FOURTH EDITION

CLINICAL HANDBOOK OF
PSYCHIATRY & the LAW

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Dedication

To our students and colleagues

About the Authors

Paul S. Appelbaum, M.D., is one of the country's leading experts on psychiatry and law. He is Professor and Director, Division of Psychiatry, Law and Ethics, Department of Psychiatry, Columbia University College of Physicians and Surgeons. Previously, he served as the A.F. Zeleznik Professor and Chair, Department of Psychiatry, University of Massachusetts Medical School. Dr. Appelbaum lectures widely on legal and ethical issues in psychiatry, both in the United States and overseas, and serves frequently as a consultant to clinicians, lawyers, policy makers and the media. He is a graduate of Columbia College and Harvard Medical School.

Dr. Appelbaum is past president of the American Psychiatric Association (APA), former chair of APA's Commission on Judicial Action, and current chair of APA's Council on Psychiatry and Law. He is also a former president of the American Academy of Psychiatry and the Law (AAPL), and of the Massachusetts Psychiatric Society. As a member of the MacArthur Foundation Research Network on Mental Health and the Law, he conducted pathbreaking research on violence and mental illness, and on the assessment of decision-making capacity. He is currently a member of the MacArthur's Research Network on Mandatory Outpatient Treatment, studying the use of leverage to achieve compliance in community settings. He was the Fritz Redlich Fellow at the Center for Advanced Studies in the Behavioral Sciences, and has been elected to the Institute of Medicine of the National Academy of Sciences.

Author of many research studies, theoretical articles and books, Dr. Appelbaum is a four-time winner of the Manfred S. Guttmacher Award of APA and AAPL for outstanding contributions to the literature of forensic psychiatry. His award-winning books, in addition to this one, include *Almost a Revolution: Mental Health Law and the Limits of Change (1994), Assessing Competence to Consent to Treatment (1998)* (with Thomas Grisso), and *Rethinking Risk Assessment (2001)* (with several co-authors). He is a recipient of APA's Isaac Ray Award for outstanding contributions to forensic psychiatry and the psychiatric aspects of jurisprudence, the Philippe Pinel Award of the International Academy of Law and Mental Health, and the Seymour Pollack Award of AAPL for distinguished contributions to forensic psychiatry.

Thomas G. Gutheil, M.D., is Professor of Psychiatry at the Harvard Medical School. He has been associated with the Massachusetts Mental Health Center, Boston, for more than a third of a century and has served as a staff member there for 33 years. A nationally known teacher, lecturer, author, and consultant on medicolegal issues, risk management, and malpractice prevention, Dr. Gutheil is the first Professor of Psychiatry in the history of the Harvard Medical School to be board-certified in both general and forensic psychiatry.

Dr. Gutheil is a graduate of Harvard College and Harvard Medical School. He is currently Assistant Director of Medical Student Training and Co-Founder of the Program in Psychiatry and the Law, Department of Psychiatry, Beth Israel Deaconess Medical Center, Harvard Medical School. He is also former Visiting Lecturer, Harvard Law School; Lecturer in Psychiatry, Tufts Medical School; President, Law & Psychiatry Resource Center; former Special Consultant to the Risk Management Foundation of the Harvard Medical Institutions; Past President, American Academy of Psychiatry and the Law; and Affiliate Member, Boston Psychoanalytic Society and Institute.

Dr. Gutheil served as an American Psychiatric Association delegate to the American Bar Association's Task Force on the insanity defense. In addition, he has served as consultant to the American Bar Association's Task Force on Competence to be Executed and as Special Consultant to the Department of Justice of the Federal Government of Canada. As a twice-board-certified

Forensic Psychiatrist, he has served as consultant or expert witness on cases in 44 states. Dr. Gutheil received the Seymour Pollack Award and the 2005 Golden Apple Award from the American Academy of Psychiatry and Law for distinguished contributions to the teaching of forensic psychiatry; and the "Teacher of the Year" Award from Continuing Medical Education and the *Psychiatric Times*. He received the 1997 Prix Philippe Pinel from the International Academy of Law and Mental Health for significant contributions to teaching and research in legal psychiatry and the 2000 Isaac Ray Award from the American Psychiatric Association for outstanding contributions to forensic psychiatry and the psychiatric aspects of jurisprudence. Dr. Gutheil was listed in the 1994 and 2005 editions of *Best Doctors in America* for forensic psychiatry and has been elected a Distinguished Fellow of the American Psychiatric Association. He is the author or co-author of more than 200 articles, books, and book chapters in the national and international clinical and forensic literature as well as several teaching audiotapes and videotapes. He is a three-time winner of the Manfred S. Guttmacher Award for outstanding contributions to the forensic psychiatric literature. Dr. Gutheil lives and works in the Boston area.

Preface

In an era in which the pace of change in every aspect of life seems to be accelerating, the field of psychiatry and law is no exception. Since the first edition of this book won the Manfred S. Guttmacher Award of the American Psychiatric Association and the American Academy of Psychiatry and the Law, we have been committed to bringing clinicians the most up-to-date guidance possible on how law affects clinical practice, and how psychiatry can contribute to the law. This fourth edition is the latest result of that commitment.

The third edition of the *Clinical Handbook* was written just before the start of the new millennium. Since then, federal regulation has brought substantial changes in clinicians' obligations to protect the privacy of patients' medical information, at the same time as the spread of electronic information technology has created unprecedented threats to confidentiality. New data and new approaches to the assessment of decisional capacity and of violence risk have brought increased empirical rigor to areas previously dominated by clinical impressions. Outpatient commitment is increasingly common across the country. Attitudes toward seclusion and restraint and new regulations have moved strongly in the direction of minimizing use and seeking alternative means of controlling violence. The steady stream of new medications for psychiatric disorders, and the often-conflicting data on their use, have created new liability risks for psychiatrists and underscored the important role of informed consent. Expert witnesses, not previously accustomed to thinking of the potential for liability from their activities, have had to face greater scrutiny from ethics committees, licensure boards, and the courts.

All these developments and others as well are reflected in this updated edition. The acclaimed format of the earlier editions remains intact. Even as many new references have been added to the lists at the end of each chapter, we have tried to retain those classic citations that remain timely even today. In sum, we hope that this fourth edition of the *Clinical Handbook of Psychiatry & the Law* will offer to clinicians of all disciplines the same caliber of information, guidance, and clinical wisdom that ensured the popularity of its predecessors.

Paul S. Appelbaum, M.D.
Thomas G. Gutheil, M.D.

How to Use This Book

"I'm a clinician, not a lawyer. All I want to do is help people. Why doesn't the law just let me do my job?"

This plaintive cry of the clinician, which can be heard these days echoing down hospital corridors, through the recesses of private offices, and in the interview rooms of outpatient clinics, expresses the *raison d'être* of this book. Decry it as they may, mental health professionals of every theoretical orientation and in all types of practice settings can no longer afford to be ignorant of the law. Court decisions, statutes, and administrative regulations have so affected clinical practice that few everyday decisions can be made without awareness of the legal rules governing such actions and, equally important, of the effect that those rules may have on the treatment of the patient.

The problems that arise from this situation are generically different from those with which clinicians (or lawyers) have been accustomed to dealing in the past. Rather than facing a dilemma that comes clearly labeled as "clinical" or "legal," clinicians now frequently confront problems in which the clinical and legal aspects are so intertwined that they seem nearly inseparable; neither the lawyer nor the clinician, using only the tools of his primary discipline, can take fully into account the complexities of such a situation. Only with an understanding that passes freely across disciplinary boundaries can one perceive the relation between the components of the problem and anticipate the impact on the problem as a whole of an intervention in either the legal or the clinical realm.

Of course, the ideal solution to the needs created by this radical change in the requirements for clinical practice would be for every clinician to have available for consultation an expert in legal psychiatry whose knowledge encompasses both worlds. Although such experts have assumed consultants' roles in some of our larger psychiatric teaching centers, there are too few of these individuals to make the goal of easy access for every clinician a realizable one.

We hope that this book provides the next-best alternative: a manual for ready reference that will become the point of departure when questions arise about the impact of law or regulation on the daily practice of psychiatric and psychological care. Mental health clinicians from all disciplines and from every level of training will find this work designed to respond to the questions both complex and mundane that develop in the customary course of practice. Psychiatrists who are unfamiliar with the area will find this handbook a useful study aid in preparation for the forensic psychiatry sections of the specialty board examinations. Lawyers and law students who want to understand—from the critical perspective of the clinician—the issues in mental health law will also be able to begin their researches here.

It is the firm conviction of the authors that textbooks or reference works that attempt to divorce the legal from the clinical, as so many do, are bound to fail to be handy tools for the clinician who must, of necessity, relate *every* aspect of her work to its effect on patient care. Likewise, works that try to impart only a dry list of legal rules for the clinician to memorize and obey, without conveying an understanding of, or an appreciation for, the legal reasoning that underlies them, will be equally unsuccessful; legal rules apply only to a unique factual situation and often survive only until the next court ruling or session of the legislature. The clinician who is able to understand the basis for the rule will, on the other hand, be able to apply the basic concepts to unfamiliar circumstances and, when the law changes, to follow knowingly its evolution. Hence, this book consistently strives to accomplish two ends: (1) always to interrelate the legal and the clinical aspects of an issue; and (2) to convey whenever possible something of the history of the law's approach to a problem, in the recognition that today's rule is in most cases merely the most recent unstable equilibrium that the historically contending sides of the argument have attained.

A word is in order, too, about what this book is *not*. It is most emphatically not designed to give legal advice or to take the place of a consultation with a competent attorney. Rather, the information contained herein will help the clinician decide when to contact an attorney (and describe how to avoid coming to the pass where that becomes a necessary step). In addition, because the comments one elicits from an attorney are commonly as cryptic as those from one's physician, this book should help the clinician understand the basis for the legal advice he receives.

This is not, moreover, a comprehensive textbook of psychiatry and law. Not only would a work of that magnitude require several times the bulk of this volume, but in consequence, it would be so unwieldy as to frustrate the busy clinician in search of an accessible and easily understandable explanation. For similar reasons of convenience, we have chosen not to burden the reader with a profusion of footnotes. Instead, each chapter concludes with a representative bibliography, which provides a way to investigate in greater depth.

Finally, the clinician will not find enumerated in this work the particular details of law and regulation that govern practice in the 51 diverse jurisdictions of this nation. Even had we attempted such a task, the rapid changes of case law and statute would have made the work outdated before it reached the reader's hand. For specific features of the laws that govern their work, all clinicians should become familiar with the applicable statutes and regulations in their jurisdictions. Statutes and regulations are easily available online today, from federal and state government websites and a number of private services. These materials often appear unnecessarily intimidating to the nonlawyer but can yield much useful information if used as one would any other reference work: carefully locating the information desired in the index (e.g., mental health law, psychotherapist-patient privilege) and reading the relevant statutes or regulations. An alternative is to contact the local branch of the professional organization for each of the mental health disciplines to ask for their guidance in comprehending the implications of the appropriate laws.

Now, something about the format of this work. Because most mental health clinicians need both to acquire a basic overview of legal issues in their work and to have a ready reference when future questions arise, this handbook has been designed with both purposes in mind. Those with little background in the field will want to read it through to acquaint themselves with the basic issues. Then, as needed, they can use the detailed table of contents of each chapter, with their numerous subheadings, and the frequent cross-references in the text to locate rapidly the information that they need.

Each chapter is divided into seven sections:

I. CASE EXAMPLES

These case summaries open each chapter on a clinical footing and attempt to frame the legal and clinical issues that will be discussed. Based on real (but thoroughly disguised) cases from the authors' consultative and supervisory experience, they are presented in two parts, this first part intended to give the reader a chance to think through the issues for himself before grappling with the solutions posed by the collective experience of the legal and mental health systems in the epilogue.

II. LEGAL ISSUES

This section reviews, highlights, and interprets the most important legal cases and statutes, while always attempting to convey the rationale that underlies the law's approach. Historical, ethical, and philosophical perspectives are also offered. Emphasis is placed on those legal issues most directly related to everyday clinical work, but special situations, such as criminal forensic evaluations, are covered as well.

III. CLINICAL ISSUES

In recognition of the impact of abstract legal doctrines on actual clinical practice and on the subjective experience of the patient, this section describes these effects and outlines practical means of coping with them within the treatment context. Also addressed are the clinical issues involved in more traditional forensic work, including evaluations performed for the courts, as well as the clinical effects of a variety of legal procedures.

IV. PITFALLS

The pitfalls section of each chapter addresses the psychological difficulties that clinicians face in attempting to deal with problems of a mixed clinical and legal nature. Although the dynamic psychiatrist might label these pitfalls as manifestations of the counter-transference, they represent obstacles to good patient care about which all clinicians, regardless of theoretical orientation, should be aware.

V. CASE EXAMPLE EPILOGUES

Integrating the material contained in the preceding sections, these follow-ups return to the cases described at the beginning of the chapter and outline their resolution. They also serve as a handy self-assessment of the reader's understanding of the chapter.

VI. ACTION GUIDE

A unique operational summary of the chapter, the Action Guide places the elements discussed in the chapter into a condensed, action-oriented framework. It serves both as a quick-reference outline for appropriate responses to clinical-legal dilemmas and as a means for rapid review of the material in each chapter.

VII. SUGGESTED READINGS

Each chapter is followed by a selection from the most notable, provocative, and useful articles and books on the topic, designed to serve as an entry point into the literature for clinicians and lawyers alike.

It is our hope that this book will contribute to increased mutual understanding on the part of both the clinical and legal disciplines, whose respective representatives differ from their counterparts only in having undergone a different kind of professional training. That understanding is indispensable to a reconciliation between the legal and mental health systems that would permit the realization of the legitimate goals of each without negating the ends of the other; it should be apparent that only a sympathetic understanding of both traditions of caring for and about people will lead to the attainment of this reconciliation.

Paul S. Appelbaum, M.D.
Thomas G. Gutheil, M.D.

Contents

CHAPTER 1

Confidentiality and Privilege

I. CASE EXAMPLES

A. CASE EXAMPLE 1

A 27-year-old man appears at a psychiatric hospital's emergency room looking dirty and disheveled. His communications are impaired by marked loosening of associations. He is judged by the examining resident to require hospitalization, but because he has already included the doctor in his fluid paranoid system and has made a number of threatening remarks toward him, the resident requests that a security guard stand by in the room as the patient is processed for admission. During the course of eliciting the basic demographic data, the resident is stunned to hear the patient blurt out a confession to a murder. Expressing great remorse and desire for punishment, the patient recounts that he bludgeoned an elderly woman to death the previous night on the waterfront and then dumped the body into the harbor. The resident completes the admission, but is then uncertain how to proceed.

B. CASE EXAMPLE 2

For 2 years a 34-year-old woman, diagnosed as a chronic paranoid schizophrenic, has been in intermittent supportive therapy with the same doctor. Several hospitalizations have taken place during this period. The patient has given birth to two children, but because one was given up for adoption several years previously and the other is living with a foster family under the supervision of the department of welfare, they play little role in her life and are rarely mentioned. To the psychiatrist's surprise, she one day receives a subpoena to testify at a hearing concerning the younger child. Discussion with the patient reveals that the welfare department is now seeking permanent custody of the child. A call to that department reveals that it is hoped the psychiatrist's testimony will complete the case by depicting the patient as an unfit mother. The psychiatrist's protestations that she knows nothing of the patient's capacity to raise children, because they have never discussed it, are dismissed. The patient firmly requests that the doctor not testify. In light of this, the doctor fears that any information she gives will be perceived as a hostile act and will impair the fragile therapeutic alliance. She would like to avoid that outcome, but does not know how.

C. CASE EXAMPLE 3

A 28-year-old newly married man is referred to a community mental health center from a nearby hospital. The social worker making the referral mysteriously refuses to say why it is being made. When the patient arrives, he is clearly distraught. After considerable discussion, he reveals that he has just received the results of a human immunodeficiency virus (HIV) antibody test, which was positive. He denies any history of homosexual activity or intravenous drug use, though he comes from a neighborhood in which experimentation with drugs is common among young men. The patient is uncertain whether he wants psychotherapy but agrees to a short-term contract to allow him to explore the issues surrounding his HIV status. During the second session, the patient mentions casually his intention to have a child with his new wife. When confronted, he says clearly that he does not intend to tell her about his HIV-positive status, because that would mean they could never have a child and he would not be a “real” husband. The therapist discusses over the next two sessions the risks posed to the patient’s wife and to a child who may be conceived. However, the patient still refuses to discuss the issue with his wife or to permit her to be notified. Motivated by concern about his responsibility to the patient’s wife on the one hand, and about maintaining the patient’s confidentiality on the other, the therapist ponders what to do.

D. CASE EXAMPLE 4

A certain amount of atypical behavior is not unexpected in the waiting room of a small group psychiatric practice, and the receptionist and file clerk are neither particularly surprised, nor distressed, by the curious actions of the man sitting in the corner. He is a tall, well-dressed man in his 30s who has acknowledged that he is two hours early for his appointment, but that he does not mind waiting. While waiting, however, he is seen to scribble occasionally on a pad; stare off into space with his head cocked, as if responding to internal stimuli; and turn his head sideways at intervals, apparently listening to his cupped hand. After some wary glances reassure them he is not a threat, the receptionist continues to answer calls, handle faxes, and chat with the file clerk, while the latter attends to multiple clerical duties, responding to requests via her intercom and her portable telephone headset to bring specified files back to the doctors’ offices.

At the appointed hour, Dr. Bell’s voice on the intercom intones, “Please tell the risk manager to come on in.” Having stiffened momentarily at the words “risk manager,” the receptionist calls out, “Dr. Bell will see you now; he is the second door on your right.” Gripping his notepad, the man thanks her and strides into the doctor’s office, fixes the doctor with a piercing eye, and—before sitting down—states emphatically: “Dr. Bell, you have a serious HIPAA problem here!” An anxious look crosses Dr. Bell’s face, but old clinical reflexes reassert themselves, and he indicates the “patient’s chair,” saying, “Why don’t you sit down and tell me about it?”

II. LEGAL ISSUES

A. CONFIDENTIALITY

Confidentiality refers to the right of an individual not to have communications that were imparted in confidence revealed to third parties. It is derivative of the broader right to privacy, which guards against a variety of intrusions on an individual’s freedom from unwanted attention.

Privilege, often more accurately called *testimonial privilege*, can be viewed as a narrow offshoot of the right to confidentiality. An individual with testimonial privilege has the right to bar another person from testifying based on information that person has gained from communications with him. Privilege applies only in judicial or parajudicial settings, and its extent is strictly limited by case law or statute.

1. Historical Evolution of a Right to Privacy

In English common law, the corpus of court decisions reaching back to the Middle Ages that is the foundation of Anglo-American jurisprudence, no explicit formulation of a right to privacy exists. In the United States, it was not until 1890 that Warren and Brandeis’ landmark article, “The Right to Privacy,” offered the first theoretical construction of a general right to privacy, although before then a variety of doctrines had protected narrow interests in freedom from intrusion and in the confidentiality of particular communications (e.g., mail or telegraph messages). Individuals, however, had no remedies for invasions of privacy except in unusual cases in which a criminal statute was violated by the disclosure of personal communications, or the information revealed was untrue and thus constituted grounds for libel. The innovative idea in Warren and Brandeis' formulation was that all citizens shared a general right to privacy, which could be enforced by bringing suit for damages against those who violated it.

A right to privacy caught on slowly but ultimately became firmly ensconced in American common law. This right consists of four separate components, guaranteeing freedom from intrusion on seclusion, appropriation of one's name or likeness for commercial purposes, publicity given to one's personal life, and publicity that places one in a false light. The area covered by the right to privacy has grown tremendously in recent decades, as it has been declared by the U.S. Supreme Court to be inherent in the other rights granted by the U.S. Constitution; it has served as the basis for decisions at all levels of the judiciary, in such disparate areas as the right to use contraception, access to abortions, and the right to refuse psychopharmacologic agents.

The rights of patients in therapy to protection of their confidences received little attention in the development of the law of privacy. None of the four subcategories of a right to privacy is easily applied to therapists' breaches of patient confidentiality. The one that comes closest—publicity given to one's personal life—has generally been held to require actual publication of the disclosure to a general audience. In contrast, those situations most disturbing to medical and psychiatric patients usually involve disclosures to a single person (e.g., a spouse or an employer) or a small number of persons (e.g., law enforcement authorities). Although the law was paying little attention to protecting patients' confidences, the helping professions themselves had not neglected the area.

2. Ethical Bases for Protecting Confidentiality

Long before the development of a lawfully recognized right to privacy, medicine had embraced an ethical proscription against the needless divulgence of patients' confidences. The Hippocratic Oath, as well as later codes, enjoined physicians from disclosing information they acquired from their patients: "[W]hatsoever I shall see or hear in the course of my profession . . . if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets."

The ethical foundations of confidentiality in medicine and the other helping professions are twofold. First, confidentiality is based on the belief that revelation of patients' confidences—communicated in the course of diagnosis and treatment—would discourage patients from seeking medical and mental health care. The resulting harm to society would exceed the benefits of disclosure. Thus, the greater good lies in shielding patients' communications. This argument is based on the utilitarian principle that we should follow the rule that yields the greatest good for the greatest number of people. Note that it depends on empirically testable propositions, such as the assumption that incursions on confidentiality affect patients' motivations to seek treatment.

Does such empirical support exist? Numerous surveys of therapists, patients, and nonpatients support the importance of confidentiality in treatment settings. Adolescents seem particularly sensitive to the possibility that their medical care, including treatment for substance abuse and other psychiatric conditions, might not be confidential. It is harder to demonstrate that patients would be deterred from seeking treatment if confidentiality were not protected, although anecdotal evidence and patients' beliefs appear to support this. Most patients surveyed, however, are ignorant of legal protections of their confidentiality (or the lack thereof), instead trusting their therapists to protect their disclosures. Does this mean that legal protection is unimportant or only that patients believe they can take it for granted? The answer is unclear.

In contrast to the utilitarian approach, the second argument in favor of confidentiality does not rely on the consequences of the rule chosen for its justification. Advocates of this approach argue that medical and mental health professionals induce their patients to reveal personal information by creating situations in which confidentiality is implicitly or explicitly promised. Having made such a promise, the clinician is obligated to keep it. An ethical argument of this sort falls into the category of a "deontologic" justification, dependent on an analysis of moral duties rather than on the consequences of the act. Even when considered through this approach, though, confidentiality is not an absolute principle. In the face of countervailing duties (as seen in Sec. II-A-5), it may have to give way.

Most mental health professionals would probably offer utilitarian and deontologic reasons for protecting patients' confidentiality, although it is the former that are most frequently discussed in the literature. Regardless of the ethical underpinning, every mental health discipline endorses the importance of confidentiality in its code of ethics.

3. Current Legal Bases for Confidentiality

The lack of clear-cut common-law doctrines for protecting confidentiality has not prevented the development of substantial legal protections for patients. Three mechanisms have been used to achieve this end: judicial, statutory, and regulatory. Courts have used traditional privacy doctrines to impose liability on physicians and psychotherapists who have disclosed information communicated to them in confidence by their patients. Courts have also begun crafting a new doctrine explicitly recognizing the right of persons in certain professional settings—including psychotherapy—to protection from disclosure. This new theory has generally gone under the term *breach of confidence*. One limit to this approach, of course, is that it provides a monetary remedy only after the damage has been done.

Simultaneous with this activity in the courts, state legislatures have passed statutes attempting to prevent breaches of confidentiality in the first place. Prohibitions against disclosure may be found in physician or psychotherapist licensure statutes (in some states), physician-patient or psychotherapist-patient privilege statutes (see Sec. II-B), and in laws creating a "patient's bill of rights." All these sources of the doctrine of confidentiality prescribe a common standard governing the release of information: With rare exceptions, identifiable data can be transmitted to third parties only with patients' explicit consent.

Perhaps the most important development in recent years has occurred on the regulatory front. Authorized by the 1996 Health Insurance Portability and Accountability Act (HIPAA), the federal Department of Health and Human Services (DHHS) issued a detailed set of regulations governing medical confidentiality (referred to in the regulations as "medical privacy"), which went into effect in 2003. The promulgation of the regulations was motivated by the desire to facilitate the development of what has been called a "health information infrastructure." Advocates envision computer-based medical record systems governing all patients that could be linked for clinical, administrative, and research purposes into a system capable of providing both access to individual records and comprehensive aggregate utilization data. The promoters of this interlinked medical information network—who see benefits from improved clinician access to patients' records and from the ability to identify anomalous patterns of use—recognized that some minimum level of confidentiality protections would be essential for the public to support their proposal. Hence, the requirement for the confidentiality regulations was built into the HIPAA legislation, along with such provisions as the development of unique identifiers for every patient and every provider, and standardization of formats for electronic transmission of health information.

Many of the specifics of the voluminous HIPAA regulations are discussed in the following sections. However, several aspects of the regulations deserve emphasis here. First, only clinician or health care entities that engage in specified electronic transmission of health information—for purposes such as verification of insurance eligibility and billing—are covered by the regulations. Though it seems probable that the reach of the regulations will be extended more broadly in the future, for now clinicians who avoid the specified electronic activities are exempt from HIPAA-based obligations. Second, the regulations are intended to set a floor for privacy protections, in the absence of more stringent legal rules. Thus, at least for now, state laws or other federal laws that are more deferential to privacy concerns than the HIPAA regulations take precedence and must be obeyed. Finally, although the HIPAA rules permit disclosure of health information to third parties in a variety of circumstances, they do not mandate disclosure in any situation (other than to patients themselves—see Sec. II-A-4-b-iii below). Clinicians and facilities always retain the discretion to be more protective of patients' interests in confidentiality by adhering to stricter standards for disclosure. Several helpful reviews of the HIPAA regulations aimed at mental health professionals have appeared and can be consulted for further details (see Appelbaum, 2002, and Brendel & Bryan, in the Suggested Readings).

4. Release of Information to Third Parties

a. General principles. Although the principles of confidentiality embodied in professional ethics and most state laws on medical privacy generally require patients' consent before disclosure, the HIPAA regulations take a more permissive approach. For functions related to treatment, payment, or health care operations, the HIPAA rules allow disclosure without patient consent. Among the persons or entities to whom identifiable health information can be released under these categories are other treaters involved in the patient's care, insurers, utilization reviewers, accrediting agencies, and a host of others. For other purposes, release of information requires what the federal regulations refer to as "authorization"—which resembles traditional written consent, with certain aspects of the form specified by the HIPAA rules. Thus, forms must indicate the information to be disclosed, the purposes to which it will be put, the recipients of the information, and the expiration date of the authorization. There are, in addition, 12 uses of information that are exempt from the authorization requirement, including release "to avert a serious threat to health or safety" or to report child abuse or neglect. Several kinds of disclosures to law enforcement authorities and for purposes of litigation are also included.

Surveys of patients' views on confidentiality have consistently reported that patients believe that they should determine who has access to their medication information, even when it comes to physicians and other professionals who may be involved in their care. Although the HIPAA rules reject that approach, they do not prevent clinicians and facilities from adopting more traditional approaches to disclosure based on patients' consent. We encourage mental health professionals to seek patients' consent before information disclosures except in emergencies, when disclosure is required by law, and in other exigent circumstances. When possible, consent should be written and time-limited. This approach has been endorsed by the Ethics Committee of the American Psychiatric Association as most in keeping with psychiatrists' responsibilities to their patients. Of course, where state statutory or case law requires consent before disclosure, clinicians must obtain consent regardless of the more permissive approach of the HIPAA regulations. Within this general framework, we turn to specific situations in which disclosure may occur.

b. Specific instances of disclosure

Other physicians and therapists. The exchange of information among medical and mental health professionals has long been a hallmark of relations among caregivers. These informal relationships, however, are often no longer optional. Health maintenance organizations (HMOs) routinely require primary care physicians who are referring patients to specialists to send detailed consultation requests and, in turn, require specialists to send information concerning patients' evaluations and treatment back to the referring physicians. Hospitals, eager to hold on to the goodwill of referring practitioners in the community, require their physicians to maintain contact with patients' community-based physicians during hospitalization and to rapidly send patients' operative notes and discharge summaries to those physicians after patients leave the hospital. This increased communication is, in most cases, beneficial to patients' care, which can more easily be coordinated.

Nonetheless, patients may have good reasons for wanting their confidential treatment information not to be transmitted from one caregiver to another. This is especially true for psychiatric data, which may be embarrassing or otherwise compromising. If patients are willing to pay the cost in reduced coordination of their care, they should have this right. Thus, before sending out information to other caregivers, clinicians should always obtain patients' consent. If patients refuse consent, and HMOs inquire why their policies regarding communication with referring physicians were not adhered to, it is perfectly acceptable from a legal and ethical standpoint to indicate that the information was withheld because the patient did not consent to its disclosure.

As health systems grow and medical records are computerized and placed online, it becomes increasingly possible for clinicians who are part of a single health system—which may encompass many hospitals and clinics—to gain access to patient records. Because psychiatric records are particularly sensitive (though psychiatric data are by no means the only sensitive information contained in medical records), we would argue that patient control of access to these records should be maintained by partitioning them from the general medical record. Access should require a special password and be limited only to those caregivers directly involved in patients' treatment, for whom patients have given consent to view their records. Model electronic record systems of this sort have been developed, although most commercially available systems do not allow this degree of patient control. At a minimum, if this is not the case in any facility or system, patients should be informed at the outset of the way in which records are kept and who has access to them.

Two additional points regarding disclosure of information to other physicians and therapists should be noted. First, the useful practice in many academic centers and group practices of obtaining informal consultations from colleagues and peers can, of course, continue, so long as the patient's privacy is protected by alteration of her name and other identifying data. Continuing case conferences and presentations in rounds and seminars should be governed by similar rules. Second, it is often particularly difficult to resist sharing information with clinicians who have previously had contact with the patient, but who are no longer actively involved. Having left the circle of those caring for the patient, however, these clinicians are no longer entitled to receive confidential information. Although this may require a good deal of tact to accomplish in practice, responding to such requests with a sincere apology, but a firm refusal, best protects the interests of the patient. Follow-up, to be sure, is an important element in the clinical growth of the therapist, but this is one occasion in which it must be sacrificed for a more important end.

Insurers and managed care companies. Disclosure of information to third-party payers and the entities with which they contract to manage mental health benefits has become among the most problematic issues of confidentiality. Patients usually are required to sign blanket consents for release of all medical and psychiatric records as a condition of insurance coverage. Insurers and managed care companies (MCOs) have an unquestioned need to assess, in general terms, the basis for, and progress of, treatment. Pressures to contain health costs, though, have led insurers and MCOs to demand increasing amounts of data before, during, and after treatment. No longer satisfied with summaries of patients' care, perhaps because mental health professionals have been less than frank in the past about patients' diagnoses, insurers demand actual records (sometimes in their entirety) in many cases.

Professional organizations have attempted to work with insurers and MCOs to change these practices, but they are widespread. It is difficult for clinicians to protect patients' confidentiality when insurers can compel patients to consent to release all data or bear the cost of the treatment. Although some outpatients choose to pay the full cost of therapy to avoid passing records to their insurers, this is often not a practical option, especially for hospitalized patients. Threats to confidentiality are even greater when insurance forms are processed in-house by patients' employers in an effort to hold down health care costs. Insurers' dedication to confidentiality is suspect in the absence of state or federal laws prohibiting redisclosure. The requirement in the HIPAA regulations that only the "minimum necessary information" be released (except to other treaters) may ultimately be helpful here, but it has not yet been tested with regard to insurers. In the meantime, the only reasonable approach is for clinicians to exercise great care in the information they include in patients' records in the first place, eliminating compromising information not essential to patients' care. Of course, this does not deal with the entire problem, because even the fact of psychiatric diagnosis and treatment may be highly stigmatizing.

The federally and state-funded Medicare and Medicaid programs have given rise to numerous controversies over confidentiality of records. Aggressive fraud control units have demanded access to full patient records to determine if services billed for were actually provided. Therapists have argued, in opposition to such broad requests, that access should be restricted to billing records and appointment books, or that records should be redacted to eliminate personal information before inspection. The courts have split in their response to these cases, but at least several opinions have supported the importance of confidentiality and denied prosecutors blanket access. Legislative options to restrain overbroad prosecutorial initiatives have not been pursued, but would seem to be a promising approach in this area.

Families. Family members are not usually viewed as third parties by therapists. In fact, those who take a family or systems approach to therapy consider the family to be as much a focus of the therapeutic effort as the identified patient. Families of the severely mentally ill, who are starting to play an active role in formulating mental health policy, often complain most bitterly of the failure of clinicians to discuss their relatives' conditions with them, even when they are the primary caretakers. The HIPAA regulations are more permissive with regard to release of information necessary for persons—such as family members—who are involved in patients' care. But patients often object to disclosure, and information concerning the patient's treatment and prognosis should, in most cases, be revealed to family members only with the patient's consent. Nonetheless, it may be possible for mental health professionals to be more helpful than they have been to family members, even within current constraints. Greater efforts can be made to obtain patients' consent for discussions; nonconfidential items can be revealed; and information relating generally to severely mentally ill persons (e.g., the side effects of medication and how they can be treated) can be discussed without referring specifically to the situation of a patient who refuses to grant permission for disclosure. It may be the attitude of mental health professionals, which has often communicated the absence of an interest in collaboration, more than what is or is not disclosed, that has most upset family members.

Patients themselves. Although patients themselves are technically not third parties, the question of patients' access to their own records is generally considered along with other confidentiality issues. The HIPAA regulations grant patients the right to view and copy their own charts, though the records themselves belong to the facility or clinician. Only a small number of exceptions exist to this fairly sweeping right of access, the most important being when "the access requested is reasonably likely to endanger the life or physical safety of the individual or another person." If patients believe their records are factually inaccurate, they can request an amendment. These regulations set the first national standards for patient access to medical records.

A growing number of studies have been performed in inpatient and outpatient settings to assess the effects of allowing psychiatric patients to see their records. Almost all studies suggest a positive effect from greater patient access, particularly when efforts are made to prepare patients for the session and someone is on hand to explain material that may be unclear or confusing. In contrast, most studies of clinicians' perspectives on this process demonstrate their concern about the emotional impact on patients of reading progress notes and other materials. Clinicians are also troubled by the possibility that their charting practices may be distorted by the knowledge that patients will have access to records in the future. Some detrimental impact on the quality of charts that are made available to patients has been found.

An issue of special concern when patients receive information from their own charts is the possibility that the records contain comments solicited from relatives or friends of the patient, based on assurances that patients would not learn of their role. Although ethical considerations similar to those involving patients apply to these other sources of information, the legal situation is not as clear-cut. In principle, data obtained from sources who have requested anonymity should be excised from records before they are released. The HIPAA regulations, however, do not recognize the importance of this step, instead granting total access to patients. This is one area in which recording practices might need to change, with greater care taken to protect sources of information, or informants may need to be told frankly about patients' right of access to records. In fact, many clinicians who are reluctant to keep secrets from their patients already routinely tell informants that they disclose any such information to patients. This practice obviously precludes later problems.

c. Psychotherapy notes. The HIPAA regulations define a category of records referred to as "psychotherapy notes," similar to what used to be referred to among clinicians as "process notes" (see Sec. III-G-2). To be included in this category, the records in question must consist of the contents of patient's disclosures or reflections upon them; not include general information such as medications, diagnosis, and treatment plans; and be kept separately from the rest of the patient's record. Records that meet these restrictive qualifications can usually not be released for any purpose without patient's specific authorization, although they still may be subject to subpoena in jurisdictions without a testimonial privilege or where an exception applies (see Sec. II-B). Unfortunately, only a small part of the information generated in the course of treatment is eligible for the added protections afforded psychotherapy notes.

d. Release of information for research purposes

Protecting patient confidentiality in research procedures. Gathering information for research purposes often creates risk that identifiable information about patients will become available to third parties. Federal regulations governing the conduct of research, which apply to most medical research in this country, require patients' consent for research participation in most cases, and hence have served to insure that medical information will not be disclosed to researchers without patients' knowledge and agreement. Exceptions are limited to situations in which the risks of the research—including those related to confidentiality of medical information—are minimal and it would be infeasible to obtain consent. Projects involving larger-scale medical record reviews constitute the most frequent category of projects conducted without patients' consent.

The HIPAA regulations have added another layer of complexity to the process of review and approval of research projects, which is conducted by institutional review boards (IRBs). HIPAA rules require patient authorization (now usually incorporated into research consent forms) for access to protected medical information by researchers, but allow IRBs or specially designed privacy boards to waive these requirements according to criteria similar to the usual federal research standards. The major impact of HIPAA in the research realm has come not from the terms of the regulations themselves, which impose few new requirements, but from their interpretation by IRBs. Despite permissive interpretations from the federal Department of Health and Human Services, which administers the HIPAA regulations, many IRBs incorrectly believe that HIPAA does not allow them to grant researchers access to patient information for screening and recruitment purposes. This has significantly complicated the work of research personnel, with little gain for patients' privacy.

Beyond any explicit legal requirements, there are many things that researchers themselves can do to limit threats to confidentiality. Two useful means of protecting confidentiality in research are to limit the number of people with access to identifiable data and to separate patient identifiers and confidential information. Data forms should contain codes, rather than patient names. If it is necessary to retain a record that links codes and names (e.g., to conduct a follow-up some months or years later), these forms can be kept separate from the data. Most IRBs require that research data files be securely locked and that identifiers be destroyed as soon as it is feasible to do so. The advantage to confidentiality in the last requirement is balanced by the loss of opportunity to use the same sample in subsequent studies not yet conceived. The possibility of future investigations must be considered carefully when confidentiality protections are being designed.

Publication of identifiable information. Not all research in psychiatry originates in formal protocols. Many important contributions have been made by clinicians who have reviewed and reported their clinical experiences with one or more patients.

Patients' privacy can be infringed by publication of data that are not sufficiently disguised to render them anonymous. The most famous case to reach the courts dealt with a psychoanalyst who published detailed transcripts of analytic sessions in a book. The courts held that even though the work was intended as a scientific demonstration for a professional audience, the patient's right to privacy had suffered. Obtaining the patient's consent to publication would have obviated the problem; however, a casual mention that the therapist was working on a book that might use case material of the patient, as occurred in the case noted here, was not sufficient. As the Group for the Advancement of Psychiatry noted, "Sometimes material may be so impossible to camouflage that it should not be published at all, in spite of its scientific value. Such ethical requirements take priority over research objectives." Of course, the same principles hold for videotapes and audiotapes of patients' sessions. (See also Chap. 4, Sec. II-D-2.)

Recently an international group of editors of medical journals noted that "complete anonymity is difficult to achieve" when case reports are presented, and suggested that "informed consent should be obtained if there is any doubt" that patients' anonymity will be protected (see Snider in the Suggested Readings). The practices of journals and publishers seem clearly to be moving in this direction.

e. Liability resulting from release of information to third parties. Patients whose confidential disclosures have been released without their consent can seek compensation from those responsible for harms they may have suffered, including emotional harms consequent on others knowing of their affairs. Courts have developed a variety of theories under which such claims are adjudicated, including actions in tort (the law of civil wrongs) for invasion of privacy, breach of confidentiality, and malpractice; and actions in contract for breach of an implied warranty that confidentiality will be maintained. (See Chap. 4, Sec. II-D-2.) Several cases have indicated that those persons who induce a therapist to reveal confidential information (e.g., the patient's employer) may also be held liable for resulting harms.

Under the HIPAA regulations, fines can be imposed on violators, an approach that may deter breaches of confidentiality but offers no compensation to patients who may have been harmed.

Other options for the aggrieved patient include seeking punitive action against the clinician from the state's professional board of licensure. A complaint alleging breach of professional ethics can also be brought before the therapist's professional association. If a "patients' bill of rights" exists in the jurisdiction, penalties for violation may also apply.

5. Exceptions

As important as confidentiality is to patients, from both utilitarian and deontologic perspectives, few people question that there are times when other interests must take priority. Disclosure of information without patients' consent may be legally justified, or even required in such circumstances as outlined in the following sections.

a. During an emergency. Physicians and other therapists retain the obligations of a fiduciary relationship—to act in the best interests of the patient. When, in an emergency situation, a patient refuses to give consent or cannot be located for consent, a therapist may sometimes disclose appropriate data in the patient's interest. The situations in which this might be thought to be the case are so numerous—almost any refusal to grant consent can be construed as not in the patient's interest—that if the exception is not to exceed the rule, such action should be limited to situations in which the patient's immediate welfare is clearly at stake. Such release is permitted by the HIPAA regulations.

Some examples are fairly clear-cut. When the therapist is contacted by a hospital emergency room where the patient, thought to be psychotic and unwilling to answer questions, is being evaluated, information concerning the patient's diagnosis, medications prescribed, pattern of illicit drug use, and the like may be essential to proper evaluation and treatment. Such information should be revealed, in the patient's interests, even without explicit consent, and if the patient's physical well-being is at stake, probably even over his explicit objections, with the justification for such action carefully documented.

When the patient's physical integrity is not at stake, the extent of an emergency exception becomes harder to define, especially under the HIPAA regulations, which narrowly define the exception as limited to serious threats to health or safety. A social service agency, for example, may contact a therapist asking for information that would establish the patient's continuing eligibility for subsidized housing. The patient has not been seen for some weeks, and consent for a disclosure of this sort was not previously obtained. Without the therapist's evidence, though, the patient will lose her apartment. Is this enough of an emergency to warrant a response in the absence of consent? Pre-HIPAA, we would have urged clinicians to rely on the assumption that a reasonable person would want a disclosure to be made and to act accordingly. Now, however, the likely impact on the patient's health or safety must be considered prior to disclosure.

b. When the patient is incompetent. If the treating clinician believes that his patient is not legally competent to give or to withhold consent (e.g., for release of information for disability benefits), he should attempt to obtain a substitute consent. If the patient has a guardian, that person is legally entitled to act on the patient's behalf. Many patients who are functionally incompetent, however, have never had a formal adjudication and lack guardians. In such cases, the consent of a close relative may be adequate. HIPAA allows everyone who is authorized to make health care decisions for another person to make decisions about his medical records as well. In situations in which a substitute for the patient's consent cannot be obtained (e.g., she has neither a guardian nor relatives available), the legal situation is ambiguous, but we believe that the therapist should be able to release information that is necessary to serve the patient's best interest.

c. Acting to hospitalize or commit the patient. When disclosure of information is required to effect the involuntary commitment (as by giving evidence of a patient's inability to care for himself) or voluntary hospitalization of a patient, such release is permitted in most states and under HIPAA. Some jurisdictions, however, restrict therapists from releasing confidential information in commitment proceedings over patients' objections. In those states, special examiners conduct commitment evaluations without input from treating clinicians.

d. Acting to protect third parties. Before the mid-1970s, psychiatrists' obligations to protect third parties from their patients' violent acts were limited to situations in which psychiatrists took physical control of a potentially dangerous person (i.e., hospitalized that person). Their duties extended only to ensuring that these patients did not escape or were not prematurely released due to the psychiatrist's negligence. No need to breach confidentiality existed to fulfill this duty.

Tarasoff v. Regents of the University of California, a case ultimately decided by the California Supreme Court in 1976, changed that. *Tarasoff* recognized a duty of all mental health professionals, not just psychiatrists, to protect their patients' potential victims, even if the patient had never been hospitalized. Although the court required therapists to take "whatever steps are reasonably necessary" to discharge their duty, it especially emphasized the possibility that warnings may have to be issued to the victim or the police, or both. Most states have similar judicial decisions or have adopted statutes defining some sort of obligation analogous to the one fashioned in *Tarasoff*, and the HIPAA regulations permit disclosure for this purpose. Most experts advise therapists in states without current law relating to a duty to protect to act as if some version of the obligation exists in their jurisdiction. (For a more complete discussion of potential liability resulting from a failure to fulfill the duty to protect, see Chap. 4, Sec. II-A-3-e.)

As noted, the duty to protect is not synonymous with a duty to warn. Other measures can be taken without breaching confidentiality and should ordinarily be considered first, including changing the nature of therapy to focus on the feared violence, adding or changing medications, expanding therapy to include a threatened intimate of the patient's, and hospitalizing the patient. Circumstances exist, however, in which disclosure is necessary to protect potential victims. If harm results from the therapist's failure to disclose information, liability may be imposed. Conversely, disclosure made in a good-faith belief that a third party is endangered does not result in liability for breach of confidence. Many states have adopted statutes providing explicit immunity from suit in such circumstances.

The duty to protect was developed in the context of violent behavior by patients, but it has been extended by some courts to include property damage and harm caused by dangerous driving. Among the most problematic areas to which a duty to protect may apply is the protection of sexual partners of persons infected with HIV. Laws in some states forbid disclosure of patients' HIV status to sexual partners, whereas others allow it. Suits against physicians for failure to inform a sexual partner have been rare, and there are substantial problems of proof (e.g., was the partner infected before or after the therapist learned of the patient's condition?). But, whether or not required by law, many clinicians feel an ethical obligation to inform endangered sexual partners. It is generally agreed that efforts should first be made to get the HIV-infected patient to discuss the issue with her partner and to bring that person in for counseling. Failing that, however, the American Medical Association and American Psychiatric Association have issued statements indicating their support for disclosure when necessary to protect a sexual partner. Public sentiment also appears to be swinging in this direction. No statutes yet mandate disclosure. An alternative approach for clinicians who are reluctant to contact sexual partners directly is to pass the information along to public health authorities, although the nature of their response varies from state to state.

e. Acting in conformance with reporting requirements. States are imposing an ever-growing number of obligations on physicians, other mental health professionals, and other caregivers to report specified conditions and behavior. The HIPAA regulations permit required reports to be made. Although each reporting obligation adopted by the legislature represents a decision that public knowledge of the condition or behavior in question is more important than the maintenance of confidentiality, one must question the cumulative impact of these requirements.

Historically, all states have required the reporting of cases of specified communicable diseases to allow public health measures to be implemented. The range of conditions, symptomatic and asymptomatic, associated with infection with HIV is a controversial addition to this group. Similarly, all jurisdictions require professionals to notify authorities about cases of suspected child abuse, although the statutes vary considerably in their requirements. Some impose an obligation only if the professional has seen the child or if the abuse is recent and likely to continue; others require reporting even of abuse that occurred in the distant past, regardless of whether the child has been seen in person.

More recent legislation has been enacted analogous to child abuse reporting statutes to cover other groups at risk of abuse. These include the elderly and the mentally and physically disabled. Some states are attempting to enforce older requirements for reporting of persons who may be unsafe drivers, including but not limited to, the mentally ill, epileptic patients, and drug and alcohol abusers. Impaired health care professionals, especially physicians, who come to the attention of other providers, must be reported in some jurisdictions. Furthermore, in some jurisdictions mental health professionals are required to report instances of sexual contact between therapists and patients when these are revealed by their patients.

Clinicians who do not to live up to their mandatory reporting obligations may be subject to civil and criminal penalties that are part of many statutes. In addition, should harm later occur that would have been prevented had they reported the situation, potential civil liability may exist as well.

It should be noted that in almost every jurisdiction, and under federal law, previous crimes of a patient that come to the therapist's attention do not have to be reported. The common-law doctrine of misprision, which required all citizens to report felonies of which they became aware, has been rejected repeatedly by courts in this country, although a few states retain misprision statutes. Some state mental health systems and the Veterans Affairs system may have administrative rules requiring reporting of past crimes. When evidence of a past crime raises the strong possibility of future crimes, as in the case of a repetitive sex offender, a clinician's duty to protect potential victims may require that some action (not necessarily reporting) be taken.

f. Supervisors and collaborators. Disclosure of information to those who are assisting the primary caregiver's efforts is not considered a breach of confidentiality, and is included under the "treatment" exception to HIPAA's requirement for patient authorization. This includes supervisors, members of a hospital's milieu staff, and colleagues who are involved directly in the patient's treatment. These individuals, once in possession of the data, are likewise under the same obligation to maintain confidentiality as the primary therapist. In-house quality assurance proceedings are undertaken under similar presumptions, as are reviews by accrediting agencies.

g. Administrative requirements. Under HIPAA, along with learning new rules for disclosure of medical information, clinicians and facilities have to meet a number of administrative requirements. Formal privacy policies and procedures need to be developed, and a staff person must be designated as a "privacy official" to receive complaints and provide information to patients. All staff members must be trained in these policies, and as noted below, new patients need to be provided with a notice of the relevant privacy practices. Patients have the right to receive an accounting of all disclosures from their medical records in the past six years, except for those made for treatment, payment, or health care operations, those that they themselves have authorized, and a small number of other categories. Every clinician, practice, or facility needs to create and sign contracts with all business associates who are given access to identifiable information about patients (e.g., billing, transcription, and accounting services) binding them to observe the terms of the regulations—to which, under the terms of HIPAA itself, they would not otherwise be subject. Many professionals and specialty societies, including the American Psychiatric Association, have developed model forms and procedures for members.

B. PRIVILEGE

1. Historical Evolution

Since Elizabethan times, when courts first assumed the power to coerce testimony from unwilling witnesses, there has been some sense that certain parties had a right—a privilege—to resist that coercion. Initially, it was the right of all gentlemen to refuse to divulge embarrassing confidences in court. As that privilege was abrogated, it was retained for a few groups. Clients were permitted to prevent their lawyers from testifying against them, on the grounds that to allow such testimony would so impair the lawyer-client relationship as to make it worthless. Husbands and wives were not permitted to testify against each other, although in part this privilege was motivated by the high risk of perjured testimony. These constituted the only protected relationships in English common law. Patients of physicians were never accorded a privilege comparable to that of clients of attorneys, despite arguments about the importance of protecting patients' disclosures.

In New York in 1828, the first statute specifically granting doctors the right to refuse to testify passed. Since then, a majority of the states have passed some kind of medical privilege statute. Those statutes are generally under attack as unnecessary impediments to the discovery of truth in judicial proceedings. Opponents argue that promises of confidentiality are not needed for good medical care.

Such arguments seem to carry less weight in the psychotherapeutic situation. All states have provided some means of preventing compelled disclosure of communications by mental health professionals. Psychiatrists are covered by physician-patient privileges, where they exist, and by psychotherapist-patient privileges in all other jurisdictions. Psychologists with doctorates are included in the latter statutes, or may be covered by privileges specific to them alone. Other mental health professions, including clinical social work, marriage and family counseling, rape counseling, and school counseling, are covered by privilege statutes in some states. Clergymen who conduct pastoral counseling may be granted privilege in those states that recognize a "priest-penitent" privilege. The trend is clearly toward broadening the classes of therapists covered by privilege statutes. Due to the patchwork of legislation, though, the actual terms of the privilege may vary substantially among professions even within the same state.

2. Ethical Bases for Privilege

As with confidentiality in general, two approaches can be taken to justifying a testimonial privilege, utilitarian and deontologic. Most discussions of privilege emphasize the former. Thus, Wigmore, the leading legal commentator on the rules of privilege, elaborated four rules, stating that privileges should be recognized when (a) the communication sought to be protected was made with an expectation of confidentiality; (b) confidentiality is essential to the relationship in which the disclosure took place; (c) the relationship is one that society should seek to foster; and (d) the harm to the relationship caused by disclosure is greater than the benefit to the litigation process. Mental health professionals have generally accepted this framework and argued that the psychotherapy relationship meets these criteria. When privilege has been applied to the mental health context, it has almost always been accepted because of this argument.

In fact, though, as scholars have pointed out, it is not easy to find empirical support for some of these propositions. Evidence exists, to be sure, about the importance patients say they place on confidentiality, and there is a common-sense belief that widespread breaches would reduce patients' willingness to seek care. But the proposition that the absence of a privilege would impair psychotherapy is difficult to test. Would the small risk of disclosure in later court proceedings really deter patients who required mental health treatment from seeking it? Jurisdictions that at some point have been without privileges do not appear to have had very different rates of patients seeking mental health care from states with a privilege. Additionally, the fact that most privileges have many exceptions means that even where they exist, patients still run substantial risks of courtroom disclosure. Is it only patients' unawareness of the risks, or their indifference to them, that keeps them coming to their therapy sessions?

The difficulty in validating the utilitarian requirements for a therapist-patient privilege (i.e., one in which a net gain to society exists) has led many people to turn to other ways of justifying it. They speak in deontologic terms of the value that the privacy of the therapeutic relationship has in its own right. Such relationships should be protected from intrusion, they argue, even at some cost, because of the importance of providing a private sanctuary—the therapist's office—in which one may freely discuss one's most personal thoughts. A society that encourages and protects such discussion and reflection, this approach maintains, is a morally better place to live.

3. Current Legal Bases for Privilege

As noted (see Sec. II-B-1), most privileges that affect the therapist-patient relationship have a statutory basis. A codified privilege represents the conclusion of the legislature that the sacrifice of evidence at trial is worth the benefits from protecting therapeutic confidentiality. When a therapist-patient privilege is not explicitly provided for by statute, it must be assumed not to exist. Courts still retain the power, however, to create privileges on a common-law basis and may do so occasionally, using Wigmore's four requirements. More frequently, however, courts find themselves interpreting privileges created by legislatures; an example relevant to the mental health professions is the many "rape privilege statutes" that have been enacted around the country. These laws are aimed at preventing the communications of rape victims to their therapists or counselors from being accessed by defendants, who are seeking to highlight alleged discrepancies in the victims' accounts, and thus encouraging post-rape treatment.

For many years, the situation in cases in which federal courts were applying federal law was unclear. The Federal Rules of Evidence contain no privilege of any sort, but they give the federal courts the power to create privileges "governed by the principles of the common law as they may be interpreted . . . in the light of reason and experience." Although lower federal courts resisted using this power to create a psychotherapist-patient privilege, the U.S. Supreme Court did exactly that in its 1996 decision in *Jaffee v. Redmond*. Faced with a factual situation that strongly aroused their sympathy (a police officer was trying to protect the confidentiality of records of the therapy she had begun after a distressing episode in which she had shot and killed someone), the justices provided a rousing endorsement of the importance of confidentiality in psychotherapy and of the courts' recognition of a privilege. In addition to its immediate impact on federal law, *Jaffee* may help to persuade state courts to retain or expand privileges in their jurisdictions.

Two federal statutory privileges should be noted. The first exists for records of patients in drug and alcohol treatment programs supported, even indirectly, by federal funds. Those records cannot be released without a specific determination by a judge that the public interest in disclosure outweighs negative effects on the patient and his treatment. Another privilege may be invoked for research records for projects in which the investigator has obtained a certificate of confidentiality from the appropriate federal agency. Certificates can only be issued under certain circumstances, but appear to provide almost complete immunity from prosecutorial or judicial access to records. It should be noted, though, that the scope and strength of this privilege has yet to be tested in court.

4. Exercise of Privilege

The right to bar testimony of a therapist belongs to the patient—that is, the privilege is hers to exercise. If she chooses to waive her privilege and to permit testimony by her therapist, the latter has no basis on which to refuse to testify. In some cases the right to waiver may belong to the patient's guardian or heir. If the patient does exercise her privilege, the information that the therapist has obtained, though usually not the fact of treatment itself, may not be revealed in court in pretrial proceedings. If the patient is not present to claim her privilege, the therapist may be obligated to claim it for the patient, pending the patient's appearance. (See also Chap. 8, Sec. I.)

5. Exceptions to Privilege

The situations in which a patient may not exercise testimonial privilege vary from state to state and in some cases may be interpreted so broadly by the courts as to almost negate the use of the statutes. These exceptions include the following:

1. Cases in which the patient has initiated litigation to which his mental status may be relevant (the so-called patient-litigant exception).
2. Cases in which the examination has been ordered by the court for purposes of determining competence to stand trial or criminal responsibility.
3. Cases in which the therapist was asked to aid in the commission of, or avoidance of punishment for, a crime or tort.
4. Situations after the patient's death (some jurisdictions limit this exception to issues concerning the disposition of the deceased's property).
5. Cases in which the patient represents a danger to herself or others.
6. Cases in which the patient has initiated a malpractice suit against the therapist.
7. Cases in which a patient fails to pay his bill and the therapist undertakes court proceedings.
8. Criminal cases (though some jurisdictions explicitly permit privilege to be exercised even in criminal actions).
9. Child custody cases in which the good to be gained for the child outweighs the negative effects of disclosure (some states extend this standard to all court proceedings).
10. Investigations of billing fraud by the therapist. Federal rules governing access to therapists' records may be deemed to override state privilege statutes in cases, in which federal health insurance programs are involved.

It should be emphasized that the extent of exceptions differs from state to state, and a careful reading of local law is essential before testimony is undertaken. In all jurisdictions, if the patient herself testifies about some aspect of the privileged relationship, she is considered to have effectively waived all future claims of privilege. Privilege may also be abrogated by the patient's or therapist's disclosure of information to third parties outside the courtroom. One court has even held, anomalously one hopes, that submission of forms for insurance reimbursement constitutes such a waiver of privilege. The extent of the exceptions, if any, to the federal privilege created in *Jaffee* remains to be determined.

6. Subpoenas

Any litigant can obtain a subpoena to compel the appearance of a witness or the production of relevant documents in court or at deposition for the purpose of examination, or both. The mere fact that a subpoena has been issued does not compel a therapist to testify, only to appear. At that point, it is for the judge to decide whether the testimony or records in question are subject to a claim of privilege. Receipt of a subpoena should be a stimulus for the therapist to contact the lawyers involved to determine the information sought. If the right of a patient to claim privilege may be at issue, the patient or his lawyer should be notified too. Finally, this may be a good time for the therapist to contact her own attorney to clarify her rights and responsibilities in the case at hand. Under no circumstances should records be altered or destroyed when a subpoena is received.

7. Communications Made in the Presence of Third Parties

Traditionally, statements made in the presence of third parties were held not to be susceptible to a claim of privilege. Court opinions in recent years have differed as to this; however, some states may void privilege if any third party is present, others only if that party is not involved collaboratively in the patient's care (e.g., social worker or nurse), whereas other states continue to permit privilege to be claimed. In such cases, the therapist may be exempt from testifying, but the third party may still be obligated to testify. The most difficult cases of this sort are divorce proceedings, in which one spouse may attempt to force the therapist to testify about statements made by the other spouse during marital therapy. The success of a claim of privilege here varies with the jurisdiction.

8. Group Therapy

Revelations made in group therapy represent a special instance of communications in the presence of third parties. Unless the privilege statute explicitly grants privilege to the group situation, as suggested in the American Psychiatric Association's Model Law on Confidentiality, it should be assumed that testimony about any material revealed in the group can be compelled from any member of the group. Group therapists should alert members to this reality when they discuss other confidentiality issues at the inception of therapy. Published data suggest that disclosure about the limits of confidentiality in groups is frequently neglected by group leaders.

C. CONFIDENTIALITY AND INFORMED CONSENT

As exceptions to confidentiality in mental health treatment have multiplied, questions naturally have arisen as to how much patients should be told about the risk of disclosure. Practices in this regard have been heavily impacted by the HIPAA regulations. Among their requirements is disclosure of privacy practices to all new patients, including situations in which information may be released without patient authorization. Practices and facilities that are HIPAA-compliant must develop written disclosures for this purpose (APA members can access sample disclosures and consent forms on the organization's website, www.psych.org). However, HIPAA-exempt clinicians have greater flexibility and may have good reason to avoid providing new patients with lengthy lists of circumstances under which disclosure may take place, which may be misinterpreted as meaning that their confidences will almost certainly be revealed. When their own ambivalence about entering treatment is at its height, the perception that they are about to embark on a venture that is likely to end with embarrassing information becoming public or being used to their disadvantage may well lead them to reject the idea of treatment altogether. A more reasonable approach can certainly be outlined.

For most patients, the risk that information discussed in therapy (apart from that required by their insurers, HMOs, or MCOs) will be revealed is small. Most risks, in fact, have such a low likelihood of materializing that a reasonable patient would not take them into account in making a decision about entering treatment. Even under the most rigorous views of informed consent (see Chap. 4, Sec. II-B-2-a), discussion of such information with patients is not required. That conclusion is reinforced by the likelihood of patients being frightened away from therapy at its inception.

On the other hand, it may be possible to identify risks of disclosure that are more than minimal. For patients with insurance, this includes the information that will need to be revealed if coverage is to be obtained for their care. Group therapy also presents substantial risks of unwanted disclosure. Patients should be told at the outset of treatment, when possible, of foreseeable risks of disclosure that have some significant probability of occurring.

Another situation with which clinicians may be confronted concerns patients with a long history of violent or self-destructive behavior, who might create a situation in which the clinician would feel compelled to breach confidentiality to protect a third party or the patient himself. It may well be appropriate to inform these patients at the initiation of therapy, or when the potential for breach of confidentiality becomes apparent, what the therapist intends to do. This ensures that even if the patient's confidentiality must at some point be violated without his consent, he will not have consented to participate in therapy without an understanding of the possible consequences.

Whatever is done at the initiation of therapy, inevitably situations arise in which the therapist unexpectedly learns, in the course of treatment, information that must be revealed. If at all possible, disclosure of confidential information should be reviewed with the patient before it takes place, even if HIPAA and state laws would permit disclosure without authorization. The reason for disclosure can be discussed and the patient asked to consent to the therapist's action, or to suggest some alternative, if he objects to the planned revelations. This process changes nonconsensual disclosure into a more collaborative decision.

Patients, of course, may not agree with the disclosure. Even so, studies suggest that patients are less likely to leave treatment if clinicians make an effort to inform them of the reasons confidentiality is being broken. Such discussion allows the therapist to explore the patient's responsibility for creating the situation that warrants breach of confidentiality in the first place. In cases in which the therapist may wish not to disclose information, but is compelled to do so by existing law, that too can be made clear.

III. CLINICAL ISSUES

A. TRUST AS THE BASIS FOR THE THERAPEUTIC ALLIANCE

The alliance in therapy is based on a collaboration between the therapist and the nonpathologic (or "healthy") aspects of the patient's personality. To attain this collaborative stance, the therapist attempts to see the world through the patient's eyes, striving for a state of empathic rapport. At the same time, in tension with this collaborative approach, the therapist must inevitably work in opposition to the pathologic (or "sick") aspects of the patient's psyche (e.g., a tendency toward harshly punitive self-appraisal), in effect acting as an advocate for the healthy side of the patient.

The foregoing requires from the patient an openness in self-disclosure and comfort with candor, in respect to which the clinician owes the protection of confidentiality.

1. Confidentiality and the Question of Agency

The term *agency* describes for whom one is working (i.e., who has hired the therapist). Agency is, thus, the operational basis for the therapeutic alliance. Several varieties of agency exist.

a. Individual patient agency. The individual patient agency is the outpatient adult model. In this model, the consenting adult hires the therapist as a consulting specialist; therefore, the therapist is considered to be working for that patient only. The individual patient's material is kept confidential from all other parties in the absence of consent, barring exceptional circumstances.

b. Couples, group, or family agency. In the couples, group, or family agency models, the therapist works for the good of the couple, group, or family as a unit; this may mean at times contravening the wishes of one member, even the designated patient. In any case, confidentiality is kept within the couple, group, or family.

One potential problem with this matter should be noted. It is well known that, in family therapy, family members may keep secrets from each other as part of their normal or pathologic functioning. The danger is that the treatment team may fall into this pattern and perpetuate secrets in treatment through avoidance or other defense mechanisms. This may represent an exaggeration of a right to confidentiality to nonconstructive degrees. For example, a family may maintain that their psychotic son would “go crazy or kill himself” if he finds out that he is adopted. The treatment team may fall into the trap by viewing the son as too fragile to be told this information. Both groups (the family and the treatment team) may not recognize that the perceived fragility of the son is, in and of itself, a symptom and product of the adoption secret.

In this example, the therapist is being asked to divide agency “within his patient” (the family). Approaches to this problem demand treating this wish to keep a secret as resistance to the process of therapy. The therapist should explore the family’s fantasies as to the results of “telling” and reaffirm that the contract with the family is to explore areas that may be causing family distress. Finally, the therapist should urge family members to consider revealing the secret themselves, within the family therapy session if possible, to permit maximum utilization.

c. Institutional agency and split agency. In the United States, pure institutional agency in treatment situations is rare; rather, the clinician’s agency is usually split in varying proportions between the individual and the institution. Examples of a split therapeutic agency might occur in military, court, school, or occupational mental health work. Although the clinician in those settings owes some loyalty to the institution, the well-being of the patient is usually not completely ignored.

In some cases, confidentiality may also be split between the individual and the institution, in varying degrees. A court psychiatrist, for example, may owe disclosure to the court concerning material relevant to the purpose for which the evaluation is being performed; in some jurisdictions the extent of the disclosure may be limited by statute. A military psychiatrist may be obliged to report on whether a soldier is a security risk, for example, but may keep other material confidential. (See also Chap. 6, Forensic Evaluations.)

d. Confusion of agency. It is important to realize that confidentiality should work only one way; that is to say, with the exceptions noted above, nothing should be told about the patient (or family or group) to the outside world. Relevant outside information, however, should (and in some cases, must) be reported to the patient; that is, phone calls, letters, and other kinds of information that come to the therapist from outside ethically belong to the treatment process and should be reported to the patient. Failure to follow this guideline, especially with paranoid patients, may result in the patient’s flight from treatment or other unfortunate outcomes. For example, the mother of a paranoid schizophrenic patient may call with certain information and may urge the therapist not to tell the patient that she called. Some approaches have been found to be useful in such situations. Some therapists attempt to state, as early as possible in the conversation (interrupting if necessary), that information will be shared with the patient. This approach reduces the chance of feelings of betrayal in the caller that might otherwise arise from being told, after having revealed a confidence, that it will be shared. The therapist might tell the mother that she must tell the son about their conversation by virtue of her agreement with the patient, but the therapist should encourage the mother to tell the patient first. Failing that, the therapist must tell the patient about the call at the earliest opportunity. Delay in reporting this call may leave the patient unclear as to whether the therapist would have told him without the matter coming up in the process of treatment. Thus, the therapist must, as it were, remain above suspicion in her willingness to report material from the outside into the treatment. Such doubts can be severely problematic in work with paranoid patients.

A second example is one in which the parents of an adolescent girl demand to know from the therapist about the patient’s sexual or drug-related activities. The family may argue, “After all, we are paying the bill.” The approach here requires clarification with the parents about the differences between the therapeutic contract and the contractual arrangements concerning payment for the sessions. Again, as in this example, the therapist should urge discussion with the patient herself. If no resolution is possible, the therapist must refer to the original confidentiality or agency agreements that, ideally, are made at the outset of the treatment of either a minor patient or an incompetent patient. Clearly, when the payment will be coming from a source other than the patient, identification of the arrangements concerning confidentiality should be made before treatment begins. Thus, the therapist might say at the outset: “I will be seeing Jane in treatment and you will be receiving the bills. I will rely on Jane to tell you as much as she wishes about the therapy. If you want to talk to me about something, I will get Jane’s permission, and we will meet with her present. Is that acceptable?”

Such an agreement, negotiated during what may be a period of calm at the start of treatment, goes a long way toward averting misunderstandings and antagonisms that may flow from feelings stirred up by crises during the treatment or in the patient’s evolving relationship with the family.

Under certain circumstances, should all of the above measures fail, treatment may have to be stopped by the therapist, because her alliance with the patient is shattered (but see Chap. 4, Sec. II-A-3-h regarding abandonment).

2. The Ethical Issue in Agency

Split agency is not necessarily a problem; ethically, however, candor is required to delineate the nature of the agency before material is explored in any situation in which agency is not limited only to the patient. Thus the therapist might say the following: "I am evaluating you for the court [school, company, battalion], Mr. Jones; what you tell me will be [may be, may in part be] shared with the court [etc.], so please keep that in mind. Within that limitation, however, I would like to be as helpful to you as I can." Obtaining the patient's informed consent to the split in agency is essential to prevent the patient from being, or feeling, victimized by the situation. (See also Chap. 6, Forensic Evaluations.)

B. RELEASE OF INFORMATION TO THIRD PARTIES WITH CONSENT

It must be kept in mind that the patient's signed consent (or in HIPAA's terminology, authorization) overcomes only the legal barrier to release of information. Clinical standards require separate scrutiny.

1. How Much to Tell

The best rule to follow in deciding how much to tell third parties about confidential material is designated the "rule of austerity"; to wit, the minimal necessary data to answer the question posed by the third party is the preferred amount. This is true even in those circumstances in which HIPAA's "minimum necessary" standard does not apply. In selecting data, one must keep in mind that facts are more useful than speculations and that direct observations and personal assessments are more useful than reports or hearsay data.

Certain information can be conveyed with minimal disclosure by the use of negatives in writing an opinion; for example, "There are no psychiatric contraindications at this time to [driving a car, getting a job, moving into special housing]." The use of this double-negative format may avoid the necessity of extensive supporting data.

In general, unconscious material, fantasies, and psychodynamic formulations have no place outside the immediate clinical sphere and should be excluded from communications to third parties. However, under HIPAA and many state statutes, patients generally have the right to authorize release of their entire record, psychotherapy notes excepted.

2. Handling the Patient's Wish for Altered Clinical Data

On occasion, a patient may directly or indirectly request altered data for social, financial, narcissistic, or legal gain. For social gain, for example, the dangerous alcoholic may request a letter supporting the return of his driver's license to allow greater convenience in using his car. In the financial realm, the patient may request a reimbursable diagnosis on an insurance form or may request a statement of (nonexistent) disability to permit collection of benefit payments. In the narcissistic realm, the patient with a grandiose paranoid illness may request statements that "nothing is wrong" addressed to various places, to perpetuate her denial of the illness. In the legal realm, a patient who is in therapy as a condition of parole from a criminal sentence may request that the therapist "not tell them anything," despite agreement and permission from the outset for regular reporting to the parole officer. Similar requests may be made in those circumstances in which treatment is an element of probation. The following principles guide the therapist's response (see also Gutheil and Hilliard, 2001, in the Suggested Readings).

1. The therapist may be fallible, but should not be corruptible—that is, although he may make mistakes or miss something relevant, the therapist should not knowingly falsify, misrepresent, or ignore factual data.
2. The therapist must represent reality or the viewpoint of realistic observation.
3. The patient's request can, and should, be discussed at length to extract the maximum data about the patient's ego functioning and world view that can subsequently be used in therapy.

3. Reviewing the Information with the Patient

As a rule, whenever it is possible, the therapeutic course is advanced when doctor and patient have the opportunity to review together any material that is going to third parties; this may include forms, letters, and discharge summaries. This is true even where HIPAA and state statutes permit unilateral disclosure by the clinician. A joint review tends to support the alliance position. Indeed, the majority of difficulties that arise around confidentiality do so not because confidentiality is breached *per se*, but because the patient is surprised by finding out that some unexpected person or agency knows something about her that she did not anticipate. This surprise factor appears to be the major trigger for litigation in this area (see Chap. 4, Sec. III-A). Thus, reviewing with the patient everything that leaves the office is the best liability preventive measure, as well as a means of conveying respect for the patient.

In handling the release of sensitive information, one issue that frequently arises is the question of the patient's or a third party's judgmental interpretation of certain technical and descriptive terms, especially those used in psychodynamic psychotherapy and psychoanalysis. Such terms might include "latent homosexuality," "incestuous wishes," and the like. Although these terms have specific meanings to the therapist in relation to the patient's unconscious dynamics, they are often thought of by laypersons (who may include third parties) as critical or pejorative. More important, third parties, including legal authorities, tend to see these terms as literal, conscious, and action-related rather than symbolic, unconscious, and fantasy-oriented. The distinction between these two categorizations may be unclear to the uninitiated.

The following approaches are suggested: First, the use of judicious euphemism is indicated in writing the report. The word "oedipal" or "developmental" rather than "incestuous" would be a preferable way of stating this issue. Similarly, "identity concerns" would be preferable to "fear of homosexuality."

Another valuable approach involves blending candor in the written discussion with an eye to maintaining a perspective on human experience. This would mean indicating to patients or third parties that these seemingly deviant feelings are common to all human beings and are part of the normal human experience.

A third approach embodies the diplomatic choice of expressions. One resourceful clinician, working in a clinic where all patients read all notes, wrote the following self-explanatory entry: "This woman seemed so suspicious, I wonder if she is paranoid, though she says she is not." This manner of describing the episode clearly communicates to clinicians who might read the record the important clinical data that it intended to communicate.

C. RELEASE OF INFORMATION TO THIRD PARTIES WITHOUT CONSENT

1. Emergencies

Emergencies in general constitute exceptions to the usual rules governing confidentiality, including under HIPAA. Under certain emergency conditions involving danger (e.g., risk of suicide or impending assault), confidentiality may—and in certain circumstances, must—be breached without consent (as noted in Sec. II-A-5-a). For example, the therapist may tell the patient's spouse that the patient is suicidal and may urge that the police be called, thus breaking the confidentiality of the therapist-patient relationship. In such situations, the alliance has been temporarily abandoned. The therapist is forced into the position of social agent, both by law, and, more important, by the overriding concern for the safety of the patient and others (see Chap. 2).

Such breach, needless to say, has effects on the alliance itself. The patient may feel abandoned or betrayed during the emergency and may feel himself in opposition to (rather than allied with) the therapist. During the emergency, the therapist should candidly describe what is happening: "I am breaking our agreed-on confidentiality because in my judgment we face an emergency situation . . . [explain], and I must act in your interest, even against our agreement."

After the emergency is resolved, attention should be paid to the repair of the transiently broken alliance. In this approach, the therapist invites the patient to join with her in a study of how the loss of alliance occurred and why it was necessary temporarily to abandon the agency of the individual patient.

2. In Court

Under certain circumstances, testimony may be compelled from the therapist with privilege absent or waived (as described under Sec. II-B-5). Effects of such forced testimony may be similar to those of other instances of disclosure without the patient's consent. The therapist should personally explain to the patient the circumstances of this disclosure and should pledge to divulge the minimum necessary information. Under specific circumstances, and preferably with the advice of counsel, the therapist may choose to refuse to testify on certain points, even at risk of contempt charges, if she thinks such testimony will harm the patient in some way and if she is willing to face the consequences.

3. Obtaining a History

Often, an evaluating clinician in an emergency setting or on an inpatient unit is unable to obtain sufficient data from the patient alone and is forced to turn to third parties, even without the patient's consent. At this point, a tension develops between (a) the patient's right to confidentiality concerning the emergency and (b) the evaluator's need to get information to treat the patient appropriately, because gathering data without revealing some aspect of the patient's situation is difficult. The evaluator must decide on clinical grounds how much information must be revealed to third parties to elicit necessary treatment-related information.

> ***Example 1.*** An evaluator calls the parents of a floridly psychotic teenager, despite his objections, to obtain a possible history of drug ingestion that would directly affect the decision to prescribe neuroleptics. He makes this call, against the patient's will, even though it betrays the patient's illness, evaluation, and possible hospitalization to the parents.

Many informants (e.g., family or friends) are extremely concerned about, and interested in, the patient and may press the evaluator for information, statements, and prognoses. Here again, the evaluator must reconcile the patient's right to confidentiality with the often-pressing need to enlist and recruit family or friends for future work with the patient.

> ***Example 2.*** After their son was admitted in an acutely psychotic state, the parents pressed the ward social worker to tell them what he said, especially what he was saying about them. The son adamantly refused the social worker permission to talk to the parents. The social worker compromised by telling the family: "I am legally forbidden to talk to you, but I can listen to what you tell me that may help your son. When he's better, he may give permission, and we can talk then. Meanwhile, let's meet regularly."

4. Acting as Informant

At times, the evaluator is on the other side of the fence, as informant in an emergency situation. Here, too, trade-offs similar to the foregoing may be called for, as well as some use of discretion and ingenuity.

> ***Example 3.*** In an emergency, the lawyer for a patient who had been newly admitted telephoned the psychiatrist to ask if the patient was in that hospital, because he had to meet with the patient to discuss charges arising out of the patient's actions during the current psychosis. The psychiatrist explained that acknowledging without permission any patient's presence in the hospital was a breach of confidentiality. The lawyer reiterated his demand. Realizing that the patient's interests were at stake, the psychiatrist sought and obtained the patient's permission for the disclosure, notwithstanding his agitated state. The lawyer arrived at the hospital to meet his client shortly afterward.

> ***Example 4.*** A psychotic inpatient had adamantly refused permission for the staff to talk to her parents. The patient's mother visited while the patient was still acutely ill and, shortly after seeing her daughter, sought out the psychiatrist on the case. Tearful, frightened, and desperate, she beseeched, "What's wrong with her? She doesn't even recognize me! Will she ever know me again?" The psychiatrist realized that a dry recitation of the rules of confidentiality would have alienated the mother as a potential ally for the treatment and, furthermore, would be nonresponsive to her human distress. He elected to use the generalized third person, thus stating: "Sometimes when people are very ill they can't recognize their loved ones for a time; when we get the illness under control, they usually recognize them again." In addition to relieving the mother, the psychiatrist's comments were generalized and betrayed nothing confidential about the patient in question.

In bona fide emergencies, the patient's welfare must predominate over other considerations. The evaluator should attempt to convey to other institutions or providers the nature of the emergency to obtain needed data. Such steps, of course, require careful documentation from both participants in the conversation. At a later point, the evaluator should explain to the patient the reasoning behind any such interventions, especially those that took place against the patient's will. The goal is not only to reestablish the alliance as founded on the patient's best interests, but also to model a realistic assessment of a situation.

5. Preserving the Alliance While Breaching Confidentiality

In addition to the patient's review of materials that leave the office (see Sec. III-B-3), other techniques can preserve the working alliance with the patient even when confidentiality must be breached. These are described in the next sections.

a. Advance notice. Whenever possible, clinicians should alert the patient to possible need for a breach, in advance of its being required. Examples include patients involved in child abuse, reportable diseases, sexually active patients with a diagnosis of acquired immunodeficiency syndrome (AIDS), and histories of violence. Such anticipatory discussion permits the subject to be broached at a calmer time than during an acute crisis (when sound judgment is more difficult).

b. Use of a hierarchy of interventions. When, for example, a patient is persisting in driving in dangerous or potentially destructive ways, the clinician should not "blow the whistle" as the first intervention. Rather, the clinician should first counsel him about driving, exploring the matter therapeutically, and recommend some alteration in driving behavior. That failing, the clinician should strongly urge the patient to change his ways. Then she should threaten to intervene. Finally, she should tell the patient that he must cease driving or report the matter to the department of motor vehicles, or she will. The speed with which the steps of this hierarchy are accomplished depends on the situation. Careful documentation of this process and (if needed) consultation have become particularly important in the wake of the driving cases that have sprung up in the courts. (See Chap. 4, Secs. II-A-3-e and III-A-2-g–i.) This hierarchical approach can, of course, be applied to other risky behavior as well.

Finally, even when confidentiality must be breached without the patient's permission, the patient should be told of the breach, as a courtesy, and the matter therapeutically explored. Even in such a circumstance, the core of what a patient has confided in the clinician should be the most actively protected and the most reluctantly disclosed. As in all cases, the minimum necessary information for the purpose should be revealed.

c. Remembering the nature of the alliance. The clinician should bear in mind that his alliance is with the healthy side of the patient, against the illness. Thus, the clinician is not working against the patient or turning into an agent for social control merely by opposing certain destructive behaviors or honoring reporting requirements. Even reporting on child abuse or neglect (see Harper and Irvin in the Suggested Readings) or management of the violent patient can be tactful, supportive, and, ultimately, more useful by attending to the alliance with that part of the patient that wishes not to abuse, that part of the violent patient that wants to keep control, that part of the self-destructive patient that wants to survive, and the like.

D. CIRCLE OF CONFIDENTIALITY

The circle of confidentiality is illustrated in Figure 1-1. Those within the circle may share patient information; those outside the circle require the patient's permission to receive such information.

The patient's family or attorney is outside the circle; being a patient's relative or legal representative does not constitute entitlement to obtain clinical information. For a patient in the hospital, the primary care physician or the outside therapist is also excluded from the circle of confidentiality as we conceptualize it, HIPAA notwithstanding; although, as a matter of clinical wisdom, these participants should obtain permission as early as possible to obtain essential historical material and to discuss the case, for the patient's benefit. Indeed, experienced clinicians believe that the data gained during hospitalization of a patient who is in therapy can often serve as a valuable consultative function to the ongoing treatment.

The police are outside the circle, too. If the police call a hospital or mental health center and ask if a certain individual is there, the only proper response is, "We cannot give out that information.

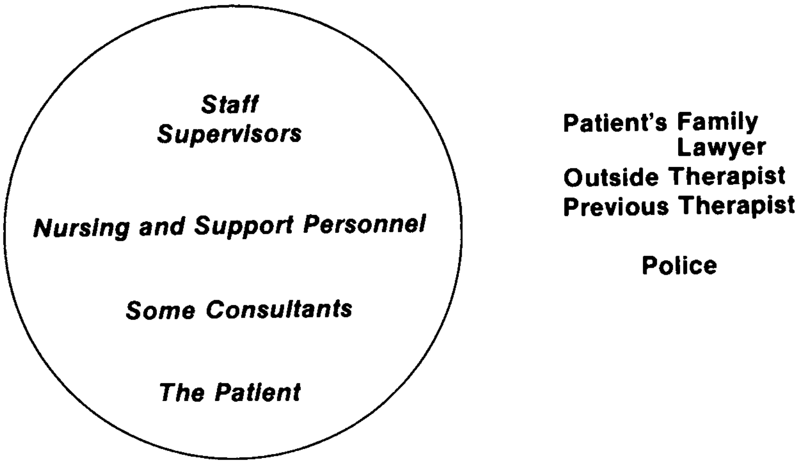

FIGURE 1-1 ● The circle of confidentiality.

However, we will make inquiries, and, if anyone by that name is here, we will encourage him to call you." Note that this response is appropriate regardless of whether the sought individual is, in fact, there as a patient.

Within the circle, information may, and perhaps should, be shared. Staff supervisors in teaching settings are considered to be within the line of responsibility and thus part of the treatment team. The same can be said for treatment staff of all disciplines. In a similar fashion, those consultants who actually see the patient (as, for example, a gynecology consultant for a patient in a psychiatric hospital) clearly must be informed about the clinical situation, a reality recognized by HIPAA's rules regarding release of information for treatment purposes.

Finally, the patient herself is inside the circle—a point perhaps so obvious as to be overlooked. Because the patient has no professional obligations to anyone, the patient might, theoretically, appear on national television and reveal the secrets of her life story to the entire country. In more practical terms, clinicians should recall that the patient, if able, may pass along information in those ambiguous situations in which the requirements of confidentiality are uncertain. The patient can inform family, agencies, and other caregivers. The more tricky and complex the situation, the more valuable the patient's role.

Having the patient convey important information has a particular value in a most counterintuitive context: having the patient warn a putative victim of his dangerousness. Empirical experience suggests that, although such communication cannot always be achieved, direct conversation by supervised telephone call or monitored visit may defuse the potential danger in the relationship, a result far more desirable than merely meeting some legalistic "duty to warn." When patient and victim are talking to each other, they are not shooting at each other; paranoid fears and fantasies can be tested under clinical supervision, misunderstandings corrected, spleens safely vented, and tensions eased. Having the patient "do the warning," then, in those rare instances in which this is indicated, avoids the ethical tension caused by the clinician's unilateral breach of confidentiality, no matter how justified.

E. PATIENT'S REQUEST TO SEE OWN RECORDS

At certain junctures in the treatment process, the patient may request to see her own records. Under HIPAA, of course, patients have this right in almost all circumstances. But that doesn't negate the importance of responding to the situation in a clinically appropriate manner. In the usual situation, this request is an expression of certain fantasies about the state of the treatment and requires, among other things, exploration in the therapy and a reality response. In general, exploring the reason for the request implies identifying fantasies frequently related to the patient's questions "How am I doing?" or "What do you think of me?" One attempts, in managing this, to deal with concerns and questions in the usual exploratory manner.

In certain situations, the wish to see a record may have a basically paranoid core with delusional components (e.g., the patient may believe that some of his secret thoughts are being read or that accusing indictments are being leveled at him in the content of the record, and that this record is being revealed or is potentially revealable to third parties).

The request to see the record may be used constructively to advance the therapeutic process, both because of the fantasies that may be brought to the surface and because distinct advantage to the therapy may accrue from going over the actual chart material. The patient and therapist might, for example, review together certain nursing observations made during the time the patient was psychotic. When properly handled and with proper preparation within the therapy, this review may aid integration of the patient's psychotic experiences into her nonpsychotic self-image.

All the difficulties cited previously (see Sec. III-B-3), with regard to the patient's potential misinterpretation of technical terms in disclosed information, are equally applicable to the patient's review of the record. The goal of all clinicians should be to avoid such difficulties by eschewing the use of misinterpretable technical terms in the patient's record (see Sec. III-G-2)—that is, by writing the record in anticipation of the patient's reading it.

F. CONFIDENTIALITY IN GROUP THERAPY

Group therapy poses special problems with regard to confidentiality, which experienced group therapists attempt to minimize by using the following approaches: (a) using only first names of members in conducting the group and in keeping charts on group members; (b) urging group members to see themselves as cotherapists together with the group leader and, thus, subject to the same moral obligation to keep group material confidential (in this way, one appeals to the group's conscience and the conscience of individual members to encourage confidential behavior); (c) discouraging members from meeting or socializing outside the group; (d) analyzing breaches of confidence, if they occur, as part of the normal group process; and, finally, (e) terminating treatment with members who breach the group's confidentiality to outside parties (see also Suggested Readings, Slovenko).

G. INFORMED RECORD-KEEPING THAT PROTECTS CONFIDENTIALITY

1. Clarity of Sources

In keeping records, the importance of clearly distinguishing data known by observation to be factual from speculation, report, and allegation cannot be overemphasized. It is also important to note both the source of any data not obtained by observation and that source's reliability. For example, one might note, "The arresting officer reports . . ." or "The parent, known to be a good historian, reports . . . ." For potentially or ostensibly criminal matters, the word "alleged" is proper usage, as in: "the alleged theft [assault, rape, felony, etc.] . . . ." (See Chap. 4, Sec. III-A-3, for extensive discussion of this topic in terms of malpractice prevention.)

2. Concept of "Two Sets of Books"

A useful approach is to distinguish between process notes (records of the patient's fantasies, feelings, and experiences, intended for the therapist's use in treatment) and progress notes (objective records of facts, observations, and treatments for use in communications to other parties and in utilization review of care given). This corresponds to HIPAA's distinction between psychotherapy notes and the patient's treatment record. The progress notes should theoretically be open to the patient and third parties after the provision of consent (see Sec. III-B) and should be written from a perspective that anticipates such release. The former are totally private, although still recoverable by subpoena, of course.

For clinicians working in institutional settings, the process or psychotherapy notes remain their property, even after they leave the facility. Therapists who intend to write papers based on data collected from their clinical work can use process notes for this purpose, because they are ordinarily denied access to patient's records (the official progress notes) at a facility at which they no longer work (but see Chap. 4, Sec. II-D-2). Once active work with a patient is terminated, it is advisable for the therapist to remove identifying marks from the process notes, so that their later use for didactic or academic purposes will not jeopardize the patient's confidentiality. This can be done by removing the patient's last name or by using a numbering system for coding the records and keeping a copy of the code elsewhere. In most circumstances, the progress notes, which are the property of the facility, should not be photocopied for these purposes. Many facilities have rules explicitly forbidding such copying for personal use, a situation again underscoring the utility of keeping process notes.

Progress Notes Versus Process (or "Psychotherapy") Notes

	Progress Notes	Process (or "Psychotherapy") Notes
Location	Front, ward, clinic, or public chart	Therapist's private notes
Content	Facts, observations, tests, procedures, treatments, services, laboratory results, and medications only	Anything that comes to mind: conscious or unconscious, fact or fantasy
Viewpoint	Operational/descriptive	Therapeutic/investigative
Purpose	Treatment planning, recording, documentation, and utilization review	Understanding total patient for treatment
Language	Austere, factual, descriptive, clear and legible, showing follow-up of problems, may be problem-oriented format	May be quotations from doctor or patient, may use private shorthand or abbreviations

3. Acquired Immunodeficiency Syndrome (AIDS) and Related Matters

Because our society at large is still undecided as to how to view AIDS, HIV seropositivity, and the presence of risk factors for infection, it is not surprising that considerable confusion and inconsistency prevail around record-keeping on this topic. Some jurisdictions require separate consent and separate charting, or both, for HIV-related material.

In the present state of flux, clinicians must familiarize themselves with relevant local regulations and statutes. In the absence of legal reporting requirements or other exceptions to the HIPAA regulations' rules governing release of information, patients' authorizations are required prior to disclosure.

4. Audiences for the Record

In writing the psychiatric record, it is useful to keep in mind those audiences for whom the record is intended and those audiences who may see it in the course of medical and legal activities.

The first audience to consider is the patient. Under HIPAA and many state laws, patients have relatively unrestricted access to their records. Attention should be paid to word choice. Use of tactful expressions and similar approaches demonstrate appropriate respect for the patient and minimize distress, should she read the record.

Other staff, such as team members, supervisors, and attendings, may also need to see clinical notes—a strong argument for their legibility.

Certain agencies may have access to the record as well. These include regulatory bodies, insurers, managed care reviewers, HMOs, and Medicaid "fraud squads."

The record may need to be scrutinized by peer review committees, quality assurance reviewers, and utilization reviewers.

The record may also be required for covering clinicians, during the primary clinician's vacations or other absences, and for emergency clinicians who may need to attend to the patient.

Finally, various attorneys may need to read the record, sometimes in a malpractice suit against the clinician. In the tossing seas of malpractice litigation, a solid record is the clinician's best life raft.

The existence of all the audiences for the record place a burden on the clinician, captured by the CATO rule (see Palisano in Sec. C of the Suggested Readings): The record must be *c*omplete, *a*ccurate, *t*imely in its completion, and *o*bjective, as well as legible. Corrections should not black out, white out, scribble out, or otherwise render unreadable the original notations. Errors should be stricken out with a single line, initial, and date, and corrections made without obscuring previous entries. One aims at "transparency"—that is, the original, the correction, and the time when each was made should be "transparently" clear.

H. SPECIAL RECORD AND CONFIDENTIALITY ISSUES

1. After the Death of a Patient

When a patient under treatment has died, confidentiality should not die at the same time. The patient's administrator or executor, who is appointed by a court to represent the patient's estate, should speak for the deceased patient as to release of record material. This is consistent with the requirements of the HIPAA regulations. Under some circumstances, records of deceased patients may be no longer protected by privilege, but this varies with the jurisdiction and the issue; local attorneys should be consulted.

When the record of a particular patient contains material that the clinician believes the patient would not have wanted revealed (a good example is negative information about the executor), the clinician should resist release until the matter is reviewed by a court. This would mean turning down the executor's request and waiting for a court order.

2. Obtaining a Consultation

If a consultant actually sees or interviews the patient, the latter's permission would be obtained; but an anonymous consultation may always be solicited, with or without permission. This resource may be especially helpful in a crisis or a situation in which the best course is uncertain.

3. Treating an Impaired or Ethics-Violating Clinician

In jurisdictions that require reporting of impaired colleagues, clinicians are often uncertain what to do when a clinician-patient whom they are treating reveals or manifests substance abuse or similar impairment, or admits to ethics violations, such as having a sexual relationship with his own patient. Although the treater is free to urge self-referral or even self-reporting for the clinician-patient, the confidentiality of the treatment relationship usually trumps competing obligations. The only exception might be clear emergencies (e.g., your surgeon-patient, clearly intoxicated, plans an operation immediately after the session) or other manifest threats to patient safety.

4. Retaining Records

As a rule, records for past patients should be kept for seven to ten years. At that point, a one-page or one-paragraph summary can be made and kept forever and the remainder of the record destroyed. Some practices employ professional record storage companies.

5. Revelation of Past Crimes

Clinicians mindful of duties to breach confidentiality under conditions reflected in the *Tarasoff* case, in which third parties are threatened by one's patient (see Chap. 4, Sec. II-A-3-e), may mistakenly believe that they have a comparable duty to breach confidentiality and report a patient's past crimes when they are revealed in the clinical setting. In fact, confidentiality predominates in this situation: Because the clinician knows of the crime only by report (hearsay), there is no legal duty to notify anyone. The issue should be explored therapeutically; under some clinical circumstances, the patient should be urged to obtain legal counsel and consider resolving the matter appropriately.

6. Miscellaneous Tips

- Make separate records for all those who attend a session.
- Control access to records; limit it to authorized persons.
- Separate record components (e.g., billing, progress notes, records from other sources).
- Write or dictate promptly and legibly.
- Note cancellations, no-shows, late shows, and follow-up.
- Put a name or identifier on each page to permit refiling if separated from the chart.

I. PSYCHIATRIC RECORD SECURITY IN THE INFORMATION AGE

The same technological advances that ease clinical work, record-keeping, and communication with other caretakers and agencies also pose a host of problems in the area of preserving confidentiality, as Case Example 4 of this chapter illustrates. Thoughtful approaches to these pitfalls protect the patient and the treater from bad outcomes.

1. Computerized Records

Computerized record-keeping may soon become the usual form of documentation in medicine, including psychiatry. Federal legislation to encourage this process has already been enacted, and more sweeping laws—and perhaps funding—may soon be on the way. Some authorities note that the great advantage of computerized records is untraceable erasure, and the great disadvantage of computerized records may also be untraceable erasure. Although typographic errors may yield to spell-checker programs, and awkward phrasing can be effortlessly modified, the record no longer stands as firmly as a durable archive of the ongoing treatment as was the case in “paper days.” (Of course, electronic medical records can be set up to track every change, mitigating this problem.) Individual practitioners using computerized records may wish to consider printing out notes or summaries every so often and signing them in ink to provide an “anchor point” for subsequent authentication.

Security risks for computers usually occur in three areas: access to records by unauthorized readers; transmission problems, as when material is sent to remote sites via phone lines or networks; and transfer of data to nonmedical information systems such as insurers.

Approaches to these problems should include individualized passwords for authorized users and data entry personnel, automated audit trails identifying specific users of the system, and restrictions on copying or downloading of files. Experts also recommend ensuring that departing employees, especially disgruntled ones, no longer have access to patient files. Remote access should be avoided or conducted through secure systems to minimize the chance of hacking.

Special care should be taken when dealing with third parties involved in electronic repair and maintenance that may permit access to confidential material; formal (i.e., written) confidentiality agreements should always be used with repair agencies, accountants, and billing companies and are required by the HIPAA regulations. Antivirus software should be used routinely, and back-up systems should be in place to avoid data loss. For greater security, back-up data may be stored offsite. Patient records should generally not be stored on laptops, which may be mislaid and are popular items for theft.

2. Faxes

Transfer of medical records by fax has allowed great improvements in continuity of care and emergency treatment, but with predictable problems. It is stunning how often we receive faxes with medical information meant for some other physician. We recommend that faxed material be sent in encrypted form if at all possible. In any case, each transmission should have a cover sheet that identifies the sender and intended recipient and defines the material as confidential, with numbers and addresses provided in case of mistransmission. Calling before and after transmission to confirm readiness for transmission and receipt of same is also warranted. Information on a patient’s HIV status and other especially sensitive data should never be faxed.

The receiving fax machine should be located in a private area where unauthorized parties or casual passers-by are not likely to read sensitive material.

Finally, speed dialing should not be used because of the ease of error in hitting the wrong button. Clinicians may also wish to consider the greater security offered by overnight mail or express delivery, when possible and clinically acceptable.

3. E-Mail

Unencrypted e-mail is generally regarded as an insufficiently secure mode of transmission of sensitive data; encrypted e-mail is relatively secure. Several commercial companies now offer secure e-mail links for patients and clinicians via Web-based systems. The APA has produced a series of helpful FAQs (frequently asked questions and answers) on use of e-mail, which are available to members on the APA’s website.

4. Answering Machines and Voicemail

Both these helpful modalities should generally not be used to transmit confidential information, because it is not possible to know who may access, hear, or overhear the information. The clinician should be ever mindful that even the existence of the clinical relationship is confidential. For example, when calling a patient at home, consider saying, “My name is Jones; could Mr. Smith please call me,” rather than “This is Dr. Jones calling for Mr. Smith to cancel his psychotherapy appointment of next Tuesday.”

A clinician’s answering machine in a home office setting should be kept private with the volume low or off to prevent overhearing; alternatively, appropriate soundproofing should be used.

5. Cellphones and Wireless Phones

Though now ubiquitous, cellular telephones and wireless telephones differ in a significant way from standard land-line telephones: Calls can be intercepted by a number of electronic devices. To cure one’s doubt of this point, one has only to hear the neighbor’s telephone call coming in loud and clear over the baby-room intercom. As a general rule, then, confidential information should not be transmitted by these devices. If necessary to do so, the patient should be informed that the clinician is on such a telephone and of the potential for overhearing, and the patient’s consent should be obtained. Alternatively and preferably, the conversation should be postponed until land lines can be used.

Clinicians and their employees should remember to log, or enter in the record, the information obtained in telephone calls; beyond its clinical use, such information may be critical to a malpractice defense in the event of an unforeseen outcome.

Indeed, obtaining the patient’s consent to the particular form of information transmission is an excellent idea for all the modalities listed in this section.

IV. PITFALLS

A. INAPPROPRIATE SECRECY

Appropriate attention to confidentiality may be confused with a patient’s counter-therapeutic demand for secrecy. Inappropriate secrets in the milieu of the inpatient ward can be very destructive. For example, the patient may ask a new staff member not to reveal her plan for suicide or escape because that would violate the patient’s trust and confidentiality. This loaded secret leaves the staff member in an impossible, no-win position. Either the staff member loses the alliance and trust of the patient, or may lose the patient herself. This approach by the patient usually reflects covert hostility toward the staff member. A second example is a case in which a psychotic male patient’s homosexual concerns make the resident or other trainee so anxious that, in the name of confidentiality, he does not pass them on to the staff. The staff, not being warned about this, may inadvertently provoke a panic by allowing male staff members to come too close to the patient, rather than preferentially utilizing female staff members, as is ordinarily done in such clinical states.

A potential, unexpected outcome of inappropriate withholding of information by staff members confused about the requirements of the HIPAA regulations is litigation by persons intent on gaining access to the data. Staff who, despite patients’ authorization, withhold information from, for example, family members, may trigger suits filed “just to find out what happened.”

B. CONFUSION OF AGENCY IN INFORMING

Most clinicians are alert to the importance of not discussing a patient with, say, the patient’s family member without permission. A family’s urgent request not to tell a patient about a telephone call, however, ostensibly to avoid needless upset, may be forceful and persuasive, leading the clinician to omit informing the patient. Here the clinician may be influenced by overidentification with the parent’s protective impulse. Other seemingly trivial information about the patient from various sources may similarly, but inappropriately, be dismissed as irrelevant to the patient’s care and thus undeserving of being passed on to the patient.

Here, wishes to spare the patient distress may fuse with considerations of convenience, expediency, and the wish not to be the bearer of bad tidings to the patient. The pitfall here is clear: A patient who learns from other sources that the clinician knew something (no matter how trivial) and did not pass it on may not easily recover trust for the clinician. The wish of outside sources to sneak information past the patient to the clinician can be explored with the various parties as a legitimate therapeutic issue.

V. CASE EXAMPLE EPILOGUES

A. CASE EXAMPLE 1

In Case Example 1, because the hospital and the resident are not obligated to report the patient's confession to the police and a privilege statute in the state where this occurred bars such disclosure even at trial in criminal cases, it would appear that the resident has no further legal obligation. He is concerned, however, that the patient's story, if true, might shed light on his future dangerousness and on the need for involuntary commitment, both estimations that he is legally obligated to undertake. The need to confirm the patient's story appears to conflict with the principle of confidentiality.

In this case, means are available of verifying the patient's account without breaching confidentiality. The resident calls the police and, without informing them of the patient's identity, reveals the nature of his confession. The police officer reports that the site of the alleged crime was used for a massive fireworks display the previous night and, given the tight security precautions, it is highly unlikely that the patient could have committed such an act undetected. In addition, no body was found in the harbor that morning. The resident takes no further action.

One week later, after medication has rendered the patient much less psychotic, he admits that his confession was a fabrication.

B. CASE EXAMPLE 2

In Case Example 2, the doctor could be the beneficiary of the state's privilege statute, which bars disclosure of material gathered in therapy. However, the statute specifically exempts child custody hearings from a claim of privilege when the presiding judge determines that disclosure of the information in question is more valuable than maintaining the confidential doctor-patient relationship.

The doctor, before her appearance in court, discusses her dilemma with the patient and explains that, though she does not want to testify, she may be compelled to do so. When she arrives in court, prepared to ask the judge to receive her data *in camera* to rule on its applicability, she discovers that the judge disavows any knowledge of the privilege statute. As she has not brought a copy of the two-page statute along with her, she can not refer him to its specific provisions and, faced with a direct order to testify or to face contempt proceedings, she acquiesces.

The resulting breach of confidence provokes the expected difficulties in her relationship with her patient, who is much more reticent about talking with her thereafter.

C. CASE EXAMPLE 3

The jurisdiction in Case Example 3 has no statute regarding the disclosure of information about patients' HIV status, although it does require patients' written consent for the disclosure of information from mental health facilities, except in emergencies. The therapist must therefore judge whether the threat to the patient's wife is serious enough to warrant being called an emergency under the HIPAA regulations. He is also concerned that if word gets out that the mental health center is contacting sexual partners of HIV-positive patients, such people will stop coming in, despite their need for care.

After considerable thought, he decides he must contact the patient's wife, unless the patient does so first, and so informs the patient. At this point, the patient says he has already told his wife, and that she has agreed with his plan to try to have a child. The therapist doubts the accuracy of the patient's report. To forestall the patient's intercepting his communication, he sends a registered letter to the patient's wife, asking her to come in to discuss an important issue with him and the patient. When she arrives, she discloses that the patient has told her about his HIV status, but only after the letter was received. She is confused about the meaning of the test result, and simultaneously angry at her husband and fearful of losing him. The therapist supports an airing of the issues by both husband and wife, then arranges for them to meet with a counselor specializing in AIDS-related issues to discuss the implications of the patient's status. Although angry at the therapist for forcing him to tell his wife, the patient agrees to counseling and to continue in therapy.

D. CASE EXAMPLE 4

The risk manager in Case Example 4, Mr. Redmond, sits down with a fastidious jerk at the knife-edge creases in his trouser legs and squares the pad on his lap. Straightening in his chair, he begins to speak in a formal manner, "At your request, I performed an informal information security survey of your office by seating myself in your waiting room for the previously agreed-on two hours. I submit the following report."

He glances at his pad. "In that interval, I was able to obtain nine patients' full names; five diagnoses from that pool of persons; three insurance claim numbers and 11 unidentified phone numbers. I have also determined that a Ms. Lovelace is becoming progressively and dangerously sicker; that a Mr. Wilson may be a threat to his children; and that a Mr. Lewis is a very bad credit risk." He pauses, clearing his throat. "I also have your MasterCard number."

He leans back in his chair. Dr. Bell, staring at him in dismay, realizes his mouth is open and closes it. Rubbing his forehead, he sighs, "Well, I guess I found out what I wanted to, but I didn't know it was *that* bad. How did you get all that, and what can I do?"

Mr. Redmond describes how he has obtained all of this confidential information by relatively simple means: overhearing staff chat with each other; overhearing the staff side of telephone conversations to patients, insurers, and office suppliers; and overhearing names announced on the intercom (the leakage is especially explicit when names are spelled aloud and repeated for accuracy). By using his cellular telephone (concealed in his cupped hand), he was also able to "tap into" fragments of calls to the clerk's portable telephone handset. By walking once to the restroom, he was able to read, in passing, a computer screen and an incoming fax, both with patients' names and addresses.

Over the ensuing weeks, Mr. Redmond helps Dr. Bell develop simple procedures to improve information security in his office so that he could be in compliance with the federal HIPAA standards. These include staff training, relocation of both physical and computer records and files, a glass wall for the receptionist's desk, phone mouthpiece privacy hoods to decrease ambient information, and similar interventions. Dr. Bell considers the time and money well spent in preventing liability and embarrassment and providing patients with a setting respectful of their privacy.

VI. ACTION GUIDE

A. CHECKLIST FOR RELEASE OF INFORMATION TO THIRD PARTIES

1. *Explore* reason for request.
2. *Determine* extent of disclosure required.
3. *Be certain* patient understands potential implications of data release.
4. *Obtain* written consent for disclosure, compliant with the HIPAA standards, if applicable.
   a. Should specify the content of the material to be disclosed (e.g., history of outpatient treatment since 1995 or lifetime medication history).
   b. Should be renewed for each subsequent disclosure.
5. *Organize* material to be released.
   a. Whenever possible *communicate* in writing, not over the telephone.
   b. *Reveal* minimum necessary data.
   c. *Stick* to facts and firsthand knowledge.
   d. *Avoid* psychodynamic material.
   e. *Write* letter as if patient will read it—patients often do.
6. Whenever possible, *review* letter with patient before it is sent.
7. When patient requests falsification or omission:
   a. *Derive* stance from incorruptibility.
   b. *Side* with healthier part of patient's ego.
   c. *Discuss* issues thoroughly with patient.

B. CHECKLIST FOR RELEASE OF INFORMATION WITHOUT PATIENT'S CONSENT

1. *Determine* if one of usual exceptions apply, including:
   a. Clearly acting in emergency situation and in patient's best interest.
   b. Patient incompetent and substitute consent not available.
   c. Patient incompetent and substitute consent obtained.
   d. Acting to hospitalize or commit patient.
   e. Acting to protect third parties.
   f. Required to report data by state law.
   g. Sharing data with collaborative caregivers or supervisors.
2. *Document* efforts to obtain patient's consent and existence of exception.
3. *Alert* patient that information is to be released.
   a. *Discuss* basis for decision.
   b. *Discuss* impact on therapeutic alliance.
4. *Reveal* minimum necessary data, in writing if possible.
5. *Repair* alliance afterwards, focusing on how situation evolved and patient's feelings about it.

C. CHECKLIST FOR RELEASE OF INFORMATION FROM PATIENT'S RECORD TO THE PATIENT

1. *Explore* reasons for request.
   a. *Identify* fantasies.
   b. *Be alert* for delusional basis.
2. *Determine* whether one of the exceptions under HIPAA apply.
   a. Likely to endanger life or physical safety of patient or others.
   b. Information in record about third party and release likely to cause that person substantial harm.
3. *Prepare* patient for impact of disclosure.
   a. *Discuss* confusing, technical, or seemingly pejorative terms.
   b. *Discuss* possible impact on ongoing therapy.
4. Whenever possible, *go over* record together with patient.
5. *Use* material revealed to advance therapy.
   a. *Use* as means of integrating past experience.
   b. *Explore* effect of fantasies confirmed or denied.
6. *Do not alter or destroy* records before patient sees them—potential legal liability.

D. CHECKLIST FOR REVELATION OF INFORMATION IN COURT PROCEEDINGS

1. If request is from patient, no privilege applies—*handle* as in checklist C, above.
2. If request is from party opposing patient, *determine* laws governing privilege in your locale.
   a. If no patient-doctor or patient-psychotherapist privilege exists, *handle* as in checklist B-3, -4, and -5.
   b. If privilege exists, *determine* if this case constitutes an exception or not.
3. When subpoena arrives, *remember* that it mandates your appearance only—judge must still decide if privilege exists.
4. *Consult* with lawyer requesting subpoena to see what information is desired.
5. *Notify* patient and patient's lawyer of arrival of subpoena, giving them a chance to challenge it.
6. Consultation with your own lawyer may be useful.
7. If your testimony is inevitable, *follow* checklist C-3 through C-6.

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CHAPTER 2

Legal Issues in Emergency Psychiatry

I. CASE EXAMPLES

A. CASE EXAMPLE 1

A middle-aged man shuffles into the office of the psychiatrist on duty in the emergency room and slumps into the chair; his deep sigh releases a whiff of alcohol, and he remarks, “Perhaps I shouldn’t have come.” He is graying, unshaven, and his somewhat disheveled clothes fit him loosely.

Empathic questioning reveals that two months ago he lost his job because of alcohol-related absenteeism. This event proved to be the last straw for his wife, who took the children and decamped to her parents' home. He is sleeping little; his appetite is gone. His drinking buddies no longer find him "fun to be with," his parents are not interested in hearing from him, and he has no relatives or close friends in town. He has been thinking seriously of suicide.

The doctor on call recommends hospitalization. The patient demurs at first, then argues, and then threatens. The doctor is firm. The patient looks searchingly at the doctor for a long moment, sighs quietly, and says, "Okay, Doc, you've convinced me. I'll go pack some things and meet you here in an hour." Rising, he turns toward the door.

B. CASE EXAMPLE 2

A middle-of-the-night call to an emergency service of a community mental health center announces the imminent arrival of a transfer from a nearby general hospital. The patient in question, age 28 years and mildly intoxicated, had just received extensive stitching for two self-inflicted superficial lacerations running the length of each arm. After the lacerations were sutured, the patient went into the bathroom of the emergency ward and removed each stitch. He was resutured and is now being transferred for psychiatric hospitalization.

On his arrival, it is apparent that he is not psychotic, but is furiously angry with his stepbrother, with whom he has been staying since his arrival in the city three weeks ago. When his stepbrother ordered him to leave the house after an altercation, the patient procured a razor blade from the bathroom and, in front of his stepbrother's little daughter, carved up his arms. He will not say whether he intended to kill himself or if he is still bent on self-destruction. He does give a history of previous hospitalizations after other self-destructive acts, all of which ended with his angrily signing himself out of the hospital within a few days. After eliciting this story, the psychiatrist pauses to consider his options for handling the case.

C. CASE EXAMPLE 3

Nearly frantic with concern, the mother of a 23-year-old woman calls a psychiatric center to ask for help. Her daughter, who until last month had held a responsible secretarial job, has, since then, been acting rather strangely. She has withdrawn large amounts of money from her bank account to buy flashy clothes, has begun to drink a good deal, and has threatened her relationship with her boyfriend of two years, beginning a series of wild one-night stands with men she meets in bars. In addition, she is now extremely suspicious of her mother, with whom she formerly had a very close relationship.

On the previous night, the daughter had gone with her boyfriend to a disco, but soon left the establishment somewhat intoxicated in the company of another man. Her boyfriend discovered that she had taken his car and, not far from the disco, had smashed it into a guardrail on the highway, causing extensive damage, but no injuries. He does not wish to press charges, but would like to see her obtain psychiatric care. She was last seen leaving the scene of the accident in the company of a cabdriver who had stopped to help. A friend reported that she had called to say that she was spending the night with the cabdriver. The mother pleads that something be done to give her daughter the care she needs.

II. LEGAL ISSUES

A. THE PSYCHIATRIC EMERGENCY

The clinician who sees patients with presenting complaints of an emergent nature, whether in the office or in the psychiatric emergency room, is faced, as the examination proceeds, with two critical clinical-legal decisions: (a) does this patient require hospitalization or is some less drastic form of intervention preferable; and (b) if hospitalization is required and the patient refuses to consent to admission, does the patient meet those criteria that would permit hospitalization against his will? Clinicians are also concerned with the impact of both of these decisions on their potential liability should something untoward occur. Although most of the court cases arising from emergency treatment settings have involved physicians, the principles elaborated are applicable in most circumstances to other clinicians as well.

B. LEGAL RESPONSIBILITIES OF THE CLINICIAN IN THE EMERGENCY SETTING

1. When a Duty of Care Exists

A clinician becomes responsible for a patient's care only when a treatment relationship is established between them. Thus, a clinician accosted in the street by someone whom he has never previously met and who threatens suicide is, moral considerations aside, not legally obligated to undertake an evaluation or to arrange a disposition. When a patient is seen in a treatment setting, however, such as a private office or a walk-in clinic, and it becomes apparent even during the initial assessment that an immediate intervention is required, a therapeutic relationship is assumed to exist despite the absence of a formal contract. Facilities advertising emergency services have a duty to provide urgent care to all comers. Failure to provide for proper care (which may consist merely of stabilization and referral to another, more appropriate facility) leaves the clinician open to a charge of abandonment. Before a patient is permitted to leave, an assessment ought to be made sufficient to rule out the possibility that further immediate steps are required.

The determination of whether the caregiver has assumed a duty of care toward the patient is not always clear-cut. Phone calls from people who have not previously been in treatment but who are seeking aid, or the casual inquiries of friends that reveal emergent issues, leave the clinician in an ambiguous position. Though no definite pronouncement is possible, courts have frequently held that when a physician has responded to the inquirer as a physician—not merely as a friend—a therapeutic relationship has been established, and a duty of care exists.

2. Clinicians' Duties in the Emergency Setting

Clinicians have two general obligations toward patients once a duty of care is established in an emergency setting: evaluation and proper disposition.

a. Evaluation. The nature of the duty to evaluate the patient differs somewhat in the emergency context. Mental health evaluation in office, clinic, or hospital-based practice need not be an expeditious process. Information can be gleaned from patients over more than one visit. Records of previous mental health contacts can be requested. Once the therapist has a reasonably firm relationship with the patient, family members or other informants may be invited to join the patient for a session at which their perspectives can be explored. As long as no symptoms require urgent attention, the completion of the evaluation, along with formulation of a working diagnosis and initiation of definitive treatment, can be postponed until more information is available.

Emergency evaluations have quite a different character. In a brief period, the clinician must gather sufficient information about the patient to assess her current condition and to formulate plans for immediate intervention. This data-gathering process is focused and rapid. Interviews are highly structured. Information from other caregivers is obtained by telephone, rather than by mail. Informants who have accompanied the patient to the evaluation are interviewed on the spot. Laboratory tests may be performed, with results returned before the evaluation is completed (e.g., serum lithium level, blood alcohol level, toxic screen). If a definitive diagnosis cannot be established, at least a differential diagnosis is formulated, with the most likely possibilities identified.

Several important legal implications flow from the unique nature of the emergency assessment. First, the standard of thoroughness to which the clinician is held is not the same as in a nonemergent context. The law recognizes that, should legal proceedings ensue as a result of the evaluation, the resources (including information and time) available to the emergency evaluator are restricted. Although the resources at hand should be used, decisions may need to be made before all the information that one would desire is available. For example, the patient's therapist may be unreachable during the evaluation, and critical data concerning the patient's functioning may have to be foregone. Thus, the questions asked to evaluate the clinician's performance are: Did she make reasonable efforts to obtain the necessary information? Given the constraints on available data, was the assessment performed as well as could be expected?

An important corollary to this limited amount of information for the evaluation is that a decision about the nature of the patient's condition—at least sufficient to make disposition plans—cannot be deferred simply because not all of the information is in. Clinicians dealing with emergencies have to tolerate a fair degree of uncertainty, but must make their best judgments. A decision to defer intervention pending further data is equivalent to a judgment that the situation is not emergent enough to require intervention. When some intervention is clearly required, the law shields the mental health professional who acts despite gaps in the database, but it also may hold culpable the clinician who cannot make up her mind.

b. Disposition. Three options are available to the emergency evaluator: no further treatment, outpatient treatment, and inpatient hospitalization.

No further treatment. The clinician in an emergency setting is not obliged to recommend further psychiatric treatment. Psychiatric emergency rooms are frequently visited by persons who may neither need nor desire psychiatric care. These include homeless people hoping for bed and board in a psychiatric hospital; persons brought by family members or friends because the latter perceived a problem (e.g., premarital sexual activity) that on evaluation turns out not to be indicative of psychopathology; and persons brought by the police because of bizarre or violent behavior, but who are personality disordered, unreceptive to treatment, and therefore essentially untreatable. Once an appropriate evaluation has been performed and both its conclusions and the recommendations given to the patient carefully documented, the clinician may decide that the perceived emergency does not represent a situation that requires further involvement from the mental health system.

