months. She was eventually brought to Bellevue by police who picked her up for vagrancy. The lawyer suggested that the patient fled Chicago because her daughter was making an effort to hospitalize her, whereas the psychiatrist felt differently.

LAWYER: And then at the age of sixty-one she came to New York rather suddenly; is that correct?

DOCTOR: Yes. She was running away from assassins who were trying to kill her in Chicago.

LAWYER: Whatever the reasons she told you when she came in, she did come to New York City, and to your knowledge she had no resources or any place that was prearranged to live; is that correct?

DOCTOR: That's inaccurate. She had no place to live because she doesn't arrange and doesn't plan ahead.

JUDGE: Because what?

DOCTOR: Because she doesn't plan ahead. So she had no resources. But actually she has an income of — she had a small income, I think a thousand dollars a year, for some years, and her daughter was willing to send her forty dollars a week when they could find her. But she often gave addresses at which she no longer—

LAWYER: When you say the patient doesn't plan ahead, how do you explain her successful living alone in Chicago all these years?

DOCTOR: I don't think it was very successful. As I say, I think she has gotten worse. But I don't think her living for many years was successful.

LAWYER: Is it possible that she came to New York without resources and without planning ahead and that being in a strange city with no place to go would have put her suddenly in the condition you saw her in when she came to the hospital?

DOCTOR: I think it certainly aggravated the condition. But I think this will happen again. I think she will more and more get in this condition if left to her own resources at this point.

LAWYER: If she made contact with the Welfare agency and said she herself would be willing to take Welfare funds and find a place in New York, could you make a judgment about her ability to live on this basis somewhat as she lived in Chicago?

DOCTOR: I think she isn't able at this time, and I will give you an example. We had a trip going out about two weeks ago. The patients often go out on trips in small groups. Four or five of them were going to the Zoo and the Frick Museum, and I thought the patient might enjoy the Frick Museum. She told me she hates zoos, and I could understand that. And I said, "What about the Frick?" She said, "I really can't go out, because if I were to walk up Fifth Avenue and people were to see me, everyone knows me and something would happen."

JUDGE: And something?

DOCTOR: "And something would happen."

Our two analysts suggested that in the above case, both the testifying psychiatrist and the lawyer considered the patient "not dangerous." The testifying psychiatrist implied that this patient would again run away from the supposed assassins who were trying to kill her in New York City, and would again put herself in the same "emaciated and disheveled" condition (from the two-PC) as she was when brought to Bellevue.

Purpose of Hospitalization

Psychiatric hospitalization is not always recommended for the sake of the patient alone. Rightly or wrongly, hospitalization is frequently sought for the sake of others, such as family or society. Disputes between lawyers and psychiatrists often arise over the purpose of the hospitalization.

In case 11, noted above, the psychiatrist's testimony, attributing to the patient the words "and something would happen," reflected her concern for the patient's welfare. In other cases, testifying psychiatrists expressed concern not about the patients themselves, but about possible

harm to others. For instance, in case 10, the psychiatrist stated: "She is a very nice and peaceful person, but when you are dealing with a paranoid person *you never know how she will react. . . .*" In case 53, the psychiatrist expressed her apprehension by referring to the patient's statement: "No, I'm not going to talk about this. *Something bad will happen,* someone will get hurt if I talk about this." The lawyer in case 13, as mentioned earlier, recommended the discharge of a seclusive and inactive patient, summarizing her position: "If he cannot [function in the community], the worst that can possibly happen to society is that he be returned." Both the analysts found agreement among the participants that the patient was "not dangerous." The testifying psychiatrist, however, was apparently recommending hospitalization for the protection of the patient.

Attitudinal differences between psychiatrists and lawyers over "hospitalization for the protection of the patient" were clearly reflected in case 31.

> LAWYER: Now, if she were on a course of medication and this were given with regularity, would you think that her condition might improve in, say, two months, three months?
>
> DOCTOR: I think it's really, more or less, stabilized at a level that she is in now.
>
> LAWYER: You don't expect any changes in that case?
>
> DOCTOR: I don't expect any remarkable change. Change is a relative matter and percentagewise I can't estimate the particular amount, but I think she is stabilized, let's put it that way, around this level.
>
> LAWYER: Is there any particular value to confinement for her, then?
>
> DOCTOR: Only insofar as poor judgment and poor reality testing, she may get into a situation which may be provocative somewhere on the outside; other than that, I don't know.
>
> LAWYER: You are aware, however, that this last time she came in with her sister. She said she had spent one month in the Y State Hospital also when brought by her sister. She has never really had any sort of problem with strangers.
>
> DOCTOR: The fact that something hasn't happened in the past does not preclude its happening in the future.

In that case, the psychiatrist expected no additional improvement in the patient to result from further hospitalization. In the following

case, a somewhat different situation existed. As noted earlier, the lawyer and the psychiatrist had also disagreed over the dangerousness of the patient.

Case 30

LAWYER: I'm aware of that, Dr. X. The point is that you testified that the symptoms were irreversible, the disease is irreversible. Do you consider this man dangerous?

DOCTOR: To himself, yes . . . If you want to take him home and take care of him, feel free. I am wondering about this case, what would happen to him—

LAWYER: Is it the consensus that among other doctors, in that, confining him is the answer? Is that the consensus that conforms to the record?

DOCTOR: If you want to look it over?

LAWYER: Your Honor, this is a very relevant question when this man's liberty is at stake.

DOCTOR: Being away from toxic substances is sometimes the only way one can avoid being made ill by those toxic substances.

LAWYER: In other words then, this patient would have to be permitted to live in the hospital for life? That would keep him away from toxic substances.

JUDGE: There is no such testimony.

LAWYER: Doctor, you just testified to it. Is that right, doctor, that sometimes the only way to keep people away from toxic substances is to hospitalize them.

DOCTOR: If you had sutures after surgery would you appreciate very much being discharged, or would you like to be given half a chance for full recovery, or at least fully recoverable until you are capable, that's all I'm asking.

LAWYER: I want to ask one more question.

JUDGE: Go ahead. You haven't been curbed.

LAWYER: No, I think this is a good case on the doctor's own statements. Doctor, has this man inflicted any type of injury on himself?

DOCTOR: Yes, constantly.

LAWYER: When?

DOCTOR: Every time he refused to take medication, and going to keep him—

LAWYER: No, let's limit—

DOCTOR: No, let's not limit. Let's deal with the realities.

LAWYER: Doctor, I would appreciate your answering the questions.

DOCTOR: Yes. What do you think gave him alcoholic gastritis and impended D.T.'s. This isn't an injury inflicted on oneself? It can develop into brain damage, seizures, no one knows. This was self-indulged.

Marked animosity between the lawyer and the psychiatrist complicated that court hearing. The testifying psychiatrist equated protection with hospitalization and also implied therapeutic gain would result from hospitalization by using the analogy of recovery from surgery. The psychiatrist's viewpoint was bitterly challenged by the lawyer. Going back to case 14, the testifying psychiatrist's assertion of therapeutic gain from hospitalization was questioned by the lawyer in that case as well.

LAWYER: Doctor, you are aware that this lady, after an early hospitalization in 1961—

DOCTOR: No, there is a '58 one here.

LAWYER: '58 to '61 for eight years after that she was continuously employed and had no admission to any hospital.

DOCTOR: That's right.

LAWYER: What would you conclude from that?

DOCTOR: I would conclude that she has a potential for reorganization, which I obviously concluded because for a month I was attempting to help the patient to reorganize sufficiently, to go out. Now, I don't think, if you look into her adjustment, that it was ideal, but I don't expect that. I think that she will reorganize and go out of the hospital again. This is a—

LAWYER: Well, Doctor, what is ideal? If an individual is continuously employed, and even if — I don't say that that's true, but even if she has some mental problem, she is continuously employed and in eight years requires no hospitalization, certainly she has considerable powers of concentration.

DOCTOR: She does, and she has considerable powers to be a contributing member of the community. At this time she is not able to use them.

LAWYER: Now, her most recent hospitalization — and I am not including Bellevue — was at the Bronx [State Hospital] for two months?

DOCTOR: Yes.

LAWYER: Did you know that while she was at Bronx Hospital she was permitted to go out of the hospital and to return to classes?

DOCTOR: She was here too. I permitted her to go out. It was on the basis of this that I finally had to draw the conclusion that she is not ready to function in the community on her own.[15]

In both cases, 30 and 14, the participating lawyers were apparently suggesting that the patients had gained maximum benefit from hospitalization and further improvement could not realistically be expected.

Benefit of Doubt

Eventually, toward the end of the hearing in case 14, the testifying psychiatrist and the presiding judge entered into an exchange of therapeutic philosophies of sorts.

JUDGE: [to the patient] Now, I am releasing you. I think you need care. As to whether or not the care should be of a custodial nature at the present time, I am not sure. I will be frank with you. But I am giving you the benefit of the doubt. Do you follow?

PATIENT: Yes.

JUDGE: But if you find that you do need care, come back.

PATIENT: Yes.

JUDGE: All right.

LAWYER: Thank you, your Honor.