Outpatient treatment. Even the presence of a genuine emergency does not mandate hospitalization. Most patients who present to psychiatric emergency rooms or walk-in clinics are referred for outpatient follow-up. To recommend outpatient treatment, the emergency evaluator does not have to reach conclusions concerning the patient’s definitive diagnosis or ultimate treatment plan. She need only determine that the patient can be safely maintained in the community until the follow-up visit is scheduled, at which time reevaluation of the patient’s status can take place. The timing of that visit should be commensurate with the urgency of the clinical situation. Some patients may need to be seen days later; others, weeks later.

Ordinarily, the degree of anticipated cooperation by the patient and the availability of supports in the community are important determinants of whether outpatient therapy is feasible. If the patient resists the referral, or it appears clear that she will not follow through, consideration must be given to whether the patient meets the criteria for involuntary treatment—on an outpatient basis, as allowable in some states (see Sec. II-F-4), or on an inpatient basis. If the patient is not committable, and the patient is not willing to negotiate an acceptable treatment plan, there may be no alternative but to allow the patient to leave. For patients whose competence to make decisions about treatment may be in question, family members can be advised to seek an adjudication of incompetence, allowing the appointment of a substitute decision maker to consent to treatment on the patient’s behalf (see Chap. 5, Sec. II-C-1).

The outpatient option remains available even if the patient qualifies for involuntary hospitalization under applicable state laws (see Sec. II-D). These laws are permissive, not mandatory. That is, they define circumstances in which commitment may occur, not conditions under which it must. In fact, many statutes incorporate a “least restrictive alternative” criterion, permitting commitment only when no outpatient option is feasible. Studies showing that only a minority of “committable” patients are hospitalized involuntarily may help ease the fears of clinicians about treating such patients in the community.

Hospitalization. Often, the only reasonable option for dealing with a psychiatric emergency is to seek the patient’s hospitalization. This may occur on a voluntary (see Sec. II-C) or involuntary (see Sec. II-D) basis. When the patient is amenable to the recommendation, voluntary hospitalization is usually the most desirable course of action. If the patient resists hospitalization, however, the clinician must determine whether he meets the criteria for involuntary commitment, and if so, begin that process.

Confusion often exists as to whether patients who desire voluntary hospitalization may be committed anyway. Some states limit this practice, but the majority have no barriers to it. Involuntary hospitalization may be preferable when the patient has a history of signing out of the hospital soon after admission; in these circumstances, it simplifies the task of treating the patient, and it provides a message to the patient about the seriousness with which the staff views her situation. Commitment may also be the best choice when state laws would make it difficult to hold the patient if she later elected to sign out of the hospital but would probably allow commitment in the emergency context.

As if the clinician did not face sufficient difficulties in considering whether to hospitalize a patient, an additional worry exists. Common law rules, codified in some places, have held those who unjustly deprive a person of his freedom to be liable for suit in tort for false imprisonment. Although any patient can claim that she has been unjustifiably committed, the key point is that the courts are unlikely to hold liable a clinician who acts in good faith, in accordance with the laws of the state, to hospitalize a mentally ill person. Many state commitment statutes have provisions that grant immunity to clinicians who act in compliance with statutory mandates. Liability is limited to those cases in which the clinician has acted willfully and maliciously to deprive a person of her freedom, knowing that the patient did not meet the required criteria. Good record-keeping, with a clear recitation of the basis for the decision, should effectively foreclose liability.

c. Managed care in the emergency setting. Emergency evaluation has been complicated by the tighter oversight of insurers and managed care companies, which typically require that they be contacted before dispositions requiring insurance coverage (e.g., inpatient hospitalization, intensive outpatient treatment, referral to a drug or alcohol detox facility) are initiated. Such requirements increase the pressure faced by emergency clinicians, who may find themselves spending precious time trying to justify their recommendations to a reviewer on the telephone, while their emergency service is overwhelmed with urgent cases. Even more destructive is the practice of some managed care companies to insist that patients be held in the emergency room until their own staff members can arrive on the scene and interview them personally.

Despite these complications, the clinician's legal duties to her patient in the emergency setting remain largely unchanged. Adequate evaluation must take place, and an appropriate disposition must be recommended. If a managed care company refuses to authorize payment for the disposition chosen by the evaluator (e.g., inpatient hospitalization), the clinician must make a further determination of the degree of urgency posed by the patient's state. In circumstances in which the patient or others would be endangered by a failure to follow the recommended intervention, the clinician may be obligated to engage in vigorous advocacy with the managed care company—and with her own facility or others that can provide the needed care—while an appeal of the coverage decision is made. When the situation is less urgent, or other treatment options may be acceptable, the emergency clinician can work with the patient to review his choices and help select the best available course of action (a decision in which economic considerations may play a sizable role). For a more complete discussion of the clinician's legal obligations and risks of malpractice in a managed care environment, see Chapter 4, Section II-C.

C. VOLUNTARY HOSPITALIZATION

1. History

Ironically, the idea that the mentally ill might be able to sign themselves into psychiatric hospitals voluntarily is a relatively new one. Although the first statute allowing a mental patient to enter voluntarily was enacted in Massachusetts in 1881, by 1949 only 10% of patients were voluntarily admitted. It was not until 1972, after two decades of widespread revision of commitment laws to encourage voluntary status, that the majority of admissions were accomplished in a voluntary manner.

The reasons voluntary admissions took so long to become common are twofold. First was the issue of administrative convenience; it was feared for many years that permitting a patient to leave a psychiatric facility at will, as the concept of voluntary admission seemed to allow, would paralyze the treatment program and overwhelm the paper-processing apparatus. Second, many thought that the presence of mental illness *per se* rendered a person incompetent to consent to hospitalization, and such an act required the intervention of a court.

Psychiatrists were the strongest advocates of voluntary hospitalization, particularly after the psychoanalytic movement made its mark on the country. They thought that a patient's cooperation was essential for effective treatment and that such collaborative treatment should begin at the time of admission. For many years, advocates of patients' rights had also favored voluntary status as less restrictive of patients' freedom.

Today, the debate over voluntary hospitalization has changed somewhat. Some advocates of patients' rights oppose any admission without court review, holding that the mentally ill are often subject to unwarranted coercion at the time that the admission decision is made. These proposals, if adopted, would represent a return to the situation as it existed in most jurisdictions in the 1940s; they evoke the arguments that were then urged in favor of removing the admission process from the courts: a lessening of the stigma of admission to a mental hospital, which resulted in part from the quasi-criminal procedure; a greater sense of autonomous functioning on the part of the patient who has chosen to sign herself into the hospital; and an explicit contract for treatment between the patient and the hospital. In addition, substantial practical problems exist in requiring scarce psychiatric resources to be spent in hours of court hearings, not to mention the burden on the courts themselves. For all of these reasons, almost all mental health professionals, and probably a majority of the mental health bar, favor the retention of voluntary admissions as the most frequently used means of ingress to a psychiatric hospital.

Finally, an ironic note should be mentioned. The percentage of voluntary patients in state hospital systems has been falling in recent decades as the policy of deinstitutionalization has drastically reduced the number of available beds. Some public mental health systems now restrict hospitalization only to involuntary patients in an effort to hold down inpatient censuses. Others accept only patients who meet commitment criteria, though they may allow them to sign in voluntarily. Whereas voluntary but noncommittable patients with insurance coverage might once have been sent to the private sector, many managed care companies have acted similarly in limiting authorizations for payment for hospitalization to those patients who meet commitment criteria. Thus, dangerousness-based criteria, developed largely out of concern for the civil liberties of patients faced with involuntary commitment, have become a tool for restricting the hospitalization of patients who desire inpatient treatment. Voluntary hospitalization, once encouraged as a means of enlisting patients in their treatment, has become a victim of widespread retrenchment in mental health services, public and private.

2. Types of Voluntary Admission

All states today permit patients voluntarily to enter psychiatric hospitals, with some statutes additionally requiring that the patient be in need of care and that the facility be capable of providing such care. The age at which adolescents can consent to their own care ranges from 12 to 18 years. The different types of voluntary status vary as to the procedure for ultimate egress.

a. Pure. Under the pure status, sometimes called “informal” admission, the patient is free to leave the hospital whenever he chooses. Because of the potential for manipulation by patients of the therapeutic situation with such leeway, some states limit, by law or policy, the scope of pure voluntary admissions.

b. Conditional. A modification of the pure form, the conditional status allows the facility to detain a patient for a certain period, usually several days, after notice is given of a desire to leave. This interval is designed to be used for the evaluation of the patient with respect to the possibility of instituting proceedings for involuntary commitment and for preparing discharge plans if the patient must be released. If the facility decides to seek commitment, the patient can continue to be held until the commitment hearing takes place. Otherwise, the patient is free to go. This period is frequently used in practice as an interval during which an angry, impulsive, or manipulative patient can reconsider her decision to leave.

3. The Question of Competence

If one were to analogize the act of voluntarily entering a mental hospital to other acts of great importance to the individual, such as making a will, one would assume that the person would need to be legally competent to be able to do so. Early statutes authorizing voluntary admissions, indeed, made this requirement explicit. More recent laws, however, designed to encourage voluntary admission on the theory that it aids treatment, omit such requirements in all but a handful of states.

The dilemma is that requiring competence to consent to hospitalization would probably deprive many patients of the benefits of such admission; some experimental data exist to support this conclusion, though the strictness of the definition of competence has an obvious impact on the proportion of patients found to be incompetent. On the other hand, ignoring the question of competence leaves psychiatrists and facilities open to charges of improperly manipulating clearly incompetent patients (e.g., severely demented patients). In addition, some legal experts argue that the benefits of voluntary status are illusory and are easily outweighed by the lack of automatic judicial review and the potential deprivation of freedom that follows from it. At present, the issue is unresolved, although in practice—absent state law to the contrary—the question of competence is usually ignored.

A 1990 U.S. Supreme Court decision (*Zinermon v. Burch*) has drawn increased attention to this issue. The court held that in those states, such as Florida, that require a patient to be competent before signing in voluntarily, the failure to screen out incompetent patients violates those patients' constitutional rights. It is unclear whether the court would actually restrict voluntary hospitalization only to those patients found competent, assuming a state's statute is silent on the issue. The decision itself did not address this question, but some of its wording suggested that the court may be leaning in this direction. Clearly, there are legitimate interests on both sides.

A reasonable resolution of the competing values was suggested by the American Psychiatric Association (APA)'s Task Force on Consent to Voluntary Hospitalization (see Suggested Readings, American Psychiatric Association). Recognizing that little benefit exists for anyone in preventing voluntary hospitalization of a person who understands in general terms what is involved and desires admission, especially when a psychiatrist concurs in that judgment, the task force suggested that only a minimal level of capacity be required. If a patient understood that he was entering into a hospital (rather, for example, than believing that he was checking into a motel) and recognized, as is true in most states, that he might not be able to leave at will if he were thought to be a danger to self or others, that understanding would be sufficient to render the patient competent for this purpose. Even incompetent patients might be admitted (at least for a limited time) if they agreed to enter the hospital and some in-hospital review process were available to pass on the appropriateness of their decision. This approach seems decidedly preferable to judicial review of each admission in which a question of competence is raised, either prospectively or retrospectively, which would face severe practical problems of implementation, delaying treatment and overburdening the resources of both the courts and the treatment system.

D. INVOLUNTARY HOSPITALIZATION

Although the power to hospitalize a psychiatric patient against her will is often taken for granted by many caregivers, it actually represents a marked deviation from the traditional tendency in Anglo-American jurisprudence to maximize individual autonomy. To understand the unique position of the mental patient (e.g., no competent *medical* patient can be admitted against her will) one needs to examine the evolution of the concept and the underlying rationales.

1. History

a. Confinement of the Mentally Ill in the Colonies and the Young Republic. In the earliest years of the settlement of North America, no facilities for the specialized care of the mentally ill were created. Indigent persons with mental illness who did not present a threat of violence were cared for in poorhouses by their own communities. Here they were mixed with the physically ill, widows and their children, and the unlucky destitute. All of these groups could be detained against their will at the order of the overseers of the poor. Occasionally, towns made provision for harmless mentally ill persons to be boarded out to local families at town expense.

Separate provisions were made for violent mentally ill persons, sometimes called the "furiously mad." They might be detained in jail until it was thought safe to release them. At that point, if they were not residents of the town, they would be transported to the borders of the community and "warned out," responsibility for their care falling to the next town along their path. A similar fate befell nonresident, harmless mentally ill persons who wandered into a community.

As the colonies matured, hospitals began to be established, the first in Philadelphia in 1751. These institutions treated both physically and mentally ill persons, with similar procedures for admission used in each case. Ordinarily, family members brought prospective patients to the hospital, where admission was determined by two factors: a doctor's judgment as to the need for hospitalization and the family's ability to pay for a period of care in advance. Patients played little or no role in negotiating these admissions, or in deciding when they might leave.

b. Involuntary commitment in the nineteenth century. This informal system of hospitalization, free of statutory control, began to change in the second quarter of the nineteenth century, as the first great wave of building state hospitals got underway. With the states taking responsibility for care of the mentally ill, a statutory framework was required. The earliest statutes, though, did little more than formalize the existing system. Families and hospital superintendents (then always physicians) dominated the admission process, with overseers of the poor standing in for families in the case of indigents. The only criterion applied to determine the appropriateness of commitment was whether the patient was in need of treatment. If patients felt unjustly confined, their sole recourse was to seek a writ of *habeas corpus* from the courts, which precipitated a hearing on the issue. It appears from the extant records that relatively few cases went that route.

In the 1860s and 1870s, allegations of abuse began to rise, probably in connection with a decline in the quality of institutional care. Included among these were legendary stories of wives who were “put away” by their malevolent husbands, with the connivance of psychiatrists. These protests led to the introduction of criminal-style procedures, designed to ensure that deprivation of liberty was not arbitrarily undertaken. Judicial hearings were required, representation by counsel allowed, free communication with the outside world guaranteed, and, in some states, even trial by jury on the issue of mental illness was afforded. Although some states clung to a family- and physician-dominated model for several more decades, by the end of the nineteenth century most jurisdictions had adopted judicial review of commitment.

c. Involuntary commitment in the twentieth and twenty-first centuries. With a single exception, all of the major changes in commitment law after 1900 were prefigured before that time. The first two-thirds of the twentieth century saw an alternation between periods in which the primary concern was that criminalized commitment procedures made it too difficult to hospitalize those in need of care, and in which worries about protecting patients from unjust confinement predominated. Marked relaxation of procedures occurred during the Progressive Era (1900–1920), when short-term, emergency commitment on physician certification was introduced. A similar period followed World War II, with psychiatry’s prestige at its peak, when statutes were widely revised and judicial procedures relaxed. Every period of procedural relaxation was followed by an era of tightened procedures, as no permanent accommodation between the conflicting interests could be achieved.

The period of widespread reform, however, that began in the early 1970s, differed from all that preceded it. To be sure, the usual, periodic recriminalization of commitment procedures took place. In addition, an assault was made on the standards for involuntary hospitalization for the first time in American history. Standards based on need for treatment were rejected by many courts (the leading case was *Lessard v. Schmidt*, a 1972 federal court decision in Wisconsin) as unconstitutionally vague and overbroad. Such courts ruled that only standards based on clear evidence of patients’ likelihood of endangering themselves or others were permissible. Meanwhile, legislatures had been coming to similar conclusions, albeit generally for a different set of reasons. They saw narrowed commitment criteria as an easy mechanism for trimming the size of state hospitals, encouraging deinstitutionalization, and saving money. By the end of the 1970s, almost every state in the nation had shifted to commitment criteria based on dangerousness, an approach that continues today.

2. Legal Rationales for Involuntary Commitment

Contemporary common wisdom holds that two separate bases exist for involuntary hospitalization of the mentally ill.

a. Police powers. The government has always had the power, reserved in this country by the U.S. Constitution to the individual states, to take those actions necessary to maintain the safety of society. These are broadly referred to as *police powers*. The extent to which each state can protect the public is limited by the state’s constitution and by the Fourteenth Amendment of the U.S. Constitution, which guarantees all citizens “due process” and “equal protection” of the laws.

Use of police powers to confine the mentally ill dates back to colonial times, when the “furiously mad” were incarcerated in local jails. These days, some theorists would argue that all dangerousness-based commitment laws rely for their validity on the state’s police powers. The legitimacy of confinement, in this view, is based on the state’s power to prevent mentally ill persons from hurting others or themselves. Police powers are also exercised in so-called "criminal commitments," including hospitalization of defendants whose competence to stand trial is in question, or (at least for the period immediately after trial) who have been found not guilty by reason of insanity.

b. Parens patriae. The concept expressed by the Latin phrase *parens patriae* denotes the state as acting in place of the parent. It derives in Anglo-American law from the power of the English kings, who were viewed as the fathers of their subjects, to act in their subjects' presumed interests when the subjects were not capable of protecting themselves. Historically, this meant that the king might appoint a representative to oversee the castle and estate of a nobleman gone mad. *Parens patriae* justifications for involuntary confinement of the mentally ill in this country date back to colonial confinement of the insane in poorhouses to allow the community to provide them effective support. As statutes began to be passed establishing need for treatment as the main criterion for commitment, *parens patriae* became the theoretical linchpin of commitment law. The state was acting, in theory at least, from purely beneficent motives in hospitalizing the mentally ill. Many observers believe that the shift to dangerousness-oriented statutes in the 1970s rendered *parens patriae* justifications irrelevant to American commitment law.

c. An alternative perspective: survival of parens patriae *justification for commitment.* The widespread belief that current commitment laws are based solely on the state's police powers is almost certainly mistaken. Although the state may have a substantial interest in protecting the public order, by itself that interest is insufficient to justify commitment of the mentally ill. Persons who are likely to harm others, but who are not mentally ill, cannot be detained against their will until they have committed a crime. This is true even for criminal recidivists with long histories of violent behavior. Similarly, persons who behave in ways likely to cause themselves injury—rock-climbers who do not use safety equipment, for example—cannot be confined unless they too are mentally ill.

If the state's police powers are at issue here, why should the presence of mental illness make a difference? Why is the presence of dangerous behavior by itself not sufficient to justify state intervention? The only reasonable conclusion is that actions to protect society's interests—standing by themselves—are insufficient bases for state action when significant deprivation of liberty is the cost. The difference between a dangerous psychotic person and a dangerous non–mentally ill criminal is that hospitalization of the former is likely to benefit him and, not incidentally, allow ultimate return to society in a more functional state. Confinement of the latter would be solely for preventive purposes, and might have to be indefinite to achieve that end. In short, the availability of care and effective treatment justifies dealing differently with the mentally ill. *Parens patriae* rationales are therefore inherent in any system of commitment, even one limited to dangerous persons. The commonly accepted dichotomy is false. (See also Chap. 5, Sec. II-E-1.)

3. Current Standards of Involuntary Hospitalization

Standards for involuntary commitment vary greatly from state to state, even under prevailing dangerousness-based approaches, and are frequently subject to revision by courts and legislatures. Here we outline the principles underlying the various criteria. It is the obligation of every clinician to remain informed about the most recent developments in his jurisdiction. Professional societies can often supply copies of current statutes and keep members up-to-date on changes as they occur. Every clinician should take the time to read the state's commitment statute and other legislation relevant to mental health practice.

a. Emergency commitments. Most jurisdictions provide for the short-term hospitalization of patients in emergency situations until a court hearing can be held. The period before the hearing may vary from as little as two days to as long as three weeks. Usually, a physician or psychologist must sign the commitment certificate, but some states require more than one professional to sign and some allow agencies, such as the police or the courts, to initiate commitments when no mental health professional is available. Some states have screening requirements of varying degrees of rigor. At the lower end of the spectrum, states mandate that the committing clinician call in to a central screening officer to obtain permission for commitment, at least when the patient's bill will be paid by a public mental health agency. More significantly, other states require a full investigation by an independent agency of the need for hospitalization and the availability of alternative placements in the community.

Most often, the criteria that must be met are identical to those required for court-ordered commitment, although sometimes emergency commitment criteria are broader. Facilities must decide at the end of periods of emergency commitment whether to release the patient or to petition for court-ordered hospitalization. The strict time limits on the duration of an emergency commitment are sometimes subverted in practice by the long periods required for the court to schedule a hearing. Thus, patients may be involuntarily detained for many weeks before a hearing. The power to commit represents such a significant limitation on the freedom of the individual that those who hold it should exercise it only with extreme care.

b. Court-ordered commitments. Prior to the expiration of an emergency commitment, or if imminent dangerousness is not an issue at the time the decision to hospitalize is made, the court of appropriate jurisdiction can be petitioned for an order of commitment. The hearing that follows may take place, depending on the state, in a district, superior, family, or probate court. A small minority of states substitute an appearance before an administrative board or hearing officer in lieu of a formal judicial hearing at this stage, reserving the courts for review of subsequent, longer-term commitments; these are sometimes called “probable cause” hearings, since the decision-maker is charged with determining whether probable cause exists to believe that the patient meets commitment standards.

Some states guarantee the patient the right to have a jury decide on the question of commitment, but the vast majority of cases are heard by judges. In some states, the duration of the commitment is explicitly limited (e.g., to 30 days, 6 months, or 1 year); recommitment after that period requires a rehearing. Other states specify no period for commitment or allow an indefinite period, depending on the patient’s condition. Court decisions suggest that, even in this latter group of states, a periodic review of the patient’s status is constitutionally required to determine if the criteria for involuntary commitment continue to be met. The standards that the patient, as a result of being mentally ill, must meet to be committable include the following six criteria.

Danger to others. Many states require “danger to others” to be imminent, and some require proof of a threat, attempt, or occurrence of harm (often called an “overt act”). These demands for concrete evidence of dangerousness reflect society’s trade-off of some measure of protection of the public at large in favor of a more stringent limitation on the number of those who face involuntary commitment. Although these requirements appear to objectify the decision-making process, in fact a great deal of discretion remains in the hands of the committing physician, who now must judge the dangerousness of a person’s threats or acts, rather than the degree of danger represented by his mental state.

Danger to self. The “danger to self” criterion addresses suicidal or severely self-destructive behavior (e.g., self-mutilation). Criteria tend to be less strict here than for dangerousness to others, but even so there are states (e.g., California) that do not allow long-term commitment of suicidal patients. Immediate likelihood of harm and direct evidence of threat or attempt are other frequently included requirements.

Unable to care for self. Usually limited to an inability to provide for the essentials of food, clothing, shelter, and medical care, such that the patient is at risk of serious physical harm, the “unable to care for self” standard can be subsumed under a broad definition of dangerousness to self. The ability of care need not meet middle-class levels; many chronic patients who live on the streets have developed remarkable talents for meeting their basic needs. In some areas, this standard is known as *gravely disabled*. Even if the patient cannot care for herself, hospitalization may not be permitted if alternative provision is available in the community.

Danger to property. “Danger to property” is an infrequently used criterion. Court decisions have indicated that involuntary commitment on the basis of danger to property in general is unconstitutional, but statutes requiring that the danger be one of substantial property loss or damage may pass constitutional muster.

In need of treatment. “In need of treatment” is the old pure *parens patriae* standard but no longer stands on its own. It is frequently used in combination with the “danger to others,” “danger to self,” “unable to care for self,” and “danger to property” criteria; patients not in need of treatment, despite dangerousness to self or others, may not be committable in these states.

At risk of deterioration. A few states, beginning with Washington state in 1979, have permitted involuntary hospitalization if a severe deterioration in the patient's condition is likely, such that he will predictably meet dangerousness-based criteria in the future. This represents an effort to reinject something of a need-for-treatment approach into commitment law. (See Sec. II-F-1.)

Miscellaneous criteria. A small number of jurisdictions require that patients be incompetent to make treatment decisions (see Sec. II F-1-a), at least under certain of their commitment criteria (e.g., Kansas). An increasing number of states, spurred by court decisions, require that the option of commitment be the "least restrictive alternative" that meets the patient's needs. This generally means excluding nursing home and group home placements, day hospitalization, and outpatient care as options before hospitalization is pursued. A number of practical difficulties exist in using a "least restrictive alternative" analysis. Although legal thought has always assumed that a lesser degree of governmental intervention is inherently less restrictive, that assumption may not always hold true in psychiatric settings. Critics of the concept have pointed out the difficulty in determining whether it is truly "less restrictive" for a psychotic patient to wander the streets uncared for or for him to be involuntarily hospitalized in a safe, clean, therapeutic milieu where not only his physical needs can be met, but the grip of the psychosis on his mind can be broken. Some clinicians and researchers have advocated a substitution of "most therapeutic alternative" in place of the "least restrictive" test. Most courts, however, who are the final arbiters of any such change, have not yet shown themselves inclined to accept it.

4. Procedural Issues

a. Standards of proof. The degree of legal certainly required before commitment can ensue was the object of a 1979 U.S. Supreme Court decision (*Addington v. Texas*). The possible standards include: (a) a preponderance of the evidence—the standard in civil cases and generally conceived of as "more likely than not" or 51 chances out of 100; (b) clear and convincing evidence—roughly 75 chances out of 100; and (c) beyond a reasonable doubt—the standard in criminal cases, approximately 90 to 95 chances out of 100. Deciding among these, the court ruled that the preponderance standard was insufficient when liberty was at stake but, given the difficulty psychiatry would have in meeting the most stringent standard (of beyond a reasonable doubt), clear and convincing evidence was all that was constitutionally required. Nonetheless, some states, either by statute (e.g., Hawaii) or by state court decision (e.g., Massachusetts) continue to require proof beyond a reasonable doubt. Given the inherent difficulties psychiatrists have in the prediction of future behavior, this is a difficult standard to meet. But it should be kept in mind that what must be proven is not that it is beyond a reasonable doubt that dangerous behavior will occur. Rather, because almost all states specify that a "likelihood," "significant risk," or "imminent risk" of dangerous behavior is required, it is only the existence of that risk that must be proven beyond a reasonable doubt. It is a good deal easier to be certain that someone is at risk than to be certain that the risk will materialize.

b. Other procedural requirements. The trend toward criminal-style procedures in civil commitment cases reached its apogee in *Lessard v. Schmidt*, the 1972 Wisconsin case. In that case, the court required comprehensible and timely notice to the subject of the hearing of the allegations on which the request for commitment was based; similar notice of all rights, including the right to trial by jury; no detention longer than 48 hours without a hearing on probable cause; no detention longer than 2 weeks without a full hearing on the grounds for commitment; and the right to representation by adversary counsel, to exclusion of hearsay evidence, and to remain silent when examined by a psychiatrist or at trial. Some states, in addition, consider information revealed by patients to treating clinicians as privileged (see Chap. 1) and—regardless of relevance—exclude it from evidence at the hearing.

Not all courts, and certainly not most legislatures, have gone this far. The rights to notice, timely hearing, and assistance of counsel have been widely accepted. States vary considerably, though, in rules governing the need for and timing of a probable cause hearing, the use of hearsay evidence, and the right against self-incrimination. Considerable differences may exist between probable-cause hearings (usually conducted a few days after detention, often by nonjudges) and full-fledged commitment hearings. In general, though, the latter are required to stick fairly closely to the kinds of procedures seen in criminal cases.

How closely do the courts adhere to procedural requirements? Studies before the reforms of the 1970s showed hearings in many jurisdictions to be *pro forma*, with little effort made to investigate the patient's status. Postreform studies show many jurisdictions still having difficulty adhering to a full adversarial mode; but in many others, procedural requirements are rigorously observed.

E. ASSESSING THE CURRENT SYSTEM OF INVOLUNTARY COMMITMENT

Current approaches to civil commitment, which link dangerousness-based standards with criminalized procedures, are usually critiqued on three grounds. A description follows.

1. Exclusion of the Nondangerous Patient in Need of Hospitalization

Many, perhaps most, clinicians believe that existing commitment criteria and procedures make it too difficult to commit patients who are desperately in need of inpatient care. These patients are not dangerous to others and may, at this point, represent no immediate threat to their own physical safety. Yet they are experiencing great emotional distress and run the risk of severe deterioration. Included in this group are manic patients in the early stage of an episode, whose poor judgment is threatening their own well-being and that of their family; disorganized schizophrenic patients, roaming the streets, but able to beg or find enough food to sustain themselves; and depressed patients in considerable anguish, but so pessimistic about the possibility of improvement that they reject care.

Numerous papers in the professional literature report anecdotes of patients not qualifying for commitment under current standards who later came to harm. Most clinicians can offer examples from their own experience. Surprisingly, though, it has been difficult to demonstrate the existence of such a group in the few empirical studies that have addressed the question. Those patients most in need of treatment seem to be admitted. The "unable to care for self" criteria apparently absorb most of them. Few are released.

Needless to say, the research to date is not without flaws; noncommittable patients may not make their way to the emergency room, as those who would ordinarily bring them have learned of the futility of the effort. But the failure so far to identify significant numbers of such patients is provocative. It suggests that, in most cases, dangerousness-based criteria, including inability to care for self, may not significantly restrict hospitalization of patients truly in need of care. Rather, it may be the sustained policy of reducing inpatient beds, followed in most states for over 35 years, that accounts for the largest part of the difficulty in hospitalizing mentally ill persons.

2. Difficulties Predicting Dangerous Behavior

Most mentally ill persons are not dangerous, either to themselves or others. In fact, existing research suggests that mentally ill persons are only marginally more likely to be dangerous to others than the non–mentally ill, and that the group at increased risk may be limited to those who actively abuse alcohol or drugs. As in the general population, therefore, prediction of future dangerousness requires identification of a small fraction of problematic people in a much larger group. A common objection to the prevalent dangerousness-based commitment criteria is that they require mental health professionals to perform a task that simply cannot be accomplished, the prediction of future behavior dangerous to self or others.

a. Theoretical considerations. Some authors have pointed to the statistical impossibility of accurately predicting a low-frequency event (e.g., violence or suicide) without accruing a large number of false-positive findings (e.g., nonviolent individuals incorrectly classified as violent). These authors cite examples similar to the following: Assuming 1,000 mentally ill individuals are screened, of whom 5% are potentially violent, with a test that is 80% accurate in predicting violence, then 40 of the 50 violent patients would be detained. However, given the 20% inaccuracy, 190 of the 950 nonviolent patients would also be detained. The use of a less accurate screening test, which is probably closer to the actual situation, gives even poorer results.

Other factors have been cited as contributing to this tendency toward overprediction. These include the fear of the clinician that if even one violent or suicidal individual is mistakenly discharged, the clinician will be subject to public castigation and to damage suits in the courts; the desire of the clinician to treat illness wherever possible, leading her to err in favor of committing potentially treatable patients; and the apprehensions of violence that many psychiatric patients evoke, even in the professionals who deal with them daily. It is difficult to imagine measures that might be effective in reversing these biases, even though people with serious mental disorders account for only 3 to 5% of violence in the United States each year. Many question whether the benefits of detaining a small number of potentially violent or suicidal individuals are worth the costs of violating the rights of a large number of nondangerous patients.

b. Empirical data. By now, a considerable body of literature has accumulated examining the predictability of dangerousness toward others. These studies can be broadly separated into those looking at clinical prediction (i.e., predictions made entirely on the basis of clinical information) and those assessing actuarial prediction (i.e., predictions based on the application of structured scales or interviews). Clinical predictions have been largely disappointing. Early studies showed clinicians were accurate at best in only one of three cases when they predicted that a patient was likely to be violent in the future. However, those studies suffered from methodologic problems, including a focus on long-term predictions that are inherently unreliable, and more recent investigations have been somewhat more encouraging. The more recent studies, based on short-term predictions made in hospital emergency rooms about violent behavior after discharge, reveal much better results, with predictive accuracy of determinations of a likelihood of future violence in the range of 40 to 60% and considerable consistency among clinicians in judgments of dangerousness. Even these studies may underestimate the rate of correct predictions, because the institutional setting in which many patients are placed may preclude the predicted dangerousness from becoming overt. However, the difference in rates of violence between groups predicted to be violent and those not so predicted (e.g., 53% versus 36% in one important study), though significant, is modest. Hence, these studies suggest that predictions of dangerousness by mental health professionals—with an accuracy for affirmative predictions, at their best, in the range of 50%—are problematic bases on which to rest a deprivation of patients' liberty.

Another set of studies has taken an actuarial approach to prediction. These studies have applied one or more of the growing number of risk-assessment instruments (see Sec. III-C-3) to clinical populations. Scores on the better instruments (such as the HCR-20) consistently correlate with likelihood of future violence, suggesting that the variables being used are predictive of dangerousness. But when a cut-off is used to simulate the clinical prediction process—in which dichotomous determinations of violence risk must be made on the basis of which commitment decisions will be predicated—it becomes clear that these instruments leave a great deal to be desired. Although predictions that someone will not be violent are usually highly accurate, the accuracy of predictions of future violence (especially when "verbal aggression" is excluded) tend not to be superior to clinical predictions, and in some cases are worse. However, there is clearly a role for these instruments in the assessment process, as discussed below.

Oddly, many fewer studies have examined the prediction of suicidal behavior than violent behavior, although a large number of correlates of suicide have been identified. Actuarial-type studies have been no more successful, and often much less so, in predicting which patients will attempt to harm themselves than in identifying those who may harm others. Self-harm resulting from grave disability has, to our knowledge, not been studied in the same way. Most clinicians feel more comfortable with predictions of this sort, but whether that comfort is justified remains to be established.

3. Distortion of the Role of the Mental Health System

Even assuming the problems with prediction could be managed, many mental health professionals object to dangerousness-based approaches because of the effect they have on the functioning of the mental health system. By emphasizing the need to identify and treat dangerous persons—especially those dangerous to others—current statutes force clinicians into quasi-police roles. This may lead patients to identify the mental health system with the criminal justice system, making it more difficult to encourage them to present for needed care and to confide in their treaters.

Furthermore, as use of inpatient hospitalization continues to fall in both public and private settings, the emphasis on dangerousness has led to high concentrations of violent patients, making institutions difficult places to work and making it hard to treat other types of problems. Ironically, the effect may be to force out those patients with the most easily treatable problems (e.g., depression, acute psychosis) in favor of patients who are most resistant to current approaches (e.g., patients for whom dangerous behavior is the target symptom, especially those with personality disorders). A few efforts have been made to document these effects. Although the increasing percentage of patients who are dangerous to others has been confirmed in a number of studies, it is unclear if the rate of in-hospital violence has risen.

F. ALTERNATIVES TO THE CURRENT COMMITMENT SYSTEM

Given the level of dissatisfaction suggested by the previous section, it should come as no surprise that many proposals have been offered to alter the dominant approaches to civil commitment.

1. Introduction of Modified Need for Treatment Criteria

If the emphasis on dangerousness is the cause of many current problems in civil commitment, a logical response would be to move away from exclusive use of that standard. Several proposals have been offered to supplement or replace dangerousness criteria with need-for-treatment–based standards, modified to respond to the objections of civil libertarians that the old standards were too vague and overbroad.

a. American Psychiatric Association model law. The most ambitious of reform proposals was offered by the APA in 1983. Based on the work of psychiatrist Alan Stone, the model law would establish the following commitment criteria:

1. Presence of a severe mental disorder.
2. A reasonable prospect that the disorder will be treatable at the facility to which the patient will be committed, and that this is the least restrictive alternative for treatment.
3. Refusal or inability of the patient to consent to treatment.
4. Lack of capacity of the patient to make an informed decision regarding treatment.
5. Likelihood that the patient, as a result of the severe mental disorder, will cause harm to self or others, or will experience substantial mental or physical deterioration.

The effects of the APA proposal would be to limit commitment to patients who, though dangerous to self or others, also lacked the capacity to make their own decisions about treatment of their severe mental disorder. This emphasizes the *parens patriae* basis for commitment, because many commentators argue that this doctrine can be applied only when the person is incompetent to make her own decisions.

Another important change would be the hospitalization of patients who were not dangerous, but were likely to experience deterioration associated with significant distress. This is a group that, though its size is unclear, attracts a great deal of attention from those unhappy with the present system.

No state has adopted the APA model in its entirety, although several states have borrowed pieces of the model. States' reluctance may be based on their fear that the APA approach would increase the number of committable patients, flooding the public mental health system. Data suggest, however, that requirements similar to the APA's, especially severe mental illness and lack of capacity, actually restrict the number of committable patients when compared with straightforward dangerousness standards. Thus, the APA model might effect a true reorientation of the commitment system toward more severe, and perhaps more treatable, types of psychopathology.

Additional reasons for reluctance, however, are less easily dealt with. Civil libertarians are, in many cases, unalterably opposed to any effort to move away from dangerousness criteria. Furthermore, the APA model would exclude from hospitalization persons dangerous to self or others, yet competent to make treatment decisions or not seriously mentally ill. That would limit commitment of many personality-disordered patients now apparently absorbed by the system. Legislatures may be leery of giving up the idea of the hospital as a dumping ground for persons that no other system has the ability to deal with.

b. More limited efforts. A number of states have adopted one or another of the kind of proposals embodied in the APA model. Several have followed the lead of Washington state in adding commitment of patients likely to experience substantial deterioration to their dangerousness-based criteria.

These statutes may require significant functional impairment to be associated with deterioration or evidence of previous deterioration in similar circumstances. They open the commitment net for an important population but do not otherwise address the problems associated with dangerousness criteria.

2. Relaxation of Dangerousness Criteria

The original dangerousness-based statutes of the 1970s frequently were framed in highly restrictive language. They required an overt act indicating dangerousness before commitment, sometimes within a specified period, or they mandated that the threat of dangerous behavior be "imminent and substantial." A number of states have modified these requirements in light of concerns over the rigor of their statutes, deleting the overt act requirement or allowing a verbal threat to serve in its place, and abandoning the language defining the degree of risk. Other states have added inability to care for self criteria to statutes that were previously limited to danger to self or others.

3. Relaxation of Procedural Requirements

Procedures for involuntary commitment are always susceptible to modification when reform appears called for. After all, a century-and a-half's tradition of such moves exists. Yet there has been surprisingly little activity on this front since the statutory efforts of the 1970s. Criminalized procedures have come to be taken for granted by most participants in the commitment process, and there are few serious proposals for change. Perhaps the debates over substantive commitment criteria have diverted attention from the procedural aspects.

4. Outpatient Commitment

Easier access to inpatient hospitalization is not the only possible answer to current problems with civil commitment. A particularly frustrating group of patients are those who stop their medications shortly after discharge, rapidly deteriorating and soon requiring rehospitalization. Although statutes with deterioration criteria for commitment might allow that trajectory to be interrupted, they would not help to stabilize the patient in the community. Proposals for outpatient commitment apply at this point.

In some respects, outpatient commitment is an old idea, related to the practice of "paroling" mental patients from state hospitals or giving them trial discharges. Patients who could not adapt to the community would then be recalled to the hospital without further legal proceedings. In its new guise, however, it is not limited to former inpatients but can serve as a disposition of choice at a commitment hearing. Courts can order patients "committed" to a course of outpatient treatment specified by their clinicians. Even some civil libertarians endorse outpatient commitment (albeit in a limited fashion) as an alternative to more restrictive inpatient settings.

Almost every state has implicit or explicit provisions in its statutes authorizing outpatient commitment, but only in relatively few states are they used with any frequency. This is due, in part, to the lack of clinical and administrative structures to carry out court-ordered outpatient treatment. Other problems include judicial unfamiliarity with the concept, the absence of discrete criteria for outpatient commitment, and the absence of enforcement mechanisms.

The states that have taken outpatient commitment seriously, including North Carolina and New York, have created different criteria for outpatient than for inpatient commitment. The criteria focus on the likelihood of relapse that would eventuate in future dangerousness, and in some cases require that a pattern of dangerous behavior when unmedicated be evident. Enforcement of judicial orders is a major problem, with most statutes silent on how this is to occur. Even statutes that make provisions for patients to be brought before a judge if they do not comply usually limit the judge's power to admonishment; inpatient hospitalization is possible only if patients are found to meet the usual commitment criteria.

A small number of empirical studies have demonstrated varying results with outpatient-committed patients. Much of the variance may be due to the different capacities and interest of mental health systems in undertaking involuntary outpatient treatment. The question of whether some enforcement mechanism (perhaps short-term detention and involuntary administration of medication) will be needed when patients discover that they can often avoid current orders with impunity is the long-term question. Outpatient commitment is an interesting approach that bears careful study as different models are tried out in a number of jurisdictions.

5. Nonstatutory Approaches

Not everyone believes that changing commitment statutes is the best way—or even a very good way—to reform commitment practices. A good deal of empirical data suggests that commitment law changes, especially changes in substantive criteria, make relatively little difference in who gets committed (see Suggested Readings, Appelbaum, *Almost a Revolution: Mental Health Law and the Limits of Change*). Decision-makers operate independently, within broad bounds of statutory criteria, guided by their innate sense of who belongs in a hospital and who does not.

A great deal of discretion is embedded in the current system. Witness the frequent phenomenon of sharp rises in local commitment rates after well-publicized acts of violence by mentally ill persons. Some people argue that the best way to affect commitment decisions is to educate gatekeepers about the consequences of severe mental illness, thereby leading them to broaden the scope of cases they define as committable.

Nonstatutory approaches may also be of use in amending commitment procedures. Much of what takes place in the commitment process is determined not by statutes but by administrative rules, judicial practices, or simple custom. The National Center for State Courts has issued guidelines for reforming the less functional elements of the commitment process and suggests that groups of concerned participants from the mental health and legal systems meet regularly to discuss problems and implement these local-level reforms.

III. CLINICAL ISSUES

A. PERFORMING THE EMERGENCY ASSESSMENT

The emergency evaluation is often a precipitous, stressful, unprepared-for encounter between strangers, both of whom are caught up in the tensions of the moment. Moreover, patients, families, and members of the community may turn to the emergency service, sometimes quite unrealistically, as a panacea for personal, familial, or social dysphoria. These conditions may give rise to an oppositional posture of clinician and patient operating at cross-purposes or seeking different goals. The challenge of "reaching for the alliance" despite the circumstances belongs to the clinician; his basic wish to help must lead him to reach out empathically to make contact with the distress in the patient. This process holds true even if the evaluator must finally disappoint, refuse, or turn away the patient on clinical grounds.

Specifically, the evaluator seeks the patient's best side, the resources and strengths, and attempts to recruit these traits to the tasks of data gathering and intervention. Without this fundamental rapport, the emergency encounter is more a collision than a collaboration.

In practice, the decisions that must be made at the point of a psychiatric emergency address the issues of treatment versus no treatment, hospitalization versus no hospitalization, and psychiatric versus nonpsychiatric intervention (e.g., an apparent psychiatric emergency may be a matter for neurology, internal medicine, surgery, or the criminal justice system).

In relation to these considerations, the emergency assessment may involve legally significant compromises, procedures, and trade-offs rarely used in nonemergent settings or situations. One implication of this situation is that emergencies are considered exceptions to many well-established rules. For example, breaches of confidentiality and many treatment interventions, even if involuntary, are understood to be permitted in the context of a bona fide emergency. Predictably, such an extension of the clinician's license to act mandates well-documented assessment and identification of the factors that make the present situation a true emergency.

1. History and Record in the Emergency Assessment

a. Obtaining the history from the patient and others. Significant data that should be obtained from the patient include the details of previous episodes of the current illness or problem, previous successful interventions, and previous attempted solutions. When the patient cannot provide historical data, the evaluator must turn elsewhere for the information, even without the patient's consent, under color of the emergency.

When obtaining information from informants requires revealing information that may prove embarrassing to the patient (e.g., that he is mentally ill and in need of hospitalization), the harm done to the patient's right to confidentiality must be carefully weighed against the expected benefits.

But in a genuine emergency, the immediate clinical needs of the patient should always be the primary determinant of the course chosen; this approach is consistent with existing regulation and law (including HIPAA), and with professional ethical standards. (See Chap. 1, Secs. II-A-5-a and III-C-3.)

This illustrates another important clinical-legal difficulty of emergency assessment. In general, certain steps taken under color of the emergency may involve acting *on* the patient (e.g., involuntary hospitalization or emergency breach of confidentiality), which may pose future difficulties for the therapeutic alliance when the issue is working *with* the patient in a trust-based collaboration.

b. The evaluator as user of informants. The evaluator is frequently in the position of structuring the inquiry to elicit usable data from random and unsystematic observations and perceptions of family, friends, school personnel, police, and passers-by. Although to the lawyer these may represent “hearsay” evidence, such observations may be the only sources of information for the front-line clinician. The optimal approach to gathering data focuses on previous psychiatric history; recent behavior or behavioral change; significant alteration of circumstances (e.g., loss of job); bizarreness of ideation or action; threats to self or others, or related behavior such as the purchase of poison, rope, or a gun; history of substance abuse; giving away treasured possessions; and the like. By concentrating on factual elements in the informants’ presentations, rather than on their subjective evaluation of the situation, one minimizes the possibility that a patient will face a major, potentially liberty-depriving intervention without adequate justification. Of course, the responses that the patient elicits in others may be useful data in themselves, but they should be viewed merely as another element in the picture, not as a necessarily accurate appraisal of the patient’s mental state.

One practical tip of inestimable value is often overlooked in the rush and confusion of many emergency settings: obtaining names and telephone numbers from anyone who has accompanied the patient, including family, police officers, and individuals from other agencies. If the patient is admitted and a more exhaustive workup can be undertaken, these numbers prove enormously useful for following up on clinical issues raised during the emergency evaluation. Obtaining this information from all accompanying individuals should become a reflex for emergency room clinicians.

c. Informant reliability. The variation in reliability of informants represents one of the complexities of the emergency evaluation. The evaluator is charged with determining the apparent veracity of each informant’s data based on a necessarily brief, ad hoc assessment in a situation in which one cannot easily, or at least overtly, administer a mental status examination to the informant. Apparent prejudice toward the patient, anger at the patient, fear of the patient, or wishes to shield, blame, or deny are factors to be considered in this determination. Certain types of professionals (e.g., police officers) may be, by training, more skilled in observation and more objective than family members, especially under conditions of stress.

d. Ulterior motives. Under certain circumstances, informants may, for ulterior motives, reveal distorted, selective, or even fabricated data.

> ***Example 1.*** A family wishes to be at least temporarily rid of a patient whose chronic psychosis has exhausted them for days; they exaggerate the patient’s distress, dangerousness, suicidality, or symptomatology in the hope of having the patient admitted.
>
> ***Example 2.*** An internist wishing not to take care of an alcoholic patient, refers the patient to an emergency psychiatrist without mentioning the obvious odor of alcohol as a possible causative factor in the stated symptoms of confusion and hallucinations.
>
> ***Example 3.*** The husband whose wife has just, in hysterics, declared her intention to leave him, presses for her admission on fabricated grounds, out of the magical wish that the hospitalization will “cure her” of her wish to leave.

Admission may in fact be indicated or contraindicated in any of these examples; the point at issue is the contamination of informant reliability by ulterior motives.

e. Solicitation of information as an alliance threat. In many cases, the very act of solicitation of information may provoke violent objections that threaten the alliance with the patient. The evaluator attempts to keep the assessment as the task before them, a task to which all parties must address themselves and in which all parties have a common interest; thus, this community of interest serves as an initial framework for alliance formation in the emergency setting.

> ***Example 4.*** As the evaluator turns to the psychotic teenager's mother, the patient screams furiously, "Who are you gonna believe, me or her? *I'm* the one who needs help!" The evaluator responds, "Look, we have a real crisis here and we'd be unwise to pass up hearing anything from anyone that might help us to figure out what's going on. I'm not here to believe her or you, just to understand what's happening."

The use of "we" in the example enlists all parties present into the evaluative effort; the shift of emphasis from "belief" to "understanding" paves the way toward the nonjudgmental exploration of future issues.

f. Documentation. It should be underscored that the assessment process described in the foregoing sections must be documented explicitly in the record; the documentation should include (but should clearly distinguish among) observations, allegations, and direct examinations. The differential weighting and the inclusion or exclusion of data should be described together with the evaluator's rationale. Such documentation may prove the decisive preventive against a claim of negligence in regard to the evaluation.

The clinician is well advised to document more extensively the decision to take the less conservative approach. That is, the decision to release or send out a patient in an ambiguous situation should require a far more careful risk-benefit analysis than when the patient is being definitively hospitalized or treated. (See Chap. 4, Sec. III-A-3.)

2. Assessing the Patient and the Environment in Evaluating an Emergency

In addition to the more traditional historic and diagnostic elements of the evaluation, the evaluator must clarify those factors that influence the urgency of the current situation. These factors extend beyond the concept of "precipitants," and may be grouped into risk factors and resource factors, external and internal. Careful determination of these factors provides the legal justification for clinical interventions.

a. Risk factors. Risk factors tend either to increase the urgency of the current situation or to decrease the supportive or coping mechanisms available to the patient. The patient's past behavior, given a set of risk factors similar to the current ones, is often the most useful prognostic guide.

External risk factors. External risk factors include the following:

- Loss, alienation, or absence of significant objects (e.g., family, therapist, lover) or circumstances (e.g., job, residence, school).
- Hostile environmental factors (e.g., family wants patient dead, patient only African American in racially troubled neighborhood).
- Acuteness of or lack of preparedness for emergency situation, or both.

Internal risk factors. Internal risk factors include the following:

- Lack of ability to use available resources (e.g., severity of disturbance in cognition or behavior—all toxic states, retardation or other organic impairment, language barrier).
- History of marginal intellectual or interpersonal adaptation, poor achievement or level of functioning (e.g., never employed, high school dropout, living on the street, not able to make friends).
- History of impulsivity, substance abuse, criminal record, violence, or suicidality.
- Intolerably dysphoric feeling state (e.g., rage, panic, agitated depression).
- Preoccupations, obsessive thoughts or fantasies with destructive content (e.g., constant thoughts of revenge or of "resting in peace").

b. Resource factors. Factors under this heading tend either to decrease the urgency of the current situation or to increase the supportive or coping mechanisms available to the patient.

External resource factors. External resource factors include the following:

- Availability of family, spouse, friends, therapist, protective setting (e.g., group home, halfway house).
- Preservation of supportive circumstances (e.g., boss will give back job, school open for reapplication).
- Availability of specialized resources (e.g., veterans' benefits, medical treatments for disabling conditions, financial supports, social agencies).

Internal resource factors. Internal resource factors include the following:

- History of impulse control, obsessional defenses, intellectual and social achievement, high functioning, home and work stability ("rootedness").
- Absence of history of substance abuse or toxic or organic states.
- Presence of a number of personally acceptable options or choices at point of crisis.
- Durable religious faith or ethical convictions with low conflict about them.
- Marketable vocational or professional skills.
- Social skills; ability to enlist and relate to others.

B. ASSESSMENT OF SUICIDALITY

Assessment of suicidality represents, among other things, a special case of the risk/resource evaluation just described in general terms (Sec. III-A-2). The central clinical and legal concerns involve negligence in evaluation and in involuntary interventions (usually hospitalization). Although this topic might well occupy a book in itself, we here outline general principles, drawing on both empirical data and received wisdom.

1. Diagnostic Considerations and History

Many scholars in the area of suicide assessment and prediction have considered the epidemiology of suicide in subject populations. Our focus here is primarily on the individual and her assessment, whether in an emergency room or office—an assessment that should be performed routinely on intake of individuals seeking psychiatric treatment, whether or not overtly depressive features dominate the presentation. We present an outline of factors demonstrated in suicide research (see, for example, Suggested Readings, Jacobs) to have empirically validated utility.

a. Personal context. Research suggests that men are more at risk than women and that the years after reaching middle age are the riskier ones for suicide. Despite the rise in suicide rates among young people, this finding remains significant. The divorced and the widowed are at higher risk; also at high risk are the separated. Perhaps the most important variable is that of psychological isolation, which can derive from a number of sources (for example, immigrants who have not found a local community, those who are retired or unemployed, those living alone, even those living in transient or disorganized areas such as resort towns whose populations fluctuate wildly on a seasonal basis). Finally, Catholic faith appears to pose some barriers to suicide; Protestant faith appears the most vulnerable to it; Jewish faith lies in between.

b. Previous history and background. Important variables appear to be family history of affective disorder, suicide, or alcoholism. Previous suicide attempts themselves are complex predictors, in that frequent suicide attempts may paradoxically decrease the likelihood of serious intent. Witnessing suicide or identifying with someone who has committed suicide is a risk factor. Highly publicized suicides, even if committed by someone unknown to the patient, can increase the risk of emulation, resulting in "clusters" of suicides, such as are seen on college campuses.

c. Current stressors. Important stressors likely to be associated with suicide are acute bereavement or separation from loved ones; recent geographic move, especially to a more isolated situation; loss of job; significant alcohol use and the complications of alcoholism; physical illness; and, with the elderly, terminal illness.

d. Personality disorder factors. Issues most relevant to risk of suicide appear to be cyclothymic personality and sociopathy (antisocial personality), intensified by substance abuse of any kind. Patients with borderline personality disorder appear statistically to threaten suicide or engage in parasuicidal acts, rather than to commit suicide. However, a small percentage of such patients do commit suicide, at times by accident, such as when a "minor" overdose proves lethal. The risk of suicide increases when borderline personality disorder is comorbid with a major depression. (See Suggested Readings, Gutheil, 2005.)

e. Psychiatric illness. Depression predictably leads the list of illnesses correlated with suicide, especially in the context of recurring depression or full-fledged bipolar disorder. Substance abuse is highly represented, as are various forms of organic conditions and impairments in the elderly. Data suggest that panic disorder significantly increases suicide risk, and that as many as 10 to 15% of schizophrenic patients ultimately kill themselves.

f. Symptomatology. Leading the list of symptoms for risk of suicide are depressive symptoms or a recent history of the same (the patient at the time of presentation may be less acutely depressed than before, having made the decision to die) and communicated suicidal intent in both verbal and written form. Particularly serious are states of agitated and dysphoric depression that convey an "excruciating" quality. Patients in this condition are subjectively extremely difficult to sit with; indeed, the examiner's countertransference impulse to retreat from the patient may have diagnostic force. Other significant ominous feelings are pessimism, hopelessness, and, in particular, ideas of reunion with a lost loved one. A state of emotional exhaustion also appears to be a risk factor for suicide; the patient speaks of being "too tired to go on."

g. Context of the suicidal act. Suicidal acts of a high-risk, low-rescue sort (see Sec.III-B-3) are particularly ominous, as are suicide attempts accompanied by certain preparatory actions (e.g., writing suicide notes, revising wills, giving away possessions). Lethal and violent methods should alert clinicians to particular risk.

h. Clinical wisdom concerning suicide. In addition to these empirically validated elements of the assessment, some clinical wisdom may stand a practitioner in good stead. Individuals attempting suicide through "respiratory" means—hanging, drowning, gas, various forms of asphyxiation or strangulation—may represent a somewhat more lethal subpopulation of suicide attempters. The one exception to this rule is individuals, usually male, who are attempting a strangulation experience to intensify masturbatory excitement in the form of autoerotic self-hangings. This paraphilic activity may trigger social responses as though it represented attempted suicide, whereas it is really a variant of erotic activity.

The second important point in the assessment of the suicidal patient is the understanding that one of the clinician's most essential tools, empathy, may mislead or misguide the evaluator. The reasoning, though subtle, is clinically important. Individuals on the brink of suicide may be cut off from their own despair. Thus, the evaluator attempting empathic linkage with the patient may perceive someone who "seems to feel okay." In this context, the examiner may have to exercise humility and augment the empathic assessment with what might be termed *cerebration*, in which careful attention is paid to the actuarial risk factors earlier delineated. The individual who appears to have a serious loading of risk factors but who "feels okay" in the immediate evaluation may require use of more active safeguards until the entire situation is better understood than may be possible in the brief emergency context. Further investigation and use of ancillary sources may clarify the situation either way. (See Suggested Readings, Buie.)

Other elements of the clinical picture that appear to increase the risk of suicide are the presence of psychosis, especially with command suicidal hallucinations; a history of suicide attempts, successful suicides, or psychosis in either the patient or family; and the presence of specific anniversaries that recall major losses.

Religion may operate to increase risk through fomenting guilt but may decrease risk through prohibition of suicide; as a rule, patients who state that their religion condemns suicide should have this resource taken seriously, absent strong evidence to the contrary. A common omission for clinicians dealing with suicidal patients is failure to explore the patient's religious history. This information helps to identify risks and resources and to capture a picture of the afterlife to which the patient is considering sending himself. Religious agencies may be an additional source of needed support.

Finally, some experienced evaluators note that, as part of the normal response to the depressed patient, the evaluator feels somewhat depressed. Confronted with the suicidal patient, however, the examiner may feel an inexplicable fear. Careful introspection and attention to this diagnostically useful countertransference response may be extremely illuminating and helpful.

A series of factors validated by experience define a continuum of increasing suicidal risk, which may aid the clinician in assessing the urgency of the situation.

Suicidal ideation. Suicidal ideation is nearly a universal experience under certain circumstances.

Suicidal intent. The decision to die, suicidal intent, may be accompanied by an ominous decrease in tension or dysphoria and an increase in calmness or an elevation of mood.

Presence of specific plan. A plan for suicide gives increasing focus and affective intensity to fantasy around intent; it may channel energy toward the goal.

Availability of means. Immediately accessible means (e.g., pills, a gun, a rope, a bridge) combine with a plan to heighten risk.

Attempt. The patient actually taking action against herself is the most serious warning sign. Almost equally serious are rehearsal activities, such as seeing what a loaded gun feels like in one's hand or what the gun barrel feels like in one's mouth.

2. Tools for Systematic Assessment of Suicidality

No assessment instrument exists with proven predictive value in identifying persons likely to commit suicide, and given the difficulty to date in formulating even *post hoc* predictive algorithms, one is not likely to be developed in the foreseeable future. Clinical practice of suicide risk assessment, however, is evolving in the direction of utilizing standardized questionnaires to systematize the assessment process. The value of such approaches lies both in reducing the risk that an important question will go unasked, and in providing documentation of the assessment itself. At this point, no single instrument stands out as of particular utility; indeed, many facilities and clinicians use forms of their own devising. The key is making sure that the major empirically validated predictors are addressed, along with the other variables that a reasonable clinician would ordinarily consider.

3. Assessment of Suicide Attempts

Patients may present to the emergency setting at the last stage of urgency (i.e., after having already attempted suicide and survived); referral may be from general medical physicians or from the police. A useful guideline for assessing such attempts is the risk/rescue rating popularized by Weisman and others (see Suggested Readings, Weisman and Worden). The evaluator must bear in mind throughout this determination, however, that the population of suicide attempters (regardless of low-risk, high-rescue circumstances) is at greater risk for suicide than other populations. In increasing order of lethality, typical examples follow.

- Low risk, high rescue: patient takes a small number of aspirins and immediately tells friend.
- Low risk, low rescue: patient attempts to slash wrists with piece of glass while alone.
- High risk, high rescue: patient shouts "I'm going to jump!" and lunges for distant window of crowded room.
- High risk, low rescue: patient buys gun and rents motel room under false name.

It is important that, when the evaluator makes the determination that serious suicidal risk exists, she act decisively, without permitting delay, postponement, or an unobserved or unprotected interval during which the patient could "get some things." Patients at the crisis point may attempt suicide in the emergency room itself, in rest rooms, or while going for a cigarette. When significant suicidal risk is present, the approach must be guided by a consistent, serious, and unambiguous assumption of responsibility for the patient by the clinician.

This authoritarian, taking-over attitude is guided by the truism that depression is usually temporary and treatable; suicide is permanent. The evaluator aims at a realistic moratorium on action, not an omnipotent interdiction against death. An experienced clinician used to say to patients at the brink, "It would be a pity if you killed yourself while depression clouded your judgment. Let's get you undepressed; then, if you still want to kill yourself, I know I can't stop you." This posture conveys the locus of eventual responsibility, the indirect optimism for treatment, and the realistic limitation of the evaluator's power.

4. Manipulative Suicide and the Problem of Regression

Although the idea is confusing to the layperson, a number of people attempt suicide without a wish or intention to die; rather, their goal is to change or to improve their manner of living. That is, an apparent effort at dying represents a wish to live better. Not all such patients require hospitalization or even intervention. Hospitalization in these cases may foster unwanted regression.

> ***Example 5.*** After her boyfriend breaks up with her, a high school girl slashes her wrist superficially and blames her guilt-stricken boyfriend when he meets her in the hospital emergency room. The boyfriend begs her to make up and swears eternal fidelity. Suicidality in the patient disappears, at least temporarily.
>
> ***Example 6.*** A woman in her 20s arrives at the admission office with two paper bags, ostensibly containing clothes and possessions, sits down and glares at the admitting doctor. When asked, "Can I help you?" she barks, "I'm here to be admitted!" When asked to explain, she retorts, "There's nothing to say, I'm here to be admitted." When told she must give a reason, she states, "Admit me or I'll kill myself." Many minutes of questioning reveal that the woman is enraged at her live-in boyfriend and had hoped to be admitted to "show him."

Other examples of the threat of suicide with nonlethal intent include the destitute patient seeking a roof for the night and the felon wishing to escape detection by the police. These clinical situations must be distinguished from true suicidality.

5. Special Suicidal Conditions

a. Chronic suicidality. A specific population requiring consideration are chronically, as opposed to acutely, suicidal patients. Whereas acute suicidality may be styled a problem in the metabolism of despair, chronic suicidality often presents as a problem in the metabolism of responsibility. The patient must learn to take control of his life when he is "never not suicidal." This type of patient offers a unique challenge to the diagnostician in the emergency setting, because actual suicide is a perpetual risk, yet hospitalization tends to promote regression and should often be actively resisted. This poses a legal dilemma as well as a clinical one, because the clinician faces the constant fear of a jury finding him negligent after, potentially, the one time the patient's usually half-hearted attempt suceeded. Furthermore, laypersons tend to view hospitalization as a panacea and rarely grasp that hospitalization may be harmful to such patients.

The clinician must place the best interests of the patient first and act accordingly; however, careful attention to documentation of the clinical rationale is mandatory when the calculated risk (not admitting the self-confessedly suicidal patient) is taken.

A useful guideline in this difficult situation may be to assess the patient's capacity (or competence) to follow through on treatment planning or, more particularly, to weigh the risks and benefits of giving or withholding information from clinicians about suicidal impulses. Essentially, this assessment helps distinguish the patient who can report to the clinician about her condition—but chooses to withhold this information—from the patient who is too ill, sick, hopeless, depressed, or regressed to do so. This may have some implications for future liability assessment. Thus, the clinician should make (and document) an assessment of the patient's ability to be a reporter on his own internal state of risk. This permits the clinician to draw useful conclusions about the state of the alliance with the patient, which may be itself a significant suicide preventive.

b. Time-based or contingent suicidality. Time-based or contingent suicidality is a unique clinical problem that, though widely encountered, is not often discussed. Yet it presents the clinician with one of the most stressful clinical dilemmas. The problem is exemplified by the following typical complaints.

1. If my wife leaves me, I will kill myself.
2. If I am not better after 6 months of therapy, I will kill myself.
3. If I am not married by the time I am 30, I will kill myself.

In these and similar expressions, the patient conveys clearly that he is not now acutely suicidal, but that—at a certain future time or under certain future circumstances he will be. The countertransference strain of working with such a patient may be considerable, especially as the deadline approaches. The subject is covered more extensively elsewhere (see Suggested Readings, Sec. D, Gutheil and Schetky), but the essential recommendations may be summarized as follows: First, the date with death represents a communication to the clinician that should be recognized and actively explored for its therapeutic potential. Second, because such patients are often trying to blackmail fate out of feelings of helplessness, exploring the topic of helplessness may permit empathic contact with the patient who may be attempting to hold the clinician at a distance. Third, ineffectual power struggles around the patient's suicide plans should be avoided. Fourth, attention must be paid to inevitable countertransference factors. Fifth, the patient's competence to inform clinicians of imminent suicidality should be assessed and documented to guide decision-making about the clinician's response. Finally, a low threshold for involuntary commitment should be maintained.

C. ASSESSMENT OF DANGEROUSNESS TO OTHERS

Dangerousness to others is in certain ways more complex and more emotionally charged than suicidality, because the danger threatens to involve innocent bystanders—a situation exerting significant influence on the degree of risk the clinician can accept. Nevertheless, prediction of dangerousness is a fundamentally unreliable endeavor (see Sec. II-E-2). The diagnostician is constantly challenged to balance the individual patient's rights and freedoms against the safety of society.

The situation is profoundly complicated by the fact that threats against others (including, of course, the therapist) are an extremely common event, a result in part of the mobilization of powerful feelings that often occurs in psychiatric treatment. It would be unreasonable, unethical, and surely impossible to respond to every one of such threats as though it represented an acute and present danger to others; yet legal decisions like the *Tarasoff* ruling (see Chap. 4, Sec. II-A-3-e) intensify the pressure on the diagnostician to winnow the chaff of idle threats from the wheat of serious intent to harm, because different courses of action must follow and a different tack must be taken in regard to an alliance-threatening breach of confidentiality. The duty to protect must be weighed against the possible risk to the therapeutic relationship.

In light of the evidence presented earlier that strongly suggests that psychiatrists are poor predictors of dangerousness (see Sec. II-E-2), it may seem paradoxical to outline herein a framework within which an assessment can be made. Helpful in this regard is reframing the process not as involving a dichotomous judgment as to whether a patient is dangerous, but rather an estimate—albeit imperfect—of the degree of risk a patient presents, so as to facilitate development of a strategy for treatment and reduction of risk. Risk assessment, rather than prediction of violence per se, has come to be seen over the last decade as the most realistic goal of clinical assessment.

1. Research-Based Variables that Elevate Violence Risk

As in the assessment of suicide, the data used in this prediction consist of both statistically validated findings (see Suggested Readings, Monahan and Steadman) and received wisdom derived from practice in the field.

The following elements are repeatedly found, in empirical studies, to correlate with future dangerousness to others: past violence, age, gender, race, socioeconomic status and stability of employment situation, substance abuse, and personality traits.

a. Past violence. Past violence repeatedly appears as the strongest correlate in actuarial studies of violence and related phenomena. Clinicians must overcome their denial, based on discomfort with the issue of violence, to make a specific inquiry about this subject. A particularly useful question is "Have you ever, for any reason, accidentally or otherwise, caused death or severe injury to another human being?" This may elicit unexpected but highly relevant data, including incidents involving police, negligent homicide through vehicles, military combat experience, and the like.

b. Age. Age is another familiar variable in violence assessment. Violence peaks in the teenage years, declines slowly through the 30s, then drops precipitously after age 40.

c. Gender. Males are much more likely to commit acts of violence. The ratio in many studies is 9:1, although it may well be a lower ratio among persons with mental illness.

d. Race. Even corrected actuarial data that attempt to filter out differential selection due to preferential arrest of racial groups conclude that nonwhite individuals have significantly higher rates for violent crimes. This effect may be due to the impact of socioeconomic and related factors.

e. Socioeconomic status and stability of employment situation. Multiple studies suggest that economic status and stability of employment are inversely correlated with recidivism for violence.

f. Substance abuse. The use of many psychoactive substances, particularly alcohol, clearly correlates with increased violence in mentally ill and non–mentally ill populations. Phencyclidine (PCP) and cocaine are believed by many clinicians to be major triggers of violent behavior.

g. Personality traits. Whether a major mental disorder is present, psychopathic personality traits—as measured, for example, by Hare's Psychopathy Checklist (discussed in Suggested Readings, Monahan and Steadman, *Violence and Mental Disorder*)—increase the risk of violence. A propensity toward reduced impulse control and a "short fuse" may also potentiate violent behavior.

h. Victimization in childhood. Victims of child abuse or neglect are significantly more likely both to victimize their own children and to engage in violence with others. Even pathological family environments that fall short of being characterized as abusive can elevate later rates of violence.

i. Predictions in the presence and absence of past violence. When a patient has no history of previous violence, a judgment must be made as to the relative balance of inhibitory versus instigative factors. In close decisions, the longer the period that the present balance has existed, the stronger the possibility that it represents a stable equilibrium. In contrast, when the situation is rapidly changing, some value may exist in erring on the side of safety.

In the presence of a previous history of violence, the assessment becomes somewhat easier. The clinician must ascertain those factors that appeared to contribute to the previous violent act and determine the degree of amelioration. The greater the change, the lower the likelihood of recurrence. A useful distinction here is between state-dependent and non–state-dependent violence. An example of the former is a person who is violent only when intoxicated or psychotic; the latter is exemplified by a chronically hostile person with a life-long "short fuse." For state-dependent violence, the focus should be on the inducing state (intoxication, psychosis, etc.). Non–state-dependent violence requires a focus on the person's characterologic style (e.g., anger management).

2. Clinical Wisdom Concerning Dangerousness to Others

Moving to the "received wisdom" in the field, clinicians note that patients with a tendency to externalize are more likely to see the locus of their problems in the outside world and to seek solutions by acting on it there. This category of patients includes those with paranoid conditions, impulse disorders, and substance abuse disorders, as mentioned earlier. Other features historically considered important include the following:

- A history of dangerous intentions or thoughts (e.g., lasting grudges; obsessive thoughts of revenge or retribution; persecutory delusions fixed on specific persons; and some forms of the delusion known as *erotomania*: the belief that a person, usually someone of higher perceived status, is secretly in love with oneself).
- Membership in violence-oriented ethnic or cultural groups (e.g., street gangs), which may militate in favor of increased dangerousness.

- A history of victimization as an adult (e.g., adult violence, public shame, humiliation, or embarrassment; rejections, provocations, and related injuries to the ego, particularly in significant relationships such as with loved ones).
- Ownership of weapons and related items (e.g., gun collection, knife collection, martial arts degrees, membership in mercenary groups).
- A tendency to make lists (mental or written) of people who have wronged one and whom one would like to "pay back," kill, or see dead or eliminated; a tendency to keep diaries or journals with similar content.
- Appearance: Physical tension (e.g., grimacing, clenching fists or jaw), preoccupation, pacing, presence of real or possible weapons (e.g., knife, length of pipe).
- Mood and speech: Angry, threatening, glaring, or hostile looks, words, or threats.
- Thought content: Persecutory delusions; command hallucinations directing violent acts; obsessive thoughts, fantasies, and ruminations of assault, loss of control, and revenge.
- Circumstances: Patient brought in, in handcuffs, by four policemen after assault; patient seen raving in restraints, and other such circumstances.
- State of controls: The clinician must assess the impulse-versus-controls balance in a manner similar to the risk-versus-rescue balance in suicide.

One should also consider the external and internal support available to the patient:

- External: A number of concerned, strong family members may be able to sit with the patient until alcohol wears off and transient dangerousness passes, whereas a lone patient just arrived in town may have no such resources.
- Internal: An obsessional patient terrified of losing control is more likely to maintain control than an impulsive, methamphetamine-abusing street fighter.

Clinicians should explore these areas candidly because, although commonly omitted in the casual assessment, they are of significant value in rounding out a picture of the patient's potential for danger.

Weapon availability deserves special note. Every emergency assessment should include queries about weapons on the person and weapons (especially firearms) in the residence. In emergent situations, informants or family should be told to remove firearms temporarily, and this instruction should be documented and followed up; family denial of the situation is common. In some circumstances, police may need to be involved.

3. Structured Professional Judgment and the Assessment of Violence Risk

Research over the last two decades has led to the development of a growing number of structured assessment instruments that incorporate empirically based predictors and yield quantitative assessments of violence risk. Among the best-known of these instruments are the HCR-20, the Violence Risk Assessment Guide (VRAG), and more recently the computerized Classification of Violence Risk (COVR). (In the Suggested Readings see, respectively, Webster et al.; Quinsey et al.; and Monahan et al., 2005.) In general, higher scores on these measures correlate with an increased incidence of subsequent violence. Yet the instruments are neither sufficiently specific nor sensitive in identifying patients at high risk of violence that clinicians ought to rely on them exclusively for the estimation of a patient's risk of violence. Moreover, patients (especially paranoid ones) may refuse to participate in or cooperate with these evaluations. Rather, as suggested above for suicide risk assessment, these instruments should be seen as tools for structuring an evaluation, following which clinicians should take into account other variables that may increase or mitigate violence risk. This model has been referred to as "structured professional judgment" (see Suggested Readings, Douglas et al.).

4. Relationship of Violence Risk to Mental Illness

The relationship of violence to mental disorder has been much debated. At this point, it seems likely that mental illness heightens the risk of violence in some patients (by increasing impulsivity or the likelihood of substance abuse, which interacts with the underlying disorder to reduce behavioral controls), whereas it reduces violence risk in others (as when defect states in schizophrenia reduce social interactions and thus the opportunity for acts of violence). One major prospective study indicated that recently discharged mentally ill people who did not abuse substances had no higher rate of violence than other persons in their neighborhoods (see Suggested Readings, Steadman et al.). Even the retrospective studies that have found some greater degree of violence risk associated with mental illness *per se* (especially with psychotic symptoms) suggest that the proportion of violence in American society that can be attributed to persons with mental illness is small (perhaps 3% of the total). (See Suggested Readings, Swanson et al. in Monahan and Steadman, *Violence and Mental Disorder*.)

Nonetheless, the public's views of violence and mental illness are complicated by popular ascriptions of diagnoses to all people who engage in aberrant behavior. A layperson may have difficulty seeing that the belligerent bully who has traveled through life on his fists may have maladaptive personality traits, but not a mental disorder that justifies coercive psychiatric interventions. Even mental health professionals sometimes find it hard to distinguish between these groups, especially as their concern grows that they will be held responsible for the violent behavior of anyone with whom they come into contact. But, as challenging as it may be to draw the line, involuntary psychiatric interventions should be reserved for persons with disorders likely to benefit from them. All other situations are matters for the police.

D. ASSESSMENT OF ABILITY TO CARE FOR SELF

The "ability to care for self" criterion for commitment reflects the awareness by lawmakers that not all psychiatric emergencies are characterized by a clearly definable "active risk" of dangerousness to self or others. A significant category of patients who need immediate care includes those who are so psychotic, hallucinated, demented, or the like, that they represent a "passive risk" to themselves such as being run over in traffic; being mugged, raped, or assaulted; dying of pneumonia from exposure to cold; or starving to death.

By its very ambiguity, this category is the most ethically, as well as diagnostically, challenging, because its breadth of scope creates—depending on one's viewpoint—either the greatest flexibility to bend the law to help the patient, or conversely, the greatest potential for paternalistic abuse. To aid clinicians in thinking rigorously about this issue, structured scales have been developed for the assessment of ability to care for self, and seem to have some utility (see Suggested Readings, Grisso).

1. Illness-Versus-Functioning Dilemma

Assessment of the ability to care for self depends far more on the history and observed evidence of functioning than on any diagnostic category or even the severity or chronicity of illness. An example would be the so-called street schizophrenic who is able to exist (though perhaps not thrive) by means of a practical knowledge of sources of food, clothing, and shelter unknown to the average urban dweller.

> ***Example 7.*** One such man lived for seven months in this manner, seeing his father only to pick up a Social Security check, otherwise living on the streets. He was hospitalized only when a combination of unusually cold weather and purulent leg ulcers made this way of life untenable.

2. Issue of Available Resources

Patients may be rendered unable to function only when certain resources break down or become unavailable. Being evicted from a halfway house or a nursing home may snap the thread that makes extra-institutional living possible; a similar last straw may be the patient's alienating a supportive family member or a trusted therapist, nurse, or aide, or even the temporary absence of a nursing home dietitian. These and similar seemingly minor events may threaten the balance of resources so as to render a previously equilibrated patient unable to continue self-care. The clinician must look for problems that can be remedied by short- or long-term direct interventions to return to the patient the capacity for self-care or to provide the necessary caretaking environment.

E. CLINICAL ASPECTS OF EMERGENCY ASSESSMENT

1. Documentation

Interventions made in the emergency setting should reflect a well-thought-out formulation of the problem that generates a rationale for the type of intervention used; meticulous documentation and record-keeping should demonstrate not only careful efforts at data gathering and at assessment of the patient, but also the steps of reasoning followed to arrive at the treatment plan. This is critical from both clinical and risk-management perspectives. The emergency evaluation is a frequent source of malpractice litigation.

> ***Example 8.*** An emergency room note found in a patient's chart read, in its entirety, "Chief complaint—can't sleep. Rx Prozac 20 mg qd. # 30, see Tues." The author of the note omitted documenting several crucial steps including that (a) the assessment of the patient revealed depression as the cause for insomnia, and (b) the assessment revealed no acute suicidality, implying that the patient would probably live until Tuesday.

2. Consultation to Existing Relationships

The emergency room serves as the arena where difficulties in relationships (including therapeutic relationships) may be played out.

> ***Example 9.*** A patient, refused benzodiazepines by his doctor, continued to obtain them from an emergency room psychiatrist who did not inquire about current treatment.

> ***Example 10.*** A patient whose husband minimized her anxieties convinced him to bring her to the emergency room with an unconscious intention of proving she was "that upset."

The evaluator is often challenged to perform what is essentially a consultation to an official or unofficial therapeutic relationship; the consultative effort may be obvious or subtle.

> ***Example 11.*** A patient in therapy came to the emergency room with an anxiety attack, asserting that he "could not bother his doctor with these trifling concerns." The emergency room evaluator merely pointed out that the patient was self-defeatingly undermining his psychiatrist's taking him seriously, and that something serious enough for the emergency room was serious enough to call the doctor about. The patient agreed and called.

> ***Example 12.*** A couple with two teenagers came to the psychiatric emergency room demanding commitment of the younger child as a result of a tremendous family fracas just before a long trip; the parents were furious, the children upset but clearly not in need of hospitalization. Careful exploration and considerable time spent interviewing the whole family revealed that the trip in question would have been, in all probability, the last time the family would have seen the seriously ill grandparents alive, though the family had kept this fact from conscious awareness. The upset had resulted from submerged tensions about this, and the visit to the emergency room had aborted the conflicted trip. The family was encouraged toward psychological termination with the grandparents.

Although the issue is generally not considered in these terms, an intervention with a patient who is threatening harm to another party could also be looked at as having a consultative focus, because the relationship—now potentially violent or homicidal—is badly in need of external modification. It may prove beneficial, not only in diminishing the actual dangerousness of the situation but subsequently in diminishing liability in the event of a bad outcome, to have the dangerous patient actually contact the putative victim (e.g., by making a phone call from the evaluator's office) and share her grudge verbally. This verbal contact, in addition to being superior to physical ones, may permit the reality testing of paranoid fantasies, the ventilation and catharsis of unmanageable rage, and other salutary processes that may defuse the dangerous situation (see Suggested Readings, Wulsin et al.).

3. Environmental Manipulation

In the broadest terms, environmental intervention usually boils down to removing a patient from a noxious situation or placing the patient in a more protected environment, or both. The former action may involve, for example, finding an emergency shelter for a battered wife; the latter may involve hospitalization in a psychiatric facility.

a. Voluntary hospitalization. Hospitalization is offered voluntarily to decrease the pressures of external responsibility when the patient is overwhelmed by them and to provide structure, a supportive milieu, protection, intensive care, closely supervised pharmacotherapy, electroconvulsive therapy, or other forms of treatment. A voluntary patient, by definition, accepts the treatment recommendations of hospitalization.

b. Involuntary hospitalization. The legal indications and standards for involuntary hospitalization have been well delineated in Section II of this chapter. The clinical problems require a different perspective, directed to preservation of the alliance despite an involuntary (by definition, oppositional) position due to circumstances. Because involuntary commitment is sought not only during emergency circumstances but also as a response to the wish of the voluntary inpatient to leave, we address both circumstances.

Some jurisdictions appropriately indicate a preference for voluntary hospitalization over involuntary. On occasion, this leads to a form of emergency room "blackmail" of the committable patient: "If you do not sign in voluntarily, I will commit you." The volunteering of such a signature, of course, is highly suspect.

Both clinical and ethical good practices enjoin clear separation of the two issues. If the patient is committable, the clinician should express this unambiguously: "I plan to bring you into the hospital; if you wish to sign in, you may do so. However, your condition requires admission regardless of whether you sign in."

Wishes Versus Interests. The patient's *wishes* determine most of the treatment except when the patient's *interests* (survival, preventing harm to others) take priority; the evaluator may make this quite explicit: "Though you feel everything is hopeless, Mr. Jones, I am obliged to act on your behalf to hospitalize you until we get your depression under control."

Conflicted Wish for Hospitalization. Most clinicians are familiar with the paranoid position, in which a patient may wish for some response, but is prohibited from asking for it by the need to project (externalize the issue); in certain circumstances, then, the wish not to be hospitalized or the wish to leave the hospital may be a highly ambivalent one, so much so that the conflicted wish to stay is actually the stronger. The overt expression of a wish to avoid hospitalization or to leave the hospital may be intended by the patient as a test of the therapist's caring.

An interesting ethical dilemma arises in relation to cases of questionable dangerousness. In most jurisdictions, dangerousness alone constitutes the grounds for commitment; this criterion is the judge's concern, separate from issues of the patient's need for, or likelihood of benefiting from, treatment. If the physician were the final arbiter of the commitment decision, it would be inappropriate to petition on grounds other than clear-cut dangerousness; however, the judge is the final arbiter, through a process that protects the patient's rights.

Because of this automatic judicial review process, the physician need not feel totally constrained to use a rigid and clinically narrow dangerousness standard, especially when the dangerousness is unclear, unpredictable, or labile; because due process protects the patient, the physician may freely petition in doubtful cases and leave the outcome to the legal process, even though actual commitment may be uncertain.

This petition has clinical advantages. As experienced by the patient, the act of petitioning may convey that the clinician takes the patient's problem or illness seriously and wants to take care of her. Thus, even if the judge releases the patient, a strong statement of seriousness of intent (another form of commitment) has been made by the clinician that may form the nucleus of the outpatient treatment alliance.

To put it another way, the clinician need not feel required to anticipate or to second-guess the judge's ruling, especially because judges (or even the same judge at different times) are notoriously unpredictable in this regard.

Judicial unpredictability and the alliance. In a paradoxical way, the very unpredictability of judges may serve to support the therapeutic alliance. Patient and therapist can see the situation as one in which they are in opposition around the question of hospitalization and are placing their disagreement in the hands of an authorized "referee." Both parties are in ignorance of what the judicial ruling will be and are thus united in uncertainty, which may serve as the nucleus of a bond: patient and therapist jointly discuss the question of what will happen and the possible consequences in a state of equal perplexity. This alliance posture of joint discussion may pave the way for future collaborative efforts after the issue of commitment is resolved. (See Chap. 3, Sec. III-F-3.)

c. Target Hardening. This concept, used by security consultants, represents an approach to emergency intervention when the potentially dangerous person cannot be found or detained. The clinician may recommend steps that render the potential victim safer. Such steps might include flight, relocation to an anonymous or secure setting, or other approaches based on concealment or increased protection.

4. Contraindications to Hospitalization

A number of clinical situations pose relative contraindications to hospitalization. The clinician is reminded that, given the layperson's view of hospitalization as a panacea, the decision not to admit a patient who wants to be admitted or who seems to need hospitalization requires as much documentation as the decision to admit. It may, perhaps, require even more, because not admitting a patient who is threatening suicide, even if the threat is considered specious, involves a calculated clinical and liability risk. The clinician is well advised to think out loud for the record, making a case for the course selected, and carefully noting the evidence on which the decision is based. (See Suggested Readings for Chap. 1, Gutheil; and see Chap. 4, Sec. III-A-3-c.)

Typical situations include the following:

1. The patient without psychotic or suicidal symptomatology feels anxious and overwhelmed by reality factors (e.g., approaching final exams) and wants to get away from them. In this situation, the patient is discouraged from using the hospital and encouraged to make reality-based decisions instead.
2. The patient has no place to go. This factor should rarely be the sole reason for admission. The patient is better directed to a shelter, safe house, Salvation Army facility, or the like. Exceptions may, of course, be made.

> ***Example 13.*** A geriatric patient who is found to be unsuitable for psychiatric admission is sent from a nursing home that then refuses to take him back after the assessment. Admission may be the only humane alternative to the patient's being sent back and forth numerous times between the two institutions; placement can then be attempted anew.

3. The chronically suicidal patient. As earlier noted (see Sec. III-B-3), such patients must sometimes be actively denied admission to forestall serious regression and fostering of disabling hospital-centered chronicity.

5. Involuntary Nonadmission: Sending the Patient Out

For completeness in this section, we consider involuntary or administrative nonadmission. This term defines the situation when a patient is refused admission against his will for reasons that are not purely clinical; these include (a) lack of insurance, (b) treatment refusal, and (c) infraction of rules (e.g., aggressiveness, theft, sexual acting out).

Each of these situations, though not defined in strictly clinical terms, nevertheless requires the hospital to maintain a clinical perspective. If a patient's coverage has lapsed or the managed care company has declined to authorize further care and that patient clinically needs the hospital, the hospital is obliged to arrange transfer to a facility that can hospitalize the patient or otherwise provide for his care (see Chap. 4, Sec. II-C-2). The patient refusing treatment for whom it is safe to leave may be sent out, but alternative care (e.g., outpatient appointments, referral) must be offered. Even the noncommittable patient abruptly sent out for rule infractions must be offered at least a list of possible places to stay (e.g., shelters) if no residence exists already. Of course, the patient too ill to be discharged safely may not ethically be discharged; other approaches must be invoked. This issue is further explored for inpatients in Chapter 3, Section III-G.

IV. PITFALLS

A. DENIAL AND UNDERREACTION

The anxiety of dealing with life-and-death emergency situations may mobilize in the evaluator a number of defensive operations, including denial of acuteness, seriousness, urgency, and dangerousness. In Case Example 1, the evaluator might have been influenced by the patient's apparent acquiescence to the plan of hospitalization so as to permit the patient to visit home briefly despite the danger of this move. Evaluators must be cognizant of both their own defenses and statistical and epidemiologic trends in emergency populations. Often, underreaction takes the form of a focus on detail at the cost of the total picture.

> ***Example 14.*** A psychotic woman, before witnesses, stabbed herself vigorously with a knife. The evaluating resident fixed on the fact that the knife was somewhat dull and did not inflict too deep a wound. This minimizing perspective missed the severity of the psychotic disturbance and the resultant dangerousness of the total clinical state.

B. CONTAGION AND OVERREACTION

At the opposite extreme, the evaluator who attempts an appropriately empathic assessment may be swept out of a position of perspective and into the contagious urgency of the patient or others. A panic-stricken family, frenziedly demanding admission of one of their number, may interfere with dispassionate assessment of the actual need for hospitalization on patient-centered clinical grounds. In addition, the alternative—refusing to admit the patient—may be rendered difficult by the family's belligerent, threatening, or litigious demeanor.

The patient's own anxiety and urgency may impair the calm thoughtfulness of the emergency evaluation and create the pressure within the evaluator (like that within the patient) to do something immediately—a pressure that may promote precipitous, ill-thought-out action before the clinical situation is sufficiently clear.

In a related manner, the empathic assessment of severe depression may breed specious hopelessness and helplessness in the evaluator that belie the actual likelihood of a favorable response to treatment of this illness.

C. FAILURE TO ACT OR TO CONFRONT

The failure to act or to confront stands in relation to denial as action is to perception—that is, even if the danger is acknowledged, decisive action may be blocked by countertransference-based conflicts around aggression, sadism, and authoritarianism.

Involuntary commitment, for example, represents the opposite of the desirable alliance posture of amicable collaboration; instead, the evaluator directly opposes the patient's intention, risking the latter's anger, enmity, or accusation. These fears work against the clinician's natural wish to be liked by patients or, at least, to be seen as a helper or benevolent ally. From this viewpoint the position of opponent or enemy represents a narcissistic injury for the clinician.

Similarly, though acting within well-defined legal parameters, the evaluator who participates in involuntarily hospitalizing the patient may believe himself to be pushing the patient around, controlling or punishing her, or behaving like a jailer or a tyrant. Sadistic and aggressive feelings evoked by these fantasized roles may generate conflicts in the evaluator. Concurrently, anxiety may block necessary inquiry about weapons possession.

Such conflicts impair the evaluator's ability to overrule and override the patient's stated wishes, threats, or demands when the clinical situation calls for such a decisive response.

Confrontation of the patient, moreover, is often made difficult by the patient's own unflinching denial; manic euphoria, elation, and grandiosity; or relentless paranoid projection of responsibility or blame. The unassailable conviction and energy with which such patients can maintain delusional views may make an evaluator quail at the thought of opposing the patient's forcefully stated wish or intent.

V. CASE EXAMPLE EPILOGUES

A. CASE EXAMPLE 1

The psychiatrist is momentarily nonplussed, but manages to ask the patient to wait. Summoning additional personnel, the doctor explains forcefully that he is taking over responsibility for the patient because his depression is clearly impairing his judgment, at least temporarily. The patient threatens a lawsuit, but grudgingly complies.

Three days after admission, he confesses that he had bought a gun on the day of presenting to the emergency room, and—had he been allowed to go home "to pack some things"—would have used it on his wife and then on himself. Six months later, when his vocational and alcohol rehabilitation are well on their way, he expresses gratitude for having his momentary wish overridden.

B. CASE EXAMPLE 2

It seems likely that this nonpsychotic but impulsive patient, with a borderline personality organization, would not benefit a great deal from hospitalization. His previous history suggests that his despondency over the rejection by his stepbrother would soon be externalized and transformed into anger against the hospital staff, a process facilitated by the regressive hospital environment. The only indication for hospitalization is the threat of further self-injury in the immediate future, which might justify a brief inpatient stay.

After an initial assessment, the psychiatrist elects to let the patient sit in a supervised area for several hours to think about his situation, while the psychiatrist explores alternatives to hospitalization. In repeated interviews during this period, the psychiatrist insistently tries to shift responsibility for the patient's care back to the patient himself. As his demands to be cared for are met with offers to help him plan his own care, the predicted externalization takes place. Becoming angry at the psychiatrist, the patient reveals that in three days he has a court hearing scheduled on a rape charge and that he had hoped that hospitalization would help him avoid the hearing. He is furious that the hospital has not cooperated in this plan. Nonetheless, he is no longer despondent and now convincingly denies self-destructive intent. Consequently, he is permitted to leave the facility with the strong recommendation that he return when the outpatient clinic opens in the morning to begin outpatient treatment.

C. CASE EXAMPLE 3

The evaluator feels moved to help the obviously distressed mother, but recalls that signing a commitment petition on an unexamined patient is ethically, clinically, and legally unsound. The evaluator empathizes with the mother's concern about her daughter, but stresses that unless the latter is willing to come to the hospital or to a private psychiatrist's office for an evaluation, there is, regrettably, little that can be done. This is followed by an explanation of the laws governing involuntary commitment and of the criteria that must be met. It is carefully explained that the determination of dangerousness to oneself or to others that was required for hospitalization can, despite the genuine nature of the mother's story, be made only after an examination of the patient herself. The distraught mother is advised as to the means that could legitimately be used to persuade the daughter to come for evaluation, as well as the possibility of the family's involving the police or the courts if the patient's behavior seems acutely dangerous. Finally, an attempt is made to stress the systemic nature of the difficulty, particularly with hypomanic patients, whose judgment, though poor and often resulting in acts deleterious to themselves, is not always clearly dangerous to themselves. The mother agrees to work within the confines of the system to help her daughter receive an evaluation. Later that day, having been persuaded by her boyfriend and mother, the daughter appears at the center for assessment. She is found to be imminently dangerous to herself and is committed on an emergency basis.

VI. ACTION GUIDE

A. GENERAL PRINCIPLES

1. *Document* data, source, reliability, reasoning, and rationale in developing plan and interventions; obtain all available telephone numbers.
2. *Decide* recommendations explicitly and record them, together with availability of resources.
3. *Obtain* consultations freely as needed to determine course of action.
4. *Determine* whether specific intervention is necessary.

B. DANGEROUSNESS TO OTHERS

1. *Overcome* denial about violence potential of individuals being interviewed.
2. *Look for* past violence, including encounters with police, vehicular homicide, military combat experience, and the like.
3. *Note* age, gender, race, socioeconomic status, and stability of employment situation.
4. *Consider* substance abuse, especially disinhibiting drugs such as cocaine, PCP, and alcohol.
5. *Weigh* patient's tendency to externalize, presence of paranoid conditions, and impulse disorders.
6. *Determine* history of dangerous intentions or thoughts, fixed persecutory delusions, grudge lists; though the data are somewhat contradictory, consider delusions of influence, thought control, thought insertion, or persecution.
7. *Determine* membership in violence-oriented ethnic or sociocultural groups.
8. *Obtain* history of victimization, narcissistic injury.
9. *Inquire* concerning ownership of weapons, especially collections, present possession of weapons, and related factors.

C. DANGEROUSNESS TO SELF

1. Suicidality.
    a. *Evaluate.*
        i. Personal context: stages of life, psychological isolation, religious faith.
        ii. Previous history and background: family history of affective disorder, suicide or alcoholism; suicide attempts (remember variability).
        iii. Current stressors: acute bereavement or separation, recent geographic move, job loss, alcoholism, physical or terminal illness.
        iv. Personality disorder factors: cyclothymic personality and sociopathy.
        v. Psychiatric illness: depression, especially recurring depression or bipolar disorder, panic disorder, schizophrenia.
        vi. Symptomatology: depressive symptoms, communicated suicidal intent, states of agitation and dysphoria, hopelessness, and ideas of reunion with deceased loved one.
        vii. Context of suicidal act: high-risk/low-rescue attempts, preparatory actions, rehearsal, recent violent methods.
    b. *Consider* received wisdom issues.
        i. Suicide by asphyxiation, pitfalls of empathy.
        ii. Command hallucinations.
        iii. History of suicide attempts, successful suicides, or psychosis in patient or family.
        iv. Anniversary phenomena.
        v. Mixed role of religion.
        vi. Depressive countertransference response in observer.
2. Inability to care for self.
    a. *Check* for degree of illness versus degree of functioning by history and availability of resources (e.g., residence, family, others).
    b. *Assess* present functioning and remediable problems.
    c. *Attempt* return to self-care state or provide caretaking environment.

D. THERAPEUTIC INTERVENTIONS

1. Crisis intervention.
    a. Verbal: *allow* abreaction, ventilation; *define* problem; *validate* difficulty; *attempt* to reestablish perspective.
    b. Chemical: *treat* acute states with appropriate psychopharmacologic agents; *begin* long-term medications if safe and indicated.
2. Consultation to existing relationships.
    a. *Assess* point or issue of breakdown of preexisting relationship.
    b. *Attempt* to restore relationship, *recruit* assistance of objects, facilities, family, community resources.

   c. *Return* the patient if possible to previous supportive relationship.
3. Environmental manipulation.
   a. *Remove* patient from noxious environment (*move* to friend's or family's residence, or emergency shelter).
   b. *Place* patient in protected environment: "asylum" concept. (This may be a hospital.)
4. Hospitalization: indications.
   When the patient:
   a. Requires immediate intensive psychiatric observation and monitoring.
   b. Requires specific psychiatric treatments best delivered in an inpatient setting (e.g., pharmacologic equilibration, introduction to new therapist).
   c. Requires protection of containment in hospital because of dangerousness owing to mental illness.
   d. Requires asylum from deteriorating, chaotic, overburdened, or overwhelmed extrahospital support structures.
   e. Requires intensive support during stressful interval (e.g., parents' vacation, loss of therapist).
5. Hospitalization: contraindications.
   When the patient:
   a. Presents serious danger of nonconstructive regression.
   b. Presents history of persistent failure to use appropriately, or to benefit from, hospitalization.
   c. Desires to use hospital for nontherapeutic purposes (e.g., to escape law, avoid final exams, as a place to sleep).

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CHAPTER 3

Legal Issues in Inpatient Psychiatry

I. CASE EXAMPLES

A. CASE EXAMPLE 1

A 23-year-old man is tolerated by his family despite a slow slide into a withdrawn, catatonic state, until one day, after an argument, he assaults his father. The family then brings him to the state hospital, insisting on his admission. At that time, he is found to be unwilling to undergo a mental status examination, saying to the examiner only, “Do whatever you want to me.” He sits rigidly, appears to be hallucinating, and does not respond when asked if he is willing to sign himself into the hospital. He is admitted on an emergency commitment on grounds of dangerousness to others.

Once in the hospital, the patient begins to take antipsychotic medication, becomes a little less withdrawn, and is more open in expressing his fears that certain people are out to harm him. Now willing to talk with the ward staff and male psychiatrist in charge of his care, he steadfastly maintains that he is not ill and not in need of hospitalization. Nonetheless, he generally adapts well to the ward milieu. When his emergency commitment expires, he is committed by a court for a six-month period, the judge agreeing that he represents an imminent danger to his family.

Approximately four months into his stay, after a series of increasingly silent therapy sessions, the patient fails to appear for his appointment, and the psychiatrist goes to seek him out in his room. Attempting to engage the patient in conversation, the psychiatrist is surprised to find himself picked up and carried to the door by the patient, who closes the door behind him and refuses to come out. From that point on, the patient also refuses to take his medication.

For nearly three weeks, the psychiatrist attempts to talk directly with the patient, but is continually rebuffed. Other staff members, with whom the patient will talk, report that he says that he hates his doctor, “for what he did to me, robbing me of my freedom.” Recognizing that his patient is obtaining little benefit from a hospitalization characterized by neither medication nor psychotherapy, the psychiatrist seeks out the chief psychiatrist in the hospital to discuss the situation.

B. CASE EXAMPLE 2

No one on the ward had expected that Mr. B. would be the average patient, yet no one was quite prepared for what is occurring, and as the legal-psychiatric consultant hears the case presented to her, she frowns in thought.

Mr. B. is in his mid-20s and bears the triple burden of recurring psychotic episodes, mental retardation, and a seizure disorder; surprisingly, however, none of these bears on his admission to the hospital. Instead, it is his tendency to set fires when distressed that provoked a string of court-ordered evaluations, the last of which evolved into a civil commitment for dangerousness.

On the ward, however, fire setting has not been attempted; the patient has tolerated being restricted from matches and has made no efforts to obtain them. The problem behaviors are (a) the patient’s pattern of finding and swallowing an appalling number and variety of small metal objects such as screws, tacks, and soda-can fliptops; and (b) a tendency, when frustrated, to bang his head violently and repeatedly against the wall.

Even these behaviors are far from novel to the seasoned staff; what makes the situation intolerable (and provokes the consultation) is that the patient is always smiling delightedly while engaged in these activities, treats them apparently as teasing games to be played with the staff, and appears to relish—with great enthusiasm—the dismay, consternation, and fury evoked in the ward personnel.

The chief resident relates how the treatment team initially responded to the first screw swallowing and head banging with aggressive medical, neurologic, and radiologic attention, but with each successive episode the enthusiasm for these procedures has waned. The medical consult service has taken to sending back contemptuous notes after working up the patient yet again, suggesting that the psychiatric staff's inability to "keep this patient from harming himself" is probably grounds, as they see it, for malpractice proceedings.

The chief sums up the problem: "We could restrain the patient, but that could go on forever; there's no endpoint. Medication doesn't work; talking doesn't work; seclusion doesn't work; we can't just do nothing! What do we do?"

C. CASE EXAMPLE 3

The new psychology intern looks grimly around the closet-sized office to which he has been assigned for his supervised inpatient year of practical experience at the psychiatric hospital. After a strenuous but obligatory cleaning frenzy he is just beginning the laborious process of moving his books, papers, and equipment into place when the telephone rings. Feeling a mixture of excitement and nervousness, he answers.

There is a short, heavy-breathing pause. Then a hoarse voice inquires, "Are you *my* therapist?"

The intern begins to explain that he has been assigned a few patients but has not yet had a chance to meet them; he is interrupted somewhat brusquely. "Look, I've been assigned to you. And what I wanna know is, what are my rights in this hospital? I wanna know what they are."

The psychology intern has no idea but recalls a handout from the orientation course just presented to all the interns. Groping for his briefcase, he fumbles out the patients' rights booklet distributed at orientation and begins to read aloud the state statute summarized therein. When he reaches the listing about the right to use the telephone, the caller stops him.

"That's what I thought. Listen, you know, I'm calling you on the hospital phone and they're standing right here. They aren't letting me use the public payphone up here in the locked unit, and I wanna call my girlfriend and my lawyer, and I wanna complain about this dump to somebody in authority downtown, and they won't let me. They won't even let me sign out!"

The psychology intern is nonplussed.

"Uh, okay, well, I'll tell you what, I'll come up to meet you, and we can try to figure this out. You're on the locked unit, you say?"

The patient grunts assent.

"Fine! Uh, I mean, I'll be right there."

Arriving somewhat winded on the fourth floor where the locked unit is, he urgently thumbs the buzzer for admission. For long moments he fidgets as nothing happens. Finally, the door is jerked open. A tall, burly man in jeans and a Grateful Dead T-shirt shushes him; he is disturbing the ward meeting. Abashed by the large surrounding audience, the intern asks to see the patient who called him. Rolling his eyes, the man points him to a hallway, from which someone is signaling to him. The intern goes to meet his first patient.

The psychology intern introduces himself to the patient, who is a short, slender man in his 40s, whose features are marred by two scars extending into his cheeks outward from the corners of his mouth. Trying not to stare at this deformity, the intern obtains a repetition of the complaint with more details, couched in an unmistakable tone of blame for him, the intern. He is impressed by the fact that a violation of rights does, indeed, appear to be taking place. He promises the patient that he will investigate and try to right this wrong. A hurried check with a nurse in the hallway who is hastening to another task confirms the patient's complaint. Becoming annoyed at feeling thrust into the role of persecutor of a patient he has barely started with, he goes in search of the supervising clinician on the ward.

II. LEGAL ISSUES

A. RIGHT TO TREATMENT

One of the most misunderstood of the legal doctrines that have affected psychiatric practice is the idea that psychiatric patients have a *right* to receive treatment. Although the concept has been used in various ways by the activist mental health bar, by the mental health professions, and by patients themselves, the courts' definition of the "right to treatment" is a narrow and somewhat shaky formulation that has been limited in its impact on the mentally ill.

1. Early History of the Doctrine

The idea that treatment is a right of the psychiatrically ill patient first arose as a theoretical construct in the early 1960s. Even in its initial appearance, the nascent right was limited to the involuntarily committed patient; the theory was that the involuntary patient was entitled—as a matter of fairness, given the deprivation of liberty that hospitalization entailed—to receive active treatment and not merely confinement and the barely adequate essential services that many large state facilities provided. The earliest court decision on the issue, *Rouse v. Cameron* in 1966, dealt with a patient who was committed after being found not guilty by reason of insanity, but was receiving no treatment. Although the case was decided on statutory grounds, there were hints in the decision of a constitutional right to treatment.

Not until 1971, in the famed *Wyatt v. Stickney* class-action suit that challenged conditions in the Alabama state hospitals, was the right to treatment enunciated by a court on constitutional grounds. Failure actively to treat involuntary patients was deemed a deprivation of Fourteenth Amendment rights to due process and equal protection because treatment was due the patient as a *quid pro quo* for involuntary detention. It is important to note that this case was decided at the federal district court level and affirmed at the level of the court of appeals, but was never considered by the U.S. Supreme Court.

A case that did reach the nation's highest court was *O'Connor v. Donaldson*. This problematic 1975 decision considered a Florida case with a unique situation: A paranoid schizophrenic Christian Scientist was involuntarily hospitalized for 14 years despite the absence of dangerousness to himself or others, without treatment that he would accept (he refused medication, a fact usually overlooked in discussions of the case), and in the face of offers to care for him from responsible outsiders. He was judged to have been deprived of his right to liberty guaranteed by the Fourteenth Amendment, but the contortions of the court to fit the scope of the decision to specific facts of the case reveal on what uncertain ground the right to treatment rested. The court held that a nondangerous, involuntarily committed patient could not be hospitalized, in the presence of viable alternatives in the community, "without more"—presumably appropriate treatment.

Notwithstanding *Donaldson,* numerous lower courts followed the lead of the *Wyatt* decision, finding a right to treatment for involuntary patients. The *Wyatt* court, in an approach later followed in other jurisdictions, issued a detailed decree implementing its decision, defining minimally acceptable treatment in precise terms, down to the number of square feet of floor space required for each patient and the number of cooks who must be employed in the kitchen.

Yet, as popular as this approach became, it was evident that the courts were having difficulty enforcing these decrees. When legislatures refused to appropriate sufficient funds to pay for the improvements, the courts were confronted with a constitutional crisis. In the end, they had little power to coerce recalcitrant legislatures. Although the early right-to-treatment decisions clearly led to improvements in many state facilities, the limitations of the approach are evident from the subsequent history of *Wyatt.* The court continued to supervise its decree for more than a decade and a half. At no point, however, did Alabama facilities come fully into compliance with the initial judgment.

2. The Consent Decree

In an effort to avoid the adversary posture and heel-dragging by the state that characterized the *Wyatt* litigation, parties to litigation began to turn to consent decrees to resolve right-to-treatment suits. The decrees embody agreements between the two parties, typically the state's department of mental health and a mental health advocacy group, that, without finding fault, specify the conditions to be changed and have the force of law. A master to supervise the administration of the decree can be appointed by the court. Prominent elements of the decree are usually the familiar numerical ratios for staff and facilities, plans for accelerating deinstitutionalization, and the promise of individualized treatment plans. The plaintiffs avoid lengthy litigation and gain the presumed cooperation of the state in implementing agreed-to changes, whereas the state avoids the risk of more sweeping judicially ordered changes, and often gets to maintain administrative control of the system. In principle, then, the consent decree is to everyone's advantage.

But the consent decree, too, proved not to be a panacea. The executive branch of a state government would sign the decree, but its implementation was still dependent on legislative appropriations, and they were not always forthcoming. Despite the hope of a cooperative effort raised by these decrees, many of the more prominent cases are still short of full compliance years after the decrees were issued.

3. **Youngberg** *and the Right to Treatment*

The U.S. Supreme Court finally offered its view of the right to treatment in 1982 in *Youngberg v. Romeo*, a case involving a patient in a Pennsylvania facility for the retarded. Basing the right on patients' constitutional liberty interests, the court ruled that involuntary patients were entitled only to that treatment required to assure freedom from unnecessary restraint and preventable assault. No more. To the extent that these rights conflicted with each other (e.g., to prevent a provocative patient from being assaulted one might have to restrain his or her freedom of movement) or had to be compromised for legitimate therapeutic reasons, patients were only entitled to a decision by a qualified mental health professional that abrogation of their rights was required.

The narrow ruling in *Youngberg* was read by many advocates as the death-knell of the right to treatment. In fact, the right has shown surprising resilience. Three factors have fed continued efforts to expand patients' right to treatment: broad readings of *Youngberg*, state law rights, and the Civil Rights of Institutionalized Persons Act (CRIPA).

a. Broad readings of Youngberg. Lower courts have not found *Youngberg* as restrictive as many supposed they might. After paying obeisance to the Supreme Court's analysis, some lower courts have fashioned orders that look remarkably like the original decree in *Wyatt.* Some courts have also been creative in interpreting the requirement for professional judgments; one federal court, for example, declared that a facility that was unaccredited was presumed not to be making decisions according to accepted professional criteria.

b. State law rights. When revising their mental health laws in the 1970s (a major era of reform), many states inserted broad language vowing to provide appropriate treatment to all mentally ill people. This language has been the basis for a number of lawsuits accusing states of not keeping their promises. Success has been variable. Some courts have agreed that the states imposed enforceable obligations on themselves, even with regard to voluntary patients and outpatients. Other courts have interpreted the statutory language as entirely hortatory and therefore nonenforceable.

State constitutions also provide a potential source of law supporting a right to treatment. Most states have provisions echoing the federal constitutional rights to liberty and due process, but state courts are not bound by U.S. Supreme Court interpretations of the federal constitution when deciding how far state provisions extend. These provisions have been used in other patients' rights contexts (see discussion of the right to refuse treatment, Sec. II-C), and they may yet prove to be an important bulwark of patients' right to treatment.

c. Civil Rights of Institutionalized Persons Act (CRIPA). In 1980, Congress passed the CRIPA. This enabled the Justice Department to investigate conditions in state institutions and bring suit against states found to be violating patients' or inmates' federal rights. Although few cases have reached the courts, a large number of investigations have been conducted, often ending with agreements by the states to improve institutional conditions. In theory, *Youngberg* defines—and limits—patients' rights under the CRIPA, but the consent agreements that have resulted sweep fully as broadly as the *Wyatt* decree, including increases in staffing levels, controls on medication use, physical plant improvements, and more complete record-keeping.

It may be, therefore, that *Youngberg* was read too narrowly by advocates who feared its impact on the right to treatment. The same kinds of conditions required to protect patients' liberty interests, and especially to ensure that professional judgments are made when those interests must be compromised, may turn out not to be different from the conditions envisioned as constitutionally required by the courts before *Youngberg.*

4. What the Right to Treatment Is Not

Judicial activism on behalf of psychiatric patients has led many well-meaning individuals to misconstrue the impact of the phrase "right to treatment." The right is not a guarantee of treatment for all patients, optimal treatment, effective treatment, or one's choice of treatments.

a. A guarantee of treatment for all patients. Although state laws may provide otherwise, a judicial extension of the constitutional right to treatment to voluntary patients or to outpatients has never occurred. It applies only to involuntarily committed patients. For other classes of patients, states are free to decide whether they want to provide any services at all and can limit or expand them at their own discretion.

b. A guarantee of optimal treatment. Even courts that have chosen to set highly specific criteria for institutions have emphasized that they are concerned with achieving minimal, constitutionally required standards, rather than with requiring the best possible program.

c. A guarantee of effective treatment. The courts can require that professional staff be hired, but they cannot monitor their work so closely as to ensure that all patients receive the care that would be most efficacious in their situation. They can establish the preconditions for treatment but cannot guarantee that adequate treatment occurs. Similarly, courts are powerless in the face of conditions for which effective treatments do not yet exist (e.g., senile dementia). Other court actions establishing a right to refuse treatment may impact the effectiveness of the right-to-treatment rulings (see Sec. II-C).

d. A guarantee of one's choice of treatments. Hospitals have not yet been required to provide a sufficient array of treatments that patients can decide which to select or refuse. Provision of a single accepted mode of treatment for each patient would seem to be adequate.

5. Future of the Right to Treatment

For all the problems in implementing a right to treatment, there is no question that patients in many state facilities around the country are much better off today than they would have been without the court decisions and consent decrees based on that right. Even when imposed or agreed-on standards have not been met in their entirety, substantial improvements usually have taken place. Those people who recognize that half of a loaf can, indeed, be better than none can perceive the importance of litigation regarding this right. The right to treatment has been, in addition, one of the few areas of mental health litigation in which clinicians and members of the mental health bar generally have been on the same side of the issue. The desire to improve hospital conditions unites almost everyone in the field.

Nonetheless, it is clear that certain costs are attached to this process. When right-to-treatment suits focus on only one part of a mental health system, they can force reallocation of limited funds in a fashion detrimental to those patients not among the class members covered by the suit. Judicial intervention into functions of the executive and legislative branches of government—including administration and funding of the mental health system—distorts the separation of powers that lies at the core of the U.S. system of government. Many constitutional scholars are profoundly concerned with unelected judges imposing on elected representatives their views of how public monies should be spent.

The right to treatment, however, albeit in a stunted form, has achieved some security in legal doctrine. If elected legislatures do not provide for the basic care and treatment needs of committed patients, unelected judges will continue to force some redistribution of funds to help this group. A decision of the U.S. Supreme Court (*Missouri v. Jenkins*) suggested that the courts' powers in this regard may be greater than previously assumed, perhaps extending to the actual imposition of taxes to raise funds needed to remedy constitutional deficiencies.

However, a paradox must be acknowledged as well. Even as the right to treatment—on some basis or other—has become more generally accepted, changes in the mental health system have diminished the impact it might have. As a legal weapon, it has been targeted primarily at state hospitals with long-stay populations. But the number of such facilities continues to diminish, and the patients who were housed are now often cared for in community residences. When rehospitalized, as many of these patients will be from time to time, they are more likely today to be admitted to private facilities for relatively short stays. This may have been one of the major goals of the original proponents of a right to treatment. Achieving this goal, however, owes more to changes in the financing of mental health care than to the doctrine itself.

B. OTHER RIGHTS OF HOSPITALIZED PATIENTS

1. Right to the Least Restrictive Alternative

The U.S. Court of Appeals for the District of Columbia, the source of many noteworthy decisions in mental health law under the stewardship of Chief Judge David Bazelon, first applied the concept of the least restrictive alternative (LRA; sometimes called *least drastic alternative*) to the psychiatric patient. In *Lake v. Cameron* in 1966, Judge Bazelon ruled that an individual could not be committed involuntarily to a psychiatric hospital if an alternative could be found that infringed to a lesser degree on her constitutional rights to liberty. The concept was picked up by other courts and appeared in such major cases as *Lessard v. Schmidt* (1972), an early case addressing mental patients' procedural rights in civil commitment. Since then, the doctrine has become a commonplace in mental health litigation, and a feature of most right-to-treatment decisions, consent decrees, and most state statutes.

a. Least restrictive alternative in theory. LRA began not as a rule designed specifically to answer the needs of psychiatric patients, but in a far-removed context. Its first use in an individual rights case, in *Shelton v. Tucker* (1960), was for the purpose of placing a limitation on the extent of the exercise of state powers, in this case striking down a law requiring Arkansas schoolteachers to reveal their membership in all outside organizations. From its birth, it was a doctrine that demanded that the state justify its activity on a linear scale. A lesser degree of state action to accomplish an end was less restrictive than, and therefore preferred to, a greater degree of action: "Even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved" (*Shelton v. Tucker*). Furthermore, and quite logically in the context, the action of the state was assumed to be the sole cause of the resulting restriction of liberty.

b. Least restrictive alternative in practice. The concept of LRA in mental health care has often been rigidly applied. A hierarchy of alternatives has been established using the model of more governmental action equaling more restrictions, independent of consideration of the individual patient's needs, and the patient has then been slotted into the least restrictive of those options. Hospitalization is considered ipso facto the most restrictive alternative and is therefore the least favored. Partial hospitalization is given preference over full hospitalization and outpatient treatment even more so. In fact, if all services can be rendered in a social service setting (e.g., a vocational rehabilitation program) without any psychiatric input at all, that is sometimes considered better still. What has stopped this practice from making as much of an impact on mental health care in America as its advocates favor has been the limitations in most states of realistic alternatives of any sort to the inpatient unit. Although the goal of many right-to-treatment class-action suits has been to compel the states to provide such alternatives, funding has been hard to generate, and changes have developed slowly.

c. New approaches to implementing the least restrictive alternative. A decision of the U.S. Supreme Court holds some potential for reinvigorating the doctrine of LRA. Although the court declined to find a constitutional basis for the LRA in *Youngberg v. Romeo* in 1982, the court's 1999 decision in *L.C. v. Olmstead* pointed to a new basis for patients' rights to the LRA. Regulations implementing the Americans with Disabilities Act (ADA) require that "[a] public entity shall administer services, programs and activities *in the most integrated setting appropriate to the needs of qualified individuals with disabilities*" (emphasis added). Two Georgia state hospital patients challenged, as a violation of the ADA, the extension of their hospitalizations because of the absence of community facilities to which they could be discharged. Once more, advocates were looking for a means to compel state legislatures to turn on the tap of funding for mental health services.

The decision in *Olmstead* gave them a half-victory. Essentially upholding the lower courts' decisions in the case, the Supreme Court ruled that "unjustified institutional isolation of persons with disabilities is a form of discrimination" that is forbidden by the ADA. However, it also held that states could not be compelled to provide funding for community residences if that would force a "fundamental alteration" in their mental health care systems. The justices continue to be reluctant to allow courts to force legislatures to reshape their spending priorities. Despite a good deal of litigation in the lower courts based on *Olmstead*, at this point it is unclear how narrowly the "fundamental alteration" language will be read, and a diversity of lower court opinions on this issue is likely. Nonetheless, before a sympathetic judge, *Olmstead* offers another approach to obtaining less restrictive conditions and increased services for institutionalized populations. This approach to LRA is particularly interesting because it does not rely on constitutional doctrine and is applicable to voluntary patients (as were the plaintiffs in the Georgia case) as well as involuntary patients.

2. Rights in the Hospital

a. Historical perspective. To understand why hospitalized psychiatric patients are often in the position of arguing for the right to do things that other members of society take for granted as their inalienable due, one should recall the theory that prompted the founding of the first major state psychiatric hospitals in the second quarter of the nineteenth century. Mental illness at that time was thought to be caused by the pressures and stresses of chaotic urban life, seen as an unstructured melange of sensation, which impacted with particular force on those with "hereditary defects of the mind." It was from this tumult and disorder that the first patients sought asylum in the new hospitals being built out in the peaceful countryside. The asylum, with its rigid routine and invariant schedule, was thought to exert its therapeutic effect by reestablishing a basic, health-promoting order within the individual. For this to be effective, the patient not only had to submit to the daily regimentation, but also to face isolation from the world he had left behind. At the beginning, therefore, the psychiatric patient in this country surrendered, usually involuntarily, the rights of association, speech, and privacy that others in the community took for granted.

Long after the theory had withered and died, in fact well into the middle of the twentieth century, most patients remained bereft of their basic rights. Ideological fervor had given way to complacent torpor: In the understaffed and crowded caverns of the state systems of the late 1800s through the 1950s, it was easier to manage a regimented, tightly controlled mass of patients than to attempt to encourage individualistic exercise of basic rights and liberties.

b. Transitional period. This situation began changing in the late 1960s when, in the light of the victories of the black civil rights movement, activist lawyers turned their attention to other minority groups, mental patients among them. By means of court decisions (mostly notably *Wyatt v. Stickney*), consent decrees, new state statutes, and departmental regulations, the legal status of psychiatric patients has been normalized. At the same time, some limitations on their rights remain, in part because of a different set of considerations. The nature of psychiatric illness and of its treatment, at least as conceptualized today, continues to require some restriction of patient's rights, for their own protection and that of others. It is hoped that at the end of this transitional period a new and fairer balance will have been struck, one that leans toward granting patients the free exercise of their rights, except in the presence of compelling reasons for withholding them.

c. Specific rights

i. Visitation. Visits from relatives and friends, symbols of the environment outside the asylum walls, were anathema to the advocates of moral treatment who built the early asylums. Since then, the emphasis on maintaining the patient's ties with the community and on effecting rapid discharge and reintegration with life outside has grown, with most facilities encouraging visits. Therapists, in fact, often attempt to resolve family and personal issues that hinder such relationships.

Occasionally, however, visits can be suspended for "cause": for a period shortly after admission while the patient is acclimating to the hospital and the initial evaluation is being performed; during periods of extreme psychosis or agitation; and when the previous visits of a given individual have been counterproductive (e.g., ending in a fistfight) or have led to untoward consequences (e.g., a suicide attempt after a meeting with an estranged spouse). In addition, visitors who disrupt the care of other patients on the ward by selling drugs, stealing valuables, or starting fights can be legitimately restricted from visitation. Similarly, visiting hours can be limited to particular times of the day that do not interfere with ward routine or activities.

State laws often specify that certain individuals have a right of free access without limitation. These include lawyers, clergy, and private or consulting physicians. Even then, though, the patient's clinical needs come first. If a visit is truly contraindicated, as with a wildly excited manic patient, the clinician's obligation is to protect the patient from the stimulation that the visit would cause. Although the patient's visitor always has the right to seek a court order mandating his admission, in most cases a careful discussion of the matter leads to mutual agreement on what constitutes the patient's best interest.

Additional problematic issues are raised by other sorts of visitors. Does a hospital administration have the right to bar members of a "patients' liberation group" from organizing on an inpatient service? What if they are advocating that all patients refuse to cooperate with their care plans and refuse medications? Does a patient have a right to invite a reporter to visit him on the ward? Should an older man who makes advances on younger women after they are discharged be banned from visiting?

No easy answers exist. In general, and absent a statute to the contrary, the goal of regulation of visits should be to protect the patients' best interests, particularly their health, but also their privacy. Regrettably, this may sometimes interfere with First Amendment rights, but the protection of those rights lies in the hands of the courts. The clinician should protect her patients first.

ii. Communication. The right to free and open communication with those outside the asylum should be unaffected by hospitalization. Some hospitals, however, continue to monitor and restrict their patients' communications, whether letters or telephone calls. They justify this practice by citing the need to protect the outside world from potentially harmful contact—whether of a threatening, offensive, or prurient nature—with the patients. Clearly, instances exist in which communications of this sort occur, as well as others in which the patient places herself at risk by ill-considered, provocative, or foolish messages. Yet a blanket prohibition of all communication, or even uniform censorship, seems too broad a net to cast to trap the few errant missives worthy of suppression. Hospitals that have taken the opposite approach, namely permitting unfiltered communication except when protection of the patient or of others seems indubitably to require curtailment of the privilege, have found little reason to regret the more liberal stance.

Some state statutes grant explicit permission to the hospital administration to censor communications. In other states the power rests on the need to act in the patient's best interests or to protect third parties. Conversely, many states mandate unlimited free communication with certain classes of individuals, often including lawyers, government officials, and members of the clergy. Even in the absence of such a provision, a maximal effort should be made to foster free and private communication between a patient and his lawyer, if the patient's clinical state at all permits it.

iii. Privacy. *Privacy* means many things to many people. Implicit in the treatment of any illness in a hospital (even a general hospital) is the sacrifice of much of what is personal and private about one's daily life. It is coming to be increasingly accepted, however, that effective treatment is not incompatible with many seemingly small measures that together help to protect the patient's sense of uniqueness and inviolability. Patients' bills of rights, many of the right-to-treatment suits, and the more enlightened regulations require such steps as permitting patients to retain personal possessions and providing a secure locker for them, furnishing private toilet and shower facilities, allowing a minimum number of square feet of floor space for each patient, and similar measures.

Privacy also means protecting the confidentiality of patients, including not talking about patient matters within earshot of other patients or nonprofessional staff and restricting access to patients' records to authorized personnel who have a need for it, both reinforced by the regulations elaborating the requirements of HIPAA (see Chapter 1).

The most famous case concerning privacy in a state facility arose in the context of Frederick Wiseman's filming of *Titicut Follies* at the old Bridgewater State Hospital for the Criminally Insane in Massachusetts. Wiseman's film, a severe indictment of conditions at the hospital, was banned from public display in Massachusetts on the grounds that it invaded the privacy of those patients who were portrayed in it. Needless to say, the ban also protected the public officials who were responsible for conditions at Bridgewater from facing the wrath of an informed public. The case illustrates the often delicate trade-offs between various rights—in this instance, the right to privacy posed against freedom of speech and the right of the public to know—that occur in this complicated area.

iv. Rights to protection from harm. Among the few treatment-related rights that the U.S. Supreme Court has been willing to recognize is the right of committed patients to be free from physical assault. Patients' bills of rights in many states extend this right to all patients. Implementing the right to freedom from harm requires attention to those patients who may be violent toward others and to appropriate intervention, including medication, space restriction, and seclusion or restraint, when necessary. Insofar as the common law recognizes a similar right as a component of the standard of care for hospitalized patients, not protecting patients appropriately can lead to actions for malpractice.

It is not only other patients who may potentially inflict injury; staff members can be abusive as well. Patients are entitled to be protected from staff abuse by careful screening of employees and appropriate supervision. Complaint mechanisms with adequate means for investigation are also necessary. Particular attention should be given to staff members who work on night and weekend shifts with little supervision. Often, training and support of these staff members, who can feel neglected by the institution, can prevent abuse from occurring.

v. Rights to freedom of movement. Along with the right to be free of harm, the U.S. Supreme Court found a constitutional liberty interest in freedom of movement. As the justices interpreted this right, movement within the hospital cannot be arbitrarily restricted (e.g., the use of patient seclusion and restraint for the convenience of the hospital staff), but limitations must relate to legitimate therapeutic needs.

Furthermore, state restrictions on the use of seclusion and restraint are rigorous. Many states recognize the prevention of harm to the patient or others as the sole legitimate basis for seclusion or restraint. Possible therapeutic uses (e.g., limiting stimulation of disorganized patients) are no longer considered acceptable in many jurisdictions. In some ways, this is in keeping with the tendency to view hospitalization as a means of preventing physical harm, rather than as a means of treating mental illness.

Also, procedural requirements attending the use of seclusion and restraint vary from state to state and include constant observation or frequent checks of the patient, thorough documentation, periodic examinations by a physician while the patient remains secluded or restrained, and periodic time-outs that allow the patient to use toilet facilities and stretch her limbs. Not observing these requirements can result in civil penalties or licensure revocation for facilities, and the possibility of administrative sanctions or lawsuits against clinicians.

Although states have been the traditional regulators of seclusion and restraint, the federal government has now moved into this area. Prompted by concerns about continuing abuses in psychiatric hospitals, the Department of Health and Human Services has issued regulations governing the use of seclusion and restraint. Along with the rules promulgated by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), these regulations have the effect of making approaches to seclusion and restraint a good deal more uniform across the country.

vi. Economic rights. As it has become more generally accepted that the disabling effects of mental illness are often quite specific in their impact, frequently leaving large areas of a patient's functional capacity unimpaired, there has been an increasing tendency to permit psychiatric patients to manage their own financial and often even personal (e.g., marriage, divorce, child custody) affairs. Almost all facilities allow patients to hold and spend small amounts of money, and many jurisdictions require, absent a finding of incompetence, that patients be given the opportunity to handle important financial matters even while hospitalized. No states follow the old practice of equating commitment with incompetence to manage one's affairs.

On the other hand, instances occur in which the restriction of the right to spend money is in the patient's best interest and in which not enforcing such a restriction places the clinician at risk of being found negligent. A patient who is not capable of rationally dealing with her assets, even if she is not officially declared incompetent by the court (e.g., a manic patient who, if permitted, would spend her family's savings on frivolities) might later have a legitimate cause of action against any caretaker who permitted such profligacy to occur. Ideally, a determination should be made soon after admission as to the patient's ability to manage her financial affairs. Guardians, conservators, or representative payees, as appropriate, should be sought to act on the patient's behalf (see Chapter 5). Nevertheless, in those circumstances (and they are frequent) in which such individuals are unavailable, or in which the incapacity is likely to be of sufficiently short duration that such appointment of proxies would not be useful, the inpatient clinician must continue to intervene to protect the patient's needs. Although abuse of this discretion is always possible, the patient's ultimate right of appeal to the courts, combined with a healthy bias in favor of the patient managing her affairs whenever possible, should minimize this problem.

vii. Right to be paid for work. A good example of the difficulties that arise in mixing a *rights* model with a *therapeutic* model is the muddled state of the law concerning patients who perform work in the public hospital. Work was a cornerstone of nineteenth-century moral treatment. State hospitals were deliberately located in the countryside, with ample farmland surrounding them, to give patients an opportunity to perform therapeutic labor. Over time, however, the therapeutic nature of the labor became obscured by the need of the underfunded hospital to use patient labor to stay within its budget. Patients were often required to work for reasons that had little to do with treatment.

In reaction to this abuse, some courts have ruled that this uncompensated labor violates the Thirteenth Amendment's ban against involuntary servitude. Other courts have applied the Fair Labor Standards Act to require that work be compensated at minimum wage levels and that overtime provisions be applied. The only exceptions allowed are for patients who are rated as proportionately less productive than nonhandicapped workers. The result of these two lines of decisions has been to require that work assignments be "voluntary," that patients usually be paid for their work at market rates, or, in some cases, that unpaid work be limited to "therapeutic" labor (i.e., tasks not required for the maintenance of the hospital). Difficult as it is to distinguish between therapy and slavery when it comes to washing floors or folding linen, it is even more difficult to persuade tight-fisted state legislators to appropriate funds to pay patients who usually are receiving free treatment in a state facility.

Thus, the result of seeking a legal remedy for an admitted and shameful abuse is the threat of depriving all patients of the benefits of a chance to work. The benefits of work include a boost to self-esteem, the ego-integrative effects of applying oneself to a task, the improvement of attention span, a relief from the monotony of life in many hospitals, preparation for post-discharge employment, and the real improvements in the milieu that can be made by patient labor.

On therapeutic grounds alone, one would favor paying patients for the work they do. But until the legislatures agree, there appears to be no good solution to the problem. Work programs have ground to a halt.

viii. Civil rights officer. The debate over the right to be paid for labor demonstrates how problematic the appealing notion of patients' rights may be in practice; doing away with all rights and returning to the snakepit days when our hospitals were "the shame of the states" is hardly the solution. Rather, a method should be found for settling disputes over patients' rights short of recourse to the courts. A potentially effective means for maximizing patients' rights and minimizing disruption of the hospital's therapeutic functions is the appointment of a civil rights officer (CRO).

Mandated by statute or regulation in some areas, the office of CRO provides an ombudsperson for patients when concerns about their rights arise. The position should be filled by someone who is familiar with patients' needs and with ways of getting things done in the hospital bureaucracy, but someone who is outside the direct line of responsibility for patient care. The CRO should be available to patients to answer their questions about the extent of their rights and to help find a solution for problems that arise. The CRO is not responsible for resolving disputes, but for bringing problems to the attention of the appropriate officials and for aiding patients in presenting their complaints. Although the CRO is often able to settle issues raised by patients by exploration or mediation, there are times when the most appropriate step is to refer patients to outside legal assistance. To avoid conflicts of interest, the CRO should not serve in a similar advisory role to staff members; they should be able to obtain assistance with legal issues from their own consultant.

ix. Protection and advocacy services. Despite growing attention by psychiatric facilities to patients' rights, and the proliferation of internal means (e.g., CROs) to protect patients, a belief exists among mental health advocates that widespread abuses still occur. This belief led states to establish—and Congress to require—protection and advocacy services (known as P&As) for mentally ill patients.

P&As, usually staffed by attorneys and paralegals, operate independently of the mental health system. Although models differ from state to state, P&As usually station representatives at major psychiatric facilities, where they inform patients of their rights and solicit complaints. Efforts may be made to resolve complaints through negotiation with the facility, often through the CRO. If no resolution is made, P&As have the capacity to file suit against individuals, private facilities, and the state. Congress has appropriated some funding for P&As in each state, with additional money coming from state budgets. P&As can be awarded attorneys' fees by the courts at the conclusion of many types of successful litigation.

The P&A model was introduced into the mental health system from the mental retardation system, where it has functioned for much longer. Its efficacy is disputed. Advocates point to the need for some external check on the authority of administrators and clinicians in facilities where they would otherwise have unchallenged power to control every aspect of patients' lives. Opponents argue that in a situation of limited funding, a chronic characteristic of the mental health system, P&As distort the allocation process by forcing resources to be devoted disproportionately to the problems they target for attention. Some clinicians believe that P&As were created as a substitute for adequate funding of mental health programs. Little question also exists that hospital staff, already operating under considerable stress, views the presence of P&A attorneys, and the implicit threat of a lawsuit that they carry in their negotiating arsenal, as an additional unpleasant aspect of their job. Nonetheless, trends suggest that P&As are permanent additions to the mental health landscape. (See Chap. 7, Secs. II-A-4 and II-B-1-d-ii for further discussion of the relationship between clinicians and P&As.)

C. RIGHT TO REFUSE TREATMENT

As part of the more general movement to afford mental patients the rights enjoyed by other members of society, a good deal of attention has been given to their right to refuse psychiatric treatment. This right has been recognized in various forms in a large number of court decisions, and some right of refusal is granted by many state statutes or regulations.

1. History of the Right to Refuse Treatment

In principle, voluntary inpatients have always had the right to refuse treatment they did not desire, if in no other way than by leaving the facility. The situation for involuntary patients, however, was rather different. Because commitment was based on their need for treatment (see Chap. 2, Sec. II-D-1), it was presumed that the procedures required to detain them were also sufficient to allow them to be treated against their will. In this context, the right to refuse treatment was not even imagined.

When commitment statutes changed to emphasize dangerousness criteria, however, the question was raised as to where the state derived its power to treat over patients' objections. If preventing dangerous behavior was the goal, and that could be accomplished by detaining the patient under supervision, it was argued that the state had no compelling interest in overriding the refusals of unwilling patients. Furthermore, it was maintained, patients had substantial interests in having their refusals honored. These interests derived from common law rights to control what was done to their bodies and constitutional rights to privacy, liberty, equal protection, and due process.

Early cases, in the 1960s and 1970s, focused on patients' right to refuse treatments that were thought to be exceptionally intrusive (e.g., aversive therapy with drugs that induce nausea or paralyze respirations, psychosurgery, or electroconvulsive therapy). Beginning in the late 1970s, more than a score of courts extended this analysis, granting some version of a right to refuse treatment with antipsychotic medications. These decisions are often premised on a distorted view of the risk-to-benefit balance of these drugs, but the legal rationale derives from the idea that mental patients do not lose the right to decide what should befall them merely because of involuntary commitment.

2. Current Approaches

Although the right to refuse treatment with antipsychotic medication is often thought to be a unitary concept, courts and legislatures have defined the right differently across jurisdictions. Two broad approaches (treatment-driven models and rights-driven models) have been followed, with several variations of each.

a. Treatment-driven models. Jurisdictions adopting this approach have tended to recognize patients' interests in limiting inappropriate medication but not in refusing indicated treatment. Thus, when patients object to treatment, the objection must be reviewed by either the treating physician (a minimalist approach) or an independent consultant. If the recommended treatment is found to be appropriate, it is permitted to proceed. One might characterize this model as endorsing a right to object to treatment but not a right to refuse it.

Federal courts have tended to favor this approach. At this writing, the U.S. Supreme Court has not decided the contours of a federal constitutional right to refuse treatment in civil facilities, but it has given some hints of its views. Unfortunately, those hints are not all consistent. In the 1980s, the court remanded one of the cases that reached it on this issue (*Rennie v. Klein*), indicating to the lower court that it should reconsider its decision in light of *Youngberg v. Romeo* (see Sec. II-A-3). *Youngberg* had noted that patients' rights could be limited in the interests of treatment as long as a professional judgment was made by qualified personnel in this regard. This action of the Supreme Court seemed to suggest that it favored a similar approach here. Many federal courts (and a few state courts) have operated under that assumption, endorsing treatment-driven models.

Subsequently, the U.S. Supreme Court took a similar approach in a case involving the right of prisoners to refuse treatment (*Washington v. Harper*). It held that, although prisoners had a constitutionally protected interest in being free of unwanted treatment, Washington state's procedures for reviewing prisoners' objections to treatment, which included review by a three-person clinical and administrative panel, with rights to present evidence, to have lay representation, to appeal, and to regular review, were sufficient to vindicate prisoners' rights. Substantively, if a prisoner met the state's commitment criteria, and treatment was in his interests, the medication could be administered. It is unclear to what extent the Supreme Court was carving out a special exception for prisons—to whose needs it has always been deferential—or whether it would endorse an approach of this sort in a civil setting, as suggested by some of the analysis in the opinion.

Further hints of where the Supreme Court might stand if a civil right to refuse treatment case ever reached its docket came in 2003, when the justices decided *Sell v. U.S.* The case raised the question of whether a defendant who was incompetent to stand trial could be treated against his will to restore trial competence. Justice Breyer, writing for the majority, reiterated *Washington v. Harper*'s holding that there is a constitutionally meaningful interest in avoiding unwanted treatment, but suggested that sufficiently potent state interests could override a person's refusal. However, whether civil commitment *per se* creates enough of an interest for the state—the ultimate question in the debate over the right to refuse treatment—remains unanswered.

For advocates of a right to refuse treatment, however, the treatment-driven model misses the point. Although it may improve the quality of care, it does nothing to ensure that patients have the right to determine whether they will receive medication in the first place. They argue for an entirely different, rights-driven approach.

b. Rights-driven models. The rights-driven model views a patient's rights to determine whether she is treated as the primary concern. Those rights may be based on the federal constitution, despite the U.S. Supreme Court's *Youngberg* decision, but increasingly they are not. State courts, which have taken the lead in adopting rights-driven models, often base their decisions on common law rights to control what happens to one's body, state statutory law, or state constitutions. This renders their decisions nonreviewable by federal courts, allowing them to extend patients' right to refuse treatment well beyond what the U.S. Supreme Court is willing to recognize as required by the federal constitution.

The key to the rights-driven approach is to minimize the differences between the rights of involuntarily committed patients and other persons. Because noncommitted persons cannot be treated against their will unless they have been found to be incompetent to make decisions for themselves, rights-driven models incorporate a similar determination for committed patients. Some variation is evident, however, in the identity of the decision-maker and the degree of procedural protections afforded.

The simplest of the rights-driven models calls for an independent evaluator or panel to assess the refusing patient's competence, along with the need for treatment. If found to be incompetent, and if the suggested treatment is deemed appropriate, the patient can be treated over his objections. Although this model has the virtue of avoiding lengthy court proceedings, that is precisely the aspect that concerns many patients' rights advocates. Those who argue against this approach contend that it continues to grant a lower level of protection to committed mentally ill persons than that afforded to others, who would have their incompetence determined by a judge. On the other hand, clinicians are concerned that this model allows some committed patients to refuse treatment, putting clinicians in the position of being responsible for the care of patients whom they cannot treat effectively.

A proposal that would respond to these problems would limit involuntary commitment to patients who are found by a judge to be incompetent to make decisions about treatment (see Chap. 2, Sec. II-F-1-a). This would grant patients the right to a judicial determination of incompetence, while eliminating the possibility that committed patients could refuse appropriate medication. A small number of states have adopted this model for some or all committed patients; after commitment, physicians are allowed to prescribe for patients those medications they believe are needed. Decision-making power might, of course, be conferred on other parties (e.g., family members, a guardian, or even a judge).

The most popular of the rights-driven models, though, does not restrict the scope of civil commitment in this way. If a committed patient refuses treatment, she is subject to a court hearing on her competence. If found competent, her refusal stands. If found incompetent, the court makes a decision as to whether treatment should be permitted. Some courts ground this determination in their view of whether treatment is in the patient's best interests. Other courts rely on their perception of what the patient would have wanted if she were competent to make a decision—the so-called substituted judgment approach (see Chap. 5, Sec. II-D).

3. Statutory and Regulatory Approaches

As in so many other areas of patients' rights, it has been the courts that have taken the lead in fashioning the right to refuse treatment with medication. But almost all of the states have responded with statutes or regulations that echo one of the models described in the previous sections. Generally, states attempt to adhere to treatment-driven models unless compelled by the courts to adopt a rights-driven approach. They have been fairly creative in establishing procedures for review of refusals, including interdisciplinary panels and multilayered review, beginning in the facility and then moving to regional or state administrative levels. Challenges to some of these procedures, however, have led to a number of court decisions imposing a judicially-run, rights-driven model.

4. Emergencies

Court decisions have acknowledged the traditional prerogative of clinicians to take whatever steps are necessary to deal with emergencies, including the use of seclusion, restraint, and involuntary medication. The term *emergency*, however, has tended to be rather narrowly interpreted. Some courts, for example, reject a clinical definition of emergency that encompasses certain criteria, such as severe pain on the part of the patient and the likelihood of rapid deterioration, in favor of a narrower, more legalistic definition limited to the occurrence or threat of significant bodily injury to the patient or others, or the likelihood of irreversible deterioration. Within the narrower scope, medication is permitted, but only to the extent necessary to control the emergent situation. That is, if a single injection of a neuroleptic is sufficient to sedate or to diminish the frightening hallucinations of an assaultive patient, further treatment is not permitted, even though the patient remains psychotic, and the long-term risk of recurrence is present. This is consistent with a nonclinical view of the use of medication as a means of controlling behavior rather than as a treatment for illness; this view is analogous to defining dangerousness rather than need for treatment as the sole criterion for involuntary commitment.

Even with these tight criteria, the point at which an emergency begins and involuntary treatment may be initiated is often an uncertain one and requires a large amount of clinical discretion. For example, a patient who is refusing food and fluids will, at some point, become an emergency case; careful electrolyte or blood pressure monitoring may be necessary to satisfy a court that this point has been reached. The medical conservatism that may result from such legalistic criteria may place the patient at significant risk. On the other hand, a repetitively assaultive patient with a regular pattern of building up to an assault (such as cursing loudly at hallucinatory images) need not be allowed to strike someone, even under the strictest definitions of emergency, before medication may be administered. Many facilities will undoubtedly continue to use more clinically oriented definitions of emergency. In the absence of statutes or court rulings to the contrary, this is acceptable.

Clinicians acting in good faith and in their patients' best interests are unlikely to be held personally liable in such a situation.

5. Liability Resulting from Noncompliance with Rules on Patients' Right to Refuse Treatment

Three general categories exist in which liability could accrue for nonconsensual treatment in violation of legal rules in a given jurisdiction: battery, malpractice, and civil rights violations.

a. Battery. A criminal charge of battery (performing an unconsented touching) along with the related charge of assault (inducing the apprehension that a battery will be committed) are possible consequences of involuntary medication practices. Along with the criminal charge, a civil suit for damages resulting from the alleged battery can also be filed. Courts, however, are usually reluctant to introduce criminal issues into the hospital setting, where unconsented touchings are a routine part of daily work with the severely ill. The availability of other remedies, considered below, contributes to this reluctance, as does the general trend of considering issues of consent as an element of malpractice, rather than as battery. Nonetheless, such a criminal or civil action remains a possibility, particularly when circumstances suggest that medications were administered for purposes other than treatment.

b. Malpractice. The usual benchmark for judging malpractice liability is a failure to conform to the standard of practice of the profession (see Chap. 4, Sec. II-A-1-b). Thus, as nonconsensual treatment becomes less common, the practitioner who administers medication against his patient's desires places himself at increasing risk. This assumes, of course, that such action is not sanctioned by state statute or regulation. The doctrine of informed consent (see Chap. 4, Sec. II-B) has been sufficiently elaborated in nonpsychiatric medical cases to provide ample precedent for suits against mental health clinicians claiming a failure to obtain informed consent. An additional caveat is warranted: The usual standard of liability, the extent of deviation from accepted practice, can be rejected by the court if it believes that the standard of the profession itself is improper. It was through just such means that malpractice suits over informed consent became prevalent in a medical community that had generally paid little heed to such formalities. Precedents in other jurisdictions are important barometers for judging how acceptable even a widely followed standard of care is likely to be to a court. Some decisions certainly point in the direction of decreasing acceptability of involuntary medication. The old practice of obtaining the consent of next-of-kin in place of the patient's consent is similarly falling into disfavor. Rather, except in emergencies, the substituted consent of a statutorily or judicially authorized decision-maker is preferred.

c. Civil rights violations. Section 1983 of Title 42 of the U.S. Code provides that anyone who, acting under color of state law, deprives an individual of his or her federal civil rights is liable for suit for damages resulting from his or her acts (see Chap. 4, Sec. II-D-5). Such suits are targeted at employees of a state system or its functional equivalent. The crucial element is the definition of involuntary medication as a deprivation of civil rights. The same court that decides a right has been violated will be the one to determine that damages are due. Most malpractice insurance policies, incidentally, cover neither the expenses of contesting such a suit nor the monetary damages that may result.

6. Effects of Patients' Right to Refuse Treatment

A large number of studies have been published evaluating the effects of rules allowing patients to refuse treatment with medication. When the initial judicial opinions on the matter began to appear in the late 1970s, many clinicians expressed fears that inpatient facilities, particularly in the public sector, would be swept by epidemics of refusal, rendering efforts to treat the mentally ill completely unavailing. That has not been the result. Studies demonstrate that, when refusal is permitted, approximately 10% of patients refuse medication for at least one day at some point during their hospitalization. These numbers vary according to type of facility (forensic facilities have higher refusal rates) and other factors. Although this represents a sizable number of patients, it is not the epidemic that was feared.

The few studies that have followed patients from the point of refusal (rather than identifying them when efforts are made to override their objections) indicate that the majority of refusers reaccept medication voluntarily within one week of refusal. This speaks to the importance of the negotiation process between clinician and patient, rather than the legal system, as the primary means of resolving refusals (see Sec. III-D). Only a minority of refusals result in recourse to formal review, and most studies suggest that almost all of those patients ultimately are treated. This is true regardless of the review mechanism, although ironically judges appear to approve a higher percentage of treatment requests (90% to 100%) than independent clinical reviewers or in-house committees. One study found that approximately one-fifth of refusals resulted in a permanent discontinuation of antipsychotic medication, but in none of these cases did clinicians believe that medication was essential to the patient's care.

The outcome of treatment refusals thus appears to be rather benign, but the costs of the process are extensive. Judicial review, in particular, results in lengthy delays (up to several months) before hearings and costly investment of clinical and legal time. In the meantime, patients who refuse treatment are significantly more likely to commit assaults and require seclusion than nonrefusers, and are rated as highly disruptive to the therapeutic milieu. Independent, nonjudicial review is much faster and less costly but is losing popularity in the courts.

Little research has been done into the efficacy of involuntary treatment. Comparisons of voluntary and involuntary patients show similar rates of improvement at the end of hospitalization, but most involuntary patients take medications willingly, once hospitalized. Reports of refusers treated against their will with medication suggest that many of them improve; this is confirmed by clinical experience. What remains unknown is the long-term effect of involuntary treatment. Do patients treated without their consent improve while in the hospital only to stop medications and relapse once released? Are they then less willing to seek voluntary hospitalization because of their previous experiences? These are important areas for careful empirical investigation.

7. Future of the Right to Refuse Treatment

Granting involuntarily committed patients a right to refuse treatment with medication—the major modality for restoring many patients' mental health—poses something of a dilemma for the mental health system. If the justification for involuntary commitment is derived solely from the state's police powers and is limited to the prevention of harm to others and to the patient herself, then perhaps allowing committed patients to refuse treatment makes some sense. As suggested earlier (see Chap. 2, Sec. II-D-2-c), however, it is difficult to justify involuntary commitment solely on a police powers' basis. The only discernible rationale for allowing detention of the mentally ill when similar interventions cannot be undertaken with the non–mentally ill is the *parens patriae* rationale that they will benefit from treatment. To permit committed patients to refuse treatment, with the implicit consequence of indefinite detention, is inconsistent with the underlying purpose of the civil commitment system. Furthermore, given that indefinite detention is probably a more severe deprivation of liberty than is time-limited treatment with a medication that restores the patient's ability to cope, if the state has the power to impose the former, it almost certainly has the right to impose the latter, too.

This argument, though occasionally recognized by the courts, has been largely neglected in the flight from acknowledgment of *parens patriae* rationales for commitment. But the commonsense idea that, in the words of one court, "[n]onconsensual treatment is what involuntary commitment is all about," makes its way to the surface through more indirect channels. Decision-makers who are asked to rule on whether refusing patients should be treated allow treatment in the majority of cases. This reflects the belief that it makes no sense to commit patients because they are mentally ill and then allow them to refuse the only treatment that provides a hope of returning to the community.

Where does the right to refuse treatment go from here? With the tendency of state courts to adopt rights-driven models of resolving objections to treatment, a fairly strict version of the right is likely to remain in many jurisdictions for some time. But it is probable that decision-makers in those states will limit the impact of the right by allowing treatment of refusers in the majority of cases. Only when, as a society, we once again accept *parens patriae* justifications for governmental intervention can we expect to see treatment-driven approaches become dominant. In the meantime, a recognition by policy-makers of the inefficiency of judicial review and of the desirability of substituting a nonjudicial process would be most welcome.

D. LEGAL REGULATION OF SECLUSION AND RESTRAINT

The last decade has seen a dramatic increase in legal controls on the use of seclusion and restraint. Impetus for these changes has come from exposés in the popular media about injuries and deaths to patients from these procedures, as well as from changing conceptions of how to deal with disruptive patients, which now place greater emphasis on nonphysical interventions. Although many states have created their own regulations, federal regulations promulgated by what was then the Health Care Finance Administration (HCFA) (now the Center for Medicare and Medicaid Services [CMS]), which apply to all facilities that receive federal reimbursements, provide a floor below which state regulations cannot sink. Parallel requirements established by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) are likely to cover even those rare facilities that might be exempt from federal standards.

In general, these new requirements limit the use of seclusion and restraint to situations of physical danger to the patient herself or to others, and mandate that less restrictive interventions not be likely to succeed. The order of an independent licensed practitioner—usually a physician—is required to initiate a seclusion or restraint, or at least to validate it soon after it is applied. Physicians must examine patients in seclusion or restraint within a short period of time. Orders must be renewed every four hours (according to the federal regulations) and as often as every hour (according to some state regulations), and can be extended only after a personal evaluation. Facilities may be required to develop individual plans to avoid seclusion and restraint for all patients on admission, and to meet complex record-keeping requirements, including for post-event analyses culminating in written reports.

Reduction of seclusion and restraint is certainly a worthwhile goal, given the risk of injury to patients and staff alike and the psychological trauma sometimes caused to patients subject to the procedures. But many of the new requirements have the feel of regulations imposed not simply to protect patients, but to make it so difficult, costly, and time-consuming for facilities to use seclusion or restraint that they will forego employing them. An example is the requirement for round-the-clock coverage by an independent practitioner (which is essentially what an every-four-hour requirement—one hour in some states—for evaluation and renewal of the order amounts to), which is a particular burden for smaller facilities without on-site professional staff at all hours. Regulations should indicate when seclusion and restraint can be used, what procedures should attend their use, how staff should be trained, and similar requirements. But they should not be used to raise the cost of seclusion and restraint for facilities in cases where their use is indicated. Harassment is a poor mechanism for making or effecting policy.

E. RIGHTS RELATED TO DISCHARGE FROM THE HOSPITAL

In many ways, the most important right a patient has, the one that makes all the others meaningful, is the right to leave a hospital if the situation becomes unacceptable to him. The exercise of this right differs for voluntary and involuntary patients.

1. Voluntary Patients

Two classes of voluntary patients exist. The *pure* voluntary patient can leave the hospital at will, limited only to reasonable hours, such as daytime hours. *Conditional* voluntary patients (the terms differ in different states) may be required to give notice, often amounting to several days' notice, before they are permitted to leave. This period is designed to provide an opportunity for the hospital staff to evaluate the patient's potential committability or suitability for discharge. These patient-initiated discharges are often referred to as *against medical advice* or *AMA*. Strictly speaking, however, this is not always the case, as there are instances in which, for a variety of clinical reasons, the patient's caregivers acquiesce in the decision to leave. When the discharge occurs over the strenuous opposition of the clinical staff, it is sometimes useful to acknowledge this by having the noncommittable patient sign a second form, similar to that used in medical hospitals, indicating that the patient is aware of the grounds for the hospital's opposition to her departure. In addition to the potential positive clinical effects of such a procedure, the additional documentation may be useful in the event that harm befalls the patient or a third party as a result of the premature cessation of inpatient treatment.

2. Involuntary Patients

Patients who have been civilly committed by the courts, hospitalized by virtue of an emergency, or committed under any one of a number of criminal statutes, or conditional voluntary patients who are unwilling to wait the mandated time before discharge, all share a common remedy, a writ of *habeas corpus*. This traditional means of limiting the power of the state to detain individuals, protected in the U.S. Constitution, dates back to medieval England and means, literally, "may you have the body." Issued on request to a court, it provides for the immediate appearance of the patient in court (same day or next day hearings are not uncommon) to review the ground for detention. If the state is unable to make a showing that the patient is being legally detained—that is, that he had been found to meet the criteria for commitment—immediate release may be ordered.

Although the writ is supposedly more concerned with procedure than with substance (i.e., more concerned that a fair procedure for the determination of committability has been followed rather than with the outcome of that procedure), in these contexts it almost inevitably turns into a hearing at which the merits of the commitment decision are reargued. The basis for this is the frequent assertion by the patient that her condition or circumstances have changed so substantially since the original determination that a rehearing on the facts is required. The power of the writ lies in the immediacy of the response to it. Properly, it should be reserved for remedying egregious errors or for situations in which continued hospitalization is seriously damaging to the patient, lest hospital staff be overwhelmed with the necessity of responding to a large number of writs to the detriment of patient care. Concerned lawyers can often accomplish as much through negotiation with the hospital staff, assuming that, in fact, an error has been made, as they can by turning to the writ, one of the major weapons in the legal arsenal.

3. Conditional Release

Traditionally, not all patients who left psychiatric hospitals were discharged outright. Many were given some form of conditional discharge, sometimes referred to as *visit* or *trial visit status*. This status allowed the patient to retain technical inpatient status while residing for a time outside of the hospital. Advantages of the procedure included the greater ease of readmitting the patient should he require it; the sense of support imparted to the patient, who knew at this difficult time that he had not been abandoned by the institution; and the ability to continue to provide services that were restricted to those who are formally inpatients, such as the provision of free medication to a financially unstable patient or continued access to facilities for occupational therapy. In theory, patients who began to decompensate could be quickly readmitted, but in practice this did not occur frequently. Systems for the close monitoring of conditionally discharged patients simply did not exist, and courts generally required some sort of hearing before patients could be readmitted against their will. However, conditional discharge is a vanishing phenomenon. Though it still may be found in some state facilities, managed care has almost eliminated it in the private sector. As soon as patients are deemed capable of leaving the hospital, managed care companies generally decertify them for inpatient care. Thus, the controlled release implicit in visit status is, for most purposes, a thing of the past. (See the related discussion of outpatient commitment in Chap. 2, Sec. II-F-4.)

4. Involuntary Discharge

A patient may desire to remain in a psychiatric hospital even though her clinician is recommending discharge. If the impasse persists, the clinician may resort to an involuntary discharge (see Sec. III-G, and Chap. 2, Sec. III-E-5). The legal implications of such a measure vary with the specific circumstances that induce it.

a. Clinical indications. From the clinician's point of view, the most clear-cut case of involuntary discharge is that which is clinically indicated. The patient has benefited maximally from hospitalization, or faces the danger of dependency and regression, and discharge is therefore the proper course. Because the idea that a patient might want to remain in a psychiatric hospital longer than necessary is counterintuitive to most laypeople, the clinician can find herself in the position of being accused of negligent and callous treatment should anything befall the newly discharged patient. Careful documentation of the clinical basis for discharge is therefore essential, and predischarge consultation with family members can be useful as well.

b. Termination of insurance coverage. Private facilities cannot, in general, afford to continue to treat patients whose insurance coverage has been terminated by a managed care reviewer. This constitutes a reason for discharge, as long as the patient is not abandoned and no emergency exists requiring further hospitalization. Transfer of care to a state facility or to an outpatient clinician is willing to accept the patient is essential before responsibility for the patient's care is relinquished (see Chap. 4, Sec. II-C). Increasingly, public facilities are unable or unwilling to accept such patients. In those cases, there is little alternative to continuing to treat the patient, while making plans for transition to some other form of care.

c. Expiration of court-ordered commitments. Involuntary discharge on expiration of court-ordered commitments is a situation similar to that considered in Section a, except that the decision must be justified somewhat more rigorously. Before discharge, the clinician should document the clinical grounds for overriding the patient's desire to remain and the resolution of those factors, whether dangerousness or inability to care for self, that motivated the original commitment.

d. After a dangerous or disruptive act. In moving from a simple consideration of the patient's best interest (as in Secs. a and c) to a response to an act that endangered other patients or staff members, additional safeguards should be imposed to protect the patient. The patient should have an opportunity to respond to charges that she committed the act in question, and an impartial fact-finder, outside of the clinical chain of command, might be useful. However, because it is beneficial neither to the potentially dangerous patient nor to the other patients or staff to retain her on a ward that is not equipped to handle violence, if the charges are substantiated, further action is justified.

Different cases have different options. Patients who are not likely to be assaultive on the outside and who can care for themselves can be discharged outright. Patients who cannot care for themselves or who are likely to be dangerous to others outside of the hospital can be transferred to state facilities for dangerous mental patients. In cases in which psychosis is absent or is unrelated to the violence, the patient can be held criminally responsible for his acts. Charges can be filed for the initial act of violence, and discharge to the street with notification to the police is possible. A psychiatric hospital is not required to detain any person who is liable to be dangerous to others unless that dangerousness results from mental illness. Adequate notice to the police provides sufficient protection for the community. Careful documentation of all steps is, of course, vital.

e. After an infraction of the rules. A nonthreatening infraction of the rules may serve as a basis for discharge if it is in the patient's best interest for such violations to be responded to seriously or if the patient is able to care for herself outside of the hospital, and the needs of the other patients that have been infringed outweigh her need for continued hospitalization. An informal, impartial review of the circumstances is appropriate here, too.

f. After refusal of treatment. Involuntary discharge after refusal of treatment is a sensitive situation, because it may appear that discharge is being taken in retaliatory response to the narcissistic insult for the clinician that refusal of treatment entails. This action is justified when the patient is not committable, when means of overriding refusal are unavailable or contraindicated, and when it is in the patient's long-term best interest. The latter justification requires a delicate clinical appraisal of the benefit to the patient; a clear statement of the clinician's stance regarding the need for medication or other treatment must be weighed against the harm likely to result from discharge. As one of the most difficult clinical decisions, its basis should be carefully documented. Of course, if the patient can survive safely outside the hospital and is unlikely to benefit from a prolonged stay without the recommended treatment, discharge becomes clinically indicated.

III. CLINICAL ISSUES

A. IMPLEMENTING THE RIGHT TO TREATMENT

The treatment of a psychiatric patient sick enough to require hospitalization has become a subspecialty of the field of psychiatry: inpatient psychiatry. Although the topic has been explored elsewhere (see Suggested Readings, Sec. E, Principles and Problems of Inpatient Psychiatry) and clearly merits a book in itself, certain general points can be made under the rubric of clinical aspects of the right to treatment.

1. Aspects of Hospital Treatment

Four broad aspects of hospital treatment can be defined (with some overlap): acute, short-term intervention; long-term intervention; rehabilitation; and custodial care.

a. Short-term intervention. The patient may be admitted in crisis, overwhelmed by internal and external stress, and require a brief hospitalization aimed at support, crisis intervention, and plans for future, definitive outpatient intervention. The major result achieved by such intervention may be, in fact, acquainting the patient with a therapist; in other instances hospitalization may serve as a collective consultation to an ongoing therapy. Examples of clinical conditions suited to such intervention are acute but transient suicidality, severe pan-anxiety, and toxic states without sequelae. The goal of hospitalization is to return the patient to outpatient status and functioning as rapidly as possible.

b. Long-term intervention. With long-term intervention, the patient may be admitted for definitive treatment of major mental illness that is not expected to respond to short-term intervention. Needless to say, managed care has made this justification for hospitalization rare. Examples of clinical conditions that may be appropriate for such interventions include the major psychoses (the schizophrenias and the affective disorders), other severe depressions, mental illness complicated by medical disease, persisting suicidality, and personality disorders. The goals of hospitalization are active treatment of the disease in question and a return (usually on a gradual, step-by-step basis) to previous or optimum possible levels of functioning outside the hospital; ongoing aftercare and outpatient treatment are often indicated.

c. Rehabilitation. A patient may be admitted after evaluation revealing an illness of such severity or chronicity as not to be likely to respond to any great degree to definitive short- or long-term interventions. The interventions for such patients may partake less of the character of active treatment than of rehabilitation; the goals of hospitalization are vocational assessment and training, education, instruction in marketable skills, placement in workshops, instruction in personal hygiene and activities of daily living, and the like. Though this may still occur in some public systems, private facilities are almost never able to obtain payment from managed care companies or other third-party payers for this type of rehabilitation.

d. Custodial care. Despite the best efforts of the psychiatric profession, a small but ineradicable population of patients remains whose problems—whether secondary to regression, chronicity, organicity, or a combination of these states—simply do not respond to treatment. This population may require lifetime hospitalization or institutional care. Misguided attempts at deinstitutionalization make these patients their primary victims; the problems of these patients cannot be voted away by the political process. The goals of hospitalization are maintenance of human dignity; food, clothing, and shelter; activities, exercise, and entertainment, as indicated; and fostering of human relations in a structured, caretaking environment. To the extent that this function is still fulfilled by inpatient facilities, it is found entirely in the public sector. Such placements are increasingly difficult to find.

With the above models in mind, we can consider implementation of the right to treatment.

2. Individual Treatment Plans

Hospitalization *per se* accomplishes the goal of asylum for individuals and, if dangerousness is an issue, protection of the community. Clearly, if treatment is to occur beyond these rather limited goals (i.e., beyond basic custodial care), it must be carried out in accordance with a plan that systematically addresses the needs of the patient in accord with a biopsychosocial model. This plan must be clearly documented.

> ***Example 1.*** A 20-year-old street schizophrenic who lived in doorways and was eating from garbage cans was admitted, actively hallucinating. Her biological needs included nutrition and treatment for her tuberculosis; her psychological needs included treatment of an acute exacerbation of a chronic schizophrenic process; and her social needs included group home placement and a structured day program aimed at rehabilitation, hygiene, and interpersonal skills. The patient's abilities as a seamstress served as the premise of her vocational rehabilitation.

Example 1 implies the necessity for individualizing the plan to the specific strengths, deficits, and needs of the patient.

3. Periodic Review

When hospital treatment of major mental illness evolves into prolonged hospitalization (usually in a public facility) of a treatment-resistant patient, a danger exists that treatment processes will be instituted on the basis of admission symptomatology, and that this treatment will proceed unaltered and, hence, unresponsive to subtle (or even gross) improvement (or deterioration) in the patient's clinical state.

This danger may be largely avoided by regular review of the treatment plan, addressing whether the specific goals of the interventions have been achieved. This means, quite simply, deciding what is not working, and changing or stopping it, and deciding what *is* working and continuing it.

To prevent the stagnation of the treatment program into a sterile or rigid routine, regular consultation from the outside is helpful in providing new perspectives on patient care. Such external review and regular internal review must be documented in detail, not only to maintain high standards of treatment, but to provide data essential for quality control, research, utilization review, and reimbursement by third parties.

4. Use of the Multidisciplinary Team

Most inpatient treatment is carried out by a staff drawn from the disciplines of psychiatry, psychology, social work, nursing (including attendants or aides), and occupational therapy (including activities-of-daily-living, vocational, recreational, expressive, and activities therapies). It should be emphasized that this use of a team is not merely a method of compensating for the relatively small number of psychiatrists; rather, it is a means of utilizing specific abilities inherent in each discipline. The value of the unique contributions of the individual disciplines depends in large part on their successful orchestration by skilled team leadership into coordinated treatment-plan action.

5. Attention to Environmental Issues

The intensity and specialization of inpatient psychiatry may breed a parochialism of attitude that pays scant attention to the impact of the external environment (i.e., the community). The community may provide pathogenic forces in the form of crime, intolerance of deviance, extrusion of the patient, and massive disruption of structure such as displacement and forced relocation of citizens. In addition, the community may offer constructive forces such as halfway and group houses, activities, and support systems for discharged patients. The family, too, may constitute an environment offering either support and nurturance or stressors and neglect.

The hospital ward itself is also an environment deserving of attention in relation to the right to treatment. It is not only human dignity and decency that are adversely affected by dirt, disorder, lack of privacy, crowding, unavailability of essentials, and other dehumanizing factors; the patient's clinical state is also affected, because such surroundings promote regression, apathy, and institutionalism in its various forms. Although clinical personnel often have little control over the ward environment, the critical importance of a humane and safe milieu in promotion of the right to treatment must be emphasized.

B. CLINICAL ASPECTS OF PATIENTS' RIGHTS

The patients' rights movement represents an important effort to raise popular consciousness about a markedly disenfranchised population. At present, in many institutions, patients are given, on admission, brochures or leaflets that define their rights in simple language—a laudable approach, although at the point of admission many patients are in no condition to read leaflets. Patients' rights issues may have clinical impact on patients and treaters.

1. Rights Versus Economic Realities

A number of patients' rights are related to certain aspects of the milieu, such as the rights to adequate privacy, bathroom facilities, and clothing and supplies. In many public sector settings the presence of these facets of the milieu depends almost totally on public funding of various kinds, often controlled by economy-minded legislatures and processed through civil service bureaucracies. When such basic necessities are unavailable to patients, many patients and naive legal activists tend to blame the clinical staff, which often has the *least* control over, for example, the availability of toilet paper (a scarce commodity in some state hospitals). From this fallacious point of view, treatment staff is seen as withholding essential needs from patients or depriving them of their rights—a picture that casts the staff as clearly adversarial.

2. Patients' Rights in Relation to Clinical Administration

Clinical administration refers to a body of practices that determines the immediate moment-to-moment management of the inpatient; included are the use of medications, space restrictions and expansions (staying in room, leaving on pass, etc.), use of emergency treatments (seclusion, physical restraints, etc.), and other similar interventions not appropriately subsumed under the psychotherapies (see Suggested Readings, Gutheil, "On the Therapy in Clinical Administration").

Correct use of these interventions requires a specialized understanding of the problems unique to persons in states of severe psychic disturbance. Without such understanding, interventions may not be understood, or their intent may be misinterpreted.

a. Deprivation of freedom versus the prescription of space. An important and ubiquitous aspect of inpatient work is the clinical administration of space. This phrase refers to the way space and freedom of movement are prescribed for the patient on the ward; the range of possibilities includes, at one end of the spectrum, discharge to the outside, and at the other, seclusion or restraint. In between, the patient may be required to stay in a room, stay on a ward or on part of a ward, or stay within the hospital proper. Passes and visits home are also part of this system.

The rationale for this prescriptive approach rests on an understanding of the severely disturbed patient's experience of space. Patients in a number of clinical states experience a markedly increased sensitivity to sensory input in all modes; what would ordinarily be experienced as normal perception becomes sensory bombardment. The wider the space and the more activity going on in it, the greater this kind of input overload for the patient.

In addition, a greater range of movement provides more opportunities for encounters with others, unexpected experiences, and new demands for coping and mastery of one's own impulses. Conversely, a known space, thoroughly explored and thus exhausted of surprises, becomes comfortably familiar and thus supportive; the paranoid patient need not fear the hidden attacker around the unknown corner.

Finally, space may be used to support internal controls by decreasing stimulation or temporarily providing isolation for the patient who is struggling to control anxiety-based assaultiveness. The concept at issue is that of limit-setting, whereby a patient who feels internal controls giving way—an extremely frightening experience—can be reassured that external controls (like limited space or sufficient numbers of staff) are available. Deprived of such controls, many patients in these states become increasingly agitated or assaultive (see Example 4 below).

With this in mind, one can grasp how, in certain clinical states, the patient's experience of greater freedom (more room in which to move around) may be paradoxically stressful and anxiety producing, whereas less freedom may be reassuring and calming.

b. Seclusion. One area of frequent misunderstanding at the legal-to-clinical interface is the use of seclusion (see Suggested Readings, Sec. B), a technique that represents clinical use of *minimal* space. The locked door connotes to legal sources a solitary confinement, as in a correctional system. In fact, despite the potential for abuse, seclusion offers several advantages for treatment of the seriously ill.

Seclusion offers (a) *containment* of the out-of-control patient, who is dangerous to himself and others, for his protection and that of other patients; (b) *isolation* from interpersonal relationships that, due to the illness, may be threatening, overstimulating, or enraging; and (c) *decrease in sensory input* for patients in states of sensory bombardment whose sensitivity to, and distortion of, sensory input is preternaturally high.

Seclusion is misused if it is used as punishment, as a substitute for staff attention or time, or as an expression of countertransference feelings not related to the patient's actual clinical state. An important step toward the appropriate use of seclusion was the publication of a task force report in 1984 by the American Psychiatric Association addressing professional standards for seclusion and restraint. Although practices have evolved since its publication, the report was a milestone for the profession in shedding its ambivalence over this politically controversial treatment modality and for articulating appropriate standards for its use. More recently, many public systems and private facilities have made aggressive efforts to reduce use of seclusion and restraint, often with considerable success. Alternative approaches include training staff in "talking down" agitated patients, providing quiet areas to which patients can retreat voluntarily, and offering a variety of modalities of sensory stimulation (e.g., touch, smell, etc.) aimed at soothing agitated patients. It seems unlikely that seclusion and restraint can be completely eliminated, but these efforts have much reduced its potential negative impact. (See Suggested Readings.)

The topic of restraint was also addressed by the task force report. Different facilities vary widely in their choice of preferred restraints, with differences based largely on tradition and experience. Restraints range from wrist and ankle leather bracelets to wet sheet packs, camisole jackets, Posey belts, and variations on these themes. As a rule of thumb, facilities should select a form of restraint with which they are most familiar and in the application of which the staff is most practiced; other considerations are arguably secondary.

c. Least restrictive alternative. The least restrictive alternative as it relates to involuntary commitment has gained in popularity with time (see Sec. II-B-1; and Suggested Readings, Secs. B, D, E). It represents, as noted, an application of a legalistic frame of reference to treatment by arbitrarily focusing on degree of restriction as the most important vector and locating the options along it.

Although one treatment modality may have in some way less inherent restrictiveness than another, it may not necessarily be optimal in other (perhaps more important) ways, such as the amount of observation and monitoring possible and access to specialized examination and testing. Ironically, certain clinical and institutional issues conspire to make restrictiveness less straightforward than may appear, as in Example 2.

> ***Example 2.*** The combination of mild retardation, temporal lobe epilepsy, and schizophrenia burdened a young man who was prone to unpredictable, terrifying, violent attacks against women. As an inpatient in an inner-city community mental health center, he spent almost all of his time restricted to his room or in seclusion, for the safety of patients and staff.
>
> After the last in a series of attacks, he was sent to a maximum security psychiatric hospital. There he was free to go outdoors, walk about the courtyard, and otherwise enjoy what amounted to *greater* freedom and *less* restriction because of the high level of security provided by the more-restrictive-alternative hospital. These freedoms were unattainable in the ostensibly less restrictive community setting. In addition, the all-male security environment markedly diminished the patient's anxiety about losing control of his impulses toward women—an anxiety that returned in full force when he was sent back after a time to the community setting.

3. Alternative Models

The approach to the seriously ill patient embodied in clinical administration has been clinically validated in contemporary hospital practice. Those unfamiliar with the effects of major mental illness, however, are prone to two common misunderstandings of these principles and misinterpretations of the rationale for their application. These modes of misinterpretation may be referred to as the *crime and punishment model* and the *behaviorist model*.

a. Crime and punishment model. The adoption of the crime and punishment model represents an occupational hazard to which lawyers are particularly prone, in light of their immersion in the adversary structure of the criminal justice system. This model may be misapplied to clinical administration.

The following example illustrates how the same clinical event is perceived in different ways through application of the legal and clinical models.

> ***Example 3.*** Flooded by psychotic panic, a young patient fled the ward and was returned from escape by the police. Back on the ward, he was secluded for his dyscontrol and calmed rapidly over a day or so.
>
> Months later, during a *habeas corpus* hearing demanding his release, his attorney portrayed this episode as if the staff, angered by the patient's escape, had punished the patient by putting him in solitary confinement.

b. Behaviorist model. The behaviorist model, used in some institutional settings and by some legal authorities, appears similar to the practices of clinical administration; however, the differences are extremely significant.

According to this model, one reinforces adaptive or desirable behaviors by giving rewards (or removing noxae), and one extinguishes undesirable or maladaptive behaviors by applying punishments (or removing rewards). The patient learns to conform behavior to the relevant standard.

Three problems are posed by this model in relation to inpatient care. First, the model is moralistic in tone, rather than clinical. Second, it deals with the patient as an exterior, an emitter of behaviors, rather than as a person with an internal experience as well. Finally, the model is often distorted when applied to prescription of space. Decreased space is seen as punishment for bad behavior; increased space, as reward for good. Whereas such experience of space might conceivably apply to the average person, patients in psychotic states may react in the opposite manner, whereby increased space, for example, may be terrifying rather than rewarding.

The behaviorist paradigm is thus susceptible to the charge that it infringes on patients' rights in ways that do not always offer *immediate* benefit to the patient; it is designed to effect long-term behavioral change. The legitimacy of such an approach, particularly with the nonconsenting patient, is problematic. Clinical administration, on the other hand, always looks to the procedure that will most immediately benefit the patient, either as treatment, protection, or both. Immediate benefit is never sacrificed for long-term behavioral change, although, of course, the latter may well result from a properly administered clinical approach.

4. Rights Versus Needs

Legal authorities understandably place *rights* in the foreground of their perceptions of the patient, the institution, and patient care (see Chap. 7, Sec. II-A-2-c). This, however, has the effect of placing the legal authorities on a slightly different track from members of the treatment team, who are mandated to minister to the patient's *needs.* This difference in vector, as it were, may lead to clashes of priorities between the legal and the medical systems.

> ***Example 4.*** An acutely manic, agitated woman had been room-restricted despite her protests that she wanted "to walk around and get some exercise." A young law student assigned to her case aggressively demanded that she be allowed the "right" to this freedom. An inexperienced staff member, intimidated by the lawyer, let the patient out. Panicked, the patient stripped and set fire to her clothing. Facing a life-threatening emergency, the staff was forced to seclude her.

In this example, neither legal nor clinical personnel grasped the fact that in certain clinical states the *right* to a freedom can be extremely dangerous or injurious to a patient whose *need* is for external controls.

Ideally, a patient's needs are met within a context respectful of a patient's rights. But Dr. Alan Stone's cogent comment should be recalled (see Suggested Readings, Stone): "[Legal advocates] have not been willing to consider seriously the needs of the mentally ill and to formulate those needs as rights; [instead] they have treated rights *as if they constituted* the needs of the mentally ill." (Emphasis added.)

This area of potential misunderstanding requires ongoing attention by legal and clinical agencies to ensure synergy between efforts to honor the rights while meeting the needs of the mentally ill.

C. CLINICAL ASPECTS OF TREATMENT REFUSAL

From a clinical perspective, the origins of treatment refusal are manifold; in addition, the psychology of refusal of medication is not necessarily similar to the psychology of refusal of psychotherapy or of electroconvulsive therapy. Despite this heterogeneity, certain empirically useful generalizations can be proposed about the psychodynamics of treatment refusal. For convenience, we might divide the topic into illness, treatment, and alliance factors.

1. Treatment Refusal Based on Factors in the Illness

a. Denial. The patient whose illness leads her to *deny* illness, claiming to be in the hospital "for a rest," "to help the other patients," or as a "researcher" or "volunteer," may refuse treatment on this basis; the patient takes the position, "Treatment for *what?* I'm all right."

b. Manic euphoria. In a manner related to denial, a patient in manic euphoria presents the position, "Everything is wonderful, there are no problems, I feel fine," leading to treatment refusal on that basis.

c. Projection. Clinical states partaking of paranoid mechanisms may demonstrate projection onto others of responsibility for the patient's thoughts, feelings, or experiences; the patient takes the position, "Why should *I* take treatment? *They* are the ones persecuting me."

d. Delusional guilt. In schizophrenia and the psychotic depressions in which delusional guilt often plays a prominent role, a patient may feel unentitled to, and undeserving of, help. The innate pessimism, inseparable from the depressed state, moreover, may vitiate any hope of relief, leading to nihilistic despair. The patient's positions may be, "I don't deserve help; I am meant to suffer; I must atone; it's no use and nothing can help."

e. Other delusions and distortions. In various psychotic states, patients may refuse treatment on the basis of the specific content of the delusion (e.g., "I am the messiah," or "People are trying to poison me"). Medication seen as a symbol (or seen in terms of a distorted interpretation of its direct effects or side effects) may be incorporated into the delusional system. Similarly, psychotherapy may be experienced delusionally as spells being cast or as being put in someone's power. Electroconvulsive therapy (ECT) may be seen delusionally as punishment, execution, or electrocution.

2. Treatment Refusal Based on Factors in the Treatment

Certain aspects of psychiatric treatment itself (not necessarily deleterious ones) may evoke treatment refusal.

a. Primary gain. Because major mental illness often serves restitutive or defensive functions, a patient may resist alteration of this equilibrium for primary gain; a typical example is the manic patient who, when treated for his elation, becomes depressed (or at least less high) and may resist this transformation, no matter how therapeutically indicated it may be. Similar points may be made for psychoses as restitutive attempts to deal with psychic pain.

b. Secondary gain. The sick role has certain sanctions and gratifications that may be prized by the patient (or family) as a secondary gain, such as (a) being entitled to attention or special consideration or (b) receiving "license" to act out, abuse the family, or be taken into a hospital and cared for. Treatment may be refused to preserve this role and its special considerations, one of which may be meriting the staff's and the hospital's attention.

c. Specific factors in psychotherapy. By its nature and purpose, psychotherapy addresses in part uncomfortable, unpleasant, or painful aspects of one's experience, and may be resisted on these grounds.

> ***Example 5.*** A manic patient refused to meet with her doctor for a second appointment, explaining this by shouting, "I don't feel like meeting with you; all you want to do is bum me out!" This accusation, of course, was partly true, because patients in florid mania cannot truly participate in therapy until returned toward baseline or even to mild depression.

In addition, psychotherapy is inherently slow and time-consuming and may readily evoke impatience and consequent refusal. Finally, it may be refused out of hand on the grounds that talking about it will not help.

d. Specific factors in electroconvulsive therapy. Despite an efficacy rate in the treatment of major depressions approaching 90% in some studies—an index of success far exceeding that of other remedies—as well as an impressive safety record, ECT remains a frightening prospect, inspiring fantasies comparable to, or greater than, those evoked by major surgery (which it resembles in some ways [e.g., both involve anesthesia]). In addition to refusing treatment on the basis of guilt, a depressed patient may understandably fear, and hence refuse, the procedure. (We might note, however, that an occasional depressed patient *requests* ECT in part because it is viewed delusionally as punishment consistent with depressive guilt.) These fears are augmented if the depression features paranoid elements.

These concerns, coupled with a history in this country of overzealous use (and abuse) of ECT, have tended to provoke legal authorities to treat ECT in a manner quite different from medication, despite the greater safety and efficacy of ECT in many situations.

e. Specific factors in medication

i. Portal of entry. As something ingested or received by injection, medication may evoke refusal in relation to conscious or unconscious conflicts, related to the particular portal of entry into the body.

> ***Example 6.*** A patient refused nighttime medication but took the same drug and dosage freely during the day. Careful exploration revealed that a fatherly night staff member stirred up profound and conflicted yearnings in the patient, making it impossible for him to take anything into the mouth.
>
> ***Example 7.*** A violent male patient required intramuscular medication. Weeks later, when improved, he described having interpreted the experience as a homosexual assault which, though administered by a female nurse, came "from the male doctor."

ii. Dysphoric response. A category is described in the literature of schizophrenic patients who have a dysphoric response to medication, a situation characterized by poor compliance and a poor prognosis. Although it is unclear how many patients respond in this way, refusal may be based on this idiosyncratic reaction.

iii. Side effects. Like almost all powerful pharmacologic agents, psychotropic medications produce a variety of side effects. These effects, though in general not disproportionate to the efficacy of the medication, can nevertheless be quite disturbing and can prompt drug refusal. The degree of disturbance is greater if the patient has not been prepared to expect them.

The side effects that most commonly produce subjective discomfort fall into several groups, briefly (and not exhaustively) reviewed here (see also Suggested Readings, Sec. VII-C). The nature of the psychological response to the distress occasioned by a given side effect may be idiosyncratic and dependent on the patient's concerns.

- Weight gain and associated metabolic abnormalities may constitute overwhelming concerns for some patients, especially younger ones.
- The anticholinergic effects of some medications include dry mouth, blurred vision, constipation, and urinary retention, each of which can be variably disturbing. Some patients find visual blurring particularly disturbing; others are more distressed by alteration in bowel regularity.
- The autonomic side effects include postural hypotension, leading to dizziness on abrupt rising to stand.
- The extrapyramidal side effects, associated mostly but not exclusively with the older antipsychotic medications, are often the most subjectively disturbing. These include dystonias and dyskinesias (spasms and abnormalities of movement); akathisia (motor restlessness, occasionally experienced as discomfort without a movement component); akinesia or stiffness; or tremor and incoordination. When these movement disturbances affect eye muscles and tongue or pharynx musculature, they can be especially upsetting, as the eyes may roll upward and speech and swallowing may be interfered with.

These side effects can often be corrected by a change in medication, a change in dosage, or the administration of a second medication to counter these effects. However, the fear of these effects or their actual appearance may promote medication refusal.

iv. Tardive dyskinesia. For many years, tardive dyskinesia (TD) was the most problematic side effect for the psychiatric profession and the one most referred to by legal and other opponents of pharmacotherapy. The term *tardive dyskinesia* refers to lasting (tardive) effects of medication that may involve movement disorders (dyskinesias) of face and tongue musculature, as well as muscles of the extremities and more rarely other parts of the body. Fear of, or the appearance of, this effect may lead to medication refusal, although patients are often not conscious of the existence of the abnormal movements.

This deleterious effect of antipsychotic medication use poses several problems. First, in terms of diagnosis, a careful reading of Kraepelin's observations of schizophrenics, in the century before phenothiazines were first synthesized, reveals descriptions of movement disorders appearing in late life and strikingly resembling TD. Second, concerning prevention, this effect appears at times to occur even after relatively brief exposure to medication at low doses. Third, treatment response for TD has been variable but generally poor.

The development of the newer class of atypical antipsychotic agents appears to have diminished the risk of TD. Most patients now begin with one of the newer medications. The issue may be more difficult for patients who have been stabilized on an older medication, have responded well to it, and are reluctant to change. Good clinical reasons may exist—to be discussed with the patient before a decision is made—for starting or continuing patients on a medication with a greater likelihood of inducing TD, including avoidance of weight gain and the metabolic effects of the newer medications. Recent data suggesting no greater tolerability or efficacy of the more expensive newer drugs may also stimulate renewed use of the older medications. Thus, the dilemma presented by TD is likely to remain for a long time.

3. Treatment Refusal Based on Factors in the Doctor-Patient Relationship

Compliance with treatment (see Suggested Readings, Sec. VII-C) has repeatedly been shown to correlate directly with the quality of the doctor-patient relationship; a durable therapeutic alliance based on mutual trust and respect appears to be one of the best treatment-motivating factors. Conversely, distrust, hostility, or other alliance-threatening feelings may be expressed in the refusal of proffered treatment (a mode of expression, of course, not limited to psychiatry but true of medical practice in general). The major areas of difficulty follow.

a. Transference. During intensive therapeutic work, powerful feelings deriving from early, including infantile, experiences may be stirred up and may be transferred to the therapist; these so-called transference feelings may represent the inappropriate application to the therapist of either realistic assessments of the primary object ("the therapist seems to me to be as mean and cold-hearted as my father") or frankly delusional perceptions ("I am the Messiah and the therapist is my apostle, Peter") that distort, through imagination, the early relationships.

On the basis of these transference feelings, a patient may refuse to accept treatment offered by the object of such emotions.

b. Reality. In addition to transference, reality factors of all descriptions may interfere with the collaborative mutuality of the doctor-patient relationship; these interferences may lead to treatment refusal in readily comprehensible ways.

Trust failures represent major interferences: the therapist who deceives, financially or sexually exploits, or knowingly misinforms the patient; breaches confidentiality without permission; or acts in other ways contrary to the patient's best interests may forfeit the patient's trust and cooperation with the treatment plan.

Chronic irritation may precipitate treatment refusal. A therapist who is always late, is forgetful, cancels appointments repeatedly, is often unavailable without coverage, and commits similar recurrent peccadilloes may incite the patient to refuse treatment.

c. Intimacy. The intensity, shared confidences, and depth of emotional involvement in the therapeutic relationship naturally breed intimacy, but may breed conflicts as well—as in Example 3; treatment refusal may represent a patient's mode of withdrawal from conflicts around closeness.

d. Therapist's absence. The therapist's absence, a common occurrence in therapy, deserves special mention in treatment refusal as it relates to issues of transference and reality. Issues of separation and abandonment spurred by therapist absence may unleash powerful feelings of rage, terror, and sorrow, barely credible to the nonclinician. Therapist absence is a familiar cause for patients who are normally treatment compliant suddenly to discontinue their medications, occasionally to the point of decompensation and of need for hospitalization. The psychological issue, conscious or unconscious, often takes a retaliatory form: "If you won't stay around, I won't take 'your' medication."

e. Family pressures. Families of inpatients may interfere in the doctor-patient relationship from a number of motives, including jealousy of the doctor-patient intimacy, competition with the treatment team over who is more helpful, and struggles over the patient's loyalty to hospital versus loyalty to family. Family rivalry over who metaphorically feeds the patient better may lead to the treatment refusal as the patient refuses medication—the doctor's "special food"—in response to these family pressures.

f. Autonomy. Autonomy enters into the doctor-patient relationship in direct and transferential ways. A patient may feel an intense need to maintain his boundaries against the actual or experienced intrusions of family members and, by extension, of the intrusively experienced clinician. The patient may thus attempt to defend his embattled autonomy by saying "no" to treatment and, commonly, to other expectations (e.g., taking showers, eating hospital food, changing clothing, and participating in groups).

Ironically, the drive toward autonomy is an essential positive factor in the recovery process—a factor that may operate in the reverse direction, toward maintaining the pathologic status quo.

The clinician is challenged to preserve the patient's strivings for autonomy while, paradoxically, attempting to contravene them in the service of treatment.

g. Other elements. An early study of drug refusal revealed that refusal was often used by chronically ill, severely thought-disordered patients as a nonspecific method of communicating individualized distress from a wide variety of causes, such as frustration and as a means of expressing a wish to talk with staff, a request for attention, and the like.

D. CLINICAL APPROACHES TO MANAGING TREATMENT REFUSAL

1. Exploration of Issues

The psychodynamics of a patient's refusal of treatment are as legitimate a topic of therapeutic investigation as the matters that brought the patient to the hospital. The patient's posture of denial, persistence in repetitive patterns of self-defeating behavior, delusional guilt, or other problems should be explored in the customary manner in relation to treatment refusal. At times, the legal atmosphere surrounding the right to refuse treatment can obscure the fact that refusal is, at base, far more nearly a psychological problem than a legal one; the clinician must attend to the issue in treatment. In particular, clinicians must actively resist the temptation to shift immediately into an adversarial role and to invoke too readily the legal mechanisms for processing treatment refusal cases before careful clinical exploration has taken place.

2. Maintaining the Alliance

The patient's refusal of the therapist's recommended treatment places the two parties in an oppositional stance that represents, most significantly, a threat to the treatment alliance. Faced with this problem, the clinician must address and recruit the highest level of the patient's functioning that remains available; the clinician allies herself with this level. Practically, such an approach requires seeing refusal as a problem facing the dyad, not solely the therapist or the patient.

3. Amelioration of Causative Influences

In addition to the psychotherapeutic investigation or intervention, specific influences leading to refusal may be identified and ameliorated directly. Subjectively troublesome side effects may be managed in the usual ways; ventilation of unexpressed hostility may be encouraged; misinformation about the medication may be corrected through education; conflicts and impasses on the ward may be resolved; family members may be involved constructively; and interpersonal attention may be paid in various ways. All of these responses may correct the situation that sparked refusal.

4. Alternatives in the Face of Persistent Refusal of Treatment

The clinician faced with a patient whose refusal does not respond to the other approaches described in this section has a number of options available, although none of them is totally satisfactory.

a. Discharge. As in other medical situations, an inpatient who refuses recommended treatment may be discharged. This otherwise equitable solution is often precluded by the fact that discharge may not be clinically permissible (as is often the case in the population most likely to refuse). When clinically and ethically feasible, however, discharge presents an acceptable response to persistent refusal.

b. Commitment. In some jurisdictions, committed patients may be involuntarily treated whereas voluntary patients are not. In these cases, clinicians may petition for commitment of a voluntary, refusing patient under the statutes that apply. Permission to treat may be, thus, directly or indirectly granted (see also Sec. II-C-2).

c. Role of ward staff in treating treatment refusal. An early study of overt drug refusal revealed a finding nearly ignored in the literature on drug treatment: the critical importance of the nurse-patient alliance in resolution of refusal. Therapeutic work, reassurance, coaxing, and persuasion on the part of the medication nurse proved to be pivotal influences in reducing medication refusal to a mere 24-hour problem in most instances. In similar ways, nursing and other ward staff may play vital roles in reversing refusal by means of positive, caring relationships with the patient.

d. Use of formal mechanisms to adjudicate treatment refusal. As indicated in Section II-C, the states have imposed—through case law, statute, or regulation—a wide variety of mechanisms to adjudicate patient treatment refusal. These mechanisms may involve determination of the patient's competence and the invocation of a number of vicarious decision-makers—from the treating psychiatrist to a judge—to decide about treatment. Clinicians are expected to familiarize themselves with current rulings in their own jurisdictions.

Clinicians should, however, remember the importance of an alliance-based relationship with the patient, even when acting so as to contravene his expressed wishes. In addition, in legal or quasi-legal settings such as hearings and formal consultative processes, clinicians should prepare themselves appropriately by familiarizing themselves with the patient's history, especially in terms of previous responses to treatment, and present the material in a confident and forthright manner. Prehearing conferences with hospital attorneys or similar individuals are an essential part of the clinician's preparation.

In some jurisdictions, legal guardianship for the incompetent patient is invoked to respond to the problem of treatment refusal. This issue is addressed in detail in Chapter 5. If the verdict is that the patient may indeed refuse treatment, clinicians should not view this outcome as a defeat. Clinical efforts at persuasion and recommendation should continue, and every effort should be made to invoke the other modalities of treatment of the modern milieu. The patient's further deterioration should trigger a prompt return to the decision-making body for a rehearing and reassessment. Clinicians may also consider reapplication (i.e., repetitioning) when a different judge is sitting or even, under particularly egregious circumstances, appeal of lower court decisions. Although treatment refusal may trigger questions about discharge, such discharge should never be merely a retaliatory response to a negative legal finding.

E. CLINICAL APPROACHES TO INVOLUNTARY TREATMENT

Formal review of patients' refusal of treatment may result in authorization to begin involuntary treatment, which raises a number of clinical issues.

1. Maintaining Alliance Primacy

Even in a clearly oppositional situation in which the patient's stated, albeit delusionally founded, refusal is being overruled, the therapist should still attempt to speak to the healthy side of the patient's ego, emphasizing the rationale for this course of action and including exploration of the patient's feelings and reactions as a legitimate part of the procedure. The patient's attention is directed to previous positive effects of medication, if any, and to the role of treatment in rapid release from the hospital. Efforts directed toward involuntary treatment should be described candidly in terms of their purpose in serving the patient's interests, though contrary to the patient's wishes. The clinician should take an unequivocal stand against psychotic distortions of the treatment situation and maintain a realistic view of the patient's medical needs.

2. Documentation

It should be emphasized that, at all stages, all facts pertinent to the decision to institute involuntary treatment must be carefully documented. These include:

- Diagnosis and validating information.
- Indications for use of treatment and rationale for appropriateness of that particular treatment.
- History and success or failure of previous treatment(s).
- Grounds for belief that refusal is clearly a product of the illness (i.e., refusal due to incompetence).
- Legal proceedings and outcomes.
- Progress of treatment once initiated.

3. Return to Voluntary Treatment

As soon as it is possible and clinically feasible, a patient should be invited to participate voluntarily in treatment; this change should be discussed in anticipation, and the subject should be kept open for discussion during the changeover. The dynamic and environmental bases for refusal should be explored in detail to render them explicit, not only for therapeutic understanding but for future reference in case of relapse and rehospitalization. Because a number of mechanisms for deciding about treatment refusal use a model based on what the competent patient wants, careful notes should be made about the patient's reasoning in deciding to resume treatment. These data may be of central import at later legal proceedings. (See also Chapter 5.)

F. CLINICAL ASPECTS OF THE REQUEST TO LEAVE THE HOSPITAL

The freedom to leave the hospital is an important right that must be honored to preserve the voluntarity of hospitalization whenever possible. It should be a matter of course, however, to treat the request to leave the hospital as legitimate material for clinical exploration that, like any other topic, offers an opportunity to understand the dynamic context in which it arises. We refer to formal requests to leave as provided by law, rather than simply the patient's verbal initiation of the subject of discharge.

1. Exploration of Underlying Issues

On an inpatient ward, submission of a request to leave (often by means of a form that gives a few days' notice of the wish to leave) commonly heralds the emergence of the affects of underlying anger or fear in the patient. Precipitants to these affects include (a) anger or frustration at doctor, staff, or institution and (b) fears, real and paranoid, of other patients or staff.

a. Anger or frustration at doctor, staff, or institution

Example 8. Feeling considerable distress, a patient came to the medication station urgently requesting an optional dose (as required) of medication. The medication nurse, busy with another patient, said she would have to wait. Angered, the patient loudly demanded a discharge request form. After signing it, the patient spoke at length to the medical nurse and resolved her anger. She then signed a retraction of her request.

b. Fears, real and paranoid, of other patients or staff

Example 9. When a patient witnessed an attack on staff by a violent patient, barely controlled by available personnel, she was extremely frightened by this display; she impulsively signed a discharge request and, at its expiration, left the hospital.

Example 10. A patient developed the delusion that the other patients on the ward were discussing him telepathically in a pejorative way. Fearing that they were conspiring to harm him, he signed a request to leave. Medication and active reality testing by staff corrected the delusion and the patient retracted his request.

c. Other dynamic issues. Other dynamic issues include conflicts around closeness and intimacy, fears of being trapped, and dread of disloyalty to, or separation from, the family.

2. Alliance Issue

From the viewpoint of therapeutic exploration, the formal request to be discharged represents a potential strain on the therapist-patient alliance; the patient's leaving in this way derives from a unilateral exercise of legal rights, in contrast to the collaborative negotiation of the jointly planned and explored discharge. In other words, although the patient's formal request to be discharged is sanctioned by law (and discharge may be clinically indicated), the opportunity has been lost to accomplish this step within the therapist-patient alliance.

Therapeutic exploration should be directed to this lost opportunity: what feelings, thoughts, assumptions kept doctor and patient from working toward the goal of a planned discharge, as other goals in treatment are jointly explored and achieved?

3. Decision to Commit: Clinical Impact

The decision to commit was explored in Chapter 2, but we might, in summary, review the issue from a clinical standpoint.

a. Clinical effects of the decision to seek commitment

i. Positive. Improvement of alliance through demonstration of concern and the provision of "holding" or "containing" a patient's impulses are positive effects of the decision to seek commitment.

ii. Negative. Patients' decrease in autonomy and responsibility; feeling of being trapped (panic, regression); and interpretation of commitment as seduction, aggression, and the like are negative effects of the decision to seek commitment.

b. Clinical effects of the decision not to seek commitment (to release patient)

i. Positive. Enhancement of patient autonomy, turning over responsibility to the patient, and avoiding patient regression are positive effects of the decision not to seek commitment.

ii. Negative. Patients' feelings of rejection, separation fears, and failure of concern (i.e., "They don't care about me") are negative effects of the decision not to seek commitment.

G. CLINICAL ASPECTS OF INVOLUNTARY DISCHARGE

Involuntary—also termed *mandatory* or *administrative*—discharge may occur in different ways that require individually distinct modes of reasoning, documentation, and clinical management (see also Sec. II-D-4, above; and Chap. 2, Sec. III-E-5).

1. Clinically Determined Involuntary Discharge

A common type of involuntary discharge occurs when an inpatient is restored to the level of health or functioning clinically consonant with being an outpatient; consequentially, the doctor recommends discharge. However, the patient may feel (as often happens) dependent on or attached to the hospital; fearful of, or reluctant to face, the difficulties of the outside world; resistant to the loss of regressive gratifications and to the demands of autonomy; or unwilling to return to family. Profound feelings of separation, loss, and abandonment may be evoked by even an optimal discharge. Thus, from the patient's point of view, the planned discharge is involuntary.

These feelings of reluctance to leave the hospital are not necessarily indices of the inappropriateness of the initial hospitalization, the inpatient management of the case, or the length of stay, or the inefficacy of the treatment modalities used. The flywheel of human inertia turns ponderously, and many persons, not all ill, resist alteration in the status quo. Surprising as it may seem to the layperson, moreover, the shabbiest, dingiest, most verminous hospital may represent—through provision and availability of caring staff—the most consistent, reliable, and gratifying environment that some patients have ever known.

The clinical management of this type of involuntary discharge rests on the principle of the primacy of the patient's needs, even when they run contrary to the patient's wishes. Hospitalization, like other treatments, outlives its usefulness and may produce toxic side effects such as regression, loss of outside connections, and excessive dependency. The patient's objections to leaving are appropriate clinical material to be addressed in the usual manner, to identify subjective and objective elements, and to work through the effects of separation, loss, autonomy, and growth.

In the situation in which a patient is being discharged against medical advice, the clinician may attempt to use the AMA form (or its local equivalent) as a concrete focus for further exploration; the form embodies the clinician's position of disapproval of the time of the discharge.

It is clinically valuable for an AMA discharge always to be considered as inferior to a negotiated discharge. The clinician queries: "Why must we retreat to legalistic methods to allow you to leave, instead of working together to plan the best possible discharge and aftercare for you? Why can we not work this out doctor to patient, without dragging lawyers in?"

This approach frequently uncovers the patient's transference-based perceptions of the clinician (deriving from parental models) as inherently frustrating, opposed to autonomy, controlling, and coercive; thus, these perceptions become available for exploration and discussion.

2. Lapse of Insurance and Its Clinical Consequences

To be eligible for funding under the Hill-Burton Act, private hospitals must treat a specified percentage of nonpaying patients. The majority of hospitals rapidly fill this quota; thus, patients who are discovered to lack insurance may be asked to leave. Frequently, they are transferred to state facilities, though that is becoming more difficult in most jurisdictions as the number of public sector beds continues to contract. Aggressive concurrent review by third-party payers and managed care companies may result in a refusal to pay for further hospitalization with similar results.

If insurance coverage has been limited by the third-party payer, clinicians may have an obligation to appeal the decision before discharging a patient who they believe continues to need inpatient care. Whether a hospital has a duty to retain a patient whose insurance will no longer pay for his hospitalization relates to the degree of need for inpatient care and the availability of other options.

a. Economic informed consent. The most sound approach to the challenges of constraints on insurance reimbursement by managed care may be economic informed consent, which is further discussed in Chapter 4, Section II-C. Economic informed consent involves (a) informing patients at the outset of hospitalization about the financial constraints, if any, on their care; (b) anticipating the possibility that treatment may have to outstrip coverage; and (c) planning actively with patient and family for this eventuality.

Alternatives include out-of-pocket payment; transfer to public sector care; construction of an aggressive aftercare program possibly involving visiting nurse services, local clinics, family members, or frequent outpatient follow-up appointments; or negotiation with the patient, the family, or both, to accept "quicker and sicker" discharge with full acknowledgment and competent acceptance of the prematurity of the discharge.

The effectiveness of these approaches depends on alliance-based anticipatory planning with patient and family—an effectiveness that is significantly compromised when the physician springs financial surprises on those involved.

3. Expiration of Court-Ordered Commitments

Occasionally, when a court-ordered commitment of a patient expires, the patient may wish to sign in voluntarily; however, the clinician may assert (for various reasons) that this is a regressive move or otherwise not in the patient's interests. Thus, the refusal of a desired voluntary continuation of hospitalization constitutes an involuntary discharge.

The patient's experience of this event is inevitably one of rejection, often resonating with past experiences. Once again, the appeal to the most autonomous and adult side of the patient is the crux of the clinician's approach to this issue; the patient's long-term welfare is placed ahead of her wishes. Because a patient's voluntary admission may, in other instances, represent a desirable event (connoting a willingness to participate in treatment), the discharge may be difficult to explain to nonprofessionals, should an explanation become necessary. The clinician should therefore clearly document the reasoning and the bases for the decision not to honor the request for voluntary stay.

4. Involuntary Discharge Owing to Dangerousness or Disruptiveness

The inpatient clinician must constantly weigh and balance the responsibilities to the individual patient and those to the ward population as a whole. (The responsibilities to the ward are usually absent from legal conceptualizations, which tend to view the patient and his care in a vacuum.) Consider this example:

> ***Example 11.*** On repeated occasions, a volatile, impulsive patient with a character disorder had lashed out at staff when confronted about her disruptive behavior. Staff weathered this until the patient attacked another patient who refused to give her a cigarette. Because the subject patient was not psychotic, it was felt that the risk to the other patients was greater than the risk to the community (where unlike on the ward, the potential victim could leave the scene); she was discharged, protesting her wish to remain.

In understanding this example, we must note the importance of assessing the patient's differential dangerousness on or off the ward—a factor related to committability, the presence or absence of psychosis and its treatability, and the degree of danger to other patients. Crowding on inpatient units may, itself, be a stimulus to aggression for some patients.

The staff response to aggressive behavior varies with the clinical state to which the response is addressed, according to the principles of clinical administration. For the psychotic patient whose assault is often the result of stimulus-related tension overwhelming burdened defenses, the patient is moved in to closer observation and decreased stimulation. For the impulsive patient, firm external controls and the setting of limits are essentials of treatment; hence, the patient may be moved out, as a limit-setting response, conveying the message "You cannot do that here."

For better or worse, hospital staff are expected to accept some degree of risk of assault (even with attendant injury) within limits; the degree of tolerable risk is different for the patient population, which is under staff protection.

It should also be noted that involuntary discharge owing to dangerousness or disruptiveness is at base in the patient's interests because the guilt, anxiety, or criminal charges that may result from continued assault are clearly detrimental to the patient.

A controversial alternative to involuntary discharge owing to dangerousness is the use of criminal proceedings against the patient; this issue has been described in a limited literature under the rubric of prosecuting patients for assaults on staff (see Suggested Readings, Sec. E). In this model, the hospital staff presses charges against the patient, either by having the assaulted staff member bring the charge or by encouraging the assaulted patient to do so. This legalistic solution may have some value in dealing with patients with personality disorders as a form of external limit setting; however, with more severely emotionally disordered individuals, the legal system is often quite indifferent to pursuing these cases.

In deciding whether to bring charges against a patient who has assaulted other patients or staff members, hospital administrators might consider the patient's motives for the behavior (i.e., assaults motivated by psychosis should probably be dealt with as a clinical issue, whereas assaults committed for purposes of intimidation, retaliation, or acquisition of property may well belong in the criminal justice system), as well as the likelihood of success (i.e., there is little point in bringing criminal charges against an inpatient in a jurisdiction where the prosecutor is known not to pursue them or the courts routinely dismiss them). Hospitals should develop policies regarding when charges will be brought in advance of needing to make decisions. Advance liaison with the local prosecutor may make pursuit of criminal sanctions easier when they are called for.

An interesting compromise between active prosecution and dismissal of a complaint is for a court official (e.g., the clerk of the court) to open a folder on the case, as it were, but to take no formal legal action. The legal system explains to the patient that he is on an informal probation (i.e., prosecution is deferred) and that repeated offenses will result in formal prosecution. No reliable empirical data exist concerning the long-term efficacy of filing criminal charges against disruptive patients; in at least one study, some patients became unmanageable or were lost to treatment as a result of these proceedings. Thus, this intervention's usefulness is uncertain.

5. Involuntary (Administrative) Discharge Owing to Infraction of Rules

Though related to involuntary discharge owing to dangerousness or disruptiveness, discharge owing to infraction of rules extends to areas that are matters of policy rather than representing danger or inherent disruptiveness.

In some hospitals and on some wards, specific actions are considered violations of the rules and may be grounds for administrative responses, including discharge. Examples might include bringing alcohol, drugs, or weapons onto the ward; engaging in sexual or other physical contact with other patients; or coming late or being absent too often for scheduled activities. Whenever possible, of course, the patient should be informed before admittance, verbally or by brochure, of what the rules and expectations are, and—except for blatant criminal acts like rape or drug dealing—she should be given the benefit of the doubt. Needless to say, all these data should be well documented and actively explored as therapeutic issues to discover the dynamic bases for the acting out.

In this consideration, we should not lose sight of the specific value to the patient's treatment of an attitude of responsibility and accountability for one's actions and behavior—for hospital rules no less than societal.

6. Involuntary Discharge Owing to Treatment Refusal

As indicated earlier (Sec. III-D-4-a), the clinician who is faced with a patient who undeviatingly refuses the prescribed treatment despite all efforts has the recourse of discharging the patient and no longer assuming responsibility for his inpatient care. Again, this response presumes that the patient's clinical condition permits discharge with maintenance of ethical standards of practice, the grounds for this assessment being appropriately delineated in the record.

The clinician's next move, however, is fraught with ambiguity. To continue to see the patient on, say, an outpatient basis is to support the patient in a suboptimal mode of treatment. Nonetheless, it may be the best that can be done for the patient. To refer the patient to another therapist is problematic because, effectively, the clinician would be attempting to find someone who would do for the patient what the referring clinician is unwilling to do herself; to let the patient do what he wishes would respect the patient's freedom of choice, but the clinician may be reluctant to make a decision of such total rejection, especially when the patient's decompensation in the not-too-distant future may be predicted.

In so complex a situation, the clinician is best guided by flexibility. The best that can be done for a patient is always constrained by the patient's preferences. When the best is something less than optimal care, the clinician may want to document her recommendation to the contrary, but can certainly be justified in allowing it. On occasion, though, the clinician will be persuaded—after careful reflection—that the course of action desired by the patient is so contrary to his interests that it is insupportable. At that point, he may choose to adhere to an open door policy: "Should you at some future time decide to comply with my prescribed regimen, you may, of course, return to treatment here." A clinically validated (but ethically complex) observation is that certain patients have to be hospitalized several times in succession at the onset of their illness before they fully grasp its seriousness and fully understand that it will not be remedied by itself; on occasion, treatment refusal is a component of denial of the problem.

IV. PITFALLS

A. COUNTERTRANSFERENCE FACTORS IN THE RIGHT TO TREATMENT

The clinician is frequently subject to conflicting tropisms toward, and away from, the inpatient in need. The positive side of this ambivalence may be manifested by excessive treatment zeal and rescue fantasies. The term *rescue fantasy* describes a blind therapeutic optimism that may overlook the indispensable role in treatment of the patient's own motivation and wish to change, so that the therapist is actually more eager than the patient that delusions be given up, that experience be faced and worked through, and that pathogenic relationships be terminated. The costs of this attitude are diminution of the patient's central responsibility in her illness and treatment; a coercive posture that, in effect, unilaterally demands recovery no matter what the patient's desires may be; and an intrusion on the development of the patient's own capacities to make responsible decisions. Coercive measures taken in the name of a right to treatment may thus result in the negation of positive steps toward change.

Equally problematic in this situation is clinician withdrawal from the stresses of engagement with the seriously ill patient, which can result in discharge of the patient or refusal to provide needed treatment on the basis of a wish to be rid of the patient, thus effectively depriving the patient of a right to treatment. The ideal position for the clinician is one that permits the patient maximal freedom, responsibility, and self-determination; only in instances in which the patient cannot safely function in this way is the clinician obligated to intervene authoritatively.

B. COUNTERTRANSFERENCE FACTORS IN PATIENTS' RIGHTS

The clinician must be attentive to the patient's needs in a context of rights. Inappropriate guilt or other conflicts may be evoked by the interventions in clinical administration (e.g., the clinician cannot stand to seclude the out-of-control patient because it would mean depriving the patient of freedom). In such a situation, a moralistic (rather than clinical) view leaves the patient untreated, and his needs unmet.

Another countertransference issue seen in teaching settings is what is called *legal defense as ego defense* (see Suggested Readings, Gutheil, "Legal Defense as Ego Defense"). In this instance, the clinician-trainee retreats into legalism to avoid the strains of empathic engagement with the seriously ill patient; the legal issues preoccupy the trainee to the detriment of clear perception of the patient's experience.

C. COUNTERTRANSFERENCE FACTORS IN TREATMENT REFUSAL

Refusal of treatment may be experienced inappropriately by the clinician as a narcissistic injury. As one saying goes, "Telling a doctor his pills are no good is like telling a mother her baby is ugly." In addition, the clinician may believe this refusal to be a personal rejection rather than the outgrowth of factors already detailed. The pitfalls here might be of two kinds (a) a punitive or rejecting response that essentially abandons the patient or (b) a reaction formation, an avoidance of the conflict, expressed by failure to pursue the approaches and alternatives as responses to treatment refusal.

In refusal deriving from depressive mood, the patient feels undeserving of help and is blinded by depressive pessimism as to the hope of recovery; a pitfall may manifest itself in the clinician's succumbing to the depressive position and becoming convinced of the futility of intervention and the hopelessness of the situation. This miscarriage of empathy obscures the generally quite hopeful prognosis in depression—a prognosis the clinician must keep firmly in mind to counter contagious depressive conviction.

D. COUNTERTRANSFERENCE FACTORS IN INVOLUNTARY TREATMENT, HOSPITALIZATION, AND DISCHARGE

Direct opposition to a patient's stated wish or intent may evoke fantasies and conflicts around aggression and sadism, no matter how thoroughly the involuntary intervention has been sanctioned by due process. Conflict in these areas, especially in regard to evoked guilt for opposing the patient's wish, may produce its effect through inaction (e.g., failure to petition for commitment, failure to seek guardianship, failure to intervene decisively in an emergency). Open discussion among treatment personnel and legal counsel, clinical consultation, and clinical supervision may mitigate these difficulties.

In summary, the decision to commit may be contaminated by wishes to control, keep, contain, or coerce the patient for reasons other than statutory criteria of committability; and inappropriate release (or involuntary discharge) may be fostered by decathexis of, frustration by, or hostility toward the patient, as by over-identification with the patient's wish to leave, denial of illness, or flight from engagement in treatment.

V. CASE EXAMPLE EPILOGUES

A. CASE EXAMPLE 1

The chief and the patient's psychiatrist agree that the patient is receiving little benefit from continued hospitalization. The options appear to be (a) continuing in the current state until the initial commitment expires, while making ongoing efforts to reengage the patient; (b) obtaining a judicial finding of incompetence that would permit the patient's involuntary treatment; and (c) discharging the patient.

The supervisor points out that the reaction the patient appears to be having is not uncommon among paranoid schizophrenic patients, who often develop positive feelings for therapists of the same sex, only to panic at what they fear are signs of homosexuality. Unable to tolerate that thought, they then project those feelings onto the therapist. This patient's refusal of medication and of further contact with the psychiatrist appear to stem from the fear that these are attempts by the psychiatrist at control and penetration. Given such a situation, further efforts at legal coercion into treatment (e.g., guardianship)—although often necessary in other cases to resolve such an impasse—are likely to be seen by this patient as intrusive and assaultive, only confirming his fears and dooming future long-term collaboration.

In the absence of positive benefit from hospitalization, and with clear contraindications to the more intrusive options, the therapist is asked to consider whether any indications exist for continued hospitalization. It is pointed out to him that the judicial commitment order actually allows retention of the patient for up to six months, but gives the psychiatrist discretion as to when the patient may be able to be released before then.

With that advice, the psychiatrist rethinks the situation and concludes that the patient is no longer imminently dangerous to anyone. Although clearly in need of treatment, he is not receiving any direct help in the hospital. The psychiatrist recognizes the dynamics underlying the patient's need to refuse treatment and decides that letting his refusal stand may facilitate future cooperation. Despite the fact that the patient appears quite comfortable on the ward and has not at any point asked to leave, discharge appears to be the only means of honoring the patient's autonomy while maintaining the posture of the hospital as a place in which active treatment takes place. It has the further advantage of bringing home to the patient the need to accept responsibility for the consequences of his acts.

The psychiatrist notifies the family and informs the patient that discharge is being recommended. The family comes to the hospital for several stormy sessions in which they accuse the hospital of failing to take proper care of their son, but the psychiatrist firmly explains to them that he sees little medical value in detaining him any longer. The patient is released after he has had a chance to make plans for himself. Outpatient appointments are arranged, but the patient never appears. Six months later, the psychiatrist receives a telephone call informing him that the patient has been hospitalized for several weeks in another nearby institution and is again refusing treatment.

B. CASE EXAMPLE 2

The consultant, herself an experienced clinician in addition to her legal expertise, ponders the dilemma, then makes recommendations.

She suggests that, though doing nothing would be a mistake, the staff should not struggle so hard, because to do so is clearly inciting such a patient to greater self-destructive activity in the service of obtaining attention. She speculates that this pattern repeats a family situation in which the patient's chronically depressed, withdrawn mother could be drawn out of her apathy only by the patient's harming himself, at which the mother would feel compelled to proffer grudging attention.

The consultant recommends that all staff meet together to review and implement a treatment plan, carefully documented. The patient should be told in simple language that staff cannot intervene in these episodes without fruitless encroachment on his rights; that the patient will be observed after a swallowing or banging event, but will not be extensively worked up medically unless gross symptoms develop.

The chief resident protests, "But something could happen to him before we knew about it! That's pretty risky, it seems to me."

The consultant nods. "A calculated risk, yes, but the alternatives are more destructive to sound care over the long haul. Remember, we aren't in the business of stopping people from each and every short-term harm; we must rehabilitate the whole patient in a lasting way."

The treatment team, dubiously at first, applies the plan. Over approximately two weeks, indeed, the patient loses interest in the game, settles down, and begins a vocational program.

C. CASE EXAMPLE 3

Finding the supervisor free, the psychology intern introduces himself. Apologizing for starting off the year with a problem, the intern describes the situation and shares his dismay at being, however inadvertently, a participant in an apparent breach of civil liberties; the patient is, indeed, not being permitted his legally mandated calls or being allowed to sign out. He waxes resentful of being "set up" in this manner by being assigned a new case in which the patient is already probably biased against him (the intern) because of having his rights violated.

The supervisor patiently hears out the intern and invites him to sit down. She explains that the patient in question cannot sign out because he is here on a court commitment for evaluation of competence to stand trial. He can only be returned to court.

"Did you ask him what his charge is?" the supervisor inquires.

"Well, no," the intern admits.

"It's his umpteenth arrest for making harassing telephone calls. This guy makes limitless calls to his lawyer, the superintendent, the governor, the Senate, the White House; deluges them with paranoid nonsense; and turns harassing when they don't yield to his delusional demands. He has shown that he can get calls out of places you wouldn't believe—maximum security, you name it. He also gets other patients to place the calls; the victim doesn't recognize the name, then the patient gets on the line and harasses him. He has somehow managed to get two calls off despite the fact that we have him on absolute telephone restrictions."

The psychology intern rubs his forehead, abashed. "I . . . I guess I didn't get the whole picture."

The supervisor is reassuring. "He can get past anyone, we've seen that. Don't worry about it. Just remember: Even rights have exceptions, when the rights of others are affected."

The intern nods. "My first lesson. I'll go up and talk this over with him. By the way, how did he get those scars on his mouth?"

The supervisor looks grim. "They do that in prison when you talk too much."

VI. ACTION GUIDE

A. RIGHT-TO-TREATMENT CHECKLIST

1. *Provide* psychiatric and medical evaluations immediately after admission and before any medications are administered.
2. *Mandate* development of individualized treatment plan shortly after admission with attention to variables.
   - a. Underlying psychiatric illness, if known.
   - b. Further diagnostic procedures needed.
   - c. Precipitating stresses and measures planned to ameliorate them.
   - d. Proposed use of medication or other somatic treatments based, if possible, on history of previous response.
   - e. Behavioral problems that might interfere with inpatient treatment and suggested response.
   - f. Involvement of family and friends in patient's care.
   - g. Assessment of social and vocational skills, with appropriate rehabilitative measures.
   - h. Early attention to postdischarge planning, including plans for housing, income, and follow-up care.
   - i. Maximal possible participation of patient in treatment and postdischarge planning.
3. *Allocate* adequate staff to implement treatment plan.
4. *Maintain* physical facilities to implement treatment plan.
5. *Require* formal, periodic review of patient's hospital course and progress toward goals as outlined in treatment plan; *revise* treatment plan as necessary.
6. *Advocate* with legislatures to provide needed services.

B. OTHER-RIGHTS-IN-HOSPITAL CHECKLIST

1. *Allow* visitation.
   - a. By family and friends subject to reasonable limitation on hours and requirements of patient's condition.
   - b. Maximum possible access for attorneys, private physicians, and members of the clergy.
2. *Promote* communication.
   - a. *Grant* access to public telephone to make and to receive confidential calls, subject to limitation only if clearly contraindicated by patient's condition or by patient's abuse of the telephone (e.g., threatening calls).
   - b. *Grant* uncensored mailing privileges for sending and receiving letters.
     - i. *Provide* reasonable amounts of stamps and stationery, if otherwise unavailable to patient.
     - ii. *Screen* outgoing mail only if reason exists to believe that others are being placed at risk.
3. *Ensure* privacy by providing for:
   - a. Use and secure storage of personal possessions.
   - b. Private toilet and shower facilities.
   - c. Guarantee of denial of access of third parties to records without patient's consent.
4. *Foster* economic rights.
   - a. *Permit* appropriate use of reasonable amounts of money.
   - b. *Allow* right to manage personal affairs.
5. *Recognize* right to be paid for work performed.
6. *Respect* miscellaneous rights.
   - a. Right to vote.
   - b. Right to marry or divorce.
   - c. Right to reasonable living conditions
   - d. Right to notification of all rights.
7. *Provide* a CRO, one who is freely available to patients to handle complaints of abridgment of rights.

C. RESPONSES TO MEDICATION REFUSAL AND THE WISH TO LEAVE THE HOSPITAL

(Note: Responses to medication refusal and the wish to leave the hospital are considered together because initial responses are similar.)

1. *Identify* underlying issues: for example, conflict, medication problem, vacation, delusional percept, milieu stress, family pressure.
2. *Explore* identified issue as legitimate therapeutic material in usual ways (clarification, interpretation, reality testing, ventilation).
3. *Recruit* adult, healthy side of patient into alliance, appealing to realistic perception of long-term benefits of treatment.
4. *Ameliorate* contributory factors (*counter* medication side effects, *work through* crisis issues, *promote* staff discussion, *resolve* milieu disputes, *obtain* consultations as needed, *intensify* or *redirect* casework with families).

D. RESPONSES TO PERSISTENT REFUSAL OF MEDICATION (OR OTHER TREATMENT OF CHOICE)

1. *Consider* possibilities of alternative treatment and *decide* if alternatives, though accepted by patient, constitute negligent, suboptimal, or unethical treatment.
2. *Offer* alternative treaters, if feasible, who may accept patient's preferred treatment and *transfer* responsibility.
3. *Consider* discharge as possibility if clinical condition warrants this; *arrange* for appropriate aftercare and follow-up.
4. If discharge contraindicated, *seek* appropriate authorization to permit involuntary treatment.
5. *Prepare* for review proceedings.

E. INVOLUNTARY TREATMENT CHECKLIST

1. *Document:*
   a. Need or justification for treatment.
   b. Reason alternative modes of treatment are inappropriate.
   c. Reason refusal is viewed as incompetent (delusional content, expressed reasons, muteness, characteristics of clinical state).
   d. Anticipated response to specific treatment, risks or benefits, history of previous treatment response.
2. *Inform* patient of rationale, reasons for treating against wishes, legal authorizations of treatment, legal recourses for patient.
3. *Treat* while monitoring results and *attempt* to return patient to voluntary treatment collaboration as soon as possible.

F. RESPONSE TO PERSISTENT ATTEMPTS TO LEAVE THE HOSPITAL

1. *Assess* committability by standards in local applicable statutes.
2. If standards proposed by local applicable statutes indicate patient is not petitionable, *assess* whether discharge should be against medical advice and, if so, *respond* by offering form or documenting this view, or both.
3. If committability standards are met, *petition* for commitment and *await* judicial decision.
4. *Offer* aftercare plan with follow-up, provisions for return, and an open-door attitude.
5. *Maintain* position of alliance as possible even during oppositional phase.

G. INSURANCE COVERAGE ISSUES

1. *Prepare* patient for possibility of exhaustion of coverage before treatment is complete.
2. *Obtain* economic informed consent.
3. *Explore* alternative treatment or funding options.
4. *Develop* alternative care plans.

H. COUNTERTRANSFERENCE DIFFICULTIES

1. *Avoid* rescue fantasies, wish to control patient, doing for patient what patient can do for himself.
2. *Resist* succumbing to depressive pessimism, despair, manic insouciance, or delusional world view.

3. *Work through* conflicts in areas of sadism, guilt, or anxiety around needed interventions.
4. *Obtain* consultation, legal and supervisory, as needed.

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CHAPTER 4

Malpractice and Other Forms of Liability

I. CASE EXAMPLES

A. CASE EXAMPLE 1

After attending a continuing education program at which the problems of antipsychotic-induced metabolic syndrome were discussed, a hospital-based psychiatrist decides to examine her entire caseload for signs of weight gain and metabolic abnormalities, and to obtain explicit informed consent from all of her patients who are receiving psychotropes. When the laboratory results arrive, she notices that one of her male schizophrenic patients has a significant number of abnormal findings, including elevated blood glucose and an abnormal lipid profile. Although she is convinced that she must confront the patient with her findings and obtain informed consent to continuation of antipsychotic therapy, she is troubled by his past history.

Originally hospitalized at age 21 years, after a slow descent into psychosis, the patient was diagnosed as a catatonic schizophrenic and was started on moderate doses of medication. Despite the efforts of his therapist and an intensive milieu, he showed little progress during his first three years of hospitalization. In fact, during that period, he made two serious suicide attempts, one of which was followed by a course of electroconvulsive therapy (ECT). However, during his fourth year of hospitalization, while placed on large doses of a different, newer neuroleptic and treated with continued psychotherapy, he began a slow improvement. That improvement has progressed for three years, and he is now subject to only occasional delusions and a mild thought disorder and is holding a volunteer job in addition to his partial hospitalization program.

At the time the patient's status was improving so dramatically, his therapists made numerous attempts to decrease the large dosage of medication he had been taking, but he resisted them all, just as he resisted suggestions that he switch to one of the older antipsychotic medications. He said that he was afraid that without his current medication he would relapse and require rehospitalization, and that if that happened, he was not sure that he would survive it. Reviewing his records, his doctor can find no evidence that he ever gave a specific consent to neuroleptic treatment, though it is apparent by now that the patient is thoroughly familiar with the direct effects of the medications. She is concerned that raising the issue now could lead the patient to become paranoid about the medication or to become so angry at the hospital and at her that he stops taking the medication and requires rehospitalization, perhaps even becoming a risk again for suicide. She seeks legal-psychiatric consultation as to how to proceed.

B. CASE EXAMPLE 2

Miss C, a 24-year-old woman, experiences an acute psychotic episode after breaking up with a boyfriend with whom she has had a brief realistic acquaintance and an elaborate fantasy relationship. On admission, she is actively hallucinating visions of Christ calling to her, and she has the delusion that she is possessed by a devil who creates disturbing sensations in her body.

Several weeks of medication and psychotherapy result in marked remission of symptoms; the resident psychiatrist continues in psychotherapy with the patient to elucidate the precipitants to her falling ill.

Six months into outpatient work, the therapist begins to explore the patient's childhood feelings toward her father and the manner in which these feelings were recapitulated in the relationship with the lost boyfriend. The resident interprets the patient's growing discomfort as related to the sensitive nature of the material. During one session, after discussing the boyfriend, the patient trails off into silence, squirms in her chair, starts to speak, turns crimson, and stares vacantly ahead into space. The resident asks quietly, "What are you feeling?" At that, the patient leaps from her chair and bolts from the office.

Early the next morning, the resident receives a call from the patient's father. In a towering rage, the father accuses the resident of taking sexual liberties with his daughter that have made her illness worse, warns that his attorney is on the way with a subpoena for the patient's records in preparation for a lawsuit, and slams down the telephone. Panicked, the resident telephones his supervisor, protesting, "I didn't go near her, what's going on?" The supervisor suggests they review the case together after the resident alerts the hospital's risk manager and his malpractice insurer.

C. CASE EXAMPLE 3

A new patient bustles in cheerfully, hand outstretched, saying, "Hello, Doctor." Glancing about, the patient murmurs, "Lovely office," and sits down. Under her other arm is a thick book, clutched so that her arm hides the whole title except for the word "courage."

Sitting down on the edge of her own chair, the psychiatrist smiles tentatively, and says, "Nice to meet you. How can I be useful?"

The patient's demeanor turns serious as she reports that her readings, coupled with "image work" by her previous clinician, have revealed to her that she is a survivor of satanic ritual abuse. When her clinician moved away, she sought to continue her healing. She pauses. "You do know about ritual abuse, don't you?" she asks worriedly.

Hesitantly, the psychiatrist responds, "I have certainly heard of it." The patient interrupts and launches into a review of her abuse history that lasts the entire session. Her psychiatrist listens and makes notes, but to the psychiatrist's dismay she is barely able to get a word in. When the time is up, the patient bounces from the chair and heads out, turning in the doorway to remark: "I'm *so* glad I found someone who believes me and can help me at the trial."

The psychiatrist blinks. "What trial?"

"The suit against my father, of course," the patient replies as she leaves. The psychiatrist's response, "Well, I'm not sure I . . . ," is cut short by the closing door.

Shaking her head in bemusement, she thinks for a few minutes, and then makes a call to a colleague in the building who does medicolegal consultation. "Hello, Judy? I think I've got a problem. Are you free?" Her colleague apparently agrees, because she signs off with, "Great, see you in two minutes," and heads purposefully out the door.

D. CASE EXAMPLE 4

With a somewhat heavier tread than usual, a psychiatrist with a mixed inpatient and outpatient practice meets with a patient's family. The patriarch of the family was admitted four days earlier in a severe depression, and although treatment with ECT was begun almost immediately, his mood has lifted only slightly—a promising sign, but not a complete recovery by any means.

Five family members are gathered around the bed where the father lies dozing; five pairs of suspicious, mildly hostile eyes turn to regard the doctor as he enters the room.

The oldest sibling speaks first. "How is he doing, doctor? Is there some problem we don't know about?"

The psychiatrist answers, just a bit too fast and too loud: "No, no! No problem, exactly. That is, your father is doing fine, just fine, coming along." He trails off. Drawing a deep breath, he begins again. "See . . . here's the situation. Um, his coverage . . . you know, his insurance? . . . It's running out, and he's supposed to leave the hospital tomorrow."

The hostility in five pairs of eyes is naked now, mixed with shock. A paternal cousin snarls through his teeth: "What the devil do you mean, 'leave tomorrow'? Look at him! He's *still sick*!"

As the psychiatrist spreads his hands conciliatingly, he responds, "Look, I don't make the rules, but we all have to abide by them. I admit we haven't quite finished with him yet but remember, he's only approved for five days, and I had to pretend he was suicidal to get that."

The patient's son levels a finger at the psychiatrist. "If my father is kicked out and he dies, I'll have your job, your license, and the fillings in your teeth!"

A familiar inner conflict arises in the psychiatrist between his patient's welfare and the financial realities of the modern era. "Look," he says, "let's see if we can fight this. I don't know if the 'no' is final. I'll report back to you as soon as I know what we can do." Leaving the room in some turmoil, the psychiatrist heads for the office of the hospital's risk manager.

II. LEGAL ISSUES

A. MALPRACTICE

The increase in litigation against physicians and other health professionals, which has provoked repeated crises since the 1970s, is probably the least understood of the powerful factors shaping medical care today. Although most people have heard of the difficulties physicians have obtaining malpractice insurance coverage at affordable rates, few of them, even few of the professionals most directly affected by the situation, are familiar with the changes in the legal system that have combined with new kinds of societal pressures to provoke the crises. Psychiatrists continue to maintain their position as one of the least-frequently sued of the medical specialties. But they, too, are feeling the pressure that heightened litigiousness has wrought, as are the other professionals in the mental health field.

Psychiatrists are the mental health professionals for whom the most data on malpractice suits are available. The incidence of malpractice claims per 100 psychiatrists has risen from 0.6 claims in 1980, to approximately 4 claims in 1990, to 10 to 12 claims in the late 1990s. More recently, that rate of claims appears at least to have been sustained. Premiums have also risen dramatically, especially in high-risk states.

One effect of increases in claims and premiums is that practitioners may be overly wary of legal issues in their treatment of patients, sometimes to the detriment of patient care. Some clinicians may also have a tendency to refuse to treat patients perceived as high-risk. The mental health professions have not seen increases in malpractice insurance costs dramatic enough to force practitioners to change locations or abandon practices—as has occurred in some surgical specialties—but that may occur in the future. The reasons for the recurrent malpractice crises and suggestions for ways of dealing with them are considered in Section II-E, after an exploration of the basic legal doctrine involved.

1. Definition

A malpractice suit falls into the legal category of an action in tort. A tort is a civil (i.e., noncriminal) wrong, not based on a breach of contract, that has led to harm to another person. An action in tort is a request for compensation for the harms that have occurred. Malpractice is a negligent tort, committed by a physician or some other professional, that leads to damage to a patient or client. As a subcategory of tort law, malpractice litigation must conform to all of the complex procedural and substantive requirements that have evolved over centuries of Anglo-American jurisprudence in this field and proceed under some rules peculiar to this area. Four basic elements must be proven to sustain a claim of malpractice.

a. Duty. Before a patient can claim that a clinician's negligent act caused him damage, the patient must first establish that he and the clinician entered into a relationship in which the clinician undertook to treat the patient in a nonnegligent way. In other words, the clinician must have assumed a duty to care for the person. Many people are surprised to discover the restricted scope of duty in Anglo-American (as opposed to Continental) law. Ordinarily, no individual is obligated to care for another. Thus, a passerby who sees a toddler trip in a wading pool and begin to drown is subject to no legal penalty if she does not help the child. The same is true for a physician who, except in rare instances where the law specifies otherwise, is not obliged to render assistance to all the infirm she comes across. Once the physician has agreed to provide aid, however, whether by working in an emergency room where that promise is implicit in the setting, by explicitly agreeing to treat an individual who has come to her office, or by acting in some other way such that the patient might reasonably be led to assume that a doctor-patient relationship has been established, the duty to act nonnegligently applies. When a duty to care has been initiated, it can be terminated by outright discharge (but only if medically appropriate) or by the transfer of the patient to the care of another physician. The same rules apply generally to all the mental health professions.

b. Negligence. The clinician who has agreed to care for a patient cannot act negligently toward her, but because negligence is a relative concept, some external standard against which to measure care is required. A deliberately exaggerated example may clarify this point. A large number of medical tests exist that a psychiatrist could order before starting a patient on lithium. Because toxic effects of lithium on the function of the brain have been reported, particularly in those patients with preexisting lesions, an electroencephalogram and a magnetic resonance imaging scan might be obtained. The kidneys are another source of concern; although a serum creatinine test might be sufficient as a measure of renal impairment, perhaps an intravenous pyelogram, or even a renal biopsy, would yield additional data. A bone marrow biopsy could rule out a preleukemic state, a possible source of concern. What determines if a physician is negligent in omitting one of these procedures if a complication that could theoretically have been avoided later develops? Malpractice law has traditionally held, with some important exceptions (see Sec. II-B-2-a), that the custom of the profession, as reflected in the standard of care common to other professionals of the practitioner's training and theoretical orientation, is to be taken as the benchmark against which negligence is to be measured. Thus, if all psychiatrists who prescribe lithium began on reasonable grounds to order magnetic resonance imaging scans before beginning treatment, that would become the standard by which the defendant-physician would be judged.

All jurisdictions formerly accepted one qualification as to the nature of the peer group to which the comparison was made: only the practices of clinicians in the defendant's own locality were considered to be relevant. More recently, the homogenization of practice made possible by widely disseminated professional journals, continuing education programs, national professional meetings, and uniform standards for peer review has led many—but not all—juridictions courts to abandon the locality rule. Clinicians are generally judged by the standards of their confreres of similar training and orientation throughout the country. This is true for all the clinical professions.