DOCTOR: May I say one other thing, your Honor? That I think this question — I have heard a Judge on one occasion

15. The testimony referring to incidents outside the hospital, while the patient was permitted to go out, is cited earlier in the text. *See* pp. 21–23 *supra*.

say to a patient, "I am going to let you go, but I don't want you to hear voices." That was the extreme. You see, I don't think the benefit of doubt always is not to get care. I think the benefit of the doubt for many patients may be actually to get the care when it is needed.

JUDGE: Well, absolutely. So I think that I am trying to give her the benefit of the doubt that would be the best for her too.

DISCUSSION

Out of a total of fifty-five cases, thirty-one were found by either or both of the analysts to contain "issues" among professional participants. In the remaining twenty-four cases, neither analyst found any issue of conflict among the professionals. We may conclude from this that these twenty-four cases were probably presented to the court only because of unresolved problems between the psychiatrist and the patient. However, we will not explore this factor because our focus in this article is only on "issues" among professional participants inside the courtroom.

Our qualitative inquiry into the hearing materials, steered by the two independent analysts, revealed a number of definitional, conceptual and attitudinal differences between lawyers and psychiatrists. However, it is not clear to what extent these perceived differences were the result of the built-in rules and procedures of a court hearing itself rather than the product of the opinions and views on civil commitment espoused by the two professions.

As noted earlier, New York State's Mental Hygiene Law does not specifically define the concept of "dangerousness."[16] As to the criteria for commitment, the statute simply states: "If it be determined that the patient is mentally ill and in need of retention for care and treatment, the court shall forthwith issue an order authorizing the retention of such patient for care and treatment in the hospital . . . ."[17] The concepts of "mental illness" and "care and treatment" are statutorily defined as follows: "A 'mentally ill person' means any person afflicted with mental disease to such an extent that for his own welfare or the welfare of others, or of the community, he requires care and treatment;"[18] " '[c]are and treatment' means medical care, surgical attendance, nursing and medications, as well as food, clothing

16. *See* note 14 *supra.*

17. N.Y. MENTAL HYGIENE LAW § 72(3) (McKinney 1971).

18. *Id.* § 2(8).

and maintenance, furnished to a patient . . . ."[19] These statutory definitions are apparently too broad and do not appear to restrict the opinions and views expressed by the participants in the hearings.

It is possible that the procedure of the Bellevue Court could have affected some of our findings. The hearings dealt only with involuntary hospitalization of the mentally ill. The testifying psychiatrist, not assisted by counsel in presenting the hospital's case, was forced to recommend hospitalization for one reason or another. Within this limitation, a psychiatrist *could* still have tried to maintain the position of "expert witness," simply informing the court concerning mental illness of the patient and presenting pros and cons of hospitalization. However, in the particular setting, it was very difficult.

The lawyers were present to represent the patients, but they found themselves in a much more flexible position than the psychiatrists. A lawyer could be representing the "patient's interest," which would usually have meant "discharge," or representing the "best interest" of the patient, which may indeed have meant hospitalization in the personal judgment of the counselor. The absence of an issue among professional participants in many cases indicated that the lawyer had not infrequently assumed the position of judge, not advocate. Nevertheless, the Bellevue Court is, on the whole, still adversary in procedure, frequently forcing the professional participants to assume positions of "prosecutor" and "defender."

On the other hand, it may be argued that the procedure did not minimize differences in such substantive areas as the relevancy of "abnormal" behavior to the determination that "mental illness" was present. Psychiatrists here microscopically scrutinize unusual behavior, emphasizing "mental illness," whereas lawyers try to limit the relevance of unusual behavior, explaining it away in terms of everyday experience. It is noteworthy that our lawyer-analyst saw more of an issue on "abnormal" behavior among participants than his psychiatrist counterpart (Table 1). In the cases pointed out by our lawyer-analyst, judges and lawyers were essentially asking the psychiatrists what "inappropriate affect" is. Who isn't illogical, and who is not bizarre at times, they seemed to be asking. Disagreement which reached the proportions of an "issue" or point of debate on this matter was most clearly seen in case 51, noted by both analysts.

JUDGE: Is she hostile?

DOCTOR: Yes, and she is laughing.

19. *Id.* § 2(6).

JUDGE: When she is hostile, she is not violent?

DOCTOR: No, she threatens to blow the whole place up, and then calms down. We had to put her in seclusion on several occasions, and she acts strange at times.

JUDGE: Doctor, would you agree that there are a great many people walking around in the streets — many, many — I'm now looking at your report, and starting with the first descriptive word: ". . . the patient is irrelevant . . ." Will you agree with me that there are an awful lot of people walking around the street who are irrelevant?

DOCTOR: Yes, but not in the hospital.

JUDGE: And, would you agree with the Court? The Court will take judicial notice of the fact that there are many, many people who are illogical? Would you agree?