That standards of care are judged according to one's specialty does not imply that a psychiatrist necessarily will be judged not to have been negligent if he performs as well as other psychiatrists would have. There are medical procedures—for example, cardiac catheterization—that a psychiatrist is simply not trained to perform. The standard of the profession requires psychiatrists to refer patients in need of catheterization to qualified interventional cardiologists. To have done otherwise probably constitutes negligence in its own right.

c. Harm. Even a grossly negligent act (e.g., a psychiatrist's prescribing antipsychotic medications by telephone for a patient whom he has never seen) does not leave the clinician liable for damages unless some harm occurs. The harm can be physical (e.g., a dystonic reaction in a patient who did not require neuroleptics in the first place that causes the patient to lose control of her car and crash) or emotional (e.g., the anguish that the patient's spouse suffers after hearing about the crash). Potential damages can be astronomical: In this example, in addition to the cost of replacing the totally ruined car, the psychiatrist can be liable for the patient's hospital bills, a lifetime of lost wages, compensation for a future filled with days of pain and suffering, and compensation to the spouse for his anguish and loss of the usual marital relationship (or, in legal terms, *loss of consortium*). The tendency of juries to grant large amounts of money for pain and suffering—even $50 a day over 30 years amounts to more than a half-million dollars—has contributed to the enormous inflation in damages awarded.

d. Causation. Causation is the most complicated of the four elements of malpractice. In brief, even a negligent act committed by a clinician with a duty to care for a patient-plaintiff who has suffered a permanent harm is not compensable unless the negligent act in question caused the harm. Although that may sound simple or self-evident, it is neither. A psychiatrist who hospitalizes a suicidal patient in a facility that fails to observe him closely enough to prevent the patient's ultimate demise can, in one sense, be said to be a causative agent of the patient's death. If the psychiatrist knew, or reasonably should have known, that the facility was likely to be negligent in observing the patient, a court might conclude both that the psychiatrist was negligent and that his negligence was so closely related to the patient's death as to constitute a proximate cause (the term indicating a sufficiently close link as to establish causation for legal purposes). Some courts believe proximate cause to be present whenever the harm might have been or should have been predicted in advance—or in legal terms, when the harm was foreseeable. If the patient's death, however, resulted from being pushed by another patient down a flight of stairs and that act could not have been reasonably foreseen or prevented, the psychiatrist could not be held liable despite the practitioner's original negligent act in committing the patient to a facility he knew to be inadequate and despite the fact that "but for" his action, the patient would still be alive. "But for" causation is not sufficient to establish proximate cause.

2. Problems of Proof

The existence of each of the four elements of malpractice must be proven by the plaintiff—the party who is suing—by a preponderance of the evidence. Certain difficulties of proof are inherent in the usual therapeutic setting.

a. Lack of witnesses. Common to many medical situations, and certainly the rule in psychiatry, is that the interactions in question have not been observed by anyone other than the two parties to the case: the plaintiff-patient and the defendant-clinician. Only they can give direct evidence of whether a duty of care was assumed and if the negligent act alleged was actually committed. Because the testimony of each party can be assumed to be self-serving and is often directly contradictory of the other's, corroborative evidence assumes tremendous significance. As a result, the patient's records, which represent the clinician's ongoing description of the relationship, can be determinative of the ultimate findings in the case (see Sec. III-A-3). The importance of complete and accurate records cannot be exaggerated.

b. Res ipsa loquitur. Problems of proof that are difficult in the usual clinician-patient relationship become overwhelming when one of the two parties cannot testify directly as to what has occurred. Take, for example, the case of a patient who suffered a respiratory arrest during the administration of ECT and who was subsequently revived. Although the patient may have reason to suspect that the behavior of her physicians contributed to her arrest, she has no way of proving that the physicians were indeed negligent by administering too large a dose of barbiturate anesthesia, except by reference to the medical record of the treatment. Because the formulation of that record, however, was under the control of the doctors accused of negligence in the first place, the plaintiff might suspect that it does not accurately reflect everything that occurred. The law, which has as its primary concern the compensation of those who have suffered injuries, has provided a way out of this dilemma.

The doctrine of *res ipsa loquitur* (meaning, literally, "the matter speaks for itself") can be invoked in such a case. *Res ipsa* requires four elements to be present: (a) that the harm that has occurred rarely happens in the absence of negligence (a requirement not likely to be met in the ECT example, but one that could be the subject of dispute in court); (b) that the defendant (i.e., the physician) had exclusive control of the means that caused the injury; (c) that the plaintiff did not contribute to the bad result; and (d) that only the defendants, and not the plaintiff, have access to the information about what actually occurred. Although some commentators claim that *res ipsa* represents nothing more than a complicated codification of common sense, it does have several important technical legal functions. First, in some courts, once the four elements have been established, the burden of proof shifts to the defendant, who must prove that the negligent act alleged did not occur. Second, it prevents a plaintiff's case from being thrown out of court in the absence of direct evidence of negligence. Finally, *res ipsa* is one of the means that the courts have developed to circumvent the usual requirement for expert testimony to establish negligence; although an expert may be required to prove the first element of *res ipsa,* namely that the act in question is unlikely to have occurred without negligence on the part of the physician, one is not needed to answer the more difficult question of whether the particular physician in question was actually negligent.

c. Expert testimony. Courts in the past generally have required that expert testimony be presented to prove at least one element of malpractice: that the performance of the defendant did not conform to the standard of care of the profession. Under the traditional rules, the expert had to be of the same theoretical school as the defendant (a particularly important requirement in psychiatry, where practices among various schools still diverge widely) and practicing in the same locale or at least a similar one (e.g., a nearby small town or a comparably situated small town in a neighboring state). Combined with the natural reluctance of colleagues to testify against one another in court (deemed by frustrated plaintiffs a "conspiracy of silence"), the requirement for an expert's testimony could be a formidable barrier to the successful waging of a malpractice suit (see Chap. 8, Sec. II-A).

The barrier has been substantially lowered in the 1990s, however, as the result of several changes in evidentiary requirements in malpractice cases. The locality rule has all but disappeared, in part in response to the need to broaden the pool of professionals from which potential witnesses can be drawn. A physician or other mental health professional who is willing to testify in malpractice cases for either the defense (although under the traditional rules, defendants had many fewer problems finding experts to support their case) or the plaintiff can travel around the country to fill that role. Trial lawyers' magazines, in fact, display many advertisements from physicians and other experts who are eager to be called on to testify. (Ethical questions in this area are addressed in Chap. 8, Sec. II-C-2.)

In addition, the requirement for an expert's testimony has been done away with altogether in those instances in which the court determines that the alleged negligence is of such dimensions that even uninstructed laypersons could recognize it. Cases of this sort are rare in psychiatry, but the following is an example: a physician who, while drunk, examines a patient and prescribes medication for a condition that the patient does not have; the medication subsequently leads to an adverse reaction.

Finally, even in cases of psychiatric malpractice in which expert testimony is still required to establish negligence, some inroads are being made in the use of nonmedical mental health professionals, primarily psychologists, to testify to the standard of care. As the psychologists' role in the care of the mentally ill expands (in many areas they are permitted to testify in commitment or competency proceedings and to admit patients to mental hospitals, and in a small number of states they can acquire prescribing privileges), the increasing congruence between their activities and those of psychiatrists makes them, from the lawyer's viewpoint, even more attractive as potential witnesses.

3. Common Forms of Psychiatric Malpractice

The incidence of malpractice litigation in the mental health professions is rising and settlements are growing in size. Knowledge of the bases on which suits are brought is, thus, increasingly important to understand trends in malpractice litigation and to develop strategies to correct underlying problems. Growing awareness of the number of allegations against mental health professionals (e.g., concerning sexual contact with patients) has led to concerted efforts by the professions to deter such potential grounds for litigation. (See Sec. II-A-3-f.)

Despite the obvious importance of data on the frequency of particular types of malpractice claims, much is lacking in our ability even to rank order the most common causes of suits. A number of reasons exist. Only the rare malpractice suit contains a single allegation; most state several related claims against the clinician. Further, the same negligent acts might be described differently in otherwise similar suits. A patient's death by overdose with a medication that was prescribed by his psychiatrist, but was not indicated for his condition, might be characterized as misdiagnosis, negligent prescription of medication, failure to properly monitor medication, failure to assess suicidal ideation, or any combination of these.

Even if common categories could be agreed on, getting comprehensive information about malpractice cases is a daunting task. It is estimated that only 10% of cases get to trial, and only a fraction of these result in appeals with published opinions. Insurance companies, which have records of all claims lodged against policyholders, are often reluctant to allow researchers to read their files, although they may publish periodic summaries of claims lodged against them. Our knowledge about the relative frequency of malpractice claims is based on these data and the rare independent research studies.

Because categories differ from company to company and are subject to biases, the result is little consensus on the relative importance of types of malpractice. We make no effort to offer a hierarchy of causes of psychiatric malpractice by frequency of allegations. Rather, the major categories of malpractice for mental health professionals are reviewed, with special attention to those categories that raise problems unique to mental health care.

a. Misdiagnosis of psychiatric disorders. *Misdiagnosis* usually refers to a negligent failure to recognize the nature of the patient's condition, with harm resulting from the consequent failure to implement proper measures of care. A psychiatrist, for example, may be held liable for negligently diagnosing a patient with a personality disorder as schizophrenic, but only if the misdiagnosis affects treatment in a manner that leads to subsequent harm. If, as a result of the diagnosis, the patient receives neuroleptic medication and later develops TD, liability may well be imposed. Liability may also be imposed if the patient is deemed likely to have improved had the correct diagnosis been made. The mistaken diagnosis, however, must be the result of the clinician's negligence. Had the psychiatrist properly inquired about the signs and symptoms of both schizophrenia and personality disorder, only to have the patient lie about the presence of delusions, the resulting mistake could not be attributed to the psychiatrist's misfeasance. Similarly, if after conducting an evaluation that conformed to the standard of care, the psychiatrist was left with a difficult diagnostic dilemma and made a reasonable judgment that turned out to be incorrect, liability should not accrue.

The advances in biological treatments of demonstrated efficacy have heightened the importance of proper diagnosis. If the negligent failure to consider a diagnosis (e.g., the possibility that a psychotic illness represents bipolar disorder and not schizophrenia) leads to a failure to use a potentially efficacious agent (e.g., a mood stabilizer), with prolonged suffering and repeated hospitalization as a result, a good case for malpractice would seem apparent. If anything prevents such cases from proliferating, it is probably (a) the condition of many of these patients, who are chronically ill and socially impaired and thus unlikely to initiate legal remedies; and (b) that still no absolute one-to-one correlation exists between specific illness and specific treatment with certain efficacy. Otherwise, misdiagnosis would seem to be a ripe area for future litigation.

The term *misdiagnosis* does not always refer to the failure to make a proper diagnosis of mental disorder in the psychiatric sense. It can also refer to alleged failure to detect a patient's suicidal or homicidal propensities. (See Secs. II-A-3-d and II-A-3-e for a discussion of these issues.)

b. Negligent use of somatic treatments. Most of the issues in cases of negligent use of somatic treatments differ little from those faced by physicians in any other medical or surgical specialty. Use of the wrong medication for a patient's condition, prescription of improper dosages (i.e., too high, leading to toxicity; or too low, leading to delayed improvement), failure to monitor side effects, failure to take proper precautions to prevent side effects from developing (as by using insufficient amounts of muscle-relaxant in administering ECT), and prescription of medication despite contraindications can, in psychiatry as in the rest of medicine, be construed as actionable under malpractice law.

One issue relatively specific to psychiatric practice is the negligent failure to use somatic treatment. Practitioners who rely entirely on psychotherapeutic approaches for all of their patients, and who do not refer patients for whom pharmacotherapy might be appropriate to more biologically oriented colleagues, are at risk for suits of this sort. Such suits are not common, in part because of the "respectable minority" rule. If a respectable minority of a profession follows certain practices, even if those practices are rejected by the majority of practitioners, the courts have been reluctant to find members of the minority to be negligent. This deference to minority opinion is a reflection of the courts' disinclination to be used to enforce orthodoxy among the professions. But the clearer the evidence for efficacy of medications or other somatic treatments, and the less apparent the benefit from the alternative approaches used, the greater the risk run by a clinician who fails to consider somatic treatments.

c. Negligent use of psychotherapy. The number of possible permutations of negligent behavior by a psychotherapist constitutes an obsessive's nightmare and a scholar's delight. Although many articles and books are filled with speculations about the kinds of harm that might be induced by negligent psychotherapy, such works almost always conclude with the barely noted caveat that malpractice cases alleging negligence in psychotherapy are exceedingly rare. Among the explanations for this are the good relationships most patients have with their psychotherapists (although negative transference reactions of significant severity are hardly unusual); the patient's low index of suspicion for negligent acts, given the patient's usual unfamiliarity with technical aspects of psychotherapy; the difficulty in proving that the act was negligent, because of the absence of witnesses and other corroborative data and because the techniques of many forms of psychotherapy have diverged so greatly from the original analytically oriented model that a professional consensus on what constitutes an adequate standard of care is difficult to obtain; the crucial role of the patient's own participation and, hence, responsibility; and the difficulty in establishing a causal link between a therapist's statements and the subsequent harms that accrue to the patient. In fact, so rare are reported cases of actual suits about the psychotherapy process itself that most discussions of this topic concentrate on cases involving nonpsychotherapeutic interactions between patients and therapists, such as sexual intercourse (see Sec. f) or other abuses of the fiduciary relationship.

Nonetheless, it *is* possible to be negligent in conducting psychotherapy, just as it is possible to be negligent in any other form of treatment. A divergence from the standard of care for psychotherapists usually flows from an intrusion of countertransference feelings into the treatment process. Thus, a therapist who, in anger at a patient's provocative behavior, berates that patient or suggests that the patient undertake some action that is not in the patient's best interest would, problems of proof aside, be liable for whatever harm occurs. Although it is possible to imagine a suit stemming from a patient's belief that, even absent any such extraordinary events, the psychotherapy was conducted so poorly as to inhibit the patient's recovery, the problems of proof in such a case are so overwhelming as to make a successful action extremely unlikely.

A growth in malpractice claims against psychotherapists has stemmed from the "recovered memory" controversy. Patients who develop memories of childhood abuse during therapy, when those memories have been absent for many years, sometimes come to doubt the truthfulness of the recovered memories. These patients may make accusations against their alleged abusers, only to retract the charges subsequently. Turning to their therapists, whose behavior they blame for inducing memories they now reject, such patients may file suits claiming that improperly suggestive techniques were used in their care. Unfortunately, some therapists engage in dubious practices that reflect their own presuppositions about the etiology of their patients' problems (e.g., believing that every patient with an eating disorder was sexually abused as a child). The result has been substantial verdicts for plaintiffs in a number of high-profile cases. (See Sec. II-D-4 for a discussion of liability to third parties in these cases and Sec. III-B-2 for consideration of steps that can be taken to reduce liability risks.)

d. Negligent failure to prevent patients from harming themselves. Of the many categories of psychiatric malpractice, allegations related to patients' attempts at suicide are, in many respects, the most perplexing. Such allegations may be cast in a variety of ways, generally encompassing failure to detect suicidal propensities and failure to act appropriately to control them. Unlike the previously discussed malpractice categories, however, harm to the patient as a result of suicidal behavior requires the patient himself to act as a causal agent. That is, whatever errors the clinician makes in the course of treatment, harm would not accrue were it not for the ultimate actions of the patient. Generally in tort law, such behavior would be considered contributory negligence by the patient, rendering the clinician, even if negligent, free from liability, or—at most—apportioned some fraction of resulting damages.

Why is contributory negligence not often considered where suicide is concerned? Although not usually explicated clearly by the courts, the governing assumption seems to be that psychiatric patients whose suicide attempts are motivated by their disorders lack either the ability to control their impulses or the capacity to think clearly about their options. Put somewhat differently, it might be said that they are incompetent to determine their own behavior. Thus, the legal significance of a suicidal patient's actions as contributory negligence is diminished, leaving clinicians who committed negligent acts solely responsible for the outcome.

The difficulty of predicting suicidality was discussed in Chapter 2 (see Sec. II-E-2-b). Needless to say, clinicians are not considered negligent merely for having failed to predict suicidal acts, as long as they take the steps considered necessary by their profession. In general, patients should be asked at the time of initial evaluation about the signs and symptoms of depression and about suicidal history and current suicidal intent. Should patients falsely deny suicidal ideation and later act on it, the clinician can hardly be held responsible. If suicidal ideation is present, the difficult task of assessing its degree and seriousness remains. (See Chap. 2, Sec. III-B.)

Just how far a clinician must go to prevent a patient from attempting suicide is unclear, though the burden is clearly greater in an inpatient setting, where the clinician has a greater degree of control over the patient's behavior. Most experienced clinicians believe that a patient who is set on killing herself will find a way to do so, regardless of the precautions taken. Thus, the task is to design responses to decrease the likelihood of successful suicide among those who are deterrable, while recognizing the limitations of the clinician's realistic capabilities and the need to balance safety concerns with other requirements for effective treatment.

Must involuntary hospitalization be pursued if it is the only means of deterring suicide? Many suits have been decided under the assumption that civil commitment of the seriously suicidal represents the standard of care. At least one decision, however, has challenged that standard as a matter of law. At present, it is safe to assume that commitment may be necessary if other courses of action are likely to be ineffective, though this is an issue to be watched in the courts.

e. Negligent failure to prevent patients from harming others. Psychiatrists have always faced the potential for suits as a result of negligently allowing patients to be released or to escape from inpatient facilities when those patients later cause harm to others. The California Supreme Court decision in *Tarasoff v. Regents of the University of California*, in 1976, extended the duty to protect third parties to situations in which clinicians (not just psychiatrists) had never exercised physical control over their patients. The court ruled that when clinicians know or should know that their patients represent a danger to others, they have a duty to take whatever steps are reasonably necessary to protect those identifiable persons. Since the California decision, most states have adopted some version of the *Tarasoff* rationale by case law and statute. Where no state law exists on the matter, most experts would agree that it is prudent to behave as if a duty to protect exists in that jurisdiction anyway. (See also Chap. 1, Sec. II-B-5-d.)

The *Tarasoff* decision has been subjected to a great deal of criticism from the mental health professions on two grounds. First, it is argued that the inability of clinicians to predict future dangerousness saddles them with a responsibility that they cannot reasonably fulfill. Even when predictions of possible violence are made, clinicians have a limited range of abilities to protect potential victims, many of whom are intimates of their patients. Second, opponents of the duty to protect maintain that the harm from imposing a duty outweighs whatever benefits may be obtained. Faced with the threat of breaches of confidentiality, those patients most in need of treatment may decline to seek it. In addition, other patients may be deterred by an unfounded fear of disclosure, and clinicians may overuse maximally protective options (e.g., hospitalization) from fear of liability.

These arguments have had relatively little impact on the courts. In response to claims of inability to predict dangerous behavior, they point to assertions by many clinicians—documented repeatedly in surveys—that they *can* predict violence. The courts then note that they are asking clinicians to live up to the standard of their colleagues (i.e., to do as well at prediction as would any reasonable mental health professional). Of course, this standard becomes problematic when expert witnesses testify at trial, in retrospect, that they—and therefore other reasonable clinicians—would certainly have known that the patient would be violent and that the defendant should have as well. The courts have been willing to tolerate the putative negative effects of imposing a duty to protect (while noting that they have not been demonstrated) to avoid the harms that might result from clinicians failing to act to protect likely victims when they believe that danger may exist.

Legislatures have been somewhat more responsive to clinicians' concerns, particularly claims that court decisions often left it unclear when the duty arose and what means were sufficient to discharge it. A growing number of states are adopting roughly similar legislation to limit the duty to circumstances in which patients make overt threats against identifiable victims, thus diminishing the problems of prediction. Further, the statutes generally provide that the duty is fulfilled if one or more of a small number of options is selected, including warning the victim or the police, or both, and hospitalizing the patient, voluntarily or involuntarily. These statutes may provide an acceptable compromise between public safety concerns and clinicians' fears of unreasonable imposition of liability.

Clinical approaches to dealing with the requirements of the duty to protect are considered in Section III-A-2-g.

f. Sexual activity between patients and therapists and other boundary violations. Surveys of mental health professionals show that 5% to 10% of therapists admit to sexual activity with patients, with male therapists confessing such behavior outnumbering female therapists between 2:1 and 5:1. Other work suggests that patients who engage in sexual activity with their therapists almost uniformly suffer adverse effects, frequently severe. The idea that sexual contact may constitute a beneficial aspect of treatment has been rejected entirely. Thus, a consensus has developed that sexual contact between patients and therapists is *never* acceptable, a view reflected in the codes of ethics of all the major mental health professions.

It is possible, of course, for any two people who work together intimately over a prolonged period to develop feelings of fondness and sexual desires for each other. The special conditions of a psychotherapeutic setting and its contract, however, call for an exploration of those feelings with an eye toward helping the patient understand their genesis and their relationship to other events in his or (usually) her life. The therapist is likewise called on to examine the origin of his feelings about the patient and to prevent them from interfering with the treatment process. Acting on those feelings represents, for the therapist, a failure of self-exploration and self-restraint to such a degree as to constitute negligence. The claim that in no other setting would the physical expression of sexual longings be categorized as negligence on the part of one of the parties, although true, merely emphasizes the uniqueness of the psychotherapeutic dyad. Three factors contribute to this uniqueness: the special vulnerability of patients who seek mental health treatment; the power differential between therapists and patients, heightened by the phenomenon of transference, which makes it difficult for patients to resist therapists' sexual advances; and the strong likelihood that patients are harmed by whatever sexual contact ensues.

Courts are unsympathetic to claims that sexual involvement was the result of overpowering passion and should therefore be excused, to allegations that the patient's freely given consent should absolve the therapist of any responsibility, and to arguments that because the sexual activity took place outside of the therapy, it is not properly considered under malpractice law. Instead, the courts are likely to stress the fiduciary relationship that exists between patient and therapist (i.e., the idea that in the development of a therapeutic relationship the patient is induced to place full trust in the therapist, believing his position to be that of the patient's ally, who is committed to act unfailingly in the patient's best interests). Sexual activity is, in this view, always a betrayal of the patient's trust and an unfair capitalization on the patient's transference feelings.

As the area of sexual involvement has been explored, additional issues have been considered. It was once considered acceptable for therapists who fell in love with their patients to discontinue treatment, refer the patient to another therapist, and then pursue romantic involvement. This is no longer the case. The American Psychiatric Association's ethical code reflects the new belief that sexual contact with former patients is always exploitative of them, because it is likely to be based on unresolved transference, and therefore unethical. It may also be the basis for a malpractice suit.

Because sexual activity with a patient is an intentional act, it may seem problematic to characterize it as malpractice, which is a negligent tort. From plaintiffs' point of view, however, this characterization is desirable, because it gives them access to clinicians' malpractice insurance policies for purposes of compensation. Although many insurers try to avoid indemnifying clinicians who are found to have engaged in sexual contact with patients, on the grounds that their actions fall outside of the negligent behavior the policies are designed to cover, plaintiffs are generally successful in overcoming these arguments. One usually successful technique is to characterize therapists' behavior as a negligent form of treatment (because therapists should know that harm is likely to result), particularly a mishandling of the transference. This allegation of negligence may even be made against practitioners who do not use insight-oriented psychotherapy and therefore do not see themselves as dealing with transference (e.g., behavioral therapists and psychopharmacologists). In supporting these charges, the courts seem to be saying that this is one area that no clinician can ignore. Some insurers agree to defend accused therapists in such cases but try to avoid paying the judgment if therapists are found liable. Clinicians should be aware of their insurer's policies in this regard.

An active policy debate is whether malpractice policies should cover sexual misconduct. On one side are those who argue that malpractice insurance was never meant to deal with intentionally harmful behavior. To include sexual contact within the scope of malpractice policies is to place a tax on the majority of therapists who do not have sexual contact with their patients, to the benefit of those who do. On the other side are people who believe that some compensation ought to be forthcoming for patients who have suffered harm at the hands of sexually abusive therapists. Without malpractice coverage, payment in many cases is not possible, as therapists lose or dispose of their assets. Because someone must bear the cost of the harms suffered by patients, it is argued that rather than leaving the burden on the abused patients, it is fairer to spread it among all practitioners.

In response to the perception that the professions have been ineffective in sanctioning sexual activity with patients, the states have become much more aggressive. Complaints to licensure boards routinely result in therapists losing their licenses. A growing number of states are passing laws requiring the reporting of sexual activity known to other health and mental health professionals, making it easier for patients to sue (e.g., defining the cause of action, extending the statute of limitations), and even criminalizing the behavior. Therapists found to have had sex with patients, and in some cases former patients, face long prison terms in some states. This activity by licensure boards, combined with education by professional organizations and the risk of civil and criminal liability, may have resulted (though accurate numbers are difficult to establish) in a considerable reduction in therapist-patient sexual activity.

Sexual contact with patients—and in most circumstances, ex-patients—has moved from a deplored, but tolerated, status to being clearly rejected by practitioners and the public alike. Sex with patients is never justified; following that simple rule prevents much distress for patients and therapists alike.

As issues related to therapist-patient contact have been clarified, the focus of concern about boundary violations (see Sec. III-A-1-a for a discussion of the concept) has grown to encompass other forms of patient exploitation, including improper physical contact that stops short of sexual intercourse, the development of social and business relationships with patients, and requesting or accepting personal favors and expensive or intimate gifts from patients. Much of the reason these behaviors initially attracted attention was because they were seen as stepping-stones to sexual relationships; they have come to be seen as harmful to and exploitive of patients in and of themselves. Boundary violations can precipitate malpractice actions, licensure proceedings, and ethics complaints to professional societies.

g. Negligence in supervision. Negligent supervision has become a more significant issue for psychiatrists as managed care has altered the way in which most mental health treatment is delivered. With psychiatrists often limited to providing medications, psychotherapeutic treatment has frequently been turned over to other mental health disciplines. This shift has encouraged the development of group practices and clinics in which a handful of psychiatrists may participate in the care of hundreds of patients who are being seen primarily by therapists of other disciplines. (This phenomenon was first seen in community mental health centers, which adopted a similar approach in response to their own resource limitations.) The nature of psychiatrists' liability risks in this type of venue depends on their precise relationship with their clinical collaborators.

For psychiatrists who employ other professionals, liability problems derive from the law's assumption that those who are subject to their supervision are actually their agents—in other words, that the patient's relationship is established primarily with the physician (even if the patient never meets the physician) and is only mediated by the nonmedical mental health professional. As such, the physician is held responsible for the acts of her agents and for their negligence as well. The relevant legal doctrine is often known by its Latin name, *respondeat superior*— "let the master reply." That the psychiatrist did not know about the act in question is no defense; the standard of care to be met is the standard of the psychiatric profession, and the failure of the psychiatrist to make reasonable efforts to ascertain that her agents were living up to that standard is proof of negligence in itself.

The liability question may be less clear in clinics in which psychiatrists are themselves hired to supervise other mental health workers, rather than employing those workers directly; in some jurisdictions, a direct employer-employee relationship may be required before *respondeat superior* may be applied. In other states, a psychiatrist's responsibility for the acts of others may vary depending on whether the psychiatrist operates in a consultative capacity—proffering advice that may be accepted or rejected—or in a supervisory capacity. In the latter case, the psychiatrist may be viewed as having ultimate responsibility for the patients' care, a responsibility that the psychiatrist actually exercises through those professionals under her supervision, but cannot shed completely should a negligent act occur. Psychiatrists in such settings should clearly define the nature of their responsibilities, preferably in writing. Many clinic and practice situations are inherently unsatisfactory from the perspective of potential liability; while endowing the part-time psychiatrist with responsibility for supervising the care of large numbers of patients, such settings provide too little time for a careful monitoring of the care to take place. Psychiatrists would be well-advised to avoid such positions, as well as clinics or practices in which they believe that, regardless of the amount of time spent in supervision or the extra training provided, the personnel employed cannot possibly provide an adequate level of care (see Sec. III-B-3 for a discussion of risk management strategies in supervision).

With the spread of statutes allowing independent practice for psychologists, social workers, and other therapists, issues regarding *respondeat superior* and negligent supervision are no longer the exclusive concern of psychiatrists. A psychologist supervising other nonmedical mental health professionals, for example, must also take reasonable steps to ascertain that they are conforming to the standard of care.

h. Abandonment. When the question of abandonment is raised, the law's concern is that the trust that the patient has presumptively lodged in a mental health professional should not be abused by the sudden termination of the patient's care. Because of the trusting—or fiduciary—nature of the relationship, the clinician must in practice frequently do more than an average person would in comparable circumstances. At the least, before a clinician unilaterally stops seeing the patient, a proper locus of referral should be identified. Ideally, the clinician should first contact the practitioner or agency to which the referral is being made and obtain agreement for the transfer of care.

i. Patients who threaten their therapists. The law, of course, recognizes that instances exist in which this orderly approach to termination is untenable (e.g., when the patient has seriously threatened the physical safety of the therapist). Yet even then a clinician cannot simply refuse to see the patient and leave it at that. An effort at referral to an appropriate source of care must be attempted. Although one can argue that this effort requires an extraordinary amount of devotion on the part of a therapist whose life may have been threatened, the law tends to see it merely as a *quid pro quo* for the benefits that the clinician obtains from the relationship: money, status, and a certain measure of power over patients who repose their trust in him.

ii. Patients who fail to pay. Courts look less favorably on therapists who have stopped seeing patients because of failure to pay their bills than those who have terminated patients for any other cause. Although the realities of the situation are quite different, the popular—and this includes the legal—view of psychiatrists and other mental health professionals is that they not only charge exorbitant fees, but are unmerciful in dropping patients who cannot afford to pay them. Clinicians, therefore, who find that they have exhausted the usual recourse of extensively discussing the situation with the patient and who desire to terminate treatment with a patient who has not paid a bill over a substantial period would do well to document the repeated discussions carefully, to make clear to the patient that if the bill is paid she can return, and to offer referral to a public clinic or other available source of care. (See also Secs. III-A-1-c-ii and III-A-2-h.)

iii. Patients who do not cooperate. As with a patient who fails to pay bills, one who fails to comply with a clinician's instructions may remain resistant to exploration and interpretation and may thus lead the therapist to desire to terminate therapy. This is a tricky matter. To the clinician it may make perfect sense that, if the patient does not follow advice (e.g., to abstain from alcohol or to avoid hallucinogens), there is little point in continuing treatment. The layperson—and it is laypersons who sit on juries—sometimes sees things differently. Mere contact is often viewed as being therapeutic, as captured in the phrase, "I am being seen by a doctor." Even in the face of no progress whatsoever in treatment, a jury might—perhaps correctly—perceive a valuable supportive function of continuing therapy. A similar problem arises when a patient is denied admission to the hospital, another thing that laypersons may see as therapeutic in itself.

A decision to terminate treatment for compliance failure is not always inappropriate, however, but in light of popular biases against such a move, the grounds for the decision should be recorded carefully. Frequently, this involves the clinician's judgment that his approval of the patient's conduct implicit in continuing treatment is actually more destructive to the patient than terminating treatment altogether, with an option for reentry should the patient's behavior change. The reasoning should be explained to the patient, and the patient should be given a chance to respond. If the decision is made to terminate treatment, the patient should be given sufficient time to make alternate arrangements for care.

iv. Disliked patients. Psychiatrists and other psychotherapists, unlike orthopedists for example, may find it impossible to continue to work effectively with a patient whom they dislike. This goes, of course, to the core of the psychotherapeutic process, which is built on a mutually accepting and trusting relationship. Nonetheless, to discharge a patient from care because the patient is disliked may seem like the paradigm case of abandonment. If it is clear that, because of personality differences, the psychotherapeutic work is stalled, then the situation should be explained to the patient, and noted in the record, in those terms. A good-faith referral to another caretaker should complete both the clinical and legal aspects of the termination.

v. Coverage during absences. Abandonment, to result in liability, need not be manifested by a permanent withdrawal of services to a patient. The negligent nonavailability of a therapist, even for a brief period, is equally culpable. Clinicians who work with patients for whom emergencies are likely to arise when they assume the patient's clinical care, commit themselves in the eyes of the law to more than just one hour per week. They must be reachable in an emergency and able to provide care or referral as needed. Whether this obligation applies equally to nonmedical caregivers is not as clear—although it is likely that as nonmedical caregivers assume roles more comparable to those of psychiatrists, they will be held to have assumed similar obligations.

As no therapist is ever continuously available, the law permits the delegation of this responsibility to another professional. Clinicians who are unavailable for a prolonged period (e.g., if a therapist leaves town for the weekend) should arrange in advance for coverage for their practice and ought to notify their patients of how the covering clinician can be contacted. Although the primary clinician is not held responsible for the negligent acts of the covering clinician, the primary clinician is held liable for negligence in the selection of coverage (e.g., if coverage is arranged with someone who the primary clinician knows or ought to know is not capable of performing properly, the primary clinician shares liability for his acts). Whether coverage is needed for short periods of unavailability is strictly a function of the clinician's practice and of how likely it is that an urgent situation will develop in the interval in question. A psychiatrist with an active inpatient practice may want to have continuous coverage or may choose to use a pager to ensure her availability at all times. Psychiatrists working in clinics or hospital-based facilities may be able to use 24-hour emergency or walk-in services to provide coverage.

4. Malpractice Insurance

Most independent practitioners purchase malpractice insurance to cover the costs of litigating claims against them and paying settlements or judgments. Some states require physicians and other clinicians to carry insurance, often with a certain minimum amount of coverage. However, other states allow practitioners to "go bare"—that is, to practice without any coverage and to bear the costs that would be paid by an insurer themselves. This practice, though it has its advocates (who believe that it deters patients from filing suits), leaves the clinician open to potentially devastating financial consequences. All mental health professionals should carry malpractice insurance.

Two general classes of malpractice insurance policies exist: claims-made policies and occurrence policies. Claims-made policies, as the name suggests, cover the clinician for any malpractice claims filed from the date the policy is purchased forward, so long as the policy is still in force. However, should a practitioner allow the policy to lapse (e.g., when she retires), claims made subsequent to that time (even if based on events that occurred while the policy was in force) will not be covered unless additional "tail" coverage is purchased. Early in their lives, claims-made policies are usually a cheaper alternative, but after a period of time their costs tend to rise to the same level as the alternative option—occurrence policies. A clinician who purchases an occurrence policy will be covered for any claim arising from an event that took place while the policy is in force, regardless of when the claim is filed. Occurrence policies do not require "tail" coverage when clinicians change states, retire, or let their policies lapse for other reasons.

As litigation has increased, policies have begun to vary in the kind of activities they cover. All policies cover routine clinical work. But psychiatrists who do electroconvulsive therapy, for example, may not be covered for that work unless a special, more expensive policy is purchased. Administrative activities and forensic work are two other categories that are not always included in standard malpractice policies. Not all policies will defend mental health professionals from complaints brought before regulatory bodies, such as boards of licensure. Some companies allow the covered clinician to determine whether or not a case is settled before trial, a decision that can have adverse consequences for physicians in particular (since it must usually be reported to the national practitioner database), even if it may be in the interest of the company. A clinician looking to purchase a malpractice policy is well-advised to investigate all of these issues before committing to a particular program.

Although coverage for the mental health professions tends to come at lower cost than the policies that cover high-risk medical specialties such as obstetrics and neurosurgery, it too has become more expensive over the years. Thus, state laws aimed at reducing malpractice costs by such strategies as capping compensation for non-economic losses (e.g., pain and suffering) may impact psychiatrists and psychologists (see Sec. II-E-2). Conflicting empirical accounts are offered as to whether such laws actually reduce claims and thus lower the costs of insurance, or whether the natural cycle of the insurance industry—in which the prices of policies tend to rise and fall cyclically—are responsible for the positive changes sometimes seen after such laws are enacted. The vicissitudes of the insurance industry also contribute to occasional bankruptcies of insurers. Although all states have guaranty funds that are supposed to cover the costs of claims filed against persons insured by bankrupt companies, the caps on the claims paid by such funds are often much lower than typical malpractice awards, leaving clinicians in this situation at considerable personal risk. Checking on the financial solvency of an insurer prior to purchasing a policy is a wise precaution, though rapid changes in industry conditions mean that it is not absolute protection against having to face this situation.

B. INFORMED CONSENT

1. Evolution

Under common law, any unconsented touching constitutes a battery, even if that touching takes place for the purpose of rendering medical care. Therefore, physicians, particularly surgeons, have long operated under the obligation to obtain the patient's consent before proceeding with treatment. Obtaining a valid consent, however, was once a simple matter, requiring only that the physician disclose the nature and purpose of what the physician proposed to do. The patient's assent to this proposition was sufficient to protect the physician from liability.

The rationale for the law's approach to liability for unconsented touchings was to protect patients' rights to bodily autonomy, an interest highly valued in our society. By the late 1950s and early 1960s, however, many courts had concluded that the existing requirements for consent were insufficient to accomplish that end. With the growth of multiple approaches to most medical problems, each with its own balance of risks and benefits, protection of the right to determine what is done with one's body required that patients be told more than just the nature and purpose of the one procedure selected by the physician. In place of this limited duty, the courts began to require an "informed consent" and began to create a body of decisions that defined what that meant. Although it was unclear at first whether treatment, especially surgery, that took place in the absence of an informed consent, constituted a battery or an act of malpractice, that issue has been substantially resolved: Treatment without any consent or over a patient's objections may constitute a battery, but treatment after an inadequate consent is properly considered as a form of malpractice.

The application of informed consent to treatment in psychiatry is less clear than in general medicine. In general medicine, it is widely agreed that invasive surgical and diagnostic procedures, as well as treatment with medication, require the patients' informed consent. This requirement applies to psychiatric treatment in which medication is used and to other psychiatric treatments directly affecting the body, such as ECT. Whether informed consent is required for nonsomatic psychiatric therapies, such as psychotherapy, is unclear at present. (See further discussion in Sec. II-B-5-b.)

2. Elements

Because the doctrine of informed consent evolved from a series of court decisions, it may differ from jurisdiction to jurisdiction. Despite this, the general outlines of the doctrine are fairly well agreed on. Three components exist: information, voluntariness, and competence. (See also Sec. II-B-3-b, where the relationship of these components to malpractice is explored, and Sec. II-B-6, where difficulties in the doctrine of informed consent are explored.)

a. Information. The information component of informed consent marks the greatest departure from the previous legal standards. Consent given in the absence of sufficient information is no longer considered to be an adequate consent. Of course, the question immediately arises as to how much information is enough. Physicians argued that the standard of care of the profession should be the measure applied here: The sufficiency of information should be judged by how much most doctors reveal to their patients.

Many courts agreed, adopting a “professional standard” of disclosure, which is still the law in roughly half of the states. This was an instance, however, in which a large number of courts rejected the right of a profession to set its own standard of care. Some judges argued that to permit this essentially would be to maintain the status quo, which was insufficiently respectful of the rights of the individual to control what happened to his person. The alternative standard that has evolved requires the physician to disclose all information that a reasonable person might want before deciding to accept or to reject treatment, including precisely what the treatment consists of, the potential benefits of the treatment, its potential risks, any alternatives that exist and their benefits and risks, and the benefits and risks of no treatment at all. An opportunity should also be offered for the patient to ask questions.

The “reasonable person” standard is a halfway step between allowing physicians to disclose whatever they consider material and the radical position of requiring disclosure of all information pertinent to the patient’s decision. If a patient is fearful of being in tall buildings, for example, the information that after the operation she will be cared for on the fifteenth floor of the hospital might be quite material to her decision on whether to have the operation; under the “reasonable person” standard, however, such disclosure would not be required because most people would not find it pertinent to their decision. Therefore, although the informed consent standard of disclosure goes a long way toward ensuring individual autonomy and allowing for idiosyncratic opinions, in almost all states it stops short of the ultimate step. However, the existing standard does not prevent the clinician (in the interest of having an optimally informed patient) from inquiring about the particular concerns of his patient and individualizing disclosure accordingly.

b. Voluntariness. In conformance with previous common law notions, a consent, to be adequate, must be freely given. Voluntariness (or its converse, coercion) can be a gross or a subtle matter. Obviously, a patient threatened by the hospital staff with not being fed or with not getting her clothes back until she agrees to take medication is being coerced in a way that undermines the autonomy of her decision. However, more subtle forms of coercion exist as well. It might, for example, be suggested to a patient that a letter necessary for obtaining welfare benefits might not be attended to very promptly unless he goes along with the recommended course of treatment. Clearly, this is illegitimate.

Even more subtle, and controversial, forms of coercion might be called “situational coercion.” Some believe that residents of total institutions, whether psychiatric, penal, rehabilitative, or other, cannot be presumed to be giving a voluntary consent to any procedure desired by the institution. The reasoning is that these individuals are so dependent on the institution for their every need, and in some cases for the opportunity to return to the outside world, that they face subtle coercion to agree with the institution’s recommendations. Although such cases may exist, the result of applying the theory broadly—namely, depriving all inhabitants of total institutions of the right to make any decisions on matters of importance—hardly seems in accord with the desire to maximize autonomy, a desire that underlies the whole concept of informed consent. Coercion, in its subtlest forms, exists in all interpersonal relationships and, at this level, should probably be excluded from consideration by the legal system. This last idea is in keeping with the usual legal and philosophical approaches to the analysis of coercion, which emphasize that in order for pressure to constitute proscribed coercion it must be illegitimate—meaning that the justified exhortation of a caregiver to a patient to accept a recommended treatment or the equally acceptable pressure from family members to consent to, or refuse, care does not render the patient’s decision void. Only illegitimate forms of pressure, such as those described above, have this effect.

c. Competence. The law of informed consent requires that the patient be competent to offer a consent. The intricacies of competence are discussed in detail in Chapter 5. For our purposes here, we consider that the goal is to ensure that the individual has sufficient mental abilities to be able to engage in the informed consent process. Types of patients who may have an impairment of their competence include the mentally retarded, the organically impaired, psychotic patients, and children. (See Chap. 5, Sec. II-A.)

Children are, by law, deemed incompetent until they attain the age of majority, regardless of their actual capacity at any given age. State laws vary widely with regard to the age at which an individual is no longer a minor for the purpose of consent to mental health treatment. Exceptions often exist as well for "emancipated minors"—those who have lived on their own for a period—or for certain kinds of diagnosis and treatment (e.g., treatment of venereal disease or consent to abortion). Every practitioner should be aware of the laws in her particular state.

3. Lack of Informed Consent as Malpractice

Informed consent may now be required before the treatment of psychiatric patients can proceed, but the simple failure to obtain an adequate informed consent does not, in itself, constitute malpractice.

a. Elements required. The elements required to establish malpractice on the basis of improper informed consent resemble those required in malpractice cases generally (see Sec. II-A-1). The existence of a clinician-patient relationship, and therefore a duty of care, is usually self-evident from the fact that the clinician did something to, or with, the patient. In this case, the clinician's negligence would consist of not obtaining a proper informed consent for what was done; most cases revolve around the specific issue of whether the patient was adequately informed before the procedure or treatment. Even if a proper consent was not obtained, the patient must additionally establish that some harm occurred as a result of the procedure. And finally, a link must be drawn between the failure to obtain an adequate informed consent and the resulting harm. This last goal is usually attained by requiring the patient to prove to a preponderance of the evidence that, had a reasonable person been given the information that was omitted, that person would have chosen not to proceed with the procedure or treatment. Some courts allow the patient merely to prove that the patient, himself, would not have consented had the information been available. Even in the absence of demonstrable negligence in the actual procedure or treatment, should a bad result occur, the physician may be liable if a proper informed consent was not obtained—because that in itself is evidence of negligence.

b. Problems of proof. The difficulties of establishing that a duty of care existed and that a harm occurred are no different in the informed consent case than in malpractice cases generally (see Sec. II-A-2). What is special about these cases is determining the adequacy of the consent and establishing causation (see also Secs. II-B-2 and II-B-6).

i. Information. The patient-plaintiff is usually in the position of alleging that certain key information was not presented to her before she decided to proceed with the treatment. If no records exist, it is a matter of the jury choosing between believing the patient and believing the clinician, assuming the clinician alleges otherwise. Most clinicians, who are, naturally enough, uncomfortable with this situation, would prefer to have documentary evidence with which to counter the patient's allegations.

Two documentation options are generally used. Some practitioners and facilities prefer to have a patient sign a written consent form that outlines the relevant material. Although useful in some cases, written consent forms may be avoided because of the possible implication that the material in the form was the only material communicated to the patient. Additional discussions between the doctor and the patient, or between the patient and other personnel, are not recorded on the form and may be ignored in court. In addition, routine use of consent forms often has the effect of turning what should be a free and spontaneous interaction between clinician and patient into a rigid procedure in which the clinician uses the form—often loaded with jargon—as a substitute for a clear presentation of the facts to the patient, rather than simply as documentation of such presentation.

The second documentation option is for the clinician to record in the patient's chart that a consent interview has taken place, enumerating the topics covered in general terms, and noting specifically whether the patient had particular concerns. The patient need not sign the note. Courts are usually quite willing to accept such notes as evidence of the consent discussion and, because they are not exhaustive, there is scope for the clinician to elaborate on the contents of the discussion in court. The good faith demonstrated by placing the note in the chart is generally supportive of the clinician's supplementary testimony.

Of course, more imaginative options for documenting consent exist. Some practitioners audiotape or videotape consent interviews, an unnecessarily conservative step that can backfire on a competent clinician who, for example, comes across poorly on tape or on a video screen. In any event, some record of the consent transaction is important. Several studies have demonstrated that patients often forget much of what was discussed in such sessions or forget that the session took place at all. Patients can sometimes, in good faith, argue that they were not informed about potential risks, when in fact the information was conveyed. Naturally, memory limitations apply to clinicians as well: It can be acutely embarrassing to be asked, several years after the date in question, to reconstruct in court the exact contents of a consent interview without any record on which to rely.

ii. Voluntariness. Depending on the type of undue influence alleged, it may be quite difficult in retrospect to determine the level of voluntariness of a given consent. Determination of voluntariness is, in fact, usually a policy issue (i.e., whether a given class of patients has been subject to coercion) rather than one that affects an individual patient. Nonetheless, if some special circumstance might be construed as impairing voluntariness (e.g., the threats of staff members to beat up a patient unless the patient consents to ECT), the reasoning as to why that is—or is not—the case should be recorded carefully along with the record of the consent interview.

iii. Competence. The prime difficulty in establishing a patient's status in regard to competence is continuing uncertainty about the standards to be used (see Chap. 5, Sec. II-A). Again, the rule is that if any reason to doubt the patient's competence in retrospect might exist, a careful examination for competence should be conducted (see Chap. 5, Sec. III-A) and its results recorded. Structured instruments for the assessment of decision-making capacities have been developed (see Suggested Readings, Grisso and Appelbaum) that provide objective scoring of patients' performance. Such instruments may be of particular use in difficult cases or where court involvement is likely.

iv. Causation. Drawing a causal link between deficiencies in the informed consent process and ultimate harm is very difficult. It requires the patient's demonstration that—had the additional information been supplied—his choice, or the choice of a reasonable person, would have been different. The subjective nature of this assessment is demonstrated by the numerous court decisions that have varied greatly in the kind of risks that they deem to be significant enough to have been disclosed. Cases range from risks of 3% chance of death and 1% chance of loss of hearing in which disclosure was required to those decisions in which disclosure of a 1.5% chance of loss of eye and 1/8,000,000 chance of aplastic anemia was not required. (See also Sec. II-E-4, in which it is suggested that the courts may be influenced in setting these standards by a desire to award compensation.) Some legal commentators look closely at the statistical probabilities of various outcomes, whereas others say that any risk that might deter the patient, no matter how unlikely it is to occur, should be disclosed. The latter seems too extreme a view to be implemented, but two guidelines are (a) the more severe the potential harm, the lower the threshold should be for disclosure; and (b) the most common risks of most treatments or procedures should probably be disclosed, even if they are relatively minor. Unfortunately, more definitive guidelines are not available for the practitioner.

4. Exceptions

The objections of many psychiatrists to the doctrine of informed consent are rooted in the supposed rigidity of the doctrine and its inapplicability to clinical psychiatric practice. Some of the difficulties with informed consent are considered later (see Sec. II-B-6), but we begin the discussion of exceptions to the requirements of informed consent by noting that the law itself recognizes some of the difficulties and provides for four situations in which they do not apply: during emergencies, when patients would be harmed by disclosure of information, with patient waiver, and when the patient is incompetent.

a. Emergencies. Informed consent need not be obtained in emergency situations. The key to this exception, of course, is how an emergency is defined. The definition is more clear-cut in general medicine than in psychiatry. In the case of a near comatose patient in diabetic ketoacidosis, a severely traumatized patient with internal bleeding, or a patient in a hypertensive crisis, it is apparent that the time required to obtain an informed consent (or a substituted consent if the patient is not competent to offer a consent—see Chap. 5, Sec. II-C) would so delay the needed treatment as to pose a direct danger to the patient's life. In such circumstances, the physician may treat without a formal consent. The law, to make its balance sheets come out even, creates the fiction of an "implied consent" in these cases; because almost any rational person facing an acute, life-threatening crisis would elect to proceed with treatment, the law allows the physician to read the consent as being implicit in the situation.

Genuine emergencies do, of course, exist in psychiatry. A violent, excited, or self-mutilating psychotic patient in the emergency room or on the inpatient ward may require immediate restraint or medication, or both, to prevent physical harm to self or others. This is perhaps the most clear-cut case and the only exception to the informed consent requirement that has been granted consistently in court decisions concerning the right to refuse treatment. Other situations are more ambiguous from the legal standpoint. Acutely psychotic, nonviolent patients, although suffering great distress, may not, in some jurisdictions, present a sufficiently emergent situation (from the legal viewpoint) to justify complete disregard for obtaining informed or substituted consent. The same appears true for severely depressed patients, even if food and fluid intake are minimal to nonexistent, as long as their physical status (i.e., electrolytes, blood pressure, cardiac function) is stable. In both these cases, in some jurisdictions, an attempt must be made to obtain an informed consent before treatment or, if the patient is incompetent, to obtain a substituted consent.

Many psychiatrists argue that psychiatric emergencies should be defined more broadly (see Chap. 3, Sec. II-C-4 on the right to refuse treatment) to encompass a variety of acute situations in which the potential for great suffering or for rapid decompensation exists. Some courts have agreed, and psychiatrists in other states continue to hew to a more clinically oriented standard, awaiting a definitive court ruling in their jurisdiction.

b. Therapeutic privilege. Even before the time that the requirement for consent became the mandate for informed consent, situations existed in which the normal procedure for informing the patient about the nature of her condition and the proposed treatment could be suspended if it were in the patient's best interest to do so. This exception, called *therapeutic privilege*, applied whenever the physician felt that the information to be conveyed would in itself be so damaging to the patient that disclosure would be antitherapeutic. Whether a patient was told that he had cancer often revolved around this issue.

Some doctors are delighted with the idea of therapeutic privilege, because it reinforces their status as someone who is allowed to decide what is or is not in the patient's best interest and because it seems to provide an exception to the requirement for informed consent. "If I tell any of my paranoid schizophrenic patients about the side effects of their medication," a psychiatrist who falls into this group might say, "of course they'll refuse to take it. Then they'll decompensate and require rehospitalization. So it's clearly not in their best interest for me to get an informed consent from them." Naturally, if the courts accepted this construction of the therapeutic privilege, it would all but vitiate whatever impact the informed consent requirement has had. More alert courts, realizing this, have drawn the privilege much more narrowly: If the information itself might be directly damaging to the patient, it can be withheld (e.g., a fragile schizophrenic patient need not be told her diagnosis), but not if the damage would be mediated by the decision of a well-informed patient to refuse treatment. Judicial decisions have emphasized strongly that the option to refuse is precisely what the informed consent doctrine was designed to allow. In theory, if the disclosure would interfere with the patient's powers of rational decision-making, it could be withheld, but that, too, is likely to be construed narrowly where the nondisclosure of risks is involved. So construed, the situations in psychiatry in which therapeutic privilege can be invoked are relatively circumscribed.

c. Waiver. The right to an informed consent, insofar as it belongs to the patient, can be waived by a patient who chooses to do so. No clinician is required to reveal information to an unwilling patient. In sensitive situations, waiver can be a subtle phenomenon. A physician who begins to explain the risks of a procedure to a patient, only to have the latter say, "That's okay, Doc, I trust you. Just go ahead and do whatever you have to," has just received a waiver that, if properly recorded, would probably stand up in any court. Waivers of basic rights are usually required to be "knowing waivers" (e.g., in a criminal setting, a suspect must be told of the right to speak with a lawyer before she can be said to have waived that right). Although it is not clear whether such a strict interpretation applies to the informed consent process, in situations in which it is uncertain whether the patient is actually aware that he has a right to the information, a comment such as, "I'd be glad to tell you whatever you'd like to know about the treatment, but of course we don't have to go through it if you'd rather not," might ensure that the waiver is truly a knowing waiver. Patients may waive either their right to information or the right to consent, or both.

d. Incompetence. An incompetent patient is, by definition, not capable of giving an informed consent regardless of the category of incompetence, whether legal (e.g., patient is a minor) or functional (e.g., patient is psychotic). This issue is discussed at length in Chapter 5. The exception to the informed consent requirement in the situation of incompetence differs from the other three exceptions in that the requirement is not negated altogether: rather, its form is changed. Although consent cannot be obtained from the incompetent patient, it must usually be obtained from a substitute decision-maker, whose identity varies across jurisdictions (see Chap. 5, Sec. II-C).

5. Special Problems with Informed Consent in Psychiatry

a. Tardive dyskinesia (TD). For many years, the most complicated and controversial issue of informed consent in psychiatry concerned how much psychotic patients who require neuroleptic medication should be told about the long-term risk of TD (see also Chap. 3, Sec. III-C-2-e-iv). The salience of this question is undoubtedly diminished by the dominance of the newer generation of atypical antipsychotic medications. But recent data suggesting that the newer medications may have few advantages compared with first-generation antipsychotics, and present a difficult array of side-effects for clinicians to manage, may increase the use of the older medications. There is no satisfactory answer that applies in all situations about how much disclosure is required regarding TD, nor is there much guidance from the courts on the subject. One opinion among clinicians is that acutely psychotic patients should not be told about the risk of TD when treatment is initiated because, given their psychotic state, they can neither comprehend the information nor balance the risk with possible benefits, and might thus be led to refuse treatment. This opinion, however, appears to be based on a combination of the common misconception about therapeutic privilege (see Sec. II-B-4-b)—that if information will lead a patient to reject needed treatment, it can be withheld—and the assertion that acutely psychotic patients are incompetent to consent to treatment anyway—which is certainly true in many cases, is not true in others, and may call for a substitute decision-maker or special consent procedure in any event.

Another common rationale for withholding information from psychotic patients about TD is that the risk of TD does not accrue until several months after treatment begins, thus allowing disclosure to be deferred until then. This rationale, however, does not apply to a previously treated patient, whose putative "grace period" for TD risk may have expired long ago. Nor, given the evidence suggesting that TD is in part a function of total lifetime dose of neuroleptic medication, is it true that any period of administration is without risk. Finally, it seems unfair to patients to neglect to mention an important long-term side effect of a treatment they may come to rely on, only to reveal it to them later.

Thus, there is good reason to reject approaches that fail to provide some information to patients about TD, even at the beginning of treatment. An acceptable practice may be to titrate the amount of information disclosed to the patient's ability to assimilate it (assuming that the patient is consenting to treatment on his own behalf). This would mean some mention of the risk of TD at the initiation of treatment, with more details provided as the patient improves. This sensitive process should be documented in the patient's chart, but would be difficult to incorporate into a procedure that required the use of written consent forms. An identical rationale applies to disclosures regarding the metabolic effects of the newer atypical antipsychotics, which have replaced TD as the side-effect of greatest concern.

b. Psychotherapy. It has never been clear whether the requirements of informed consent apply to procedures that do not involve direct intrusion into the patient's body (e.g., psychotherapy). In favor of requiring informed consent to psychotherapy it has been argued that (a) many patients are unaware of what is involved in psychotherapy and need to know something about the process before becoming involved in it; (b) risks are attached to the process, including the risks that the patient will get worse or regress in therapy and that confidential information may fall into the hands of others (see Chap. 1, Sec. II-B-4); and (c) alternative treatments exist for most conditions, including other forms of psychotherapy or medications, of which patients have the right to know before committing themselves to a particular therapeutic approach.

Pressure for legislation requiring informed consent to psychotherapy has come from advocates who express concern about therapies aimed at recovering memories of past trauma. Although framed as laws requiring informed consent—including disclosures of the possibility that non-veridical memories may occur—many of these proposals would go much further, essentially banning forms of psychotherapy that have not been empirically validated. These are poorly crafted, destructive proposals that, despite widespread introduction in state legislatures, have yet to be adopted anywhere.

Opposition to obtaining informed consent to psychotherapy comes in part from therapists, trained in psychoanalytic approaches, who believe that discussions of the sorts of issues mentioned above would contaminate the transference and foster nonconstructive intellectualization and therefore undermine the therapy. Therapists of other schools of thought may minimize the risks associated with psychotherapy, maintain that patients know what they are getting into, and (in the case of nonmedical therapists) be reluctant to assume a consent burden that traditionally has been associated largely with the medical profession. Yet others still note the paradox of the patient's giving consent to what are essentially her own productions, psychotherapy being almost entirely the patient's own procedure.

No clear guidance in these situations exists, from either case law or statutes. It does seem reasonable, however, for patients to be told something of what they might expect in psychotherapy at the initiation of treatment. An exception might be made for psychoanalysis here, on the grounds that most analytic patients come to the analyst with a fairly good idea of what the process entails. It is difficult to believe that discussion of the treatment would undermine most nonanalytic therapies; many psychotherapists, supported by literature on the therapeutic alliance, already orient their patients to the process in precisely this way. When medication would be a reasonable alternative to psychotherapy, some discussion of this option may well be indicated. (Nonmedical therapists should probably offer to refer patients to a consulting psychiatrist for this purpose.) Also, when a particular threat to a patient's confidentiality is likely to arise (e.g., for patients involved in custody disputes with current or former spouses), a comment should be offered on the likelihood of this being a problem. On the other hand, formal consent forms and detailed notes would seem to be excessive precautions.

6. Assessment of the Doctrine of Informed Consent

The construction of the doctrine of informed consent is an ambitious effort by the legal profession to alter the nature of medical and psychiatric care; by attempting to change the elements of the clinician-patient interaction, it appears to hold the potential for what many would deem a radical redistribution of power in the therapeutic relationship. Such a conclusion, however, may be excessively optimistic. In addition to the practical problems of the doctrine, significant theoretical difficulties exist with informed consent law.

a. Practical problems. When courts began to require that doctors provide patients with all the information material to their decision whether to undergo treatment, they were operating with a model that rested on several implicit assumptions: that patients would pay attention to the information, that they would understand it, and that they would use the information in reaching their decisions. Empirical studies (although most suffer from methodologic problems) have cast serious doubt on these propositions. Patient attention and understanding, as measured by tests of recall, have almost always been found to be poor. It has been suggested that this might be a result of the way in which the information was presented (i.e., use of technical language, complicated sentence structure), but it is also possible that simplification of much medical information to a layperson's level is either impossible or is so difficult that it is practically impossible in everyday clinical work. Even given the requisite simplification, it is unclear if, in many cases, an individual without a medical education has the context in which to analyze the information. Further, to the extent that illness induces a state of regression in which patients seek a reliable authority figure on whom to depend, they may ignore the information altogether, preferring to ask the doctor at the end of the recitation, "What do you think I should do?"

Also implicit in the model of informed consent is the idea that the revealed information, assuming it is assimilated and understood, has some bearing on the patient's decision. This has been challenged from several directions. If we examine the situation temporally, it is clear that many patients make up their mind to accept or to refuse a given treatment well before the formal consent interview, perhaps even as early as the time they decide to seek medical attention. Nor is the kind of information that is transmitted by the physician necessarily the kind that most influences a patient's decision. Other factors—such as family pressures, the financial burden of entering a hospital or of refusing to, the attitude toward a particular form of treatment in the patient's social milieu, the vast store of information and misinformation on the Internet, and the nature of the setting in which treatment takes place—may be more influential than a description of potential side effects with unpronounceable names and remote statistical probabilities. Yet, the informed consent doctrine implicitly assumes that these other factors are relatively unimportant determinants.

b. Theoretical problems. Insofar as the doctrine of informed consent was intended as a mechanism to force clinicians to share information with patients, many legal commentators charge that the ways in which the doctrine has evolved have short-circuited that objective. These critics point to such factors as the use of a professional standard of disclosure, the classification of failure to reveal adequate information as a matter of malpractice rather than battery, and the difficult problems of proof confronting plaintiffs who allege failure to obtain informed consent as substantially limiting the impact of the doctrine. Together, these factors make it unlikely that clinicians will be sued for failure to obtain consent (an allegation validated by the data on the frequency of such cases) and even more unlikely that such suits will be successful. This, it is argued, in turn limits the degree of compliance with the mandates of informed consent law, which is consistent with empirical studies of informed consent in psychiatry and general medicine.

c. Synthetic approach to informed consent. If the realities of dealing with patients make it unlikely that disclosure of information will alter their decision, and if the law itself is a relatively weak means of enforcing this requirement in the first place, what is the point of the doctrine of informed consent? Would clinicians' lives not be simpler without it? Perhaps; but the practical and theoretical objections to the current shape of consent law are, in many ways, beside the point. Even granting their legitimacy, there are strong reasons to value informed consent in psychiatric practice.

Some patients may reject attempts to inform them about their treatment, but many patients desire such information, even if they do not intend to use it to make their treatment decisions. (See Suggested Readings, Schneider.) Ironically, most physicians and other caregivers probably fall into this latter category when they themselves assume the patient role. Given the high value our society places on the right of persons to make knowledgeable choices about important issues, it does not seem unreasonable to respect the right of patients to receive this information. Even more importantly, the process of informed consent can be used to strengthen the therapeutic relationship by enhancing trust and understanding between clinician and patient (see Sec. III-A-2-c). Thus the process may have positive therapeutic benefits, when used properly, that go well beyond those envisioned by even its most ardent legal advocates.

C. MALPRACTICE AND MANAGED CARE

As managed care represents the most profound change in the organization and financing of medical care in recent decades, it would be surprising indeed if it did not have significant implications for clinicians' malpractice liability.

1. Origins of Managed Care

Before the advent of managed care, it was assumed that physicians could see to it that their patients received the care they needed. If hospitalization was required, the physician arranged for admission; if outpatient care was indicated, the physician scheduled the appointments. In either case, the patient's insurance company could be counted on to pay for care. Of course, the situation with regard to psychiatric care was never so simple. Many insurance companies had caps on the amounts they would pay for inpatient or outpatient care or on the number of sessions or days of hospitalization that would be covered. Many psychiatric patients simply lacked insurance coverage of any sort and were relegated to care in public systems.

But students of the loosely controlled insurance systems of the 1960s and 1970s watched the cost of coverage increase as new technologies were introduced and usage grew, and pressure developed to hold down the ever-growing costs. Initial efforts in this direction involved retrospective review of care, with the threat of disallowing claims if they were found to be unwarranted. The failure of this effort to contain yearly double-digit increases in medical costs led, in the middle to late 1980s, to the development of prospective review systems, which evolved into managed care as we know it.

In psychiatry, management of benefits is typically “carved out” to specialized behavioral health management companies, which are paid a per-member-per-month capitated rate to provide all needed care. They contract with physicians and facilities to accept their substantially discounted fees in exchange for referral of patients. Initiation of treatment usually requires prospective authorization of medical necessity, with further prospective approvals needed as treatment continues. Without such approval, claims for treatments provided will be denied. In essence, managed care so constructed takes the authority to requisition the resources necessary for patients’ care away from physicians. Psychiatrists and other mental health professionals can decide what their patients need, but—unless patients can pay out of pocket—they cannot guarantee that the treatment will be provided.

2. Clinicians’ Duties Under Managed Care

Because they can no longer simply order hospitalization or begin outpatient treatment without a managed care organization (MCO)’s authorization, clinicians’ responsibilities to their patients have clearly changed. Their new duties might most productively be conceptualized in terms of informed consent. After making an appropriate diagnosis and recommendation for care, the clinician consults with the patient to obtain her informed consent to the proposal. If the MCO fails to approve payment, the clinician returns again to the patient to discuss the new situation. They may agree to appeal the denial, because most companies have internal appeal mechanisms and many jurisdictions make independent external appeals available. However, the patient should also be made aware of the possibility of paying out of pocket for care or of alternative treatment plans that might be approved by the MCO or otherwise be within the patient’s means. Should the appeal be denied, clinician and patient may decide to pursue one of these alternate treatment options.

The clinician in this situation still retains an obligation to do the best she can for her patient: to make the correct diagnosis, to offer appropriate treatment, and to advocate for the patient’s interests. In contrast to non–managed care situations, however, the clinician is not expected to provide care in the absence of approval of payment. (Emergency care, of course, is an exception.)

3. Malpractice and Managed Care

What happens if patients are harmed by treatment provided by a clinician operating in a managed care paradigm? The courts have not yet provided a definitive answer. Extrapolating from the early cases and preexisting law leads us to several conclusions.

Clinicians retain their core duties of conforming to the standard of care for diagnosis and treatment planning. If patients are harmed as a result of clinicians’ failure to conform to the standard of care for these functions, they can be held liable for malpractice. Having made a proper diagnosis and treatment plan, however, practitioners ought not to be held responsible for the refusal of the MCO to authorize payment, nor be expected to provide care without compensation. Rather, their duties are fulfilled if they consult with their patients and pursue appeals or alternative courses of treatment, or both.

Concern is often expressed regarding the use of second-best approaches to care when MCOs decline to pay for the treatment that a clinician thinks is indicated. If a particular treatment was not the course of action that the treater thought best initially, how can it be defended in retrospect if the patient suffers harm as a result? The answer begins with the recognition that clinicians often provide less than optimal care. For example, the specialized facility that would be optimal for treatment of eating disorders may simply not exist in one’s area. As another example, the patient may decline to go along with the psychiatrist’s recommendation for antidepressant medication or long-term psychotherapy. Whatever the reason, clinicians often must do the best they can within the constraints imposed on them.

Managed care is one omnipresent constraint. Patients and clinicians must work together to fashion an appropriate treatment plan taking into account available resources and given the contingencies faced by the patient. If that plan—properly implemented—fails to prevent harm to the patient, the clinician should not face liability as a result.

4. Liability of Managed Care Organizations and Their Reviewers

As of this writing, a striking asymmetry exists in the risk of liability for patients covered by managed care. Clinicians can be sued for their negligent behavior, while most decisions made by MCOs—including decisions to deny needed care—are immune from compensatory and punitive damages. This situation derives from a federal statute known as ERISA—the Employee Retirement Income Security Act of 1974. Originally intended to protect workers' pension plans, ERISA provides federal regulation of employment benefits, including health insurance. It allows legal action to recover benefits illegitimately denied, but not compensation for negligence and the harm that it causes. Moreover, ERISA preempts any remedies that might apply under state law. Thus, most nongovernment workers who receive health benefits as a condition of their employment cannot sue MCOs and reviewers who deny them care—except to recover the actual cost of care.

Few people would argue for the fairness of this situation. It seems to have been incorporated into the statute in the pre–managed care era without anyone realizing what its consequences would be. Now, powerful forces, including insurers, MCOs, and business groups are fighting to maintain the status quo, arguing that any change would result in increased health care costs. In the absence of the possibility of compensation from those who actually make the decisions about their access to care, injured patients have an obvious incentive to shift blame to their caregivers and to attempt to obtain compensation from them. At the same time, facing no risk of liability, MCOs are subject to the temptation to increase their own profits by denying needed care. Courts have made some minor dents in the shield that surrounds MCOs, but congressional action is the only sure remedy for this situation, and Congress has been decidedly reluctant to act.

D. OTHER FORMS OF LIABILITY

Malpractice is not the only form of liability that the mental health professional faces. In addition to the kinds of suits to which everyone is susceptible (e.g., the patient who sues after slipping on an unsecured rug), several other categories of liability exist that are especially relevant to the clinician-patient relationship. Most of these fall under the general heading of torts (i.e., noncontractual civil wrongs) but, as we shall see, civil rights actions and criminal actions can also be brought to trial. Some of these types of actions are discussed in previous sections and are therefore discussed only briefly here. The most important aspect they have in common is that they are not covered under the usual malpractice insurance policy.

1. False Imprisonment

False imprisonment occurs when one individual deprives another of his freedom in an unjustified manner. In psychiatry, such an allegation is most likely to occur when a patient is involuntarily committed to a hospital. Unlike malpractice, which is a negligent tort, false imprisonment is classified as an intentional tort; to be liable, the clinician must willfully have deprived a person of her freedom, though she was aware that the person did not meet the legally mandated criteria for commitment. False imprisonment does not necessarily involve the use of force. If a patient is simply told that he cannot leave and he believes that to be true, that is sufficient to demonstrate that he was held against his will.

Willful acts of this sort by a clinician are the stuff that lurid movies are made of, but they are undoubtedly rare in practice. More common are acts of negligence that lead to involuntary confinement. A clinician who fails to examine the patient carefully or who is negligently mistaken about the scope of the commitment laws can be sued for malpractice. In most jurisdictions, practitioners who examine patients for the court (e.g., in a court clinic) are considered to be acting as officers of the court and are thus immune from suit for negligent (but not willful) acts. Some states provide statutory immunity for all clinicians who participate in commitment proceedings, as long as their actions were neither grossly negligent nor intentionally harmful to the patient.

2. Breach of Privacy

The law has traditionally pointed to four ways in which an individual's privacy may be invaded: her likeness or name may be appropriated for commercial purposes; her state of seclusion may be intruded on; her activities or condition may be cast publicly in a false light; or public disclosure of facts that she considers embarrassing may take place. These may constitute either negligent or intentional torts. In theory, any of these injuries to the individual's privacy can occur in psychiatric practice. As noted in Chapter 1 (see Sec. II-B-3), breach of privacy *per se*, in a relationship in which an expectation of privacy exists, has been recognized by the courts as a legitimate cause of action. Although remedies for violations of patients' confidentiality are usually pursued as malpractice actions alleging departures from the standard of care, they can result in complaints in any of the following categories.

a. Appropriation of a likeness or name. This tort requires that a person's likeness or name be appropriated without his consent for the pecuniary benefit of a third party. Thus, the potential for this tort arises, for example, when an illustrated case history or chapter is published in a book or periodical and the pictures used have not been sufficiently disguised so as to render the patient unidentifiable. The remedy is obvious. All published or publicly presented pictures of patients should be altered enough to make identification unlikely. If that is not possible, either because to do so would obscure the significant clinical details, or because the case is so well known as to be immediately identifiable, the patient's consent should be obtained before publication. Needless to say, patients' actual names should never be used in publications.

b. Intrusion on seclusion. It is not uncommon for emergency room or walk-in service clinicians to be approached by concerned friends, neighbors, or relatives of someone whom they claim is behaving strangely and is mentally ill. They may report that the person in question has cut off all his ties to the outside world and has retreated into his house. They usually ask the clinician to "do something."

Whether the clinician does something should depend on whether he believes that he has sufficient evidence that the person in question both is mentally ill and meets one of the criteria for involuntary emergency commitment. An action taken in the absence of such evidence might leave the clinician open to a suit for invading the seclusion of someone who may turn out to be an eccentric, but hardly committable, person. In general, people have the right to be left alone. Clinicians faced with such a situation who do not believe that they have sufficient data on which to act—or who, even more wisely, refuse to write commitment orders for patients they have never personally examined—would do well to refer the informants to the police (who are empowered to conduct further investigations) or to the courts (which can issue warrants of apprehension, permitting persons to be brought for evaluation).

c. False light. False light is related to the tort of defamation and represents an alternative cause of action in situations in which a person has been publicly portrayed in an offensive and incorrect manner by someone who knew, or recklessly disregarded, that the information was false. Publications and presentations containing identifiable data about patients place practitioners at risk.

d. Public disclosure of embarrassing facts. Public disclosure of embarrassing facts is usually similar to the problem of appropriation of a person's name or picture (discussed in Sec. a). Again, the need to disguise the identity of the individual in a publication, or alternatively, to obtain the patient's permission to use his name or likeness, is emphasized.

e. Breach of privacy. Breach of privacy is becoming a tort in its own right. A mental health professional who discloses information obtained in confidence leaves herself open to suit (e.g., a psychiatrist who informs a patient's employer of his diagnosis and prognosis without the patient's permission). Some states, in addition to a common law cause of action, have enacted statutory protections for patients' privacy, which can constitute alternative grounds for recovery of damages. At least one case has held the person soliciting the confidential information—in this case, the employer—to be equally liable with the psychiatrist who revealed the data.

3. Defamation

Defamation is defined as a communication that "tends so to harm the reputation of another as to lower him in the estimation of the community or to deter third persons from associating or dealing with him." There are two types: libel, in which the communication takes a written form, and slander, in which the communication is oral. The defamatory communication is usually false, although it may be possible to allege defamation if true, but compromising, information is revealed solely for the purpose of causing harm to the person in question. In some circumstances (e.g., when public figures are concerned), the U.S. Supreme Court has ruled that the defendant must have acted in malicious disregard of the fact that the information is false.

The precautions concerning disguising published material should be extended to include ascertaining carefully the veracity of any material to be published. A clinician should refrain from public discussion of a patient's case whether the statements made are accurate or otherwise; if they are inaccurate, liability may accrue for slander as well as for breach of privacy. The rules dealing with a plaintiff's recovery for acts of slander are more stringent than those for libel: The plaintiff must usually prove pecuniary loss. Actions for slander are also allowed if the plaintiff has been imputed to have a "loathsome disease" or if aspersions have been cast on his ability to perform in his business, trade, office, or profession. Many statements about patients in psychiatric treatment, and sometimes even the statement that someone is *in* psychiatric treatment, could be construed as being in one of these two categories. Thus, good legal and ethical reasons exist for not speaking of one's patients, except insofar as the communication is necessary for their care (see Chap. 1, Sec. II-B-5).

4. Liability to Third Parties

In general, clinicians' duties are to their patients, and only patients have the right to sue for breach of those duties. We have already considered one exception to this rule (see Sec. II-A-3-e): Third parties injured by a patient whose clinician has failed to take appropriate steps to protect them from a foreseeable risk of harm have a cause of action against that clinician in most jurisdictions. Other exceptions include claims for wrongful death and loss of consortium by a patient's family members in the wake of a suicide and the very infrequently seen claims for interference with advantageous relations and alienation of affections.

Of greater concern is litigation against therapists who are alleged to have caused harm to third parties by negligently inducing false memories of childhood sexual and physical abuse in their patients (see Suggested Readings, Appelbaum, "Third-party suits against therapists," and Sec. III-B-2). Typically, patients who believe that they have been abused cut off contact with the allegedly abusive family members and may take public actions, such as identifying the alleged abusers and filing suits for damages. Accused family members will maintain their innocence and, looking for someone on whom to place responsibility for their situation, sue the therapist for the consequences of the therapist's presumed negligence.

Only a small number of decisions have been reported in cases such as these, but they have generated anxiety among psychotherapists. The legal basis for the expansion of therapists' liability usually rests on some variation of the idea that by directing their actions toward third parties—as by instructing patients to cut off contact with certain family members, to confront them, or to file suit against them—they have created a duty toward those persons and opened the door to liability if their actions have been performed negligently. The mental health professions are concerned about these cases in part because this rationale could extend third-party liability to many aggrieved family members in other psychotherapeutic situations (e.g., the overprotective and enmeshed parent who is convinced that his son's therapist is responsible for Johnny's decision to leave home).

It seems clear that the courts have seemingly used these cases to express their concern about treatments that emphasize recovery of "repressed memories." They are motivated to find a way of dealing with the unusual situation such cases present: The object of the alleged negligence (the patient), who has a right to sue, believes the therapist has acted properly, whereas a third party who has been injured has no remedy under law. Nonetheless, one hopes that the courts will recognize the problems inherent in expanding liability to third parties, including the power it gives them to interfere with the therapy of a family member when they dislike its focus or outcome. Until then, therapists would be well-advised to act cautiously in "recovered memory" cases, refraining from encouraging patients to take actions against alleged abusers and cautioning them about the uncertain nature of uncorroborated memories recovered after a substantial period.

5. Civil Rights Actions

A long-neglected nineteenth-century law, Section 1983 of Title 42 of the U.S. Code, was resurrected in the late twentieth century to provide one of the most potent weapons for plaintiffs who believe that their civil rights have been infringed. Section 1983 provides that "every person who, under color of any statute, ordinance, regulation, custom, or usage of any State or Territory, subjects or causes to be subjected, any citizen of the United States . . . to the deprivation of any rights, privileges or immunities secured by Constitution and laws, shall be liable to the person injured in an action of law. . . .”

Civil rights actions have become popular means for members of the mental health bar to attempt to effect system-wide changes. They provide for both injunctive relief (the halting of the practices in question) and the possibility of compensation to those who are found to have been deprived of their rights. In addition, successful plaintiffs’ attorneys can have their legal fees paid by the defendants, usually state governments, even in cases (unlike the situation in a malpractice case) in which no monetary awards are made. Lawsuits for deprivation of rights can be directed against those in charge of the system (e.g., the state commissioner of mental health); they can also be targeted against the line personnel who deliver psychiatric care. This puts the psychiatrist who has merely followed state regulations (e.g., in administering medication to refusing patients) at risk for being sued for violating patients’ constitutional rights. Because the existence of these rights is usually not clearly defined before the final court ruling, clinicians are left with little guidance as to how to proceed with patient care while minimizing the risk of suit.

The courts are not totally unsympathetic to the awkward position of the person responsible for direct patient care. They have ruled, in general, that good-faith actions on the part of the individual, as opposed to the governmental agency for whom she works, provide immunity from liability for damages. Nonetheless, the individual clinician often has had to undergo a traumatic and prolonged legal process before her immunity is proclaimed and may also have to withstand appeals. What complicates the matter is that malpractice insurers may refuse to provide either legal assistance or coverage for damages for Section 1983 actions because they do not come within the scope of traditional malpractice. Their refusal can result in astronomical legal bills for the unlucky practitioner. So far, most Section 1983 suits have been targeted against state facilities: psychiatrists or other clinicians in private facilities are generally not held to be acting “under color of statute, ordinance, [or] regulation” and thus are not subject to suit.

6. Fraud

Fraud can be either a criminal or a civil action. Therapists need to be concerned about its occurrence in two modes. First, to the extent that a therapist advertises falsely, that is, when he promises a patient a certain result that he cannot deliver, the therapist is liable for a charge of fraud. The advertising need not be in public; the promise of a good result to a prospective patient is sufficient. (In those circumstances in which the therapist did not knowingly deceive the patient, but nonetheless promised a result that was not obtained, a civil suit for breach of contract can be filed.) The lesson should be obvious: Promising that any results other than that the therapeutic process will take place is unwise. What can be promised is that the therapist will work with the patient to understand the problems involved (in a psychotherapeutic model), to help the patient alter the behaviors involved (in a behavioral model), or to control the patient’s symptoms (in a medical model). Patients’ inquiries as to the likelihood of success can be answered frankly with statistical data, answered with acknowledgment of ignorance of the future, used for interpretative purposes, or ignored, as best fits the model of the practitioner’s school, but no guarantees should be made. (See also Sec. III-A-2-b.)

A second circumstance in which fraud can occur involves violations of the tight set of rules developed to govern the interactions between third-party payers and the therapist, especially when the third party is the government. Clinicians who provide false diagnoses (even if done to maintain patients’ privacy), who bill for sessions that have never taken place, or who otherwise falsify the information on the billing forms are subject to prosecution for criminal fraud. The same is true, although the practice is reported to be widespread, for psychiatrists and psychologists who certify that they have personally attended to patients who, in fact, are being treated by other mental health workers under their employ. Such practices should be shunned. One potential source of fraudulent claims, billing for missed appointments, can be avoided by working out an agreement in advance with the patient. It is more advantageous, on clinical and legal grounds, to hold patients who miss appointments directly responsible for the payment for these sessions than to attempt to bill the third party.

E. MISCELLANEOUS PROBLEMS OF LIABILITY

1. Liability of Nonmedical Mental Health Professionals

Although the bulk of the literature and case law on malpractice deals with the medical profession, it should be clear from the discussion in this chapter that many of the same problems exist for the other core mental health disciplines. As clinical psychology, clinical social work, and the independent practice of psychiatric nursing have become professionalized, they, too, have become liable to suits for malpractice. The same will be true for other mental health professions as they achieve licensure. The standard of care to which each of these disciplines is expected to conform is established by the discipline. Furthermore, to the extent that non-psychiatric mental health professionals assume primary responsibility for patient care, they establish the same kind of duty of care, within the context of a fiduciary relationship, that exists for psychiatrists.

Many professional organizations and some private insurance companies sponsor malpractice insurance for these other disciplines. Nonmedical professionals who are supervised by psychiatrists or by other physicians are not free from liability simply because of that supervisory relationship; although the doctrines of *respondeat superior* and negligent supervision may force the psychiatrist to assume partial responsibility for their acts, nonmedical professionals retain liability for the consequences of their actions.

2. The Insurance Problem

What makes any kind of medical or mental health practice possible in the face of potentially enormous damage judgments is the availability of malpractice insurance; this was not always the case. Until the 1800s, insurance for negligent acts was not permitted as a matter of public policy; it was thought that enabling individuals to insure against their negligence would encourage recklessness. This changed as the pace of industrialization increased and negligent acts were recognized as statistically inevitable occurrences: If enough people are performing a given act frequently enough, someone is bound to make a negligent mistake. The moral opprobrium that once attached to negligence disappeared. Remnants of that approach remain however, in that most policies do not cover intentional torts (*intentional* is used in the sense of any voluntary, nonnegligent act) or other intentional acts (e.g., civil rights violations).

Given the importance of malpractice insurance coverage to the health professions, the periodic crises to which the industry is susceptible is obviously a matter of great concern. In addition to the usual problem of the insurance cycle, in which rates fluctuate according to the industry's strategies for investment and competition, malpractice insurance is subject to increased pressure as the number of suits and sizes of judgments climb in relation to societal preoccupations. The malpractice crisis of the 1970s was caused by just such an increase in litigation and judgments; rates soared and many companies left the business. Professional associations stepped in to provide coverage that members were otherwise unable to obtain, a service that continues today.

Rates of malpractice claims against psychiatrists and other mental health professionals have been rising in response to new areas of litigation, such as therapist-patient sexual contact, "recovered memory therapy," and the risks associated with managed care. Nonetheless, they are far from the staggering rates faced by some medical specialists, such as obstetricians and neurosurgeons. Future trends will depend on developments within the profession, in the insurance industry, and in Congress and state legislatures, where changes in the rules governing malpractice liability are made. The American Medical Association has been lobbying actively for states to adopt caps on damages for pain and suffering, an intervention that appears to reduce the size of malpractice awards (although this conclusion is controversial). Although successful in California and several other states, the AMA has had less success elsewhere, where legislators have resisted what is often seen as a limitation on patients' rights to be compensated for all of the harms they have suffered.

3. The Systems Issue

Health care professionals in general, and mental health professionals especially psychiatrists in particular, have borne the brunt of a desire for certain kinds of social change that has been prevalent in the country. The inertia inherent in legislative bodies and their general conservatism has led reformers to seek alternative means of providing new rights or creating new systems of care. What they have found has been a way to achieve their goals by using the personal liability system, originally erected to permit those who had suffered harm to obtain compensation.

The desire of reformers to promote individual autonomy has been advanced by the promulgation of the doctrine of informed consent, enforced through the tort law. The goal of improving the performance of psychiatric care systems has been pressed by widening the possible grounds for malpractice and for civil rights actions. That individuals bear the burden of the resulting suits and the damage judgments—when the system or the society is, in fact, responsible—is ignored in this rush to achieve social change. Professionals, who are put on the defensive by what they perceive as direct and personal assaults, are then often forced into the position of opposing generally desirable changes in society (e.g., improved care for the mentally ill and mentally retarded) because of the fear that they will be asked to pay the price of this progress individually.

That is not to say that genuine abuses—negligent medical care, deprivation of civil rights, and the like—have not taken place and that some individual practitioners might not be responsible for them. But in general, members of professions who are probably better trained and more highly skilled than they were 40 years ago are subject to an enormously magnified legal burden compared with that time.

It is hard to know what to do about this tendency to use individuals in the professions as the battering rams of change. It would be ingenuous to expect reformers to give up a highly useful tool. The legislatures, whose hyporesponsivity is often the cause of the problem in the first place, are unlikely to provide a basis for relief. Perhaps all that can be hoped for is to decrease the tendency for the professions to respond to these trends with wildly directed anger, sulking hurt, or withdrawal from the political system. A sustained effort to educate the public about the root causes of this aspect of malpractice litigation in the professions might ease the way for the development of means of accomplishing social ends that are less personally traumatic—but it also might not; to the extent that someone must bear the burdens of change in every period of societal reorganization, the health care professions seem to have been chosen for this role today.

4. The Move Toward Strict Liability

As one element of the process described above, court rulings in a number of areas have sought, by altering the rules that govern liability actions, to prevent the wealthy from benefiting at the expense of the poor. In place of a system in which a finding of liability requires proof of negligence, a system of strict liability is developing. Strict liability means that whoever performed the act or produced the product is liable for whatever harm results, even if every possible precaution was taken to prevent that harm. The justifications for such a change are socioeconomic: (a) the producers or providers tend to be wealthier than the consumers or clients; (b) the producers or providers are in a better position to defray the cost of damages, either by insurance or by raising their price or fee sufficiently to provide self-insurance; (c) the cost of damages is in reality a cost of producing the good or service and thus, for reasons of efficiency, ought to be borne by the producer or provider; and (d) in an increasingly complex society in which one is likely to become a victim without any forewarning or any action of one's own, it is only fair to provide compensation for victims, because society benefits from the products or activities that have led to the injury.

Strict liability has not yet been adopted in malpractice law, although it has been suggested as a standard. Negligence is still ostensibly required to obtain a damage judgment. However, professionals are not incorrect when they sense that the rules of evidence and of proof and legal reasoning tend to be twisted in such a way as to provide compensation whenever possible if some harm—*any* harm—has taken place. Although professionals, especially doctors, often take this tendency as evidence of an attack on their profession by the courts, it is in fact part of a wider change in the nature of tort law that is designed to redistribute some measure of wealth in our society.

Whether it is just to use law to foster a particular economic viewpoint is a matter of controversy, although legal scholars maintain that every legal system advances one or another economic philosophy. If the trend continues, it is likely that, when the new system settles out, a mechanism will evolve for preventing the professional from bearing too large a part of the cost of that redistribution. In the meantime, it appears little can be, and some would argue ought to be, done to stop it.

5. No-Fault Approaches to Liability

Among the suggestions regarding ways to make the malpractice system fairer to both patients and clinicians is to move toward a system of "no-fault" payments. Currently, injured patients must establish that a clinician's negligence was responsible for their harms before they can recover damages. Large-scale studies have suggested that most patients who are injured in the course of clinical care do not file suit and do not receive any compensation. At the same time, some patients receive large awards, arguably well in excess of their real economic losses. To remedy this imbalance, some commentators have suggested adoption of a no-fault system, in which patients would not have to demonstrate that anyone was at fault before collecting compensation for injuries suffered at the hands of the medical system. With the need for malpractice insurance eliminated and "defensive practice" reduced, it is argued that this change would result in net societal savings, as well as more just distribution of resources to those injured by no fault of their own. But the current system seems fairly well entrenched and no-fault proposals have made little progress in the United States.

III. CLINICAL ISSUES

A. PREVENTION OF NEGLIGENCE AND MALPRACTICE

Section II addressed the legal and technical definitions of the elements of malpractice. The real-world basis of malpractice litigation is usually a malignant synergy between a bad clinical outcome for any reason and what might be called *bad feelings*. Proof of this assertion is found in empirical studies demonstrating that only a small percentage of bad outcomes result in litigation; and in the common observation that top-level care may trigger litigation, whereas remarkably low-level care may not evoke a lawsuit. Although bad clinical outcomes are only to a limited degree under clinicians' control, the presence of bad feelings may offer some opportunity for clinicians' tactful and empathic interventions.

The bad feelings in question encompass a wide variety of human reactions to bad outcomes, but the most common ones leading to litigation are (a) guilt, particularly the kind that survivors of a suicide may feel; (b) rage, particularly outrage triggered by a clinician's insensitivity, unavailability, or arrogance; (c) surprise, particularly when the patient experiences a side effect of treatment about which she had not been forewarned; (d) a basic feeling of betrayal evoked by the sense that the clinician was practicing entirely defensively and did not make the patient's interests of primary concern; and (e) psychological abandonment, or the patient's belief that—after a bad outcome has supervened—the clinician's unavailability, lack of outreach, lack of responsiveness, and at times active avoidance of the patient leaves the latter experiencing the feeling of being "left out in the cold" to cope with the bad outcome entirely alone. All of these reactions may trigger a fundamental adversarialization of the doctor-patient relationship, which may be expressed in its ultimate form, the malpractice suit.

At the beginning of any discussion of preventive measures directed against negligence or malpractice, some caveats establish a frame of reference: (a) anyone can initiate a lawsuit against anyone for (almost) anything; (b) a suit may occur for perfectly valid reasons or utterly irrational (even psychotic) ones; and (c) given the complexity of the field, the relative absence of hard standards, and the variability of juries, being free of blame does not in fact necessarily lead to one's being found to be free of blame.

These points, however realistic, justify neither despair nor nihilism. The approaches addressed in this section can effectively tip the balance in favor of avoiding charges of malpractice or of prevailing if suit for malpractice is actually brought. These approaches may be organized around four rubrics: behavioral approaches to prevention; technical approaches to prevention; and the twin pillars of malpractice prevention: documentation and consultation.

1. Behavioral Approaches to Prevention

A dominant principle of the medicolegal field is that good clinical practice and careful attention to the work are fundamental elements of malpractice prevention. This timeless principle might be modified to the effect that the therapeutic alliance—conceived as a fundamentally collaborative attitude on the part of both clinician and patient—represents the best antidote to the adversarial posture whose extreme result is the malpractice suit. Therefore, the best behavioral preventive to malpractice litigation is maintenance of the therapeutic alliance. Some particular examples of this basic approach are described in this section.

a. Avoidance of exploitation. The clinician should avoid any manner of exploitation of the patient. To do otherwise would violate the principle of fidelity to patients' interests and clinicians' fundamental ethical principle, *primum non nocere*, "first, do no harm." This approach should include avoiding financial exploitation (e.g., charging for services not rendered, charging exorbitant fees, or seeing the patient at a needlessly high frequency); sexual exploitation (see Sec. II-A-3-f and further discussion below); or more subtle exploitation of the patient's feelings (e.g., using the patient to express one's dependency needs, one's wish to be liked, or one's wish to control others). The clinician must behave as a professional, in the employ of the patient, who is dedicated to that patient's interests, well-being, and health.

In today's litigious climate, particularly with the greater attention by boards of registration, courts, and the media to clinician-patient sexual misconduct and other boundary violations, clinicians should avoid even the *appearance* of exploitive interactions with patients. This notion of remaining above suspicion flows from several phenomena common to sexual misconduct cases.

i. Boundary issues. One of the most important concepts for the clinician is that of boundary violations. A boundary is the edge of appropriate behavior. The boundaries in question are the boundaries of the professional role and of the clinician-patient relationship, based on the recognition that this relationship represents a power asymmetry (the clinician has the power to do certain things to, and with, the patient that the patient does not have toward the clinician). Experience further suggests (see Suggested Readings, Simon) that many sexual misconduct situations begin with minor boundary violations that gradually become more egregious until actual sexual relations occur—an extreme form of boundary violation in themselves. In a related manner, fact-finders in such matters—courts in malpractice suits brought for sexual misconduct, ethics committees of clinical societies, and licensure boards—find accusations of sexual misconduct more credible when an acknowledged history of boundary violations exists. Indeed, some malpractice suits alleging sexual misconduct are settled not necessarily because the clinician is culpable of this behavior, but because those nonsexual boundary violations acknowledged to have occurred are so pervasive that the defense attorney despairs of convincing a jury that the clinician—who crossed so many boundaries—drew the line at the last one, as it were.

Some critics muse that, under managed care, no patient will be allowed to be in psychotherapy long enough to develop erotic transferences, and so sexual misconduct will die a natural death. Others note that—thanks to heightened awareness of the issue among clinicians—new cases of overt therapist-patient sex are less frequent, whereas lawsuits for pure boundary issues (transgressions short of sexual intercourse) are increasing. These trends, if factual, have two implications. First, treaters of all disciplines and ideologies should educate themselves about boundary issues for their own, and their patients', benefit; boundary questions do not, as some believe, arise only in psychodynamic psychotherapy. Second, the aim of the present discussion is not to encourage rigidity in boundaries, because that approach would stultify therapeutic work. Rather, establishing firm but flexible boundaries that define the limits of the professional relationship allows such factors as empathy and compassion to cross over into the patient's psychic space without harming even the sensitive patient (see Suggested Readings, Sec. D).

Boundary issues may be divided heuristically into two major types: *boundary crossings* and *boundary violations*. *Boundary crossings* represent deviations from ordinary therapeutic practice but are helpful and not harmful to the patient; they may advance or even enable the therapy. Examples include offering a crying patient a tissue (although that is not talk therapy), helping up a patient who has fallen (although that involves touching the patient), and telling a patient how to reach you in an emergency (although that constitutes self-disclosure).

Boundary violations, however, are distinguished by the fact that they cause harm to the patient, most commonly through some form of exploitation. Examples include excessively intimate physical contact; giving the patient special gifts and favors; and using the patient essentially as one's own therapist by disclosing one's emotional problems, personal issues, and psychological conflicts to the patient, a phenomenon called *role reversal*. In each of the last examples and the many others seen in litigation, the therapist's needs, goals, and wishes are served rather than the patient's—hence the exploitation. Indeed, the presence or absence of exploitation is one of the hallmarks distinguishing boundary crossings from violations, a process that may occur in the context of a licensure board complaint or ethics committee hearing.

ii. Some further examples of boundary issues. Some common boundary violations include having sessions outside of the office (such as in cars, in restaurants, over meals, or—under certain circumstances—in patients' domiciles); nontherapeutic interactions between doctor and patient (e.g., asking the patient to bring in food, pick up laundry, clean the office); and shifts in the relationship such that some ambiguity intrudes as to who is therapist and who is patient (e.g., clinicians' self-disclosure of significant personal details including those about their social, financial, and sexual difficulties—presumably in the interest of having the patient console them, or at least listen sympathetically, a role-reversal in which the patient is taking care of the clinician).

Other forms of physical contact—some would say regrettably—have become ill-advised in the current stringent atmosphere militating against boundary violations. Whereas handshakes and occasional pats on the shoulder may be acceptable contact within the therapeutic envelope, kissing the patient and any form of hugging (including quick squeezes around the shoulder, even if performed in the most asexual and sympathetic manner) have probably come to be unacceptable boundary violations with many adult patients. The issue here derives not only from even minor physical boundary violations lending credence to a later accusation of sexual misconduct; rather, an even more relevant factor, misunderstood by many clinicians, is that the clinician's nonerotic intent may bear no correspondence to the patient's potentially highly erotic response.

Although none of the described boundary violations by itself necessarily constitutes malpractice in mental health, and though each may indeed serve innocent purposes, the intensified ambiguity about such interventions and the more suspicious climate (created, in part, by the real and appalling extent of sexual misconduct) may have a serious implication: Such contacts should, on principle, be forsworn. Such restraint by clinicians may actually reassure many patients, especially those with previous histories of boundaries having been violated and of various forms of trauma; in addition, such clarity may strengthen the clinician's capacity to challenge specious charges of misconduct if such are brought.

The boundary issue is a particularly complex concern for clinicians who practice behavior therapy. Going on trips with patients to confront fear of flying, or even going along in certain circumstances on rather personal errands, may be part of the legitimate treatment regimen within a behaviorist context, despite the fact that such acts would be considered significant boundary violations (and hence, anathema) in an analytic context (see Suggested Readings, Goisman and Gutheil). This dilemma has not been addressed extensively either in the literature or in case law, but represents an area of potential ambiguity of a dangerous sort. This ambiguity, according to a theoretical school of thought, also underscores the absolutely critical role of context in boundary assessment.

To deal with boundary issues and related phenomena, clinicians should consider the use of a medical technique used widely in other branches of medicine, namely, chaperoning. Although the presence of a chaperone (such as a nurse or office assistant) may represent a significant and perhaps prohibitive intrusion into some clinical work, it may be a valuable investment in defense against future litigation. Normal clinical procedures particularly meriting consideration for the use of chaperoning include amytal interviews, hypnosis, home visits, and the use of behaviorally based sexual dysfunction interventions (e.g., the use of dilators in treatment of vaginismus).

Clinical experience also suggests that borderline patients pose special difficulties for clinicians, not only in the area of boundary violations but also in the area of sexual misconduct. In one survey, borderline patients accounted for more than 90% of the litigation cases of true sexual misconduct, and accounted for 99% of the false accusations of sexual misconduct (see Suggested Readings, Gutheil, 1989). False accusations appear to represent broad expressions of borderline rage and the wish to punish the object, in this case, the therapist. A growing impatience with sexual misconduct and its widespread occurrence, even in the case of a false accusation, can have a significantly destructive effect on the clinician. To make matters even more complex, borderline patients, who often have difficulty themselves maintaining boundaries, call for the clearest of boundaries to be maintained by the clinician. With these points in mind, clinicians are well advised to adhere strictly to boundaries and to keep the clinical work unambiguously in the forefront of their intentions.

In addition, clinicians dealing with patients of any diagnosis might do well—when the transference becomes eroticized or when direct statements or requests concerning sexual contact arise in treatment—to begin presenting the case to a clinical supervisor, peer, consultant, or specialist in this area; such consultation may be anonymous to protect the patient's privacy. Such presentation not only offers an opportunity for valuable consultative input, but may also decrease the isolation of the clinician and patient in an emotionally intense dyad, often steeped in feelings of mutual admiration and idealization—a magic bubble of insularity, which consultative experience demonstrates to be proof against later influence by advice or supervision. Such presentation, in addition, renders a false accusation of sexual misconduct more dubious, should an accusation arise.

iii. Types of boundary cases. Boundary problems may be aired in three common venues and one less common one, the last being a criminal complaint in the roughly one-third of the states in which therapist sexual misconduct has been criminalized. The three major venues are: civil litigation for a claim of malpractice, a complaint to a licensing board, and a complaint to the ethics committee of one's professional association. Each of these venues addresses a different question.

As detailed in Section II-A, a civil (malpractice) trial determines whether the therapist's conduct deviated from the standard of care and, if so, what harms directly resulted. Either a loss at trial or a settlement is reportable to the National Practitioner Data Bank.

In a complaint to the state's licensing agency, the matter turns on fitness to practice, in a form such as the following: "If the boundary violation complained of by this patient is true, is the treater's fitness to practice her profession called into question?" Various sanctions might flow from a "yes" response, ranging from censure to irrevocable loss of license, depending on a multitude of factors. Action against one's license is also reportable to the National Practitioner Data Bank.

In an ethics hearing, the sole question is whether the conduct complained of, if true, represented violation of one of the explicit standards described in the organization's ethics code (e.g., for psychiatrists, the American Medical Association's Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry). Ethics committees may be quite concrete in their interpretation of what is ethical: What is ethical is what is in the book. An ethics complaint and any resultant sanctions are tied to a particular section of the code. Sanctions range from reprimand or censure to suspension or expulsion from the professional society. Any action that affects a member's status (as opposed to a reprimand) is reportable to the National Practitioner Data Bank.

Finally, no rule prevents suitably determined patients from bringing all three complaints: civil suits, licensing board complaints, and ethics committee complaints. They are not redundant because they involve different areas of discourse.

Sometimes, of course, curious ethics complaints may surface, including allegations of boundary violations for introducing the therapist's children to the patient, the therapist's joining a patient's book club, and the therapist's agreeing to write an introduction to a patient's book. Because it is often difficult to determine exactly what constitutes an ethics violation, ethics committees and their expert witnesses do best when they pay close attention to contextual factors and the varieties of treatment philosophies.

Experience indicates that licensure boards may be especially literal-minded and even punitive in their prosecution of boundary complaints; that is, they may lose the distinction between the harmless boundary crossing and the harmful boundary violation. The notion of a "slippery slope," whereby progressive boundary incursions often end up in sexual misconduct, becomes a "slippery cliff," whereby even small boundary incursions (such as using the patient's first name) are treated as though they were tantamount to intercourse! This bias places an additional burden on the licensee to document carefully all boundary incursions and their rationale, along with their post facto discussion.

The following example captures some basic principles of boundary management: A clinician leaves the office at the very end of the workday and notes that a heavy snowfall with deep drifts has occurred during the day. Driving home, he sees the last patient of the day struggling on foot, and offers the patient a potentially life-saving lift home or to local transport in his car. The clinician (1) behaves professionally during the ride, deferring clinical issues to the next meeting; (2) carefully records the situation and context when next in the office; and (3) explores or debriefs the patient on the experience at the next session, also recording that. The three general principles noted may constitute the critical distinguishing factors in subsequent challenges between a crossing and a violation.

b. Manifesting respect for the patient. Patients are entitled to be treated with respect and with the compassion deserved by all individuals in distress. Untold numbers of malpractice suits are filed not primarily because the patient has suffered egregious harm, but because he has felt himself to be the object of outrageous conduct on the part of the therapist. The clinician who—in the presence of a receptionist and a family waiting to be seen—yells after a departing patient, "Mr. Jones, you are the most impossible patient that it has ever been my misfortune to treat!" is guilty of such outrage. The preventive approach is, of course, to maintain reasonable social manners throughout and, for example, should yelling at a patient be necessary as a therapeutic approach (as it occasionally is), to maintain the same privacy about it as about other communications in the treatment. The patient deserves no less.

In this regard, clinicians may well want to reconsider the tendency to use first names in therapeutic work, using rather the last name with an appropriate honorific. Although use of last names might seem excessively formal, and hence likely to promote an atmosphere of distance and coldness, recalling that the use of a last name is also a sign of interpersonal respect is helpful. Furthermore, it may clarify those very boundaries addressed above (see Sec. III-A-1-a) and may help both parties maintain a clear focus on the fact that the therapy is serious work and not an affectionate relationship between chums. In addition, use of the last name may promote emergence of an adult observing ego and decrease the patient's tendency (if present) toward inappropriate regression.

c. Avoidance of abandonment. As a contractual relationship between consenting adults, one might expect that the usual outpatient therapy could be terminated at any time by either party; however, an asymmetry exists that must be acknowledged. The patient may stop without prejudice, with or without notice to, or the agreement of, the therapist; for good reason, bad reason, or no reason; with the work finished, unfinished, or partly finished. The therapist is not free, however, to stop treatment in a similarly arbitrary manner; the risk of so doing is the charge of abandonment (as outlined in Section II-A-3-h). However, in addition to this legalistic form of abandonment, another, more psychological form of abandonment exists—one in which the patient feels deprived of the therapist's support even if no technical legal rule has been violated. Such feelings may be productive of litigation and should be foreclosed by careful attention to avoiding psychological abandonment.

The preventive approach in this situation might be termed the *open-door policy* (see Chap. 3, Sec. III-G-6), which means in practice that a patient, once in treatment, may almost always return.

> ***Example 1.*** A highly entitled patient dropped out of treatment and was unreachable by phone or letter. The therapist made note of each phone call and kept a copy of each letter of inquiry. After the third letter, the therapist wrote that he could no longer keep the time open and scheduled another patient for that time. Six weeks later the patient, who had gone impulsively to California, reappeared and demanded her time. The therapist scheduled the patient for a new time, answering her objections about its inconvenience by showing her the record of his attempts to contact her after she had left. The patient settled down and began work on understanding the entire episode.

By sending serial letters (and retaining copies) and by offering an alternative time for the patient, the therapist avoids any semblance of abandonment, legal or psychological.

A similar "approach of three letters" (the precise number is not sacred and under some circumstances one may suffice) should be actively considered for patients who disappear from treatment. The patient who attends two sessions of an evaluation sequence and then disappears represents a potentially risky ambiguity in the medicolegal arena: Is that patient still one's patient? In certain cases of injury by patients to third parties (further discussed in Sec. III-A-2-g), courts have claimed that the duty that the clinician once owed the patient during treatment continued to exist, long after the clinician has forgotten the patient and closed the case.

The content of such a letter, sent after several attempts to reach the patient, might read as follows:

> ***Example 2.***
> Dear Patient,
>
> I have not heard from you in [amount of time; this should be a long enough time to permit patients who are uncertain or ambivalent to have adequate time to consider whether they wish to continue]. I assume you no longer wish [treatment, extended diagnostic evaluation, etc.] at this time. I am closing your case. [At this point the duty may be presumed to end, but the question of abandonment still remains.] Should you at any future time wish to use mental health services, please do not hesitate to call me [the clinic, the center] for an *evaluation.* [Note: Treatment should never be offered, only an evaluation; the offer of treatment might be construed as the offer of continuing treatment, implying that the duty persisted. Actual phone numbers of the clinician's answering service or the local clinic should be provided in the letter.]

Such an approach remains respectful of patients' potential autonomous decisions to drop out of treatment without notice, but exerts some control over plaintiffs' attorneys claiming potentially limitless extension of duties to patients who later injure others or themselves.

i. Emergencies. Emergencies—which constitute exceptions to various rules including confidentiality (Chap. 1) and the right to refuse treatment (Chap. 3, Sec. II-C)—are also exceptions to the rule that one may stop treating anyone at any time. In a state of emergency, the patient must be shepherded through the crisis to a state or place of safety, only after which the clinician can terminate therapy. Usually, one hospitalizes the patient and terminates on the inpatient service, participating as needed in the assignment to a new therapist.

There are, of course, situations in which rational approaches to avoiding abandonment are untenable. If a patient has seriously threatened the physical safety of the therapist or the therapist's family, immediate steps are warranted to protect the potential victims; this may include immediate cessation of sessions with the patient, civil commitment, filing of a criminal complaint, requesting a restraining order, or notification of the police. Even then, however, a documented referral to an appropriate alternate source of care (e.g., the local community mental health center) is good practice, not only to prevent the charge of abandonment but to acknowledge that a treated patient is liable to be less dangerous in the long run than an untreated one.

ii. Patients who fail to pay. The problem of dealing with patients who do not pay their bills is hardly limited to therapists. Nonetheless, delinquent payments often take a different form in psychiatric practice. A patient's failure to pay may be a manifestation of the very difficulties for which she is presenting for care: narcissistic entitlement, counterdependent acting out, or the desire to provoke a rejecting response from an authority figure. The psychiatrist's, or other therapist's, response should take these dynamic considerations into account by seeking to bring the issue of payment into the therapy. It is not uncommon for a patient to refuse to pay for months, only to begin payment again when the underlying issue has been explored. However, limits to what is expected from a therapist exist. If, after exploration of the issues, it appears that the patient still has no intention of paying her bill, a clinician who refers the patient to a public clinic or other available source of care can hardly be faulted. Such a referral should not be made if the patient is acutely ill and requires immediate care, with no other source of care available; the original treating clinician has an obligation to continue to shepherd the patient through the acute episode until termination can be accomplished safely. An extremely important clinical issue in this situation is the need for the clinician to begin discussions of delinquent fees before she becomes too angry at the patient to explore the matter with the requisite cool dispassion.

> ***Example 3.*** A patient was derelict in paying a bill and the back balance mounted up to the point that the therapist could no longer afford to treat the patient. Treatment then stopped and the therapist sent the patient a letter (with a copy for her own records) stating that, as discussed, they could no longer continue in therapy at that time. If the patient wished to continue at some future time, he could do so (i.e., "the door is open") provided he paid the back balance (or 50% to 75% of it) and perhaps something in earnest of future good faith (e.g., paying each session in advance or paying some part of the back bill each month).

Needless to say, the therapist should explore the therapeutic implications of nonpayment as a clinical issue (see also Section II-A-3-h-ii, and compare section III-A-2-h, concerning management of defaulted payment).

iii. Patients who do not cooperate in their care. Similar to a failure to pay one's bills, the failure to comply with a therapist's instructions may derive from the patient's underlying psychopathology and should be considered as a therapeutic issue. In addition, the patient should be given every benefit of a doubt that he is exercising an autonomous choice; the clinician's position should be extremely flexible. Once again, though, the use of continued treatment may be dubious if, even after exploration, the patient cannot conform to the recommended procedures, whether they be ingestion of medication or abstinence from alcohol. In making this often conflicted decision, the therapist must determine his own ethical threshold: the point beyond which he would be in the position of rendering bad care—a situation diligently to avoid. If, because of the patient's actions, the therapist finally decides he cannot provide adequate care, it does not constitute abandonment to terminate the relationship with the patient. (This may not be true if the patient is incompetent to understand what is taking place.) Whether less than optimal care is better than no care at all is a more difficult question. In any case, referral should, of course, be attempted (see Sec. II-A-3-h-iii).

d. Coverage during absences. Not only malpractice prevention, but conscientious practice, requires all clinicians who work with patients or clients to provide some form of backup for emergency situations. Optimally, a trusted colleague agrees to cover, receives necessary information about urgent or pending matters (in a "sign-out"), and makes herself available in some way (e.g., by providing a phone number). At a minimum, patients can be given the number of a clinic, hospital, mental health center, or similar agency to call as needed.

The role of the covering clinician is a difficult one because the substitute must act with all the authority and responsibility of the original therapist but without the alliance with, or knowledge about, the patient. The person covering, in practice, is often torn between the wish to temporize until the absent clinician returns and the wish to provide a definitive resolution to the crisis or problem. Ideally, the covering clinician should deal with the patient as her own and should see the goal of the evaluation or intervention as resolution of the acute crisis. If the matter is not critical (e.g., an optional prescription refill), it may be postponed until the absentee's return.

In those cases where the covering clinician is a stranger to the patient, the clinician should probably make greater-than-usual efforts at availability, personal interviews, data gathering, documentation, and conservative practice, because the therapist-patient bond cannot be invoked in the usual manner. The absence of this bond not only dilutes the positive interpersonal component of the intervention, thus making it more difficult for the covering clinician to accomplish the therapeutic goal, but it also increases the risk of a malpractice suit should something go awry. The patient, already resentful of his therapist's absence and suspicious of the interloper who is covering, may choose to express his anger at his therapist in a displaced, and therefore psychologically safer, manner by suing the covering clinician. Covering clinicians may also be named as defendants to increase the award pool.

To look at the issue from another perspective, note that the covering clinician, who independently evaluates a colleague's treatment during coverage and finds it to be adequate, is actually supporting that colleague's standard of care. If this happy chance occurs, it should surely be documented (see Sec. III-A-4 on consultation).

e. Patient selection. In general, as a preventive measure to charges of malpractice, clinicians should only treat patients within their capabilities; patients, for example, with medical problems or with a clear need of medication should probably be treated by physicians. If treated by nonphysicians, close medical backup, consultation, or supervision should be available (see Sec. III-A-4).

f. Role of apology in liability prevention. A remarkable number of plaintiffs comment during interviews in connection with litigation, "If that clinician had only admitted he was wrong and had apologized, I would not have sued." Clinicians vary in their willingness to take such comments at face value, but experts agree that the improvement in the tone of a relationship under stress and restoration of the therapeutic alliance can be fostered to a remarkable degree by an appropriate apology.

What constitutes an appropriate apology? If a clinician were to say, "I apologize for deviating from the standard of care so as to proximately cause you these harms," her insurer would doubtless consider that remark infelicitously phrased, because that is the technical definition of malpractice. However, short of such statements, there is significant room for expressions of apology. First, clinicians should maintain a low threshold for admission of simple or minor errors, such as misplaced lab slips or misscheduled appointments. A rigid policy of refusal to apologize, based on some distorted psychodynamic rationalization, is ultimately destructive to the alliance. Similarly, all clinicians should feel—and express—regret, sympathy, or condolences for bad outcomes of any kind. Under narrow circumstances clinicians might apologize for more serious error: "I'm truly sorry that I missed that side effect [or medical problem, diagnosis, choice of medication type], but I will continue to do my best to treat you appropriately."

Clinicians may worry about placing a weapon in the hands of the plaintiff's attorney. Is saying, "I'm sorry" tantamount to saying, "I did wrong, so sue me"? Legislatures can considerably lessen this understandable fear by enacting an apology statute that ensures freedom to say one is sorry. Massachusetts law provides one version of such a statute:

> Statements, writings or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering or death of a person involved in an accident [defined as a nonwillful occurrence resulting in injury or death, hence including malpractice contexts] and made to such a person or to the family of such a person *shall be inadmissible as evidence of an admission of liability in a civil action.*
>
> —Massachusetts General Laws, C.233, s. 23D; emphasis added

In those areas where comparable statutes do not exist, regional professional societies should attempt to promote their enactment. Such protection for saying one is sorry has the potential to avert litigation by resolving the "bad feeling" component.

2. Technical Approaches to Prevention

Certain approaches directed toward preventing charges of negligence and malpractice fall under the rubric of technique, not in the sense of the technique of therapy itself, but in the sense of technical handling of the administrative transactions surrounding the treatment.

a. Treatment contract. With surprising frequency, this essential component of treatment (and an important factor in malpractice prevention) is omitted, largely by being inappropriately taken for granted. In practice, the exchange might go something like this:

Patient: My wife's been after me because of my drinking.
Doctor: Fine, I'll see you Mondays at eleven o'clock.

In this interchange, of course, there is the illusion of a contract being formed, but no actual statement is made by either party of their intentions, their goals, their wishes, or what they are agreeing to (i.e., there is, in actuality, no contract at all). This example represents an heuristic exaggeration; however, one can readily imagine milder versions occurring with distressing frequency in daily practice.

The significance of the absence of a true contract is that, without one, it is impossible for therapy to succeed or fail because the goals or problems to be solved are not agreed on; however, it is not impossible to be sued in this situation, because the absence of clear agreement allows the patient's wishes and fantasies about the results of treatment to burgeon unchecked and allows the disappointment at their nonfulfillment to be equally unbounded.

The technical remedy for this problem is to begin any treatment with a clear understanding of the agreed-on goals. For the same reasons, it is equally important to spell out policies for fees, billing, handling of missed versus canceled appointments, and the like at the earliest appropriate opportunity.

b. Acknowledging limitations versus making promises. Related to the notion of contract is the clinician's acknowledgment of the limitations of treatment, so as not to make promises impossible to fulfill. This matter is especially charged in connection with prognosis; a prognosis is a statistical and epidemiological prediction, yet may be interpreted by patient, family, or attorney as a promise to deliver certain results. Among familiar promises therapists are asked to make are keeping someone alive, stopping someone from drinking, getting back the departed spouse, getting someone married, and getting someone through examinations. Although therapy may be quite helpful with all these goals, their actual realization does not lie in any therapist's power and this limitation must be candidly acknowledged, perhaps even in the case record.

For similar reasons, excessive therapeutic optimism is inappropriate for the written record, again because it may be seen as a contractual promise. Attorneys are occasionally prone to seeing clinical forecasts as contracts, as in the following example.

> ***Example 4.*** A committed patient's attorney decided not to file a writ of *habeas corpus* when told by the patient's physician that the patient would probably be sufficiently recovered by the next Monday. Over the intervening weekend, however, the patient's clinical state worsened markedly and commitment had to be petitioned for.
>
> At the hearing, the attorney maintained that a Monday discharge had been "promised" (in the sense of a contractual agreement); thus, he failed to recognize the significance of a clinical estimate and to understand that the patient's actual state must, from the clinician's viewpoint, govern what happens. The patient is being treated, not the calendar.

The clinician is urged to bear in mind, especially when speaking to attorneys, possible misperception of clinical forecasting and to attempt to avoid making statements that can be construed as promises (see also Sec. II-D-6).

An essential component of this issue is the importance of the clinician's treating within his competence, thus avoiding seeming to promise expertise without a basis.

c. Informed consent and the sharing of uncertainty. Offering a realistic view of future possibilities may be viewed as an aspect of informed consent. This topic was extensively reviewed in Section II of this chapter and is further explored in Chapter 5. Certain clinical dimensions are expanded on here.

For a regrettably large number of clinicians in all specialties of medicine, informed consent represents little more than obtaining the patient's signature on a lengthy, occasionally multipage document, whose use of legalistic language may do far more to confuse and obfuscate the matter for the patient than to inform, as it is ostensibly intended to do. More significantly, the patient's mere signature on such a form provides empirically a very feeble defense against the malpractice claim of failure to obtain informed consent: When read aloud in court, the consent form is as baffling to the jury as it was to the patient. Predictably, the result is the jury's identification with the patient, a process inimical to the clinician's hoped-for outcome.

Informed consent, appropriately conceptualized, represents an atmosphere of openness and honesty, nurtured by an ongoing dialogue between clinician and patient that begins from the first encounter and lasts for the duration of the relationship. It is not a brief conversation, capped by the patient's signature on a form that renders the issue closed. The model explicated here has been described as a *process model* of informed consent (see Suggested Readings, Lidz, Appelbaum, and Meisel) in which differing perceptions of illness, values, and expectations are shared in a manner termed *mutual monitoring* by patient and clinician. Envisioned in this manner, an informed consent dialogue can represent an effective preventive to the kinds of bad feelings earlier noted that lead to litigation.

Specific cases at law have faulted clinicians for saying both too little and (rarely) too much in informing the patient; it appears that the ideal degree of information appears to be "just enough," titrated to the patient's capacity to integrate the information. We suggest that this focus on the information in question may be too limited to exploit fully the benefits of the informed consent model. The outcome of the informed consent process should be a sharing between clinician and patient of the fundamental uncertainty of both the patient's condition, the clinician's proposed treatment regimen, and indeed, of the future itself. When clinician and patient conjointly confront, within a therapeutic alliance, the inherent uncertainties of the course on which they are about to embark, the relationship becomes less susceptible to those bad outcomes that may supervene (see Suggested Readings, Gutheil, Bursztajn, and Brodsky).

To understand the operation of this approach, we must begin by appreciating that individuals who are ill experience, as part of the normal process of illness, a regression to more magical stages of mental development. Magical wishes, deriving from infantile feelings of omnipotence, lead patients unconsciously to seek out clinicians for magical cures, even though their conscious assessment of the situation may be quite realistic. The clinician who offers only reasonable clinical care is thus in danger of disappointing the patient's unconscious magical expectations, a result leading to potential bad feelings in the context of a bad outcome.

The appropriate intervention for this dilemma is an effective, albeit counterintuitive one. The clinician begins by empathizing with the patient's unrealistic wishes, in a manner that brings them into the open, yet permits a gradual disillusionment (one might even call it *weaning*) of the patient from these magical fantasies. Several examples of how this might sound in practice may be more illuminating than the concept in the abstract.

Example 5

"I sure wish the good Lord had invented a medication that was guaranteed to be entirely free of side effects."

"I sure wish I had a written guarantee that this course of psychotherapy would be guaranteed to keep you alive despite your suicidal preoccupations."

"I wish I could assure you that the couple's work that we are about to embark on would be certain to save your marriage."

> "I wish I could promise you that with this treatment regimen you would be guaranteed to lose this crippling phobia of yours."

Note that these interventions (which represent, of course, short forms of an entire spectrum of interventions, depending on the particular clinical situation) illustrate the clinician's overt acknowledgment that he, too, wishes for magical solutions to life's problems. Yet the tone of rueful regret in which these communications are couched begins the process of tactfully bringing forward the uncertainty of all clinical work. The desired outcome of this intervention is to render the alliance strong enough to tolerate a bad outcome without bad feelings, because the uncertainty of the intervention has been faced squarely by clinician and patient and thus made available for integration, processing, and joint discussion.

In psychiatric practice, medications and ECT are the most significant areas to which informed consent applies. Each presents its own difficulties.

For ECT (as noted in Chap. 3, Sec. III-C-2-d), complex issues concerning the treatment and the illnesses for which the treatment is used render informed consent problematic (see also Chap. 5, Sec. II-B-2-b). The problem is further compounded by the common side effect of memory loss for the time period surrounding the treatment. Even when applied unilaterally, on the nondominant side, ECT tends to produce some loss of memory; because the forgotten period usually contains one of the most painful human experiences (severe depression), the loss is usually viewed by patients (and clinicians) as benign. However, the act of consenting is not uncommonly included in the memory blank, a fact that places a significant burden on the documentation process.

With medication, a slightly different problem presents itself. For functioning outpatients being started on medications, one usually (but not always) has the leisure to negotiate a reasonably informed consent with presumption of reasonable competence in the outpatient. The newly admitted inpatient, on the other hand, presents with far more equivocal competence to consent to medication as treatment.

Furthermore, reading a package insert to the acutely psychotic patient would clearly be as futile as it is self-defeating. Yet to fail to alert the patient to some of the direct effects and side effects to be expected from the medication is to risk further distressing the patient who may have delusional ideas about what is happening to her—a situation that may readily induce panic, rage, increase in psychosis, or flight, and strain alliance with, and trust in, the physician.

In clinical terms, a compromise is indicated. Information is titrated to the patient's needs and condition and is individualized to the patient's fears, concerns, vocation, lifestyle, and similar considerations. Needless to say, all such informing transactions and the patient's responses should be documented in the record.

d. Therapeutic disinterest and the question of advice. The technical point at issue in the question of whether to offer patients advice is complex and controversial, in part because so many different forms, modes, and styles of therapy exist. Under most circumstances the psychoanalytically oriented psychotherapist eschews giving advice; the supportive cognitive or behavioral therapist, on the other hand, may use directive instruction or advice as a primary currency of the interaction. Clinicians whose practices emphasize the pharmacotherapies are dealing extensively with a form of advice—prescription: "You should take this medication." Yet one forensic issue related to advice-giving is of concern to all therapeutic orientations: the problem of litigation for undue influence (see Sec. II-D-4).

The problem of undue influence may arise clinically when one member of a couple is being treated and the result of treatment is an actual or threatened breakup of the relationship. In this context, the therapist must make clear from the outset (and repeatedly during treatment, if the issue arises again) that the therapist works for the individual's interests, which under therapeutic scrutiny may not turn out to be identical with the interests of the couple or the marriage.

For example, the husband may recognize through therapy that his wife represents another in the line of maternal figures on whom he has been hostilely dependent all his life; or a wife may realize that her marriage represents another of the self-defeating, masochistic relationships she has unconsciously sought time and again. These realizations may or may not prompt these individuals to try to change their situation, but that is up to the individual and ought not to be the thrust of the therapist's directives. (In couples therapy, of course, the contract differs and may legitimately include attempts to save a marriage.)

The most useful stance for the therapist in such cases is that of a neutral and disinterested consultant, one who has no particular stake in the patient's remaining in (or leaving) a marriage, a job, a school, a career, or a relationship. The therapist is there to explore, not to advise and certainly not to influence. Although a therapist's opinions are inevitably conveyed to the patient, even if only by unconscious cues, such subtle influences are not the stuff of which suits are made.

The indications for this dispassionate stance are not entirely forensic, of course. Because the therapist learns more and more about the question as time passes and as the relationship deepens in candor, his evolving understanding of the issue may alter its clinical significance (e.g., an apparently gratifying relationship may emerge as fundamentally frustrating on closer inspection). This universal clinical experience must serve as a powerful caveat against advice or other directive interventions based on early impressions of the status quo.

Are there exceptions to this posture of persistent neutrality? Most clinicians would answer in the affirmative. These exceptions would include emergencies, when direct action may be obligatory (see Chapter 2); states of severe regression, where directive measures may be required in the short run; and certain therapeutic techniques (e.g., role-playing in behavior therapy) where directive interventions may play a role. In any case, directive measures should be used judiciously.

e. Technical handling of legalistic acting out. The forms, papers, and other paraphernalia of the legal aspects of psychiatric practice are not uncommonly put to use by some patients in acting out against authority figures; these legal paraphernalia represent embodiments of a judgmental, authoritarian attitude attributed by the patient to treatment personnel or to the institution against which the patient rebels. Adolescents, borderline or psychopathic patients, and manic patients are particularly prone to use these legal forms to provoke or to test the interpersonal field, or as a signal of some distress not otherwise communicable.

> ***Example 6.*** A borderline adolescent girl discovered, several days into her voluntary admission to a psychiatric hospital, that the desire to leave could be conveyed by a form giving three days' notice of this wish (a "three-day paper"); she further discovered that the paper could be revoked by another form. She then launched a veritable paper blizzard of three-day papers and last-minute retractions. Because by law the patient had to be given the papers on demand, the staff felt helpless, manipulated, and furious at the patient.

> ***Example 7.*** A man with bipolar disorder, beginning the manic upswing, became obsessed with the delusional idea that a previous commitment to the facility had been illegal; he initiated a two-month campaign (culminating in another admission) of vituperative phone calls and letters to many state officials (some completely uninvolved in mental health), attempting to gain acknowledgment of this claim. He called the hospital as well, the calls escalating to dawn-to-midnight harangues, interfering with hospital routine.

In the first example, staff were tempted to refuse to give the patient the forms because "she's just playing games"; such a move would have been both illegal and ineffectual—the behavior simply would have escalated. The legal-psychiatric consultant suggested giving the patient the forms without hesitation, but asking each time about what the patient could not put into words. The therapist also led a virtual chorus of staff members in pointing out to the patient that the paper blizzard was keeping everyone—patient, staff, and therapist—from taking her problems seriously and from being of any use. Faced with this unified front, the patient became first angry, and then bored with the "game," and then eventually ready to talk instead.

In the second case, hospital officials designated one doctor, Dr. X, to be the pipeline for the legal issue. All other personnel referred calls and letters to Dr. X; Dr. X's invariant and repeated response was, "Of course, your record can be checked, just have your lawyer call me." Even when the storm abated because of the patient's admission, the invitation was proffered and eventually accepted. The lawyer reassured the patient about the record.

In these two examples, the clinical approach followed certain basic principles, outlined in the following sections.

i. Remaining cool. Being swept up into the passion of the encounter is useless and self-defeating. Obtaining consultation, if needed, may help to restore perspective.

ii. Avoiding fruitless struggle in the legal arena. Even if the transaction transparently represents symptomatic acting out, the patient's legal rights must be respected. Note that abstaining from struggle in this way does not rule out, for example, going to court to contest a *habeas corpus* writ on clinical grounds, when the clinician believes discharge may be dangerous to the patient.

iii. Actively confronting or interpreting the clinical meaning of the acting out, resistance, or both. The intervention should occur in the therapeutic sphere, preferably in a unified manner with team, staff, or institutional support as needed, as indicated in Examples 6 and 7.

iv. Extracting maximum therapeutic value from the issue for ongoing exploration. The resolution of the issue does not close, by any means, the possibility of further work in the treatment. The patient's behavior can be considered as a symptomatic act that requires exploration.

f. Importance of clinical outreach in homicide and suicide. Families or parties involved with patients who commit suicide or homicide experience major personal disasters. The catastrophic reaction for the living (which includes the patient who, while in a state of psychosis, has killed someone else) takes precedence for the clinician over all other issues. It matters not if the clinician believes that one person in the family drove another to suicide; at the moment of crisis the living require the best, nonjudgmental efforts of the clinician.

In practice, of course, the matter is emotionally enormously complex; every clinician who has lost a patient by suicide experiences feelings of grief, guilt, anger, regret, or a sense of failure. These and other feelings are powerful and preoccupying, making it difficult to think of solace to others, but there are two major reasons to make this considerable effort.

First, clinical outreach is discussed under the heading *technical approaches to prevention of suit* because, in fact, it often defuses the guilt, shock, and rage of the afflicted family so that the common reaction does not occur, namely translation of these painful feelings into blame fixed not on the original object (the patient) but on hospital and treatment staff. It would be unduly cynical, however, to present this as the sole motivation for outreach. The second major reason to reach out with clinical skills is that it is the humane response to profound need. Because the clinical staff has essentially shared the catastrophe with the family, they are in an ideal position to be of help, for a potential alliance exists based on shared loss.

The treating therapist and the clinician working with the family, as well as staff members who worked closely with the patient, should consider attending funeral or memorial services for a patient who has committed suicide. Although those who attend such an event often experience great conflict about it initially, they invariably report afterward that they found it helpful in dealing with the loss and in terminating with the memory of the patient. Families of the deceased are usually grateful for the respect thus shown by the treatment staff; one bereaved mother later told her social worker that it meant so much to her to see staff members there because, of all persons present, they alone fully understood the horror of the experience and the meaning of the loss to her. At a minimum, personal condolences should be sent by individual staff members who worked with that patient.

A psychiatric patient who commits homicide presents a different problem. Treatment staff are usually fearful of a murderer and do not always realize that they are not important enough to the patient to be at risk in most cases (i.e., the feelings toward them are not intense enough to provoke murder). Nevertheless, the patient needs clinical aid, and clinicians must labor to leave the legal aspects of the case to the criminal justice system; the patient is their object for a clinical reaching out. Although inexperienced staff members are often ethically confused by this issue, it is not condoning murder to treat the patient for an illness. Individuals who have committed murder or crimes of violence while psychotic, for example, need clinical aid to recover from and overcome such experiences, not unlike trauma victims in other contexts. The fact that the patient was the author of the trauma does not alter the need for help.

Another form of outreach that again serves the dual role of malpractice prevention and humane clinical response to need focuses on the relatives of the victim (who may of course be in the patient's own family) who have suffered an acute bereavement under shocking circumstances. To avoid a conflicted and charged situation, the outreach to the relatives should be undertaken by clinical personnel not directly involved with the patient-murderer.

In all the foregoing intense matters, the value of documentation with appropriate consultation, forensic and clinical, cannot be overestimated.

g. Duty to protect and related matters. The duty to protect citizens from danger from a patient one is treating is a thorny and controversial issue (see Sec. II-A-3-e). In clinical terms, the possibility of imminent danger to third parties has always called for action, such as emergency commitment (according to the requisite criteria, if mental illness is involved) or notification of the police. The California Supreme Court recognized a cause of action for failure to protect the potential victim from an outpatient. Most jurisdictions now have similar rules.

> ***Example 8.*** A man suffering from bipolar disorder with a recent history of death threats to his girlfriend was voluntarily admitted in psychotic decompensation. He was told that hospital staff would have to inform his girlfriend if he escaped or left prematurely; staff members posted the girlfriend's number in the ward nursing station. After some weeks, the patient signed a notice of intent to leave from a voluntary admission. He was evaluated and found not to fit criteria to commit at that time. However, he was told that his girlfriend would be notified of his leaving on the grounds that it was clinically premature (although legally not preventable), and that the risk to his girlfriend was still substantial.

For the clinician, the task posed by the threatening patient is assessment of risk, much as in other emergent or preemergent situations. Laypersons are surprised to hear of the frequency with which powerful feelings, including murderous ones, are unleashed in intensive psychiatric treatment; these feelings are a recognized part of the process. The clinician faces the burden of (a) deciding when the feelings, statements, or both portend actions (rather than being pure feelings, fantasy, or wish) and (b) markedly shifting the agency away from alliance with the patient and toward protection of society, at the cost of no longer keeping confidential the material itself and at other costs to the treatment as well.

The clinician is best advised to use an approach similar to that mentioned earlier (see Chap. 2, Sec. III-A) in relation to suicide and homicide: careful assessment matched by equally careful documentation of the decision-making process either to take action to protect the hypothetical victim or not. Ethical practice prompts informing the patient of the intention when it crystallizes. Clinicians should choose the intervention that occasions the least disruption of the therapeutic relationship while still being effective. On some occasions, hospitalization is appropriate; on others, police notification serves the purpose. Circumstances seeming to call for warning a putative victim usually represent an emergency meriting police notification in addition to (or instead of) that warning.

Under the added burden of this duty to protect, some clinicians have taken a pseudopreventive approach, saying to their patients (literally or in effect), "Don't tell me about any past crimes or crimes you may intend to commit, because I can't keep that confidential." This appears ill-advised, from several viewpoints.

First, the clinician is under no legal obligation to take action in regard to past events, felonious or not, because almost no citizen is obligated to report a crime; merely not reporting a crime does not make one an accessory (see Chap. 1, Sec. II-B-5-d). In addition, the clinician has no evidence (other than hearsay in many cases) that events reported by patients are not fantasies. (Consider the large number of people who falsely confess to publicized crimes in large cities.) The prohibition thus serves only to close off potentially usable material from the therapeutic work: under the umbrella of "possible felony," much highly charged germane material may be hidden in therapeutic resistance. That is, the patient may independently (and erroneously) decide that a whole list of relevant things are under the heading: "Don't tell me."

Second, the clinician thus potentially cuts herself off from helping the patient overcome the conflicts leading to the dangerous situation, that is, from treating the causes of the potential crime. This is of course the clinical crux of the dilemma. The clinician is torn between wanting to treat the patient for the problem versus protecting the potential victim (as legally indicated), possibly losing the patient in the process. As earlier noted (Sec. II-A-3-e), it is unclear whether the patient's leaving therapy benefits the potential victim or society (see also Chap. 1, Sec. II-B-5-d).

Unexpected benefits may accrue from the duty to protect potential victims in regard to the therapeutic alliance with either the patient or the family. As has been noted (see Suggested Readings, Wulsin et al.), the threat of harm often involves members of the patient's immediate family who, by virtue of the duty to protect, may be brought into the therapeutic purview. Thus, it might even be said that the *Tarasoff* decision forces a family-systems approach on the clinician. Clinical experience confirms that attention to the possibilities of forming (or repairing) an alliance with family members through the "warning" itself may yield valuable therapeutic advantages for the patient; a liability threat is thus transformed into potential clinical leverage.

As earlier noted in Chapter 1 (see also Suggested Readings, Wulsin et al.), further clinical benefits can accrue from having the patient herself warn the potential victim, because such intervention may defuse the actual dangerousness of the situation as well as serving the purpose of refuting the charge of negligence. Such a warning by a patient most typically occurs from the clinician's office by telephone with the clinician as witness—but other approaches may also be useful.

i. Clinical aspects of liability for patients' driving. A growing number of cases have imposed liability on clinicians for injuries caused by negligent driving by their patients. These cases range from allegations that the clinician failed to warn the patient of the impact of medication on alertness, to claims that the clinician knew, or should have known, that the patient represented a danger behind the wheel. In the latter formulation, driving cases represent an extension of the *Tarasoff*-like duty to protect (see Sec. II-A-3-e). They are particularly troubling because clinicians rarely observe their patients' driving; are not trained to ask about it routinely, and would in any event have to rely on patients' own reports; and generally lack the skills to determine which patients ought not be behind the wheel. Most clinicians can recall examples of seriously disturbed, even psychotic, patients whose driving remained unimpaired.

How ought clinicians to respond to cases in which patients' driving safety is in question? They could modify their practices to ask routinely about driving history. This is unlikely to be a useful move, and it may paradoxically increase the risk of liability for the clinicians who follow this practice and for the mental health professions at large. If a clinician takes a driving history, she is expected to do so accurately, probe appropriately, and follow up with interventions if necessary. If the practice becomes widespread enough, it may be taken as a standard of care and imposed wholesale on the professions.

Until the courts in most jurisdictions take such a drastic step, more moderate measures are appropriate. Clinicians sometimes learn of patients' actions behind the wheel that raise significant questions as to their safety. In such cases, clinicians may want to consider implementing a hierarchy of interventions. If the patient's driving is suicidal in intent, the appropriate interventions for that condition should be invoked. If other factors appear to account for the dangerous driving, the clinician should first counsel the patient about the relevant dangers (e.g., the risks of driving after consuming even a small amount of alcohol with prescribed medication). The effects of such advice should be monitored with later inquiries. If no change in the dangerous behavior occurs, the clinician should recommend in increasingly strong terms that a constructive change take place. Family members can be involved to restrict the patient's driving. If this is to no avail, the clinician may consider threatening to inform the motor vehicle bureau. Before this occurs, the patient should be asked for permission to inform the agency. If permission is refused, the clinician must note this and then decide if the dangerous behavior constitutes an emergency. If not, the other efforts should continue. If so, the motor vehicle bureau should be informed by letter, with a copy to the patient's chart. The letter should be limited to noting the relevant behavior, and the clinician should make no claim as to having knowledge of the behavior (when this is the case) other than from the patient's report. Thus, the letter constitutes notification of a situation to be investigated by the agency, rather than the clinician's own conclusions.

Members of the American Psychiatric Association should avail themselves of the APA's Position Statement on driving issues. Among other benefits, this document provides a recommendation and rationale for leaving driving assessment to motor vehicle agencies. The availability of private, computerized assessments of driving skills constitutes another resource in cases in which it is difficult to determine whether a patient's driving is problematic. Patients or family members can be encouraged to make an appointment for this evaluation at an appropriate local facility. This may be particularly helpful for elderly patients with mild to moderate dementia, whose skills are declining but who are resisting the surrender of their car keys. Assessments may be more definitive for patients with early dementia than for patients with serious mental illnesses, whose conditions are more susceptible to extreme fluctuations.

Clinicians should also be aware of a factor that appears to influence the resolution of driving cases once they reach the courts. Observers note that the clinical care rendered to the patient in some cases often appears to exude an "odor of negligence"; generally sloppy or substandard care appears to have been given, independent of the driving issues. The courts' findings—an ostensible failure of the clinician to prevent a driving injury by the patient—may serve as a vehicle for the court or jury to punish clinicians for care seen as broadly deficient. This hypothesis may help to explain why courts seem willing to stretch the realistic limits of clinical predictability to hold clinicians to duties to patients weeks or even months after patients' last contacts (see Suggested Readings, Pettis and Gutheil).

h. Managing defaulted payment. The clinician who has responsibly performed services according to the treatment contract is entitled to the agreed-on fee (see Secs. II-A-3-h-ii and III-A-1-c-ii). When a patient has been terminated from treatment for failure to pay, clinicians vary in their approach to soliciting the unpaid balance.

Some clinicians request payment but do not pursue the matter if there is no response (and, perhaps, if the amount is not excessive), reasoning that the effort is not worthwhile and the loss should be written off. This conservative approach makes the fewest litigational waves, but is clinically controversial because it appears to deny the reality—or worth—of the services rendered.

Other clinicians treat the matter of nonpayment in strict business terms, employing collection agencies or filing lawsuits to obtain the unpaid balance. This is accepted practice but requires one caveat: Overintrusive or harassing behavior by the collecting agency or attorney can render the clinician liable for countersuit. One remedy is a choice of reputable agents who are persistent but controlled.

Clinicians pursuing collection should be aware that some patients, reacting to collection efforts, may attempt to fabricate specious liability claims to reverse the flow of currency, as it were, or may manifest other kinds of reactions to the antagonism created by the clinician's collection efforts. Recall that any litigation in this context occurs against the societal perception of clinicians (physicians in particular) as excessively wealthy; thus egregious efforts to collect fees may be seen as particularly sordid and hence compensable in a harassment action.

In either case, the clinician who becomes emotionally caught up in the matter does his work a disservice and becomes more likely to act in legally compromising ways. A clinical perspective should prevail (see Sec. III-A-1-c-ii).

i. Dispensing dangerous medications. Commonly, a physician must prescribe medications that can be abused for a patient whose condition predisposes to that abuse. The most serious (and familiar) example is the depressed (and thus potentially suicidal) patient who is being treated with a monoamine oxidase inhibitor, the only medication that has proven effective for him in the past, but potentially lethal in overdose or if a low-tyramine diet is not followed.

Many clinicians deal with the tension inherent in giving potentially lethal medications to patients in potentially suicidal clinical states by prescribing limited amounts of medication at any one time (e.g., one week's worth of medication at each weekly appointment or one prescription for a limited amount with no refills). For a variety of reasons, clinical and legal, this may be a somewhat empty gesture:

- A patient seriously intending suicide can simply hoard pills, or obtain more from other sources.
- Similarly, life virtually bristles with alternative methods for committing suicide (even within hospitals), rendering absolute prevention of suicide a fantasy.
- The focus on the psychiatrist's dispensing, rather than the patient's use, of the prescription shifts the focus of ultimate responsibility from patient to doctor.
- The practice, if widely followed, creates the illusion of control over something not truly controllable; this illusion may either lull the clinician into a false sense of security or convey to lawyers the equally false sense that outpatient suicide is preventable and, consequently, that *not* to dispense medication in small amounts is automatically negligent.
- All too often clinicians using this method do not engage in an open and free discussion of the issue. If this approach is used, it should take place within an alliance-based, collaborative assessment of the patient's history of impulsivity and a joint agreement that having only small amounts of medication on hand is indeed helpful.
- It could readily be argued on clinical grounds that a patient so fragile as to be swayed by the size of the prescription should be in a hospital, receiving ECT, or both.

Some clinicians maintain that prescribing in this controlled fashion conveys to the patient a sense of the clinician's concern and wish to take the patient seriously. Impulsive patients, or those not well known to the clinician, may also benefit from this practice. Whether these benefits outweigh the foregoing problems must be evaluated on a case-by-case basis.

j. Clinical clearance. On occasion, clinicians are requested to provide clearance for patients' abilities to perform certain life tasks—abilities thought to be potentially compromised by a history of mental illness or hospitalization; examples include owning firearms, taking a job, earning a security clearance, and driving a car. As a risk-management technique, clinicians should avoid attesting that the patient has certain abilities, because this position may portray the clinician as seeming to endorse the patient's performance of the task. For many of these tasks, the clinician may not have the requisite knowledge (e.g., may not have seen the patient actually work). Such ostensible endorsement may create a claim of liability if the patient performs the task inappropriately (e.g., misuses the firearm, drives dangerously).

The wisest course of action is for the clinician to address only what he knows—the patient's condition—in the form of a double negative, thus:

"Based on my evaluation of the patient on _____, it is my professional opinion that there are *no clinical contraindications* to Mr. X's [going back to work, owning a gun, etc.]."

This double negative clarifies that the evaluator can only state the absence of a clinical condition, based on an evaluation, that would bar the activity in question. Any semblance of endorsement or of prediction of future success in the activity is therefore avoided.

k. Psychiatrists as medical backups. Psychiatrists are commonly asked to serve as medical backups or to prescribe for the patients of nonmedical clinicians. In this role, they are usually expected to assess the patient's needs for medication, prescribe appropriately, and follow the patient periodically. Several liability issues complicate the medical backup role.

First, law lags somewhat behind practice in this area. It has long been assumed that when a physician and nonphysician collaborate in a patient's care, the physician is in charge and bears ultimate responsibility for all treatment decisions. This assumption may bear little relationship, however, to the realities of collaborative care today. A psychiatrist who serves as medical backup may assume no clinical responsibility for a patient's psychotherapy (indeed, the nonphysician psychotherapist may be by far the more experienced member of the team), seeing the patient monthly or even less frequently to reassess his status relative to medications. Decisions concerning hospitalization and the need to respond to potential suicidal or homicidal emergencies may lie outside the scope of his backup role.

If the psychiatrist is to avoid undue risk of liability in these cases—a risk heightened by the fact that physicians' malpractice insurance coverage is usually more extensive than that of other professionals—clarification of the collaborative relationship should be made explicitly at its inception. A letter from the psychiatrist to the referring nonmedical clinician should make clear the responsibilities assumed and not assumed in the backup role. In particular, the psychiatrist's function as a medical backup should be distinguished from a supervisory role, because the latter leaves the psychiatrist open to vicarious liability for the nonmedical therapist's actions. The letter should also address emergencies, coverage for absences, and similar contingencies. A similar form should be prepared for patients, so that their expectations are congruent with their psychiatrists' and therapists' expectations. (See Suggested Readings, Gutheil, 1994.)

A second problem that must be addressed is the common practice of clinics and community mental health centers hiring part-time psychiatrists to fill the medical backup position for a large number of nonmedical clinicians. Anecdotes abound of cases in which psychiatrists are asked to prescribe medications for hundreds of patients, when their limited hours at the agency make it impossible for them to follow so many patients with any reasonable degree of care. At its worst, this system leads to psychiatrists leaving signed blank prescription forms for nonmedical therapists to complete, or mechanically signing dozens of prescriptions for patients they have never seen. Needless to say, both of these practices represent an abdication of the psychiatrist's clinical, ethical, and legal responsibilities.

Physicians should not work in settings in which they are being asked to provide substandard care. If they cannot negotiate reasonable caseloads that permit them adequate time to meet with patients and discuss them with other caregivers, they should get out. Facilities' efforts to save money by forcing psychiatrists into situations in which the standard of care cannot be met are reprehensible.

Occasions may also exist in which the medical backup role is stretched beyond mere prescription of medications. Psychiatrists may be asked to sign treatment plans, team summaries, and insurance forms on a routine basis. A useful axiom for such cases is: "If you sign, the case is thine." The psychiatrist will likely be held responsible as the supervisor of the care for patients in these cases. Psychiatrists should familiarize themselves with published guidelines concerning the implications of their signatures. (See Suggested Readings, American Psychiatric Association; Appelbaum, 1991; and Gutheil and Duckworth.)

l. Ethical approach to problem-solving. Certain exceedingly complex or novel situations—such as the multiple dilemmas around managed care—occur in an area in which relevant, unambiguous legal rulings have not yet occurred and where clinical wisdom provides no easy answers. Faced with such a situation requiring action, clinicians may wish to attempt an ethical analysis as a solution to a clinical and legal impasse; that is, an ethical analysis—an extensive and documented discussion of the goods and harms to be expected from different approaches to a problem—may appropriately portray the clinician as nonnegligent in areas in which the standard of care is impossible to determine with confidence. Clinicians should reserve this technique for clinical situations susceptible of no other resolution.

3. Documentational Approaches to Prevention

Second in importance to "do no evil" is "write no evil," and it is a close second, indeed; documentation has represented the "make or break" determinant in countless acts of litigation. Chapter 1 addressed some important considerations in areas of record-keeping; here we review and expand on this topic as it concerns the prevention of negligence and malpractice.

Clinicians should consider, by way of overview, that simply writing more in the chart is not in any sense a liability preventive strategy. Documentation is most effective when the clinician writes more efficiently, which may indeed mean writing less—a viewpoint inspiring relief in many clinicians overwhelmed with paperwork.

Documentation for both clinical and risk management reasons should focus on three realms of discourse that often represent linchpins of both clinical decision-making and subsequent second-guessing of such decisions in a litigation context.

The first realm represents the risk-benefit analysis—explicit or implicit—of the intervention proposed. Recall that decisions usually involve at least two alternatives (i.e., to do it or not to do it) although many more, of course, may be involved. Each of these forks in the path, moreover, has its own separate risks and benefits. Thus, when a patient is being considered for a pass, both going out on the pass and remaining in the hospital without a pass have demonstrable risks and benefits. Clinicians tend to focus more on the riskier side of the decision—in this case, going out on pass. The clinician who has performed a careful, documented risk-benefit analysis may be proven by later events to have made the wrong decision, but the care in preparing the risk-benefit analysis refutes the claim of negligence.

The second important realm for documentation is the exercise of the clinician's judgment at key decision points in the work. Based on the risk-benefit analysis, what was the clinician's response and, most importantly, what was the reason for the response? Clinicians are often in danger of recording only the final steps of the decision-making process without allowing subsequent caretakers (and subsequent juries) to witness the training, experience, and thoughtfulness that may have gone into the decision in question. In this instance, the "thinking out loud for the record" (see Sec. c) becomes particularly important.

Finally, the third realm is an assessment and record of the patient's capacity to participate in treatment planning. This ability is related to the competencies addressed in the next chapter. One could indeed speak meaningfully of the patient's competence or capacity to weigh the risks and benefits of giving or withholding information to or from the treating caretakers. In dealing with the suicidal patient in particular, the information in question might include the status of the patient's suicidal intent or impulsivity, as well as the nature of internal controls and the ability to resist such lethal inclinations. In the more general sense, careful assessment of the patient's ability to manage her own care and make reasonable decisions therein may exonerate the clinician from an obligation to intervene in a highly parental or protective manner.

Accurate evaluation of the patient as having the capacity to share this sort of information may play a significant role in capturing the patient's ability—and actual responsibility—to inform the clinician about a change for the worse in his suicidal condition. This may free the clinician from the apparent requirement of reading the patient's mind during particular interventions (e.g., passes or discharge from the hospital). In addition, the image of the patient as a competent decision-maker refutes the common image of the patient, favored by plaintiff's attorneys in such litigation, as an incompetent child who is incapable—because of being "too sick" or "too crazy"—of letting the clinician know what is going on in her mind. Because competent patients universally can reject or refuse lifesaving treatment, a suicidal patient competent to weigh the risks and benefits of giving or withholding information may elect not to call or notify caretakers when suicidal feelings reach the danger point—but this is not the clinician's failing.

Note, furthermore, that this view of the patient as competent to weigh disclosure risks and benefits should rest on a rock-solid clinical foundation. That is, a patient whose illness *does* render him incapable of sharing information about his inner state with the clinician should indeed be treated in a much more conservative or protective manner. The next example reveals how this assessment might take place.

> ***Example 9.*** A borderline patient admitted for suicidal preoccupations is being assessed for discharge. In exploring the issue, the clinician asks, "You realize that I can't help you if you don't level with me? The only way I'll know what's on your mind is if you tell me." The patient acknowledges awareness of this. The clinician then begins an inquiry as to whether the patient is aware of the interventions available to her, should her suicidal preoccupations return or increase. The patient is able to articulate the responses: calling a friend to be with her; making phone calls to the hospital's emergency room, or at worst, having her family or an ambulance bring her on an emergency basis back to the hospital. The results of this assessment, appropriately recorded in the chart, capture the nature of the patient's autonomous adult capacities to participate in the treatment planning, to the degree of being able to share her internal state with the clinician who is in a position to make the appropriate interventions. The patient is not assumed but assessed to be able to seek or reject available help.

From the standpoint of these general principles, areas of particular relevance are addressed in the next sections.

a. Facts. The major use of the record, of course, is as a durable statement of what has happened or what has been done. This function is so forensically powerful that it commonly operates in its converse: courts assume that if an event is not recorded it did not happen. At times, even eyewitnesses are less convincing than a statement in a record or chart that something occurred.

The record of certain aspects of the patient's care is crucial. For inpatients, the neurological examination is essential: It serves not only to detect illnesses with neurological components, but also to establish baseline readings against which injuries in the hospital (falls, assaults), medication side effects, and TD may be measured—all matters of great significance in court.

For all patients, medication allergies and sensitivities are particularly important items for recording, as are concomitant medical conditions and other medications taken (e.g., nonpsychiatric drugs).

Another recording function of the chart or record is to describe the impact of interventions made by the therapist (or by the inpatient treatment team). Space restrictions, medications (changes in dosages, additional or different medications, etc.), psychotherapeutic approaches, and the like all have some effect or result, even if that result is "no change." Effects should be noted not only for forensic purposes, of course, but to ensure the quality of patient care.

Emergencies should evoke particular scrupulousness in recording details, both because emergencies are critical points in care where details are required to assess the meaning of the events and because emergencies are disproportionately charged with potential liability.

b. Judgments. The clinician's problem in many a malpractice suit is the fact that the clinician's judgment is assessed *post facto* (after the crucial event that catalyzed the suit has occurred) with all the specious clarity and certainty peculiar to a retrospective view. Thus, it is essential that the bases for the clinician's judgment in general, and certainly during crises, be articulated for the record.

> ***Example 10.*** A patient voiced suicidal ideation and, after careful exploration of the subject, the clinician elected not to hospitalize the patient. The record of that session contained specific assessment of risk factors (see Chap. 2, Sec. III-A-2) and resources, especially those that the clinician knew from familiarity with the patient and her history. This material is often taken for granted because it is so well known to the clinician that he fails to spell it out in the record. The record articulated the bases for the decision in terms of disadvantages of hospitalization and factors making continued outpatient status desirable (i.e., preservation of autonomy). Finally, specific mention was made of pathways by which the patient could report any change of status, especially for the worse (i.e., giving therapist's phone number, covering clinician's number, and the number of the local emergency ward).

The data suggested for recording in the example may seem excessive as a response to so ubiquitous a clinical event, yet one must weigh such material, not in anticipation of the possibility of patient's successfully weathering a difficult period and going on to improve, but of the patient unexpectedly committing suicide and the family bringing suit. The clinician faces the possibility of the jury reasoning that, "because the patient *did* kill herself, the decision not to hospitalize must have been negligent." To counter this "retrospective certainty," the clinician must have evidence of care in judgment, care in thinking through the issue, care in meticulous weighing of the pros and cons, and care in consulting with other clinicians when warranted—evidence that can be supplied only by the words written at the time of the actual assessment (see also Sec. c). The clinician, scared by tales of the whimsicality of judges and juries, may take heart from the knowledge that her clinical skills and unique knowledge of the patient do count for something—but only if recorded in the chart.

A particular form of recording judgments relates to the question of indications for treatment, especially novel, experimental, or atypical applications of known treatments (e.g., the use of lithium for bipolar illness is well accepted, but lithium has proved effective also in selected cases of impulsive violence and suicidality; thus, an atypical usage that would require more documentation of indications and risks and benefits). Although all treatments sometimes fail, failures of atypical applications of known treatments or of experimental treatments tend to be more forensically sensitive, for obvious reasons.

c. Reflections. The average record entry should be crisp, detailed, specific, and objective, though there are certain exceptions (hinted at in Sec. b) where a more narrative, first-person mode of recording may be indicated—an approach of "thinking out loud for the record." This approach should be invoked whenever the clinician is about to take a calculated risk (as in Example 3) or to make a less conservative decision (e.g., not hospitalize the patient). The thinking out loud should represent a record of the clinician's assessments, reflections, standards, and indices of decision-making, reports of supervisory or consultative insights, and the like. The justification for this kind of thinking out loud is based on the fact that not thinking (or not leaving a record of one's thinking, which may amount to the same thing) may be seen as negligent. (See also Suggested Readings for Chap. 1.)

d. Anticipating evidentiary use of the record. As a field, psychiatry does not do well in the prediction of future behavior. However, a certain degree of anticipation of future events forms a legitimate part of record-keeping.

The clearest example of necessary anticipation occurs when it appears that the clinician may need to petition for involuntary commitment at some future point. This possibility places a premium on recording signs of dangerousness (or, for that matter, lack of dangerousness) so as to have available the data for the eventual hearing.

If a patient injures another patient, one may anticipate possible future litigation; thus, detailed descriptions of the event from all observers, as well as recording all the findings of examinations and the clinical responses of the staff, fulfill the anticipatory role.

In this regard, it is useful to review one's records as if they are being examined in retrospect; that is, one must ask, "What ambiguity or misperceptions may arise from this note if read in the future by a stranger?" (Needless to say the most infelicitous such occasion would be a reading by the plaintiff's attorney.) With this in mind, it is advisable for trainees learning to write progress notes to imagine the note being read aloud to a jury by a hostile counsel, a fantasy that aids perspective in note writing!

> ***Example 11.*** A resident reviewed a progress note that said, in part, "Patient was asking repetitive questions, so he was secluded." The resident realized that this would appear illogical and illegal to readers (because seclusion is permitted only for dangerous behavior or threat of same); he then included the datum (so familiar to him that he took it for granted), "The patient's history gives numerous examples of repetitive questioning in a compulsive manner being the prelude to assaultiveness."

This dramatic example clearly illustrates the value and purpose of reviewing documentation with an eye toward retrospective review.

e. Professionalism in record-keeping. As in other aspects of the treatment relationship, a professional attitude should prevail in the records (see Chap. 1, Sec. III-G, concerning the distinction between progress and process notes and related matters; see also Suggested Readings for Chap. 1; and see Sec. III-A-1-b). An objective, descriptive tone should govern the recorded material. There is no place in a professional record for derogatory, judgmental, value-laden, abusive, sarcastic, mocking, or ridiculing remarks; even mild facetiousness or witticisms are potentially destructive, not only because they are rarely quite so funny when read aloud in court, but because they may convey disrespect or an unsympathetic attitude toward the patient—a serious problem for the clinician attempting to counter a charge of negligence by avowing that she had the best interests of the patient at heart. Even more significantly, the difference between an appropriate description or a psychodynamic formulation and evidence of a clinician's lack of concern about a patient may turn on such matters of professional intent conveyed by the tone of the material.

f. Correcting the record. An omission detected in a review of the record can most appropriately be corrected by making clear the retrospective nature of the emendation.

> ***Example 12.*** July 20, 2007, 5:00 p.m. Review of note of July 14, 2007, reveals inadvertent omission of notation of patient's parent's visit, which contributed to the upset of the next day; currently, . . ."

Under no circumstances should corrective notes be interpolated unlabeled into the body of the chart; done even with the best of intentions, such interpolations may seem duplicitous in the light of subsequent review, especially in the context of litigation. The difference between the conscientious remedy of an oversight and a venal attempt at fudging the record may lie in the transparent depiction of the time frame and context of the inserted note. A "flag note," dated and signed, is acceptable, as in the next example:

> ***Example 13.*** For the situation in Example 12, one might place in the margin of the earlier note (July 14, 2007) the following signed note:
>
> July 20, 2007, marginal note: See progress note of July 20, 2007, for additional data.

Any attempt to squeeze emendations, obscuring cross-outs, interpolations, or corrections into existing chart notes is especially to be avoided. Clinicians should be aware that forensic document experts are extremely skilled at identifying the relative timing of written material. Document experts aside, the words "suicide precautions" squeezed between two closely set lines of a written progress note, so that the insert clearly overlaps existing letters beneath it, requires no document expert to detect its *post facto* nature. Recall that in the process of litigation, such tiny handwritten inserts appear on four-foot by six-foot foam-backed displays that sit on easels in front of juries. At those frequent moments in the trial when the material is boring, the eyes of jurors will wander to that inept emendation, with its inescapable aura of retrospective cover-up, no matter how contemporaneously and honestly the correction was made. Clinicians should sacrifice the wish to save paper and use the retrospective annotation note, as in Example 13.

Finally, attempting to go back to correct data after a suit has been filed is not only futile but self-defeating. Instead, for forensically sensitive events (e.g., assaults, suicides), a clinical review of the entire situation (perhaps presided over by a senior clinician under peer review protections) often proves valuable, not only in unearthing data that might be lost in the tumult of the emergency, but also in maintaining and demonstrating ongoing attention to and review of clinical problems in the service of high standards of care; such reviews are often additionally helpful in providing data useful in countering charges of negligence brought at some subsequent date (see also Sec. III-A-4-e and Chap. 3, Sec. III-A-3).

g. Hospital policies and related documents. Clinicians may be subliminally aware of the existence of large volumes of documents on hospital policies and regulations; such documents are often an important part of the accreditation process for hospitals. As a practical matter, it is unusual for those clinicians not involved in the direct design of hospital policies ever to have a close familiarity with them, although they may have read—or at least received—them as part of the initial credentialing process.

For good or ill, such policies represent the institution's own self-set standards; thus these documents bear directly on the question of the standard of practice of the clinicians at that institution. Clinicians on treatment units should have at least some general familiarity with policies involving clinical-administrative decision points (e.g., What does it mean in this institution to be on suicide precautions? How often are such patients checked? What are the official procedures regarding the assignment of a pass? How are various kinds of medications handled?).

In complementary fashion, those clinicians involved in designing hospital policies should design them with significant flexibility and with an eye toward providing a great deal of discretion for the treating clinician on the scene. Despite their often functionally negligible role in the actual running of the hospital, such policy documents provide an easy target for attorneys attempting to point out that clinicians violated the policies of their own institution and, thus, were more likely to have been negligent. Policies designed with unrealistically high standards are invariably self-defeating.

h. Question of old records. Most clinicians would agree that a patient's previous clinical record is of great importance to the clinician for treatment. The same clinicians would easily agree that obtaining those old records—in particular, obtaining them before the patient's hospitalization is over and the patient is discharged—is often difficult because of short inpatient stays and the problems of understaffing and high work volume in many institutional record rooms throughout the United States.

The clinician faced with this reality of institutional life should not, however, assume the ostrich position and either fail to send for previous records or send off the request and assume that the records will be a long time in coming. Instead, especially if the patient's history contains risk elements of suicide or violence to others, clinicians should consider calling up previous institutions or arranging for such data gathering and obtaining at least the highlights of clinical care. If the patient cannot or will not give permission, or if the previous institution will not release such information, one should make the best of the situation, but in many cases, certain key points constituting emergency information may be transmittable in this informal fashion. It may be helpful, for example, to ask a former treater by phone, "Just tell me, yes or no, were you (or your staff) concerned about his potential dangerousness?" A broad question regarding the patient's dangerousness demands no profound disclosure of the patient's confidential revelations, but aids considerably in decision-making. A discouragingly common element in litigation involves the imputation that the clinician failed to obtain significant old records that allegedly would have altered the treatment plan.

i. Limits of documentation. Clinicians on the scene, and forensic experts reviewing records in the context of subsequent litigation, should keep in mind the limits of documentation itself. Everything that transpires cannot be recorded, for the simple reason that—if attempted—no time would remain for the care of patients. Core documentation addressed to the three principles outlined above (i.e., risk-benefit analysis, clinician judgment, and patient capacity to participate in treatment planning) is more than adequate for clinical and risk management purposes.

There are two areas that are clinically meaningful, but that almost never appear in formal fashion in the records: subjective data and inter-staff communication. *Subjective data* refers to those impressions gained by the clinician from direct observation of the patient's tone of voice, body language, facial expression, sounds, and even smells—and to the clinician's internal subjective responses to these data—that are not transmissible to individuals not on the scene. Whereas such sensory observations may be determinative of clinical decision-making in a given case, they are rarely conveyed directly in the record in a form that permits their perception by later observers.

Documentation cannot record the entire clinical experience, especially the subjective aspects; thus it is important that subsequent readers of the record give the benefit of the doubt to the contemporary observer of the scene as to what was observed and what was interpreted from those observations (e.g., the patient's diagnosis). Primacy of the contemporary on-site observer is relevant when expert witnesses perform their inescapably retrospective assessments of the care that was delivered (see Chapter 8).

The second area rarely captured in record-keeping is the astonishing amount of inter-staff communication that goes on at all times, among staff members at the nursing station, in the halls and cafeterias, and the like. Such informal sharing of information may also powerfully influence decision-making, but rarely appears explicitly in the record.

Subjective data and inter-staff communication need not necessarily be recorded comprehensively in the chart. Clinicians should remain aware, however, of the fact that documentation possesses inherent limits and should not be confused with the totality of the care delivered: The menu is not identical to the meal.

4. Consultative Approaches to Prevention

As indicated in Section II-A-1-b, the benchmark used in the assessment of negligence is the prevailing standard of practice of the profession. It is this point that adds a preventive dimension to the generally laudable use of clinical consultation. Consultation—the second pillar of liability prevention—may be used in a number of ways.

a. Consultation versus supervision. Consultation is an arrangement in which an outside clinician is invited to provide information to the clinician who has responsibility for the patient's care without assuming any clinical responsibility for the case. The information offered by the consultant may be primarily educational in nature (e.g., when a clinician hires a more experienced psychotherapist to review his treatment of one or more patients) so as to enhance the consultee's psychotherapy skills. (Note that in some areas this person is referred to—erroneously—as a *supervisor*.) Or the consultant may be asked to make suggestions relative to the treatment of a particular patient, with broader educational goals secondary to the immediate problems of patient management. In either case, the hallmark of a consultative relationship is that the consultee is free to accept or refuse any suggestions made by the consultant.

In contrast, in a supervisory relationship the supervisor shares some degree of responsibility for the patient's care flowing from the structure of the situation rather than from an invitation. This is generally the case in formal training programs, such as psychiatry residencies, psychology internships, or social work placements. It may also be the case when one clinician, usually a psychiatrist or psychologist, allows another clinician to bill third-party payers under the first clinician's name; this widespread practice results in the first clinician—knowingly or not—assuming supervisory responsibility for the conduct of the case. When a true supervisory relationship exists, the treating clinician is not free to disregard the supervisor's views of how the case should be managed. Legal aspects of the supervisory relationship are discussed in Sections II-A-3-g and III-B-3. We consider pure consultative situations in the next four sections.

b. Occasional consultation. In occasional consultation, a consultant is invited to review at a specific point in the treatment an inpatient or outpatient case; this is the mode most familiar in teaching settings, but it is used in private practice as well, typically when a clinician seeks out a senior colleague for help with a treatment impasse. This represents perhaps the most common form of obtaining a second opinion, as in general medicine. More importantly, even a very brief and informal consultation represents a "biopsy" of the standard of care.

c. Ongoing consultation. In ongoing consultation, a clinician hires (either privately or through an institutional arrangement) a senior colleague to review her work on a regular basis (e.g., weekly or monthly). The consultation may cover a single difficult case, the consultee's entire caseload, or anything in between.

d. Peer consultation. The peer consultation approach may be formal or informal, individual or group consultation in which clinicians of comparable levels of age, training, or professional development give ongoing suggestions to each other about patient care and clinical work.

e. Retrospective review. Retrospective review is a form of consultation in which a *post facto* attempt is made to understand more about why a particular event occurred. Examples of such events are a flight from therapy, a suicide or serious attempt, an adverse treatment reaction, an escape from a hospital, an admission to a hospital, and a severe assault. Many utilization and peer review procedures fall into this category. Such reviews are aimed at monitoring and improving professional care through education and better understanding of critical events in treatment.

Depending on state laws and the mechanisms by which such reviews are accomplished, some retrospective reviews are subject to discovery in subsequent litigation, whereas others enjoy immunities from such exposure. Regulations on this charged subject reflect the tension between the value of clinicians' candid peer-scrutiny and peer-criticism, and the appropriateness of the plaintiff in a lawsuit gathering hindsight evidence for his case. Regional and institutional policies vary on this subject; many forms of quality assurance activity are not discoverable, for example. However, licensure boards often can obtain access to otherwise protected information generated by peer review. Under federal law, protection and advocacy agencies—which each state is obligated to create—can obtain access to peer review materials in facilities that fall under their mandate. Clinicians and institutions should clarify these issues before reviewing case materials retrospectively.

All the four foregoing consultative approaches (see Secs. b–e) serve the purposes (among others) of malpractice prevention by bringing the individual practitioner into touch with representatives of the prevailing standard of practice (i.e., colleagues in the field). In fact, in all but the most egregious forms of dereliction, a second opinion exerts a powerful counterforce to the accusation of negligence; the clinician who seeks professional advice thus gives evidence of scrupulousness of practice and so stands to present the disputed action as an honest error in judgment rather than negligence—an error shared, moreover, by more than one party in the profession. (See also Sec. III-A-3-b and Chap. 3, Sec. III-A-3.)

B. SPECIAL ISSUES IN MALPRACTICE

A number of issues that have surfaced in recent years require attention as potential areas in which malpractice litigation can be brought.

1. Issues in Managed Care

A growing literature documents the controversies and the special problems relating to the impact of managed care on the contemporary practice of psychiatry; the various forces at work are described in Section II-C. From the viewpoint of malpractice prevention, however, the complex issues involved can be distilled to a central principle: The clinician must act in accordance with her own clinical judgment for the patient's welfare, despite the pressures of impaneling; reimbursement; ostensible medical necessity as defined by an MCO; and the like.

a. Maintaining clinical judgment. One dimension of maintaining clinical judgment relates to the role of the standard of care in liability determination. Treaters should exert every effort to maintain their high standards of practice in the face of fiscal constraints. If the clinician makes a treatment-related decision that falls below her standard of practice, it will not be possible later to defend that decision as lying within the profession's standard of care should a bad outcome ensue.

A second dimension of the problem is the resistance of American citizens to any constraints on their medical care; juries are notoriously impatient with, and even dismissive of, physicians' economic justifications for denying care or providing inadequate care. From this viewpoint, additional risk-management principles are relevant to the special problems of managed care.

b. Economic informed consent. As Case Example 4 at the beginning of this chapter suggests, the physician who serves as the bearer of bad tidings about the MCO's refusal to pay for services may meet the fate familiar to such messengers. The treater is then identified with the withholding insurer—a problematic position evocative of the bad feelings that are the wellsprings of litigation. The best prevention for this occurrence is a procedure that we and others have termed *economic informed consent*, an exchange between doctor and patient addressing the economic context of the services provided and serving as an adjunct to the informed consent needed for treatment.

Economic informed consent describes the dialogue with a patient in which the physician—at or near the very inception of hospitalization or a course of treatment—reviews the extent of insurance coverage for the proposed treatment or hospital stay. If that coverage appears to be insufficient, physician, patient, and family members should devote anticipatory planning to constructive and creative solutions to the economic shortfall. Possible solutions might include: (a) the patient or family paying out-of-pocket for the extra costs; (b) transfer to the public sector or other form of free care; (c) construction of an alternative care system (e.g., a system of outpatient visits supplemented by visiting nurse attention and telephone contacts) when full inpatient care is not covered; (d) recruitment and basic instruction of family members to serve as observers and even treaters (e.g., showing a relative how to monitor urine sugar or blood pressure, dispense medications, etc.); and (e) negotiating with the patient and family to accept the patient's being discharged "quicker and sicker" to avoid extra costs.

Anticipatory planning, especially when involving the family, prevents the patient and others from being taken by surprise at the point of discharge from the hospital or in the midst of outpatient treatment by the financial straits in which the patient may find himself. The elimination of this bad feeling is beneficial; more importantly, the physician's working alliance with the patient and family may be preserved as the sides collaborate, working together to achieve an optimal result.

c. Appeals. In addition to maintaining sound practice in the face of economic disincentives and using economic informed consent, the clinician should not passively accept denial of reimbursement. When an MCO rejects a treatment or intervention that the clinician believes in good faith to be necessary for the patient's welfare, the clinician may be obligated—if the patient concurs—to appeal that decision. As a practical matter, the physician should attempt to (a) discuss the case with a physician-reviewer as opposed to a reviewer of another discipline; (b) go above the initial reviewer, if needed, to a higher supervisory level; (c) obtain and document the name and position of the reviewer dealing with the appeal (see Suggested Readings, Appelbaum, 1993).

d. Communications. As a rule, a physician should not be forced into communicating to the patient that he bears the responsibility for denial of coverage by an MCO. It should be made clear to the patient when the MCO has denied coverage for a requested service. Then, physician and patient should explore collaboratively the full spectrum of options available that take economic constraints into account. Open disclosure should replace the heinous "gag orders" imposed by some companies; the physician who accepts being "gagged" risks losing a critical opportunity to discuss the issues and "detoxify" their noxious impact.

A second communication problem concerns medical records under managed care. No reliable empirical data on this subject exist, but anecdotal reporting suggests that in some cases the seriousness of patients' complaints are exaggerated by clinicians for goal-directed purposes, such as obtaining authorization for a hospital admission; thus, a depressed patient may be described as suicidal without a clinical basis. Without condoning such fraudulent practices, one can understand the frustrations that may give rise to them; but the physician who succumbs to this temptation vitiates the most important defensive factor in the malpractice arena: a valid, accurate record. If a bad result indeed supervenes, the physician who has painted a picture of the patient's condition as more serious than truly exists may become accountable for an inadequate or insufficient response to that (specious) description of the patient's state.

2. Issues in Recovered Memory

Another area of great complexity and controversy in the field of psychiatry is the recovered memory controversy described in Section II-A-3-c (see Suggested Readings , Sec. A, 9 and 10). The subject not only divides clinicians, but also provides a number of bases on which even well-meaning and responsible clinicians may be sued, sometimes successfully, for malpractice. Because almost all forms of therapy direct the patient's attention to his past, if only during initial history-taking, clinicians have occasionally been paralyzed with fear of future litigation when a patient in therapy spontaneously recalls a previously forgotten incident. Although such anxiety is usually a needless overreaction, clinically sound principles provide clinicians greater reassurance in their psychotherapeutic practice (see Suggested Readings, Gutheil and Simon, 1997).

a. Documentation and consultation. Documentation and consultation are discussed throughout this chapter and are not reviewed here. The critical points to record are the context of the patient's recovery of memories and the clinician's avoidance of suggestive interventions.

b. Abstinence and neutrality. Abstinence and neutrality, once-sovereign principles of analytic practice, have become less widely known, but they remain invaluable in guiding the treater away from intruding unnecessarily into the patient's life, either as an advocate or one who imposes beliefs on the patient (see also Sec. III-A-2-d on therapeutic disinterest). Urging the patient to take a case to court to sue an alleged abuser or recommending that a patient cut all ties with the family are two common forms of such inappropriate intrusion. Like other major life decisions considered in the midst of therapy, these actions should instead be discussed and, usually, worked through rather than acted on.

c. Remaining in the clinical chair. Clinicians should avoid being swept away emotionally, swept into a rush to judgment, or swept off their feet by countertransference overreactions to reports of abuse; instead, remaining in the chair of clinical professionalism is the safest posture.

d. Historical versus narrative truth. Whereas the therapist's empathy and identification with the patient are desirable traits, in most instances the therapist really only knows what the patient reports (sometimes called *narrative truth*), not what actually happened (called *historical truth*). Even well-intentioned therapists may lose sight of this fundamental distinction in their wish to help the patient. Therapeutic receptivity to the patient's report should remain clearly distinguished in the record from the therapist's inappropriately claiming to know what really occurred. In the absence of corroborative information, patients should be cautioned that the credibility of recovered memories cannot be established.

e. Treater versus expert roles. Overenthusiastic treaters and those who are persuaded by overenthusiastic attorneys for the patient may be tempted to take on the role of expert witness for their own patients; this is not good practice on several grounds. (See Chapters 6 and 8 and their Suggested Readings for fuller discussion of the incompatibilities of treater and expert witness roles.) A separate individual should be responsible for any medicolegal involvement; however, taking such cases to court is generally undesirable (but may sometimes be unavoidable), because the law is a blunt and untherapeutic instrument for resolution of past traumas.

f. Hypnosis and amytal. Although historically useful in clinical work, hypnosis and sodium amytal interviewing have been rendered legally complex by controversy over admissibility of testimony after these inescapably suggestive procedures. These interventions should be used with caution, especially when a patient contemplates litigation.

g. Professional associates. Psychiatrists who collaborate with other professionals should perform independent assessments of patients and should remain alert to their collaborators' theories of diagnosis and treatment of abuse victims. Of concern is the possibility that the psychiatrist may be held vicariously liable for the other professional's deviations from standards of care in this area. Section 3 below is also relevant to this point.

h. Role of family members. In many recovered memory cases, families are the litigants; indeed, the novel aspect of some of these cases is the manner in which courts have granted nonpatient family members standing to sue the therapist, even when the patient is quite satisfied with the treatment. An important principle is clarity about when family members are also patients and when they are brought into sessions as an adjunct to the designated patient's treatment. This distinction should be clarified, discussed, and documented.

3. Issues in Supervision

Section III-A-4-a describes the consultation issues in liability prevention; Section III-A-2-k covers the role of the psychiatrist as medical backup. Supervision has several additional aspects and implications.

a. Supervisor in the chain of clinical responsibility. The most familiar example of a supervisor in the chain of clinical responsibility is the attending psychiatrist as supervisor for the resident on an inpatient unit. Because the resident is essentially a trainee, the supervisor is vicariously responsible for the care of the patient by the principle of *respondeat superior*, described in Section II-A-3-g. Note that in this situation the supervisor may be vicariously liable for the resident's negligence despite not having had any direct contact with the patient or any role in that patient's care.

A different supervisory exposure is the claim of negligent supervision. When a bad result occurs from negligent supervision, the supervisor is held accountable for her own behavior in allegedly failing to provide the supervisee with proper guidance, instruction, direction, or, at worst, control.

b. Varieties of supervisory experience. Supervisors must clarify the extent of their role in terms of whether they are expected to provide direct oversight of the supervisee's work (with the implication of greater direct responsibility) or whether the supervisory role is directed more at personal growth or education for the trainee. For example, the attending on the inpatient ward may have direct responsibility for all the patients on that ward; in contrast, an off-site supervisor who is not in the line of responsibility may be provided by the training program just to deepen the trainee's understanding of clinical issues.

c. Risk management for supervisors. Supervisors endure some particular forms of exposure to liability. Boundary issues arise in the supervisor-supervisee relationship as well as in the clinician-patient one. Some of these issues parallel sexual harassment concerns because the supervisor can directly influence the trainee's grade and career; as in other sexual harassment contexts, the supervisee's consent to a social, romantic, or sexual relationship may partake of coercive elements.

Can the supervisee really refuse? Is the supervisor who invites all supervisees to an end-of-the-year party in the same conceptual place as one who invites an opposite-sex supervisee to dinner alone?

The supervisor should maintain a clinical and task-oriented focus during the supervision, placing uppermost the welfare of the patient(s) whose care is being supervised.

C. RESPONDING TO CHARGES OF NEGLIGENCE AND MALPRACTICE

1. Opening Gambits

Any practitioner, regardless of experience, training, unimpeachable standards of practice, or success in the field, may be charged with malpractice. Although clinicians may take heart from having followed the preventive measures above to aid in the outcome, the actual experience of being charged is always demoralizing and distressing. To maintain perspective, one must keep in mind certain fundamentals of the experience.

The announcement can come from a variety of sources and in various forms: from one's institutional superiors, when the suit names and includes the facility; from a letter from the plaintiff's attorneys or directly from the plaintiff-patient; or from a face-to-face confrontation with patient, attorney, or both. One of the most disconcerting aspects of attorneys' letters, calls, or statements is the style of many attorneys of entering bombastically; that is, their tactical approach to the inexperienced clinician (and most clinicians are inexperienced in these events) often appears to involve accusing everybody involved with the patient of having done everything not merely wrong, but willfully and maliciously wrong. The average practitioner has never heard such accusations outside of psychotic transferences, but these are often part of the routine. The clinician's own attorney may respond with threats and accusations of libel against the charges, and so on.

Recognizing that these are standard opening maneuvers may aid the clinician in retaining composure under this assault; none of the accusations is meaningful until proven in court. Clinicians who overreact with panic or rage on receipt of these terms may act rashly and self-defeatingly.

The clinician must also remember that, at the point of initiation of litigation, it is only a distraction—albeit a comforting one—to interpret what is occurring in dynamic terms. That is, it may well be the case that the charge represents the patient's transparent acting out of the transference, of psychotic fantasies, or of entitlement or rage at the patient's parents, all being expressed by the patient filing suit; such insight into the patient's behavior, no matter how perspicacious, should have no influence on a serious, businesslike, and realistic approach to the matter.

The first reaction, of course, should be to contact one's insurer immediately with the news of a possible suit; it is almost always the insurer's lawyer who is responsible for the defense, should a suit be filed. In addition, clinicians working in institutions should notify the institution's risk manager. One should, in addition, never respond in any manner to the plaintiff's lawyer's communication; a response should be left to one's own lawyer. Statements made in haste at such times are often repented at leisure. Communications should be made only to one's defense attorney.

Finally, under no circumstances should the existing record be altered by the clinician. It should be secured by one's attorney or liability insurer.

2. Working with a Lawyer

Few experiences are as reassuring as working with a skilled and experienced attorney during malpractice litigation; success in this crisis often depends on how well the lawyer and clinician collaborate. Certain principles should guide the clinician in this undertaking.

a. Collaborative approach. Numerous ways exist in which the nuances, unique issues, and approaches to psychiatric malpractice litigation differ even from general medical malpractice suits, and these differences may be pivotal. The defendant-clinician should recognize that his attorney may not always be possessed of the familiarity with psychiatric (or general medical) issues that the clinician himself enjoys. The clinician's most useful role in the defense may be to fill in evident gaps in his lawyer's knowledge. Psychiatrist and lawyer should work as a team.

> ***Example 14.*** A malpractice suit hinged on the testimony of opposing psychiatric expert witnesses. At the defendant-psychiatrist's prompting, his attorney asked whether the opposing expert witness was board certified. He was not, as it turned out; the plaintiff's attorney had not ascertained this datum, being ignorant of its significance. This revelation severely weakened the impact of the testimony of that witness.

b. Absolute candor. The courtroom is the arena in which the attorney makes tactical decisions about which evidence is best introduced; in the lawyer's office, admissibility should be total. Questions, uncertainties, subjective assessments of the situation, acknowledgments of omission or wrongdoing, impressions, and self-assessments are all legitimate subject matter for communication to the attorney; self-effacement, grandiosity, entitlement, and any form of concealment of these data are utterly inappropriate.

c. Expert witness selection. The clinician can be further helpful to the attorney by making recommendations for selection of expert witnesses, because—unless the attorney has acquired capable clinicians from previous cases—the clinician may be better acquainted with members of the field who have special expertise on the disputed subject. Important qualities of a desirable witness include:

1. Experience not only in the subject matter, but also in being on the stand, being cross-examined, and thinking quickly under stress.
2. Renown in the subject area, perhaps as conveyed by an extensive curriculum vitae, many books and publications, high academic rank, or wide reputation.
3. Personal knowledge of the clinician and reasonably good opinion of her (although too close a personal relationship or friendship may constitute a disqualifying bias).
4. If possible, personal knowledge of the patient (e.g., from having consulted on the case, given a conference on the patient, etc.). Of course, the witness should not be in the line of clinical responsibility for that patient.
5. Most critically, similar orientation to treatment. (See Chapter 8 for further discussion of expert witnesses.)

d. Role of the records. Under most circumstances of a suit, an attempt is made by the plaintiff's attorney to obtain the patient's records, sometimes under subpoena, sometimes merely with the patient's release; here, of course, the impact of the preventive measures of Section III-A-3 is most keenly felt. The experienced lawyer requests all records, which include private notes (i.e., process notes; see Chapter 1). If an attorney requests the official record, the front record or progress record is indicated; the clinician is under no obligation to volunteer her private notes unless specifically asked to do so. All requests for records should be channeled to the clinician's attorney and acted on only with his advice. The clinician should either give her attorney the originals or retain them and provide clear photocopies as needed.

The clinician's candor should be reserved for her own attorney. Declining to volunteer gratuitous information to the "other side" of the case is a good general rule for all communications; blurting "I didn't mean any harm!" when called by the patient's attorney would be considered a notable *gaucherie*. Communication should take place via the attorneys.

Attorney and clinician are well advised to go over the records carefully together to clarify ambiguities, technical jargon, unsuspected omissions, latent implications, or possible misinterpretations. Under certain circumstances, a given patient's record or chart may contain material irrelevant to the subject of the suit but potentially damaging, embarrassing, or otherwise harmful to the patient or others. The clinician cannot legally or ethically withhold such material; however, through his attorney a request to the judge may be made to review that material in chambers to decide if it is indeed irrelevant and may thus be excluded from public revelation at trial. If the judge refuses the request, the clinician should attempt to prepare the patient (preferably by lawyer-to-lawyer communication) for the possible impact of disclosure. (See Chap. 8, Sec. III-B-2, concerning use of records by the expert witness.)

D. TREATING PATIENTS DURING MALPRACTICE PROCEEDINGS

This section confronts two aspects of a complex subject: the treatment of patients in general by the sued clinician and the treatment specifically of the suing patient.

1. Effects of Being Sued on the Clinician's General Patient Treatment

Clinicians in the regrettable position of being sued describe the enormous power of the suit to preoccupy them, not just at odd moments during the day, but even during work with other patients. The issue of the suit resonates with similar material from the treatment session, serving as a distraction from concentration on work. In addition, clinicians describe having flashes of association to some important issue or question in the suit while seeing a patient, wanting to continue working with the patient before them, and yet feeling terror that they will lose or forget the crucial datum.

Clinicians experiencing malpractice litigation may stop seeing certain types of patients; consider early retirement from the practice of medicine; and seriously discourage their children and others from entering the field. More significantly, physicians experiencing litigation clearly indicate that it causes suffering to them and to their families (see Suggested Readings, Charles et al.). It is of interest that work by Charles and associates reveals that physicians for whom being sued was the most significant catastrophic event in their lives were coping far less effectively than those physicians who had had an earlier catastrophe in another context—suggesting that the experience of trauma provides either armor or practice with a set of coping skills.

In conclusion, clinicians must weigh heavily the impact of litigation in the short run on their capacities to do good work and should consider limiting new patients or responsibilities, even perhaps cutting back on those they are carrying. Certain aspects of this difficulty may be unavoidable. For example, consider the clinician sued for negligence by the family of a patient who commits suicide. It may happen that another patient expresses suicidal feelings—a not unusual experience in psychiatric practice, but always stressful in its own way. Clearly the clinician cannot bring to bear the same dispassionate assessment as would be possible were there no suit. Ethically, however, the clinician's duty is to be as useful as possible to the patient then before her. In this exceptionally charged situation, the most appropriate approaches would involve active use of consultations, strong efforts at introspection and consciousness raising, and—as a last resort, if the conflicts become unmanageable—conscientious referral of the patient to another clinician, with appropriate explanations. Responsible referral in this manner avoids the further charge of abandonment of the patient.

The danger to be especially guarded against is avoidance or turning away from patients' distress because patients, sensing this withdrawal, may become increasingly desperate, additionally so because they have no way of correctly interpreting the basis for the clinician's reaction.

2. Treating the Patient Suing the Treater

Treating the patient suing the treater is a situation that requires some explanation at the outset. Modern defense attorneys sophisticated in the medicolegal sphere openly recommend continued treatment by the clinician of the plaintiff. They reason that the patient's staying with the clinician makes a positive impression on the jury: The clinician can't have been all that bad. For psychiatry, however, this model is far less applicable because of the requirement that the relationship be free of encumbrances. This has several implications. First, when there is a choice, the clinician should not elect to treat the patient suing him, because legally there is a danger of adding fuel to the forensic fire, and clinically because of the countertransference problem. The reason the question can be discussed at all is threefold:

- The fact that the patient (or others) is suing the clinician does not necessarily eliminate the patient's need for care.
- The existence of the suit does not automatically imply that the patient no longer wishes to see that clinician; the patient's filing of the suit may reflect, in curious form, the intensity of the patient's involvement with that clinician. Thus, wanting to continue seeing the clinician being sued is a logical contradiction, but not a clinical one.
- In the public sector, especially, other choices may not be available. For example, the head of a ward at an overcrowded, understaffed state hospital may be the target of a suit by a patient in that catchment area; should the patient require readmission during (or, conceivably, because of) the litigation, there may simply be no other bed space, facility, or clinician available. Thus, it may happen that a clinician, as in this example, may find himself in the position of being clinically responsible to treat a patient by whom he is being sued.

This extraordinary dilemma admits of no easy approach, but the patient's transfer to another facility (perhaps under an exchange agreement) is the only acceptable course. The reality that the clinician must consider that the defense of her case totally contaminates the work; not only is the clinician's purpose slanted toward proving herself correct, but her interventions must of necessity be suspect as attempts to convince the patient to change her mind. Ethical treatment is probably impossible under these circumstances.

IV. PITFALLS

A. DEFENSIVE PRACTICE

We have intentionally avoided, so far, the concept of *defensive practice* or *defensive psychiatry*, in favor of focusing on negligence prevention. This terminological distinction highlights the pitfall at issue, namely, seeing the patient as the enemy even before any litigation arises. Such a view is enormously destructive to the treatment alliance, to empathic receptivity, and to one's ability to listen perceptively. The preventive approaches outlined in Sections III-A and III-B enhance patient care and provide insurance against possible litigation. Ironically, defensive practice may actually provoke the very result it purports to avoid. Feeling antagonized, alienated, and defended against, the patient may believe that the clinician is not placing his interests foremost and may express this view in litigation.

B. REMAINING THE CLINICIAN

Staying in the therapeutic chair is one of the most difficult tasks of the clinician facing or fearing suit; the temptation is strong to behave like a lawyer under the stresses of litigation. Because the patient has a lawyer, the clinician should have a lawyer; however, she should retain the dedication to treatment of the patient.

C. POLITICAL USE OF THE RECORD

The record should, at all times, be used for its documentational and communicative purposes. Clinicians should actively resist the temptation to fight outward battles through the chart; to admonish (or for that matter, inspire) other clinicians; or to demonstrate one's skill, intellect, baroque verbal facility, and the like. No amount of staff amusement or improved morale can repair the destructive impact on this legal document of such approaches in a liability context.

V. CASE EXAMPLE EPILOGUES

A. CASE EXAMPLE 1

The consultant reviews with the therapist recent court rulings on informed consent, especially those concerning the extent of the therapeutic privilege—the right of the doctor to withhold information that might damage the patient. He notes that this privilege is usually invoked only when the information might be harmful in itself and not when the information might provoke the patient to refuse treatment, which might then lead to harmful results. In addition, he cites the writings of leading psychiatrists who assert that information about the potential for metabolic syndrome need not be exhaustively disclosed to acutely psychotic patients, but that after a period of several weeks to months, whether the patient had improved significantly or not, the matter has to be discussed fully.

Reluctantly, the clinician decides to raise the issue with her patient. She notes that she is not sure if all the risks, benefits, and alternatives to medication have been explained previously and that she wants to go over them with him now. She further notes that her concern has been evoked by his weight gain and laboratory findings that she thinks represent a side effect of the medication.

After she explains the long-term risks of continuing neuroleptics in a patient who already has signs of metabolic syndrome, the patient asks what the alternatives are. The doctor says frankly that the medication can be tapered or changed to one not currently thought to contribute to the syndrome, but either course of action would create a risk of relapse. The patient responds that he is aware of his weight gain, because his family points it out to him whenever they are angry with him, and although he does not like it and certainly would not want it to get worse, he is more afraid of relapsing and being readmitted. Consequently, he wants to continue taking the medication. Because he says that he would continue with the medication in any event, there is no point in further work-up of the condition, although ongoing monitoring will continue.

The feared paranoid reaction does not develop nor does the patient become overtly angry. When the psychiatrist asks him to share his feelings about the discussion they have just had, he says that he appreciates the way she has brought him into the decision-making process and interprets that as a sign that she respects the progress he has made toward becoming “normal” again.

B. CASE EXAMPLE 2

After alerting his malpractice insurer, the resident hurries to the supervisor's office and presents the entire case in review. The supervisor nods. "Sounds like you needed to pay more attention to her transference to you; she may have become psychotic as a defense against those feelings, just as she did with the boyfriend. I suggest you try to get the family together to discuss this. Meanwhile, call the lawyer who issued the subpoena and try to get him into the meeting, together with our hospital counsel."

The supervisor goes on to explain that the intensity of therapeutic exploration can mobilize powerful earlier feelings that—ideally—become available for necessary therapeutic work. These feelings, he cautions, may also burgeon undetected, with the result that the ideas that accompany these feelings may become delusional when the patient's defenses can no longer contain the affect. The supervisor's session is interrupted by a call that the patient has been readmitted.

Energetic efforts by the social worker to have the father come in to discuss the issue are successful. A group conference with patient, resident, supervisor, social worker, father, and both lawyers aids in clarifying the issue. The father dubiously agrees to hold the suit in abeyance; although confused by the whole matter, he is influenced by his daughter's willingness to continue work with the resident. Months later, the patient describes the earlier office incident: "I was flooded with the strongest sexual feeling; I sort of blanked out, and I thought we'd made love—you know, through the air." More months of therapeutic work permit the patient's greater acceptance of her sexual feelings.

C. CASE EXAMPLE 3

"So that's the situation," the psychiatrist concludes wearily. "She has every detail of this down pat: the robes, the hoods, animal sacrifices, dead babies—the works. She's assuming I'll support her in this suit against her father, when I don't believe in any of that satanic stuff. I'm being set up for a false memory suit, and I want no part of it. So I need advice."

The consultant nods encouragingly. "I certainly see the problem, but fortunately—or maybe unfortunately—it's not a new one. We need to put on the brakes." She encourages the psychiatrist not to engage in a struggle over believing or disbelieving the claims of satanic abuse. Instead, therapy should focus on present dysphoric symptoms directly. She should explain to the patient that, as a treater or "fact witness," she will not be particularly helpful at trial. Moreover, the patient should be urged to abide by the therapeutic maxim of avoiding major real-life changes—including divisive litigation—before extensive discussion in therapy. The psychiatrist is advised to be scrupulous about clinical boundaries and maintaining appropriate therapeutic distance. The patient should be strongly encouraged to seek therapeutic resolution and perspective, not by legal but by clinical means. The consultant concludes, "If the patient will not cooperate with this approach, you might have to consider seriously withdrawing from the case."

Relieved by the clarity of this plan, the psychiatrist confronts the patient at the second session with the goal of helping her reframe the task of therapy. Initially distressed and hurt, the patient agrees to hold off on immediate litigation. Months of careful, nonsuggestive exploration, focusing on present experience, reveal the kernel of true abuse amid the satanic chaff. In a strengthened therapeutic alliance, doctor and patient agree to work through this issue in therapy.

D. CASE EXAMPLE 4

As he drops into the chair in the office of the hospital's risk manager, the psychiatrist summarizes the story. He finishes with "and, in any case, I know they mean business; I spotted them as litigious from the word go."

Nodding thoughtfully, the risk manager comments, "You may be right. The real point, however, is that you have just discovered the traditional fate of the bearer of bad tidings." He draws a forefinger across his throat.

"There is little question that the patient's welfare is the doctor's responsibility. We should have used a different approach; I call it economic informed consent. Right from admission you and the staff need to be planning together with the family for the patient's disposition, given the coverage limits. Recruit family members to help monitor the patient; set up outpatient ECT; check out the public sector; get visiting nurses involved; open the discussion of out-of-pocket payment—*anything* that might work."

The psychiatrist weighs this silently, as the risk manager levels a finger at him. "I know what you're thinking: Where can I find the time for this?" The psychiatrist nods sheepishly. "Think of it as an investment of time to avoid, above all, surprising the family. Surprise triggers more litigation than you can imagine."

Sighing, the psychiatrist says, "I'll know better next time. But what about this patient and his family?"

The risk manager rises calmly from his chair. "Let's talk to them together and see what we can negotiate. The feeling of our planning together may blunt their litigiousness."

VI. ACTION GUIDE

A. CHECKLIST FOR PREVENTING NEGLIGENCE AND MALPRACTICE

1. Behavioral approaches.
   a. *Refrain* from unprofessional behavior.
   b. *Avoid* exploitation of patient (sexual, financial, dependent) and boundary violations.
   c. *Maintain* "open door" policy to avoid abandonment; *send* letters (with copies) signaling cessation of treatment, cancellation of time slot.
   d. *Treat* patients within area of competence; *refer* others.
2. Technical approaches.
   a. *Establish* a clear treatment contract.
   b. *Acknowledge* limitations and *avoid* statements implying promises.
   c. *Exercise* care regarding informed consent and its documentation; *remember* memory loss from ECT as factor; and *renegotiate* information about medication at point of clinical stabilization or discharge from hospital (see Section E, below).
   d. *Maintain* a position of therapeutic disinterested impartiality; *resist* giving premature advice.
   e. For legalistic acting out:
      i. *Remain* calm.
      ii. *Avoid* struggle in the legal arena.
      iii. Actively *confront* and *interpret* clinically.
      iv. *Extract* maximum therapeutic benefit from the event.
   f. *Reach out* to victims and affected parties in suicide or homicide; *consider* attending funeral.
3. Documentational approaches.
   a. *Record* factual details, especially forensically sensitive events (e.g., emergencies).
   b. *Describe* in detail the bases for clinical judgment, especially in sensitive areas.
   c. *Think out loud* for the record, especially for calculated risks and indications for nonroutine interventions.
   d. *Anticipate* forensically significant events (e.g., commitments, possible suits) and *write* record with clarity from viewpoint of future readers.
   e. *Maintain* a professional tone throughout record.
   f. *Correct* errors and omissions in transparent, current-time manner.
4. Consultative approaches.
   a. *Participate* in peer review, private review, private supervision, retrospective review; *seek* specific colleagues' advice in complex, risky, or unusual areas.

B. CHECKLIST FOR RESPONDING TO CHARGES OF NEGLIGENCE AND MALPRACTICE

1. *Maintain* calm and perspective under an aggressive approach of attorneys; *resist* dynamic formulation of suit at outset.
2. *Obtain* legal advice.
   a. *Use* collaborative approach with attorney.
   b. *Inform* attorney with absolute candor of all relevant data, including uncertainties, ambiguities, and omissions.
   c. *Assist* attorney in selection of expert witnesses; *weigh* witnesses' renown and experience, personal knowledge of patient or clinician (or both), and similar theoretical viewpoint.

   d. *Surrender* only requested records and only through your attorney.
   e. *Avoid* discussions with plaintiff's attorney; *refer* to your attorney.
   f. *Never alter* the existing record.

C. CHECKLIST FOR TREATING PATIENTS DURING LITIGATION

1. *Avoid* increasing caseload or administrative responsibilities, if possible.
2. *Avoid* electively treating patient suing you.
3. If inevitable:
   a. *Obtain* consultation actively.
   b. *Attempt* transfer to alternative facility.
   c. *Remain* alert for inevitable countertransference difficulties.

D. GENERAL

1. *Avoid* seeing the patient as an enemy.
2. *Remain* the clinician.
3. *Use* record for clinical and risk-management purposes only.

E. CHECKLIST FOR OBTAINING INFORMED CONSENT

1. *Provide* sufficient information concerning:
   a. Nature of procedure or treatment.
   b. Risks and benefits of procedure or treatment.
   c. Risks and benefits of alternatives.
   d. Risks and benefits of no treatment.
2. *Simplify* language so that laypersons can understand.
3. *Offer* opportunity to ask questions.
4. *Test* patient's understanding after process is completed.
5. *Reeducate* as needed according to gaps in knowledge detected by testing.
6. *Consider* presence of factors that might impair voluntariness of consent.
7. *Assess* patient's competence to offer consent (see Chap. 5, Action Guide).
8. *Document* all relevant factors.
   a. Patient's consent, either by patient's signature or clinician's note in chart.
   b. Material disclosed.
   c. Patient's understanding.
   d. Voluntariness and competence.

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CHAPTER 5

Competence and Substitute Decision-Making

I. CASE EXAMPLES

A. CASE EXAMPLE 1

A 38-year-old clinical psychologist is voluntarily hospitalized after unexplained and seemingly self-injurious behavior occurring at a religious retreat house where he lives. He was seen striking his head on the ground and deliberately falling down a flight of stairs; when confronted about this, he attempted to plunge through a closed first-floor window.

Extremely bright and articulate, the patient consistently denies after admission that there is anything wrong. Nonetheless, almost daily self-damaging acts continue and his body begins to accumulate a series of cigarette burns, ecchymoses, and hematomas. A tentative diagnosis of depression leads the resident psychiatrist to suggest to the patient that he might be benefited by a course of antidepressants. The patient refuses, claiming that the only medications he needs are natural foods, which will purge his body of impurities, and that he deserves the punishment he is receiving because of unspecified misdeeds earlier in his life. Shortly thereafter, the patient is observed on several occasions eating his own feces, bars of soap, and cigarette butts. He drenches himself in his urine, which he carefully collects in cups in his room.

Throughout this period, he remains pleasant, at times even witty, and delights in philosophical discussions of existential issues. Records of his only previous hospitalization reveal that a similar state resolved after a short course of neuroleptic medication. After extended hospitalization, during which the patient showed no response to the milieu or to psychotherapy, the resident is considering initiating neuroleptics, but the patient refuses, claiming that his previous experience with them did not benefit him and that the side effects were particularly troublesome. State regulations forbid the nonconsensual administration of medication without a judicial declaration of incompetence and the appointment of a guardian.

Because of the peculiar, dichotomous nature of the patient's mental state, the resident believes that this refusal is actually motivated by the patient's delusional desire for continued punishment and is thus not a competent refusal. He confronts the patient with this belief and with the option of initiating a petition to have the patient declared incompetent and a guardian appointed for the purpose of consenting to treatment. The patient's mother, who has been concerned about his situation, is (as next of kin) the logical choice for guardian; his father is dead and no other friends or relatives are available. Having described a lifelong passive-aggressive mode of struggling against his domineering, success-oriented mother, the patient objects violently to the possibility of her assuming control over this crucial element of his life. The resident wonders how to proceed.

B. CASE EXAMPLE 2

A psychiatrist on a consultation-liaison service in a general medical hospital is asked to see an elderly patient who has been hospitalized for a prostatectomy. The request, though coming from the attending surgeon, actually was initiated by the patient's son, who told the surgeon that he believes his father is no longer able to handle his affairs. He asked that a psychiatrist sign a statement to that effect so that he, the son, could be appointed guardian of his father's property. The son's lawyer has the petition for an incompetence hearing already prepared, save only the physician's statement. Approaching the surgeon before speaking with the patient, the psychiatrist is told that the patient is "a nice old guy," that the surgeon has no idea whether he is competent, and that he filed the consult to accommodate the family.

On meeting the patient, the psychiatrist finds that, despite the discomfort of an indwelling catheter, the man is good-humored, oriented, with an intact memory, and an otherwise normal mental status. He has, in the 20 years since the death of his wife, always lived on his own, handling his own cooking, finances, and housekeeping. The close-knit ethnic neighborhood in which he lives contains his few remaining friends and many acquaintances, and he spends his days walking up and down the streets exchanging pleasantries. He and his son have had increasingly sharp differences over his lifestyle recently, the son believing that the father was "too old to take care of himself" and urging that he move to a retirement home to which the son had arranged admission. The psychiatrist is perplexed by the inconsistencies before him.

C. CASE EXAMPLE 3

Ms. A. is in her early 40s when she is brought by her widowed mother to the hospital and admitted. Her symptoms include hearing voices telling her that she has been chosen for a special, divine mission and having the conviction that her mother is trying to poison her.

The patient has always been extremely tied to her mother who, in effect, rules her life. Since her father's death a month earlier—an event ungrieved by the patient in any observable way—she has grown more agitated until, on the day of admission, she threatened her mother with a knife because she believed the mother was trying to poison her. The mother brings her daughter for help.

On the ward, the patient settles in quietly except for one pervasive difficulty: refusal. She refuses to eat hospital food, to take a bath or shower, to change her clothes, to participate in ward activities, and to take any medication. To all these issues she states, "My divine mission requires purity above all; God's voice tells me not to soil myself with food, bath, medications. . . ."

Legal guardianship to permit involuntary medication is the customary approach to treatment refusal in that jurisdiction, and the mother is viewed as a logical candidate to be guardian. When the social worker broaches this plan, the mother's face lights up, her eyes gleam, and she blurts out, "Yes! That's just what I need to solve my problem!"

When the worker points out that it is the patient's problems that are the subject under discussion, the mother looks confused and angry. Later, at a meeting of the treatment team, the worker expresses her concerns about the choice of the mother for guardian. A fierce debate ensues.

The social worker points out that the mother seems excessively eager to maintain what is essentially a lifelong symbiotic tie to her daughter. The worker sees her task as helping the mother let go of the patient so that the patient can get on with her life; instead, the worker protests, "You're asking me to do the *opposite* of my job for legal reasons. The mother can barely distinguish herself from the patient."

The psychiatric resident argues that the patient is in serious danger and legal action must be undertaken to protect the patient. Bitter experience has taught that judges in this jurisdiction rarely respond to guardianship petitions unless someone is proposed for the role; ergo, the mother appears to be the only choice.

The impasse is referred to a consultation conference.

II. LEGAL ISSUES

In the United States, an emphasis is placed on individual rights; the right to choose is among the most highly valued of powers. Our society grants people enormous discretion in deciding with whom to associate, how to dispose of their assets, and in which activities to engage, even when those activities may generate substantial risks of harm (e.g., mountain climbing). This deference to individual choice is based, in large part, on the view of persons as rational beings, entitled to make decisions for themselves. When that presumption of rationality falls, however, our society steps in to make decisions on behalf of those whom we now deem incompetent.

Competence can be seen as a threshold requirement for persons to retain the power to make decisions for themselves. An attribution of incompetence is a serious issue, because, if substantiated, the person found incompetent can be deprived of many of the rights the rest of us take for granted. In a general sense, two kinds of competence exist: competence to decide (e.g., competence to consent to treatment, competence to contract) and competence to perform an act (e.g., competence to parent). The latter category is broader because it encompasses both decisions and action; however, it is the former—decision-making competence—that is the primary focus of this chapter.

Competence is a major issue for psychiatry, given that so many patients with mental illness may have their competence called into question. Although competence is a legal concept and, strictly speaking, can be determined only by a judge, the realities of psychiatric practice require that clinicians often make their own assessments of a patient's likely competence. In a clinical context, a psychiatrist must satisfy himself that the patient has the capacity to make a competent decision about medication before beginning treatment with a neuroleptic. In the forensic setting, a mental health professional may be called on to assist a court in determining a person's competence to make a contract or execute a will.

In this chapter, we address conceptual and practical issues related to the assessment of competence that apply regardless of the type of competence being evaluated. Special attention is given, in the examples, to competence to consent to medical and psychiatric treatment, because of its relationship to the doctrine of informed consent discussed in Chapter 4 (see Sec. II-B). Chapter 6 (see Secs. II-A to II-C) addresses issues unique to selected competence assessments in civil and criminal areas.

Four issues must be addressed when the question of competence is raised: What standards do we use to determine whether a person is competent? Who is charged with making that determination? Who assumes decision-making authority for the incompetent person? How do they make their decision?

A. STANDARDS FOR COMPETENCE

The concept of *competence* is too broad to consider in an undifferentiated way. It is analytically useful to distinguish between general competence and specific competence. General competence, described in many of the statutes governing guardianship procedures, is determined by the ability to handle all one's affairs in an adequate manner. Specific competence is defined only in relation to a particular act: whether one is competent to write a will, make a contract, testify in court, or stand trial for murder.

1. Standards of General Competence

The question of a person's general competence is raised, in the usual case, when an allegation is made that the person no longer has the capacity to make decisions about the entire range of his affairs. A common situation in which this may occur is when the family of an elderly person with dementia fears that she is no longer capable of paying her bills, caring for her residence, or protecting her health. The family may request an evaluation of the person's general competence before or after filing a petition for guardianship. In either case, the mental health professional is confronted with the issue of what standards to apply to the determination.

Statutes and court decisions have done little to move beyond the vaguest descriptions of what constitutes general competence. The Uniform Probate Code defines incompetence as follows: "A mentally incompetent person is one who is so affected mentally as to be deprived of sane and normal action, or who lacks sufficient capacity to understand in a reasonable manner the nature and effect of the act he is performing." State statutes vary from vague: "Incapable of caring for himself" to somewhat more specific: "Unable to properly provide for his own personal needs for physical health, food, clothing, or shelter." It seems apparent, from a review of the law, that the tendency has been to give the judiciary maximal flexibility in determining that an individual is incompetent and therefore in need of guardianship. This has advantages—individuals in need of assistance are unlikely to fall through any legal cracks—and disadvantages—the uncertainty of the standard makes it difficult to prevent abuse in cases in which the judge is too uncaring or uninformed to conduct a sufficient inquiry before ruling; the frequent failure of the adversary system, leaving the potential ward without adequate representation, exacerbates this problem. In any event, the law provides little guidance for clinicians who are attempting to determine if the patient they are examining is in fact incompetent, or who are preparing testimony for a competence hearing.

It may be useful, in beginning to define standards, to note what standards are not appropriate to use in such situations. The mere presence of psychosis, dementia, mental retardation, or some other form of mental illness or disability is insufficient in itself to constitute incompetence. General incompetence, as does its counterpart specific incompetence, requires a functional assessment. A reasonable approach to this evaluation follows. It should be used in the absence of more specific guidance in most jurisdictions and is based on an approximation of the standards that most courts apply in these situations.

a. Awareness of situation. An individual should have an adequate sense of the current status of the major elements of his life. Thus, he should be aware of circumstances of living, sources of support, extent of resources, significant supportive relationships, any limitations on natural functions, and the presence of any threats to immediate security (e.g., trust fund running out or major lawsuit pending).

b. Factual understanding of issues. To the extent that the individual suspected of incompetence is required to make decisions about the major elements of her life, those decisions should be grounded in a clear understanding of the facts involved. A patient who is supported by a trust fund may, even given an awareness of the nature of the fund, not be able to comprehend the issues involved in altering the periodicity of the payments.

c. Appreciation of the likely consequences. An understanding of the facts of a person's situation must be supplemented with a cognitive and emotional appreciation of the implications of those facts. An elderly person may understand at a basic level that once the family homestead is sold, it will no longer belong to her. She may not, however, appreciate the consequences of this action (i.e., that she will have to find another place to live that is unfamiliar and to which it is difficult to adjust). Similarly, the elderly person who does not pay his utility bills may understand that the bills are requests for money to cover services rendered, but does not appreciate that power will be cut off, leaving him without heat or electricity, if he remains delinquent (e.g., "They are always sending me those bills. I don't take them seriously.").

d. Rational manipulation of information. Assessing rational manipulation of information is the segment of the competence examination that psychiatrists have traditionally been most comfortable performing and sometimes the segment to which they have exclusively directed their efforts. The reason for this single-mindedness of approach is self-evident: Psychiatrists have their greatest expertise in the assessment of irrationality. A focus on rational manipulation of information, however important, should not exclude the other elements of the examination from consideration.

This part of the examination considers the basic components of the patient's mental status: orientation, memory, intellectual functioning, judgment, impairment in rationality (hallucinations and delusions), and alterations of mood. The effect of deficiencies in any of these areas on the patient's actual functioning ought to be tested by means of explicit examples that require the patient to manipulate data and to reach a conclusion. Hypothetical business transactions often meet this need nicely.

e. Functioning in one's own environment. Competence is not a fixed attribute of the individual that remains invariant regardless of environmental factors (see Sec. III-A). A mildly demented patient might function quite well in the familiar environment of her home but become confused and disoriented shortly after admission to a hospital. In addition, a person may structure her natural environment in such a way that supports her essential tasks (e.g., a retarded person may have a neighbor or relative available to help with shopping and bill paying; her inability to perform calculations is thus not crippling in her own environment). The ecology of a person's functioning must be taken into account in a competence evaluation. This may mean examining the person *in situ,* or at the least inquiring about the existence of natural supports.

f. Extent of demands on patient. Patients should not be deemed incompetent because they are unable to perform tasks that they may, in fact, never be called on to perform. An individual whose primary support is a monthly Supplemental Security Income check, and who turns the entire check over to a halfway house in exchange for the provision of all necessities, should not be considered generally incompetent despite profound difficulties with managing sums of money. However, a similarly impaired individual possessed of a large estate would certainly require the assistance of a conservator for its management and is, in a genuine sense, incompetent.

2. Standards for Specific Competence

Specific competence is a newer concept than general competence (see Sec. II-C-1-b). Although the term itself suggests a more focused evaluation, the law at first glance appears not to have been terribly helpful here either. Court opinions cite a wide variety of standards to be applied to determinations of a given specific competence (e.g., competence to consent to treatment), sometimes even within the same jurisdiction. Each court tends to try to derive standards *de novo,* without relying on precedents from other courts. This compounds the confusion.

Careful review of court decisions and statutes in this area, however, suggests that most legal standards are actually composed of one or more of four basic elements. When a clear standard exists in a jurisdiction, the composite elements should be identified and an evaluation structured accordingly. If no clear standard has been formulated by the legal system, evaluators should assess the alleged incompetent on all four standards (i.e., communication of choice, factual understanding of the issues, appreciation of the situation and its consequences, and rational manipulation of the information), allowing the court to select which are relevant in the case.

a. Communication of a choice. It may seem self-evident, but a person cannot be considered competent unless he can communicate the choices that he makes. This capacity refers to more than just being able to say "yes" or "no." A choice should be sufficiently stable that it can be acted on before the person changes his mind. Although a change in decision is not in itself a sign of incompetence, vacillation of a degree that precludes implementation of any choice—especially in the context of mental disorder—may constitute a basis for a finding of incompetence.

b. Factual understanding of the issues. A competent person ought to have the ability to understand the facts relevant to the proposed decision. If competence to consent to treatment is at issue, the person should understand the information required to be communicated by the doctrine of informed consent: the nature and purpose of the proposed intervention, its risks and benefits, and the possible alternatives (along with their risks and benefits). For competence to make a will, the testator should understand the nature and amount of her property, and the identity of and relationship to her natural heirs. Understanding can be tested by asking the evaluee to paraphrase the information provided to her or to state her understanding of the situation.

c. Appreciation of the situation and its consequences. As in the case of general competence, mere factual understanding in specific competence may be insufficient. A person can understand what he is being told without grasping the implications of that information for his own situation. For example, a psychotic patient faced with a decision about treatment may understand that the doctors believe he is ill and that medication is needed, but his denial that he is mentally disordered will short-circuit any effort at competent decision-making. In the case of someone writing a will, his understanding that he has two sons, whom most people would consider the natural objects of the inheritance, may be distorted by his delusional belief that they have been plotting to kill him so they can inherit his money. He lacks appreciation of the nature of their relationship to him. Appreciation can be assessed by an exploration of the subject's conceptions of the situation at hand, the likely outcomes of alternative courses of action, and the motives of those involved.

d. Rational manipulation of information. Rational manipulation (sometimes referred to as *reasoning*) involves the use of logical processes to compare the benefits and risks of various courses of action. When it is used, the outcomes selected are logically consistent with the starting premises. It should be emphasized that the process is being tested, not the outcome of that process. If the reasoning process flows logically from its starting premises, although the result might be rejected by most people (e.g., a person refusing potentially life-saving medical treatment), we cannot say that rational manipulation is impaired. Examination of the person's chain of reasoning is required to test this capacity.

3. Issues Involved in the Selection of Standards for Competence

a. Policy considerations in choosing a standard. Implicit in this discussion has been the idea that there is no single standard of competence. Decision-making competence is not a scientifically determinable state, nor a medical condition. It represents a level of functioning at which society is willing to allow a person to continue making her own decisions. As such, the standards selected and the levels at which cut-offs for incompetence are set should be expected to reflect policy considerations such as the degree to which individual autonomy in general, and in relation to this decision in particular, ought to be encouraged; the extent to which the interests of the decision-maker or of third parties ought to be protected, regardless of the wishes of the decision-maker; and the ability of society to intervene in the name of either of these goals in a manner generally perceived as fair.

Given the differences that are likely to arise when an effort is made to balance these factors, it is not surprising that different jurisdictions have reached varying conclusions concerning standards and cut-offs for a particular competence determination, or that within the same jurisdiction standards and cut-offs may vary for competence to perform different acts. Courts frequently say, for example, that although the standards for competence to write a will are similar to those for competence to contract, the cut-offs for calling the actor incompetent differ. Greater leeway is given to the allegedly incompetent author of a will (i.e., courts are more reluctant to call him incompetent) because of the belief that once he is dead, there is little point in trying to protect his interests, as distinct from his expressed wishes—and little ability to do so fairly. On the other hand, competence to contract is judged more rigorously because the interests of a living incompetent person may outweigh his wishes as reflected in the contract.

Similar, although more controversial, arguments come into play where competence to consent to treatment is concerned. Advocates who believe, for example, that treatment of psychotic persons with neuroleptic medication is undesirable, and that given the choice many psychotic persons will decline treatment, argue for less rigorous standards for competence or higher cut-offs for declaring someone incompetent, or both. Those who agree that refusal is likely, but believe that it will usually be deleterious to the patient, urge stricter standards, lower cut-offs, or both, so that those decisions can be overruled.

Nothing is inherently dishonest about setting standards of competence to achieve policy goals, although mental health professionals accustomed to objectively determined standards (e.g., for the diagnosis of mental disorders) may be uncomfortable with this process. Those involved, however, should recognize the policy-relevant nature of standards of competence and join the debate on those grounds.

b. Sliding scale approaches to competence. Given the relative nature of competence standards, it should not be surprising that suggestions have been offered for varying standards and cut-offs applied in particular cases (not just among different kinds of decisions) according to the values at stake. The argument has been advanced particularly with relation to consent to medical or psychiatric treatment. It has been suggested, for example, that patients consenting to low-risk, high-benefit treatment should be allowed to do so even if fairly impaired on most measures of competence, because their autonomy, interests, and physical well-being will benefit thereby. They might be considered competent if they can merely communicate a choice. In contrast, patients refusing such treatment might be held to higher standards, because they run the risk of serious physical harm. The standards for competence used in their case might require understanding, appreciation, and rational manipulation.

From a purely abstract perspective, the sliding-scale approach is problematic because of the discretion it appears to allow the evaluator in setting the standard, or cut-off, used. Thus, a physician who believed that a patient's decision to reject recommended treatment was wrong could adjust the standard of competence used to ensure that the patient was declared incompetent. This is troubling. In practice, however, there is a common-sense feel to the sliding-scale method. It limits the need for formal declarations of incompetence when such procedures would be unlikely to change the outcome (e.g., a marginally competent patient consents to low-risk, high-benefit treatment). Furthermore, it appears maximally protective of patients' health interests in settings in which it may make sense to give these priority (e.g., a marginally competent patient refuses low-risk treatment that will almost certainly save his life). Regardless of the formal standards in place in any jurisdiction, it is likely that a sliding scale approach, with regard at least to cut-offs, is being used in practice in health care settings, and probably in courts, as well.

B. PROCEDURAL ASPECTS OF DETERMINING COMPETENCE

A finding of incompetence results in the deprivation of basic individual rights. Such limitations ordinarily occur only after a formal adjudication by a court. Criminal defendants are not deprived of their liberty to choose where to live and how to spend their time unless a court finds them guilty of a crime and imposes a sentence. Even a mentally ill person in need of treatment cannot be held beyond a limited, initial period without court authorization. (See Chap. 2, Sec. II-D-4.) It might be assumed that the deprivation of decision-making power associated with a finding of incompetence similarly requires court action; although that is often true, it is not always the case.

1. General Competence

Consonant with the usual models for deprivation of rights, a finding of general incompetence always involves a judicial proceeding.

An interested party can initiate a petition to the court of proper jurisdiction (often a probate court) alleging that the individual in question is incompetent and in need of a guardian. The usual standard that has to be met is a finding that the proposed ward is simply incapable of managing her affairs or unable to care for her property or for herself. In addition to the mentally ill and retarded, subjects for guardianship proceedings might include the demented, alcoholics, drug addicts, the physically disabled, and spendthrifts. Medical testimony might or might not be required, and notice is usually given to the subject of the petition.

Whether or not a physician testifies, the petition is accompanied by an affidavit from a physician attesting to the patient's incompetence, often in global and conclusory terms. Optimally, a framework for assessment such as that outlined above (see Sec. II-A-2) will form the basis for the physician's evaluation. In some states, the court is required to appoint an independent investigator, who meets with the alleged incompetent, explores his situation, and reports to the judge on the perceived necessity for appointment of a guardian. The judge listens to the testimony, including sometimes the testimony of the alleged incompetent (although in many states that person can be excluded from the hearing), and makes a determination as to whether general incompetence has been proven, applying the relevant standards. If so, a guardian is appointed with power to make all personal and financial decisions for the incompetent ward. This model varies little from jurisdiction to jurisdiction.

A guardian might be selected from among the members of the family or, if the estate warrants more professional supervision and contains sufficient funds, a lawyer or banker might be appointed. The guardian's expenses and—if not a family member or friend—fees are defrayed by the ward's estate, and in turn the guardian is required to file periodic notice with the court of the status of the property entrusted to her care. In the absence of a family member or friend who can serve as guardian and of sufficient funds to compensate a professional to fill that role, courts often ask attorneys to serve as pro bono guardians or, in some states, can turn to public guardian services. Guardianship can be terminated by a showing that the ward no longer meets the criteria that warranted initiating the process: that a child has attained majority, a physical infirmity has been ameliorated, or an abnormal mental state has resolved.

2. Specific Competence

Specific competence can also be adjudicated through a judicial proceeding. The proceeding may take place in advance of a decision being made by the alleged incompetent person (e.g., before the person enters into a contract) or it may occur after the decision has been made in an effort to void it. With greater recognition by courts and legislatures that impairment does not have to be global to be worthy of attention, a larger number of adjudications of specific incompetence are taking place.

a. Determining specific competence to consent to medical treatment. In at least one important context, however, specific competence is determined—for all practical purposes—outside of a courtroom. When the capacity to consent to medical treatment is in question, physicians traditionally have conducted their own assessments of patients' abilities to consent. If the patient is thought to lack capacity, his family is asked to consent on his behalf. This model continues to be followed in almost all general health care settings. Only in the absence of family members, or when they are in disagreement among themselves or make a decision that the caregivers believe is not in the patient's best interests, is recourse had to the courts.

To be sure, physicians are not making a determination of competence, although that language is often used. Competence can be decided only by a court or some other authorized adjudicatory body. However, the physician's determinations of functional capacity have the same effect as formal rulings on competence, because the patient loses decision-making power.

The desirability of this nonjudicial process has been debated widely. On the one hand, it is argued that enormous potential for abuse exists when physicians and family members can collude to deprive patients of decision-making rights. The seriousness of the deprivation militates in favor of a judicial proceeding. On the other hand, the evidence for such abuse is all but nonexistent, and the health care system would slip into paralysis if it had to delay treatment of the large percentage of severely ill patients who are incompetent until a court hearing could be obtained. Based on these latter arguments, the President's Commission on Ethical Problems in Medicine and Biomedical and Behavioral Research, among others, endorsed continued reliance on informal, physician determinations of decision-making capacity.

b. Determining specific competence to consent to extraordinary procedures. Competence determinations by physicians, or their functional equivalents, are not accepted for all classes of medical procedures. The courts have identified several categories of treatments that they have termed *extraordinary*. Even guardians are not allowed to consent to these procedures without explicit judicial approval. As this doctrine has evolved, sterilization, psychosurgery, and (in some states) electroconvulsive therapy (ECT) have been included in this category.

As described in Chapter 3, Section II-C-1, courts and legislatures in some states have added treatment with neuroleptic medications to the category of extraordinary treatment. The usual rationale is that, as with the other procedures listed in the previous paragraph, they can lead to permanent adverse effects (e.g., tardive dyskinesia and related syndromes); are susceptible to abuse (e.g., used to sedate patients solely for the purpose of ease of management); and have the potential to alter mental functioning (although this latter is frequently misinterpreted because the effects are usually normalizing). Thus, in many states, physicians cannot, on their own, determine whether patients' consent is acceptable. Some more structured and independent assessment is required, especially when patients refuse treatment. (See Chap. 3, Sec. II-C-2.)

C. SUBSTITUTE DECISION-MAKERS

Whether a formal or informal mechanism is used to assess patients' competence, a finding of deficient capacities results in someone other than the patient having to make the decision in question. A variety of potential decision-makers are available and are used in different situations.

1. Guardians

Guardians are appointed by the courts after formal judicial hearings at which persons' incompetence is adjudicated. They are given the power to make decisions on behalf of incompetents, with legally binding effect, as if the decisions had been made by the persons themselves.

a. Traditional concepts of guardianship. The role of guardian dates back to Roman times, when it was first recognized that a permanent or temporary disability experienced by an individual left his property subject to dissipation unless an arrangement for its supervision could be provided. Anglo-American law traces the role of the guardian to the traditional power of the lord of the manor to assume responsibility for the property of those who were not able to care for it themselves (e.g., minors, the physically infirm, and the mentally retarded). As that prerogative was absorbed by the Crown in medieval times, the mentally ill also came to be seen as worthy of such protection. Yet, historically it was only the *property* of the incompetent individual that was the responsibility of the guardian, not the individual himself. The goal of such intervention was to conserve the property in question for the benefit of potential heirs, dependents, and creditors, and to prevent the ward from becoming a burden on the public purse.

Modern law recognizes a broader potential scope of concern for a guardian—the well-being of the individual herself. This form of guardianship over the person, which might coexist with, or exist independently of, control over the individual's property, grants broad powers of decision-making over the personal affairs of the ward, such as living situation, choice of medical treatments, and changes in personal status.

Until the 1970s, appointment of a guardian led to major losses of rights for the ward. In general, no distinction was made between guardianship of property and of person; a finding of incompetence usually applied to both. Thus, the ward lost the power to make contracts, to allocate and spend his money, to initiate lawsuits, to hire agents (attorneys, doctors, etc.), to marry or divorce, and to decide where to live. All these powers were transferred to the guardian. In many instances, although forfeiting the right to drive a car, the ward retained the power to make a will. When a guardian was appointed for the purposes of managing the estate alone, an exception to the general practice, she was often called a *conservator*. In that case, the ward lost only the power to control his economic affairs.

b. Newer concepts of guardianship. The all-or-nothing nature of traditional guardianship obviously leaves a good deal to be desired. Patients whose illnesses interfere with a closely circumscribed area of functioning, yet who are able to handle many other of their affairs quite well, are faced with the choice of operating without the protection afforded by a guardian or of forfeiting their rights to control every aspect of their lives. Because this situation most frequently arises among the mentally retarded (who might be incapable of managing their finances, but perfectly able to choose a place to live), the idea of limited guardianship has received the greatest impetus from law in the area of developmental disability.

Under this concept, the needs of each patient are carefully evaluated and a guardian is appointed with powers delimited to the specific incapacities of the individual. The advantage of this approach is that each ward enjoys the maximal possible freedom consistent with his disability; the disadvantages include the expense of the evaluation process and the difficulty of determining, before specific problems arise, the real scope of the patient's incapacity. Some studies have shown that even in the states in which limited guardianship statutes exist, the power to tailor the guardianship to fit the patient is infrequently used, with standard guardians being appointed instead.

An obvious congruence exists between the concept of assessing specific competence and the use of limited guardians. The powers of a guardian can be limited to those functions for which specific incompetence has been found to exist. One of the more promising areas for the application of limited guardianship is consent to medical treatment. Because many patients who incompetently refuse treatment have delusional perceptions specifically related to medication, surgery, or other interventions, whereas their other areas of functioning remain intact, they are ideal candidates for a guardianship that deprives them only of the right to decide about their treatment course.

c. Advantages and disadvantages of guardians as substitute decision-makers. The clear advantage of a judicially appointed guardian lies in the system's ability to hold that person accountable for her decisions. Guardians must make regular reports to the appointing court concerning their actions. These records can be reviewed by interested parties and can be used to challenge a guardian's judgment. The appointing court can be petitioned by an interested party to hold a hearing on the performance of a guardian, and guardians can be removed and even sanctioned if they violate the trust that has been lodged in them. Thus, the system is quite useful when decisions must be made that have low visibility and in which the interests of the guardian and the ward may differ. Management of assets is a good example of a situation for which formal guardianship may be the best available option.

It must be recognized, though, that the use of formal guardianship has certain costs as well. Formal proceedings are expensive and time-consuming, requiring attorneys for all parties, and often testimony from expert witnesses. Privacy of the alleged incompetent is compromised. Subjects of these hearings may feel as though they are on trial. If a guardian is appointed who is not familiar with the incompetent person, the decisions he makes may not reflect that person's preexisting wishes or interests. When situations exist in which the advantages of a guardianship process are not likely to obtain, there may be good reason to seek some other form of decision-making. Decisions concerning medical treatment may be a good example of this. These are usually high-visibility decisions, made in the context of a medical care system that is ostensibly charged with protecting the patient's interests. Although conflicts of interests can exist between decision-makers and patients, they tend not to be common. A less formal decision-making process than guardianship may be appropriate here.

d. Stresses on the guardianship system. Several factors have combined to increase the demands being placed on the guardianship system. The attention being paid to competence to consent to treatment, the regulations requiring widespread screening of mentally ill and mentally retarded populations for competence (frequently a spin-off of right-to-treatment suits), and the resulting influx of indigent persons into a system that traditionally functioned to preserve wealth—all these have pushed the process for obtaining guardians to the breaking point in many states. In the absence of funds from the patient's estate to pay the guardian, it has become impossible to provide guardians for all who need them. Previously, lawyers or others would serve *pro bono* for those few indigents who required guardianship, but that is no longer an adequate solution when thousands of such cases exist. Evidence suggests that these practical difficulties have frustrated the intent of those who support widespread, individualized competence assessments; in many places, despite the law, these are just not being done.

Several possible solutions exist. The state itself could pay guardians directly. Given the amount of time required to perform conscientiously in the guardian's role, particularly when such issues as overriding the patient's refusal of treatment must be dealt with, it is unlikely that the states would be willing to provide sufficient funds to entice members of the legal profession—the traditional source of guardians—into that role. The as-yet-undefined liability of guardians who oppose their ward's stated wishes in relation to treatment and other issues is another patent deterrent. In past years, hospital superintendents or other staff were often appointed as their patients' guardians, sometimes serving simultaneously as guardian for thousands of patients, but society appears no longer willing to accept the ostensibly inherent conflicts of interest resulting from combining those two roles.

e. Public guardians and other solutions. Another possible solution is the appointment of state employees to positions as full-time guardians, responsible for the oversight of a number of wards. Ideally, such individuals would have some training in those clinical areas required to understand and to make decisions about their wards' disabilities and would be independent enough of those agencies that deal with their wards to be free of conflicts of interest (see Sec. III-F-4). Social workers might be ideal candidates for such positions. However, in some states in which this has been tried it has led either to (a) a token guardianship, with one person responsible for hundreds of patients, so that no real protective influence is exercised; or (b) a merger of public guardianship into the regular duties of social workers in departments of welfare, leading to conflicts of interest and the interment of a personal relationship under the burdens of a staggering caseload. A variation on this approach is to contract out the responsibility for guardianship to nonprofit corporations, a technique that might minimize conflicts of interest but, in the absence of sufficient funding, is prone to the same problems of overburdened workers as the public sector.

What is lacking in all these arrangements, of course, is the sense of intimate concern for the incompetent individual that most people think of when they envision a guardian-ward relationship; and perhaps missing, too, is a sense of trepidation about making decisions for other people that touch the most fundamental aspects of their lives. To the extent that the protective function becomes bureaucratized, one wonders about the value of interposing a faceless third party between the individual and the professionals with whom she deals, who previously would have taken it on themselves, acting within the ethical tradition of their profession, to make the decision for the patient.

f. Abuses of the guardianship process. It should be noted that legal scholars raise a number of objections to the manner in which guardianship laws are administered. Despite the widespread trend for reform of state guardianship statutes, many still lack those elements traditionally associated with due process in other settings. The alleged incompetent does not always receive notice of the hearing. When notice is issued, little effort may be made to assure that the person facing the proceedings actually understands what is at stake. Although lawyers may represent the person, they are frequently not required to do so; if the person cannot afford a lawyer, often none is available. Even the person's presence at the hearing may be waived. A number of studies have, furthermore, shown that the presence of the presumed incompetent and of a lawyer representing her is no guarantee of a rigorous examination of the situation by the court. Lawyers tend to be unfamiliar with the guardianship laws and with possible alternatives, and they are often uninterested in challenging medical or psychiatric testimony. The standards under which incompetence is determined are vague (see Sec. II-A) and susceptible to almost any interpretation; the distinction between deviance and incompetence is frequently obscure.

From the point of view of the psychiatrist or other mental health clinician who is called to testify in guardianship proceedings, knowledge of this potential for abuse should signal caution. The careful clinician who is looking toward her patient's best interests will want to investigate who is requesting the competence hearing, what the real basis for the request is, and what the impact is likely to be on the patient of a finding of incompetence. Because none of the other parties involved may consider possible alternatives short of guardianship, such as the provision of social services that would enable an elderly person to live on his own, the psychiatrist ought to take the initiative in considering such alternatives as a legitimate and appropriate element of her evaluation. The patient should of course always be carefully examined, and important or decisive information that is obtained from family members or friends should be corroborated before it is accepted.

2. Judges

The courts have reserved the right to make decisions about extraordinary procedures for incompetent people. In addition to sterilization, psychosurgery, ECT, and use of neuroleptic medications, this category may include psychiatric hospitalization. The advantages of judicial decision-making in these cases are presumed to relate to the more dispassionate attitudes they can take toward these cases, especially in comparison with involved family members. They have the ability to order investigations of relevant matters, as by appointing a guardian *ad litem*, and to take testimony before making a decision. In addition, judges are the quintessential makers of the tough decisions in our society. It may seem fitting to relegate these difficult choices to them as well.

In contrast, the ability of a judge to learn about a case is undoubtedly limited by her other responsibilities and the degree of interest she has in the area. Not knowing the incompetent person, the judge starts at a relative disadvantage compared with family members or friends who may be appointed guardian or make decisions informally. The costs of learning what she should know may be steep. A judge's ability to monitor the incompetent person's state as the situation evolves is also limited, given her usual need to rely on testimony presented in court.