DOCTOR: Yes, I will agree.

JUDGE: The next one is ". . . incoherent . . ." The same thing by the Court, that there are many, many people incoherent; right, you agree with that?

DOCTOR: Absolutely.

JUDGE: And, ". . . affect inappropriate . . ." a little ambiguous to the Court, affect inappropriate. Could you explan that to the Court ?

DOCTOR: Yes, inappropriate means that the facial expression of the patient doesn't agree with the—

JUDGE: Doesn't correspond to the nature of the feelings? In other words, the patient may be saying a very sad story and might be laughing? The facial expression doesn't correspond with the story or with the words?

DOCTOR: Exactly. Well, you have seen her inappropriateness.

JUDGE: In other words, she wouldn't make a good actress? She wouldn't qualify on the stage to make a good actress?

DOCTOR: Maybe, she would, I don't know.

JUDGE: All right, the first adjective or description that I found that might be pertinent is delusional and, of course, we go to paranoid—

LAWYER: Perhaps, Doctor, if you explain to the judge what — mention some bizarre activity or threatening activity on

> the ward. On what do you base your recommendation that she needs further hospitalization, what acts, what statements has she made, her conduct on the ward?

In that case, the judge's overt assault on psychiatry reflected the confrontation of public conceptions of mental illness with the professional conception.[20] Law professionals, part of the general public, are less sensitive than psychiatrists to the concept of "abnormality." They do not see behavior or events from the same perspective as psychiatrists, either qualitatively or quantitatively. They are more likely to seek plausible explanations for "psychotic" or "inappropriate" behavior. For example, confronted with hostility and belligerence exhibited in the ward, lawyers ask: "Who wouldn't be angry if one is locked up against his will?" However, on the whole, law professionals do not challenge psychiatrists' testimony as to absence or presence of mental illness. Diagnosis was judged to be an "issue" in only one case of the fifty-five, case 34, and in that, by our lawyer-analyst alone (Table 1). In that case, the lawyer had merely asked whether or not the patient suffered from brain syndrome, since it had been mentioned in the two-PC. Judges and lawyers did not go so far as to make "diagnoses," though they could have challenged the hospital's diagnosis by asking for an independent psychiatrist's evaluation of the patient's mental status. The two independent psychiatrists who did appear in these hearings, however, joined "issues" with Bellevue psychiatrists on the question of the further therapeutic benefit of hospitalization, but not on "diagnosis."

In civil commitment, the problem is apparently not one of "digging out" abnormality, but of determining how overt it is. We might borrow the phrase of the judge in case 51 in a different context: "the first adjective or description that I found that might be *pertinent* [to forced hospitalization] is . . . ."[21] The judge had no difficulty understanding the words of the psychiatrist; he simply was not convinced that the behavior described warranted confinement. In the process of assessing the extent of "abnormality," loose interpretation of facts and terms by psychiatrists comes under attack from law professionals.

Another factor which may affect attitudinal differences between lawyers and psychiatrists, especially the apparently apprehensive and

20. *See* Dohrenwend, Bernard & Kolb, *The Orientation of Leaders in an Urban Area Toward Problems of Mental Illness,* 118 AM. J. PSYCHIATRY 683 (1962); *The Public's Ideas About Mental Illness,* Address by S. Star, Annual Meeting, National Association for Mental Health, in Indianapolis, Ind., Nov. 5, 1955.

21. Emphasis added.

protective attitude of psychiatrists towards patients, is that lawyers do not share the burden of ultimate responsibility in discharging a patient, whereas judges and psychiatrists do. It is true that psychiatrists shift this responsibility to the judge in the courtroom, but in everyday practice, the responsibility is theirs. The lawyer, while participating in the decision-making process, is never charged with the responsibility for an ultimate decision. The judge, also a lawyer by profession, shares the responsibility with the psychiatrist, and is, therefore, much more "conservative" in his judicial rulings than his brother attorneys. In fact, the patient's chance of being released by the psychiatrist in an out-of-court agreement is much greater than in the courtroom. In part, perhaps, for this reason, lawyers appear to make great efforts to settle the cases outside the courtroom.[22]

Active involvement of lawyers in the decision-making process related to hospitalization of the mentally ill has barely begun in American psychiatric practice. Lawyers are now learning the realities of the equivocal and yet genuine problem of "mental illness." The silence of the "defense" in many cases at the Bellevue Court may be an indication that many patients indeed need "protection." However, the question for both lawyers and psychiatrists is, how far do we go in "patronizing" our clients or patients and how much more should we know before we begin to impose our personal, or for that matter, professional values on patients.

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22. *See* Gupta, *supra* note 8.