Should judges make substitute decisions? Unless a class of decisions can be identified in which substantial bias is likely to exist among other decision-makers, it would seem wise not to place these decisions on the judiciary. There may also be some point to using judges for decisions about procedures so controversial that an assurance of absolute independence and incorruptibility is needed. In other cases, though, some other mechanism is preferable.

3. Informal Decision-Makers

Informal decision-makers are people who know the incompetent person—family or friends—and who make decisions on his behalf without being formally appointed to that role by a court. Most commonly, this occurs in the medical setting. A number of states, recognizing the advantages of this approach, are beginning to codify it in statutes, at least for particular kinds of medical decisions, such as consent to "do not resuscitate" orders. Typical statutes, as in Virginia, establish a hierarchy of relationships with patients that governs who is asked to provide consent (i.e., spouse if available before children; children if available before siblings; etc.). Many cases also occur in which family members, without formal procedures, take over responsibility for managing the life and finances of an impaired relative, especially an elderly one. Unless challenged by another disgruntled relative, this procedure usually works fairly well and reduces the cost associated with formal guardianship. The obvious disadvantage is the absence of checks on the good will and disinterested posture of the family member, or less frequently the friend, who assumes this role.

A commonly used, nonjudicial mechanism for allowing someone else to make decisions about an incompetent's finances is the practice of federal and state agencies making disability payments to someone who may be characterized as a *representative payee*. After a physician determines that a patient is not capable of managing finances as a result of physical or mental illness, or alcohol and drug abuse, the recipient identifies a person to whom payment will be made. That individual then parcels out the money to the recipient. The system seems to work reasonably well.

a. Durable power of attorney. Mechanisms exist in most states for a competent person to select a substitute decision-maker for a projected time of future incapacity. Documents embodying these choices are called *durable powers of attorney*. Unlike ordinary powers of attorney, they continue to be in effect, or first come into effect, when the person becomes incompetent. The decision-maker selected then has legal sanction, without the necessity of a court proceeding, for making decisions about the issues indicated in the document. Among the advantages of this approach is that it allows a person to discuss her preferences in advance with the substitute decision-maker and to select a person whom she believes will act according to her wishes.

b. Advance directives. Because the status of durable powers of attorney with regard to health care decisions is unclear in many jurisdictions, states increasingly have adopted advance directive laws. These statutes typically permit the designation of a proxy decision-maker specifically for medical treatment purposes, and may also allow the person to identify limits on the proxy's powers (e.g., "under no circumstances do I want CPR"). State laws are often specific about forms to be used and information that must be contained. Failure to abide by the requirements may invalidate the proxy designation. Typically, the advance directive is invoked when a physician determines that the patient has lost capacity, but even in that circumstance the patient's objection to a course of treatment cannot be overridden without a judicial determination of incompetence. Minnesota was the first state to experiment with an advance directive statute specifically addressed to psychiatric treatment. Roughly one-third of the states now have such laws. The relationship among the expressed desires of a patient, as embodied in an advance directive, and the laws governing involuntary hospitalization and treatment remains unclear. In the leading case to date, a federal circuit court upheld the priority of a patient's wishes expressed in an advance directive over a state's procedure for treating patients involuntarily (*Hargrave v. Vermont*). Whether this decision will apply to other jurisdictions, and what its implications might be for the future use of advance directives is unclear.

Since the early 1990s, the federal Patient Self-Determination Act (often referred to by its initials, PSDA) has required health care entities that receive federal funds (including Medicare and Medicaid) to inquire of all patients on admission whether they have an advance directive, and if they do not, to inform them of the availability of such mechanisms under the applicable state law. Although intended to increase the use of advance directives, it remains unclear to what extent the PSDA has had the desired effect.

4. Clinical Staff

It was once common for clinical staff, especially physicians, to become *de facto* decision-makers for incompetent patients, particularly with regard to medical or psychiatric treatment. If incompetent patients required treatment and no family members were available, the physicians themselves authorized the treatment and administered it. With greater attention to patients' rights, this practice had diminished, but it still exists in many places. In facilities with a large number of incompetent patients, such as state hospitals, chronic care facilities, or nursing homes, means and resources may simply not be available to seek appointment of a guardian for every treatment decision. When not precluded by state law, physicians may therefore take it on themselves to make these choices.

One could argue that there are certain advantages to this approach, the most salient being its low cost and ready availability. Physicians are also the most familiar of all possible decision-makers with the medical issues on which many of these decisions are based. And in many cases, there may simply not be any alternative. As discussed in Chapter 4 (see Sec. II-B), however, the doctrine of informed consent is built on the notion that these decisions are, at their core, personal and not medical. Thus, physicians or other clinical staff who make such decisions on their own run some risk of subsequent liability should something untoward occur.

A better approach when neither formal nor informal options are available may be to formulate a facility-wide policy on how substitute decisions should be made. This could involve the appointment of someone to act as a patient advocate to consult with the physician, representing a reasonable patient's point of view, before a decision is made. Alternatively, a second opinion from another physician or a review panel might be required before proceeding with treatment. Other options are possible as well, but their common element is to open up the decision-making process, soliciting input from others not directly responsible for the patient's care. Experimentation with these models may provide guidance as to which approaches are the most successful.

D. STANDARDS OF DECISION-MAKING

To this point, we have focused on the situations in which persons may be deprived of decision-making rights and on the identity of substitute decision-makers, but the question of how the decision-maker should make a choice has only been alluded to. Two general ways exist in which one individual (e.g., a guardian) can substitute her judgment for that of another individual: (a) the guardian can attempt to make a decision based on what she perceives as the best interest of the ward (e.g., asking, "Is this investment likely to yield a profit?," or "Is this nursing home going to provide better care than another?") and (b) the guardian can try to conform her choice as closely as possible to the choice that the ward *would* have made, were the ward competent to do so (e.g., asking, "Would my ward, being the person she is, prefer to live in a supervised apartment or in a group home?").

1. Best Interests

The "best interest" standard, which provides more of an objective approach to the task of decision-making, has long been the prevalent one. Ethicists and legal theorists, however, have come of late to recognize that many of the judgments made in the patient's best interest are not as clear-cut as they appear to be, but rather reflect the overt or covert values of the decision-maker.

Thus, a decision-maker who denies a retarded person the possibility of having a sexual relationship (ostensibly because he believes that retarded people have difficulty managing such encounters) may in fact be deciding on the basis of a value system that is resistant to acknowledging the possibility of positive extramarital sexual relationships for all people; the retarded person might feel quite strongly otherwise, as might a large number of competent people.

As long as guardians deal primarily with property, the chance of significant value conflicts arising is diminished—though not eliminated. Insofar as a guardianship of the person has been established, however, conflicts of values are quite likely to occur. Limited guardianships are one way of mitigating the impact of a clash of values, by excluding areas in which such conflicts are likely to occur from the province of the guardian. A second means of lessening the distortion produced by value-laden decisions is to ask a decision-maker to decide based on what she thinks the person would prefer if competent.

2. Substituted Judgment

The "substituted judgment" standard, which is a decision based on what the guardian thinks his ward would prefer (if competent), traces its roots back to English common law. Guardians, usually obligated to act in their wards' best interests, were permitted to make gifts from wards' estates (e.g., to an impecunious relative) on the basis that if the ward were competent, he would desire such a gift to be made. The doctrine has been used in the United States in several cases permitting transplantation of kidneys from an incompetent person to a close relative.

The best-known elaborations of substituted judgment have come in cases dealing with cessation of life-sustaining treatment in incompetent patients. The standard first came to prominence in the *Quinlan* case in New Jersey, in which a father was allowed by a court to authorize the discontinuation of his comatose daughter's respirator on the basis that, given her condition, she would not have wanted respiratory support continued. From there it was adopted in *Saikewicz v. Superintendent of Belchertown State School,* a Massachusetts Supreme Judicial Court ruling that dealt with a severely retarded patient with acute leukemia. Although his life could have been sustained for several months with chemotherapy, the patient, with an IQ of 15, would have had to undergo the agonizing side effects of chemotherapy with no understanding of his condition or of the purpose of the treatment. The court ruled that Saikewicz, if he were competent to decide about receiving treatment under those circumstances, would have declined it, and therefore chemotherapy could be withheld (see Suggested Readings, Gutheil and Appelbaum).

Although it attempts to screen out values foreign to the patient, the subjective standard of substituted judgment is highly problematic. In a limited number of instances, it may be possible to determine what the patient would have chosen (e.g., when a previously competent person has indicated, either informally or in a living will, what her preferences would be should she become incompetent to decide). Such a situation is relatively rare. Instead, the decision-maker, whether a court, a guardian, or a physician, is most often left to guess at the patient's preferences. From what we know about the influence of the unconscious on people's choices, it seems extremely likely that the guardian's assumptions about the patient's desires will reflect the guardian's own values (what he would want done for himself were he in that situation) or the guardian's prejudices about people similar to the ward (e.g., that poor people or the elderly have less of a desire to live when faced with terminal illness than the guardian's own peers do). In summary, it seems unlikely, except in rare circumstances, that the subjective standard (i.e., deciding as the patient would) offers any real improvement in objectivity or accuracy over the more traditional, "best interest" approach.

3. Combined Approach

As the limitations of each of these approaches have been recognized, a consensus has evolved in many jurisdictions as to when each standard should be applied. When it is clear that an incompetent would have selected a particular course of action, most courts require that the decision-maker follow that choice. In the absence of such evidence, however, rather than intuit, or guess at, what the incompetent would have desired, the decision-maker is free to act in the person's best interests, as clearly as she can conceptualize them. This seems a reasonable compromise that is likely to become the dominant approach to this problem.

E. SPECIAL ISSUES IN SUBSTITUTE DECISION-MAKING

1. Incompetence to Consent to Admission

As noted previously (see Chap. 2, Sec. II-C-3), the question of whether patients need to be competent to consent to admission is unclear, but in the aftermath of the U.S. Supreme Court decision in *Zinermon v. Burch*, states increasingly have begun to impose such requirements. This raises the question of whether guardians can consent to hospitalization on behalf of incompetent patients. A number of state legislatures and state courts have held that a ward cannot be admitted by a guardian without a court hearing, and then only if the ward meets the ordinary standards for involuntary commitment. In general, the guardian, assuming that his powers are not specifically limited by the appointing court, retains the right to admit his ward.

Empirical observations of the way that guardianship is used in practice have turned up some interesting findings. In some areas, patients who cannot be civilly committed under the prevailing standards, usually based on dangerousness, are instead found incompetent, permitting the appointment of a guardian who can then admit them voluntarily to a psychiatric facility. Although, to some, this practice may suggest malice on the part of family members or professionals, it is really a reflection of the fact that the circumscription of *parens patriae* standards in commitment laws has left a number of persons in need of hospitalization with no way of making it available to them.

The judicial and psychiatric systems, faced with the alternative of abandoning these individuals, have chosen instead to improvise, within the constraints of the current laws, a mechanism for helping those now otherwise excluded from involuntary care. That this has occurred is perhaps the most compelling evidence of the importance of a *parens patriae* approach. A proclamation of the patient's right to be free from confinement unless she is dangerous does nothing to lessen the need for care and treatment of the severely mentally ill. In many ways, psychiatrists and judges are most comfortable working with a standard designed to care for the helpless, rather than approaching the needs of the mentally ill through a quasi-criminalized dangerousness standard. The lesson must be that if laws are designed so as to ignore realistic needs, in practice the system will find some other way of having those needs met.

2. Incompetence and Hospitalization

Only in the latter half of the twentieth century did the usual route for determining incompetence become a hearing at which those who petition for guardianship and those representing the alleged incompetent present evidence before an impartial judge. Before that, most persons found to be incompetent attained that status not by virtue of an individualized determination, but rather as a concomitant of psychiatric hospitalization. It was the law in most states that involuntary commitment was the equivalent of a finding of general incompetence with all the deprivations of power that such a finding entailed. Some states modified the approach by creating a rebuttable presumption of incompetence (i.e., the patient was assumed to be incompetent and was treated as such unless and until he could convince a court otherwise). Although thousands of patients were held by law to be incompetent, no guardians were appointed to handle their affairs, leaving them in a state of legal limbo.

The laws governing incompetence related to hospitalization were so vague that in some cases they appeared to apply indiscriminately to voluntary as well as involuntary patients, and the means of regaining competent status after discharge were not always clear. In some cases, a proceeding initiated by the former inpatient was required.

It has come to be recognized that mental illness, even illness severe enough to require hospitalization, does not always result in a global loss of the ability to manage one's affairs. The distinction between committability and incompetence has become universal. Although this has raised a new set of problems related to inpatient treatment (see Chap. 3, Sec. II-C-1), it has helped to preserve patients' control over their own affairs.

Having moved from presuming incompetence despite contrary evidence to presuming competence without contrary evidence, some states are now requiring that newly admitted patients be specifically evaluated for competence by the psychiatric staff and that petitions for guardianship be filed on those who are suspected to be incompetent. Court rulings on the right of competent patients to refuse treatment have prompted this most individualized of all approaches.

3. Incompetence to Consent to Research

If advances are to be made in the treatment of severely ill psychiatric patients, it is often necessary to perform research studies with incompetent individuals. The effectiveness of new approaches to treatment (e.g., of chronic schizophrenia), whether of a psychosocial or a psychopharmacologic nature, will never be demonstrated unless clinical trials with chronically ill patients, many of whom are incompetent, are performed. Although such studies therefore are essential, they also raise significant ethical problems.

a. Incompetence and the risk-benefit ratio. If we compare incompetence in the research situation with the issues of incompetence to consent to admission and to treatment, it is apparent that certain analogies exist. It is generally accepted, and explicitly required in some state statutes and federal regulations, that subjects of human experimentation provide informed consent before an experimental procedure takes place. Competence is, of course, a critical element of any informed consent. In the absence of the ability to provide a competent consent, is a substituted consent an acceptable alternative, as it was in the treatment situation?

In the treatment setting, the object of the substitute decision-maker is to serve the patient, either by seeking the patient's best interests or by approximating the patient's own preferences as closely as possible. Because research, unlike treatment, is not usually designed primarily to benefit the individual experimental subject, and because there may often be a measure of added risk involved, the substitute decision-maker may be in the position of serving other ends: the advancement of knowledge or the well-being of society as a whole. Although it is usually agreed that any individual has the right to act to help others by placing himself at risk, as by participating in research, it is more controversial whether someone can make that decision for the incompetent patient.

The situation is not even always that clear-cut. Experimental procedures, by their nature, frequently pose an unspecified degree of risk, while holding out the promise of an uncertain amount of gain. Although that is frequently true in the clinical situation as well, there the potential benefits and the probable risks are almost always more well-defined. At what point, if any, should we permit one individual to place another at risk?

b. Possible approaches to the problem. An extreme position is that incompetent patients should never be used in research projects. That would stymie many important areas of research, while permanently foreclosing the possibility of eventual amelioration of the condition that is inducing the state of incompetence in the first place. At present, court decisions in two states (New York and Maryland) can be interpreted as taking this position. Another approach is to ignore the question of competence and to respect the patient's expressed wishes either to participate or to refuse to participate. This position of radical autonomy, however, could lead to situations in which severely disabled patients place themselves at great risk with little hope of gain and little understanding of their choice.

More moderate suggestions consider, in one way or another, the risk-benefit ratio in deciding whether a substitute consent can be given on behalf of an incompetent patient. Little objection exists to permitting substitute consent for experimentation involving little or no risk, even if no benefits accrue to the subjects. Situations of greater risk require, under some schemes, correspondingly greater potential benefits to the subject before a substituted consent is permitted. Various proposals for reviewing risk-benefit ratios and for determining if the participation of incompetents should be permitted have been devised (e.g., by the National Bioethics Advisory Commission). In general, these schemes include an absolute right of refusal for the incompetent; a substituted consent is permitted in the absence of any indication of the patient's preferences but not to override the patient's overt refusal.

At the moment, the legal status of substituted consent for research in most states is ambiguous. In some areas of investigation (e.g., dementia research) it has been routine to rely on the consent of family members, at least in the absence of overt objection by the patient. California and Virginia have recently adopted statutes allowing substitute decisions to be rendered for incompetent research subjects, essentially by the same persons who would consent to treatment for an incompetent person, though they unfortunately exclude persons hospitalized for treatment of mental illnesses. Statutory clarification of the powers of substitute decision-makers, with inclusion of reasonable standards for when substitute consent can be given, would be helpful in the vast majority of jurisdictions that currently have no law on the subject.

For disorders that are likely to result in predictable periods of incompetence at some point in the future, advance directives offer the possibility of the now-competent person deciding for herself whether to participate in research. This technique has been used in studies of Alzheimer's disease. Mildly demented but still competent patients are asked to consent to research procedures that will continue even when they become more severely disordered. The potential for using devices of this sort in disorders with cyclical periods of incompetence (e.g., many of the severe psychoses) is obvious. Indeed, some proposals would limit participation of incompetent subjects in research to situations in which they have given clear advance indications of their desires. This is an area that is likely to see considerable activity on state and federal legislative and regulatory fronts in the coming years.

III. CLINICAL ISSUES

A. ASSESSING PATIENTS' DECISION-MAKING CAPACITIES

1. Overall Strategy

Whether the question is a patient's general competence or his competence to deal with a specific issue, the competence evaluation should always begin with an assessment of general competence. Given a state of general incompetence, specific deficits of competence are more likely to be found, although it is always possible for a generally incompetent individual to be unusually capable of deciding about a specific task. Conversely, whereas it is certainly possible for a generally competent person to be specifically incompetent (e.g., a patient with paranoia whose functioning is excellent except in the narrowly circumscribed area of his life that is affected by his delusions), this dichotomy becomes a lesser probability once a good level of general competence has been ascertained.

2. Identifying High-Risk Groups

When a clinician is asked to perform an assessment of a patient's competence-related capacities, as when the patient's competence to contract or make a will is in question, the answer to the question of who should be evaluated is readily apparent. In other contexts, however, as in a psychiatric facility treating a large number of severely ill patients, clinicians must develop a strategy to screen for those patients most likely to have impaired competence to consent to treatment or to perform other relevant tasks (e.g., some states require all inpatients to be evaluated for competence to handle their assets).

Because the resources do not exist in most facilities routinely to screen all patients for competence, the process can be accomplished most efficiently by identifying particular populations whose members are at increased risk of manifesting incompetence. These include acutely psychotic patients, who often experience a delirium-like clouding of consciousness; chronically institutionalized patients, who may have lost the capacity critically to evaluate proposed interventions or actions; patients with organic impairment, often elderly, who may slide slowly into an incompetent state; depressed patients, even if nonpsychotic, whose hopeless-helpless thinking may impair reasoning about treatment alternatives and future plans; retarded patients, whose disability may be accentuated by concomitant psychiatric illness; and patients who are being asked to consent to especially risky procedures, or to procedures with little hope of direct benefit to them.

3. Preparing the Patient for Evaluation

Before a meaningful assessment of decision-making competence can be performed, the alleged incompetent person must have had a chance to learn the relevant information that the examiner expects her to be able to understand, appreciate, and manipulate rationally. As evident as this seems, it is not infrequently the case in the treatment situation that the patient has not been told about the nature of her condition (e.g., "We believe that you are experiencing a severe depression that will probably respond to medication; the fact that you feel so helpless about your situation now is actually part of your illness.") and the issues involved (e.g., the risks and benefits of medication and the possible alternatives). Even if this information has been communicated, it may have been forgotten by the time the competence assessment takes place, or it may not have been explained as clearly as it could have been. Because it is desirable to maximize the number of patients who are capable of making their own decisions, efforts should be made to ensure that the patient has been given every chance to learn about and to understand the issues involved. This means that the clinician who is conducting a competence examination should be present when an explanation or reexplanation of the material takes place to assure herself that the problem that the patient appears to be having with the decision does not, in fact, lie elsewhere than in the patient's brain.

The examining clinician should not overlook the value of written material that the patient can study at leisure; additional benefits may accrue from the use of graphics (e.g., cartoons, pictures, diagrams, or sketches) to clarify complex points, especially in patients whose abstracting or receptive capacities are impaired. For presumed incompetent patients, some settings use teaching groups that reiterate drug instructions and show prepared videotapes that provide overviews of treatment effects, rationales, and goals. All these approaches may render patients more effectively informed than an interview might accomplish.

4. Performing the Evaluation

a. Clinician's tasks. The job of the evaluating clinician is to collect information relevant to a determination of the patient's competence. When a formal hearing is to take place, the clinician presents that information to the court so that the judge can assess whether the patient meets criteria for competence in that jurisdiction. If it is unclear whether a formal hearing is warranted, or when an informal process for assessing competence is to take place (e.g., in most medical treatment settings), the clinician uses the information obtained to estimate whether the patient would likely be found incompetent by a court.

The determination of likely incompetence is made by recognizing that no one engages in an ideal decision-making process. Were all persons with less than average decision-making powers deemed incompetent, we would have the absurd outcome of one-half of the population being deprived of its decision-making rights. Rather, if we assume that decision-making capacities are normally distributed, those persons whom the courts call *incompetent* lie at the far lower tail of the curve, beyond two standard deviations. This conceptualization accords with the law's view that deprivation of decision-making rights is an extreme intervention to be used only for impairments of considerable magnitude.

Whether a court or an informal evaluator makes the decision about the patient's competence, the information that the clinician must gather is the same, and relates to the patient's functioning on the four commonly used elements of competence (see Sec. II-A), unless extant law in a given jurisdiction specifies otherwise.

b. Interviewing the alleged incompetent. Appelbaum and Grisso (see Suggested Readings) have suggested a set of model questions to structure this assessment when consent to treatment is at issue. The questions can be modified to apply to other decision-making tasks.

i. Communicating a choice

1. Have you decided whether to go along with your doctor's suggestions for treatment? Can you tell me what your decision is? (Can be repeated to assess stability of choice.)

ii. Factual understanding of the issues

1. Please tell me in your own words what your doctor told you about:
   a. What is wrong with you [or what illness do you have].
   b. The treatment or tests he or she recommended for you.
   c. What the treatment is supposed to do for you (to help you).
   d. What might happen with the treatment that you do not want to happen (that would feel uncomfortable).
   e. What else could be done for your illness or problem and the good and bad things that might happen with those other treatments.
   f. What might happen, for better or worse, if the doctor did not try any treatment at all.
2. You mentioned that your doctor told you of a (percentage) chance the (named risk) might occur with treatment. In your own words, how likely do you think the occurrence of (named risk) might be?
3. Why is your doctor giving you all this information? What role does your doctor expect you to play in deciding whether you receive treatment? What will happen if you decide not to go along with your doctor's recommendation?

Note the use of simple, basic language in these queries. The examiner should adjust the language level of the interview to that most suited to the patient's intellect, education, sophistication, familiarity with the issues, native language, and level of alertness. If interpreters are used, the examiner should spend some time emphasizing to the interpreter the need for strict, direct translation, rather than paraphrase, no matter how incoherent or irrational the patient's communications may be.

iii. Appreciation of the situation and its consequences

1. Please explain to me what you really believe is wrong with your health now.
2. Do you believe you need some kind of treatment? What is treatment likely to do for you?
3. What do you believe will happen if you are not treated?
4. Why do you think your doctor has recommended (specific treatment) for you?

iv. Rational manipulation of information

1. Tell me how you reached the decision to accept (reject) the recommended treatment.
2. What were the things that were important to you in reaching the decision?
3. How did you balance the pluses and minuses?

c. Structured assessment instruments. Recent efforts to improve the competence assessment process have led to the development of a number of structured instruments designed to aid clinicians in the process. The most widely used of these are the MacArthur Competence Assessment Tools for Treatment (MacCAT-T) and for Clinical Research (MacCAT-CR). (See Suggested Readings, Grisso and Appelbaum; Appelbaum and Grisso.) The MacCAT instruments provide a framework into which information specific to the patient's or research subject's situation can be inserted, and a standardized approach to asking questions and scoring results. Although it is unlikely that such instruments will need to be used in straightforward assessments, they can be particularly helpful in difficult cases, or where litigation is anticipated. Not only do structured assessment instruments insure that all relevant issues are addressed, but they also provide a record of patients' responses and the basis for clinicians' decisions.

d. Adjunctive sources of information. Of course, although direct examination of the patient is important, it is not the only source of data about a patient's functioning. Because of the artificiality inherent in the office or hospital situation in which most assessments for competence are performed, an attempt should always be made to secure information from those who know the patient and who have observed his functioning over a period. Although this can be of invaluable assistance in the examination, a note of caution is warranted: Third parties are often far from disinterested and may have selfish interests that turn on whether the patient is found to be incompetent. More than one source of information should be used, and the clinician should always be alert to the possible ulterior motives of his informants.

5. Making Judgments About Competence—A Model

At the end of the evaluation process, the examiner must make a decision about the patient's probable competence. To provide a more thoughtful and organized approach to this task, we offer a summary of a model developed for this purpose (see Suggested Readings, Grisso and Appelbaum, *Assessing Competence to Consent to Treatment*). The model provides a series of conceptual steps toward the practical assessment.

a. Framing the question. Asking broadly, "Is the patient competent or not?" focuses on the conclusion but does not direct the examiner to relevant inquiries. A preferable question would be: "Does this patient have sufficient ability to make a meaningful decision, given the circumstances with which he is faced?" This calls attention not only to the patient's measurable capacities, but to the decision-making context, a context that can influence greatly the evaluation outcome.

b. Framing the judgment. A useful conceptualization of the judgment about the patient is to imagine a balance scale with autonomy on one end and protection on the other; the scale should start (show a bias) tipped toward the autonomy side. Elements of the assessment can be viewed as adding to one or the other side of the balance.

c. Elements favoring autonomy. Elements favoring autonomy constitute the patient's decision-making abilities. As noted previously (Sec. II-A-2), these consist of the ability (a) to evince a choice, (b) to understand relevant information, (c) to appreciate the significance of that information for one's actual situation, and (d) to reason with the information in a logical process of weighing options. Data about these criteria are gathered by careful interviewing of the patient, with focus on the reasoning being used and the way in which information about treatment is processed. Although states show some jurisdictional variations on these points, the general framework should remain of use to the clinician.

i. The problem of partial impairments. Patients may present with a patchwork of incapacities, with other abilities relatively intact. The assessor may consider a hierarchic approach, weighting more heavily those impairments that have greater impact on the decision itself. Thus, a patient who can rationally discuss the value of lithium for mania (as well as its side effects, mechanisms, etc.), but who denies his own well-documented mania, may understand the risk-benefit concept of this treatment but does not appreciate its relevance to himself. Although appreciation is only one element of decision-making, an incapacity in this area is a decisive one. Lacking appreciation, the patient lacks competence.

Comparably, a patient may be able to reason adequately about a decision, but be unable to articulate this to the examiner. This communicative difficulty may lead to misleading results.

Finally, some consideration should be given to the baseline of the average reasoner. Most people poorly grasp statistical concepts; hence, the average competence level of the average citizen may not be too far above that of some patients being examined. Such considerations should prevent the examiner from setting the threshold of competence too high.

ii. Considering abilities relative to demands. The context in which to assess decision-making capacity is the particular treatment situation in which the patient is called on to exercise those abilities. Different settings produce different demands (e.g., camping in the woods requires far greater autonomous decision-making, as one faces nature's variety, than military basic training, where one follows orders).

d. Elements favoring protection. The clinician should consider in the balance the consequences of the patient's choices, especially in regard to the possible harms to the patient that may ensue.

i. Identifying benefits and harms. In identifying benefits and harms to the patient, benefits refer to the expected beneficial effects of the proposed treatment or treatments and the expected outcomes of such treatment. *Harms* are unwanted side effects, including injury, allergic reactions, distress, and discomfort, and also include death as a possible outcome of the treatment. This model acknowledges the often subjective nature of what constitutes a benefit or a harm (consider the severely depressed patient regarding death as a benefit) and the possibility of unconventional choices.

ii. Probable gains and risks. The clinician must consider the likelihood and magnitude of the benefits and harms. The product of a benefit's likelihood and magnitude might be termed the *probable gains* of the treatment. A similar product of harm's magnitude and likelihood would yield a *probable risk*. In this calculus, a high-magnitude harm (e.g., death) might have a low likelihood in a given procedure; however, even a small increase in likelihood would profoundly alter the analysis. A common (high probability) but low magnitude harm, such as dry mouth, might have less net impact on the decision-making.

iii. Weighting the probable gain-risk status of treatment. The clinician must take all the above factors into account, balancing gains and risks of a given treatment. One can imagine a spectrum ranging from high probable gain with low risk (e.g., treating a severely psychotic person with a modern neuroleptic) to low probable gain with high risk (e.g., treating a mild condition with a risky experimental drug) with various treatments occupying all points in between.

e. Balancing autonomy and protection. Balancing autonomy with protection (with a bias toward autonomy) requires adding in context the patient's capacities in relation to the demands of the decision with the gain to risk ratio of the treatment choice.

Some scholars have suggested that the standard for competence should be set higher when the patient chooses the option that is less optimal, less wise, and more dangerous—reflecting the concept that an apparently bad decision, seeming to call for greater protection by the treaters, must meet the test of clearer proof of autonomous (i.e., unimpaired) decision-making.

f. Conclusion. Using the above model (see Secs. a to e) allows the assessor not only to give suitable weight and attention to the elements of the decision-making process—the patient's as well as her own—but also to be able to offer other assessors, including the courts, a systematic and defensible picture of the reasoning used in that assessment. The clinician should explain the conclusion reached by the balancing process. As always, consultation with peers or experts and careful documentation remain the hallmarks of good practice.

6. Assessing the Basis for Incompetence

Regardless of the criteria used for the competence determination, it is often too easy to see competence as a legal problem rather than as a clinical issue. This is a mistake, because an individual's status as competent or incompetent is as much a function of his psychological make-up and psychopathology as are any of the more commonly discussed elements of his clinical presentation. As a result, when there is a change in the concerns, feelings, or hopes of a patient, or a change in the severity of his psychiatric illness, there may often be an alteration in his status as competent or incompetent. The clinician who ignores the underlying issues may make a single determination of the patient's status and then erroneously assume that that status is a fixed characteristic.

As paradoxical as it sounds, incompetence itself can be a symptom of a patient's illness and, like any other symptom, can respond to appropriate treatment. A proper assessment for competence does not end when it arrives at the determination that the patient is incompetent. The symptom of incompetence requires a differential diagnosis (just as the symptom of dizziness does), an investigation to determine which cause is the most likely precipitant of the symptom, and the initiation of appropriate treatment. Although the consulting clinician who is performing the competence assessment is often not in the position to perform the investigation or to begin the therapy, he ought at least to call to the attention of the responsible clinician the need for further diagnostic studies and possible modes of treatment. Common causes of incompetence include treatable psychiatric conditions such as depression, use of polypharmacy in a patient with a precarious balance of neurophysiologic functioning (especially in the elderly), patient noncompliance with medication, and the presence of undiscovered or untreated medical conditions (e.g., brain tumor, electrolyte imbalance, fever). Some of the most common remediable influences on a state of diminished competence are psychodynamic influences, psychopathologic influences, and situational influences.

a. Psychodynamic influences on competence. Patients who routinely resort to psychotic levels of defense to deal with the stresses they encounter in their lives are susceptible to marked changes in their level of competence as those stresses come and go. Thus, a patient who is faced with the prospect of surgery for breast cancer and is fearful that after the operation her friends will abandon her because she will no longer be a "real woman," may handle the situation by becoming increasingly psychotic, denying or distorting the reality of the situation. A decision to refuse surgery made in that state will be, in all likelihood, an incompetent one. If the patient can be encouraged to talk about her fears, and if their unrealistic nature can be exposed, or if some external disconfirmation of her scenario is provided, as by the sincere expression of concern by the patient's friends, the patient's need for psychotic defenses may be diminished and her level of competence may rise. A reevaluation at that point might yield a result markedly different from the original assessment.

b. Psychopathologic influences on competence. Psychopathologic influences on competence resemble the situation in which clear-cut psychodynamic influences are present. The cause of the fluctuations in the patient's mental status, however, is not always remediable. Many mildly to moderately demented patients tend to have marked fluctuations in their level of functioning, dependent on time of day, medications consumed, and concurrent physical illnesses. Although someone whose mental state changes so continuously and so rapidly that there is a steady alternation between competent and incompetent conditions is, for all practical purposes, incompetent, reassessment after the resolution of remediable influences on the patient's mental status can lead to a revised assessment of the patient's competence. This also holds true for many of the functional psychoses, whether acute or chronic.

c. Situational influences on competence. Factors other than the patient's mental state may influence the competence examination. These include the patient's rapport with the examiner; the patient's perception of the purpose of the examination and what is expected from her; and the nature of the setting in which the examination occurs. A patient who is locked in a hostile standoff with her physician, and who perceives that the doctor's interest lies in obtaining her consent, may refuse that "victory" to the doctor by consciously or unconsciously not attending to, or not understanding, the discussion, or by not communicating her responses clearly.

Because patients may simultaneously harbor rational and irrational reasons for consenting to or refusing a procedure, the reason that is presented may be a function of the setting as well. Delusional considerations may be presented to the physician in informal discussions, but when the formal examination for competence takes place, perhaps with an outside expert present, the patient may come around and justify the same choice with rational explanations. Needless to say, the unequivocal determination of competence in such a situation is extremely complex and may in fact be impossible.

7. Treating Incompetence and Repeated Evaluation

Remediable causes of incompetence should be treated and a reevaluation conducted. Even in the absence of clearly identified factors contributing to a patient's impaired competence, whenever possible (i.e., in nonemergent situations) evaluation of the patient's competence should be repeated at least once after the initial assessment. This is because multiple factors—not always identifiable—can cause fluctuations in patients' competence. Given the goal of minimizing infringement on decision-making rights, a repeated evaluation is highly desirable.

8. Evaluating the Uncooperative Patient

Perhaps the most difficult problem in assessment of competence is when the patient refuses to cooperate with the clinician. This is especially problematic when an emergency exists (e.g., as in the treatment setting), requiring a rapid determination of probable decision-making capacity. Neither of the two easy ways out of this dilemma is terribly appealing. Although the law usually presumes a person's competence until incompetence is demonstrated, to adopt such a decision rule in a circumstance like this runs the risk of not treating incompetent persons in life-threatening circumstances. Alternatively, to conclude that an uncooperative, even mute, patient is incompetent results in overriding the wishes of competent, albeit angry, persons.

The best solution would seem to be to stick with the presumption of competence, but to lower the threshold at which a determination of probable incompetence is made. When, in an emergency, substantial indirect evidence exists of impairment in the patient's capacities (as from relatives, friends, other caregivers, and based on the patient's behavior), it is appropriate to conclude that the person would probably be found incompetent by a court. Informing the patient of this determination gives him the opportunity, if he is in fact competent, to demonstrate his capacities and avoid unwanted interventions.

9. Special Problems in Competence Assessment

a. Catch-22 competence. Patients may demonstrate the ability to process risk-benefit information in the abstract while becoming less competent because of anxiety as concrete reality looms; consider the following real-life example.

> ***Example 1.*** On admission physical examination, an inpatient with schizophrenia was found to have an ominous breast mass; a biopsy was scheduled. As the date of surgery approached, the patient decompensated, so that the surgeon refused to operate on so obviously incompetent a patient and canceled the surgery. The patient, now calmer, was rescheduled, only to have the sequence repeat itself. The catch-22 was that the patient was competent to consent to surgery only when it was not scheduled; when it was scheduled, she became incompetent.
>
> Courts proved curiously resistant to imagining a future need for guardianship when the patient before them was clearly competent. During the considerable delay that ensued in attempting guardianship, the breast cancer apparently spread.

b. The problem of values. A patient's values may constitute a legitimate basis for certain treatment decisions, but the manifestation of those values may simulate, or be confused with, incompetence. Careful attention should be paid to determining the patient's authentic values, and those elements of decision-making should be respected whenever possible. The differential diagnostic effort to distinguish an issue of values from one of competence can produce curious dilemmas.

> ***Example 2.*** (See Suggested Readings, Pavlo et al.) A patient raised in the Black Muslim faith developed the delusion that he was actually a Christian Scientist (although consulting practitioners

> in the latter faith indicated that his belief was neither authentic nor doctrinally accurate). The patient stated that his claimed religious belief precluded his taking antipsychotic medications; clinicians sought guardianship. The court was presented with the case as a whole and agreed that the decision, because it was delusional, was an incompetent one; treatment was initiated by judicial order.

Note how Example 2 illustrates the complexity of value assessment in relation to competence—raising clinical, legal, and First Amendment issues, and more philosophical concerns. Must a religious belief be authentic to be valid? Should questions about delusions even be raised in relation to religious belief, because faith is sometimes defined as belief without proof (i.e., without reference to consensual reality)?

Clinicians should not be paralyzed by these uncertainties and should maintain their focus on the patient's needs; if a patient appears on any basis to be delusional about treatment, that case should be brought before the relevant court, be the outcome what it may.

B. CLINICAL IMPACT OF INCOMPETENCE IN FACT

Whether formally adjudicated as incompetent, patients with severe impairment of their decision-making capacities experience the impact of their mental state in striking ways. Family members and the treatment team may also need to confront the implications of a patient's limited capacities.

1. Impact on the Patient

A small but vivid first-person literature reports on the subjective experience of being psychotic (see Suggested Readings, Sec. C) and of being "incompetent in fact" in various areas of decision-making and mental functioning (one may be psychotic yet remain competent; see Sec. II-A). Note that the state of mind that renders a patient incompetent may be extremely euphoric (elating, intoxicating, uplifting, and satisfying); extremely dysphoric (terrifying to the point of panic, crushingly depressing, and producing a sensation of being doomed or utterly out of control); as well as encompassing all points of experience in between. One implication of this is that a person may revel in the incompetent state, or may wish passionately to be out of it, depending on the clinical characteristics of the particular disease process.

> ***Example 3.*** This is a verbatim diary account of his illness by a schizophrenic man (from *The Inner World of Mental Illness*; see Suggested Readings). Doctor help me to slow down a be content whenever I am at—I went to go the thing to fast. Help me to slow down and think mental illness is a emotion the person can not under why he did something he or she did or could not understand. . . . The stillness has to be broken before we feel free to what is the truth and who can you believe . . . Medison [medicine] is from fact for people who don't know God or don't have faith.

Although this patient's racing thoughts would clearly benefit from medication, his acceptance or refusal of it may well be incompetent.

> ***Example 4.*** (Same source as in Example 3, a woman with catatonia describing the illness in retrospect.) Shortly after I was taken to the hospital for the first time in a rigid catatonic condition, I was plunged into the horror of a world catastrophe. . . . Only a few people—myself and dimly perceived nursing staff—had escaped. . . . All personal matters relating to my family were forgotten. . . . I was also afraid that other people had power to read my mind, and thought I must develop ways of blocking my thoughts from other people. . . . I actually thought very little about my own children.

Example 4 demonstrates the way a patient may be cut off emotionally from family members by the power of the illness.

> ***Example 5.*** (Same patient as in Example 4.) At times during the first episode, certain actions of the nursing staff, such as administration of hypodermics, tightening of the sheets for wet pack treatments, etc., were interpreted as sexual assaults. . . . A different and less terrifying sense of menace was experienced occasionally in relation to men toward whom I was attracted, i.e., doctors and male attendants. A feeling of conscious attraction would be replaced suddenly by a feeling that the other person possessed special and vaguely threatening power.

This excerpt demonstrates how the illness can lead to distortion of the roles, actions, and intentions of hospital staff, including their performance of medication-related procedures.

> ***Example 6.*** (Same source as in Example 3; excerpt from Suggested Readings, Beers.) The very instant I caught sight of my letter in the hands of my brother, all was changed. The thousands of false impressions recorded during the seven hundred and ninety-eight days of my depression seemed at once to correct themselves. . . . To me, at least, my mind seemed to have found itself, for the gigantic web of false beliefs in which it had been all but hopelessly enmeshed I now immediately recognized as a snare of delusions. . . . Although insight regained seemingly in an instant is a most encouraging symptom, power to reason normally on all subjects cannot, of course, be so promptly recovered. My new power to reason correctly on some subject simply marked the transition from depression, one phase of my disorder, to elation, another phase of it. Medically speaking, I was as mentally disordered as before—yet I was happy!

As Beers articulates so clearly, the manic side of manic-depressive illness is characterized by an absolute self-confidence and sense of great understanding that bears no relationship to the patient's actual capacities and, hence, competence. (See the Suggested Readings list for further examples.) In addition, it should be noted that certain organic disorders (e.g., early Alzheimer's dementia) leave some areas of functioning intact so that the patient may remain aware of the deficit—an extremely painful experience for the individual, evoking rage, blame, grief, terror, and despair, as well as attempts to deny any problem.

2. Impact on the Family

Beyond the effect on the patient, serious mental illness that results in incompetence can disrupt a family to the point of devastation of their resources—personal, emotional, financial, and spiritual. The effects on families of patients who are violent, destructive, suicidal, raving, or wasteful are readily comprehensible and visible; more subtle are the effects on the family of the patient's psychotic withdrawal, chronic grinding depression, pervasive but quiet thought disorder that garbles all attempts at communication, or progressive senility with memory loss that encroaches on all areas of functioning and communication. Families may react, as do the patients themselves, with anger, blaming, and despair; denial of the illness or attempts to conceal it to protect their image in the neighborhood; misinterpretations of the illness (e.g., seeing the psychotic symptomatology as willful malingering); or bafflement, confusion, uncertainty, and paralysis.

Family conflict about these issues can reach murderous proportions, as in this real-life example.

> ***Example 7.*** A woman became progressively severely manic over a period of weeks. Her large family divided sharply into a faction that became increasingly desperate to get her to treatment and a faction that minimized her severe illness and characterized the first group as uncaring and groundlessly coercive. After much turmoil, effort, and struggle by the first group, she was finally hospitalized; but the second group immediately began legal action aimed at her release. In a confrontation about this, her son from one faction fatally stabbed an uncle from the other.

Added to these burdens are the human conflicts around the problem posed by the illness. Children forced to take over for a senile or otherwise incompetent parent may reexperience conflicts (e.g., even from infancy) about control, domination, and rivalry, as well as about aggression and coercion.

3. Impact on the Treatment Team

The patient who is incompetent in fact poses a challenge to the treaters who are attempting to enlist his participation in the treatment process. The search for problems and approaches to them that would ordinarily lead to forging a treatment contract tends to be impaired by incompetence, which vitiates informed and responsible collaboration in the treatment effort; the patient can be acted only on or for, not acted with. Ironically, that staff in many jurisdictions now have to seek substitute consent before proceeding with treatment places the entire matter on an even less collaborative, more adversary footing.

C. CLINICAL IMPACT OF THE LEGAL FINDING OF INCOMPETENCE

The clinical effects of the formal legal finding of incompetence on the patient, the family, and the clinical setting can be profound. When family members are chosen as substitute decision-makers, as is often the case, the impact may differ from cases in which others are so appointed.

1. Reinfantilization

For many of the seriously ill, especially younger patients, the struggle to separate autonomously from their families is central to their difficulties in growth and development, to their falling ill, and consequently to the therapeutic work. Regardless of the patient's age, the formal finding of incompetence in effect reverses the separation-individuation process; the patient becomes like a minor child. Thus, for the individual patient, the legal finding may deal a regressive blow to her strivings for independence and adulthood.

It should be noted similarly that in some cases pathologic family functioning is reinforced by the finding of incompetence in the patient—that is, families that habitually tend to infantilize the subject patient or that, for reasons of pathologic family psychology, need to see him as incompetent, receive from the legal finding an authorization for this antitherapeutic encouragement of dependency rather than autonomy.

2. Crowding of the Clinician-Patient Relationship

A second effect might be termed the *crowding of the clinician-patient relationship*; judges, lawyers, and guardians swell the treatment dyad. Ordinarily, the treatment contract is signed only with the patient. With a finding of incompetence, the contract essentially exists between the clinician who proposes the treatment and the substitute decision-maker who may consent to it. The incompetent patient, past whom the contract is negotiated, becomes a passive bystander to her own treatment. Although this is (from the legal viewpoint) the purpose of appointing a substitute, the clinician and patient may be discomfited by the absence of the experience of direct dealing with each other.

The situation is also complex in regard to the therapist-patient alliance. Ideally, the alliance is formed between the therapist and the healthy side of the patient; when the patient is found incompetent, it is unclear with whom the therapist is collaborating: Is it the patient or the substitute decision-maker? In the special case of treatment refusal, the therapist is in a complicated alliance with the consenting substitute, but remains in opposition to the treatment-refusing side of the patient (it could perhaps be argued that by proceeding responsibly to effect treatment the clinician is still allied with the submerged healthy side of the patient that would consent, were that side in dominance). Psychiatric treatment, complex enough to begin with, becomes more so under this ambiguous arrangement.

3. Impact on Self-Esteem

The patient whose illness is severe enough to raise questions of competence is likely to experience a blow to self-esteem from being so impaired from the illness itself; the actual legal (and hence, public) finding of incompetence further assaults self-esteem, the more so in those areas of life functioning in which the patient took pride in skill or ability. The formerly skilled financier who prided himself on his deft handling of money, and whose present organic dementia compels conservatorship, experiences significant impairment of his self-image.

4. Anger at Petitioners for Guardianship

Although resentment at the family or the treatment team for initiating guardianship or similar proceedings is not universal, it is neither an uncommon nor an incomprehensible reaction on the part of the patient. As a study of families involved in guardianship revealed (see Suggested Readings, Isenberg and Gutheil), the families' fear of just this response acted as a deterrent to their willingness to participate in the process. For the treatment team as well, this matter represents a problem of delicate and diplomatic negotiation in the service of being as supportive as possible to patient and family in what is essentially a shared crisis. The professionals involved must maintain a clear perspective on the goals of the procedure as being ultimately in the patient's interests; they must reject the patient's accusations that they are merely attempting to coerce and control him for self-serving motives (e.g., the exercise of personal power).

D. CLINICAL ADVANTAGES OF GUARDIANSHIP AND OTHER SUBSTITUTE CONSENT

From the clinical viewpoint, the advantages of substitute consent constitute a considerably briefer list than the disadvantages; however, we can outline certain clinically positive effects.

1. Impact on the Patient

Although most patients have considerable concerns about substitute consent, as noted in Section E-2, an occasional patient describes some feeling of security or reassurance—feelings deriving from two sources. In the case of refusal of treatment, the patient sees that a distressing disagreement with treatment staff is being taken seriously via a *referee,* as the guardian or judge may be considered. The exertion of these efforts may convey the dedication of the staff and of the system to protecting the patient's interests. Similarly, a patient concerned about his own ability to handle financial affairs may be reassured when a trusted guardian or conservator is designated to take care of him.

Along the same lines, some treatment-refusing paranoid patients experience successfully obstructing their treatment as being out of control, a threatening state. Such patients, told they must take their medication because it has been authorized by the guardian or judge, often willingly cooperate. The substitute's decision has relieved them of the need to make the conflicted acknowledgment that they are ill and need treatment—an acknowledgment that would be implicit in their accepting treatment voluntarily. The experienced clinician recognizes the familiar parallel to a patient's feeling safer when she understands that limits and controls are available from the outside, as in the following example.

> ***Example 8.*** (A violent, psychotic woman, from Suggested Readings, Kaplan.) So the monster was out and the ghost of some old berserker ancestor rose up within me . . . and I knew that no power on earth but a strait-jacket could hold her.
>
> So I went to the nurse and said, "Tie me." . . . But the nurse was so stupid she mistook the whole meaning and because I displayed no agitation she sent me back to bed. . . . They were going to make me control that which there is no holding. . . . All my energy was being expended to hold the thing down till I could be tied. [Finally, she is given a strait-jacket.] When I was tied down securely and could relax my hold upon myself, all my shame flowed out in a wild flood of tears . . . that I had not had the courage to do the thing I had such an urge to do—but more, they were tears of relief that I had not done them. . . .

Finally, some realistic benefits accrue to the extent that substitute consent actually protects the patient's best interest. In matters of treatment refusal in jurisdictions where guardianship is required to permit involuntary treatment, the advantage is clearly that the patient receives the needed treatment. When a patient's personal affairs are jeopardized by his incompetent handling of his property, the substitute decision-maker can secure the patient's financial interests to the patient's clear benefit.

2. Impact on the Family

Though rife with conflicts in their own right (as noted in Sec. E-3), substitute decisions may serve to diminish uncertainty and ambiguity in the crisis facing the family. In consequence, fears, tensions, anger, and guilt concerning what should be done about the patient may diminish, particularly if the process is uncomplicated and uncontested. If the decision-maker is a respected person outside the family, and thus, from the family's point of view, more objective, the decrease in tensions may be even greater, to the potential benefit of the patient.

3. Impact on the Treatment Team

The major effect of substitute consent on the treaters is also reassurance, but the system of due process communicates a sense of decreased risk of liability in the issue. Treatment attempted or carried out with an oppositional patient under the shadow of threat of suit is almost invariably poorer treatment, because the approach is inherently more defensive and oppositional than in the ordinary situation; hence, in this narrow sense, substitute consent may lead to more confident and therefore better treatment.

E. CLINICAL DISADVANTAGES OF SUBSTITUTE CONSENT

1. Obstacles to Treatment Created by the Procedure in Relation to Involuntary Treatment

Some of the obstacles to treatment created by the process of obtaining substitute consent have been alluded to earlier; in addition, the arrangement itself may create difficulties once it is in force.

a. Delay and its consequences. The first and most critical problem is delay—a problem from which other problems stem. Even at its most highly lubricated, the mill of the law grinds slowly; with some emergency exceptions (such as immediate hearings on some matters), due process simply does not have the inherent urgency so frequently encountered in the clinical situation. In the usual clinical setting, the absence of the doctor is managed by coverage from colleagues or superiors; however, the absence, illness, or vacation of any of the parties to the legal proceeding may lead to postponement of the hearing.

The result is delay in the initiation of treatment and the often consequent extension of the duration of the hospital course, as in the case examples for Chapter 3. This can lead to the promotion of chronicity; increased narcissistic injury deriving from the experience of being utterly out of control for long periods; increased likelihood of social labeling as a chronic patient; and loss of contact with current developments in school, job, or community.

Delay is one of the most common manifestations of so-called critogenic harms, a term meaning a judge-caused harm—intended to parallel the concept of iatrogenic harm, or doctor-caused harm. *Critogenic harms* refer to the usually unrecognized costs of the operation of the legal system, even when the system is working as well as possible. Besides the factors listed below, other critogenic harms most commonly include adversarialization of the relationship, such as inevitably occurs when conflicts are resolved or decisions made by means of the legal system (see Suggested Readings, Sec. B).

b. Cost. Closely related to delay is cost, another critogenic harm. Whereas advocates claim that rights should have no price tag, a prolonged stay in the hospital naturally costs more, and this cost must somehow be borne, if not by the patient or family, then by some third-party source or by the citizenry through taxation. In addition, the legal proceedings and personnel also consume money as well as time; the guardian, if not a family member or volunteer, should be paid for the time, responsibility, and liability involved. The cost of legal proceedings can be significant and may represent a formidable obstacle for impoverished patients, thrown on overcrowded legal aid resources.

c. Lost clinical time. Related to delay and cost is the concept of clinical time out. Treatment personnel must be irreplaceably on the scene in any court proceedings to present the clinical facts and arguments; to do so, even if the judicial procedure occurs in the hospital (as in some jurisdictions), mental health professionals must take time out from care of patients. In complex cases extending over long periods with many depositions, this time out may have to be taken repeatedly. The detriment to care is evident.

2. Impact on the Patient

One effect on the patient is the experience of coercion. Whereas we may readily distinguish judicially sanctioned coercion from that not so sanctioned, the patient feels the loss of autonomy almost regardless of the process that sanctions it. Because of the nature of certain illnesses, this fact has two distinct implications. First, for patients in whom narcissistic issues predominate, lasting grudges, resentments, and hatreds may arise around being forced to take medication or surrender their savings to another's care. These feelings may operate to the detriment of future collaboration. Second, because of the selective effects on competence of major mental illness, the patient found incompetent in a certain area is not necessarily ignorant, uncomprehending, or, in fact, incompetent in other areas. As a result, the patient may have a number of personal reactions to being the ward of someone who is empowered by a court to rule over certain of her affairs, including finances and residence. A 72-year-old man, albeit found incompetent because of dementia with regard to his finances, may yet resent receiving an allowance from a guardian or conservator as though he were a child. A rebellious 20-year-old woman may resent being placed "voluntarily" (i.e., by substituted judgment) in a residential setting that she detests.

A caution should be pointed out in regard to this last point. Guardianship is onerous; demands on a guardian's time decrease when a ward is institutionalized. This fact of life may lower the threshold, as it were, for institutional placement as a solution to difficulties experienced by the ward. The ethical guardian remains alert to this temptation to a fast solution.

3. Impact on the Family

Another effect of substitute consent may be the reinforcement or reenactment of family pathology (see Suggested Readings, Isenberg and Gutheil), in addition to the reinfantilization noted earlier (Sec. III-C-1). Family members may be forced to deal with guilt over opposing the patient's stated wishes and compelling him to accept treatment involuntarily or to surrender control of choices about finances or residence. In addition, because hospitalization of the patient is itself a burdensome crisis for the family, the family may resent the onus of bearing this additional responsibility for the patient; the acute crisis may resonate with situations in the past in which the patient or the patient's anger has burdened the family. Families may actively fear the patient's retaliatory anger at their opposition; and related conflicts about aggressive, punitive, or sadistic feelings may be generated by the implicit coercion. These feelings, some of which can be extremely powerful, may touch off preexisting strains in the family's dynamic equilibrium.

In addition, because of these preexisting or exacerbated familial difficulties, or both, the family member as guardian may not act in the patient's best interests (as in Case Example 3) in the vicarious and empathic way envisioned by the theory of guardianship. The critogenic harm of adversarialization of the relationship may exert its influence in seeming to pit family against patient, even when the ultimate goals of the two are quite comparable.

When a guardian is not a family member, closely bound or paranoid families may attempt to vie with, extrude, or thwart this perceived invader of the family circle.

F. CHARACTERISTICS OF THE IDEAL GUARDIAN

In discussing the procedure of guardianship, it is important to identify the characteristics of the ideal person to fill the role. This is no idle exercise, because the use of professional guardians is becoming the answer increasingly sought to the thorny problem presented by incompetence in the mentally ill person.

1. Availability

Because decisions in the clinical sphere often must be made rapidly on short notice and at unpredictable times, ideally the guardian must be geographically and temporally available. One implication of this desideratum is that if a guardian ever wishes to take a vacation, some sort of coverage must be arranged, in advance of need, by another party empowered in the same manner, because no guarantee exists that the ward's clinical state will remain stable during the interim. The same, of course, is true for the patient's financial and social status. However, this potentially critical detail is rarely addressed at the time of the appointment.

2. Competence

The requirement of competence for the guardian of an incompetent ward might seem tautologic, were it not for the empirical finding that disturbed patients not infrequently come from disturbed families in which no available family member possesses sufficient capacity to grasp the complexities of major decisions. Attainment of sufficient background knowledge, even in a stable family member, might require formal training in the issues of concern to the patient's life. For a patient who requires a decision about psychiatric treatment, this might include attainment of an educated layman's knowledge of rudimentary psychopharmacology; the course of treated versus untreated major mental illness; the benefits, risks, and consequences of treatment with medications, ECT, psychotherapy, and milieu; and advantages and disadvantages of inpatient and outpatient treatment, and group home and halfway house residence. Guardians appointed to aid in managing financial affairs might require similarly explicit training.

3. Empathic Intuition

Empathic intuition refers to the often desirable quality in a guardian of being able to make a difficult determination according to what the patient would want were she sane, competent, and possessed of sound judgment. At issue is the guardian's ability to make truly vicarious decisions (see Sec. II-D-2).

4. Freedom from Conflict of Interest

The guardian should be free from contamination of purpose by any conflicting interest. Such interests might include psychological, psychosocial, or socioeconomic concerns that would or might interfere with objective substituted judgment. When family members serve as guardians, these matters wax complex. A trade-off is made in appointing family members: One may obtain the empathy desired of guardians, but one is burdened with their inevitably ambiguous psychological and practical involvement with the patient.

5. Willingness

Guardianship can at times be a sinecure, but occasionally it can be a burdensome, even overwhelmingly demanding, role. It may require not only expenditure of time and energy, but tolerance of disruption of one's schedule and private life, tolerance of the emotional conflict deriving from the role, and tolerance of the ingratitude, vituperation, and sometimes the litigation of one's ward. Not surprisingly, even adequate remuneration often has been insufficient to persuade potential guardians, including attorneys, to take the job.

6. Adequate Remuneration and Protection from Liability

Although adequate remuneration and protection from liability are not virtual characteristics of the guardian but of the surrounding legal system, they should be articulated because they are the practical pillars on which must rest the creation of a cadre of professional guardians. It cannot be overemphasized that for the population of patients without families and friends (a sizable percentage of chronically mentally ill persons), these provisions may represent the only hope for ethical treatment under current legal guidelines—especially in those jurisdictions that require the petitioning party to propose a person to be appointed. The onus of arranging for remuneration and protection from liability lies on the legislatures, prodded by professional societies and lay groups interested in mental health.

We might also note a clinical dimension of the idea of remuneration for the professional guardian, somewhat analogous to the therapist-patient contract around the fee. A guardianship fee has several effects.

a. Formalization of the relationship. The role of guardian is a job, governed by contractual considerations; it is not a vocation, a charity, a favor, or another ambiguous and potentially conflicted function.

b. Inculcation of responsibility. Like other employees in other jobs, the guardian is expected to discharge his task in a responsible and accountable manner.

c. Decrease in emotional conflict. Treating guardianship seriously avoids clouding of the issues by the patient's feeling of obligation to the guardian, the physician's feeling of an intruder in the dyad, and other complicating views.

However, the "job" aspects of guardianship should not take precedence over the guardian's sensitive concern to the ward's interests (as indicated in Sec. III-F-3).

G. PSYCHOLOGICAL ISSUES FOR THE HEALTH CARE PROXY

Given the importance of health care proxies in modern medical care and the ubiquity of advance directives (an issue now addressed at almost every hospital admission), the literature is surprisingly scant on the actual experience of the person assigned this momentous responsibility.

Most proxies are chosen from family members or friends without fanfare. Consultative experience suggests, however, that individuals chosen as health care proxies experience a predictable and complex series of reactions to this role.

1. *Gratification and pride.* Persons informed that they have been nominated as health care proxy report pride and feelings of specialness at being chosen for a meaningful role in another person's life. In cases in which the designator has an existing or chronic illness, proxies often educate themselves in the relevant condition as a means of fulfilling their expected duties responsibly.
2. *Rejection and avoidance*. Other individuals find the suggestion that they serve as a proxy to be overwhelming and threatening; they wish not to assume the added burden of this responsibility. Particularly in regard to end-of-life decisions, potential proxies may reject the role.
3. *Conflict*. Gratification and pride, and rejection and avoidance may be actively and simultaneously present for the invited proxy, as in Example 9.

> ***Example 9.*** A patient with sarcoidosis asked a first cousin, with whom he had enjoyed a close relationship, to serve as health care proxy, as he had no other kin. The cousin was flattered at being chosen, and she thanked the patient for this honor. Two nights later she woke from a nightmare of the French Revolution in which the patient's head was in a guillotine and she was pulling the lever that released the blade, executing him. She spontaneously realized that the nightmare

> expressed her fears about the responsibility as guardian of the patient's life, should his condition become terminal. After talking extensively with the patient about his health care and end-of-life preferences, she nonetheless elected to remain his proxy.

IV. PITFALLS

A. INAPPROPRIATE FINDING OF INCOMPETENCE

Inappropriate finding of incompetence occurs when the clinician mistakes illness, psychosis, maladaptive functioning, and obstreperousness as equivalent to incompetence. Formal testing in the specific area under question is frequently ignored in favor of these more global impressions. Specificity is central to the issue, because some clinicians (and a surprising number of judges) do not grasp how the specificity of mental illness and its remarkably selective effects may operate to preserve competence in one area while clouding it in another. Witness one judge's attempt at irony that demonstrates how easily this point may be missed:

> . . . defendants took the position that, although a committed mental patient would be presumed competent to deed his home to his doctor, he would not be presumed competent to decide whether to follow that doctor's advice concerning taking of medication. Such an argument would make a doubter of the most credulous.
>
> —*Rogers v. Okin*

Credulousness is not the issue; the fact is that, as clinical data and common sense suggest, people have feelings about their houses that differ from their feelings about their bodies. Mental illness may affect competence in regard to one and not the other.

All these essential distinctions can be blurred by the countertransference. For example, the overinvested clinician resists finding the patient incompetent for fear that this would be seen as deprecatory; the clinician angry at the patient or in a struggle with the patient finds the latter incompetent on affective grounds, as it were, rather than by assessment in terms of formal criteria.

B. INAPPROPRIATE FINDING OF COMPETENCE

Certain forms of mental illness may present disturbance of the mental mechanism involved in decision-making in subtle and difficult-to-detect ways. Most often, these mental disorders affect the patient's interpretation of risks and probabilities but leave cognition or speech largely intact, permitting the patient to express herself in a logical, fluent, or even glib manner. Examples of these disorders include the glib paranoid patient, whose basic suspicion of the doctor's intention may coexist with a clear sensorium and fluent speech; the depressed patient, whose profound pessimism may distort any realistic appreciation of the probabilities of the success of treatment but may leave the patient able to express these pessimistic views in coherent and logical-sounding sentences; the manic or hypomanic patient whose disorder may lead to total denial of any illness, although not impairing the patient's ability to make apparently logical explanations for his decision; and the patient with anorexia nervosa whose incompetence is limited to the narrow area of food, nutrition, and body image, and who may be able to express clear and logical sounding reasons for avoidance of certain foods or treatments (see Suggested Readings, Gutheil and Bursztajn).

In all these cases, the clinician may be discouraged from petitioning for a determination of competence because of the patient's apparent lucidity; many attorneys also misperceive the patient's underlying incompetence. The clinician must make efforts through careful assessment and consultation to define and document even subtle forms of incompetence to present these data effectively in court, and thus to keep the patient from being deprived of needed treatment.

C. INAPPROPRIATE RESORT TO SUBSTITUTE DECISION-MAKING

Inappropriate reasons for seeking another decision-maker include excesses of therapeutic zeal, leading to the wish to take over and control the patient by these legal means and the wish to coerce, take advantage of, or bypass the patient as a participant in decision-making. This last point may be a result of the treater's quite understandable wish to deal with a rational person, because the patient's irrationality is so frustrating.

D. INAPPROPRIATE FAILURE TO SEEK SUBSTITUTE DECISION-MAKING

Seeking a substitute decision, as an experience for the clinician (due process aside), may evoke conflicts around coercion and sadism. Anxiety in this area, conflicts over opposing the patient's stated wishes, laziness, fear of courtroom procedures, or yielding to the family's wish to evade the role of decision-maker—all of these elements may deter or inhibit the clinician from seeking substitute decisions.

E. APPROACHES

The confusion around competence (noted in Sec. II-A) is best remedied by education of the clinician in the use of clearly specified criteria, applied in a strict manner, in the clinical setting.

The countertransference difficulties are managed in the customary manner through consciousness raising, introspection, supervision, consultation, and peer review.

V. CASE EXAMPLE EPILOGUES

A. CASE EXAMPLE 1

The resident contacts the mother, who agrees to serve as guardian and to hire a lawyer who would initiate proceedings. Based on the psychiatric testimony, the patient is found to be incompetent for the purpose of consenting to or refusing treatment, and his mother is appointed temporary guardian with power limited to approving or disapproving a treatment plan.

Furious at his mother for again intervening in his affairs, the patient refuses to meet with her and further regresses, again eating his own feces. When confronted, however, with the possibility of forced injections of neuroleptics—a treatment consented to by his mother after a discussion of risks and benefits with the doctor—he agrees to take oral medication. His response to relatively low doses of neuroleptic is dramatic. Within five days his self-abusive behavior disappears, and he becomes willing to discuss previously hidden areas of concern. Plans are made for discharge to a halfway house.

B. CASE EXAMPLE 2

The psychiatrist, puzzled by the discrepancy between his findings on examination and the reported opinion of the patient's son, is uncertain whether his examination has overlooked some crucial datum or whether the request represents an attempt to "railroad" the patient. He decides to contact the patient's son directly, explaining that he has examined the patient and, having found him of apparent sound mind, is wondering what the son was concerned about.

Somewhat sheepishly, the patient's son indicates that he, too, knows that the patient is able to manage his own affairs, but that he is concerned about his father living alone in an area distant from him should something unfortunate occur. On the advice of his lawyer, he had hoped to use the hospitalization as an opportunity to have the patient declared incompetent, either mentally or physically, to handle his financial affairs, hoping that once he was in control of his father's meager finances, he could coerce him into a retirement home.

Although empathizing with the son's concern for his father, the psychiatrist suggests that perhaps social service agencies could provide services, such as a homemaker or a daily hot lunch program, that would ease his worries and improve his father's everyday situation. The son thanks the psychiatrist for his suggestions, but in saying goodbye, mutters something about contacting the father's personal physician to see if he will sign the certificate of incompetence.

C. CASE EXAMPLE 3

Before the consultation conference on Ms. A., additional data emerge. Her mother, developing a better relationship with the social worker, confesses that she has been putting some of her own sedative capsules in her daughter's tea, "to calm her down after her father died." It was, in fact, the discovery of a partially dissolved capsule in her tea that prompted Ms. A. to express fear of being poisoned.

This evidence of the mother's pathology and her difficulty in distinguishing the patient's distress from her own proves decisive for the consultation. Efforts are made to reach other family members and, after many false starts, an uncle in a distant city is found willing to serve. The judge, although reluctant to appoint a nonresident of the locale as guardian, finally appoints the uncle, who consents to treatment, which then proceeds. The psychosis largely remits under treatment; however, the patient now incorporates the uncle into her residual delusional system.

VI. ACTION GUIDE

A. EVALUATION OF COMPETENCE

1. *Work* with low threshold of suspicion of incompetence, especially with
   a. Acutely psychotic patients who often experience delirium-like clouding of consciousness.
   b. Chronically institutionalized patients who may have lost the capacity to evaluate critically the proposed interventions or actions.
   c. Patients with organic impairment, often elderly, who may slide slowly into an incompetent state.
   d. Depressed patients, even if nonpsychotic, whose hopeless-helpless thinking may impair reasoning about treatment alternatives and future plans.
   e. Retarded patients whose disability may be accentuated by concomitant psychiatric illness.
   f. Patients who are being asked to consent to especially risky procedures, or those with little hope of direct benefit to them.
2. *Screen* for general competence.
   a. *Use* this as indicator of probability that more specific impairments exist.
   b. *Assess* awareness of nature of situation.
   c. *Evaluate* factual understanding of issues.
   d. *Determine* appreciation of basic consequences.
   e. *Assess* basic elements of mental status:
      i. Orientation
      ii. Memory
      iii. Intellectual functioning
      iv. Judgment
      v. Impairments in rationality (delusional thinking, hallucinations, etc.)
      vi. Mood alterations
   f. *Relate* performance to patient's functioning *in his own environment*:
      i. Mildly demented patient may be disoriented in the hospital, but function quite well at home.
      ii. Moderately retarded person with difficulty performing calculations may have neighbor or family member who accompanies him on shopping trips.
   g. *Consider* the level at which the individual must function (e.g., someone with a large estate may require assistance, whereas a similarly impaired patient who gives his monthly Supplemental Security Income check to a halfway house may not).
   h. *Solicit* information from those who know the patient and who have observed the patient's functioning over a period—but be aware of hidden motives.
   i. If at all possible, *observe* and *interview* the patient on more than one occasion, to minimize the effect of chance fluctuations in mental state.
3. If the patient appears to be generally incompetent, *assess* the therapeutic measures that might restore competence.
   a. *Have* medical status evaluated.
   b. *Pay* particular attention to medications that might be impairing mental functioning (e.g., tranquilizers in the elderly).
   c. *Look for* treatable psychiatric conditions and *recommend* indicated course of therapy (e.g., depression in elderly patients presenting as dementia and amenable to treatment with antidepressants).
4. *Consider* possibility that apparent general incompetence may actually be limited to specific areas.

5. *Screen* for specific competence (e.g., competence to consent to psychiatric treatment).
    a. *Examine* patient's capacity to communicate a choice.
    b. *Assess* patient's factual understanding of issues: illness; proposed interventions, including their risks, benefits, and the possible alternatives (e.g., use of medication: risks—possibility of metabolic syndrome; benefits—probable resolution of psychotic episode; alternatives—ECT, psychotherapy if feasible given patient's condition).
    c. *Test* patient's appreciation of the situation and its consequences.
    d. *Examine* patient's use of rational processes for manipulating information to arrive at decision (e.g., absence of delusional basis for deciding to accept or to refuse treatment).
    e. *Remember* that patient must be adequately informed before assessment can be meaningful; examiner should always be present when patient is informed to judge adequacy of presentation. *Consider* use of written, video, or graphic materials to supplement verbal information.
    f. *Rule out* spurious indicators of specific incompetence:
        i. Psychodynamic indicators (e.g., patient's fears evoke nonrational defenses).
        ii. Psychopathologic indicators (e.g., poor medication compliance, unknown to primary clinician, leading to impaired thought processes).
        iii. Situational indicators (e.g., enmity between patient and primary clinician leads patient to "act crazy" to frustrate clinician).
6. *Apply* model described in Section III-A-5.
7. *Remember* that in presence of general incompetence specific deficits should always be suspected, but specific incompetence can also coexist with general competence (e.g., paranoid schizophrenic may be incompetent to make a will, because of delusions about family, but may easily handle everyday affairs).

B. IDENTIFICATION OF POTENTIAL DECISION-MAKERS IF INDICTED OR REQUIRED

1. *Assess* clinical impact on patient if that nominee were chosen as proxy: regressive elements, perpetuation of family's pathologic interaction, ability to see patient's wishes and needs with reasonable objectivity and protect patient's actual interests.
2. If immediate family unable, unwilling, or inappropriate, *extend* search to more distant relatives, or, if needed, neighbors, friends, clergy, attorneys, or other professionals associated with patient or family.
3. *Assess* willingness of local legal aid agencies and similar groups to serve.
4. *Evaluate* guardian, if one is required, for suitability—according to standards in Section III-F.
    a. Availability
    b. Competence
    c. Empathic intuition
    d. Freedom from conflict of interest
    e. Willingness
    f. Availability of remuneration and protection from liability *or* proxy's willingness to serve without compensation

C. CONTACT WITH POTENTIAL PROXIES

1. Directly, as part of clinical outreach to family.
2. Indirectly, as in urging family to petition with their own attorney.
3. *Support* efforts as needed, including therapeutic interventions directed at coping with conflicts aroused by procedure itself, as well as exacerbations of previous conflicts.
4. *Support* and *remain* available to health care proxies for patients.

D. ATTEMPTS TO MAINTAIN BASES FOR TREATMENT

1. *Agency*: clarify with patient (if possible) that efforts are directed to her interests, albeit involving other persons or entities (e.g., court).

2. *Alliance*: despite potential oppositionality of procedure, attempt collaboration with most adult side of patient; elucidate procedure as part of treatment effort in patient's interests or as achievement of needed safeguards for impaired patient.
3. *Ongoing working relationship*: after proxy is appointed, explore with patient what experience is like (may include mourning loss of previous competence, autonomy, self-sufficiency, self-esteem).

E. OBSERVATION OF PATIENT WITH REVERSIBLE ILLNESS FOR SIGNS OF RETURNING COMPETENCE

As soon as feasible, *retest* for competence and—if competence has returned—*initiate* procedures to withdraw substitute decision mechanism (observation of patient with reversible illness for signs of returning competence would ordinarily not apply to fixed, chronic, functional illness, or to fixed or progressive organic illness, like dementia).

F. AWARENESS OF PITFALLS

Be aware of pitfalls, including inappropriate findings of competence *or* incompetence; inappropriate seeking or not seeking substitute decision; and failure to detect subtle incompetence.

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CHAPTER 6

Forensic Evaluations

I. CASE EXAMPLES

A. CASE EXAMPLE 1

A 25-year-old man appears at the inpatient admissions office of a community mental health center escorted by two police officers. The patient is known to the center by virtue of four previous hospitalizations for psychotic episodes dating back seven years. He carries a diagnosis of chronic schizophrenia, generally responds well to medication, but invariably discontinues his medication after discharge from the hospital. Now he again appears to be psychotic.

The police officers present an order from the court stating that the patient has been committed to the center's inpatient unit for 20 days of observation to assess his competence to stand trial and his criminal responsibility on charges of car theft. The only information given about the alleged crime is that it occurred more than one year ago. In addition, they deliver a letter from the psychiatrist in the court clinic, who examined the patient earlier that day. While providing a review of the patient's clinical history, the letter gives no indication of the patient's current legal status or why the questions of competence or responsibility were raised. In fact, the only justification for the hospitalization that is offered appears to be that the patient is psychotic.

After admission, the resident assigned to the case requests forensic consultation. She is confused about why the patient was referred, what her obligations are to the court, and whether the patient should be treated during his hospitalization.

B. CASE EXAMPLE 2

A 54-year-old man is sent to the state hospital for evaluation of competence to stand trial for assaulting his wife, with the additional question of criminal responsibility.

The resident on the case, just beginning her psychiatric training and feeling pressured and uncomfortable about her role in relation to the court, begins by interviewing the patient in the customary way. The patient takes to her immediately and shares the following history.

The patient, originally a Jewish tailor in Poland, spent his early 20s in hiding from the Nazis. For five years he slept in barns, haystacks, woods, and ditches, eating stolen food or cattle feed, befriended by farmers but constantly plagued by the fear that the friendliest host might secretly be planning to betray him to the Gestapo.

He claims in relation to the alleged crime that his wife, a younger American-born woman, "makes him crazy" with her nagging; in his broken English he explains that he reached his limit and hit her.

The resident seeks out the service chief. "Listen," she says, "my parents were concentration camp survivors; I know what the situation over there was like. This man is somewhat paranoid but, my God, who wouldn't be with a story like that?"

The service chief interviews the patient in front of the resident and presses him hard to understand what it means that "his wife makes him crazy"; could this mean the benign marital complaint "You're driving me crazy," or the more ominously psychotic "You're influencing my mind"? The patient becomes extremely upset during the interview but—to her own surprise—so does the resident.

When the patient returns to the ward, the resident turns in fury on the chief. Berating him for sadism, insensitivity, and anti-Semitic prejudice, she voices her intent to see the hospital legal consultant and storms out of the room.

C. CASE EXAMPLE 3

A young forensic psychiatrist just beginning private practice eagerly opens a case that he has received for examination from a plaintiff's attorney. An employee had apparently been held up at gunpoint while working in a fast food restaurant and during the robbery had felt paralyzed, helpless, and in danger of death, the more so because his paralysis made the gunman increasingly impatient. Although the robbery occurred without any injury or bullets being fired, the young man left work early and has claimed subsequent inability to work. The place of employment is being sued for negligence in failing to take adequate security measures, resulting in emotional harms to the complainant that have destroyed his social life, family relations, work capacity, and peace of mind. Believing that the subject is the best source of clinical information, the psychiatrist arranges for an interview with the victim as the first step.

In the interview, the subject presents as a mildly disheveled young man with poor eye contact and a tendency to stare fixedly over the psychiatrist's left shoulder. He also displays a tendency on occasion to use words that are only similar to the words that are meant, therefore nonsensical in the context used. Although rambling and far ranging, his speech does not appear to meet strict criteria for either loose associations or flight of ideas, and no other significant stigmata of mental illness are present.

Although the examinee denies any preexisting psychiatric difficulties, the psychiatrist's uncertainty about the clinical presentation leads him now to call the law firm and contact the paralegal who works for the litigating attorney. He confronts her with suspicions of an underlying, preexisting disorder. The paralegal acknowledges that indeed the patient has a significant psychiatric history and agrees somewhat indifferently to send the records to the psychiatrist.

Review of these materials reveals a significant psychiatric history dating to childhood, with recurring hospitalizations and ongoing diagnosis of chronic paranoid schizophrenia. More specifically, the examinee, on several occasions during his frequent hospitalizations, even subsequent to the robbery, has dated the origin of all his difficulties to a sexual scene that he may have either witnessed or participated in when he was nine years old, almost ten years before the time of the robbery. The forensic psychiatrist considers how to proceed.

II. LEGAL ISSUES

Mental health professionals are called on by the legal system to provide testimony in a wide variety of cases, criminal and civil. Given the impossibility of discussing the full range of forensic evaluations in this chapter, we focus on examples of the most common evaluations, which demonstrate the variety of issues with which evaluators must contend. In the criminal area, forensic clinicians may be asked to comment on the competence of a person to make decisions throughout all the phases of criminal investigation, trial, and punishment. These include the competence to waive one's rights (e.g., the right not to be searched without a warrant, the right not to answer investigators' questions or make a confession), to stand trial, to plead guilty, to be sentenced, to waive appeal (especially in capital cases), and to be executed. The first section of this chapter focuses on the most common of the criminal competence assessments: competence to stand trial. Then, the most well-known and controversial role that mental health professionals play in the trial process is considered: evaluating defendants' criminal responsibility.

On the civil side, clinicians perform a similarly broad range of functions. They may assess a number of civil competences, including competence to make a will or contract, to make decisions about one's person and property, and to marry. Clinical experts are also called on to testify about a person's mental impairments insofar as they relate to ability to work or could have been caused by an allegedly negligent act (emotional harms). These evaluations are considered below.

Clinicians who work with children are frequently involved in evaluations and testimony concerning juvenile delinquency, child custody, termination of parental rights, and newer issues, such as competence of the child to testify and how she may be protected in the courtroom. Because child-related evaluations are the basis of an emerging and rapidly growing subspecialty of child forensic practice that cannot be addressed in adequate detail here, readers are referred to the Suggested Readings that deal specifically with these issues (see Suggested Readings, Sec. G).

A. COMPETENCE TO STAND TRIAL

Probably the most common request by the judicial system of the psychiatric system is for the assessment of the competence of a defendant to stand trial. Roughly 25,000 competence-to-stand-trial evaluations are performed in the United States each year. Approximately one-fourth of the 25,000 evaluations find that the defendant is incompetent to stand trial. The best available data—though somewhat dated—suggest that approximately 3,400 incompetent defendants are hospitalized for treatment at any point in time.

At one time, psychiatrists performed almost all competence-to-stand-trial evaluations, but that has changed. Psychologists have assumed the evaluator's role as states have altered their statutes to permit them to perform evaluations. Some jurisdictions also permit social workers to evaluate competence to stand trial—a trend that is likely to grow. (See Sec. III-B-1 for a discussion of practical approaches to performing the assessment of competence to stand trial.) This section reviews the historical evolution of the legal standards concerning competence to stand trial and then discusses the forensic evaluator's approach to the issue.

1. Historical Background

The determination of competence to stand trial has a rather inglorious history. Under English common law in the medieval period, the proceedings of a trial were terminated by the failure of a defendant to plead to the charges. Therefore, officials had to resort to means of convincing the defendant to enter a plea. The procedure commonly used was referred to as *peine forte et dure*; it consisted of placing increasingly heavy rocks on the body of the defendant until either he voiced a plea or the necessity for the trial disappeared. Although many of those who refused to plead were undoubtedly criminals seeking to avoid capital punishment, some of those who succumbed to the weight of the court's persuasion were probably mentally ill and mentally retarded individuals who did not have sufficient capacity to understand what was required of them.

As the law worked its way into more enlightened times, the rocks were dispensed with in recognition that there might be some categories of individuals who were incapable of pleading and who, in addition, might not be able to participate adequately in the proceedings. These individuals were arraigned before a 12-person jury, and evidence of their mental state was presented. If the jury determined that the defendant was not able to plead, the defendant was sent to prison, to remain there until he became competent again. For many, that meant a lifetime of incarceration. Those who were thought to be malingering were tried despite their failure to plead.

The grounds on which the jury was to make its determination of competence were at first not made clear. Beginning in the late 1700s, a series of cases led, by virtue of somewhat more explicit judicial decisions, to a consensus on the legal standard to be applied: The defendant needed to be possessed of sufficient reason to understand the charges against her and to participate in the trial in her own defense. The heavy cognitive component of this standard, insofar as it stressed understanding to the exclusion of impairments of rationality or affect, was characteristic of the time and is also reflected in the nearly contemporaneous M'Naghten rule (see Sec. B) for criminal responsibility determinations.

2. Modern Standards

Modern standards for competence to stand trial differ little, in most jurisdictions, from the nineteenth-century common-law rule. Each state determines the standards that govern most criminal trials in the state, except those under federal jurisdiction. In those cases, the standard enunciated in the federal case of *Dusky v. United States* applies: "The test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding, and whether he has a rational as well as a factual understanding of the proceedings against him."

A tripartite definition of competence applies in most jurisdictions: The defendant must have an understanding of the nature of the charges against him and of the nature and purpose of court proceedings, and he must be able to cooperate with an attorney in his own defense.

A long-standing area of uncertainty is the relationship between competence to stand trial and competence to make specific decisions that arise in the course of defending against a criminal charge. For example, is someone who has been found competent under *Dusky*-type criteria necessarily competent to decide whether to plead guilty in exchange for a reduced sentence, to waive the right to a jury trial, or to dismiss her attorney and defend herself? Most courts, eager to avoid multiple competence hearings for defendants, lump these capacities together and assume that someone who meets a *Dusky* standard can make whatever decisions are required. A small number of courts and some commentators, however, criticize this approach, arguing that the possession of the minimal level of capacity envisioned by *Dusky* does not imply the presence of abilities to make complex, defense-related decisions. In 1993, the U.S. Supreme Court addressed this question in *Godinez v. Moran*, holding that further inquiry into the defendant's capacities was unnecessary once she met the *Dusky* criteria. However, Justice Thomas's majority opinion indicated that, when defendants were making decisions with regard to waiver of constitutional rights, the "trial court must satisfy itself that the waiver . . . is knowing and voluntary." The court characterized this not as an assessment of competence, but as an evaluation of whether the defendant "actually does understand the significance and consequences of a particular decision" and makes the decision in an uncoerced manner. Although not free of ambiguity, the *Godinez* decision does hold open the door to individualized assessment of defendants' abilities when decisions about waivers of rights are involved, albeit not under the rubric of a competence evaluation.

The rationale that underlies competence to stand trial standards has also undergone considerable evolution since the days of *peine forte et dure.* No longer is the law strictly concerned with the ritualistic aspects of lodging a plea. Rather, the requirement that a defendant be competent for a trial to take place is seen as protecting the fundamental fairness of the proceedings, guaranteed by the U.S. Constitution, and ensuring that all relevant information that the defendant can provide is made available to the court. It can be argued that some aspects of the trial as a ritual persist: To the extent that public faith in the criminal justice system requires a perception of inherent fairness in the process, the exclusion of those whose competence is impaired makes the entire system more legitimate. Thus, judges are constitutionally required to order competence evaluations whenever the defendant's behavior or the representations of any party raise a bona fide doubt about the defendant's competence to stand trial.

3. Role of the Mental Health Professional in Determining Competence

Unlike the English courts of several centuries ago, contemporary American courts do not rely on the unassisted lay judgment of a jury to decide a defendant's competence to stand trial. Although a few jurisdictions still use juries, the defendant is usually first examined by a clinician appointed by the court, and the clinician's report then provides an important basis for the jury's decision. In most jurisdictions, the trial judge determines the defendant's competence, again almost always with clinical assistance. Some states make use of panels of experts to assess competence.

Regardless of who is the ultimate decision-maker, empirical studies of courtroom procedure show that the opinion of the forensic evaluator is highly influential in the final determination. However, it is not always clear what standards are being used by the clinician in making her assessment.

a. Standards for assessment. Until the 1970s, little attention was given to how mental health professionals should operationalize the standards used in assessing defendants' alleged incompetence. The impression of researchers who have conducted field studies of hearings on this issue is that clinicians, as well as attorneys and judges, frequently confuse the question of competence with the questions of the presence of psychosis, suitability for civil commitment, and responsibility for criminal acts—determinations that should be clearly distinguished from one another. Evaluators' opinions have tended to be stated in a conclusory manner with little or no justification given for the opinion that the defendant is not capable of standing trial.

To focus clinicians' attention to those areas of functioning that are most relevant to a determination of competence to stand trial—and to fill the void left by the absence of clear guidelines from the courts—checklists have been devised. The most carefully constructed of the early instruments is the work of McGarry et al. (see Suggested Readings), which was empirically validated by cross-reference to the ultimate judicial disposition of the defendants on whom it was tested. The McGarry scale attempts to operationalize the competence assessment questions by looking at 13 areas of functioning, including the defendant's:

1. Ability to appraise the legal defenses available.
2. Level of unmanageable behavior.
3. Quality of relating to attorney.
4. Ability to plan legal strategy.
5. Ability to appraise the roles of various participants in the courtroom proceedings.
6. Understanding of court procedure.
7. Appreciation of the charges.
8. Appreciation of the range and nature of possible penalties.
9. Ability to appraise the likely outcomes.
10. Capacity to disclose to the attorney available pertinent facts surrounding the offense.
11. Capacity to challenge prosecution witnesses realistically.
12. Capacity to testify relevantly.
13. Manifestation of self-serving versus self-defeating motivation.

Although the McGarry scale comes with an elaborate scoring system for each of these factors, the average clinician outside of a research setting will probably find the use of the checklist to structure his own interview is sufficient to ensure thoroughness (see Sec. III-B-1). It appears that responses to several of the criteria depend on previous experience with the legal system (i.e., factors 1, 4, 5, 6, and 9). Clinicians should not regard poor showings on these factors as determinative of incapacity, unless the defendant demonstrates an inability to be educated about these issues.

In addition to ensuring a thorough and systematized evaluation, the use of a scale, whether the McGarry checklist or one of the other published works, enables the clinician to organize the report to the court in such a way that the basis for her decision about the patient's competence or incompetence is immediately clear. This avoids the problem of offering blanket statements that judges and attorneys either have to reject or to accept on their face.

b. Answering the ultimate question. Because competence to stand trial is, in the end, a legal determination, many experts believe that a clinician should not offer an opinion as to the ultimate legal question. That is, they maintain that although all the relevant data that a judge might need to decide if a defendant is competent (e.g., those factors in the McGarry scale) should be presented clearly, the evaluator should not offer an opinion as to whether she considers the defendant competent or incompetent. These experts assert that the question of whether a defendant should stand trial is not a clinical decision, but one based on a balancing of values concerning fairness to the defendant and the public's interest in resolving the criminal charges. Clinical evaluators have no special expertise in resolving these questions and are thus likely to rely on their own sociopolitical biases in reaching a decision, an outcome that is unfair to the defendant. In addition, it is argued that the clinical professions lose credibility with the public when they attempt to usurp the role of society's appointed fact-finders in this manner.

Conversely, some forensic clinicians advocate that evaluators who work in court settings should in fact view themselves as an arm of the court and should attempt to be as useful to the court as they possibly can. If answering the ultimate question would be helpful for the court, then that is a function mental health professionals should perform. These forensic clinicians would probably argue that objectivity in assessment is illusory and that, to the extent that bias exists, openly recognizing it is more likely to mute its effect than ignoring it altogether.

Something can be said for both sides of the issue, but, in the end, the clinician is an expert in human behavior, not in law. Regardless of professional considerations, it is unfair to the defendant for his legal status to be decided by clinical, rather than by judicial, fiat. Because the presentation of the bare clinical facts, even the use of a scale such as McGarry's, leaves the judge or jury with the task of making the conceptual leap from the clinical formulation to the legal desiderata (an extremely difficult chore that they prefer to avoid), attorneys and judges frequently press evaluators for a more direct response to the legal issues. Clinicians in this situation are faced with three options: (a) caving in to the pressures exerted by the judge; (b) stating to the judge that their expertise lies in assessment of the patient and does not extend to legal matters, and therefore they would prefer not to answer the question; or (c) taking the intermediate position of addressing the language of the legal test (e.g., "Based on the data I have presented, I believe that the defendant has a rational as well as a factual understanding of the proceedings against him") but without reaching the ultimate judgment of whether the defendant is competent to stand trial.

4. Misuse of Competence Evaluations by the Courts

Several empirical studies have demonstrated that a large number, in some cases a majority, of the defendants ostensibly referred by the courts for competence examinations are in fact being referred for other reasons. The prevalence of this phenomenon may have decreased somewhat in recent years, but it is still not uncommon. It usually occurs when the prosecutor or the court is interested in finding an alternative to holding a defendant in jail until the time of the trial or releasing him on bail. When the competence assessment is done on an outpatient basis or in the courthouse, the judge may use it as a way of finding a reason for denying bail (e.g., as a consequence of a finding that the defendant is mentally ill and dangerous) or for committing the defendant to a state hospital or other psychiatric facility (e.g., as a consequence of a finding that the defendant needs further evaluation for competence).

Referrals to inpatient facilities for competence assessments are even more subject to abuse. Most states permit involuntary commitments of defendants for periods of up to several weeks, with renewals for periods of up to several months. Judges are most likely to use such alternatives when defendants have a history of treatment for mental illness or have been behaving oddly, even if there is no good evidence that they are incompetent to be tried. Commitment for evaluation allows judges to avoid criticism for returning likely recidivists to the streets on bail. It also serves a judge's wish to sequester people whose behavior is so deviant, without actually violating the law, that they are a perpetual discomfort to society. These individuals can be arrested on a petty charge such as disorderly conduct and then, without a trial or a chance at obtaining bail, be committed by the judge to a hospital for a substantial period.

This kind of commitment by the judiciary obviously deprives defendants of their constitutional rights to bail and to a speedy trial and often results in unnecessary detention. On the other hand, the competence referral is frequently used for a more benevolent, though still extralegal, purpose, namely for the treatment of mentally ill individuals who will not accept voluntary hospitalization but who are in need of treatment. Restriction of civil commitment statutes in many states to criteria emphasizing dangerousness has left a large number of severely ill, but nondangerous, people roaming the streets with no means for the state to provide the care that they need. Benevolent judges often seek to thwart the intent of such statutes by committing these people after arrests on minor charges; formally, a competence evaluation is requested, but in actuality, the reason for commitment is the judge's wish that these individuals receive psychiatric care, even if only for a short period. This misuse of the competence assessment laws is a result of the pressures exerted on society by civil commitment statutes that are entirely governed by dangerousness criteria (see Chap. 2, Sec. II-D-2). It is another confirmation of the need for involuntary treatment laws that permit treatment for the patient's own welfare, not merely because someone else is being threatened by the patient's behavior.

Abuse of the competence referral sometimes emanates from the defendant's attorney, too. In addition to not protesting extralegal referrals made by the courts, defense lawyers sometimes request competence evaluations when the real issue is their desire to delay the court hearing—whether for their own convenience or for strategic purposes—or to obtain a sounding on the level of the defendant's psychopathology as it relates to the possibility of later offering an insanity defense. Lawyers may also—without consultation with the client—waive their client's rights to be released from the hospital after the statutorily permitted period of evaluation has expired.

Clinicians can do little to thwart such abuse of the system. Court clinic personnel can try in their evaluations to be as scrupulous as possible about relating their evaluations to the specific criteria for competence to stand trial (see Sec. II-A-3-a). In addition, clinicians can avoid labeling defendants as incompetent simply because they are mentally ill. Public inpatient services have no option but to accept court commitments, but they can try to accomplish the evaluations as expeditiously as possible with an eye toward returning the defendant promptly to court. The most effective move to prevent abuses—and to make the system function more efficiently—is to require that competence-to-stand-trial evaluations be performed on an outpatient basis, unless the defendant otherwise meets commitment criteria or close observation is required as part of the competence assessment. Some states have successfully implemented such outpatient-oriented assessment systems.

5. The Problem of Disposition

Medieval English courts had a ready solution for the problem of what to do with the defendant who was charged with a crime for which he could not be tried. The defendant was simply sent to jail until his condition improved enough to allow his trial to take place. If his condition did not improve, the trial did not occur, and the defendant remained incarcerated indefinitely. Surprisingly, this solution to the problem remained the common one in this country until the U.S. Supreme Court decision in *Jackson v. Indiana* in 1972. The court held that Jackson, who was severely retarded and therefore unlikely ever to reach a state of competence for trial on charges of stealing $9 worth of property, could not be given the virtual life sentence to which indefinite detention would amount. The state was ordered to release Jackson when it became clear that he was unlikely ever to become competent.

Most states were forced by the *Jackson* decision to amend their statutes concerning competence assessments. The usual post-*Jackson* statute provides for a period of evaluation, followed by a period of treatment, at the end of which, if no improvement has occurred and the patient is not otherwise committable under state law, the patient must be released and the charges dismissed. These changes have had the effect of preventing the criminal justice system from using incompetence to stand trial as a means of indefinitely hospitalizing those chronically ill, nondangerous patients whom the civil commitment laws also no longer permit to be detained against their will.

On the whole, this result represents a substantial contribution to the fairness with which the system operates. Chronic but harmless patients, many of whom are probably not likely to benefit from treatment, can no longer be picked up on minor charges and hospitalized for life by the court. It is unfortunate, though, that potentially treatable patients in this group cannot be guaranteed care through the more appropriate channel of the civil system. In addition, a small number of patients are chronically ill, repeatedly violate the law in significant ways, but are incompetent and quite unlikely ever to regain competence. Assuming that their crimes do not render them a danger to themselves or to others, there is no way in most states to deal with the problem that they present. If arrested, they cannot be tried and, after an evaluation period and a brief attempt at treatment, must be released. When released, they invariably become involved in illegal activities again, resulting in their arrest and a repetition of the cycle. Because they are not dangerous, they cannot, in most places, be committed. (See discussion of commitment law in Chap. 2, Sec. II-E-1.)

Our society's devotion to individual rights leaves no means of dealing with the majority of this admittedly small, but troublesome, class of offenders. It may be the price that society must pay to prevent worse abuses.

6. Treating Incompetence

It is suggested in this book (see Chap. 5, Sec. III-A-7) that insofar as it is the result of a psychopathologic process, incompetence ought to evoke a search for the underlying illness and an effort at treatment. Some facilities have begun innovative attempts at "treating" incompetence through an active program of education concerning the role and function of the court, including opportunities for defendants to rehearse actual participation in a trial. Although these efforts at education are commendable and perhaps should be made routine for all defendants, not just the mentally ill, they do not constitute genuine treatment of the underlying disorder that has led to the incompetent state, because simple ignorance of courtroom procedure should never in itself be the basis for a finding of incompetence. A genuine treatment for incompetence involves intervention directed at the defendant's psychopathologic state.

The treatment of defendants who are incompetent to stand trial has become a topic of controversy, often stemming from a misunderstanding on the part of many lawyers and judges of the nature of action of psychotropic medications. Their objections affect voluntary and involuntary treatment.

a. Voluntary treatment. Although one would expect that a defendant who wanted to take psychotropic medication that would ameliorate his psychosis and simultaneously restore him to competence would be permitted, even encouraged, to do so, a number of objections to this practice have been raised. Some members of the legal profession think that the state induced by the medications represents "artificial competence," which differs in some way from the "true competence" that the patient would attain if only he were allowed to improve without medications. People who offer such arguments generally do not recognize the normalizing effect of psychotropic medications: These medicines do not create an artificial state of functioning, but return the patient in the direction of his nonpsychotic baseline. In addition, to ask that many chronic patients attain competence without medication is to require the impossible; if these patients are to be tried at all, it can only be while under treatment. Because the *Jackson* rule has precluded the indefinite detention of incompetents, objections to voluntary treatment have fallen off. The criminal justice system is usually eager for a trial to take place before the defendant must be released.

b. Involuntary treatment. Involuntary treatment remains a controversial area. The objections to treating incompetent defendants against their will include those that are applied to involuntary treatment in general (see Chap. 3, Sec. II-C). Additional arguments that are offered include (a) the "artificial competence" argument, (b) the belief that it is unethical to infringe on the patient's autonomy merely to serve society by readying her for trial, and (c) the fear (on the part of the defendant's attorney) that an insanity defense will be undermined by the defendant's nonpsychotic appearance.

The argument regarding the ethics of the decision is a complicated one, but seems to lean toward the decision to treat. Not only does society's interest in trying the defendant outweigh the defendant's desire to maintain autonomy, but because the defendant's exercise of autonomy has already been massively impeded by his arrest and incarceration, it comes down to a choice of means of societal coercion, not to a question of whether coercion will take place. Adding to this, the interest of society in maintaining the integrity of the criminal justice system by preventing those who would avoid its grasp (in this case, by refusing medications) from doing so, the balance seems to tip in favor of treatment.

A careful explanation to the jury of the effect of the medications should counter the objection that treatment undermines the insanity defense. Although one can never be certain that the jury will be able to discount the effect of seeing an apparently normal defendant before them, our system entrusts the jury with many more complicated assessments; it does not seem unreasonable to ask them to take the effect of medications into account.

Attempts to resolve this issue in the courts have been underway for several decades. Some states allowed defendants to refuse treatment that would restore competence; others did not. The U.S. Supreme Court's first decision on this issue, in the 1992 case of *Riggins v. Nevada*, left many of the most important questions unanswered. So, when the court returned to this question in 2003 in *Sell v. U.S.*, its decision was awaited with considerable anticipation. Writing for a six-person majority, Justice Breyer held that the Constitution permitted involuntary medication of incompetent defendants, but with several significant caveats. "Important governmental interests" must be at stake, which usually means that the defendant must be charged with a serious crime. Administration of medication must be likely to render the defendant competent, and be "substantially unlikely to have side effects that will interfere significantly with the defendant's ability to assist counsel . . . thereby rendering the trial unfair"—not determinations that are usually easy to make in advance of treatment. Other means of restoring competence must not exist, and the treatment itself must be in the defendant's best medical interests. Finally, if other grounds for involuntary treatment exist, such as dangerousness or incompetence to make medical decisions, they should be pursued in preference to a *Sell* hearing.

Although *Sell* may define the constitutional minima for involuntary treatment of defendants, states are free to develop more restrictive approaches. How *Sell* will work in practice is still being defined by the courts. The Supreme Court decision, with its many limitations on the government's power to treat incompetent defendants, reflects the Court's hesitance to grant this power to the trial-level criminal courts, which may not have great familiarity with mental illness and the means available for treatment. Justice Breyer indicated his belief that only "rare" cases would meet the criteria he laid out. The extent to which *Sell* resolves the problems created by incompetent defendants who refuse treatment for their illnesses may not be evident for at least a decade.

7. Proposals for Altering the Current Process

The abuses of the competence-to-stand-trial evaluation process plus the enormous expense of evaluating several tens of thousands of defendants each year have led to a number of proposals for altering the system. The most innovative of these involve removing the bar to trying defendants who may lack competence. Two versions of these proposals have been offered.

It has been suggested, and actually implemented in some jurisdictions, that incompetent defendants be permitted to stand trial, with their attorneys making the best defense they can. If the defendant in such a trial is acquitted, she is permitted to go free. If the defendant is convicted, the trial is vacated and she is committed for restoration of competence, and, ultimately, retrial. This approach has the virtue of maintaining adherence to a core value underlying the rules on competence to stand trial: fairness to the defendant. It also diminishes the need to evaluate and treat those defendants who would be found innocent anyway, thus reducing costs and making abuse of the competence assessment system more difficult. On the negative side, it runs the risk of permitting some trials in which the defendant's inability to assist in her defense or behave properly in the courtroom mock the adjudication process. If many second trials were required, they might also consume whatever money is saved as a result of reducing evaluations and hospitalizations.

A second, related suggestion goes even further in mitigating the effect of a finding of incompetence. An incompetent defendant would be permitted to waive his right not to be tried in an incompetent state, as long as his attorney—acting, in effect, as a limited guardian—concurred in the decision. The defendant would then take his chances at trial or in a plea bargain. Arguments in favor of this approach (see Suggested Readings, Winick) emphasize reduced costs and that many defendants play little role in preparing or presenting their defense, with their lawyers making the decisions for them, including the decision to keep them off the stand. Not much would be lost in such a case were the trial to proceed even with the defendant still incompetent. This would allow defendants and their attorneys, as a matter of strategy, to risk a finite, often short, sentence rather than accept long-term hospitalization for restoration of competence. Substantial constitutional, ethical, and practical objections to trying incompetent defendants, however, stand in the way of adoption of such proposals.

B. CRIMINAL RESPONSIBILITY

The purpose of the insanity defense is to permit the exoneration of those individuals who society does not believe should be held morally responsible for their acts. Their lack of responsibility for criminal acts may stem from an absence of free will in their behavior, or the ineffectiveness of punishment in deterring their behavior. Because it is in the interest of society to excuse as few people as possible from the dictates of the criminal law, the defense of moral nonculpability historically has been limited to young children (below the age of seven years) and to the mentally disturbed. From the days of the "wild beast test" (under which the defendant was exonerated if he "doth not know what he is doing, no more than . . . a wild beast"), the defense evolved considerable sophistication; yet its use traditionally was limited to the psychotic defendant. Studies of those more recently acquitted by reason of insanity reveal that this is no longer the case. Between 10% and 30% of not-guilty-by-reason-of-insanity (NGRI) acquittees carry diagnoses of personality disorders. The tests that have evolved over the centuries share the common requirement that the defendant be considered mentally impaired, but differ from each other in substantial ways, which are considered in this section.

It is safe to say that the insanity defense is the single most controversial legal doctrine relating to the mentally ill. The idea that someone who has committed a crime should escape punishment—regardless of her degree of mental impairment—strikes many people as intuitively wrong. A number of misconceptions about the insanity defense contribute to popular discontent. Research has shown that laypersons and legislators tend to greatly overestimate the number of NGRI acquittals that occur. The best available data indicate that approximately 1,500 defendants per year are found NGRI. Successful insanity defenses occur in fewer than one in every 2,000 felony cases. Most determinations of NGRI result from negotiated pleas between the prosecutor and defense, rather than from a trial. Nor does a finding of NGRI typically lead to immediate release to the streets. The duration of hospitalization after an NGRI acquittal varies across jurisdictions and according to the seriousness of the charges, but the average acquittee spends several years in a state hospital, often longer than someone convicted of an equivalent crime would spend in prison. Recidivism by NGRIs appears to be no greater than rearrests for convicted criminals, when the initial charges are the same.

Thus, the salience of the issue of criminal responsibility is due less to the large number of cases or its purported role as a way to beat the system than to the pointed manner in which it raises basic questions about how responsibility for one's actions is apportioned. (See Sec. III-B-2 for a discussion of practical approaches to assessment of criminal responsibility.)

1. The Threshold Question of Mental Illness

All of the formulations of the insanity defense require that the impairment claimed in mental functioning be a result of mental disease or defect. *Defect* is usually understood to refer to mental retardation. Defining *disease* is problematic. Few of those in either the legal or the mental health professions would disagree that any psychotic illness, as long as it is not deliberately induced by the defendant's use of mind-altering agents, legitimately may be considered a disease for the purpose of criminal responsibility determinations. On the other hand, the personality disorders, especially antisocial personality disorder, and other disorders present problems a good deal more controversial.

With the exception of the American Law Institute (ALI) test for legal insanity, the law has no definitive clarification of what it means by *disease*. It is clear that, in theory, disease is not limited to psychosis (although the actual practice may be quite different). A prominent court offered the following definition: "A mental disease or defect includes any abnormal condition of the mind which substantially affects mental or emotional processes and substantially impairs behavior controls." Clearly, such a definition sets virtually no limits on what is classified as a disease.

An embarrassing example of the consequences of not clarifying the terms of *disease* and *defect* arose in the mid-twentieth century in the well-known *Blocker* case. The defendant was originally convicted of murder despite his claim of insanity because, although his psychiatrists diagnosed him as having a "sociopathic personality disturbance," they asserted that he did not have a mental illness. Shortly after his trial, the doctors at St. Elizabeth's Hospital in Washington, where Blocker had been examined, decided that henceforth they would testify that sociopaths were indeed victims of a mental disease. Blocker's conviction was overturned on appeal on the basis that he deserved "a verdict based upon the most mature expert opinion available"—in other words, the latest swing of the pendulum.

The issue is clearly not academic. Every clinician who testifies in court in a case in which the insanity defense is used is required to state her opinion as to whether the defendant has a mental disease. As of now, the answers of any set of examiners who concur in the diagnosis of, for example, a personality disorder or an adjustment reaction, do not necessarily agree with each other. The resulting confusion discredits the professions and perplexes the courts.

The inherent circularity of the definition of *disease* in this context should not be ignored. Mental disease is a prerequisite for exculpation presumably because society recognizes something in the popular understanding of disease that reduces moral culpability. The law could, in fact, define *disease* in just that way: a state of reduced moral culpability. One judge (Bazelon, concurring in *U.S. v. Brawner*) made a suggestion along these lines.

To the extent that any psychiatric definition of *disease* deviates from the tacit moral principles that underlie the insanity defense, it is likely to be rejected by the courts. For example, if organized psychiatry declared that every disorder in the current *Diagnostic and Statistical Manual of Mental Disorders (DSM)* were actually a "disease," courts would still properly refuse to accept "tobacco dependence disorder" as a disease for the purposes of criminal law. As new disorders are defined, the courts must determine whether they more nearly resemble schizophrenia or tobacco dependence disorder in their potential effects on moral culpability. This process is now occurring for such disorders as pathologic gambling and posttraumatic stress disorder.

Despite this apparent contradiction—the law asks for a definition of disease to aid in determining moral responsibility, but only accepts definitions limited to those conditions that appear to impair moral responsibility—there is a point in attempting to formulate a psychiatric definition of *disease*. First, clinical testimony, for whatever use the courts wish to make of it, will then be consistent and reproducible. Second, in that consistency the law will find a starting point from which to begin the process of clarifying its own approach to mental disease. As things stand, any individual evaluator remains free to decide for herself whether the defendant she is evaluating is mentally ill, as long as she can defend that definition in court.

2. Tests of Criminal Responsibility

Mental disease alone does not exculpate a defendant from responsibility for his criminal acts. Something more must be evident. The mental disease whose presence has been established by the threshold test must bear such a relation to the criminal behavior that the perpetrator appears to be morally nonculpable. Exactly what that relation should be has been the subject of voluminous discussion in the legal and psychiatric literature, the result of which has been the formulation of a number of tests of criminal responsibility. Those tests are examined in the following sections.

a. M'Naghten test. The most durable of the tests of criminal insanity (the term "insanity" in the law describes a state of nonresponsibility and is not related to the presence or absence of psychosis) is the M'Naghten rule (pronounced "Mac-naw-ten"), first formulated in Great Britain in 1843. It states that "to establish a defense on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know he was doing what was wrong."

A literal reading of M'Naghten leaves little room for applying it to most mentally ill individuals. Few defendants manifest a "defect of reason" such that they "know" neither the nature and quality of their act nor that it was wrong. But some courts have been more generous in their interpretations, removing "know" from a strict cognitive context and allowing it to connote an affectively infused appreciation of one's acts. A schizophrenic patient, in this more generous reading, convinced that her landlord was an agent of the devil bent on turning her mind to thoughts of sex, and who therefore had to be killed, could be held not to "know" the wrongness of her act of murder, although she might respond in the abstract that to murder was wrong.

"Wrong" is the other key word in the M'Naghten test. Courts are split on whether the knowledge that an act is wrong refers to a recognition that the behavior is forbidden by the law or an awareness of its moral wrongfulness. The latter is more consistent with the usual legal holding that ignorance of the law is no excuse, but it allows a significant degree of subjectivity to enter into the assessment by focusing on the offender's capacity for distinguishing varying shades of moral error. Assuming an impairment in moral awareness is discovered, the forensic examiner has the added burden of determining whether it is a result of the mental illness.

M'Naghten has been the subject of criticism for two reasons: First, by focusing on "knowing" that an act is "wrong," it is said to limit the scope of expert testimony to cognitive assessments alone; second, in so doing it is alleged to adopt the outdated "faculty" psychology of the nineteenth century, which divided the mind into several discrete, nonoverlapping compartments, thereby ignoring modern understanding of the interrelationship between a variety of mental functions. Nonetheless, some variation of the M'Naghten rule is still the law in the majority of American jurisdictions.

b. Irresistible impulse test. The second standard test of criminal responsibility, the "irresistible impulse" test, is usually used in conjunction with the M'Naghten test. It suggests that the defendant is not liable if, by reason of mental illness, she is unable to exert control over her acts. Once again, this test of volitional control can be construed narrowly, as its eponym suggests, to be applicable only to suddenly arising impulses that are acted on without reflection, or it can be given a broader interpretation, to encompass all acts that result from defective control regardless of the length of time between the initial thought and the act.

The problems for forensic evaluators should be evident immediately. First, it is difficult to differentiate between an uncontrolled act and an uncontrollable act; the *post hoc* temptation is to assume that every act that has occurred was inevitable. But even more difficult is the acceptance of the test's underlying premise that disorders of the mind exist that so impair the will as to leave the individual a prisoner of her impulses. Much of the approach of modern psychiatry is built on a negation of that assumption. Even psychotic patients are encouraged to bear full responsibility for their acts and are discouraged from attributing their behavior to impulses over which they have no control. Behavior modification programs, often used with the most regressed or retarded patients, work from similar premises.

Because the defense is frequently used, however, forensic evaluators must exist who disagree and who believe that patients do, in fact, lose control over their behavior. One suspects that in many of these cases the irresistible impulse test is superfluous because such individuals would fail the "knowing" test of M'Naghten (e.g., an individual in a toxic delirium). But for those instances in which this test is relied on exclusively—and the limited data available suggest that a significant number of defendants are reported to qualify for a volitional, but not a cognitive, standard of nonresponsibility—the question remains open whether any mental illness so impairs behavioral controls as to render the defendant helpless to exert any domination over her impulses.

c. American Law Institute (ALI) standard. The third major test of criminal insanity, the standard devised by the ALI and published as part of its Model Penal Code, gained in popularity through the early 1980s. It was adopted in the majority of federal jurisdictions and a significant number of states. It reads, in full:

> (1) A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the wrongfulness of his conduct or to conform his conduct to the requirements of the law. (2) As used in this Article, the terms "mental disease or defect" do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct.

In drafting the Model Penal Code, an effort was made to incorporate the two older standards in their broadest forms. Thus, the "know" requirement of M'Naghten was replaced by the "appreciate" test, an alternative designed to suggest the affective as well as the cognitive awareness of the nature of one's acts that the law requires. Similarly, the capacity "to conform one's conduct to the requirements of the law" allows the broadest possible reading of the irresistible impulse standard.

Unique to the ALI test is the requirement that the defendant have only a lack of "substantial capacity" either to appreciate the wrongfulness of her conduct or to control her behavior—this in place of the total deficits that the older tests seemingly required. Psychiatrists, reluctant to attribute a complete absence of behavioral controls to the defendant, might feel more comfortable testifying to a partial impairment—subject, of course, to the inevitable quibbling over what constitutes "substantial capacity." In a similar vein, a partial lack of appreciation of wrongful conduct might more plausibly be asserted than a complete one.

The full ALI test pointedly excludes any mental disease or defect "manifested only by repeated anti-social or otherwise abnormal behavior." Although not all jurisdictions that have adopted the ALI standard have accepted this qualification, it is clear that the intent is to exclude the defendant with antisocial personality disorder from the advantages of the insanity defense. The potential impact of changes in psychiatric diagnosis on the law is nowhere more evident. At the time that the Model Penal Code was published, many psychiatrists argued and many judges accepted that "as the majority of experts use the term, a psychopath is distinguishable from one who merely demonstrates recurrent criminal behavior." The subsequent *DSM-II* definition of antisocial personality confirmed this, stressing such elements as selfishness, impulsiveness, absence of loyalty, inability to experience guilt, and a low frustration tolerance, and stating expressly, "A mere history of repeated legal or social offenses is not sufficient to justify this diagnosis." The *DSM-IV* diagnostic criteria, on the other hand, allow the diagnosis to be made on the basis of a history of legal and social infractions alone; plainly, in any jurisdiction that recognizes the second half of the ALI test, most defendants with *DSM-IV* antisocial personality disorder must look elsewhere to establish a workable defense. Despite the many protestations of the judiciary that the law, and not the psychiatric profession, determines who is eligible for the insanity defense, this is clearly one example in which the interaction between the two is decisive.

d. Other approaches

i. Modified American Law Institute standard. In the wake of the trial of John Hinckley, Jr., who attempted to assassinate President Reagan and was found NGRI, a great deal of discussion took place about narrowing defendants' opportunities to use an insanity defense. One of the most widely endorsed approaches, which received the approval of the American Bar Association and the American Psychiatric Association (APA), involves removing the so-called volitional prong (or modified irresistible impulse standard) from the ALI test, leaving the cognitive or appreciation test on its own. The rationale for this change was the belief that volitional impairments are particularly difficult to ascertain and account for much conflicting testimony by experts.

Persuaded by this argument, although without empirical data to support it, a Congress intent on restricting the use of the insanity defense altered the federal test for criminal responsibility in 1984 to include only a defendant who, "as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or the wrongfulness of his acts." The use of the phrase *severe mental disease or defect* was designed to limit the use of the defense by persons with all personality disorders, not just antisocial personality disorder. Dropping the volitional test was thought to eliminate the most dubious cases in which the defense would be used. Some states have followed suit. Whether any of the desired results have been achieved is unclear.

ii. Abolition of the insanity defense. The furor after the Hinckley trial led some states to experiment with an attempt to abolish the insanity defense. The defendant's mental state could not be removed from consideration entirely, because the law has always required that the criminal act (in legal terminology, the *actus reus*) be accompanied by an evil intent (the *mens rea*). The nature of the intent required differs from one crime to another. Montana, Idaho, and Utah, however, abolished an independent defense of NGRI, allowing expert testimony on mental state only when, in the words of the Montana statute, "it is relevant to prove that the defendant did or did not have the state of mind which is an element of the offense." Data from Montana (see Suggested Readings, Steadman et al.) indicate that although NGRI findings disappeared after the statutory change, an equivalent number of defendants were found incompetent to stand trial and diverted to the state hospital for long-term treatment, with their charges ultimately dismissed. Thus, a *de facto* insanity defense was created in the face of a statute nominally abolishing that option. As the Hinckley trial recedes into the background, the momentum for abolition appears to have faded.

iii.* Durham *standard. The *Durham* test, which prevailed in the District of Columbia from 1954 until 1972, allowed a finding of NGRI if the accused's unlawful act "was the product of mental disease or defect." This "product" test was designed to allow psychiatrists maximal leeway in introducing evidence relevant to the accused's mental state. A similar test has long been used in New Hampshire. As clarified in a later case, it represented a "but for" approach to causation: "But for" the existence of mental disease, the act in question would not have occurred. This standard is perhaps most compatible of all with the exculpation of many of the personality disorders, for almost everyone would acknowledge that the "inflexible and maladaptive traits" (*DSM-IV*) that are their characteristic elements contribute substantially to the resultant behavior. The *Durham* standard died, however, not because of the breadth of its potential scope, but because the court believed that the psychiatrists who testified under it were defining "product" in conclusory terms that eroded the fact-finding function of the jury.

iv. Diminished capacity. "Diminished capacity" is a defense based on impairment of the mind that has evolved in several states, beginning in California (which has now abandoned it). It supplements, rather than replaces, the insanity defense, allowing evidence of any interference with the normal functioning of the mind (although in some incarnations of the defense such interference must once more be the result of mental disease or defect) to be introduced to prove that the defendant did not have the ability to formulate one of the specific mental elements required for the crime charged. Thus, an intoxicated individual accused of assault with intent to murder might reasonably claim that he was too drunk to formulate an intent to murder the victim of his assault; the result would be a guilty finding on the reduced charge of assault and battery. The defense has somewhat arbitrarily been limited to crimes that are said to require a higher-level "specific intent" rather than the "general intent" common to all criminal acts.

v. Guilty but mentally ill. Guilty but mentally ill (GBMI) is another variation on the usual techniques for dealing with the mentally disordered offender. Juries can find a defendant pleading insanity GBMI if they believe that her illness existed at the time of the crime, but did not contribute to the act to such an extent that a finding of NGRI is warranted. The mental health profession's role is not much different in this instance from that in an insanity defense; the contribution of the individual's illness (again, the problem of defining the illness arises) to her act must be assessed. Persons found GBMI are then referred for evaluation and are supposed to receive psychiatric treatment, if that is warranted.

The GBMI verdict became more popular after the *Hinckley* trial, in large part because it was seen as a way of persuading juries that they could recognize a defendant's mental illness without finding her NGRI; when applied for this purpose, it is something of a fraud. Those found GBMI are treated the same as those who are convicted in an ordinary manner; any prisoner can be evaluated for treatment and should receive it if needed. To the extent that jurors are led to find a defendant GBMI in the belief that such a verdict differs materially from a finding of guilty and is akin to a verdict of NGRI, they have been tricked. Nonetheless, approximately one-fourth of the states adopted a GBMI option, largely in the apparent hope that just such misunderstandings would occur.

Studies suggest that GBMI verdicts tend to occur in cases involving the most violent crimes and often result in periods of detention exceeding those either of persons found guilty or those found NGRI for those offenses. Insofar as a GBMI option places a defendant who pleads NGRI at risk of a more punitive response than a straightforward guilty finding, it may further reduce the attractiveness of an NGRI plea (see Suggested Readings, Steadman et al.). If there is any advantage to the plea, it may be the dubious one that defendants and their families alike can attribute the criminal act to the consequences of illness, rather than taking full responsibility for it.

3. Mechanics of the Insanity Defense

a. Raising the defense. The procedural details of implementing an insanity defense vary from jurisdiction to jurisdiction, but in general any party in a criminal proceeding can raise the issue of a defendant's criminal responsibility at any point in the process. Prosecutors often use the request for an examination of responsibility as a technique for detaining without bail those defendants whom they prefer not to see released before trial; judges often go along with these requests for similar reasons. Examinations of this sort are usually conducted in inpatient facilities whose security varies with the seriousness of the alleged offense. Allowing the prosecutor and the judge to request responsibility examinations provides an interesting potential for them to redefine "political" crimes as the act of a madman; how often that opportunity is exploited in the United States is unknown. Defense attorneys who intend to raise an insanity defense are required in many states to notify the prosecution in advance of the trial or forfeit the option.

b. Obtaining an examination. Any defendant is entitled to use his own expert witness and, since the U.S. Supreme Court's 1987 decision in *Ake v. Oklahoma,* states have been obligated to provide forensic mental health professionals to defendants facing major charges who cannot afford to hire their own. Which cases this applies to and what level of funding the states must offer are among the issues that are still being resolved by the lower courts. If the defense attorney elects not to use the testimony of a forensic expert who has examined her client, presumably because it does not support an insanity defense, the prosecutor may, in some jurisdictions, later call that expert to testify. Clinicians should be aware of the rules in their own jurisdictions, in part so they can provide accurate information to the defendant they evaluate concerning the level of confidentiality that the examination provides.

c. Burden of proof. Among states, rules concerning who bears the burden of proof in insanity defense cases vary. After the *Hinckley* trial, many states and the federal government placed the burden on the defendant to prove legal insanity by a preponderance of evidence. This proved to be the most effective way of decreasing the number of successful insanity pleas and is now the rule in the majority of states. Some states still retain the requirement that the prosecution prove the absence of legal insanity beyond a reasonable doubt, reasoning that because a *mens rea* is an essential element in any crime, the prosecution should bear the burden of proving that the defendant was actually criminally responsible. To trigger this burden for the prosecution, the defendant only needs to present evidence to the contrary. In such cases, the job of the expert witness for the prosecution, who must convince a jury beyond a reasonable doubt that a mental condition did not exist, is considerably more arduous than the task of the defense's expert, whose testimony must only raise some measure of doubt.

4. Disposition

Historically, defendants were loath to raise an insanity defense because a finding of NGRI led almost invariably to an indefinite, potentially lifetime commitment to a psychiatric hospital, usually one for the "criminally insane." Because all but major crimes (e.g., murder) held out the hope of eventual release from prison and because there was a chance that even the most seemingly guilty defendant could convince a jury of his innocence, it was almost always in the noncapital defendant's interest to eschew the insanity defense.

The insanity defense became more attractive with a number of court decisions that declared it to be a violation of a defendant's right to due process to be incarcerated indefinitely regardless of his current mental status or the severity of his crime. More recently, rules in most states allow a period of hospitalization for evaluation, often up to several months, after a verdict of NGRI. Persons who are deemed to be mentally ill and dangerous can be hospitalized for an extended period with periodic reviews of their status. If they remain ill and dangerous despite treatment, recommitment must take place on a regular basis. In some states, this process operates with rules identical to those used for civil committees. In others, variations on the rule (i.e., placing on detainees the burden of proving nondangerousness) are designed to make it more difficult to release acquittees.

The revolution in disposition procedures has heightened the desirability of using the insanity defense and has probably been responsible for an increase in its use. Also contributing to the increased use of the insanity defense is the shift of responsibility for the care of some categories of mentally ill minor offenders from the penal to the psychiatric systems. With a greater sensitivity to the presence of mental illness, the criminal justice system now frequently channels such offenders to state hospitals. Once labeled as psychiatric cases, these offenders are more likely to use and to be successful in using an insanity defense in response to future charges. Obviously the more rapid turnover of NGRI acquittees—mandated by the court decisions requiring a finding of dangerousness for continued incarceration—may also contribute to the increased subsequent use of the defense.

The most important innovation in postacquittal procedures has been the Psychiatric Security Review Board (PSRB) model initiated in Oregon and since adopted, sometimes under different names, in a number of other states. Insanity acquittees in Oregon are committed to the PSRB for the maximum time that they might otherwise have been incarcerated if they had been found guilty. The PSRB can place them in inpatient or outpatient treatment and can follow them after discharge from an inpatient facility. If the acquittee begins to deteriorate or does not comply with discharge conditions, she can be rehospitalized expeditiously, followed by a hearing before the board. This approach, endorsed by the APA as a model for the rest of the country, gets around the problem that exists now in most states: Once an acquittee no longer qualifies for inpatient hospitalization, often according to civil standards, the state loses all control over her. The PSRB model allows long-term monitoring of a class of people about whom society has every reason to be concerned. It appears to be successful, based on recidivism rates, and warrants careful consideration in every state.

Steadman and coworkers' (see Suggested Readings) landmark study of insanity defense reform showed an unanticipated effect of tighter community monitoring in New York: an increase in the willingness of those involved in the criminal justice process to agree on NGRI verdicts in cases of violent crime. Apparently, judges, juries, and prosecutors are reassured that an NGRI finding does not mean that a potentially violent offender will be released into the community without adequate treatment and supervision.

5. Mental Health Professionals' Role in Determining Responsibility

Many of the issues involved with mental health professionals' role in determining responsibility are analogous to those discussed previously (see Sec. II-A) with reference to competence to stand trial. Despite the proliferation of legal standards for determining responsibility, little attention has been devoted to translating those standards into clinically meaningful terms. Law and psychiatry have yet to find a common basis for discourse.

The basic legal doctrine can be stated simply: "Our criminal laws are premised on the view that human beings are normally capable of free and rational choice between alternative modes of behavior, that an individual who chooses to harm another is morally blameworthy or guilty, and that he is liable to punishment if his behavior and the resulting harm have been proscribed by the law" (see Suggested Readings, Brakel and Rock). From these basic presumptions, the law formulates its expectations of the mental health professions.

Clinicians, accustomed to speaking their own private language, are forced to speak in legal terms. They are asked whether individuals have acted with appreciation of the nature of their acts or with the free will to avoid violations of the law if they so choose. They are sometimes asked to evaluate the effect of a complex disease process on a remote act that they did not witness and that the alleged perpetrator may maintain has never occurred. They are asked to define *mental disease* and to apply the definition to the defendant. During the process, they must keep in mind that the system for which they are working (i.e., judicial) denies a fundamental theoretical premise of much of psychiatry (i.e., that all behavior is influenced by unconscious forces beyond the control of the actor and is thus, to some extent, involuntary and predetermined).

It should not be surprising that in this situation a number of studies have cast doubt on the objectivity of forensic evaluators. Their judgments concerning the presence or absence of criminal responsibility have been shown to relate to their political and social views in addition to taking into account the characteristics of the defendant. Part of the public discomfort with the insanity defense undoubtedly relates to the perception that mental health professionals are allowing their own opinions to influence the outcome of major trials in ways that confuse, rather than clarify, the issues to be decided.

Therefore, a strong argument can be made that forensic clinicians should avoid offering testimony on those aspects of the insanity defense that require more political or moral, rather than clinical, judgments. This means avoiding testimony on the ultimate issue of the defendant's responsibility; such a limitation was adopted by Congress for the federal courts as part of the post-*Hinckley* reforms. Clinicians may also benefit, even in this more limited role, from the development of structured assessment instruments to guide their evaluations. Several instruments exist, but they suffer from deficiencies that will, it is hoped, be rectified in subsequent research.

C. CIVIL FORENSIC EVALUATIONS

Legal interest in the opinions of mental health professionals is by no means limited to the criminal realm. As is frequently the case in criminal proceedings, however, civil forensic evaluations often focus on the competence of a person to perform a given act. In general, this concern reflects a societal consensus that it is improper to allow an individual with particular impairments of mental functioning to engage in acts that have significant consequences for himself or for others. The criteria for determining competence in these situations vary according to the societal concern that is being protected. Clinicians are asked by the courts, as experts in the evaluation of mental impairment, to ascertain the presence or absence of the indicia that are of interest to the law. The ambiguities of psychiatric evaluation and of the translation of clinical findings into legally relevant data make these assessments extremely challenging. (See Sec. III-B-3–6 for discussions of practical aspects of performing these evaluations.)

1. Competence to Author a Will

a. Legal criteria. The basic legal requirements for competence to write a will, also known as *testamentary capacity*, vary somewhat across jurisdictions. A common formulation is that those who would write a will "retain the power to understand the nature and extent of their property, their relationship to those persons who are usually the objects of a person's bounty, and the nature and operative effect of will making." In this brief definition, the societal interest in competent will making is quickly evident. It is an interest primarily of the heirs, or (more accurately) the presumptive heirs, in assuring (a) that the estate is not carelessly dissipated (hence, the requirement for an understanding of the extent of the property and of the fact that one is executing a document that controls its disposition); and (b) that they are in fact the beneficiaries (thus, the phrasing "those persons who are usually the objects of a person's bounty").

Challenge to the competence of the maker of a will is usually undertaken by expectant heirs whose hopes have been disappointed. In some cases, they seek to prove that the deceased lacked understanding of the extent of his property or of the nature of his acts—a difficult task except when there is reason to believe that an individual had dementia. The more common challenge is on the basis that the author of the will was subject to "insane delusions" (a legal term) that affected his perception of the usual objects of his bounty. Practically, this means that the deceased held a delusional belief (e.g., his wife had been unfaithful to him or that his son had been plotting to steal his money). Alternatively, in the case of a testator with some mental impairment, but not of a degree to render him incompetent, it might be alleged that he was subject to "undue influence" that overbore his will, typically at the hands of the ultimately beneficiary.

b. Ethical issues in the assessment of testamentary capacity. The entire process of evaluating testamentary capacity in court and of declaring the will of a deceased individual invalid on the basis of incompetence has been the subject of considerable ethical discussion. What the process accomplishes, the critics charge, is to rob the defenseless deceased of her last wishes for the disposition of property on the grounds that her desires do not conform to the usual expectations of society as to how an individual should distribute her wealth. Clinicians' roles in the process are also the target of invective, particularly because they testify about the condition of persons whom they usually have never examined. Some mental health professionals agree with this criticism and maintain that clinicians should never testify about anyone whom they have not examined personally. Certainly the violation of this rule should occur only when the evaluator is faced with incontrovertible evidence of a given mental state. The clinician must decide for herself as well whether the case represents an attempt to thwart the competent wishes of the deceased or is truly an instance in which an injustice would be done to the natural heirs as a result of real mental impairment in the testator.

2. Competence to Contract

a. Legal criteria. Many of the issues discussed in the section above on competence to author a will apply to competence to contract as well. The traditional standards for competence to contract were oriented along cognitive lines: that the party to the contract had "such mental capacity . . . that he could collect in his mind without prompting all the elements of the transaction and retain them for a sufficient length of time to perceive their obvious relations to each other, and to form a rational judgment in regard to them." As with wills, the presence of "insane delusions" might be one bar to forming rational judgments. These standards have broadened somewhat in an effort to include among the incompetents grandiose manics whose acts are performed with good cognitive understanding and in the absence (often) of overt delusions, but whose distorted overassessment of their own abilities or wealth leads them to make contracts that are ultimately deleterious to them. Recognition of this problem leads to the formulation of standards that add an "appreciation" test (see Chap. 5, Sec. II) to the usual understanding test used in these cases. Alternatively, some formulations have approached a "but for" test of incompetence: If, "but for" the mental illness, the individual would not have signed the contract, it should be nullified.

Courts are generally willing to void contracts on the appeal of one of the parties that she was incompetent at the time the contract was signed, as long as several conditions are met: (a) the party's incompetence is proven in court; (b) the status quo before the signing of the contract can be restored (i.e., money or real property can be returned); or (c) if the status quo cannot be restored, then the contract was an unfair one. Whether the second party to the contract had knowledge of the incompetent status of the first party, and was thus presumptively taking advantage of her, may also play a role in determining if the contract should be voided. Scholars of contract law maintain that courts commonly conflate the questions of incompetence, undue influence, and fraud in deciding whether contracts should be enforced. Thus, the fairness of the contract is a more important factor than any objective data regarding the condition of the alleged incompetent party (see Suggested Readings, Green).

Incompetence to contract may preclude a person from deeding a gift of real property or chattels, or entering into marriage—actions with contractual qualities. Courts frequently assert that the standards they use to determine competence to contract are higher than those applied to testamentary capacity (i.e., a person may be incompetent to make every other kind of contract, but will be given the benefit of the doubt when it comes to making a will); careful review of both classes of cases reveals little support for this declaration.

b. Ethical issues in the assessment of capacity to contract. Some of those involved in the discussion of competence charge that any attempt to void a contract retroactively on the grounds of mental incompetence robs the alleged incompetent of the autonomy to make decisions for himself and is unfair to the other party to the contract, assuming that he acted in good faith. This argument is supported by the suggestion that many efforts to void contracts are made, not by the incompetent party, but by guardians—often family members—or heirs, who are concerned that the incompetent's actions have damaged their own interests. Although this may occasionally be the case, it is certainly too broad a remedy to propose abolishing all efforts to void contracts of incompetents. Even more than in the case of an invalid will, the incompetent person may stand to suffer substantial harm as a result of acts performed while mentally ill, and it is consonant with society's general interest in equity to void such acts.

3. Emotional Harms

Persons injured by another's negligence ordinarily have a remedy in suits brought under the law of torts. This principle underlies such familiar causes of litigation as medical malpractice. (See Chap. 4, Sec. II-A.) Traditionally, however, persons alleging that the harms they experienced affected their mental, rather than physical, well-being have faced strict limitations on their ability to recover damages. Limitations of this sort have been based on the belief that plaintiffs fabricate claims of emotional distress and that mental health professionals are not able to distinguish between real and malingered distress.

The earliest exceptions to the common-law rule that excluded claims of negligent infliction of emotional distress developed in the mid-nineteenth century under what came to be known as the *impact rule*. Under this standard, as long as a negligent act had led to a physical touching, resulting emotional distress could be compensable. The rationale seemed to be based on the assumption that emotional distress is more likely to occur after physical impact (but not necessarily physical injury), and thus such claims are probably more legitimate. An undercurrent of sentiment may also have existed in favor of saddling a defendant who demonstrably caused negligent physical impact with all the consequences of his actions. Nearly 20% of the states still follow this approach.

Many jurisdictions found the physical impact rule too confining, however, excluding what appeared to be legitimate cases of emotional harm. Efforts at liberalization led in several directions. The "ensuing physical injury rule" allowed claims when the emotional distress led to physical symptoms (e.g., neck or back pain, headaches, ulcers). Proponents of this modification seemed to believe that subsequent physical symptomatology increased the probability that the emotional distress was not faked—a dubious proposition, given that many of the physical symptoms identified in these cases are diagnosed solely on the basis of self-reports. The "zone of danger rule" permitted recovery of claims if the plaintiff had been threatened with physical harm but escaped (e.g., a driver who left a car stalled on railroad tracks seconds before an oncoming train reached it). Persons whose distress resulted from their observation of loved ones being injured were allowed, in some jurisdictions, to recover under a "bystander rule." As exceptions to the underlying restrictive doctrine proliferated, the rationale for the overall system became less coherent.

The ultimate step taken by some courts was the abolition of all distinctions between recovery for physical and emotional injuries. This is accomplished by the adoption of a "foreseeability rule": Liability can be imposed if the emotional distress was a foreseeable result of the defendant's behavior. Only a small number of states accepted this rule, although courts in all jurisdictions are likely to allow recovery when the emotional distress was intentionally inflicted (e.g., a landlord's harassment of a tenant).

From a psychiatric perspective, rules distinguishing between physical and emotional harms appear to be based on a number of untested empirical assumptions. These relate to the probability of emotional distress occurring in particular circumstances, such as after physical impact. Clearly, though, severe emotional distress can occur without any of the limiting conditions being present. Restrictions on recovery seem unfair and arbitrary in these cases. Adoption of a uniform foreseeability approach is desirable.

4. Mental Disability

Assessments of mental disability are probably the most common civil evaluations that mental health professionals are asked to perform. Work-related disability can result in eligibility for insurance or entitlement programs including workers' compensation, Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), private disability insurance, and veterans' benefits. Each source of compensation for disability has a distinctive history and unique rules that shape the nature of the required evaluation. Two of the largest programs are considered in this section.

a. Workers' compensation. Workers' compensation plans in the United States developed in the early twentieth century as a mechanism for dealing with claims of workers injured on the job. Throughout most of the nineteenth century, workers were generally precluded from recovering damages for job-related injuries in the courts by such legal doctrines as assumption of risk, contributory negligence, and the fellow-servant rule. As these barriers began to break down in the Progressive Era, industrialists and social reformers agreed on the desirability of a non-fault-based compensation system that operated outside of the courts. The result was the establishment by the states of mandatory insurance schemes that preempted recourse to the courts, providing some (often fixed) compensation for work-related injuries.

Early workers' compensation schemes focused exclusively on physical injuries. By now, however, a growing number of states have broadened their plans to cover some categories of mental disabilities induced on the job. Because there is still considerable concern that liberal rules regarding coverage of mental disorders will lead to difficult-to-detect malingered claims, most states still limit mental disability claims in some way. These parallel the restrictions on recovery for negligent infliction of emotional distress. They may, for example, require that a physical injury precede the alleged mental disability (the so-called physical-mental case), thus excluding claims based solely on mental stress. Alternatively, mental stress on the job alone may constitute an accepted causal basis for a claim, but only if it results in physical effects as well as mental disability (known as mental-physical cases). Finally, some states permit claims alleging that mental stress caused a purely mental disability, but usually with limitations such as the requirement that the causative factor be perceived as stressful by a reasonable person (called mental-mental cases).

Workers' compensation claims are adjudicated by disability-determination commissions set up by the states. Disability need not be total to be compensable. Although fault need not be shown (i.e., the question of whether negligence caused the injury is irrelevant), evidence must be introduced to establish the fact of disability and its causal link to the workplace. Both issues usually require testimony by mental health professionals.

b. Social Security Disability Insurance. SSDI is a federal disability program to which all workers contribute as part of their Social Security taxes. It is available only to workers who have paid into the insurance fund, and benefits are partially linked to prior payments; in this way it differs from SSI, which is available to all disabled persons, regardless of past work history. The program is administered by the Social Security Administration (SSA), which has created an elaborate set of requirements governing SSDI eligibility.

To be compensable under SSDI, a disability must result in an inability to work for at least 12 months. The disability must be total. If the claimant is capable of performing any work (not necessarily her former job) available to a substantial extent in the national economy, she is not disabled for the purposes of this program. The evaluation process for claims follows a fixed sequence. First, one of the classes of psychiatric disorders that are generally agreed to result in disability must be diagnosed. Then, the degree of restriction of function is addressed, focusing specifically on four categories: activities of daily living; social functioning; concentration, persistence, and pace in job-related activities; and history of deterioration or decompensation in work or work-like settings. If impairment in these four areas is not sufficient to warrant a finding of disability, the claimant's residual functional capacity can be considered.

SSDI claims are reviewed by state disability agencies, acting under contract to the federal government. Adverse findings can be appealed to the agency, then to an administrative law judge, to a national appeals board, and under certain circumstances to the federal courts. At one point in the 1980s, substantial evidence indicated that SSA did not follow its own regulations in processing mental disability claims and performing periodic reviews. The agency's aim appeared to be to reduce costs by eliminating hundreds of thousands of claimants from the rolls. Action by the federal courts and Congress resulted in revision of SSA procedures and restoration of benefits to many chronic mentally ill people who were unfairly denied them.

III. CLINICAL ISSUES

A. PROBLEMS OF AGENCY IN THE FORENSIC EVALUATION

The role of a forensic evaluator is most clearly distinguished from the role of a treating clinician by a dramatic change in agency (i.e., the entity for whom the mental health professional works). In the clinical setting, the mental health professional is primarily the agent of the patient, although the demands of the law (e.g., the duty to protect potential victims of a patient's violence) may sometimes induce situations in which conflicting obligations arise (see Chap. 4, Sec. II-A-3-e). Many of the most challenging aspects of dealing with mental health law for the clinician revolve around the need to remain primarily the agent of the patient.

In marked contrast, the forensic evaluator is most definitely *not* the agent of the subject of the evaluation, even when the subject is paying her bill (see Sec. III-A-2-b and Chap. 8, Sec. II-B-1). The purpose of the evaluator's involvement is not primarily to benefit the subject, although that may be an incidental outcome of her work, but to produce an objective report that is responsive to the question motivating the examination. That the evaluator's conclusions may be to the detriment of the subject is (or ought to be) taken for granted by all parties. Without this possibility, the evaluation would be of no use to either side in the case.

Although the topic's complexity is beyond the scope of this chapter and is covered in detail elsewhere (see Suggested Readings, Sec. H), the critical conflicts between the treater and the expert witness roles and the difference in agency can be summarized in clinical, legal, and ethical categories.

From the clinical viewpoint, the psychotherapist must enter into the patient's subjectivity to see the world through the patient's eyes; even in psychopharmacologic treatment, the patient's perceptions of symptoms and side effects are central to the work. The clinician's empathic engagement with the patient, however, represents a bias that (although desirable in therapy) is an obstacle to objective testimony in a legal context.

From a legal viewpoint, the treater's wholehearted advocacy for the patient constitutes an unacceptable partisanship in the adversary environment, which requires objective assessment and truthful testimony, regardless of its impact on the patient herself.

Most important, from an ethical viewpoint, the expert witness is not serving the welfare of the patient as does the clinician; rather he serves the different, but equally laudable, aims of truth, justice, and dispute resolution in society. The alteration in agency results in a shift in terminology as well. The subject of a forensic evaluation can no longer properly be termed a *patient*, at least in relation to the evaluator. Thus, the terms *subject*, *examinee*, or *evaluee* are used to describe this person's role. Although circumstances may arise in which the subject-patient boundary becomes blurred (see Sec. III-A-2), these situations are problematic at best, and are most successfully dealt with by attempting to reestablish the distinction.

1. Agency in the Pure Evaluation Model

a. General considerations. Under the pure evaluation model, evaluator and examinee are strangers who meet only for the specific occasion of the examination, evaluation, or consultation. The clinician's agency is quite explicit and should be made clear to the examinee at the outset of the conversation. Explicitness is also required about which side of the case has retained the examiner, as in this example:

> ***Example 1.*** The clinician invites the examinee into the office and shows him in which chair to sit. He then says: "Mr. Smith, I want to make two points clear before we start. First, because this is an evaluation related to the lawsuit you have filed, what we say to each other is not confidential in the same way it would be with a psychiatrist who was actually treating you. In other words, what we talk about might appear in writing and might come up in open court, if it's relevant to the case. Second, you need to know that because I've been retained by the attorneys for the defendant physician, I might be considered to be working on the opposite side of the case from you. However, I can only

> be useful if I remain objective. Thus, my testimony may help your case, hurt it, or have no detectable effect, and we won't know which until it's all over. We need to have that clear before we start. If you have any questions, please ask them now."

Alternatively, if the clinician were working for the evaluee/plaintiff's side, that would also be conveyed. Experience dictates that the clinician should make clear at the outset that this does not necessarily mean that the clinician's opinion will mirror the subject's opinion (see also Chap. 8, Sec. III-B-3).

b. Factors contributing to confusion over agency. Even with a conscientious effort made to apprise the subject that the evaluation does not have therapeutic ends and that the evaluator will not necessarily arrive at favorable findings, subjects often slip back into a therapeutic mindset. A number of reasons for this exist.

i. Regression. Except for persons with antisocial personality disorder and those overly familiar with the court system, the stress of being involved with the courts (whether one is mentally ill or not) may promote a regressive eagerness to find someone to be of help or to confide in; this attitude, of course, contributes to formation of a sound working alliance in customary treatment but may pose a problem in which the subject's openness may yield evidence damaging (in the sense of self-incriminating) in court.

ii. Transference. In concert with regression, transference operates ubiquitously, whatever the official parameters of the relationship. The mentally ill person sent for evaluation may turn to the evaluator as parent, lawyer, savior, advocate, ally, or simply "my clinician"; in doing so, the subject may draw on the images of figures from the past and consciously or unconsciously transfer feelings associated with them onto the present evaluator. Insofar as the evaluator does not serve any of those roles, these images are unrealistic.

Although such a process is not really preventable, its operation should be taken into account by the conscientious clinician in formulating her true posture in relation to the subject. The matter can be challenging, as illustrated in Example 2.

> ***Example 2.*** A psychiatrist employed by an organization always told his interviewees that what they told him would *not* be kept confidential from the organization; he noticed, however, that interviewees seemed to reveal more when told this. He realized that his frankness, although ethically required, was acting as a "seduction" to candor by conveying openness and honesty.

iii. Countertransference. As in the second case example at the beginning of this chapter, the evaluator may become personally involved—positively or negatively—with the subject, the alleged crime, or some aspect of the system or question. The homosexual defendant evaluated by a clinician who is also a gay rights activist, the rapist evaluated by a clinician who has been raped, or the defendant assessed for criminal responsibility by an evaluator who does not believe in the insanity defense all represent areas of possible contamination of objectivity that may be sensed by the subject, who may respond as if the evaluator is, or is not, on "my side."

iv. Wishful confusion. In contexts that are not devoted to treatment (e.g., research), subjects not uncommonly persist in seeing the relationship to the clinician as a treatment one, despite multiple efforts by researchers to clarify the truth of the situation. Under the stresses of litigation, forensic examinees may be similarly resistant—out of a wish for help combined with confusion about the situation—to grasping the new agency. Nonetheless, examiners are obliged to ensure the examinee's ongoing awareness of the true forensic situation.

2. Agency in the Mixed Evaluation and Treatment Model

Notwithstanding the desirability of distinguishing between treatment and evaluation roles, situations may arise in which these roles blur or merge.

a. Inpatient criminal forensic evaluations

i. Dealing with conflicts in agency. Criminal forensic evaluations are often performed on an inpatient basis in public mental health facilities. When this occurs, the facility is charged with the responsibility of conducting the evaluation and treating a psychotic, depressed, or otherwise disordered patient. When staff time is at a premium, as is commonly the case, there is a temptation to ask the treating clinician to serve also as evaluator, the assumption being that time will thereby be conserved; this is a problematic situation. The newly admitted defendant is being asked to confide, for treatment purposes, in the same person from whom she may have a right to withhold information, lest it be used to her detriment (e.g., information gathered during this inpatient evaluation may later be introduced in court at the time of sentencing, affecting the nature and severity of the punishment inflicted on the defendant). Even if the evaluee/patient is able to distinguish between the two roles filled by the clinician, there may be no way for her to resolve the conflicting messages the clinician conveys concerning the desirability of disclosure.

Dealing with this situation optimally involves splitting the clinical and evaluative roles, assigning one person to treat the patient and another to examine the evaluee. This separation is strongly recommended because of the conflicts noted. Information communicated to the treating clinician ideally should not be shared with the evaluating clinician, especially if the patient has not received appropriate warnings about the potential uses to which the information may be put, and hence has not given consent to the clinician's dual role. However, although desirable, that degree of separation may be difficult to accomplish in an inpatient facility in which patients become well-known to all members of the staff.

What if this solution is not feasible (e.g., the only clinician qualified to treat the patient is also the only one available to perform the evaluation)? The Code of Ethics of the American Psychological Association proscribes such approaches, whereas the comparable document of the American Psychiatric Association offers no opinion on the issue.

The American Academy of Psychiatry and Law offers this advice in its ethical guidelines, which emphasizes the negative effect on therapy, though without addressing the potential biasing effect on testimony of the previous treatment relationship (see Suggested Readings):

> A treating psychiatrist should generally avoid agreeing to be an expert witness or to perform an evaluation of his patient for legal purposes because a forensic evaluation usually requires that other people be interviewed and testimony may adversely affect the therapeutic relationship.

It is likely that these situations will occur in practice, regardless of the positions taken by professional organizations. Should they come about, the clinician embedded in them should attempt as clearly as possible to explain his dual role to the defendant—not a satisfactory solution, but perhaps the only one available. The clinician might say, "What you tell me will not necessarily be kept confidential from the court, because I am working for them in doing this evaluation. With that reservation, however, I will try to be as helpful as I can."

ii. Effects on treatment. The confusion of agency inherent in inpatient criminal forensic evaluation may also affect the treatment the patient/evaluee receives. Because patients sent from the court must be admitted regardless of actual clinical indications, treatment staff may resent their helplessness to influence the process. The presence of some patients on the ward—the glib psychopath who has convinced a judge he is "mental"; the alleged murderer, rapist, or child molester; and the moderately mentally ill defendant who would not be sick enough to be admitted on purely clinical grounds—may evoke in the staff feelings of resentment and the sense of being inappropriately used by the court.

This feeling may be intensified by the assertion that the patient is "not our usual type of patient." This latter view may be appropriate (e.g., for the malingering psychopath) or inappropriate (e.g., for the sizable number of truly mentally ill persons who arrive on a court order) but seems to derive in part from the sense of the patient's "belonging" to the court. Inexperienced staff members may use this altered agency to justify a "hands off" policy toward the patient, preventing them from engaging him in treatment and leading essentially to rejection of the patient. The burden falls on supervisory staff to redirect attention to the patient's needs and to the requirements of the task.

When a patient is accused of a dramatic, violent, perverse, or unusual crime, clinical staff may react to or recoil from the patient (sent on a court paper) as if she were already found guilty, although that adjudication remains undetermined. The patient, of course, may turn out not to be the criminal in question; even if caught red-handed, the patient may not be clinically any different from other patients whose illnesses are uncomplicated by criminal involvements. Thus, "preconviction" may deprive the patients of careful attention and objective assessment of their actual state. Again, the remedies are supervisory and consultative in nature.

b. Outpatient forensic evaluations

i. Dealing with the conflicts in agency. Even more common than the dilemmas created by inpatient forensic evaluations are the problems that arise in the outpatient setting. Clinicians who are treating patients are frequently asked to evaluate them for a variety of forensic purposes. Patients in treatment may request assessments of their ability to care for their children, their ability to work, the emotional harm they experienced from an accident, or even their competence to stand trial. The common assumption is that the treating clinician is privy to the information required to respond to all of these questions by virtue of previous therapeutic contact.

The problems of mixed agency are as troubling in outpatient forensic evaluations as in the inpatient setting. In addition, the necessity for the clinician to reveal her opinions concerning the patient's diagnosis, functional state, and the like, as well as the possibility that the clinician's opinion will not be favorable to the patient/subject, are likely to interfere with subsequent therapy. Furthermore, given the specialized nature of the data that are required to answer forensic evaluation questions, the underlying assumption that the clinician already possesses the needed information as a matter of course may be false.

Again, the best solution is to refer the patient for evaluation by another mental health professional. And again, this is not always possible, particularly when administrative agencies require evaluation by the treating clinician. Practitioners in this situation are advised to discuss the problem thoroughly with their patients, preparing them especially for unexpected or negative opinions.

The nature of the subject's claim on the clinician's loyalty is complicated by the previous relationship in which the subject has purchased the clinician's services and, presumably, allegiance. In the new situation, the evaluee may confuse this with being purchaser of the clinician's viewpoint; in consequence a subject may expect, in effect, to dictate the result of the evaluation to the therapist/evaluator.

> ***Example 3.*** Asked to evaluate a patient's fitness as custodian for a child, a therapist declined to take either an affirmative or negative position, explaining that he had never directly observed the patient in a childcare situation nor had he any access to sources of data on this point other than the patient's own (subjective) report. The patient became enraged, shouting, "I'm the one that's paying you, you're supposed to be on *my* side."

As Example 3 hints, the patient is not alone in experiencing the private practice version of the tensions inherent in altered agency. For the clinician deriving her livelihood from the patient's fees, the economic pressure to "give the patients what they want" can be considerable.

Although the matter becomes focused with greater intensity in the forensic situation, the issues are no different in substance from other kinds of pressures—personal, social, political, or economic—tending to corrupt the therapeutic position. The ethically concerned clinician calls the situation as she sees it on clinical grounds, selling only her skills in evaluation, not her conclusions (see Chap. 8, Sec. II-C).

ii. Effects on treatment. A variety of consequences ensue from an ongoing relationship that has experienced this alteration but then reverts to a treatment contract after the evaluation has been completed and the court satisfied. Not infrequently, the patient and therapist find it difficult to return to their former understanding.

If, for example, the clinician has cleared the patient to drive a car, little strain on the alliance should result. If the findings resulted in loss of license, loss of child custody, and the like, the strain may increase; Case Example 2 in Chapter 1 gives such an illustration.

The clinician has little tactical alternative but to treat the phase of altered agency as another event in therapy, with objective and subjective elements suitable for therapeutic exploration, and as a shared experience that had an impact on both members of the dyad. As the agent of the patient, the therapist's subsequent maintenance of neutrality may make it possible for the treatment process to resume its customary evolution. If the alliance cannot be repaired, termination and referral may be necessary.

It is quite possible, in today's litigious climate, that a clinician might be treating a patient who has been, or is concurrently, involved in litigation, or who becomes involved in a civil or criminal proceeding at some point during the treatment. In these instances, the treater must keep in mind several caveats.

First, as noted in Chapter 1, a patient who makes her mental condition an issue in a case (such as in a claim for emotional damages) has effectively waived privilege as to records of mental health treatment, because those records are considered to bear directly on the claim. In our consultative experience, attorneys sometimes neglect to so inform their clients; hence the treating clinician should remain alert to this issue and call it to the patient's attention.

Second, the treater should continue to exercise the discretion and objectivity important for all record-keeping and avoid tendentious or slanted record-keeping aimed at making the case for the client.

Third, the treater should remain aware of the significant emotional stresses of all litigation, even for those with a strong case in which they seem clearly in the right, and should assist the patient in coping with these stresses.

B. PERFORMING THE FORENSIC EVALUATION

In this section, the brief descriptions of approaches to specific forensic evaluations are designed to provide an overview for clinicians unfamiliar with them. More detailed guides to performing many of these evaluations can be found in the Suggested Readings, including attempts to devise structured assessment instruments. The Action Guide to this chapter contains suggested outlines for reporting the results of criminal and civil evaluations.

1. Approaches to the Evaluation of Competence to Stand Trial

The McGarry Competence Assessment Instrument, described earlier in Section II-A-3-a and cited in the Suggested Readings, represents an outline of critical issues in competence assessment. The following guidelines may help to convert this set of variables into a clinically efficient interview that has a logical flow and maximizes the examinee's performance on the evaluation. For each of the criteria given in the headings, a set of sample questions is offered that might be asked of the interviewee. The wording should, of course, be adapted to the personal style of the examiner and the examinee's linguistic, cultural, or intellectual idiosyncrasies.

Note that ignorance does not constitute incompetence. A naive patient may need to be instructed in the relevant data, then tested to assess comprehension. Some facilities use group classes or teaching videos for this educational purpose.

a. Informed consent. "We are talking today because I've been asked by the court to write a letter evaluating your ability to stand trial. You should be aware, therefore, that the purpose of our discussion is for me to be able to give my opinion to the court, not particularly to decide how you will be treated. You don't have to talk with me if you don't want to and you don't have to answer any particular questions, but if you do, it will make it easier for me to give the court an accurate picture of your ability to stand trial. You can talk with your lawyer first if you like. Keep in mind that anything you tell me will not necessarily be confidential, so you shouldn't tell me anything that you would not want the court to find out. Do you have any questions? Can I go ahead and ask you some questions?"

b. General level of function; establishment of rapport. "Can you tell me how you happened to come here?"

c. Appreciation of the charges. If the examinee, in response to question b, does not indicate that the admission was related to court proceedings, but indicates that he is being evaluated for treatment, or is present to take care of the other examinees, to do research, to learn how to be a doctor, or to save the world, the examiner should correct these impressions in the following manner:

"I understand that you were sent here by the court or brought here by the police. Can you tell me what it is they are accusing you of having done?"

Examinees occasionally will completely deny having done anything. Needless to say, it is fruitless to attempt to discuss an event that allegedly has not occurred. Thus, some time may be required to clarify that the examiner's job is neither to indict nor to exonerate, and that he is at this time not actually concerned with what was done, but merely with the examinee's understanding of the charges, whether true or false. Efforts should be made to see if the examinee can make this distinction.

d. Appreciation of range and nature of possible penalties. "I don't know what the court or the law is going to do in this situation, but if, for example, the court finds you guilty of having done [specify charges], do you know what they could do to you? What are some of the sentences you could get? What could the judge make you do?"

If the response to this line of inquiry is inadequate, it is acceptable to ask specifically about the possibility of prison, fine, probation, and the like or—as in other competence assessments—to perform some educational efforts in clarifying sentencing procedure and then asking for the examinee's predictions. This will also convey a sense of whether the examinee grasps the relative seriousness of the crime.

e. Ability to appraise likely outcomes. "What do you think is the most likely thing to happen when you get to court? What do you think will actually happen if you are found guilty? Do you think they might find you not guilty? Why or why not?"

f. Capacity to disclose to attorney available pertinent facts. "Could you describe for me exactly the things that happened just before you were arrested? What was going on that led to the police getting involved?"

It is understandable that the interviewee may refuse to respond to questions regarding the pertinent facts, because this could readily be incriminating; indeed, the examinee may have been explicitly instructed by his attorney not to discuss the offense. The examiner might respond:

"I can understand your not wanting to talk with me about what happened [I can understand your attorney telling you not to discuss what happened], but do you think you'll be able to discuss these things with your attorney? Have you been able to do that so far? Do you think you can communicate well with your attorney?"

g. Ability to appraise legal defenses available. "How do you intend to plead when they ask you if you plead guilty or not? Has your attorney given you any suggestions about this?"

If the response is inadequate, ask specifically about guilty, not guilty, NGRI, and other possible pleas.

h. Level of unmanageable behavior. The assessment of the level of unmanageable behavior is usually made on the basis of clinical observation of the examinee in the office or, for inpatient evaluations, on the ward. Some determination of the examinee's ability to control impulses or to remain silent when urged to do so is most relevant in this situation. In some circumstances, however, direct questioning may be useful. Data from corrections personnel may be extremely helpful.

"Do you think you'll be able to control your behavior in court? In the group therapy meeting, I noticed your tendency to shout out when you didn't like what people were saying. Because that could get you into difficulty, do you think you'll be able not to do that in court?"

i. Quality of relating to attorney. "Have you met your lawyer yet?"

[If the patient answers affirmatively:] "Do you think you'll be able to work with him [or her]? Does he [or she] seem like the kind of person you could cooperate with in this work?"

[If the patient answers negatively:] "Do you think in general you would be able to work with an attorney? Have you done so in the past?"

j. Planning of legal strategy. "I don't know what's really going to happen, but let's just say that your lawyer told you that he [or she] didn't think you stood a chance of being found innocent, but that if you pled guilty he [or she] could make a deal with the district attorney to get you off with only a suspended sentence. Could you go along with that? Why [or why not]? What do you have to gain? What do you have to lose?"

Affirmative or negative responses may be reasonable, depending on the circumstances. Attorneys occasionally fall far short of their duties to inform their clients of the full spectrum of possibilities, and some probing for the examinee's awareness of these issues may be extremely useful, as may some explicit teaching to remedy deficiencies in this area.

k. Ability to appraise the roles of various participants in court. "Have you ever been in court before? [This provides the background necessary for interpreting subsequent responses.] Can you tell me what the job of each of these people is in court: the defense attorney? the prosecuting attorney? the judge? the jury? the witness? Do you know the meaning of the oath?"

l. Understanding of court procedure. "Do you know which side presents its case first in court? What happens next? What does it mean when people call witnesses?"

m. Capacity to challenge witnesses. "Let's just say that one of the officers who arrested you is testifying on the stand and says that you did something that you knew you didn't do; what would you do about it? What else might you do?"

n. Capacity to testify relevantly. The capacity to testify relevantly is usually ascertainable from the interview and, in the case of inpatient evaluation, from more longitudinal observations by clinical or forensic staff. Sometimes, however, it will be useful to ask the interviewee directly about the possibilities:

"Do you think you'll be able to tell your side of the story in a crowded courtroom, with the judge staring at you and the prosecutor asking sharp questions? Do you believe if the attorneys pressure you a bit, that you'll be able to keep your cool?"

Recall that many defense attorneys in criminal cases refrain from letting defendants testify; nevertheless, this area should be explored.

o. Manifestation of self-serving versus self-defeating motivation. The manifestation of self-serving versus self-defeating motivation is often evident either from the statements the interviewee has made in response to earlier questions or from contemporary observations on the inpatient unit. Most commonly, depressive guilt is the significant pitfall in this situation, because individuals charged with crimes or incarcerated experience depression even without preexisting illness. A masochistic posture is also problematic.

"If you could pick the result you wanted, how would you like to see this all end up? What do you think would be the best outcome?"

p. Interviewer responses. In the face of inadequate responses to Sections c, d, e, g, k, l, and m, the interviewer should make an attempt to educate the interviewee in all relevant areas. Follow-up questions should then assess the examinee's educability. At times, the teaching and reassessment should occur on repeat evaluations, because some examinees may be in the process of gradual recovery from psychotic states. Of course, an appropriate treatment regimen may restore competence.

q. Assessment. Significant impairments due to mental disease or defect on more than one question (or the interviewee's inability to be educated concerning more than one question) should raise substantial doubt about the defendant's competence to stand trial. Moderate impairments on several questions should have a similar effect. Input from the attorney may be crucial to the evaluation; for example, accurate evaluation of a defendant who claims to have a good relationship with his attorney, but who is said by the attorney to be paranoid and uncooperative, may be possible only if the attorney is contacted for this information. The interviewer should also keep in mind that various legal strategic decisions (such as not having the examinee testify at all) may compensate fully and appropriately for minor defects in the sophistication of the examinee's grasp of courtroom issues. Hence the likely demands on the defendant in the context of the particular strategy being pursued may also be appropriate to raise with the attorney.

r. Structured assessment approaches. As part of the recent trend toward structured assessments in forensic psychiatry and psychology, a number of assessment tools for competence to stand trial have been developed. These generally have the advantage of insuring that no critical part of the evaluation is overlooked, and of providing some quantitative measure of performance. When additional data become available to permit evaluators to determine where a particular evaluee lies on the spectrum of performance, these tools will have additional utility. But, at this time, no assessment instrument can be said to replace the need for a clinical evaluation of the sort outlined above, and all may be susceptible to challenge on admissibility grounds if relied upon by an examiner. (See Suggested Readings, Zapf and Viljoen).

2. Approaches to the Evaluation of Criminal Responsibility

In performing the evaluation of criminal responsibility, it is important to recall the intrinsic difference from the examination for competence to stand trial. The latter examination is like a snapshot; the clinician need only know what the actual charges are and something about the subject's clinical history to perform a reasonable assessment of her competence to stand trial. Criminal responsibility evaluation, on the other hand, is like a movie, and may begin as early as childhood and should capture a longitudinal view of the examinee, including the totality of the examinee's clinical history (with focus on the period immediately surrounding the alleged crime).

The initial steps of attaining informed consent are similar to those for competence to stand trial. The examinee's capacity to understand the warning about nonconfidentiality becomes critical, because in describing material related to the alleged crime, the examinee confronts directly material likely to lead to self-incrimination and which in some jurisdictions may be susceptible to subpoena by the prosecution, even if elicited by an examiner for the defense. Any question about the examinee's competence to understand this aspect of the warning requires immediate termination of the interview and consultation with the defense attorney.

Once acceptable consent has been obtained, the examinee should be interviewed in great detail concerning her behavior on the day of the alleged crime and all relevant mental states, as well as matters impinging on mental state (e.g., intoxication, medications, fatigue, sleep disturbance). Detailed descriptions from contemporaneous observers, including statements of victims, bystanders, arresting officers, and family members, must be obtained for external corroboration because the heart of the forensic evaluation is its transcendence of the examinee's unsupported self-report (see Sec. e, below). The examiner should review this material, whenever possible, before assessing the defendant.

Particular attention should obviously be paid to assessment of conditions that are most likely to impair the understanding of the nature or wrongfulness, or both, of one's acts and to impair the ability to control one's behavior. Typical examples of these conditions include dementia; delirium; grandiose, persecutory, or other paranoid delusions; command hallucinations; moderate-to-severe mental retardation; psychomotor epilepsy; dissociative states; and intoxications of various kinds (although intoxication is usually not considered exonerating if voluntary).

In addition to these determinations, the examiner should elicit a full clinical history from the defendant, as is usually done in the treatment context. This should include personal, social, psychiatric, and medical histories, as well as a current mental status examination. The examiner should compare the defendant's responses to questions concerning mental status at the time of the alleged crime with expected responses based on his total evaluation of the examinee. Allowance must be made for significant time lapse between examination and crime.

Clinicians should investigate specifically the areas of mental functioning at the time of the crime that are relevant to the standard of criminal responsibility used in that jurisdiction (see Sec. II-B-2).

a. M'Naghten test. The examinee should be interviewed to determine his understanding of the nature and wrongfulness of the criminal act (the M'Naghten test). Issues of wrongfulness are usually focused on the legalistic sense of the concept (i.e., *wrong* means illegal), but some jurisdictions focus on the broader concept (i.e., *wrong* means morally wrong). The defendant who says, "Murder is wrong, but killing an agent of the devil is right," poses special problems for the fact-finder when the narrower test is applied.

Scholars in this area suggest three immediate grounds for suspicion as to the validity of an insanity claim. These are efforts at flight, efforts at concealment of the crime, and efforts at concealment of evidence. For example, a murderer who set a fire to incinerate the body, threw the gun into the river, and fled to another state might be suspected of awareness of the wrongfulness of his act.

b. Irresistible impulse test. Assessment focuses on ability to control behavior in the irresistible impulse test. This is a sensitive and complex evaluation because, as the APA position statement on the insanity defense noted, "The line between an irresistible impulse and an impulse unresisted is probably no sharper than the line between twilight and dusk." To be considered irresistible in many jurisdictions, an impulse need not be sudden. A person who ruminates for months about a delusional perception of malevolence by a colleague at work, until he can no longer control the impulse to retaliate, may still qualify for this plea. When successful pleas are made under this test, they usually involve mental disorders that induce a subjective sense of loss of volitional control, including psychotic disorders with command hallucinations and delusions, dissociative disorders, and anxiety disorders.

c. American Law Institute standard. The ALI standard differs from the M'Naghten test, in part in that it seeks not merely understanding or knowledge but appreciation of the wrongfulness of the criminal act. Under this standard, affective components that may cloud a person's judgment may be highly relevant. Note that only substantial incapacity, not a total lack of appreciation, is required. The same is true for the examinee's ability to control her behavior. However, a defendant choosing not to control behavior or seeing no reason to control behavior does not manifest the requisite "substantial incapacity" to control behavior. The fact-finder, whether judge or jury, ultimately determines what degree of incapacity qualifies as "substantial."

d. Federal insanity standard. For the hybrid insanity standard, applicable in federal jurisdictions, the examiner must assess the ability to appreciate the nature and quality or the wrongfulness of the act.

e. Role of outside observers of the crime. Whenever possible, the clinician should make every effort to contact and interview others who have witnessed the events in question. Particular attention should be paid to the elements of corroboration and disconfirmation supplied by these other sources; efforts should be made to correlate witnesses' accounts of the examinee's behavior with the examinee's report. Whenever possible, family members or significant others should be interviewed to ascertain their observations of the examinee's behavior shortly before, during, or after the events in question. The clinician's diligent search for such data may assist to some degree in minimizing the effect of the major inherent problem in the assessment—namely, that it is performed retrospectively, often considerably later in time, by an evaluator who was not an eyewitness to the events in question.

3. Approaches to the Evaluation of Testamentary Capacity

Foremost among the difficulties in performing an assessment of an individual's testamentary capacity is that, in the usual case, he is already dead. (Some testators, however, anticipating a challenge to the validity of their will, may request a competence evaluation at the time they endorse or alter their will to make later attempts to overturn their disposition of their property more difficult. Occasionally, testators videotape the examination for testamentary capacity, thus leaving a durable record.) The evaluator is forced to speculate on the basis of such information as may be available from written materials and the testimony of friends and relatives (who may be far from disinterested) as to the deceased's mental state. Sometimes records are available from the testator's primary care physician, but the utility of these is frequently limited by their failure to address the key determinants of competence from a forensic perspective. (See Sec. II-C-1 for a discussion of the relevant legal standards.) In many cases, it is impossible to draw a reasoned clinical forensic opinion from the available data. Even when reports exist of flagrant symptomatology, the conclusion that the symptoms directly influenced the action of writing the will can be reported only in probabilistic terms. Any attempt to draw firmer conclusions leaves the clinician open to devastating cross-examination.

As with other forensic determinations (see Sec. II-A-3-b), including those considered subsequently in this section, the examiner may be tempted to answer the ultimate question rather than merely to report the clinical findings. Pressures to testify in this way may be great but should be resisted, in favor of leaving the drawing of legal conclusions to the court.

> ***Example 4.*** A wealthy but probably chronically psychotic woman bequeathed most of her estate to a local university, except for several thousand dollars left to her only son. The son challenged the will on the basis that his mother was mentally ill and that his mother's apparent hatred of his (the son's) wife was delusional in nature; the daughter-in-law was regularly accused of not feeding or actually poisoning the son, not taking care of him, and other adverse behaviors. The forensic assessor agreed that the testatrix's view of the daughter-in-law probably did exceed typical maternal views of the inadequacy of their sons' wives, but the three essential criteria were not affected by this belief nor by the mental illness itself. Moreover, the son did receive some concrete inheritance (although not the amount to which he felt entitled)—a point that proved the testatrix's awareness of the natural heir of her bounty.

The matter of undue influence in making a will is one of the most subtle and difficult questions put to the forensic examiner. Influence is considered undue when a testator—who usually has some degree of impairment that renders him vulnerable to influence—is pressured to write or alter his will, to the advantage of the person applying the pressure. Consider the case of a nurse hired to care for a dying millionaire who persuades him to alter the will in her favor; her tactics may include restricting contact with family members, speaking disparagingly about them, intercepting their communications, and similar maneuvers. In contrast, a husband in a second marriage may be pressured by his present wife to alter the will in her favor, to the exclusion of his ex-wife. Here, one might argue that the influence of a wife over her husband is "due influence," in the sense that people commonly allow themselves to be influenced by loved ones whom they desire to please in a host of different matters. The inherent distinctions require careful exploration of various parties' viewpoints to identify the influence involved and distinguish due from undue. In some circumstances, the examiner must be content to state that no definitive answer is possible. And in all cases, of course, the ultimate determination as to whether undue influence was exerted is in the hands of the courts.

4. Approaches to the Evaluation of Competence to Contract

Because the signing of a contested contract generally occurs at a time far removed from the challenge, the examining clinician faces the problem of determining an individual's mental status retrospectively. Unlike evaluations of testamentary capacity, in evaluations of the competence to contract, the alleged incompetent is usually still alive and available. In this respect, the evaluation is not much different from that for criminal responsibility (see Sec. 2, above), with its attendant problems, except that the evaluation of competence to contract might be called an assessment of *civil responsibility*. A good lawyer for the party requesting the examination will guide the evaluator through the legal requirements that are specific to that jurisdiction, enabling him to focus the examination on the most relevant aspects of the individual's mental state. (See Sec. II-C-2 for a discussion of the relevant legal issues.)

5. Approaches to the Evaluation of Emotional Harm

Assessment of emotional harm requires attention to several issues related to the legal standards (see Sec. II-C-3). A thorough psychiatric evaluation is essential, similar to the kind that would be undertaken for a patient entering treatment. In addition, particular attention should be paid to the evaluee's mental state as it existed before and since the alleged tortious act. The plaintiff need not meet diagnostic criteria for a particular mental disorder to recover for emotional distress, although the existence of a clear-cut diagnosis probably enhances the chances of a favorable verdict.

Some conclusions must be drawn in these cases about the causal relationship between the alleged tortious act and the plaintiff's subsequent mental condition. Posttraumatic stress disorder (PTSD) has become a popular and controversial diagnosis in these cases, because it (along with adjustment disorders) is one of the few diagnostic categories that carries the implication that symptoms are related to a particular event (see Suggested Readings, Sec. I).

Preexisting mental disorder can lead to especially difficult evaluative problems. Because compensation is available only for disability caused or precipitated by the tortious act, the cause of the ultimate emergence or worsening of psychiatric symptoms is important to the evaluation. Yet, the connection between environmental stresses and subsequent mental disorder is a controversial one and, in the individual case, may be impossible to ascertain. Clinicians must be wary of going beyond their expertise in this area.

Some efforts in research aim at distinguishing among multiple traumata as causes of the emotional harm by use of trauma scripts and physiologic measurements (see Suggested Readings, Pittman and Orr); these efforts must be considered preliminary at this point.

Given the financial rewards available to the successful plaintiff, malingering must always be considered. Careful attention must be paid to the internal consistency of the subject's report and its correspondence to known psychiatric syndromes. As in the criminal realm, corroboration of reports by third parties, including family, friends, neighbors, coworkers, and supervisors (although each of these may have incentives of their own), can be crucial, as can review of documentary evidence such as evaluations of work performance.

Evaluators whose findings are favorable to the side retaining them can expect to be asked to write detailed reports of their findings, to be deposed by the opposing side, and to testify at trial.

6. Approaches to the Evaluation of Mental Disability

a. Workers' compensation. As with all disability evaluations, the workers' compensation assessment differs from the ordinary clinical evaluation in that it focuses attention on functional, not merely symptomatic, issues. (See Sec. II-C-4 for a discussion of the relevant legal standards.) A full assessment requires a description of the onset of the mental disorder and its connection to the work environment, documentation of the subject's current mental state, some prognostic judgment, and evaluation of the impact of the subject's symptoms on his functional capacity. The importance of this last item cannot be overemphasized, because it is the key to the disability determination process. Given the well-known lack of correlation between diagnosis and functional state, the existence of a psychiatric disorder, even of some severity, does not by itself establish disability. Only a consideration of the evaluee's actual abilities addresses that issue.

Functional capacity can be estimated by careful examination of the subject's history regarding daily activities, including those related to meeting basic needs, handling money, managing interpersonal relationships, and recreation. Attempts to work, or efforts at performing in work-like situations, are especially relevant.

The workers' compensation evaluation also raises issues of the veracity of the evaluee's reports that are much more salient than in the ordinary clinical situation, in which rewards for exaggerating symptomatology are usually less prominent. Precautions similar to those suggested for emotional distress evaluations should be observed (see Sec. III-B-5). As compensation is dependent on demonstrating a causal link between an occurrence at work and subsequent disability, this issue must be carefully considered. Needless to say, familiarity with the requirements of the law in the relevant jurisdiction, especially with regard to proving causation, should be assured before doing the evaluation.

b. Social Security Disability Insurance. Unlike workers' compensation evaluations, assessments of SSDI eligibility need not address causal factors (see Sec. II-C-4-b). Diagnosis is important; Social Security Administration (SSA) guidelines begin by inquiring into whether specified disorders are present. Reports should include sufficient detail concerning symptoms to allow corroboration of the diagnosis in the review process. Standard *DSM-IV* criteria should be used. A description of the history and current status of the mental disorder must be followed by consideration of the disorder's impact on the evaluee's ability to function at work. This should be structured to address the four areas specified by the regulations that are noted in Section II-C-4-b. Because the subject's residual functional capacity may become an issue in the review of her claim, data addressing the areas identified by SSA as relevant should also include understanding and memory, sustained concentration and persistence, social interaction, and adaptation. Documentation of the existence of disability over a 12-month period or a prognostic statement concerning its likely duration for 12 months in the future should also be included. The APA has developed useful guidelines for the presentation of SSDI evaluations (see Suggested Readings, Sec. D).

7. Approaches to Evaluating the Standard of Care

As noted in Chapter 4, the central question in malpractice actions is whether the treatment given to the patient in question met the standard of care. This section considers how the forensic assessor determines this criterion.

a. Sources of awareness. How does the forensic examiner become aware of the standard of care for practitioners who may have worked in another state, in a different setting, and at an earlier time? Several possible sources for this awareness exist. First, the examiner's own practice is a starting point; however, the expert must guard against using his own practice as the sole benchmark, because the criterion in question is the practice of the *average practitioner* in a similar situation, a term that may not apply to the forensic examiner. For example, the defendant may have been practicing in a small, rural community whose resources differ considerably from those of the academic urban setting in which the expert may work.

A second source of awareness of the standard of care is national meetings, such as the annual meeting of the APA, and national journals, such as the *American Journal of Psychiatry*; these sources serve as forums in which the care of patients is discussed and regularly updated. Developments, treatment principles, and research findings are shared among the national clinical community. The expert should remain alert that the newest developments are time-sensitive and may not have diffused into common practice during the treatment in question. For example, tricyclic antidepressants were the drug of choice for decades before being largely displaced by selective serotonin reuptake inhibitors; that displacement did not occur at one specific point, but over a period of years. The expert is challenged to identify the point at which the standard of care favored selective serotonin reuptake inhibitors as the drug of first choice in treating depression and to correlate that point with the time of the treatment in question.

In those few jurisdictions that still use the "locality rule" (Chap. 4, Sec. II-A-2-c) the expert must demonstrate awareness of practice in that specific area, rather than awareness of national practices. Possible sources of this awareness are interviews of local physicians and review of professional literature from that area.

Third, another source of information about standards of care is the growing number of practice guidelines developed by professional associations and other groups. If properly developed (i.e., with broad input from the field), such guidelines can provide evidence of what some substantial proportion of the profession considers to be adequate care. It must be remembered, however, that even well-designed guidelines do not necessarily address all possible approaches to a clinical issue. In addition, guidelines may be viewed as recommendations for "best practices," rather than reflections of the practice of a typical clinician, and as not material to the determination of negligence. Thus, although a defendant in a malpractice action may rely on conformance with published practice guidelines as evidence of having met an acceptable standard of care, failure to follow a published standard does not imply that a clinician has committed malpractice. Rather, the defendant has the option of demonstrating that he conformed to some other standard that at least a respectable minority of the profession would endorse.

Fourth, the database of the case itself (i.e., the total documentation and interview material available as a result of discovery in the litigation) may provide evidence that certain treatment approaches were within the standard of care. Consultation on the patient during his treatment by colleagues, peers, or experts; the use by contemporary practitioners of similar or identical medications and therapies; and record-keeping that outlines and validates the treatment rationales used might constitute evidence that the treatment met the standard. Conversely, the mere absence of these factors does not necessarily indicate that the treatment fell below that standard, because other factors (e.g., the inherent clinical soundness of the decisions) may come into play.

b. Applying the standard. The standard of care must ultimately be applied to the case by judge or jury; however, the forensic examiner must reach an independent conclusion before agreeing to testify in the case and must be prepared to support that conclusion by clinical evidence.

More than any other element in the database, the medical record is the critical factor in documenting what practice was employed, what reasoning was used, what treatment was given, and what effects ensued. The quality of the documentation does not necessarily correlate directly with the quality of the treatment, but fact finders are not uncommonly influenced by the former in determining the latter.

The examiner should look for internal consistency among the various observers of the patient, between observations and interventions, between decisions and orders, and between patient reports and those of family members or previous treaters. In fact, the attempt to obtain previous records is itself an important element of sound practice.

In her search, the examiner should be aware of the pitfall known as *hindsight bias,* the distortion of viewpoint caused by knowledge of the outcome of a case (see Chap. 8, Sec. III-B-2). The examiner should enter into the contemporary mindset of the treaters, correlating what they knew with when they knew it and what they then decided to do.

Because the record is necessarily a summary and not a completely inclusive account, the examiner must supplement the record with deposition testimony, witness reports, and other materials. The consistency of such data with the contemporary record should be closely scrutinized; the clinical logic of treatment rationales provided in subsequent deposition testimony should be compared with contemporary progress notes.

Finally, the examiner should keep in mind the base rates of clinical events to maintain perspective on the foreseeability and preventability of adverse occurrences and to avoid simplistic, hindsight-driven conclusions. For example, a depressed outpatient commits suicide. Was the suicide foreseeable? The expert should recall that most persons who commit suicide are, indeed, depressed; but most persons who commit suicide have not consulted mental health practitioners; and the significant majority of depressed persons—and even of persons with suicidal intention—who do consult practitioners do not commit suicide. Similar actuarial contexts should be taken into account for violence against third parties, addiction to prescribed medication, and other low base-rate events.

c. Assessing causation. Even when clinical practice has been substandard and thus negligent, the plaintiff (and, by extension, the plaintiff's expert) must demonstrate the direct causal link between the negligence and the alleged harms, damages, or injury (see Chap. 4, Sec. II-A-1-d). Plaintiff and defense experts must take into account the patient's own actions, competence, and ability to inform caretakers about his condition; the acts of subsequent assessors or treaters; the natural course of the illness; and other causal factors that might have interacted with, or superceded, the defendant's negligence as the cause of the harm. Especially in cases with multicausal influences, this determination may be extremely challenging.

d. Determining harms. The process of determining harms in malpractice cases is comparable to that for emotional injuries (noted in Sec. III-B-5). Distinguishing emotional harms caused by the original negligence from the emotional stresses of the current litigation itself is challenging; the expert should be prepared to be questioned about this point. Independent witnesses, family, coworkers, and others may provide information useful in making this distinction. Since harms in malpractice cases translate into damages—the actual monetary value of the case to the plaintiff—special care should be devoted to realistic appraisal of this element. For example, if harm is attributed to the treater's negligence, rather than the progression of the plaintiff's illness, the projected costs of remedial psychiatric treatment, absent wages, loss of consortium and other damages, which may continue to accrue indefinitely, will be apportioned to the defendant.

C. TECHNICAL CONSIDERATIONS

1. Intrusions on the Privacy of the Forensic Examination

Clinicians agree that the forensic examination is best accomplished with patient and clinician alone together, absent concerns for the clinician's physical safety. However, occasionally requests are made to have other individuals (most commonly the patient's attorney, but sometimes another person) present or participating in the evaluation.

> ***Example 5.*** A female patient bringing suit for boundary violations and sexual misconduct by a previous therapist was being evaluated by the defense's male forensic expert. Not only was the session videotaped, but a request was made and granted that the patient's current female therapist be in the room during the evaluation to increase the patient's comfort. It was agreed, however, that the patient's therapist would sit behind the patient, out of camera range, and thus be unable to signal or otherwise communicate with the patient, or indicate her responses to subsequent viewers of the tape. The interview proceeded in a reasonable manner.

As many forensic practitioners can attest, however, considerable problems may exist with an attorney or other third party being present during a forensic examination. Interviewees may tend to play to the third party, pitching their material to advance their cause and make their case. Alternatively, the third party, especially a lawyer, may interrupt the evaluation, coach the examinee in some manner, or attempt to influence the subject's responses. The interviewee's consequent manner of relating may lower the reliability of the interview. All parties involved must recognize that having an attorney present for the interview does not represent a cost-free way of protecting due process rights. At least one court (*U.S. v. Byers*) has agreed.

The use of recording devices in the evaluation raises similar issues, but experienced forensic evaluators differ on the magnitude of their impact. Some clinicians routinely record all their evaluations, as a check on the reliability of their observations. Others believe that audiotaping or videotaping an assessment inevitably contaminates the evaluee's responses. Some empirical data have been generated regarding this question, but they are not conclusive. At this point, it is most reasonable to suggest that each evaluator follow the practices with which she is most comfortable, because that is likely to increase the skill with which she performs the evaluation.

Note, for perspective, that the American Academy of Psychiatry and Law (AAPL) Task Force on Videotaping of Forensic Psychiatric Evaluations has offered the following recommendations (see Suggested Readings, Sec. E-4):

1. Given the state of the research, feasibility, and possible adverse effects on the examiner and examinee, AAPL does not support a blanket rule of requiring videotaping in all forensic interviews. The Task Force finds the option of videotaping to be an ethically acceptable medical practice.
2. AAPL recognizes the existence of other legal and professional sources (statutes, case law, and practice guidelines) that may require or recommend videotaping in certain circumstances [e.g., (a) interviews in which hypnosis is used or (b) when children are being evaluated for sexual abuse].
3. Videotaped forensic interviews done by trainees and experienced experts are extremely useful teaching materials. All forensic training programs should consider the educational use of videotaping equipment.

2. Writing the Evaluation Report

In many jurisdictions, specific questions or criteria are delineated for the forensic assessment. In such cases, the clinician's report should narrowly address those criteria with specific evidence from the evaluations. Some critical principles to keep in mind in reporting findings to the court are

1. The importance of identifying the databases and sources from which the information was derived and the evaluator's assessment of the reliability of those sources.
2. The need to qualify findings appropriately (e.g., difficulty of retrospective assessment, uncooperativeness of the defendant, conflicting statements of eyewitnesses).
3. The value of keeping a focus on the clinical findings, with the ultimate question of, say, criminal responsibility being left to the court. The sample reports in the Action Guide (see Sec. VI) provide models for the task (see also the Action Guide for Chapter 8).

3. Review of Findings with the Evaluee

Although the evaluator is not the subject's agent, there may be sound clinical reasons for going over the conclusions with her, subject to the agreement of the party who has requested the evaluation. Some clinicians actually read the report to the subject, others discuss the findings more generally. This manner of including the subject in a process to which she is often a bewildered bystander demonstrates an ethical concern for the subject consistent with high standards of practice. The clinician should explain, if asked to do so, any areas that are unclear to the subject. The subject's agreement or disagreement should be considered respectfully, but should not of course influence or alter the findings.

Although a clinician may have some trepidation about being the bearer of bad tidings, this open approach may be desirable because it includes the subject as a responsible participant in the process, regardless of agency. Additionally, such anticipatory discussion may protect the subject somewhat from the traumatic effects of hearing the material in a public courtroom for the first time without preparation (see Suggested Readings, Strasburger). This approach, of course, may be more feasible when the evaluator is working for the subject's attorney, rather than for the opposing side. The impact of the HIPAA standards for disclosure of health-related information to patients on forensic evaluations has yet to be fully clarified; but a strong argument can be made that the regulations may require forensic evaluators who are subject to HIPAA (see Chapter 1) to disclose the records derived from assessments to evaluees at their request.

D. ASSESSMENT OF MALINGERING

One of the most fundamental differences between clinical and forensic assessment is highlighted by the problem of malingering. The clinician treating a patient in therapy must always begin by attempting to see the world through the patient's eyes—noncritically, nonchallengingly, nonjudgmentally. A patient's description of the insensitive boss, the sadistic parents, the unresponsive spouse, or the ungrateful children should always be taken first at face value. The treating clinician must attempt empathically to adopt the patient's world view as her own.

In contrast, the forensic expert must always assume that an examinee may cherish covert goals, under the general rubric of "secondary gain," which inevitably attend most forensic evaluations. The defendant charged with a heinous crime may find it greatly in his interests to be found incompetent to stand trial, thus postponing time in court until the memories of witnesses fade, or to be found criminally nonresponsible, because prolonged hospitalization, though far from a picnic, may be more comfortable than prolonged incarceration in prison. The forensic expert appropriately questions every element of the data and remains attuned to the need for corroboration from external sources—the more unbiased and disinterested, the better. In sum, the treating clinician should be credulous; the forensic expert should be skeptical.

Malingering refers to the deliberate and conscious simulation of symptoms, disorders, or incapacities that are not authentic; this could be termed *clinical lying*. The importance of this issue has generated a small literature (see Suggested Readings, Sec. F) whose rudiments should be familiar to forensic clinicians. Although the subject cannot be treated exhaustively in this text, knowledge of some common characteristics of malingering may be helpful to the forensic evaluator.

1. Contemporaneous Disconfirmation of Claimed Symptoms or Behavior

As one aspect of malingering, a defendant may claim to have been in a complete mental fog during the commission of a particular alleged crime. The testimony of contemporary witnesses, however, may portray this defendant as having evinced clarity and decisiveness, and as having made attempts to conceal evidence of the crime, as well as efforts to escape apprehension.

2. The Words But Not the Music

Observers of malingering frequently look for evaluees' verbal subscription to symptoms without manifestations of the ordinarily attendant behavior. Thus, an evaluee claiming psychotic symptoms characteristic of schizophrenia may be perfectly cheerful, amicable, and easy in relationships with evaluators and staff—a mode of relating usually inconsistent with that disorder.

3. Subscription to Atypical Entities

Just as hysterical conversion symptoms often reflect a layperson's perception of neurology (and thus display glove or stocking anesthesia, findings inconsistent with actual denervation), so malingered psychotic symptoms may reflect a layperson's conceptions of psychopathology. Thus, individuals may endorse highly unusual or uncharacteristic symptomatology, as in a subject who responds affirmatively to the question, "Have you ever had the belief that automobiles are members of organized religion?" (example courtesy P. Resnick, M.D. and R. Rogers, Ph.D.).

4. Inconsistency of Results

On mental status examination, a subject may manifest a highly inconsistent picture (e.g., concentration may appear high on one aspect of the mental status examination, yet low on another). Such inconsistency is especially meaningful when the disparity directly reflects the examinee's awareness of what is being tested for; thus, an examinee may be able to follow a reasonable conversation (showing concentration ability), but claim inability to perform even serial subtraction of threes (a formal test of concentration).

Although it is a truism that malingering should be considered in every forensic examination, the diagnosis is, nevertheless, a stigmatizing one; hence, it should always be put forward with tact and respect for the astonishing diversity of clinical conditions and the recognized limitations of available examination methods. Data emerging from the patient interview should be augmented, when possible, with observations by other individuals (e.g., nursing staff for inpatient evaluations), particularly observations obtained when the individual is ostensibly unaware of being observed (e.g., the subject who appears catatonic and monosyllabic during an interview might be observed to be chatting amicably with an attractive patient of the opposite sex on the ward). Such information should be correlated with the evaluator's opinion based on direct examination. Whenever possible, malingering should be an affirmative diagnosis, rather than merely a default position.

Structured instruments, including the Minnesota Multiphasic Personality Inventory, may be useful in detecting malingering in some cases (see Suggested Readings, Sec. F, Rogers). One such instrument is the Structured Interview of Reported Symptoms (SIRS), consisting of 172 items organized along a number of scales, requiring approximately an hour to administer. The test is designed to permit systematic review of such phenomena as exaggerated, overreported, atypical, or absurd claimed symptoms. Research on the instrument itself has demonstrated solid sensitivity and specificity in various populations. Given the stigma of a diagnosis of malingering and the risk of subjective influences in assigning that label, the SIRS provides greater objectivity and reliability than simple interviewing; thus, it may usefully bolster the clinician's conclusions in a sensitive area. Forensic clinicians should be familiar with the instrument and should consider its use in cases of suspected malingering.

IV. PITFALLS

A. RESCUE

As in the second case example, for reasons deriving from the subject or clinician, the clinician may misconceive her mandate as one that asks her to rescue the hapless subject from the grinding wheels of the uncaring judicial bureaucratic machine. Although laudable in spirit, such an approach rarely does the subject an actual service and may interfere with the credibility and reliability of the forensic evaluation process, as well as with the smooth functioning of judicial due process for the subject's protection. The subject in such evaluations is best served by scrupulous care in the mandated determinations.

B. REFORM

Inexperienced or overzealous clinicians, dismayed at the delay, duplicity, and entanglement of the criminal justice system, may misguidedly attempt to reform it through the medium of the court-ordered evaluation. One clinician-trainee, annoyed at "doing the court's dirty work" in evaluating defendants ostensibly referred for competence-to-stand-trial evaluations but really being sent for treatment and disposition, suggested finding every evaluee competent and untreatable (regardless of their real condition) with the goal of flooding the courts with returned defendants without dispositions; such a move would allegedly force public attention to, and reform of, the failings of the judicial system.

Besides being naive—judges are fully capable of (and may be disposed to) sending defendants en masse back to hospitals, ignoring all findings and recommendations—such an approach converts the evaluee into cannon fodder hurled against nearly impregnable walls. The subject's individual situation must ever be the clinician's focus; on her own time, in political activism, or in the voting booth, the clinician should exert her efforts toward reform of the legal system by legislative remedies.

C. REQUIREMENT TO MAKE A FINDING

Clinicians asked to perform an assessment for criminal responsibility may be in danger of becoming preoccupied with the need to find relevant data to make the case for nonresponsibility. It is essential to recall that the clinician is an objective observer who should hold himself apart from the defense attorney's unequivocal need to mount an insanity defense. The clinician should avoid feeling regret, or even taking personal affront, when a subject presents with some mild symptomatology of mental illness insufficient to meet local insanity criteria; this is not the clinician's problem. It is also fully defensible for the clinician to be unable to conclude unambiguously whether the subject meets criteria; subjects, after all, present with mixed clinical conditions—indeed, this is the rule. Unambiguous cases either way, moreover, tend to be plea-bargained before clinicians become involved.

D. COMPENSATION COMPASSION

The forensic examiner may be moved by the facts in a case to see the claimant as highly deserving of compensation in an emotional injury lawsuit or a disability context. For example, a person may claim to have been injured by the negligent indifference of a large corporation, resulting in a David-versus-Goliath image of the parties in the lawsuit. Such beliefs often derive from the clinician's empathic assessment of the claimant and the fact that the claim may indeed seem highly meritorious, socially important, and morally valid. Regardless, the ethical examiner must adhere strictly to the forensic criteria relevant to the question, putting personal sympathies aside to preserve the necessary objectivity of the evaluation.

V. CASE EXAMPLE EPILOGUES

A. CASE EXAMPLE 1

The consultant pinpoints two areas of confusion that frequently arise with such referrals. First, the transfer from the criminal justice system to the psychiatric care system has been accomplished with minimal communication of relevant information. Second, court and hospital appear to be confused about the purpose of the commitment. He urges the resident to contact the court directly, speaking first with the court clinic psychiatrist, then with the chief clerk and, if necessary, with the judge to clarify the situation.

On calling the court clinic psychiatrist, the resident discovers that the case is quite complicated. The patient had indeed been arrested at the time of the crime more than a year previously. Because he was a first offender, however, his case was diverted before trial to a mental health court program designed to rehabilitate rather than punish those with mental illness and without previous criminal records. As part of his participation in this program (in exchange for which the charges against him were not prosecuted but were left pending), the patient was required to engage in outpatient psychiatric treatment in a community clinic and was required to take medication. He did this for a short period, but for the last two months he had not taken his medication and had been missing his clinic appointments. His mother called the police when she thought that she could no longer take care of him and feared that, because of his wandering through the streets, he might be harmed.

The court, the psychiatrist confides, is not in the least interested in this patient's competence or criminal responsibility. Having diverted him from trial initially, they do not intend to prosecute him now. Rather, they have used the statute empowering them to order the pretrial hospitalization of defendants with pending charges as a means of getting the patient treated. If he has not recompensated by the end of the 20-day period, the court is willing to recommit him for an additional 20 days, as the statute empowers them to do, so that treatment can continue.

When this information is conveyed to the forensic consultant, he tells the resident that this is not an unusual state of affairs. Courts in this jurisdiction frequently use their powers to commit defendants who are genuinely in need of treatment under the only statute that they have available for the purpose, namely, the law covering competence and responsibility examinations. He advises her to perform the requisite forensic examinations to comply with the precise terms of the court order, but otherwise to approach this patient's care as she would any other patient's: seek to establish an alliance, begin treatment with medication if the patient consents, and try to develop an ongoing treatment plan to prevent rehospitalization. Although the consultant said that he recognized that some psychiatrists are uncomfortable undertaking the treatment of patients committed under statutes ostensibly designed to provide only for evaluation, he himself felt that every patient committed to his care deserved the best treatment that he could provide, assuming that they consented to it, regardless of what other tasks he was additionally required to perform with them.

B. CASE EXAMPLE 2

The hospital legal consultant ushers in the resident and, seeing her evident distress, pulls up a chair and thrusts a cup of coffee into her hand.

After hearing the story, the consultant asks, "Who are you working for?"

The resident blinks in surprise. "The patient, of course."

The consultant holds up an admonitory forefinger, "There's the problem." He continues by explaining that the resident in this situation is an agent of the court, in its employ. Although this arrangement does not entail ignoring the patient's needs, it does mean acknowledging the primacy of the mandate to assess the patient in this highly specific way.

The resident listens thoughtfully, then says, "I guess I overidentified with him; I so much wanted to help."

"You can," the consultant observes. "From your story he seems like a guy who would lose his cool in court; let's tell that to his lawyer from the legal aid group so she won't put him on the stand. That will genuinely help his case. Now, let's go up and do a formal competency exam together; then we can write the court letter and discuss our findings."

C. CASE EXAMPLE 3

Deciding that his task as forensic evaluator is to give the most valid and honest assessment possible, no matter what the outcome, the psychiatrist puts great effort into writing an extremely detailed report. This report meticulously reviews the history of preexisting difficulties, the subject's marginal functioning at the best of times, the dubious causal relationship between the robbery and subsequent claimed harms, the subject's insistence to many caretakers (as documented in the record) that the incident at age nine was the wellspring of all the difficulties, and the fact that the subject has a chronic disorder of presumptively genetic origin.

He concludes that the causal link between the robbery and subsequent injuries is a specious one unsupported by the weight of the data; thus, he cannot take the position that the robbery was the cause of subsequent harms. With marked trepidation he mails the report to the attorney.

When no word follows, the psychiatrist calls the attorney in question, this time reaching the attorney directly instead of the paralegal. The psychiatrist is apologetic about how ineffective, perhaps even damaging, his report would be in mounting a case on the subject issue. To his surprise, the attorney is completely unruffled by the thrust of the report. Indeed, he confesses, it is quite clear the case was not meritorious in the slightest; however, for client good will, he needs a report from a psychiatrist to reinforce his position, because the client tends to throw enormous tantrums in legal offices when confronted or thwarted in his often-grandiose goals for litigation. The attorney thanks the bemused doctor for his time, promises prompt payment, and hangs up.

VI. ACTION GUIDE

A. GENERAL CONSIDERATIONS IN COURT-ORDERED EVALUATIONS

1. Clearly *establish* the question of agency in court-ordered evaluation.
   a. *Define* employment (court, not patient).
   b. *State* limits of confidentiality at outset.
   c. *Repeat* a and b if patient appears to be moving into therapeutic mindset or interview pattern.
2. *Identify* specific parameters of the evaluation, according to statute or policy.
3. *Obtain* objective data from court or elsewhere against which to evaluate patient's remarks.
4. *Offer* optimal treatment during course of evaluation as accorded to other non–court-referred patients.
5. *Resist* contamination of objectivity by economic pressures, previous knowledge of the patient, attempts to second-guess the court, slanting the evaluation, and pressure from the attorney.
6. *Limit* scope of predictive aspects of evaluation report to those areas within predictive capacity; *use* a double negative (e.g., "no contraindications") when feasible.
7. *Review* findings with evaluee when possible.
8. *Beware* of potential difficulties interfering with the evaluation:
   a. Resentment of inability to influence patient admission.
   b. Rejection of patient as different.
   c. "Preconviction" of evaluee.
9. *Consider* malingering in all cases.
10. *Supervise* clinicians on misuses of court-ordered evaluation as
    a. Rescue of the evaluee as victim.
    b. Attempts at reform of court system at expense of considering the individual evaluee.
    c. Requirement of positive finding.

B. SAMPLE REPORT OUTLINE FOR COMPETENCE-TO-STAND-TRIAL EVALUATIONS

1. Identifying data

The identifying data should contain basic demographics in the standard clinical sequence: the subject's full name as well as any aliases used, age, sex, marital status, race, religion, employment status, date of birth, and Social Security number. If available, the docket number or other court reference should be recorded. In the case of an inpatient evaluation, this section should include the admission date, admission history (number of previous admissions), the name of the referring court or jurisdiction, a precise statement of the charges in statutory language, the date(s) of the alleged criminal act, and a brief statement summarizing the alleged criminal incident. For example, if the official charge is "assault with a deadly weapon," the description might illuminate this by indicating that "it is alleged that, as a result of an argument, Mr. Jones repeatedly struck his father with a tire iron on May 5, 2007."

2. Relevant statutory criteria

Relevant statutory criteria represent standard prose drawn from the actual statute or case law used in the local jurisdiction.

3. Issues relating to informed consent

This section should be a record of precisely what the subject was told about the nature and purpose of the examination, the role and function of the examiner, the absence of usual confidentiality, and the subject's right to refuse to participate or to answer questions. The subject's apparent understanding or lack of same should be noted, along with his consent to participate, if given.

4. Database

Record in the database section any additional sources of information that may have been used in the assessment (such as psychological testing), as well as the number of interviews or total time spent with the subject during the process.

5. Clinical history

Although one could argue that the snapshot of the subject needed for the competence evaluation renders the clinical history irrelevant, certain determinations (e.g., the patient's need for a secure setting or for treatment during the evaluation) may be helped by these data. In addition, the clinical history may support the evaluator's conclusions about the presence or absence of psychopathology. Some jurisdictions may require that such material be contained only in the criminal responsibility assessment.

Two important elements to include in the clinical history, if not elsewhere, are the subject's suicide risk (relevant to questions of incarceration) and the subject's previous experiences with the legal system; the latter may be directly relevant to the subject's competence to participate in the process.

6. Hospital course

For inpatient hospitalization, a summary of the subject's hospital treatment history and response, relevant clinical observations substantiating diagnosis, and similar material would be included in the hospital course. A summary of the subject's current mental status should be explicitly recorded in detailed descriptive terms; such material is directly relevant to the ultimate opinion flowing from this assessment.

7. Data relevant to competence to stand trial

The section involving the data relevant to competence to stand trial is the heart of the report and should address (a) those functions that contribute to the defendant's understanding of the nature and object of courtroom proceedings and of the charges, and (b) his capacity to participate in his own defense by cooperating with the attorney. Attention should be paid to the subject's capacity to endure the stress of the trial and any contingencies that bear on this capacity (e.g., "Patient requires continuing medication at present doses to be able to tolerate the stress of trial in a nonpsychotic manner").

Remember that ignorance is never identical to incompetence. Because competence to stand trial represents a capacity to deal with a process, the finding of incompetence should occur only when the subject has demonstrated repeated inability to be instructed about the relevant matters.

8. Conclusions

a. Subject's clinical state

The section on the subject's clinical state describes the subject's illness, functioning, and treatment issues. Some jurisdictions require a formal *DSM-IV* diagnosis; others may require merely a statement about the presence or absence of a mental illness or disorder.

b. Competence to stand trial

In the final section, the question of whether to address the ultimate issue becomes paramount. Some clinicians merely describe the patient as meeting the required criteria (e.g., "The patient appears to have the ability to cooperate with the attorney in her defense") and avoid an actual statement about competence. Others, after describing the specific statutory capacities, indicate that the patient possesses abilities "consistent with competence to stand trial." Judges (who do answer the ultimate question) vary in the degree to which they wish to have the conclusion made explicit by the clinician. Some assert that without an actual statement about the patient's competence, the report is meaningless; others feel preempted when the clinician goes beyond the factual components.

C. SAMPLE REPORT OUTLINE FOR CRIMINAL RESPONSIBILITY EVALUATIONS

1. Identifying data

The identifying data section for criminal responsibility evaluations should contain the same material as that for competence evaluations.

2. Statutory criteria for criminal responsibility in this jurisdiction

The section on jurisdictional statutory criteria for criminal responsibility evaluations is comparable to that for competence evaluations; local insanity criteria should be obtained from the attorney.

3. Issues relevant to informed consent

Informed consent for criminal responsibility evaluations is comparable to that for competence evaluations.

4. Database

The database section for criminal responsibility evaluations is comparable to that for competence evaluations, but extends further into the past.

5. Clinical history

In circumstances in which the competence and criminal responsibility reports are filed simultaneously, it is permissible to refer to the competence report to avoid needless repetition.

6. Subject's version of alleged criminal act or acts

The subject's version of alleged criminal act or acts should be recorded, as near to verbatim as possible. This should include not only physical actions and behavior, but also the subject's own statement of the varying states of mind, thoughts, fantasies, perceptions, and the like that existed contemporaneous with the actions. For completeness, the subject's hindsight view of the experiences in question should also be recorded, although, of course, this has no direct bearing on the state of mind at the time of the event.

7. Official version or versions of alleged criminal act(s)

The recounting of the official version or versions of the alleged criminal act(s) should include police and other investigative agency reports; reports of witnesses, bystanders, victims, family members, and significant others; and all other relevant and contemporaneous assessments of the subject that may exist, including clinical material if the subject was in a clinical setting at the time.

8. Hospital course

The information in the hospital course is the same as that in the competence evaluation, including detailed present mental status.

9. Criminal responsibility

In the criminal responsibility section, the forensic evaluator should attempt a retrospective reconstruction of the subject's mental state at the time of the criminal behavior in longitudinal context. If the subject experienced a short-term alteration of mental functioning, it should be described; if the subject's behavior occurred in the context of a long history of significant mental illness, the longitudinal history should be placed in perspective (as it may have led up to, and affected, the present alleged offense).

The clinician should remember that the task is neither to prove a point nor to portray the examinee as responsible or not responsible. The clinician's narrative should include material factually and completely, no matter which side of the case such material may support. Thus, the subject's delusional expressions (appearing to support insanity) and the subject's attempts to conceal the crime (seeming to support sanity) are both relevant to the report. The task is not to convince others of the subject's sanity or insanity, but to present a comprehensive (but not necessarily consistent) picture focused on the relevant determinations so that the ultimate fact finder can make an informed decision.

Remember to include, when applicable, the subject's level of cooperation and participation in the examination, the presence or absence of external corroboration, both the subject's behavior and internal mental state, any difficulties encountered in constructing a retrospective case, and even the subject's persistent denial of his participation in the crime at all.

10. Conclusions

In the conclusions section, review the subject's clinical condition and address the opinion evidence in an austere and restrained manner. Avoid wild speculation and overly confident statements (e.g., "the defendant is clearly insane" or "the subject should be found criminally responsible"). Instead, provide a distillation of the material (e.g., "incapacity to understand the nature and quality of his actions," "consistent with statutory criteria," or "appeared to be able to appreciate the wrongfulness of the conduct").

D. SAMPLE REPORT OUTLINE FOR DETERMINATION OF EMOTIONAL HARMS

1. Identifying data

The identifying data for the report of emotional harms is comparable to that of other reports.

2. Statement of the claim

In the statement of the claim, instead of statutory criteria, one provides the forensic question being addressed in the evaluation, using the language of the formal claim (e.g., "emotional harms, damages, humiliation, public embarrassment, conscious distress, and suffering resulting from being inappropriately and negligently searched for falsely alleged shoplifting while leaving department store").

3. Issues relating to informed consent

The issue of informed consent is the same as in other reports. Informing examinees if one is working for the other side of the case (i.e., the defense) is particularly important because many examinees receive multiple evaluations and may not be sensitized to potential adversarial issues. If the examiner is also the treating clinician, care should be taken to explain the shift in agency.

4. Database

The database for determination of emotional harms is comparable to the database for other reports. Typical ancillary sources include neurologic, psychological, and neuropsychological testing; previous medical and psychiatric or other clinical records (essential to determine preexisting conditions and worsening); and reports, interview data, and deposition material from relevant parties. Note also the amount of time spent with examinee. If one is unavoidably both the evaluator and the treating clinician, supply data about the treatment (e.g., "Mr. Jones was seen in weekly psychotherapy beginning June 17, 2006, for complaints of anxiety and sleeplessness and was formally evaluated in addition for six interviews related to his claim").

5. Clinical history

A longitudinal history to the present is required to place the alleged harm-causing incident into perspective as exacerbating or having no effect on any preexisting or underlying processes; clinically significant negatives should be articulated when relevant. The following are some examples:

"Prior to the alleged incident, Mr. Smith had nightmares extremely rarely, about once or twice a year."

"Ms. Green's social isolation and withdrawal, consistent with her underlying chronic undifferentiated schizophrenia, are described in a comparable manner in her hospital records."

"Ms. Wilson's chronic timidity was markedly increased to a full-fledged phobia by the accident."

"Mr. Johnson's previous combat experiences were revived in a retraumatizing way by the alleged incident."

6. Previous treatment and hospitalizations

The patient's previous treatment and hospitalizations (if any) should also be included in the evaluation. Note responses to treatment, successful or unsuccessful, and any possible exacerbating effects of treatment attempts.

7. Conclusions

The summary of the opinions given here should follow from the other material presented in a coherent and comprehensible way. Because it is a basic maxim of tort law that "the defendant takes the plaintiff as he finds him," the presence or absence of emotional harms should be described in relation to any preexisting conditions or vulnerabilities—or, for that matter, strengths and personal resources—of the examinee. Some estimate of relative severity should be attempted.

Remember to distinguish among harms, trauma, damages, and disorders. The examiner should be aware that not all traumas produce full-fledged PTSD; some produce other conditions that represent harms that are no less valid (e.g., anxiety disorders, depressions), and even severe traumas may have few lasting effects. Recall also that not all alleged harmful incidents are true; be sure to assess and comment on possibilities of malingering or delusional material presented as real. The following are some examples:

"Mr. White's previous childhood experiences of public humiliation by his father rendered him particularly vulnerable to the humiliating effect of the public 'stop and frisk' at the shopping center."

"Ms. Brown's 20-year history of chronic schizophrenia makes it nearly impossible to define an increase in social withdrawal and isolation as a result of the incident."

"In the absence of outside observers' reports, I am simply unable to determine if Mr. Black's account of the alleged incident is delusional or not, particularly because vaguely similar experiences are noted as delusions in the records of his 1999 hospitalization."

"Ms. Carpenter's inadvertent admission of being coached to simulate the 'startle response' raises a clear question of malingering of the alleged posttraumatic stress disorder."

"Although having a plane in which one was flying break apart on landing would seem fairly traumatic to anyone, Mr. Olsen's rather stolid and unimaginative character appears on examination to have insulated him from most of the expected symptomatic effects."

8. Treatment recommendations

If indicated, in the treatment recommendations suggest useful treatment modalities. Because the costs of remedial treatment are a significant factor in litigating emotional harms, supply an estimate (backed up, if possible, by empirical data in the literature) of the length, intensity (frequency), duration, and likely cost of such treatment.

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CHAPTER 7

Clinicians and Lawyers

I. CASE EXAMPLES

A. CASE EXAMPLE 1

Arriving one evening on an inpatient ward of a community mental health center, after transfer from the emergency room of a nearby general hospital, a 25-year-old patient heads immediately for the public telephone on the ward. She is overheard saying, “This place is like a jail, I want to get out.” After her phone call, she retreats angrily to her room, refusing to talk with staff members.

A few hours later, a young man describing himself as the patient’s lawyer appears on the ward and, although visiting hours are over, demands to see her. When the staff initially refuses, he threatens to sue them all. Made nervous by his aggressive manner and persistent threats, they ultimately relent. After a brief conversation with the patient, the lawyer approaches the nursing station, insisting to the nurse in charge that the patient be released immediately into his custody. The nurse informs him that she has no power to release the patient but suggests that he call the psychiatrist in charge of the ward.

Speaking with the psychiatrist, the lawyer again demands that the patient be released, saying that he spoke with her, is satisfied that she is not mentally ill, and that therefore her involuntary admission violates her constitutional rights. The psychiatrist, having ascertained from the ward staff that the lawyer does in fact represent the patient, asks if he is aware of the circumstances surrounding her admission. Replying that he is, the lawyer says that the whole situation has been blown out of proportion. He relates that the patient, a personal friend of his, accidentally took too many sleeping pills; she then had the good sense to call him, and he arranged for her to be taken to the emergency room. The psychiatrist responds that the emergency room psychiatrist thought that a far more serious and genuine suicide attempt had occurred and recommended emergency commitment. He suggests further that the patient remain on the ward overnight and that in the morning everyone involved gather to discuss the case. The lawyer reluctantly agrees.

B. CASE EXAMPLE 2

Ambling resignedly to the admissions office, a first-year resident goes to meet her newly admitted patient. Her lethargy vanishes abruptly when the admissions clerk, drawing her aside, hisses into her ear that her new patient is a lawyer, picked up by police for behaving erratically in the middle of an expressway, shouting at passing cars, and attempting to direct traffic.

Clearing a suddenly dry throat, the resident introduces herself to the patient as the doctor. He is a pale but vigilant-eyed man in a dirty, torn, navy blue three-piece suit of expensive cut, mismatched with a fluorescent orange tie. On hearing her name, the patient whips from an inside pocket a grimy notepad, the pages covered with scribbles and worn to translucency by much handling, and records the doctor’s name; he then demands and records the name of the admissions clerk and of the two arresting officers who are standing uncomfortably in the doorway. Thrusting pad into pocket with an air of triumph, the patient fixes the resident with a baleful glare and snarls, “When I get you into court for this, you’ll be lucky to have your gold fillings left.”

Three days later, the patient, who has been roaming the ward, haranguing all who would listen, has still not had admission bloodwork done, the morale of nursing staff is in shambles, and the resident has checked twice with her insurer to be sure of continued coverage. Now, after a fellow patient has refused to lend him yet another cigarette, the lawyer-patient begins to assault the refuser. Staff are about to move in to restrain him, but the resident shouts, “Wait! He hasn’t really hurt her yet, we can’t stop him.” The senior attendant, a seasoned veteran of many crises, grabs the lawyer-patient anyway and hustles him to seclusion. Returning, he shakes an admonitory forefinger at the resident and declaims, “You’d better check this case out with the attending, because this guy hasn’t gotten one ounce of treatment since he arrived.”

Angered by this unsought advice, but secretly agreeing with the attendant’s assessment, the resident seeks out the staff psychiatrist on the ward and presents the problem.

II. LEGAL ISSUES

A. LAWYERS’ PERCEPTIONS OF PSYCHIATRY

From the 1930s through the 1950s, a tremendous and sympathetic surge of interest existed in psychiatry on the part of the legal profession. In more recent decades, many lawyers developed a decided antipathy to psychiatry. A number of factors exist to account for the development of this attitude, which ranges from wariness to hostility toward the methods and motives of the mental health professions.

1. Disappointed Expectations

The expectations that psychiatrists aroused and then disappointed in the mid–twentieth century form part of the basis for lawyers' suspicions of psychiatry and the other mental health professions. In a variety of settings, psychiatrists seemed to promise to lend scientific certainty to many of the most difficult problems faced by the law. In the courts, psychiatrists and other mental health professionals began to participate in recommending alternatives to incarceration; in the prisons, they attempted to treat and rehabilitate criminals; in parole hearings, they offered opinions as to when prisoners should be released. This activity was part of an attempt to deal with crime as a symptom of mental dysfunction; measured either by the development of internally consistent theories or the rates of recidivism of those treated, it failed.

Psychiatrists also became involved in the administration of the insanity defense, appearing to promise a definitive answer to the question of who should be deemed culpable for criminal acts. This attempt also failed, as equally renowned psychiatrists reached equally well-reasoned conclusions for opposite sides of the case (see also Chap. 8, Sec. II-C-3). In the civil courts, they tried to lend scientific certainty to child custody determinations, but again without success.

This overselling of psychiatry, and the consequent disappointments, left the legal profession with a lingering suspicion about the general validity of psychiatric theories and the use of psychiatric practices. In lawyers' eyes, a taint of charlatanism had spread across the mental health professions.

2. Effects of Legal Training

Certain elements of legal training have contributed to lawyers' distrust of psychiatry.

a. Legal model. The law is, above all, a practical tool for maintaining order and resolving disputes in society. Rather than dealing with the infinite diversity and complexity of human beings (the aspects of human existence that most interest many clinicians), legal doctrines often attempt to simplify the situation by postulating certain axioms and creating certain presumptions that redefine a more easily administered reality. The axioms include, "a man intends the natural consequences of his acts," which presumes that all individuals are competent to undertake their actions until proven otherwise. Psychiatric concepts complicate the work of the law by challenging these axioms and presumptions, while offering a competing system of explaining human behavior. The ideas of unconscious motivation (supported by recent neurophysiologic and neuroimaging research) and ambivalence, for example, cast doubt on the exact intentions of our actions; the concept of regression suggests that in many situations, such as severe physical illness, human beings are not capable of acting as the competent, detached decision-makers the law envisions them to be. To maintain intellectual consistency, most lawyers must either ignore or disparage psychiatric formulations or modify their legal conceptions, the second of which many lawyers are unwilling to do.

In addition, given the law's need to rely on observable verities, lawyers are trained to be suspicious of any attempts to take people's words and actions at other than face value. Most clinicians, on the other hand, are trained to understand behavior by assuming that people rarely say exactly what they mean. Any clinician who has ever tried to explain to a lawyer why his client's repeated entreaties to be released from the hospital actually represent a reaction formation against deep-seated and frightening desires to be cared for has probably experienced the profound disbelief engendered by such an attempt to counter one of the core assumptions of legal thought. (The effect on legal-psychiatric tension of legal devotion to an adversary model is discussed in Chap. 8, Sec. II-B.)

b. "Worst foot forward" effect. The first professional contact most lawyers have with the medical and mental health professions occurs in their first year of law school class in torts, in which they are regaled with stories of general medical and psychiatric negligence that have ended up in the courts. Although this makes perfect sense from the point of view of legal pedagogy (one could hardly teach malpractice law by demonstrating the cases in which no grounds for suit exist), the cumulative effect is destructive of trust between the legal and medical/mental health professions. Lawyers, unless their attitudes are leavened by personal experience, are led to expect malfeasance, often of a gross sort, as the norm of psychiatric behavior.

Courses on law and mental health in many law schools often compound the “worst foot forward” effect. Although some such courses are cotaught by law professors and experienced psychiatrists or psychologists who can convey the complexity of clinical work and the need for a mutually sympathetic relationship between the psychiatric and legal systems, many are not. In either event, the casebooks used and the law review articles assigned again often focus on psychiatric incompetence or malevolence, and these frequently succeed in convincing idealistic students that only an aggressive attorney can truly assist the mental patient.

Even a teacher who presents the psychiatric perspective sympathetically is no guarantee against law students interpreting what they learn as evidence of the dangers represented by psychiatry. It has been pointed out that many of the most aggressive members of the mental health bar who initiated the great wave of mental health litigation of the late 1960s and 1970s were trained by those few psychiatrists, usually analysts, who began teaching courses in law and psychiatry in some of the best law schools. The mental health law reforms of the 1970s and 1980s represented, to some extent, the coming of age of their students, whose eyes were first opened to the real and potential abuses of psychiatry in those pioneer courses.

c. Rights versus needs. The law’s role in settling disputes between parties requires it to be concerned with defining the legitimate rights that each party may express and with assigning priority when those rights come into conflict. The law is so concerned with adjudicating *rights* that it often neglects to consider the *needs* of the opposing parties (see Chap. 3, Sec. III-B-4). In most cases, this neglect is not fatal, because the rational exercise of rights is usually designed to satisfy needs. But the lack of attention to needs becomes crucial when one of the parties in question has lost the capacity to use his rights in that way—that is, when the expression of rights conflicts with the individual’s basic needs.

A simple example of this situation arises when a psychotic individual is hospitalized, whether voluntarily or involuntarily, for treatment. At that point, her needs are for the development of a trusting relationship with a capable professional who administers efficacious treatment. To the extent that the individual’s rights—whether the right to freedom, the right to due process, or the right to privacy—interfere with those needs, as by preventing hospitalization, creating an adversarial posture with the therapist, or allowing medication to be refused, the conflict referred to arises.

The law, at least in the academic environment that many law students experience, tends to focus heavily on rights; the mental health professions tend to concern themselves almost exclusively with needs. Given the democratic nature of our system, in which the limitation of the individual’s rights cannot be countenanced without convincing benefit, and even then never arbitrarily, it is clear that some accommodation must be reached between those who advocate unlimited rights and those who advocate exclusive emphasis on meeting needs. But the tension between the two produces much friction across the law-psychiatry interface.

3. Effects of Antipsychiatric Literature

The popular and academic literature of the last 50 years that has challenged most aspects of psychiatric practice also affects lawyers’ attitudes. These works range from the classic descriptions of the effects of long-term hospitalization, to books that question whether mental illness actually exists, to works that challenge the basis for psychiatric diagnosis (maintaining that it is no more than a culturally determined label for deviance) and the need for psychiatric treatment (describing mental illness as a state of consciousness superior to mundane “normality”) (see Suggested Readings, Dietz). Movies depicting gruesome scenes in psychiatric hospitals, such as the administration of electroconvulsive therapy without anesthesia or the effects of lobotomy, or portraying sympathetic young people as victims of psychiatric intervention, further heighten the sense that psychiatry is a brutal and sinister agent of the state that seeks to enforce conformity at the expense of the individual’s freedom. Real abuses have also been revealed, as in exposés detailing deaths and injuries associated with seclusion and restraint.

These works are less prominent now than they were three or four decades ago, when they were staples of college sociology and psychology courses. Many attorneys, however, still view psychiatry through lenses tinted by the accounts of Szasz, Laing, Goffman, and the other “antipsychiatrists.” This is equally true of law professors, whose skepticism of the effects of the mental health system may be passed on to their students. Law students, of course, are particularly alert to evidence of such abuses, which these works allege to be commonplace in the practice of psychiatry, because the law profession has always seen itself as the means by which the oppressed can remedy their situation. Although some real abuses existed and were the basis for much of the antipsychiatric literature, the impression made on many students who are exposed only to this side of the issue is that such abuses are universal. If one assumes that contact with psychiatry is inevitably harmful, it is only a short step to the further assumption that everything possible should be done to limit its scope and powers. Psychiatry's passivity in countering such notions in the mass media has meant that many of the litigators have had little chance to temper their ideas about psychiatry with any sense of the good done on behalf of the mentally ill by psychiatrists and other mental health workers.

4. Second-Generation Legal Advocacy

Notwithstanding the effects of antipsychiatric literature, it seems clear that there has been a shift in the attitudes of many lawyers toward the mental health professions, including some of the most radical and aggressive members of the mental health bar. Several reasons for this more positive approach to psychiatry exist. The most important may be that the successes of the early litigation designed to limit the scope and power of institutional psychiatry have clearly not had the desired dramatic effects. Although it may be more difficult to commit and treat mentally ill persons, only the most hard-hearted of advocates would claim that the homeless mentally ill living on the streets have truly benefited from the change. It has become apparent to many mental health attorneys that it is not enough to state, as a matter of law, what cannot be done to the mentally ill; if their needs are to be met, one must also establish what must be done for them.

Legal advocates who are part of this self-described "second generation" thus pay increasing attention to finding ways to meet some of the needs of the severely mentally ill. They battle for entitlements to disability payments, health insurance, and community care. They oppose restrictive zoning provisions that limit the development of community-based housing. They create innovative programs to find long-term housing options. Mental health professionals and the mental health bar agree on the importance of this type of advocacy. Legal academics have described an approach to mental health law that they characterize as "therapeutic jurisprudence," arguing that law should be designed so as to maximize its positive impact on patients. The possibility of more common interests bodes well for the prospect of harnessing mental health and legal energies in tandem on behalf of the mentally ill.

B. ROLE OF THE LAWYER IN THE MENTAL HEALTH SYSTEM

Despite the lack of trust that often pervades relationships between lawyers and clinicians (and the effect of many clinicians' unfair stereotyping of all lawyers as intrusive, uncaring, money-hungry troublemakers should not be forgotten as a contributing factor), it is clear that lawyers have an important role in the functioning of the mental health system. Patients and therapists often find themselves confronting situations in which legal assistance is indispensable.

1. Situations in Which the Patient Needs a Lawyer

a. Situations related to psychiatric care. The day has passed when a patient could move from an emergency or voluntary hospitalization to an indefinite involuntary commitment without both a judicial hearing and legal representation at that hearing. If the patient is unable to afford an attorney's fees, an arrangement is made for a public defender or the equivalent to be available to the patient at no cost. Beyond this minimal guarantee of representation at commitment hearings, however, patients may face a variety of situations in which a lawyer's advice would be helpful to them, but one is not automatically provided. Involuntary patients may wish to challenge the basis for their commitment by means of a writ of *habeas corpus*, either because they believe that their mental status has improved since the initial hearing or that their representation at that hearing was inadequate. (The latter, although infrequently a grounds for a second hearing, is all too common an occurrence in many publicly funded defender systems.) Patients may wish to object in court to involuntary or improper treatment, or both, or to object to the hospital conditions. If family members have filed a petition to have the patient declared incompetent, the patient may wish to oppose that motion.

b. Situations not directly related to psychiatric care. The status of a psychiatric patient confers no immunity from the varied exigencies of life that lead to legal entanglements. In fact, given the instability of their lives, psychiatric patients may be more likely than most to require help with separation or divorce proceedings, child custody actions, eviction hearings, and civil damage suits. Pending criminal charges or the fear that such charges will be filed may also arise as a result of mental illness.

Additional problems often arise as a result of mental illness, without being directly related to the treatment setting. These include establishing entitlement to welfare, Social Security (and its many permutations), Medicaid, Medicare, subsidized housing, vocational rehabilitation programs, and other social benefit programs; arranging for the disposition of the patient's assets while the patient is hospitalized; opposing actions taken in the patient's absence by family, friends, or business associates that might be to the patient's financial detriment; and arranging for the temporary care of dependent children, while assuring that they are not permanently removed from the patient's care. These are only the most common of the many situations, including many bizarre and unpredictable ones, that are related to patienthood.

c. Handling requests for legal assistance. Inpatient clinicians should consider it their obligation to help patients in obtaining legal assistance should the need arise. Failing to act often ensures that the patient's rights will not be advocated because many inpatients are unable to take any steps toward obtaining legal help beyond discussing the matter with the clinical staff. Even when the proposed legal action is not considered by the therapist to be in the patient's best interests, he should consider basic rights before clinical sensibilities. All citizens deserve legal representation; to decline to aid an inpatient in obtaining representation is, effectively, to deny her that right.

Of course, the situation is more intricate when the patient desires a lawyer's help to oppose hospitalization or treatment that the clinician believes is essential or to sue either the therapist or the hospital. As difficult as it may be for the clinician, the obligation remains the same: The patient is entitled to representation and should be referred appropriately.

With outpatients, the situation may be even more complex. For a variety of therapeutic reasons, therapists might not want to become directly involved in assisting the patient to obtain a lawyer. However, when it is clear that the patient is not able to obtain his own representation, the clinician should, at the least, be sufficiently knowledgeable to refer the patient appropriately.

d. Resources available

i. Private resources. It is usually best for the patient to be represented by a private attorney when financially feasible. Attorneys working directly for their clients do not face the disincentives to devote sufficient time to the preparation of their cases that often stymie public defenders or legal aid attorneys. A check with the patient's friends or family may reveal that the patient has a private attorney who regularly handles her family's affairs. Failing that, a call to the local bar association should produce a list of lawyers with special knowledge in the particular area in question.

Referring the patient to friends or acquaintances of the therapist is problematic; although it may be one way to ensure that she gets good representation, it may also create the appearance of impropriety (i.e., that the clinician may be rewarded in some way for "steering" clients to the attorney) and may leave the patient uncertain about the crucial questions of confidentiality and conflict of interest. In general, it is probably better to avoid referrals to friends.

ii. Protection and advocacy agencies. Protection and advocacy agencies (P&As) have been established with federal support in all states. Based on a similar program for mentally retarded persons, the P&As are charged with representing the interests of mentally ill persons who are receiving care in a broad array of institutional and community facilities. Representation may relate to the conditions of care or access to services, including welfare, disability, and other entitlement programs. The lawyers, paralegals, and others who work for these programs can negotiate on behalf of patients, bring legal actions for them, or address broader issues through class action suits.

Although the potential usefulness of the P&As to patients is clear, the programs have not always met expectations. They are most effective when the main strategy is negotiation, rather than litigation. P&As that rely on litigation to achieve their goals, or otherwise assume a hostile posture toward providers, only worsen the situation. Legal harassment is an added inducement to mental health professionals and administrators to abandon understaffed public and publicly supported facilities. Those who remain may feel that their hands are tied in trying to provide appropriate care. To the extent that advocacy only results in shifting limited funds from one underserved group to another, its net effect is minimal; to the extent that a large number of persons are deprived to benefit a few, its net effect is detrimental. Efforts to assess the overall impact of P&As are clearly desirable, but have not yet been carried out systematically.

iii. Other nonprofit resources. For patients without sufficient funds to hire a private attorney, another possible recourse is to the widespread network of privately or federally funded legal agencies. These have various names in different cities, but are often called the *Legal Aid Society* or *Neighborhood Legal Services.* If a search of the telephone book proves unavailing, a call to the local bar association should produce the appropriate number. Some agencies do not handle criminal cases, but should be able to make a referral to a public defender group to suggest a means of having a court appoint a lawyer.

Another set of resources that should not be overlooked is law school legal aid programs. Designed to provide hands-on experience for second- and third-year law students, these programs may handle all types of cases or may be restricted to a specialized area such as civil, criminal, prison, or mental health law. The students are supervised, though sometimes only loosely, by experienced attorneys, and often make up in enthusiasm what they lack in expertise. A caveat: This is not the appropriate referral for complicated or potentially lengthy litigation.

When none of the other resources is available, the final option is to fall back on the old system of lawyers volunteering their time to help indigents and to contact the local bar association for help.

2. When the Clinician Needs a Lawyer

a. Malpractice. Although among the most feared of legal entanglements, the malpractice suit ordinarily raises few problems of representation for the therapist (see Chap. 4, Sec. III-B-2). Malpractice insurance companies automatically provide legal coverage for their clients, asking only that they be notified when even the threat of suit appears. Rarely, the clinician requires additional legal assistance. This is most likely to occur when the company is representing more than one defendant in a suit and the defense of one party depends on assigning blame to the other. The conflict of interest for the attorney is clearly unmanageable in such situations, and the clinician who knows or suspects that such is the case should ask the insurer to appoint separate counsel to represent his interests, and may want to seek private consultation. The local medical or other professional society, or the local bar association, should be able to provide referral to experienced malpractice attorneys.

b. Consultation. The ever-expanding and ever-changing nature of legal regulation of clinical practice makes it almost a necessity for clinicians to have an attorney *who is knowledgeable in mental health law* available for consultation. When the subpoena arrives, when a patient demands to see her records, when a new state law outlining patients' rights is passed—in these and countless other situations, the clinician should know that there is an attorney who can provide assistance and advice. Often, being able to say to a court, to another attorney, or to a potential litigant, "I am doing this on the advice of my attorney," has a remarkable calming effect on all parties concerned.

Hospitals and large clinics have always had lawyers retained to represent them in negotiating contracts and handling financial matters or in litigation; many have added an expert in mental health law to their legal staff specifically to handle day-to-day problems. Medium- or large-sized clinical practices might want to consider retaining the consultative services of a mental health attorney. Individual therapists may want to pool their resources with several colleagues to have such help available. Professional associations may provide legal consultation services for a reasonable fee. At the least, every practitioner should know where, in his area, he can turn for expert legal advice, even if this comes at a price. This means that in advance of trouble, the therapist should make contact with a capable attorney who agrees to respond quickly to the situations that are bound to develop. A good consulting attorney can often do more to protect patients' rights than the most aggressive of patient advocates, because, as the clinician's ally, her advice is more likely to be followed.

III. CLINICAL ISSUES

A. DEALING WITH PATIENTS' LAWYERS

Although accustomed by training and experience to dealing with the psychiatric patient, the clinician often finds herself untrained and inexperienced in dealing constructively with the patient's lawyer. This condition can be highly demoralizing and may interfere with good patient care. Certain principles may help to smooth the potentially rocky road of clinician-lawyer interaction.

1. Seeking the Alliance Posture

Although the clinician and the lawyer view the patient through different lenses and understand him by different models, they share a common interest in the patient's welfare. Because the lawyer may be inclined to view the clinician as the adversary according to her legal model (see Sec. II), the clinician must often be the one to take the initiative in seeking an alliance based on this commonality of interests.

The clinician should not hesitate to be explicit about this shared interest in the patient's well-being, because some attorneys, especially less-experienced ones, have been so primed with antipsychiatric notions as to be astonished at the thought of collaboration.

2. Educating the Lawyer

Some suggestions about educating lawyers are detailed in Chapters 4 and 8. In general terms, the clinician must realize that the lawyer, although a professional in her own right, is usually a layperson in psychiatric matters. This point has several implications.

a. Permission. The clinician must remember that, from the patient's viewpoint, even the attorney is outside the bounds of clinician-patient confidentiality. Thus, the patient's permission (preferably written, but at least verbal) should be obtained before communicating with the lawyer; the usual emergency exceptions may apply, as described in Chapter 1.

Regrettably, the clinician may occasionally encounter some lawyers for whom confidentiality is a secondary consideration. Example 1, drawn from a fictional movie, captures the problem.

> ***Example 1.*** A law-firm partner asked a lawyer about an exciting and provocative case on which the lawyer was working. The lawyer protested that the information was privileged. The partner appealed, "Come on, you can tell me. I'm one of the privileged."

The clinician faced with an attorney of this persuasion may have to set limits with him, but should first seek the alliance position. The clinician might say: "Just as soon as we can obtain the patient's permission, I'll be happy to cooperate," rather than the misguidedly adversarial: "You're not getting a syllable out of me without a witnessed consent form!"

b. Comprehension. Because of subtle (and less-than-subtle) antipsychiatric biases often found in the training of attorneys (see Sec. II-A), the clinician attempting to educate a lawyer must keep certain principles in mind to aid the informing process.

i. Disease versus myth. First, the clinician should explain the process of mental illness, recalling that the attorney may have been exposed to, and accepted, the philosophy that mental illness is a myth. The signs and symptoms that constitute the syndrome in question and the typical course of the illness (both treated and untreated) should be clearly outlined. Any particular concerns raised regarding the specific syndrome should be noted as well (e.g., suicide in depressive states, homicide in paranoid states with violence, dissipation of property in mania, need for external controls in dyscontrol states, and need for isolation from external stimuli in states of vulnerability to overstimulation) (see also Chap. 3, Sec. III-B-2 and Chap. 5, Sec. III-B). The clinician must clearly identify how apparently random combinations of symptoms or signs actually constitute clinical entities whose presence may have specific prognostic implications.

ii. Mental illness and the need for care. That mental illness severe enough to result in hospitalization usually requires some form of care or treatment is generally so clear to the clinician as to verge on tautology; however, this association may be far from obvious to patients' lawyers. The clinician must, therefore, clarify how features of the illness may create specific needs for care and treatment (e.g., thought disorder may require treatment with antipsychotic medications, impaired capacity to adapt to the demands of everyday life may require training in social skills). Even aspects of a patient's presentation that the attorney may interpret as variations of normality may actually represent manifestations of illness calling for treatment. For example, difficulty getting along with coworkers may be a manifestation of a "personality trait" or the result of a clinical entity (e.g., a paranoid disorder) that may respond to antipsychotic medication. Similarly, the pessimism that leads a patient to reject a chance at advancement may be not the result of a bilious disposition, but the outcome of a predictable state of hopelessness in the treatable illness, depression.

In the case of the patient objecting to needed treatment, the clinician should attempt to explain to the patient's attorney exactly why he believes that the patient is not acting in her best interests. This is not an attempt to co-opt the lawyer, but rather an effort to convey the realities of the clinical situation to someone who may carry considerable influence with the patient. It is not rare for a lawyer who becomes convinced that the patient really requires further treatment to attempt to persuade the patient to go along with the treatment plan; however, even if that does not occur, the establishment of a good working relationship between clinician and lawyer conveys to the patient the idea that the two sides actually have a common interest in helping the patient; at issue is a difference of opinions on how best to do so. This sense of everyone working on behalf of a common ultimate goal, though often difficult to achieve, can be invaluable in ensuring proper follow-up care for the patient, regardless of the outcome of the case. It may also prove highly reassuring to the distressed patient.

iii. Powers of prediction. Legal and psychiatric scholars are in accord on the general inability of psychiatry to make reliable predictions as to patients' dangerousness (see Chap. 2, Sec. II-E-2). However, psychiatrists are somewhat more accurate when making other kinds of predictions. In the presence of a known clinical entity (e.g., bipolar disorder) in a patient who has had previous episodes of a similar sort, clinicians may be able to predict, quite usefully, the consequences of certain courses of action, such as whether to treat or not treat, to petition to commit or release, or to begin immediate electroconvulsive therapy or wait for more delayed medication effect. Although absolute certainty is unattainable in general medicine and in mental health care alike, the attorney should be made aware that the outcomes that are likely to ensue depend on the course chosen.

iv. Clinical conditions with legal implications. The clinician should alert the attorney to those aspects of a patient's clinical picture that may have particular effects on legal matters. Many of these issues are explored in Chapters 3 and 5. Commonly encountered issues include the effect of severe psychosis or depression on attitudes toward treatment; the effects of these conditions on competence to consent to, or to refuse, treatment; the effects of fixed or progressive disorders, or both, like dementia on competence; and the highly varied and individualized relationship between illness, functioning, and committability, as reviewed in Chapter 2.

Particularly problematic are presentations of mental illness that exert a subtle but decisive effect on the patient's competence to make decisions in a particular area (see also Chap. 5 and Suggested Readings for Chap. 5, Gutheil and Bursztajn). These subtle forms of incompetence are most often observed in (a) paranoid states, which may significantly affect decision-making but may leave cognitive ability—and therefore verbal fluency—intact; (b) mania or hypomania, in which denial of serious deficit is a prominent finding; (c) depression, in which the pessimism inherent in this disorder may cloud a patient's ability to perceive benefits of any kind in regard to a risk-benefit analysis for a treatment regimen; and (d) anorexia nervosa, in which the patient may be significantly psychologically disturbed on the subject of food intake but quite rational in other areas.

The lawyer may also need education about the impact of the illness from which her client suffers on the lawyer-client interaction.

> ***Example 2.*** An agitated attorney sought out an inpatient's clinician and reported that her client, with whom she had had a long and positive relationship, had just insulted and verbally abused her, labeling her as an impostor, calling her by someone else's name, and accusing her of things she had not done. The clinician explained paranoid states of misrecognition, much to the attorney's relief.

Finally, the clinician should adopt a tone in explaining matters to the attorney similar to that she would use for intelligent next-of-kin; this involves focusing on pragmatic rather than on theoretical aspects of the problem.

3. Use of House Counsel

A growing number of institutions and other clinical settings have retained attorneys who specialize in consultation for mental health clinicians; in an institution, such an attorney colloquially may be called the *house counsel*. In large general hospitals with several lawyers on staff, one or more may develop particular expertise on psychiatric issues.

In addition to providing legal advice to the clinical staff, the house counsel may be supremely valuable in dealing with patients' lawyers, especially the overzealous and aggressive types. Indeed, when a psychiatrist and an attorney are arguing in the corridors of the hospital about, for example, a patient's committability, they are having "the wrong conversation" (see Suggested Readings, Gutheil and Magraw). This conversation should occur between the house counsel and the outside attorney. Moreover, attorneys on the strange turf of a mental hospital or clinic are often more comfortable talking to another lawyer than to clinical personnel. As an added benefit, specious legal ploys and threats tend to be ineffective with the house counsel and are thus less likely to be used.

Clinicians, therefore, should not hesitate to enlist the house counsel, when available, to assist in negotiations with the patient's lawyer. To make this collaboration succeed, clinical staff must be willing to spend enough time to inform the house counsel fully about the issues and the clinical data relating to the patient, and the counsel must be available on an impromptu basis.

4. Special Requirements of the Crisis Setting

The demands of the patient's lawyer should not be allowed to take precedence over the emergent needs of the patient; for the patient's protection, responsible patient care must outweigh other considerations.

> ***Example 3.*** A lawyer called by the family barged onto the ward where an acutely psychotic patient was being evaluated and demanded his precipitous release. The patient, hearing this as a threat of being removed from a protected setting, panicked and began to assault nearby patients. When clinical staff moved in to restrain him, the lawyer screamed, "Stop! I forbid you to touch him." Staff hesitated, uncertain what to do, and the patient's dyscontrol escalated. A senior clinician on the scene ordered staff to intervene and the patient was safely secluded. The furious attorney was referred to the house counsel.

Although avoidance of struggles and confrontations with patients' lawyers should be attempted whenever possible, decisive action may be necessary when attorneys unaccustomed to psychiatric crises lose control themselves, as in this example, and seriously impede patient care or endanger the patient's safety. Clinicians must consider the patient's interests first, even in the face of threatened suit. Excessively intrusive lawyers, deaf to persuasion, may require hospital security or outside police to be summoned to remove them, although preferably as a last resort. Severe lapses of professional conduct should be documented, supported by written witness reports, and reported to the local bar association.

B. DEALING WITH LAWYERS FOR THIRD PARTIES

Problems in dealing with lawyers hired by third parties (e.g., families, employers, insurers, and victims of the patient's actions) are often no different from problems that arise in dealing with anyone outside of the therapeutic relationship.

1. Agency

The clinician must recall that the patient, as her employer, commands her primary allegiance; the interests of other parties, except in emergencies, are secondary.

On rare occasions, attorneys may request clinicians to perform various tasks ostensibly in the patient's interest (e.g., writing letters to third parties, contacting various agencies). Clinicians can usually assume good faith on the part of attorneys but—whenever the slightest doubt exists—should check with their patients to be sure (a) that the patient desires the clinician's assistance in the manner requested and (b) that the ends expected to be attained are part of the patient's plan. Such clarifying of consent can avoid significant conflicts that may arise by an attorney's misperception of what the patient actually wants.

2. Permission for Disclosure

The clinician must have the patient's permission for sharing any information relevant to the patient or his care, as described in Chapter 1.

3. Obtaining Legal Consultation

The clinician should seek legal advice from house counsel or her own attorney, when appropriate, to define her rights and responsibilities when these are in doubt or under attack.

C. LAWYERS AS PATIENTS

A lawyer-patient (especially an inpatient) presents challenges to effective clinical management similar to those of "VIP syndrome" (see Suggested Readings, Gabbard, Weintraub), in which the "specialness" of the patient operates to the detriment of good clinical care. (See Case Example 2 for this chapter.) All the challenges cited in this section are dramatically intensified when the lawyer-patient presents with borderline personality disorder. Before reviewing approaches to these challenges, we outline them in the following sections.

1. Problems

a. Milieu anxiety. Free-floating fear of suit may raise collective anxiety among ward personnel, leading to a paralysis of action; familiar, time-tested treatment approaches may seem suddenly specious and indefensible in court, especially when applied to the lawyer-patient. Similarly, the clinician may feel severely inhibited in performing a variety of interventions, verbal and administrative (e.g., restricting the patient to the ward), even if these are necessary for the patient's care.

b. Avoidance of the patient. One maladaptive response to milieu anxiety is for staff and clinicians to avoid all but minimal contact with the patient—a classic phobic response. This does a severe disservice, of course, to the patient's clinical needs.

c. "A fool for a client." The lawyer-patient may attempt to deal with the stresses of illness, of being a patient, or of both by wearing the professional mask and attempting to act as his own lawyer, even in relation to patently inappropriate matters. This inclination is as self-defeating as that of the physician-patient who attempts to self-prescribe medications during his own mental illness.

d. Legalism as defensive avoidance. Both lawyer-patient and clinical staff may take refuge from feared confrontation or from shared psychic pain by retreating into legalism, whereby conversations on legal quibbles replace serious grappling with treatment issues (see Suggested Readings, Gutheil). Although legalistic acting out is not limited to lawyers (see Chap. 4, Sec. III-A-2-e), the defense assumes added force if a lawyer initiates it.

2. Approaches

Approaches to the problems discussed in Section III-C-1 are familiar to experienced clinicians who have dealt with other problems of milieu countertransference; the basic principles to be followed in placing the patient's needs first are reviewed in this section.

a. Informed ward leadership. Strong, competent leadership for the clinical unit provides the necessary anchor against countertransference storms directed at the lawyer-patient. Such leadership has a twofold function: (a) to focus attention unfailingly on the clinical needs of the patient and (b) to inform the clinical staff about the actual legal issues that arise, including their statutory or regulatory bases. By informing staff members about the realistic extent of their liability, energy used for unproductive and fearful speculation can be freed for patient care. In addition, senior staff must spearhead the corrective milieu process (outlined in Secs. b to d).

b. The toxicity of specialness. A patient may receive the label of "special" as a result of a number of factors; for a lawyer-patient these factors are commonly the following.

1. Overidentification with the lawyer-patient (especially if comparable in age to treatment staff) as a "young professional, like me"—an attitude that may interfere with objectivity in assessment of the patient's needs and problems.
2. Exaggerated perception of the lawyer-patient as unduly litigious (regardless of whether this is accurate) and therefore threatening to the clinical staff.
3. Reluctance of front-line staff to use their own judgment in assessing the patient, coupled with an instinctive upward transfer of authority whereby front-line staff feel paralyzed to effect even needed interventions without sanctions from staff in more senior positions; thus, the patient's care becomes managed from the top, a situation promoting schism, lowered morale, and resentment among the treatment team. The effective leader must often resist the complementary temptation to "jump in and take over" the care of the special patient—another move that worsens the situation. Instead, the leader should maintain normal delegation of authority, while staying fully informed about the case and remaining actively available for consultation. She may also have to protect the patient's treatment from well-meant, but detrimental, interferences from higher-ups in the institution or from extra-institutional pressures, as occasionally occur.
4. Jettisoning of usual procedures, assessments, interventions, and their rationales because of some aspect of the specialness.

> ***Example 4.*** A lawyer-patient in a severe depression was discovered in the ward seclusion room in the act of hanging himself with his belt; he was rescued at the last moment. In the post-incident review, staff discovered through discussion that several of them had independently subscribed to the same thought, namely, “This guy, as a lawyer, must be too smart to do a dumb thing like kill himself.” The result of this shared, but tacit, belief was that they had not removed his belt, as time-honored procedure required, not wanting to “subject a professional to that indignity.”

In sum, the consequences of specialness in a patient may form a toxic synergy leading to avoidance and mismanagement of the patient’s care. The remedy consists of active inservice education about the potential problems and about the importance of seeing the patient in need beyond the obscuring mist of specialness.

c. Role of milieu group process. Much of the toxicity of specialness can be mitigated by group discussion of the experience of working with the lawyer-patient and the difficulties and conflicts that may arise. Such opportunities, encouraged and catalyzed by the ward leadership, permit ventilation, consensual validation, and restoration of morale through sharing of experience—results that might have prevented the nearly tragic outcome of the case in Example 4.

d. Intervention against avoidance. Supervisory staff must remain alert to the potential toxicity of specialness, as it may affect the ability of staff to engage in a therapeutic relationship with the lawyer-patient; such defensive avoidances as described previously (Secs. III-C-1-b, c) must be interpreted like other distancing maneuvers that prevent optimal involvement with the patient’s issues. Front-line staff may need supervisory assistance in maintaining the proper clinical perspective to counter pressures to engage in legalistic struggles.

In short, the attorney must be confronted as a patient instead of a lawyer, especially when legalizing the relationship is a ploy attempted as a resistance. A parallel might easily be drawn with the health professional who may attempt to take on a health professional role in her own care—a maneuver recognized as destructive by all clinicians.

IV. PITFALLS

A. REMAINING THE CLINICIAN

When legal and clinical issues are in opposition (as described also in Chaps. 3, 4, and 6), the clinician must let the patient’s legitimate needs be the determinants of care. Even the patient who has a lawyer (or who is a lawyer) may need a clinician’s help—help that is subverted if the clinician attempts to remove himself from his role and become lawyerlike.

B. FEAR OF SUIT

With reasonable preventive measures (see Chap. 4, Sec. III), the fear of lawsuit may become a peripheral concern; if this concern becomes central, it can obscure a clinical view of the patient, interfering with the quality of care. Fear of legal reprisals must then be worked out through supervision, administrative resolution, legal consultation, or a combination of these, lest therapeutic care be compromised.

C. ANGER AT LAWYERS

The clinician may develop anger at lawyers for a number of reasons, including their personal and professional styles (as depicted in Case Example 1 of this chapter). Because this anger can also interfere with sound clinical functioning, the clinician must guard against possible secondary effects (e.g., getting angry at the patient in displacement because her lawyer is intrusive, hostile, obnoxious, obstreperous, provocative, or accusatory). Introspection, commiseration with colleagues, and other methods may maintain this effect within manageable bounds.

D. OVERREACTION

The impact of the involvement of a lawyer may lead to overreaction in either direction on the part of the clinician: provocative, belligerent, grudging, or withholding behavior on the one hand, and an overly submissive posture that leads to sacrifice of important clinical considerations merely for the sake of avoiding confrontation on the other. Either extreme, of course, is potentially detrimental.

V. CASE EXAMPLE EPILOGUES

A. CASE EXAMPLE 1

Before meeting with the lawyer the following morning, both the resident to whom the case has been assigned and the psychiatrist in charge rapidly evaluate the patient. They agree that the patient, a bright, attractive woman, has a borderline personality and, in the face of several interpersonal losses, had made a serious suicide attempt using sleeping pills. Only at the last minute did she change her mind, deciding to involve her friend, the lawyer, in rescuing her. She is not psychotic, nor does she appear suicidal at present, although given the lack of objects in her life, any subsequent reversal might predictably result in another suicide attempt. Nonetheless, she does not appear to meet strict commitment criteria at this moment. The psychiatrists believe that the preferred course of action would be to keep her in the hospital to enable her to establish a treatment alliance with the resident who will then follow her as an outpatient. They present this plan to the patient and to her lawyer.

Insisting that she is not suicidal and that the hospital is “worse than a zoo,” the patient demands that she be released immediately. The lawyer supports this position, saying that to retain her any longer would violate her right to due process, and that he will take responsibility for her safety if she is discharged into his care. If the hospital refuses to do so, he maintains that he will immediately go to court to seek a writ of *habeas corpus*.

Rather than risk turning the case into any more of an adversarial issue than it has already become, thus losing whatever chance remains of gaining a working alliance with the patient, the psychiatrists agree to discharge her into the lawyer’s care, on the condition that she return to see the resident on an outpatient basis. The patient concurs and discharge ensues.

For two weeks, the patient comes to see the resident, continuing to insist that there is nothing wrong and that the resident cannot help her. When she misses the third appointment, the resident attempts, without success, to contact her. One week later, the lawyer calls the ward, in shock, to inform the staff that the patient’s body was found in her apartment by a neighbor over the weekend. She had apparently taken a fatal overdose of the same sleeping pills.

B. CASE EXAMPLE 2

Hearing the description of the case, the staff psychiatrist observes that this patient, because of his profession, is receiving special treatment that is much to his detriment, especially because the patient’s manic picture demands firm and authoritative controls. He reminds the resident of the protections against suit afforded by careful documentation, frequent review with the chief resident and supervisors, and persistent seeking of an alliance posture even in the direct confrontations necessary to counter behavioral dyscontrol. In sum, the resident is enjoined to see the lawyer as a patient requiring treatment rather than as an attorney threatening suit.

The resident takes heart from this exchange and proceeds; group discussions by ward staff also mobilize new resolve. Laboratory work, previously stymied by the patient’s paranoid and grandiose refusals, is performed perforce and confirms the resident’s suspicions that the patient is experiencing a probable organic psychosis, mimicking mania, apparently produced by excessive corticosteroid intake, the result of a misread arthritis prescription. After the psychosis resolves, the patient describes the feeling of being out of control and expresses gratitude at being restrained before he injured anyone.

VI. ACTION GUIDE

A. CHECKLIST FOR DEALING WITH PATIENT’S LAWYER

1. *Seek* alliance posture.
2. *Educate* lawyer on important clinical issues:
   a. *Remind* about permission for release of information even to attorney.
   b. *Inform* about clinical realities and conditions.
3. *Seek* assistance from house counsel and *refer* outside attorneys to house counsel as needed.

4. *Place* patient needs (especially in crisis setting) foremost.
5. *Respond* to subpoena with presence, obtaining legal consultation.
6. *Attempt* to negotiate for patient's benefit instead of entering legalistic struggle.

B. CHECKLIST FOR DEALING WITH LAWYER FOR THIRD PARTIES

Recall and *review* important factors:

1. Clarity of agency
2. Permission for disclosures
3. Obtaining legal consultation

C. CHECKLIST FOR DEALING WITH LAWYER AS PATIENT

1. *Recall* potential problem areas:
    - a. Milieu anxiety and paralysis over specialness of patient
    - b. Phobic avoidance of patient
    - c. Lawyer's attempts to be own attorney
    - d. Legalistic avoidance as defense
2. *Respond* to problems
    - a. Ward leadership
    - b. Education of staff about "special patient" problems
    - c. Clarification of legal ambiguities
    - d. Encouragement of group discussion
    - e. Supervisory attention
3. *Remain* alert to countertransference factors:
    - a. Remaining the clinician
    - b. Excessive fear of suit
    - c. Anger at lawyers
    - d. Overreaction

D. USE OF LAWYERS

1. Obtaining a lawyer for the patient
    - a. *Refer* inpatients to attorney (this is clinician's obligation); *use* discretion for outpatients.
    - b. *Determine* if patient has private attorney; if so, *use* him preferentially.
    - c. If not, *determine* if patient can afford private attorney.
    - d. If patient can afford private attorney, *obtain* list of referrals through local bar association.
    - e. *Do not refer* to personal acquaintances.
    - f. If patient cannot afford private attorney, *refer* to
        - i. Legal Aid Society or Neighborhood Legal Services for most problems.
        - ii. Law school legal aid programs, if available.
        - iii. Nonprofit agencies specializing in mental health law, if appropriate to patient's problem.
        - iv. If none of the above available, contact local bar association about availability of lawyers willing to volunteer time for indigents.
2. Obtaining a lawyer for the clinician
    - a. In malpractice cases, insurance companies provide attorneys—*contact* them immediately. *Avoid* communications or statements to other parties.
    - b. If conflict of interest appears possible (company insuring multiple defendants), *seek* private consultation—*obtain* referral from medical society, bar association.
    - c. *Arrange* for availability of legal help with emergent problems in advance of their occurrence and for consultation—attorney must be knowledgeable in mental health law—through
        - i. Hospital or clinic
        - ii. Group practice
        - iii. Organization of several independent practitioners for the purpose
        - iv. Direct arrangement with a lawyer

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CHAPTER 8

The Clinician in Court

I. CASE EXAMPLE

Without warning, a therapist receives a subpoena to testify in court the following week. At first, she is sure that a mistake has been made, because she has never been involved in the treatment of offenders or in performing evaluations for the courts. When, at the suggestion of a colleague, she calls the office of the attorney whose name appears at the bottom of the subpoena, she is told by a secretary that the case in question is an action for damages after an auto accident in which the condition of the plaintiff before the accident is a prime issue of contention. The secretary says that it is her impression that the therapist is being subpoenaed because she has been treating the plaintiff.

Looking more closely at the subpoena, the therapist recognizes the married name of a current psychotherapy patient who usually uses her maiden name. The patient had begun treatment only three months previously under the stress of impending marital separation. Although patient and therapist have touched on many issues together, their sessions have focused on the patient's relationship with her husband, an extramarital affair about which the husband does not know, and her feelings about her father, who had died when she was only six years old. The accident has not been mentioned.

After the passing of her initial shock at being subpoenaed, the therapist becomes concerned at the prospect of having to testify. She worries about the time it would take for her to appear in court. The amount of money that she stands to lose is substantial, but she is also concerned about the effect of such an abrupt cancellation of appointments on some unstable patients. In addition, she fears that the testimony that she could be forced to give in court might damage her therapeutic relationship with her patient, leading the patient to withdraw from therapy at a time when she especially needs the support that the therapist could provide. Finally, it is unclear to the therapist what role the court expects her to play. She does not believe that she knows enough about the legal issues involved or about how the accident affected the patient to contribute in any meaningful way to the court's decision. On the other hand, she is fearful that some of the information that she might reveal, particularly concerning the extramarital affair, might needlessly damage her patient's life.

Faced with this confusing array of issues, the therapist decides to call her patient to inform her that the subpoena has arrived. The patient is distraught at the news and says that she will contact her lawyer immediately. She confirms the therapist's impression that she does not want her to testify in any way concerning her mental state. Quite uncertain about how to protect the multitude of interests that she now sees endangered, the therapist approaches a colleague whose practice is largely devoted to forensic work to ask his advice.

II. LEGAL ISSUES

A. THE ROLE OF THE EXPERT WITNESS

Mental health professionals are increasingly called on to serve the legal process. Sometimes clinicians are called as ordinary or "fact" witnesses to testify about occurrences they have perceived themselves (e.g., an assault by one patient on another). Other times, however, mental health professionals are called to the stand as "expert" witnesses, which allows them to serve in a different role. The function of an expert witness may be voluntarily assumed, as in the case of those forensic clinicians whose practice is almost entirely devoted to evaluations and courtroom testimony; however, sometimes clinicians are unwillingly drawn into the adversarial process. This may occur when a patient requires commitment or when the contact that a clinician had with a patient and the opinions that he formed become relevant to non–mental health litigation, such as a child-custody case or a suit for psychic damages after a negligent act. Thus, all clinicians are susceptible to unexpected subpoenas and ought to be aware of the formal and informal rules governing their participation in courtroom proceedings.

1. Definition of an Expert Witness

Wigmore's classic legal treatise on evidence defines an expert as someone who has the "skill to acquire accurate conceptions." In those circumstances in which the bare facts are inadequate to lead the average person to an informed judgment, the expert has the capacity to draw meaningful conclusions from those facts. An expert need not be possessed of a formal degree (e.g., a self-trained ornithologist, whose expertise has come to be widely recognized, might qualify as an expert in a case in which the identification of a particular species of bird is relevant). In cases of alleged mental illness, however, the courts—abandoning their historic position that even a layperson can tell if someone is crazy or not—have turned more and more to mental health professionals for help in interpreting individual behavior.

The status of expert can be granted in two ways. The legislature can determine that groups of professionals should be considered experts for a given purpose. In many states, physicians and psychologists are allowed to provide expert testimony at commitment hearings, whereas other clinicians, even those who may be quite familiar with mental disorders, are excluded. In most cases, though, it is the court that decides if an individual should be deemed an expert on the issue in question. For issues related to mental health, the tendency in recent years has been for courts to exclude nonpsychiatric physicians from expert witness status while being more liberal about allowing psychologists and occasionally social workers to testify as experts.

The use of mental health experts is increasing in both civil and criminal cases. In civil cases, for example, as the courts have become more receptive to claims of negligent infliction of emotional distress (see Chap. 6, Sec. II-C-3), mental health testimony has become more prevalent. In criminal cases, the U.S. Supreme Court recognized that the assistance of a psychiatrist may be essential to the preparation and presentation of a defendant's case, even when she is not invoking the insanity defense. The Court's ruling in *Ake v. Oklahoma* established the constitutional necessity of making mental health experts available to indigent defendants at the state's expense.

2. Admissibility of Expert Testimony

It is not sufficient for a clinician to be qualified as an expert for her testimony to be admitted. The evidence that she intends to present must meet certain standards of relevance, probable helpfulness to the decision-maker, and reliability. For many decades, the most commonly used standard to determine the reliability of expert testimony—and, hence, its admissibility to the trial proceedings—was embodied in the 1923 U.S. federal court decision in *Frye v. U.S.* The *Frye* standard required that the method by which the expert's conclusion was reached was generally accepted in her field. In the *Frye* case, this general acceptance standard was used to exclude testimony based on a lie-detector examination.

Controversy dogged *Frye* from its conception, including contentions that it discriminated against novel approaches and uncertainty over how general acceptance was to be determined. Concern was also expressed that *Frye* set the standard for admissibility too low. For example, so long as an expert used a generally accepted technique—such as a clinical interview—any conclusion at all, no matter how far-fetched or unsupported by data, could be admitted.

The *Frye* case's many problems led ultimately to its rejection by the U.S. Supreme Court in its 1993 decision in *Daubert v. Merrell-Dow*. In place of *Frye*'s general acceptance test, *Daubert* charges judges with determining the reliability of an expert's testimony, a task that extends to examination of an expert's conclusions and not merely her methods. The court eschewed any single indicator of reliability, listing instead a number of possible indicia, including publication in a peer-reviewed journal. *Daubert* itself applied only to the federal courts, and its relevance to clinical as opposed to scientific testimony was unclear. But a few years later in *Kumho Tire*, the Supreme Court ruled that the *Daubert* standards should be applied to expert testimony based on professional judgment, which encompasses most of the evidence offered by mental health experts. Subsequent cases in state courts suggest that this approach is gaining wide (though not universal) adherence and, as expected, is being applied to expert testimony rendered by clinicians.

3. The Scope of Expert Testimony

The expert witness is allowed greater flexibility within the usually strict rules of evidence than the nonexpert witness.

a. The opinion rule. In general, witnesses are permitted to testify only to facts relevant to a given case; opinions are excluded. Thus, a witness may be allowed to state that the defendant drove his car through two red lights before the accident. Should the witness insert an implicit opinion about the defendant's driving (e.g., saying that the defendant "drove through those lights like he didn't give a damn"), it would be stricken from the record as a violation of the opinion rule. The rule is based on the belief that it is the job of the jury, not of the witness, to evaluate the factual information presented; to the extent that the witness has no greater ability to do so than does the jury (or the judge), her opinions are irrelevant to the trial process.

The expert is, on the other hand, allowed to state an opinion in situations in which the average person would be unable to form a meaningful opinion from the facts of the case. The information that an individual was talking rapidly, had not slept for three nights, and was fearful that his plan for bringing peace to the Middle East might be sabotaged by the Central Intelligence Agency is, to most people, a confusing collection of interesting but bizarre, facts. Only a clinician is capable of bringing order to those facts by offering an opinion that they may represent manifestations of a manic episode, for example, with attendant grandiosity and paranoia.

Expert testimony is permitted only when the judge determines, as a matter of law, that the facts in question cannot be properly analyzed by a layperson. In some cases, an expert might be allowed to offer an opinion on one aspect of an individual's behavior but not on another, because the judge believes that the latter (e.g., the confusion of a demented person) is susceptible to determination by the untrained mind. An expert's opinion may also be excluded as irrelevant to the issue at hand or as prejudicial to the deliberations of the factfinder, the latter being more commonly invoked when the decision is being made by a jury, rather than by a judge.

b. The hearsay rule. Ordinarily, an individual's testimony is permitted to be based only on facts that she has perceived directly. Anything else is considered to be hearsay. In practice, this means that if a patient has threatened harm directly to someone, the latter can testify to the reality of the threat. If the threatened person has told the patient's psychiatrist about the threat, however, the psychiatrist may not offer the threat as evidence, because that would be hearsay. The rationale is that it is improper to admit evidence that cannot be tested in the cross-examination.

Even experts are usually bound by the hearsay rule. One exception is relevant here. Although an expert cannot introduce hearsay evidence to establish a fact (e.g., that the threat was made), she is permitted to offer hearsay testimony in support of her opinion. Thus, if the psychiatrist has concluded that the patient is dangerous and in need of involuntary commitment, she may introduce her second-hand knowledge of the threat as a basis for that opinion. In addition, she may rely on documentary information generated by others whom she has not met (e.g., a note in a previous hospital record) to bolster her conclusions. Of course, that the opinion is at least partially based on hearsay may serve to weaken it under cross-examination, but this is not the expert's problem.

c. The hypothetical question. The expert witness has the right to answer a hypothetical question, a function that ordinary witnesses, whose testimony is limited to the recounting of observations, cannot fulfill. Hypothetical questions are useful in obtaining the expert's opinion about a situation other than the one he presumes to have existed. Because the jury is under no obligation to accept the expert's version of the facts, a hypothetical question allows both sides of a case to place the expert's opinion on record with regard to any one of a number of factual situations that the jury might determine to have been present.

Hypothetical questions sometimes stretch the bounds of the expert's imagination, but they do allow the attorneys to probe more carefully the basis for the expert's opinion by altering one element of the history at a time to determine the crucial variable. The fallacy in many cases, and one that any alert expert should point out in responding, is that psychopathologic signs and symptoms often appear in conjunction as syndromes, so that to alter or omit one or another element of the presentation may present an artificial picture that has no correspondence to reality. Nonetheless, the expert may not refuse to answer hypothetical questions, and the well-prepared expert anticipates them and thinks through potential responses in advance.

d. The weight of expert testimony. Many clinicians may naively assume that, having been summoned into court to testify as an expert in a given case, their opinion will be the decisive element in its resolution. Although that may sometimes be true (e.g., empirical studies of commitment hearings have shown that unopposed psychiatric testimony is usually accepted without challenge, and psychiatric recommendations are usually followed), in most instances, for a variety of reasons, the expert's testimony is not the decisive factor. First, in many important cases, both sides obtain their own experts who often offer contradictory testimony. It is then up to the judge or the jury, the composition of which may be a key determinant of the outcome of the case, to decide which expert or set of experts to believe.

Even when expert testimony is not contradicted, the legal finders of fact are still free to disregard it. The expert is expected not only to offer an opinion, but also to state grounds on which that opinion has been formulated. To the extent that those grounds are unpersuasive, the testimony is ignored. Although this may appear to the expert witness to be farcical (because the basis for her being called to testify in the first place was the assumption that the jury members were not able to draw their own conclusions about the evidence), the jury is free to decide that the expert lacks credibility in this case. Even if the expert's factual assertions are accepted, her conclusions with regard to the legal issues can be rejected by the fact-finder. Thus, despite expert agreement that a defendant was unlikely to have been criminally responsible at the time of a heinous crime, a court might find him responsible and guilty because the values of the community are such that it will not let the perpetrator go unpunished. Although frustrating to the expert, such flexibility allows the system to express the moral sentiments of society.

4. Discrediting Expert Testimony

As with all evidence offered in court, the opinion of an expert may be subject to rigorous cross-examination. Some lines of attack are common to all challenges of expert witnesses. Opposing attorneys often challenge the expert's credentials, either as an individual (e.g., his training was insufficient) or as a member of a group (e.g., no psychiatrist can expertly testify about future dangerousness). The opposing attorney may question how much money the expert is receiving for his testimony, implying that the expert's objectivity and opinion are for sale to the highest bidder. The adequacy of his examination, the validity of the conclusions, even the theoretical basis on which his opinion was drawn—all are open to attack.

Psychiatric witnesses, moreover, are particularly vulnerable in a number of these areas. Given the profusion of schools of thought in mental health, it is easy for an enterprising attorney to find professional literature that flatly contradicts almost any theoretical assumption on which an opinion rests. Guides have been published to alert attorneys to these issues of controversy and to steer them to the relevant citations (see Suggested Readings, Ziskin and Faust). Particularly vulnerable are an expert's opinions about the nature of the defendant's diagnosis (given studies showing low reliability of diagnoses among raters), the presumed psychodynamic bases for the patient's behavior (given the panoply of anti-Freudian literature), and a prediction of dangerousness (given studies showing that psychiatrists and other clinicians are poor predictors). The relevance of medical-school training to assessing psychological problems, the reliability of information gathered in the clinical interview, the presumed effect of experience on the ability to make a more accurate diagnosis, and the propensity of psychiatrists to seek unnecessarily protective environments for their patients may also be challenged.

Any mental health professional who is going to testify regularly in court, or even in a single, particularly important case, should familiarize himself with a book such as Ziskin and Faust's, anticipate the arguments that are most likely to be offered, and gather references to refute them. Of special note is that many of the studies that showed psychiatric diagnosis to be unreliable were performed several decades ago and took into account neither the heightened awareness of psychiatrists to conditions such as bipolar illness, nor the effect on reliability of the specific criteria for diagnosis listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR)*.

Experts possess two advantages, although small ones, in this struggle. First, an expert cannot be made to answer a question with a simple "yes" or "no" when he believes that further qualification is needed. Second, no textbook or other published work can be cited to challenge an expert's opinion unless the expert either explicitly has relied on that work in formulating his opinion or acknowledges it as an authoritative work in the field.

5. The Vicissitudes of Being an Expert

a. The unwilling expert. In cases in which the expert has agreed to undertake an evaluation for forensic purposes, there is usually no question about the expert's willingness to present the data in court. Therapists who attain expert knowledge about patients in therapeutic situations, however, and are then asked to testify about that knowledge are usually less-than-eager witnesses. The reasons for their reluctance may range from an unwillingness to spend time away from their work to a fear of the impact of such testimony on their former or current patient, to a dislike of courtroom procedures and of aggressive attorneys.

Nonetheless, when a clinician is properly subpoenaed and when her patient waives privilege or when privilege is inapplicable (see Chap. 1, Sec. II-C-5), she cannot legitimately avoid testifying. She may be called as a fact witness or asked to opine as an expert. Lawyers are often warned to shun the unwilling expert, for fear that the disgruntled witness will torpedo their case by placing even favorable information in an unfavorable light. Despite this, experts are frequently called against their will because their testimony is perceived as crucial to the outcome of the case. The only solace for the unwilling expert is that she can bill the side that subpoenaed her for a reasonable expert's fee, in addition to expenses.

b. The nonexpert expert. As noted in Section II-A-3-a, the court is free to define the extent to which any individual may speak with expert status on the facts of a case. This means that a professional who is an expert in mental health may be called to testify as an ordinary witness. This is obviously true when the clinician has witnessed an event unrelated to her field of expertise (e.g., a bank robbery). The professional can similarly be called to testify only to the facts of an occurrence on an inpatient ward, as when one patient assaults another, without being asked for an expert opinion on the matter. Clinicians are frequently in this situation when called to introduce into evidence clinical records of a factual sort (e.g., medication logs that they have compiled).

Although relieved of the evidentiary and ethical burdens of the expert witness, the nonexpert expert is at a disadvantage when it comes to reimbursement for his time. Ordinary witnesses are reimbursed at a standard rate for travel and lost time, usually amounting to a fraction of their usual income. To the professional who loses hundreds of dollars as a result of abandoning clinical activities for the time involved, it is often cold comfort that our system of justice relies on such sacrifices from all of us to perform its fact-finding function.

c. The expert discovered. An expert who agrees to testify in court can find herself answering questions in quite a different setting as well. As part of the procedures for equalizing the contest between parties in a civil suit, the courts have developed a set of elaborate pretrial investigative routines that are encompassed by the term *discovery*. The discovery process permits each side of a case to summon and interrogate the principals and witnesses for the opposing side before the case reaches the trial stage. Thus, an expert who conducts a psychiatric examination for the plaintiff in a psychological damages case may find herself subpoenaed to present the results of her examination to the lawyers for the defense.

Discovery can take several forms. The questions to which the opposing party wants answers can be transmitted in writing and responded to in kind (i.e., a written interrogatory) or the witness can be summoned to an attorney's office to answer questions in person (i.e., an oral deposition). Additionally, documents such as hospital records or objects can be requested, or the opposing party may demand that the expert be permitted to perform a physical, psychiatric, or psychological examination of the plaintiff. Although each side can always challenge the other's requests for information, courts are generally quite liberal about granting the desired access. One exception is material that may be privileged in court, such as, in some states, the information conveyed in clinical sessions (see Chap. 1, Sec. II-C-3), which is similarly privileged in discovery and should not be revealed without the patient's waiver or a judicial order abrogating the privilege.

Discovery has been subjected to some criticism because of its use in malpractice and other tort suits that have been filed without adequate reason to believe that negligence occurred; aggressive discovery can then be used in a legal "fishing expedition" that is designed to uncover enough adverse facts to justify going to trial.

For the expert witness, the most important point is that testimony obtained by means of pretrial discovery can be as potent and critical as anything said in court. Discovery, whether oral or written, takes place under oath, and—although it ordinarily cannot be introduced at trial in lieu of a witness's testimony—it can be used to challenge and discredit testimony that does not correspond to the account that the witness gave earlier during discovery. The rules that a careful witness should observe, therefore, are identical to those that should govern trial testimony (see Sec. III-C); the witness should, above all, present his responses in a thoughtful manner that reflects his final conclusions on the subject. A careless comment at the taking of a deposition can completely destroy a witness's effectiveness.

d. Licensure of experts. Traditionally, expert testimony by physicians and other licensed health professionals did not require licensure in the jurisdiction in which they were testifying. So long as they were licensed somewhere, that was adequate to allow their testimony to be admitted (assuming, of course, that it met the other requirements for admissibility). This situation is now in flux, and an expert accepting a case in a jurisdiction in which he is not licensed can no longer presume, without further inquiry, that he will be permitted to testify and will not suffer adverse consequences if he does.

Changes in rules and practices regarding licensure have been driven by concern over experts who travel from state to state to testify in malpractice cases. Rightly or not, organized medicine has attributed to such experts significant responsibility for growth in the number and size of malpractice verdicts adverse to defendants. Statutes and regulations adopted by some states in response to these concerns require local licensure for any medical expert, and may define courtroom testimony as the practice of medicine subject to the review of the local licensure board. Experts without such licensure may not be permitted to testify, or if they do, may be subject to sanctions for practicing medicine without a license.

As a consequence, it behooves clinicians who are approached to act as experts in a jurisdiction in which they are not licensed to ascertain whether this will be an issue for them. The easiest way of doing this is to pose the question to the attorney who is seeking to engage them. Since many attorneys use medical and mental health experts infrequently, they may need to be encouraged to investigate the local rules. Alternatively, the clinician can contact the appropriate board of licensure in the jurisdiction in which his testimony is sought and pose the question to board staff. Should licensure be required, it may be possible to obtain temporary licensure on a courtesy basis in some states. Experts who frequently testify in a given jurisdiction may want to seek permanent licensure. It may also be possible for an expert to act as a consultant to a local, licensed clinician, who offers the actual testimony, thus avoiding the conflict.

e. Liability for expert testimony. Potential liability for expert testimony is another issue that has not been of great concern in the past, but is now something that an expert witness must consider.

In general, the law immunizes witnesses for statements made in court proceedings, so long as they are not knowingly being untruthful. In the latter case, recourse can be had to the criminal law for a charge of perjury. The rationale for this immunity is the desire that witnesses speak frankly on the stand, without fear of liability for slander or other torts. Hence, experts have traditionally operated without concern about civil liability, and so long as they were being truthful, without risk of criminal liability either.

However, aspects of experts' activities that do not directly involve testimony (oral or written) may be susceptible to a variety of claims, including malpractice. Possible grounds for such allegations include a negligently performed fact-finding process (e.g., failing to obtain or review relevant records) that results in a conclusion adverse to a party to the case, and negligent examination of a plaintiff (e.g., unskillful questioning that induces persistent emotional trauma). Given the real, but small, risk of such claims, clinicians who function as expert witnesses should be certain that their malpractice insurance covers forensic activity. Some policies do this automatically, but other insurers require the purchase of a rider to the policy at additional expense (sometimes referred to as "administrative insurance").

B. THE ADVERSARIAL SYSTEM

The culture shock that frequently accompanies the entry of a mental health professional into the courtroom setting derives from profound differences in the orientations of the legal and mental health professions. Nothing so typifies this divergence in approaches as the assumptions that underlie the adversarial system.

1. The Theory of the Adversarial System

It has long been the presumption in Anglo-American jurisprudence that truth can only be ascertained by witnessing the combat of minds, each attempting to prove the falsehood of the other's position. So important is this belief that a large part of procedural law is devoted to enhancing the ability of the contesting parties to attack each other as vigorously as possible. Such rules in civil cases as pretrial discovery, and in criminal cases as the constitutional rights to notice of the charges, speedy and public trial, confrontation of witnesses, power of subpoena, and representation of counsel, were all devised to equalize and maximize the ability of each side to prove its point.

Other approaches to truth do exist, of course. The collaborative model, in which all of the involved parties pool their data and share their insights, is the more familiar schema in scientific and clinical work. But the law generally rejects such methods as insufficiently protective of individual rights. An exception to this general practice of eschewing nonadversarial approaches occurred from the early twentieth century until roughly the late 1960s in both juvenile and mental health proceedings. Reasoning that the wayward young and the mentally ill were not really criminals and could benefit more from the collaborative efforts of the courts, the professions, and the state, legislatures relaxed the ordinarily strict procedural guidelines. Hearings were held informally, hearsay was accepted as evidence, counsel were excluded, cross-examination was shunned, and the goal was generally framed not so much to assign blame as to settle on the most desirable and therapeutic outcome.

The difficulty with this ostensibly humane approach to juveniles and the mentally ill was that what seemed desirable from the point of view of the court was not necessarily equally desirable for the individual. The *parens patriae* assumption that the state knows better than the individual what is in his best interest (see Chap. 2, Sec. II-D-2-b), although used to justify such procedures, was called into serious question when it was recognized that juveniles and mentally ill persons alike were being committed to facilities that were underfunded, understaffed, custodial at best, and brutalizing at worst. When the legal profession recognized that its abandonment of the adversarial model was in part responsible for the commitment of so many to such institutions, the quick-step march began to reinstitute the safeguards. Juvenile law and mental health law both have been dominated in the last several decades by the reimposition of an adversarial framework.

Although the return of the adversarial approach may be regretted, it can certainly be understood in this light. Clinicians may be uncomfortable with the adversarial system, but its replacement in the future (at least insofar as the mentally ill are concerned) is dependent on not only the goodwill of those involved in the courts of law, but also on the willingness of society to validate the paternalistic approach by providing adequate resources to construct truly beneficent institutions. Both seem unlikely.

2. The Role of the Lawyer

The key to the effectiveness of any adversarial approach to truth is the performance of the advocate—in this case, the attorney. If adversarial theory is fully applied, the lawyer can have only one approach to his work: an unflagging and undeviating devotion to proving that his client's position is correct. In those cases in which the lawyer actually believes this to be the case, or in many civil suits in which honest differences of opinion can arise about the issues at stake, this presents few problems for attorneys. The lawyer not only attempts to construct as solid a case as possible for his client, but also to contest at every point the assertions of the opposition. A number of ethical problems, however, arise (a) in civil and criminal cases in which the attorney believes his client to be wrong; and (b) in cases for which the goal of the hearing is not to punish or reward, but to treat or protect.

a. Criminal cases. Lawyers' codes of ethics are complicated documents that struggle with these problems but inevitably provide no entirely satisfactory solutions. The vigorous defense of those the lawyer believes to be guilty is justified by establishing certain procedural safeguards (e.g., lawyers are not allowed to present, or to let their clients present, deliberate falsehoods) and by arguing that insofar as the system requires an adversarial confrontation to establish the truth, it would be impossible (and unconstitutional as well) to deny the assistance of counsel to some defendants who are believed in advance of trial to be guilty without making a mockery of the entire adversarial system. Yet, the fact that lawyers must exert their full efforts to defend the guilty is still a troubling matter for many of them. One suspects that the reluctance of so many of the graduates of the finest law schools to enter criminal law is in part related to this issue.

b. Parens patriae *proceedings.* A different set of ethical issues is raised by legal proceedings ostensibly designed to benefit their subjects. Many juvenile court hearings and most mental health proceedings (except for commitments initiated under a pure "dangerousness to others" rationale) fall into this category. To the extent that the subjects of these hearings are less capable than the state to decide wherein lie their best interests (the basis for any *parens patriae* action), it appears at first glance something of an anomaly to encourage lawyers to defend their client's wishes as forcefully as possible. If the best interests of a psychotic individual obviously require hospitalization, the lawyer who successfully persuades a judge to release her client to the fortunes of the street may wonder what good her pleadings have accomplished. In fact, it was just this line of logic that led to periods of relaxation of adversarial procedures in the early part of the twentieth century and again in the 1950s.

What has induced the reversion to stricter adversarial proceedings has been the previously noted perception that, theory aside, the actual dispositions of the mentally ill—in most cases in state hospitals—were not clearly in their best interests. Of course, many would argue that commitment to even the less-well-run state hospitals was preferable to allowing psychotic people to roam the streets, but the impact of the social theorists of institutional life, the labeling theorists of mental disorders, and the diverse arms of the antipsychiatry movement has been to convince many members of the legal system otherwise. Few ethical problems bother attorneys who doubt that mental illnesses exist or who consider psychiatrists to be mere agents of social control. They might be expected to approach every hearing with the aim of preventing their client from being hospitalized.

Other attorneys, often those with more experience in practical mental health law or those who have had a chance to observe the natural course of mental illness, recognize a tension between their charge from the system to "defend" their clients maximally and their desire to see their clients obtain the help they need. This tension is frequently resolved by their subverting the adversarial component of their work, acting instead in what they perceive to be their client's best interests. Perfunctory challenges to psychiatric credentials and testimony, waivers of certain procedural niceties, and questions designed to display their client's level of psychopathology may be involved here. Almost every study of commitment proceedings has uncovered such behavior, but it is usually chalked up to incompetence on the part of the attorney or insufficient time or remuneration to prepare a case. Both of the latter are undoubtedly often important, but even efforts to train attorneys to perform more aggressively in circumstances in which these factors are minimized have failed. As long as the adversarial nature of the system appears to work against the needs of the mentally ill for assistance, many attorneys take what seems to them to be the common-sense approach to dealing with the problem.

3. The Adversarial System and the Expert Witness

Foremost among the complaints of most novice expert witnesses is that they were subject to a cross-examination that seemed to resemble the name-calling games of their childhood more than a dispassionate search for truth. The likely content of this attack was outlined previously (see Sec. II-A-4), but the emotional impact must be taken into account as well. A respected professional whose expertise, competence, and integrity are questioned, and sometimes shaken, before an audience of nonprofessionals may feel as violated as a victim of a street mugging. Some leading forensic experts claim to relish the combat of minds involved in a cutting cross-examination, but for most professionals, it is the low point of their careers.

4. Discovering the Truth in Court

Platitudes from civics class aside, one of the most startling revelations for novice witnesses is that the pursuit of truth is not always the judicial system's preeminent value. Some examples of this slighting of truth in favor of other values have already been alluded to. The rules governing hearsay evidence, for example, are enforced even in cases in which the evidence can be shown to be quite reliable, because the value of preserving the adversarial system itself takes precedence over the discovery of truth in any given case. A clinician who is barred from testifying about threats reported by a patient's family because he did not hear them, with the result that a patient who he asserts is dangerous is released, may be bewildered at this apparent failure of the legal system. Clinicians, of course, tend to be pragmatists, willing to adopt any stratagem or to abandon any theory if the patient is thereby helped. However, the legal system often sees things differently and should be accepted on its own terms if mutual bitterness is not to be the inevitable result of interaction between psychiatry and law.

These sorts of compromises with the unfettered pursuit of truth may seem more reasonable if viewed in a slightly broader perspective. Breaching the confidentiality of the psychiatrist-patient relationship may aid the search for truth in many instances but, because society values the benefits that derive from such relationships, it is forbidden in many circumstances in all state and federal courts (see Chap. 1, Sec. II-B-3). Similarly, forcing a defendant to testify about his own activities may produce the most reliable evidence of what actually occurred, but forced self-incrimination is precluded by the U.S. Constitution. In these and comparable instances, it is not an exaggeration to say that when truth and justice compete for preeminence in court, the avowed goal of the system is to assure that justice prevails.

C. ETHICAL ISSUES FOR EXPERT WITNESSES

1. General Principles

In clinical settings, psychiatrists and other mental health professionals owe primary loyalty to advancing patients' interests. The lack of relevance of the dominant principles of beneficence (acting to benefit patients) and nonmaleficence (acting to avoid causing them harm) in the forensic setting has led some psychiatrists to despair of finding an alternative set of principles by which forensic practice can be governed. It hardly makes sense to talk of benefiting and not harming subjects of forensic evaluations when the consequences of testimony may be decidedly adverse to their interests (e.g., conviction of a crime, rather than a finding of not guilty by reason of insanity). Does this imply that forensic practitioners are acting unethically whenever they perform an evaluation, or that they do their work in a moral vacuum?

The answer to both parts of that question is "no." Although the ethical principles operative in clinical contexts do not apply in the absence of a physician-patient relationship aimed at provision of treatment, an alternative set of principles can be identified to guide us in the forensic realm. Identification of those principles requires reflection on the societally sanctioned task that forensic clinicians perform. Rather than advancing patients' interests in health, as they would in the clinical setting, clinicians performing forensic evaluations are promoting the societal interest in justice. From this function flow the two primary principles that guide their work (see Suggested Readings, Appelbaum, "A Theory of Ethics for Forensic Psychiatry").

a. Truth-telling. Evidence of the first principle guiding forensic evaluation comes from the oath every witness takes at deposition or trial to "tell the truth, the whole truth, and nothing but the truth." Truth-telling is the *sine qua non* of the evaluation process. This principle has two components. The expert must be subjectively truthful (i.e., saying only those things he honestly believes to be true) and, as suggested by the phrase "the whole truth" in the witness's oath, objectively truthful as well. This means that, insofar as possible, the ethical expert attempts to acquire relevant information, makes clear the limitations on the certainty or reliability of his opinion (e.g., it represents a minority or idiosyncratic view of the literature), and acknowledges the legitimacy (when real) of opposing views.

b. Respect for persons. As noted (see Sec. II-B-4), the legal system is not devoted to the unalloyed pursuit of truth. At times, other concerns, such as fairness to defendants, take precedence. Thus, clinicians too, when aiding in the administration of justice, must temper their actions by recognizing the principle of respect for the persons they evaluate. This means being honest with evaluees about the purpose of the evaluation, even when deception might lead to a more accurate assessment of the situation. The principle of respect for persons also enjoins forensic clinicians from breach of confidentiality of the evaluation, with disclosures limited to advancing the purpose for which the evaluation was conducted.

c. Other principles. Clinicians sometimes wonder whether they may have residual duties of beneficence or nonmaleficence toward subjects of their evaluations that flow from their medical or other professional roles. To avoid confusion in the forensic setting, it is probably best to acknowledge clearly that it is governed by a different set of principles than clinical treatment. This does not mean, however, that a forensic evaluator cannot act to benefit the evaluee (e.g., by identifying a previously undiagnosed condition); beneficent actions remain praiseworthy. Moreover, like all persons, the forensic clinician remains enjoined from violating the principle of nonmaleficence by inflicting harm gratuitously, unrelated to her forensic function.

Finally, it should be stressed that the ethical parameters of the forensic evaluator (i.e., a clinician performing an assessment for a legally relevant purpose) are at issue here. When forensic clinicians provide treatment (e.g., in a prison setting), their behavior is properly governed by those principles that apply in the clinical realm. This is an important reason for the same clinician not mixing clinical and forensic roles with a given person.

d. Forensic evaluation and the practice of medicine. The question is sometimes asked whether a psychiatrist who is performing a forensic evaluation is engaging in the practice of medicine. The only possible answer is "yes and no." Clearly, the psychiatrist is drawing on her medical knowledge to perform the evaluation. To that extent, the forensic role resembles other aspects of medical practice. Licensure boards and professional ethics committees have not been reluctant to sanction psychiatrists for improprieties committed in the course of performing forensic work. On the other hand, the forensic psychiatrist is playing a role different from the usual function of the physician; he is advancing the interests of justice rather than of health. This difference has been recognized in the common, and in many jurisdictions continuing, practice of courts of admitting testimony from practitioners who are not licensed to practice in that jurisdiction, suggesting that they recognize forensic evaluation and testimony as distinct from the usual practice of medicine (but see Sec. II-A-5-d).

Perhaps the best solution is to conclude that the psychiatrist performing a forensic evaluation is undertaking a function that draws on his expertise but is governed by a separate set of ethical principles from ordinary clinical work.

2. The "Hired Gun" Problem

Most expert witnesses are not hired by the court, but by the defense or the prosecution. This frequently leads to confusion in the expert's mind as to the extent of her obligation to those who are paying her fee. Should the expert try to support the point of view her employer is espousing when the evidence for it is weak to nonexistent? The principle of honesty would suggest not, but that principle does not answer a host of subsidiary questions. How much preparation with the attorney of the side that hired her is legitimate? When confronted in court with evidence that seems to negate the basis for her opinion, how obstinately should the expert stick to her original conclusion?

In short, how can the expert avoid being seen as a hired gun who is being paid to express the opinion that would favor her employer's case?

a. Skills for sale. The problem of testimony biased by financial gain can be alleviated by focusing on exactly what the expert is selling in the bargain struck with an attorney. The honest expert is paid for time spent in offering a set of skills, a way of analyzing the problem, and the means of presenting that analysis in court. He should not be mongering an opinion for sale to the highest bidder and amenable to influence by the power of pecuniary suggestion. The court expects the expert to reach an opinion by an impartial exercise of the relevant skills and to present the opinion with as diligent a regard as possible for the uncertainties inherent in the evaluation process. The clinician's compensation is, strictly speaking, for the time that it takes to reach a conclusion and to appear in court, not for the vector of the conclusion.

b. The evaluation process. An expert witness who agrees to conduct an evaluation should do so with the explicit understanding that the conclusion may not conform to the outcome desired by the attorney. The expert should always arrange to be paid the same amount for the evaluation (usually depending on the time involved) whether or not the attorney uses it in court. Many experienced expert witnesses believe that payment of a retainer in advance lessens the psychological pressure on them to reach the "right" conclusion, although the poor track record of many attorneys in paying their experts is probably a more persuasive reason to arrange for such a retainer.

With that understanding, the potential expert witness should approach the evaluation by attempting to reach the most accurate assessment possible. Because of the subtle influences on clinicians in these situations to resolve doubts in favor of the side on whose behalf they have been asked to testify, the expert should search assiduously for contradictory evidence and consider it seriously before reaching a conclusion. This often means going beyond the direct assessment of the individual whose status is in question, seeking evidence from family members, friends, and others who have come into contact with him. When such corroborative evidence is necessary but unavailable, or the attorney refuses to allow the expert to interview other informants, the expert may want to consider withdrawing from the case on the grounds that a truly expert opinion is unattainable.

c. Pretrial preparation. Having performed the evaluation as described, the expert is obligated to convey her findings as precisely as possible to the attorney. This includes noting the basis for the opinion, its strengths and weaknesses, the reasonable opinions that other consultants might reach and those opinions' strengths and weaknesses, and the confidence with which the expert is able to uphold the opinion in court. If the opinion is not useful to the side for which she was asked to do the examination, her participation may end there. Assuming the attorney agrees that the expert's unvarnished opinion is of use to his case, however, it is legitimate for the expert and the attorney to rehearse its presentation in detail and for the expert to reveal ways of buttressing her testimony in court. Involved here is a switch from the role of impartial assessor to a position as a pretrial consultant, in preparation for the situation in court in which, once again, the expert assumes the neutral role.

d. Testifying. On arriving on the witness stand, the expert is expected to testify to the truth as he perceives it, regardless of which side called him into court. Of course, that the witness has arrived at this point implies that his opinion fits the expectations of those who are paying his fee. Nonetheless, he should not overstate the certainty of the conclusions he has reached, understate the likelihood that alternative interpretations are correct, or—in the face of new evidence that was previously unavailable to him—resist changing his opinion if that seems called for. Hypothetical questions should be answered honestly, even if doing so would seem to weaken the case he is supporting. The wise attorney recognizes the advantages of this neutral approach to expert testimony: The more independent-minded, reasonable, and open to input the expert appears to be, the more likely it is that his testimony will be respected by a jury.

This approach to the role of the expert, although difficult to fulfill in that it requires several complicated psychological shifts in perceived allegiance, can serve to reduce many of the ethical concerns related to expert testimony. A residuum of difficulty always remains, of course, because of the natural desire to please those with whom one is working, but unless expert testimony is to be discarded altogether on these grounds, this desire must be overcome insofar as possible by constant attention to the possibility of bias that it creates.

e. Peer review. One of the most useful—if underused—means of monitoring one's performance and staying on an appropriate ethical keel is to subject one's testimony to review by a group of peers. Review can be accomplished by informal groups of colleagues, academic departments of psychiatry, or local medical, psychiatric, or other professional organizations. The American Academy of Psychiatry and the Law has offered peer review to members for a number of years, with positive reactions as to its educational value (see Suggested Readings, American Psychiatric Association).

3. The Battle of the Experts

Among those mental health professionals who advocate complete abstention from courtroom proceedings, the most common rationale is that the diversity of expert views that can be observed in many cases does nothing but degrade the professions in the eyes of the public. This "battle of the experts" creates the impression, they continue, that expert opinions are for sale to the highest bidder and that there is no common store of knowledge on which any of their opinions rest.

Unfortunately, opinions can sometimes be bought, whether the sale takes place consciously or unconsciously in the mind of the expert. More often, expert witnesses develop ideological biases that shape their testimony in individual cases, resulting in the phenomenon of the psychiatrist who always testifies for the defense in criminal responsibility cases or one who always testifies that the mental patient should be committed. Interpersonal factors are also of importance. Even without realizing the effect of a developing relationship with the attorney who employs her, the expert may find herself drawn toward the attorney's position out of reluctance to disappoint "a friend." Many attorneys recognize this tendency and cultivate personal relationships with their expert witnesses.

The most common reason for a difference of expert opinion is simply that cases that reach the trial stage are frequently so laden with complicated factual elements that finding professionals who honestly can express differences of opinion is not difficult. Naturally, the considerable uncertainties and gaps in psychiatric knowledge contribute to this process. However, seen in this light, the much-deplored battle of the experts differs little from the vigorous disputes that take place at many grand rounds presentations, or—for that matter—disputes that might arise between experts in engineering, architecture, or geology concerning complex issues that might have forensic impact in those fields. Unless one sees value in hiding the fact that psychiatry is not an exact science—a revelation that is unlikely to surprise most educated laypersons—there seems little reason to shun courtroom confrontations of opposing experts.

4. Nonadversarial Approaches

Given all of the previously cited reasons for professionals' reluctance to get involved with the adversarial system, it is not surprising that the suggestion is frequently made to abandon it in favor of nonadversarial approaches. The most common scenario that is offered is as follows: The court appoints one expert to examine the individual or group of individuals (e.g., in child custody cases) whose condition is in dispute; all sides cooperate in making evidence available to the expert consultant, whose opinion serves as the sole basis for the argumentation of both sides in the case. Although this proposal does not remove the need for vigorous cross-examination, serving as a court-appointed expert does remove the pressures that many experts feel toward partisanship and the trauma of opposing a fellow professional in court.

As appealing as the nonadversarial approach may be (and as much as it was used, in practice if not in theory, in the juvenile and mental health systems for many years), there are sound reasons for both lawyers and clinicians to reject it. Foremost among these reasons is the spurious sense of certainty that a single opinion may tend to convey in a field that is still in its scientific infancy and is therefore riddled with uncertainties. Much of the venom that lawyers and judges direct at psychiatry today is a result of the unwarranted self-assurance with which it welcomed the task of participation in decisions about sentencing, rehabilitation, and prediction of recidivism in the early twentieth century. A return to the pretense that only one psychiatric approximation of truth exists does neither the legal system nor psychiatry much good.

In addition, to disallow the side that is disenchanted with the neutral expert's findings the right to enlist experts to challenge the assumptions and procedures used and the conclusions reached is not only quite likely unconstitutional, but on a pragmatic level serves to encourage sloppy assessments and to attract the least competent practitioners into the field. Although it is the constitutional due process issues that probably ensure that such nonadversarial procedures do not become the norm, it is doubtful that, even from the clinician's point of view, they would, in the end, be desirable.

5. The Problem of Causing Harm

One of the trickier ethical issues for mental health professionals relates to the consequences of their participation in court proceedings. Ordinarily, clinicians comfort themselves with the thought that they are devoted entirely to the welfare of their patients and to the principles of beneficence and nonmaleficence. The courtroom setting, however, clearly calls these presumptions into question.

When testifying in court, mental health professionals may contribute directly to harming the people whom they have evaluated. Testimony, for example, about a defendant's mental state at the time of the crime may lead to his being convicted, rather than being found not guilty by reason of insanity. Evidence of a low likelihood of responding to treatment may lead to the imposition of a harsher sentence. Even in civil proceedings, testimony that benefits one side harms the other, often including the person who is the subject of the clinician's evaluation.

Is this acceptable? Can clinicians (especially psychiatrists, whose ethics derive in part from the principle of *primum non nocere*—first do no harm) legitimately testify in ways that may cause harm to the people they have assessed? Some clinicians answer this question in the negative and shun all forensic work as a result. This conclusion seems too extreme. In their clinical roles, clinicians, in fact, must seek the best interests of the people they evaluate and treat. Their functioning in the forensic setting, however, is guided by a different set of principles, emphasizing the pursuit of truth, within the limits of fairness. This is not problematic, as long as the forensic evaluator makes clear the distinctions between her clinical and forensic roles. In this nonclinical task, it may still be obligatory to avoid needless harm to subjects, but harm resulting from the disclosure of information in proper legal settings is not ethically problematic.

III. CLINICAL ISSUES

A. THE COURTROOM AS A FOREIGN COUNTRY

The clinician called into court for the first time to testify on his own or another's behalf commonly regards his entry into this novel arena as something akin to parachuting unarmed into enemy territory; this view, however romantic, is usually a derivative of the clinician's ignorance of the language and customs of the courtroom, and thus confounds the unfamiliar with the threatening. Regarding the courtroom with this approach, although understandable, lends neither comfort nor assistance to the beleaguered therapist.

A more useful approach may be to view the courtroom as a friendly, potentially interesting foreign country that one has occasion to visit. Although the language, garb, and customs of the inhabitants may appear startling to the first-time tourist, potential rough spots of such a visit can be smoothed by (a) careful attention to preparation, (b) learning a bit of the language in advance, and (c) acquiring some familiarity with the customs one is likely to face, especially those governing sensitive areas of behavior and demeanor. Different kinds of courts may use different rules, but the following (see Sec. B) review of information for the clinician in court is organized around the fundamentals suggested above to help the relatively inexperienced traveler. Although the discussion that follows centers on the role of expert witness, similar reasoning often applies to the physician as defendant.

B. PREPARATION FOR APPEARANCE IN COURT

(See Suggested Readings, Sec. B.)

1. Case Selection

Not every case presented to a potential expert has merit for the side retaining her. Moreover, some cases pose contraindications for participation in the form of conflicts of interest (e.g., one of the parties is a close friend), limits of expertise (e.g., the witness has little knowledge and no experience with the type of patients or issues involved), or the absence of a relevant psychiatric issue (e.g., the attorney really wants a lie detector). The expert should also be wary of taking on a case in which the attorney appears prematurely certain of the expert's opinion; such attorneys may be seeking a hired gun (see Sec. II-C-2) who parrots the desired testimony rather than an ethical witness who forms an independent opinion.

The initial dialogue with the attorney should cover time commitments and conflicts in the expert's schedule, fee agreements, and any issues of the expert's past that might prove problematic for the attorney. This last category might include legal, credentialing, or licensure problems, previous cases in which the expert testified in support of positions that seem to favor the other side in the current case, and publications that might be seen as in conflict with the positions being espoused by the party hiring her in the case.

2. Use of Charts and Records

The database for the expert witness in forensic psychiatry consists of several categories of information. The most familiar sources of data are the records of a hospital, clinic, or individual practitioner relating to a particular case. These are examined not only as to significant form and content, as reviewed in Chapters 1 and 4, but also as to omissions, ellipses, and ambiguities in relation to the legal question (negligence, child custody, assessment of disability or damages). Further information may be sought from other appropriate sources or obtained from direct examination of the subject (see Sec. 3, below) or others. It is often wise for the expert witness to make, and then familiarize herself with, her own notes and summaries on the material she reviews, with the intent of taking these to the witness stand in place of the original materials; not only are these notes easier to manage and retrieve information from than are the voluminous documents that are part of most cases, but they offer no invitation to the cross-examining attorney to seize gratuitously on words or phrases read out of context from the record.

When reviewing materials for the first time, the expert should devise some method of indicating the critical details of the database that are probably essential to her opinion—such methods might include highlighting, underlining, summarizing, marginal comments, or use of self-stick notes or similar flags—to prevent having to reread everything in preparation for conferences with one's attorney, deposition, or trial. Particular attention should be paid (for records of inpatients) to nurses' notes, medication records, and similar parts of the chart often overlooked in casual review. These can be critical in discovering from eyewitnesses what occurred. Consistency or inconsistency should be determined (e.g., does the nurse's note on the 11:00 PM to7:00 AM shift recount the incident in the same way as the doctor's progress note written the same calendar day but actually the next morning, when new data and the benefit of hindsight provide additional perspective?).

Laboratory slips and test results of all types should also be scrutinized with care because the results may not necessarily be recorded within the body of the chart's progress notes; important bases for a decision made by the treaters may not otherwise be explicit or even comprehensible.

It is entirely appropriate, though not always possible, for the expert witness to interview caretakers or relevant parties directly, first obtaining their permission and explaining clearly both her task and the side of the case that she represents. (If the expert is employed by neither side, this too should be made explicit.)

In malpractice cases, the data gathered from these multiple sources should be organized in terms of a decision tree—that is, because clinical treatment consists of innumerable decisions in which one path is chosen over another, the expert should arrange the information to reflect the data available to the treating clinicians at the time the decision was made. The expert must be alert to the alternatives: What would have been the outcome of "the road not taken"? Was the chosen path consistent with good clinical practice? These and related queries must be seen against the backdrop of the unique aspects of the case and the consensus of the profession on guidelines for sound treatment.

> ***Example 1.*** An expert witness, testifying in a suit for wrongful death after the suicide of an inpatient, noted from the record that the depressed patient had been attempting, in a relentless manner, to strangle herself with her own clothing. A course of antidepressants had been initiated. Given the patient's documented suicidal press, the expert realized that the pivotal questions were the following: Why was electroconvulsive therapy not used? What conditions might have militated against its use? Was the failure to use it a mark of negligence, or were other factors significant in this decision? Was electroconvulsive therapy considered, and did the chart evince a careful weighing of the pros and cons?

The primary pitfall in the expert's path is hindsight bias, a universal problem in reviewing a case. Hindsight bias is the illusory foreseeability of an outcome once that outcome is already known. For example, when a patient has committed suicide and suit is brought, the established suicidality of the patient may charge every detail in the case—the presence of depression, suicidal ideation—with the apparent force of a portent, despite the fact that the vast majority of depressed persons, even with suicidal ideation, do not commit suicide.

The expert is challenged to enter into the prospective view of the treaters and to assess the validity of their decision-making from that realistic perspective, because the outcome was not known in advance.

3. Direct Examination of the Subject

As outlined in Chapter 6, subjects being examined for court-related matters deserve clear and candid explanations, before examination, about the clinician's agency (i.e., for whom the clinician is working) and about the purpose to which the information may or will be put.

Typical warnings to the interviewee include that (a) the interview is not confidential because it is part of legal proceedings; (b) the examiner is retained by a particular side, but that the testimony is only valid if objective, so that the testimony may help the examinee's case, hurt the case, or have no effect on the case; (c) the examinee may take breaks whenever needed; (d) the examinee need not answer questions, but the examiner may take notice of that fact; and (e) no treatment is provided or recommended because the interview situation is not a doctor-patient relationship. The subject should be encouraged to direct any questions to her attorney if uncertain about any of these ground rules. Finally, the expert should document the examinee's assessed competence and understanding of these rules.

Some insurers suggest that expert witnesses should develop consent forms articulating the ground rules and that the examinee or attorney, or both, should sign them. As with all such forms, a written agreement should not replace an open dialogue, but, if used, should merely supplement it.

The expert witness should also explain that his task is to deliver an opinion—no more and no less—and that, though other opinions may be vouchsafed, the judge, jury, or both will make the actual decision. This last point is important to make explicit because a number of naive subjects view the interview with the expert witness as resulting in the decision itself.

Embarking on the interview, the expert must bear in mind both that she contributes unique professional skills of inquiry and investigation and that, however skillful, she is limited in determining some of the information that judges and juries wish to obtain. The "one, true, correct" treatment decision, a person's fitness to be a parent, the actual past dangerousness of a person examined long after the danger has passed—all these issues tax, if not exceed, the capabilities of even experienced interviewers, by virtue of their complexity, their variability from person to person, and the inevitably retrospective viewpoint of the examiner.

For example, can one truly assess fitness as a parent without seeing the relationship with the child over time, and would not even that assessment be powerfully influenced (if not distorted) by the presence of the observer?

The existence of these difficulties should not preclude the examination nor should it necessarily invalidate the results; rather, such problems demand from the witness a keen awareness of the necessity for being explicit about the data from which his conclusions are drawn and the limits of such data. Few types of testimony are more damaging to the case, to the witness, or to the credibility of the profession than sweeping, final, and confident conclusions, drawn from unsupported "intuition" and "experience."

The actual interview should conform to the information-gathering, rather than the treatment, model; however, the importance of rapport with the subject, patience, tact, and respect remain unchanged from the clinical setting. In addition to exploring the key area in question, the clinician should elicit background material as to functioning in other related areas, general psychological strengths and weaknesses, and the subject's manner of relating in the interview. With proper introduction, a full mental status examination should be performed; this examination often reveals unexpected psychosis, cognitive disturbance, memory defects, and the like. As many interviews as needed should take place.

A detailed record of the interview should be made during the examination or as soon thereafter as possible. Repeated interviews may be necessary and should be anticipated, because a subject's mental state may fluctuate, or a subject may communicate more freely with someone seen more than once. Additional questions or uncertainties, moreover, frequently arise at the point when the clinician writes or reviews the notes from her first interview.

The report, if one is requested, should be organized along the general lines of a case presentation: general background, including the origin of the request for the evaluation (e.g., attorney for the plaintiff, judicial order, request by the evaluee); questions to be addressed and the circumstances of the examination; present and past historical data obtained from interview and other sources; family and social history, where appropriate; mental status examination report, including verbatim queries and responses when indicated, especially in critical areas in which the demonstration of a patient's understanding or capacities is significant; notation of areas in which data could not be obtained or conclusions would not be supportable, or both; and, finally, a summary of impressions and conclusions, together with the summarized data on which they are based. (See sample reports in Chap. 6, Sec. VI-B, -C, and -D.) Other ways of organizing reports for the court have been suggested; the expert should settle on a format that she finds comfortable and will use consistently. Experienced witnesses often include some comment about their own assessment of the validity or reliability of the examination and conclusions (e.g., "The absence of psychotic symptomatology at this point, five months after the alleged onset of the psychosis, would not imply that use of medication, at that time, was inappropriate."). If statutory criteria are involved (e.g., for an insanity defense), the wording of the relevant portion of the statute should be included verbatim.

4. Literature Review

Because attorneys engaged in mental health litigation routinely attempt to gather information from mental health literature to develop their cases, the expert witness should certainly review current professional work on the subject. The growing field of forensic research may be particularly valuable to the expert. The purpose of such a review is largely to diminish the disconcerting impact of surprise questions; in practice, no clinician can be expected to keep absolutely *au courant* with all developments, even within a specialized area of his field. Clinicians should also review their own writings on the subject in question, paying particular attention to conclusions that might seem to contradict their testimony.

Expert witnesses should be aware of the existence of extensive computer databases maintained by both plaintiff and defense law firms, which contain nearly all the deposition and trial testimony that experts have given in previous cases. These archives place a premium on the expert's scrupulous reporting of past testimony or acknowledging that she does not recall it, to prevent gratuitous attempts at impeachment. Different cases, of course, yield different opinions, but previous testimony, even only apparently at odds with current opinion, is fair game for cross-examination.

5. Preparation of the Attorney

In the metaphor of the expert witness as a traveler in a foreign country, he develops a two-way communication with his guide, on one hand learning from him the significance of the terrain, signposts, and landmarks and the expectations of proper behavior and customs, on the other hand imparting a sense of his interests, his capacities and strengths, and such information as he may already have assimilated. Similarly, an essential part of preparation for appearance in court is establishment of just such a two-way communication with the attorney representing one's side of the case.

a. The role of education. Educating one's lawyer about various aspects of the psychiatric profession, including diagnosis and treatment practices, represents one of the most vital functions of the expert witness, especially in the early preparation of the case. The amount, level of complexity, detail, and extent of this education, of course, are directly related to the attorney's experience and familiarity with the subject.

> ***Example 2.*** A deposition that had been confusing to the attorney was submitted to an expert witness; the case involved a patient with schizophrenia who had, at one point, been depressed. The expert witness realized (and explained) that the word *depression* was being used in three ways, all carrying different connotations in psychiatric parlance. The defendant physician meant the transient mood disturbance; the opposing attorney meant the full-fledged syndrome; and the Physicians' Desk Reference (from which the attorney was quoting) meant the decrease in central nervous system electrical activity (i.e., "central nervous system depressant").

The educative process, of course, is a two-way exchange of information. The capable attorney reciprocally prepares the witness as to what to expect in court, probable lines of direct examination and cross-examination, strengths and weaknesses of the case, and the pivotal legal issues.

b. Handling unrealistic expectations. Less experienced attorneys do not differ from laypersons in sharing unrealistic expectations and misconceptions of the abilities, capacities, and predictive or retrospective powers of mental health as a field and of psychiatrists in particular. As might be expected, many expectations are wishful, deriving from attorneys' desires for certainty in areas of inherent and inescapable ambiguity.

A typical unrealistic expectation is that the clinician is a human lie detector, able to detect insincerity, fabrication, or malingering on the basis of a simple examination. Whereas inconsistencies may, indeed, emerge over the course of one or several interviews, the clear and convincing determination of lying lies beyond the clinical sphere. The knowledgeable expert should be aware, however, of the relevant literature on detection of malingering and its possible application to the case (see Chap. 6, Suggested Readings, Sec. F) because consideration of possible malingering should accompany every forensic examination.

Another expectation considers the clinician someone who evokes speech. Clients who refuse to speak or answer questions when their attorney asks them are not necessarily garrulous when confronted by a mental health professional.

A third view depicts the evaluator as possessed of a time viewer or "retrospectoscope"—capable of detecting with certainty, by examination some time after the fact, a patient's mental state during the commission of an alleged crime.

A fourth expectation is based on the failure to appreciate such human factors as ambivalence, the role of the unconscious, and the operation of defenses in mental life. Thus, a parent may overtly press for custody of his child but, harboring profound ambivalence about the outcome, may unconsciously sabotage his case; a psychiatrist, asked by an angry, frustrated, or bewildered attorney to determine the genuineness of this parent's desire for custody would not be able to give a "yes" or "no" answer.

A fifth legal expectation skirts the fringes of unethical behavior. Attorneys may exert pressure on the clinician to suppress or ignore certain events that have actually taken place. For example, an attorney, having sent a particular letter to the clinician, may ask her to pretend she never received it, or the attorney may try to dissuade the clinician from retaining his private notes of an interview. Clearly, clinicians should resist any attempts that would have as an ultimate consequence lying under oath. The clinician must acknowledge receipt of all documents and all records and leave it up to the attorneys to fight over whether some material is inadmissible or privileged as a work product. When attorneys persist in the attempt to solicit unethical behavior from clinicians, clinicians should withdraw from the case.

> ***Example 3.*** A psychiatrist indicated to an attorney that he had retained certain written notes of an interview whose content might prove somewhat problematic for the case the attorney was attempting to advance. The attorney nudged the psychiatrist conspiratorially with his elbow and muttered, "Psychiatrists don't always keep those notes, you know."

Certainly no inherent ethical problem exists in discussing or negotiating with attorneys over the particular phrasing of certain points in ways that do not compromise the basic opinion, but attorneys who attempt to enter into an argument over the clinician's objective views should be gently, but firmly, resisted.

> ***Example 4.*** In examining an elderly person for competence, the expert reported to the attorney that she had "islands of competence." The attorney asked if it could be expressed that she had "areas of competence," because the metaphor might be confusing. The witness accepted this close rephrasing but cautioned that, when asked on cross-examination, the "areas" would be acknowledged to be small and isolated, like islands.

> ***Example 5.*** A forensic psychiatrist examining a patient for dangerousness in consideration of his release from a hospital obtained a fairly benign picture from the attorney and the patient, but found, on reviewing the old charts, a terrifying record of dangerous child molestation, which the patient had denied. The psychiatrist explained to the attorney that this history precluded the release. The attorney began to complain about the problem with psychiatrists always getting into history, and asked why they cannot take a patient as he stands. The psychiatrist held his ground on the point.

Another common expectation arising out of a wish for certainty is the demand for an absolute diagnosis—the production of which is a problem for the profession itself, a fact, needless to say, hard for the novice counselor to grasp. That a psychiatrist diagnosing a patient with "highs and lows" (i.e., mood swings) may need to consider not only bipolar illness, but schizophrenia, organic brain disease, an intercurrent drug habit, a personality disorder, or a variation of normalcy often bewilders attorneys unfamiliar with the diagnostician's dilemma in the field.

Although this list cannot be exhaustive, it may convey a sense of the problem; the expert witness' job includes clarifying for his attorney the manner in which some expectations cannot be realized. Of course, a similar task of "reality testing" may have to be performed on the witness stand, but one's own attorney should receive no surprises at that time.

Most attorneys experienced in this area are cognizant of these difficulties and appreciate the lack of certainty that characterizes much of clinical evaluation and treatment. For the attorney who is unaware of these elements, the expert witness should clarify the matter during pretrial collaboration.

6. Conclusions in Psychiatric Evaluation

In presenting the conclusions of the evaluation, the expert witness should keep in mind (either pretrial or in court) the uncertainties of final conclusions. The truism that there is more than one way to skin a cat is eminently applicable to the clinical sphere: There is more than one way to diagnose or treat a patient, interpret a finding, or view an outcome of a case. This realization should evoke humility in offering an opinion, recognizing the presence of human fallibility and bias, rather than presenting it as an omniscient, unitary, and absolute finding. The expert witness should avoid framing the conclusion as the ultimate issue (e.g., "the defendant is insane"); instead, she should present the relevant findings and bases for the opinion (e.g., "symptoms consistent with insanity criteria").

C. CUSTOMS AND DEMEANOR IN THE "FOREIGN LAND"

Courtroom etiquette is briefly discussed in Section II. A different perspective is taken in this section. The psychiatrist traveling to court must first dismiss his visions of courtroom drama that are drawn from television shows and other fictional portrayals. These dramas often include a scene in which the cross-examining attorney, breathing fire into the face of the crumbling witness, snarls or bellows question after question, reducing the witness to rubble before the opposing counsel can even shout "Objection!"

In reality, counsel may not physically approach the witness without the court's permission and would be severely enjoined from any such histrionics. However, the witness' knowledge of certain guidelines that do apply to court demeanor can considerably aid her effectiveness on the stand.

1. The Role of the Witness: What It Is and Is Not

If the clinician-witness, unfamiliar with the courtroom role he will play, seeks to draw on some familiar model to guide his participation, the best such model might well be his teaching experience. In that arena, the goals are to inform the audience, to impart information in the most readily assimilable way, to maintain the audience's interest and attention, and to field difficult, challenging, or provocative questions on the subject.

These precepts closely parallel the guidelines for the witness. The best teachers know the secret that among the most powerful forces in fine pedagogy is the audience's perception of the teacher's wish to convey the material and the eagerness and effort expended on this goal. This is also true of reaching a judge and jury.

These goals may be readily distinguished from other infelicitous intentions, inconsistent with optimal presence on the stand—intentions also to be eschewed by the traveler in a foreign land. Undesirable aims include the wish to be admired and to impress others by showing off one's vast knowledge and erudition; the wish to win the case through intimidation of one's audience by one's arrogant, authoritarian demeanor; the wish to fawn on, flatter, or seduce the jury; or the wish to patronize, or condescend to, one's audience from a position of superiority. All of these approaches are alienating, self-defeating, and ineffective. The seasoned expert witness is aware, moreover, that judges and juries may believe that these attitudes are present even when they are not, just as the foreigner's motives may be misunderstood by the natives; therefore, he avoids even the semblance of such inappropriate aims.

a. Informing. The task of the witness, beyond delivering an opinion based on the data gathered as described previously (Sec. III-B), is to inform judge and jury about the area of psychiatric knowledge under question; this would be the case regardless of whether there is only one expert or one expert on each side of a case. The informing function must be distinguished from arguing.

b. Arguing. The witness who provokes, or is drawn into, argument with counsel or judge betrays her function and undermines her position on the case. The view has been frequently expressed that juries decide more on the basis of dictates from the viscera than from the cerebral cortex, and the argumentative witness is viscerally less convincing. Because the witness' sole function is to provide objective testimony, the jury may be justifiably puzzled as to why this person is arguing as though she had a partisan interest in the case.

c. Preaching. The role of the witness is not to advance the cause of psychiatry, deplore legal blindness and ignorance, or propose statutory reform. The witness stand should not be confused with a soapbox. The blurring of the expert's actual role may alienate the jury.

d. Advising. The witness must recall that to judge or jury, or both, belongs the task of deciding the case on the basis of the information provided. The witness who preempts this task may face stern reprimands because, although judges vary in their tolerance for flexibility in courtroom conduct, they rarely relish having their decisions made for them.

> ***Example 6.*** An overenthusiastic witness was testifying at a hearing on the committability of a suicidal patient for whom a writ of *habeas corpus* had been filed. He stated, at the end of his response to a question, "This patient should clearly be committed because the law states that patients dangerous to self through mental illness should be committed." The judge stared in disbelief, then announced through clenched teeth that this decision was the substantive issue before the court and was, therefore, something that he alone would decide. The crestfallen witness was dismissed.

2. Technical Considerations

a. Clearing time. Legal personnel are mindful of physicians' and other clinicians' schedules and are usually (but not always) cooperative, choosing a date and time maximally convenient for the witness to appear. However, many courtroom events are of unpredictable duration. The experienced witness, therefore, clears a generous amount of time and brings work or recreational reading along. The witness who is preoccupied with a patient yet to be seen that day—as the trial drags on and the clock ticks inexorably away—has made her situation more difficult and her preoccupied, hurried, or distracted court appearance far less effective, as well as having kept the patient waiting. Directions to the courthouse and transportation and parking issues should be made clear in advance.

b. Oral presentation of material. In the entire history of jurisprudence, no expert witness ever spoke too clearly, audibly, or comprehensibly; the expert witness should keep this axiom in mind. Teaching or lecturing experience is invaluable here; absent this background, some rehearsal with an objective audience is excellent preparation, because the witness who mutters, mumbles, or speaks too softly markedly reduces his credibility, no matter how impressive his credentials.

c. Credentials. The confrontation of the experts is sometimes influenced, if not decided, by the respective credentials of the two parties; in some jurisdictions, specific case law permits judge or jury to weigh testimony differentially, based on differing levels of expertise, however determined (e.g., by extent of direct clinical experience with the type of presented problem).

Jurors may alternatively be bored by, unimpressed by, or uncomprehending of, credentials (e.g., board certifications) in which the expert takes great pride. These same jurors may be more influenced by the witness' clarity of expression and credible demeanor.

When one expert has more powerful or impressive credentials than that of the opposing side, certain tactical approaches by counsel commonly come into play. The opposing side attempts immediately to concede the witness' expert status, thus preventing the judge or jury, or both, from hearing the witness intone the lengthy catalog of her stellar achievements. Counsel on the expert's side attempts (with equal celerity) to insist that the minute details of the expert's curriculum vitae be read into the record precisely for their impressive effect. The outcome of this struggle is usually settled by the judge.

Sometimes an apparent problem with credentials may be turned to the witness' advantage by suitable humility.

> ***Example 7.*** An expert had testified that his academic rank was that of instructor in a local medical school. The attorney asked, in contemptuous tones, whether it was not true that "instructor" was the lowest academic rank at that school. The witness cracked, "You sure know how to hurt a guy." There was general laughter, and the attorney turned to other topics.

3. Subjective Aspects

a. Impugned expertise as narcissistic assault. More than any other aspect of the foreign country of the courtroom, it is the cross-examination of the expert witness by the opposing side that causes clinicians to turn pale and shudder when they hear the phrase "appearing in court."

This reaction stems, in part, from the fact that in clinical settings experts frequently and freely disagree, but usually (though not always) with preservation of mutual respect, maintenance of a diplomatic mode of conveying disagreement, and awareness that the complexity of the field allows for differing views. In contrast, the cross-examination may hew single-mindedly to a given viewpoint, in most undiplomatic terms, with apparent gross disrespect of the witness.

In understanding the experience of personal narcissistic assault (so commonly described by clinicians who have served as experts in court), it is important to keep in mind the single-mindedness of the opposition. Although the process of cross-examination is often carried out with reasonable respectfulness, on occasion the opposing attorney directs his attack against the expertise, competence, character, motivation, or corruptibility of the witness, rather than against the witness' testimony. In clinical settings, social surroundings, and formal debating procedures, it would be unfair, inappropriate, self-defeating, and proof of dubious conviction of righteousness to resort to an *ad hominem* attack (i.e., an attack on the person rather than on the substance of the issues). In court, however, such impugning of the witness' personal features is simply a technique used by counsel to discredit the witness (see Sec. II-A-4).

The mistake commonly made by the novice witness under such a barrage is to assume that this personal attack is personally intended. In his native land of clinical practice, the clinician would readily grasp that personal abuse may represent the adolescent's need to test, the paranoid's need to project, or the borderline patient's need to torture the object; such an understanding permits him to maintain perspective in the service of the clinical work. The disconcerting effect of such assault in court stems from the fact that its perpetrator is a nonpsychotic adult lawyer whose undisguised (and apparently unmotivated) hostility, hatred, and contempt bewilder the clinician. The assault is all the more demoralizing for the expert because it is (a) public, (b) unanswerable in the courtroom conditions of question and answer, and (c) so markedly in contrast with the veneration accorded by his own attorney to his pronouncements.

The primary succor to the beleaguered expert in such a situation derives from the rules of the game, realistic expectations, and defense mechanisms.

b. Rules of the game. The expert must understand that a personal attack is merely a tactic, representing one approach by an attorney doing her job, derogating the opposing testimony in an attempt to put her own side of the case in a favorable light. In a well-functioning adversarial system, the lawyer should be viewed as playing the role prescribed for her, one that she considers essential to the attainment of justice.

c. Realistic limitations. An attorney may attack a witness for the uncertainty of his conclusions or may impugn the database ("Doctor, do you mean you base your opinion on a mere four hours of examining the patient?"). The nonexistence of certitude should be accepted in clinical matters and should not distress the witness; if the time spent was adequate for the determination, this should be stated (the expert having, it is hoped, determined the adequacy of this amount of interviewing time before trial).

d. Defense mechanisms. One means of withstanding the assault is to use the high-level defense mechanisms of humor, rationalization, and intellectualization. Just as a therapist deals with an angry borderline patient by attempting to understand the dynamic issues that lie beneath the angry exterior, so the clinician in court can analyze the nature of the legal attack on her testimony. This is not to claim that humiliation can be an enjoyable experience; rather, lesser degrees of insult can be made more tolerable if the witness can psychologically step back from the proceedings to recognize the nature of the process. At times, this perspective is materially aided by such common courtroom scenes as the attorney who, after trial, sincerely compliments the same witness against whom (during the process) she was directing disparagement, scorn, and scathing contempt.

4. Structural Aspects of Trial Presentation

The expert witness goes through at least two, and perhaps four, stages of the trial process in presenting her testimony: direct examination, cross-examination, redirect examination, and recross examination.

a. Direct examination. In direct examination, the attorney for the witness' side of the case asks specific questions, which may be designed to be answered with "yes" or "no" or with a brief narrative response, with the goal of presenting to judge or jury the expert's contribution in a systematic and persuasive manner.

i. Laying a foundation. In developing the material for presentation, the attorney must create a hierarchy of statements that justify or substantiate the conclusions before they are addressed. For example, in a negligence suit about bad effects from medication, an expert witness may be examined as to the appropriateness of that medication for the illness in question. The questioning does not begin in the manner related in Example 8.

Example 8.

Attorney: Doctor, should this medication have been used for this patient?
Doctor-Witness: In my opinion, based on review of the case plus my own extensive experience, I would say, yes.

Instead, each of the several components that make up the witness' answer—an outline of her experience and her expertise, a summary of the issues, and the opinion itself—must be buttressed by previously established facts or affirmations (i.e., the foundation), some or all of which may be challenged by opposing counsel. The direct examination may evolve in a condensed form as in Example 9.

Example 9.

Attorney: Doctor, please state your name and address.
Doctor-Witness: [Does so.]
Attorney: Describe your training, please.
Doctor-Witness: [Describes in moderate detail.]
Attorney: Doctor, do you have an area of particular expertise?
Doctor-Witness: [Witness, who has several, understands that the attorney is referring to the subject in question and lists publications, awards, and association memberships in psychopharmacology, after which counsel asks for her acceptance as an expert, which is unchallenged.]
Attorney: Doctor, in the course of your practice, do you have occasion to treat patients directly?
Doctor-Witness: Yes, I do.
Attorney: Do some of these patients experience schizophrenia?
Doctor-Witness: Yes.
Attorney: About how many?
Doctor-Witness: About one-third.
[Opposing attorney objects, noting that this gives no idea of the actual numbers; objection is sustained.]
Attorney: How many of such patients is that, Doctor?
Doctor-Witness: About 50 a year for the last ten years.
Attorney: And do you ever have occasion to prescribe medication for some of these patients? [This rather redundant question, again, serves only to lay a foundation for the key question that caps the sequence of queries.]
Doctor-Witness: Yes, I do.
[Further questions establish the frequency of drug treatment decisions made by the expert, her familiarity with the medication's effects and side effects, her wide consultative experience, and the like.]

Attorney: Doctor, have you had occasion to review the case of Mr. _____?
Doctor-Witness: Yes.
Attorney: And have you formed an opinion, based on your experience and said review, as to the appropriateness of the medication for this patient?
Doctor-Witness: Yes, I have.
Attorney: And what is that opinion?
Doctor-Witness: That it was appropriate.

The denouement of this series of questions is identical to that in Example 8, though a hundredfold longer and more detailed; this meticulous questioning allows the final opinion to carry greater force. Rather than appearing as a casual self-styled expert, the witness has been characterized carefully for judge and jury as having specific experience, training, and expertise that should lead to her opinions being considered with care.

ii. Hypothetical questions and follow-ups. Hypothetical questions and follow-ups (the rationale for which is outlined in Sec. II-A-3-c) often pose a problem for the novice witness. Strictly speaking, hypothetical questions should be based only on material previously introduced into evidence; the witness should be alert to any changes from her view of the facts of the case that might affect her answer. Follow-up queries, either in the direct examination or more commonly in the cross-examination, are designed to consider alternative possibilities and to determine which elements are decisive to a particular outcome. Because their function is often speculative, hypotheticals may delineate a situation that bears no relation to the case. Failure to grasp this can lead to embarrassment.

Example 10.

Attorney: Doctor, is it possible that this patient's psychosis resulted from taking angel dust or PCP [phencyclidine]?
Novice Witness [Heatedly]: But he didn't take it!

In this example, the witness did not go along with the "what if" intention of the query, and has forgotten that the judge, jury, or both have the final decision as to which of the alternate universes of hypotheses will be considered to apply to the case. Although the attorney may have asked the question merely as a tactic to implant doubt about the diagnosis in the jurors' minds (even though previous testimony may have excluded any possibility of PCP being involved), even a psychosis with classically functional symptoms may have a number of causes. Practically speaking, anything is possible. An appropriate response addresses this.

b. Cross-examination. After one attorney has developed the expert's opinion by direct examination, the opposing counsel takes over the questioning for cross-examination, the heart of the adversarial process (see Sec. II-B-3 and II-A-4); the function of this stage is to put to the proof the assertions of the witness and the supporting data. Some specific pointers on this phase of testimony appear in Section III-D. The critical consideration for the expert is the realization that, although until now one attorney has been attempting to showcase her expertise and competence in a supportive (and, it is hoped, persuasive) manner, the opposing attorney has an equally legitimate goal. He must attempt to invalidate, derogate, discredit, or even ridicule her testimony—to induce disbelief in the minds of the jurors—by leading her to display doubt, self-contradiction, or confusion.

This intention of the cross-examining counsel should alert the witness to the need for caution in replying, care in weighing the question and its impact, and thoughtful anticipation of the line of inquiry. The cross-examiner may also lay a foundation and ask hypothetical questions to establish the position he wishes the jury to perceive. A witness should keep in mind that the best response to a screaming, abusive cross-examination is an unfailingly polite and level tone.

One of the most difficult problems for the novice expert is the "throwaway question." This is a question whose answer is obvious and inarguable, but curiously tempting toward argument, obsession, or excessive qualification. An attorney cross-examining a plaintiff's expert in a malpractice case involving a suicide may ask, "Isn't it true that some patients will kill themselves no matter what?" The only credible answer is an unqualified "Yes." Beginners may be tempted to continue, "But in this case proper treatment wasn't given." This argumentative response can only undercut the witness' credibility with the jury and thus should be resisted.

c. Redirect and recross examinations. As the names suggest, redirect and recross examinations permit the expert's attorney and the opposing counsel, respectively, to have their final opportunity to elaborate or challenge any points that may have emerged during the first two stages of the testimony. On occasion, these last two stages are waived. After that point, the witness is usually dismissed, although on occasion (especially if new developments supervene) the expert may be recalled. Forensic etiquette directs that, when dismissed, the expert should gather up his materials (but not court exhibits) and leave without further conversation with the courtroom personnel.

D. THE "FOREIGN LANGUAGE" OF THE COURTROOM

In the clinician's work environment, his native land, two kinds of language prevail: (a) narrative, the language of the case presentation, lecture, textbook, article, or clinical report; and (b) dialogue, the language of the interview, case discussion, team treatment planning session, or consultation.

In the courtroom, narrative is brief, if present at all, and the dialogue evinces certain peculiarities and unique locutions that make it foreign to the clinician's ear; these peculiarities may be divided into structural aspects, substantive aspects, and technical aspects. The clinician bound for court, like the experienced traveler, does well to familiarize himself with the language of the land.

1. Structural Aspects of Courtroom Language

a. The scope of the question. In many clinical settings, questions addressed to the consultant (expert) are open-ended; a question like "Do you think that this patient's diagnosis was correct?" might, with full appropriateness, call forth a 15-minute response covering diagnosis, precipitants of the clinical reaction, and dynamic formulation of the case, each with corroborative material, anecdotes, personal associations, and examples from the consultant's practice. In contrast, the examining attorney's question is usually "closed-ended," directed to a brief response or even to a "yes" or "no" answer. The expert witness is strongly advised always to stay within the question addressed to her.

This constraint poses several difficulties. First, many clinical questions (perhaps most) cannot be answered in this manner but require qualifications. The expert may then state that the question requires a qualification, about which the attorney (or the opposing counsel) may subsequently ask; some questions are so phrased as to evoke "It depends" as the only possible answer.

While being asked questions, the expert may wonder if the answer is germane to the case or even admissible as evidence. This matter should be left to the attorney; the witness should concern herself only with the question before her. This restraint should entail avoiding volunteering information; unlike the situation in clinical settings, the usual courtroom question is not an invitation to discourse. The exception, of course, is the question specifically aimed at a discursive answer, such as, "Tell us the purposes of the mental status examination."

In answering, the witness must recall the structure imposed by the need to lay a foundation. Thus, when the attorney asks, for example, "What—if any—treatment did you administer?" the "if any" is not a disparagement of the witness's wish to treat the ill; rather, it is a locution designed to avoid appearing to assume that treatment had been administered.

b. "I don't know." A major pitfall for the novice witness is equating "expert" with "omniscient." The witness should candidly acknowledge ignorance when he does not know the answer to a particular question or when the phrasing of the question—because of vagueness, infelicitous choice of words, or irrelevance—makes it impossible to answer knowingly.

> ***Example 11.*** A cross-examining attorney was attempting to shake the expert witness' testimony as to the value of the use of seclusion for a patient in a particular case; the witness had been established as an expert on seclusion. The attorney asked, "What would be the effect of seclusion on a normal person?" The witness realized that the problem with this disarmingly simple question lay in the fact that normal people are never secluded in psychiatric inpatient settings; hence no theoretical or clinical data on this situation exist. Overcoming her anxiety at admitting ignorance to so deceptively simple a query, the witness replied, "I don't know." The attorney feigned astonishment and asked further questions, to which the witness gave the above explanation for her answer.

Clinicians should also remember that some information is simply not discernible by any clinician, no matter how gifted. For example, a member of a racial minority with schizophrenia committed, while drunk, an apparently racially motivated crime that had no reliable witnesses, contemporaneous police reports, or other objective observers. He later disavowed any recollection of the event. A clinician evaluating that person for criminal responsibility could not be expected to give an assessment of the subject's mental state at the time of the offense, nor of the respective roles quantitatively played in the crime by the defendant's schizophrenia, intoxication, or response to racial slurs. A clinician asked such questions may wish to consider pointing out (although perhaps not in the actual courtroom itself—better in depositions or in conferences with the attorney) that some material is simply not clinically knowable.

c. Reasonable medical certainty. In most civil litigation, experts are expected to testify that their opinions are accurate to a "reasonable medical certainty" or "reasonable medical probability." (Psychologists are held to a "reasonable psychological probability.") If they do not express this minimum degree of confidence in their judgments, their testimony may be excluded from consideration by the judge or jury. Thus, in a malpractice case, after a foundation has been laid, an expert may be asked, "Doctor, do you have an opinion to a reasonable degree of medical certainty as to whether Dr. Jones conducted his practice with that degree of care and skill required of a reasonable psychiatrist at that time and in those circumstances?" (See Suggested Readings, Rappeport, Reasonable Medical Certainty.)

Considerable confusion exists, however, over just what constitutes a reasonable medical certainty. Some jurisdictions have case law that clarifies this issue, but many do not. Reasonable medical certainty may mean a 51% likelihood or more probable than not. Alternatively, it can be conceptualized as that degree of confidence in her opinion that a physician would need before undertaking treatment of a patient. Before testifying, an expert who is uncertain of the meaning of the standard in her jurisdiction should clarify this with her attorney. If no clear standard exists, there is some value in the expert herself specifying the meaning that she gives to it. For example, she might begin her response to the question regarding Dr. Jones by saying, "If by 'reasonable medical certainty' you mean more likely than not, then I do hold my opinion to that degree of certainty."

Novice experts are occasionally disconcerted when a question of possibility, rather than reasonable medical certainty, is asked of them. Asking a question in terms of possibility is (because this is not the requisite standard of proof), in most cases, an attorney's ploy to place some image before a jury that competes with the image proposed by a reasonable medical certainty. Thus, an attorney, working for the plaintiff in a suicide case in which the occurrence of negligence is doubtful, might ask the question: "Doctor, is it possible that a psychiatrist might miss the suicidal thinking in a patient?" This question, of course, is irrelevant because (a) anything is "possible," (b) the issue is not possibility but reasonable medical certainty, and (c) the question should focus on this case rather than a hypothetical case. Regardless, the attorney may be attempting to suggest to the jury that the doctor could have missed something.

Experienced witnesses simply take questions about possibility at face value. Because anything is possible, the answer to a question of possibility is generally "yes." The opposing attorney may, of course, object on the grounds that the possibility is irrelevant to the matter. Clinicians should simply answer questions about possibility in the affirmative, leaving it to the attorney to straighten out the questions of admissibility.

2. Substantive Aspects of Courtroom Language

a. Describe versus interpret. The witness in court should remember the first lesson of microscopic pathology: First describe, then interpret. This brings the judge or jury, or both, into the sequence of data gathering leading to certain conclusions, and it demonstrates the substantiation process. Direct observations, examinations, and measurements should be identified as such and distinguished from inferences, intuitions, impressions, and hypotheses drawn from clinical experience or premonitions.

b. The qualities of an expert witness' answers. After the swearing-in process, the psychiatric witness should abandon his role as advocate for one side of the case and become, in effect, an advocate for clinically founded truth. This fundamental principle contains certain implications for the content of the witness' answers, including the following:

- The answers should be true to the best knowledge of the witness.
- Answers should be germane to the issue.

- The answers should embody objectivity in examination and evaluation and austerity in expression. Prolix or opinionated responses should be avoided.
- The responses should be clear, expressed as simply as possible, with attention paid to making the answers comprehensible to a lay audience.
- The answers should be expressed in a manner designed to avoid provoking or alienating the audience. Often this principle is best served by total avoidance of jargon. In the courtroom, everyday language, spoken in a noncondescending manner, is more convincing by far than a profusion of polysyllabic terminology aimed at conveying vast erudition.

3. Technical Aspects of Courtroom Language

The substance of technical aspects of courtroom language might be described as "tips and traps," a phrase referring to the hints that can make testifying easier and more effective and the well-known snares set by attorneys—the awareness of which may prevent the informed witness from being caught therein.

a. Tips on responding to queries

i. The value of delay. The habit of pausing a moment before answering can be of significant value to the witness, because it allows time to check on whether one understands the question, to replay the question in one's head, and to weigh and choose one's answer. In addition, it allows the nonquestioning attorney to object if desired, thus perhaps preventing compromising or inappropriate answers from being expressed. If the witness realizes that the query requires considerable reflection, he should ask for a moment to think over the question—a move that tends to reduce the audience's impatience at the delay.

ii. Unanswerable questions. Certain questions that are phrased very simply are yet unanswerable on clinical grounds; for example, "Would a patient with schizophrenia be likely to assault his mother?" The response "I don't know" is not nearly so apposite as "I can't answer that question"; the inability to answer a question phrased confusingly or without qualifications (schizophrenia per se being irrelevant to the patient's likelihood of assaulting his mother) should be freely and frankly admitted. Ideally, the judge directs rephrasing the question, or the attorney does so without prompting from the judge.

The experienced witness can convey certain hints to his attorney that aid in the elucidation of the testimony.

> ***Example 12.*** In a case involving a violent patient, commitment had been sought based on violent behavior that had occurred just before hospitalization. The attorney asked the expert witness (who had supervised the case only in the hospital) a question including the phrase "violent while under your care." The witness replied, "I can't answer in that time frame." The alert attorney realized the problem and broke down the query into subsidiary questions that clarified the timing of the violent behavior in relation to the petition for commitment.

In a similar manner, such responses as "I can't answer that phrasing" or "I can't answer without qualifiers" may aid the attorney in developing the point at issue.

iii. The context of the question. Although second-guessing the attorney can lead to serious difficulty for the witness, the astute expert attempts to tune in to where the question is coming from, on what assumptions it is based, and in which direction the question is headed. This approach permits forethought and diminishes surprise.

The expert witness should remain alert to the possibility that the questioning attorney may reveal by the phrasing or content of a query that she is confounding distinct entities (e.g., the attorney may treat mental illness as inherently equivalent to incompetence, irresponsibility, or committability, or psychosis as identical to schizophrenia). If confusion exists, the witness should protest an inability to answer the question and hope that the opportunity is provided to clarify the matter.

iv. Qualifiers. Especially when being cross-examined, the witness is well-advised to be alert to qualifying phrases in his response because the attorney may interrupt after the part of the answer he desires has been given.

> ***Example 13.*** In reply to a question as to whether a certain situation could occur, the witness wanted to respond, "Yes, but that situation is rare and unlikely, in fact, to occur." However, he had

> only uttered “Yes” when the attorney said briskly, “Thank you, doctor; no further questions,” and the judge intoned, “Witness may step down.” The expert was, in essence, turned off with little recourse short of causing a disturbance in court.

In anticipation of this difficulty, the witness should develop the habit of leading with qualifying phrases; opposing counsel is motivated to permit completion of the response because the desired portion is not stated until the end.

> ***Example 14.*** In the same situation as Example 13, the witness might respond, “Although that situation is rare and quite unlikely, it is theoretically possible.”

v. Metaphors and analogies. Although these rhetorical devices may be immeasurably useful in clarifying a point for the jury, due care must be exercised in judicious use thereof, and the limitations of even the most apt analogy must be delineated. Careful forethought should be devoted to designing precise, familiar, and clear metaphors and analogies to help jurors formulate a point.

> ***Example 15.*** Attempting to distinguish data based on his single evaluation of a patient from data that could be obtained over a period, a witness characterized the evaluation as being like a snapshot. Opposing counsel proceeded to begin each subsequent query with, “Now, regarding this—this snapshot you took, Doctor . . .” With each repetition of the metaphor the expert’s examination was more embarrassingly trivialized, so that by the end of cross-examination the expert felt (and appeared) like an incompetent dilettante in photography rather than like a competent psychiatrist.

b. Consideration for the subject’s presence. In most cases, the subject of the examination is present during the proceedings. With this in mind, the witness should remain the clinician by exercising tact and consideration in choosing diplomatic (yet accurate) ways of expressing her opinions or findings. It is preferable to state, for example, “The defendant revealed a history of antisocial acts over ten years,” rather than, “The defendant is your typical common thug of the born-loser type.”

Indeed, the psychiatric literature (see, for example, Suggested Readings, Strasburger) suggests that intense negative reactions can occur when the subject believes that his innermost thoughts are being revealed.

> ***Example 16.*** The subject of one expert witness’ testimony stated “I had the feeling [on hearing the witness’ testimony in the courtroom] I was on an operating table and you had a dissecting knife and you just opened me up wide for everyone to see . . . [it was] frightening, positively frightening . . . [I] just wanted to be dead, I didn’t want to be in that room.” This subject further described struggling with severe, acute suicidal feelings after the testimony.

On an ethical basis, it might be argued that clinicians have a duty to explain to attorneys the potential negative impacts of such disclosures in their client’s presence.

c. Some common maneuvers by attorneys in court. Attorneys’ approaches to a witness vary from respectful to abusive and over all points in between. Certain familiar traps should be watched for because of their ubiquity.

i. Fee as focus for attack. As suggested in Section II-A-4, attorneys may raise the issue of the consultation fee in an attempt to impugn the integrity of the witness. The most common provocative question is, “How much are you being paid for your testimony, Doctor?” a remark that implies that the witness is corruptly vending his testimony instead of his time. The witness should come to terms with a reasonable fee earned for time spent (as well as time lost from usual professional activity) and should state the fee if asked about his time. One’s forensic peer group may provide useful standards for fees.

Example 17, an excerpt from an actual deposition, illustrates how this might occur.

Example 17.

Attorney: What year was this that you gave your testimony (in a previous case)?
Witness: Three years ago, maybe, roughly.
Attorney: Were you paid for your testimony in that case?
Witness: No.
Attorney: You did that for free?

Witness: No.
Attorney: Then how do you explain that inconsistency?
Witness: I was paid for my time. My testimony cannot be bought.
Attorney: Are you being paid for your time in this case?
Witness: I certainly hope so.

Some experienced witnesses, asked about their charges, respond disarmingly, "It depends how long you keep me here." Others, asked if they are being paid for their services, assume a worried expression and say, "Gosh, I certainly hope so!" Such ingenuous remarks usually defeat the attorney's attempt to taint the witness with the suspicion of venality. These ploys are usually reserved for juries; attorneys arguing before a judge alone (as sometimes occurs) rarely resort to such gimmicks, because judges are rarely impressed with them.

ii. "Never say never." Attorneys may attempt to build queries around "always" and "never"—two referents that rarely fit any real clinical situation. The expert should not worry about seeming indecisive or unsure but should stick to the realities of experience, uncertain though they may be.

iii. The lulling series. An opposing attorney may ask a series of questions, all calling for a "yes" answer, for example, after which a question requiring "no" is unobtrusively inserted, in the hope that the witness is so lulled into the rhythm of assenting that momentum alone, as it were, generates an inadvertent "yes" to the last query. The obvious remedy is alertness and use of the time-lag in responding alluded to earlier to allow individualized attention to each question.

A related problem may arise when an attorney launches a salvo of rapid-fire questions, tempting the witness to respond rapidly. Even if the witness' answers refute the attorney's points, the witness invariably sounds harassed and defensive. A slower, thoughtful answer sounds more credible and solid and breaks the attorney's fast pace.

iv. The use of literature as authority. The expert's view in court may be challenged by references to the psychiatric literature. Although this may be an intimidating encounter, the novice expert should be aware that the citation (from a book, article, or monograph) must first be recognized as an authority by the expert before it can be used to challenge her testimony (see Sec. II-A-4). Although this principle may lead to disclaimers redolent of hubris ("Freud had his theories, I have mine"), the expert is best advised to be reluctant to award authority to any work except possibly her own published material; even in the last case, the expert still may determine whether the cited point applies to the case. Commonly cited authorities are the Physicians' Desk Reference, the Comprehensive Textbook of Psychiatry, and DSM-IV-TR. Note that many works are multiauthored compilations of sometimes uneven quality.

DSM-IV has a disclaimer noting that the diagnostic criteria it contains are not necessarily synonymous with legal definitions of mental disorder. In particular, because DSM-IV-TR is designed to maximize reliability of diagnosis, cases that are in some way atypical are often left without a category into which they can fit. This limitation on the use of the manual in legal contexts, however, is frequently neglected, as attorneys attempt to equate a plaintiff's or defendant's failure to meet all the criteria required for a particular diagnosis with the absence of legally relevant mental disorder.

Given the inconsistencies of the book, experts legitimately can make diagnoses other than those contained in DSM-IV-TR (e.g., simple schizophrenia) or can assign diagnoses covered by the manual even when patients do not meet all of the DSM-IV-TR criteria, as long as they acknowledge that they are departing from the standard nomenclature and are prepared to justify and explain the bases for their conclusions. Within the diagnostic system itself, the category of disorders denominated "atypical" or "not otherwise specified" provides considerable flexibility for cases that depart from typical presentations.

v. Inaccurate quotations. The expert should be wary of questions that begin "Doctor, you testified earlier, did you not, that . . . ." It is a common attorney's dodge to alter the previous testimony slightly in quoting it, so that the misquoted remark may be used to throw the witness' testimony into contradiction. The expert should always critique such queries in her mind to see if they are accurate. The stenographic record may be consulted if there is doubt and if the point is critical.

Thus, the attorney who claims that the witness testified that most people who are depressed commit suicide can be corrected usefully in several ways: "Unfortunately, that's backwards, counselor. I said, and it is true, that most people who commit suicide are found to have been depressed; depression is common, but suicide is rare." Another response might be: "I certainly don't recall that testimony, and it certainly isn't accurate; perhaps you can show me where I said that." This places the burden of the claim back on the attorney.

vi. Simple harassment. Attorneys on occasion resort to certain locutions designed to needle and thus rattle the witness. Examples are: "Now, Doctor—it is 'Doctor,' isn't it?"; referring to the witness as Mister rather than Doctor; referring to a psychiatrist as a psychologist and vice versa; or using heavy sarcasm and disparagement concomitant with the examination.

The best counter to those ploys is a deadpan, strictly factual response to the substance of the question. The attorney who harps on "Mister" more than a few times soon begins to sound petty and foolish and normally ceases before alienating the jury. The witness who becomes irritated, contentious, or sarcastic in turn is, of course, in danger of vitiating the force and credibility of his testimony.

vii. Testifying about preparing to testify. Another point of attack for the attorney trying to discredit the witness is the pretrial preparation (alluded to in Sec. II-C-2-c). Although review of anticipated testimony and some rehearsal of possible cross-examination is customary practice, this rehearsal may be painted by opposing counsel as coaching, implying that the witness is simply mouthing preformed testimony supplied by counsel for her side.

On the stand, the witness should acknowledge that time was spent reviewing the case and her testimony. Some experienced witnesses disarm the accusational tack by saying, for example, "Counsel recommended that I tell you the truth," or "The attorney told me to answer your questions as honestly as possible."

As usual, the ethical balance here pivots on the autonomous functioning of the witness who offers independent conclusions based on unbiased evaluation. The clinician who permits counsel to dictate her testimony has sold out to the law.

viii. Incomprehensible questions. Some questions are put to the witness in a form so grammatically complex or maladroitly worded that even a correct answer, somehow arrived at, would only heighten the preexisting confusion. A rewording may be respectfully requested; alternatively the witness may simply want to state that she does not understand the question or the wording. Consider the following real-life example.

Example 18.

Attorney: Would it be speculative on your part to give an opinion as to whether therapy and treatment wouldn't have been effective even if she had not attempted this suicide?

Witness: I'm sorry. I got lost in the double negatives.

Other Attorney Present: Me, too.

Example 19. An actual deposition (see Suggested Readings, Gutheil: The Psychiatrist in Court) contained the question: "Was that explanation amplified in any way with any details as to what that sexual abuse was supposedly to consist of during that conversation?"

Another form of incomprehensible question is one in which the attorney attempts to ask several questions at once, as it were, in an effort either to confuse the witness or to render the witness apparently befuddled.

Example 20. A malpractice case in which a patient had killed his girlfriend turned on the question of whether the patient should have been committed. The patient, however, was with his family, and without any professional observers present at the critical moment. The following questioning occurred in the courtroom:

Attorney: At the time the patient was with his parents, was this patient committable?

The expert paused a moment to think about this question because the patient's committability would have been difficult, if not impossible, to assess in the absence of professional observers accustomed to thinking in terms of the statutory standards. As he paused a moment, the examining attorney declaimed, dramatically:

Attorney: Do you mean you even have to think about it? That's a yes or no question.

Predictably the other side's attorney objected to this question. The single question really has three components: first, the question of the patient's committability in the absence of observers trained to make that legalistic assessment; second, the question of whether a witness under oath should indeed have to or be allowed to think about answers given in that context; and third, the question (disguised as a statement) as to whether in fact so complex an issue is answerable with a simple "yes" or "no."

In the real-life example, after the objection, the questions were broken down and answered separately. However, the expert might have had several options, assuming the opposing attorney had not objected:

Witness (Option 1): That's three questions, counselor. If you'll just choose the one you'd like me to answer first, I will be glad to take a crack at it.

This response is useful for whenever multiple questions are asked at once.

Witness (Option 2): Of course I have to think about it. I take being under oath very seriously and I think about every answer I give you, just as I think about every question you ask me. Why is that so surprising to you?

Witness (Option 3; witness turns to ask the judge): Your honor, I need your guidance on what to do. It seems I've been asked three questions at once; what's the appropriate procedure for a witness under these circumstances?

All these responses permit a rapid reaction to the attorney's question by the expert, but allow the full duplicity of the examining attorney's multiple queries to stand out (while conceivably gaining some sympathy and support from the judge in the last example).

Note that for those experts wishing to improve courtroom skills, the American Academy of Psychiatry and Law offers educational peer review of psychiatric testimony.

E. SUMMARY

The citizen in his native land, aided by the knowledge of a native language and culture, may be able to muster sufficient glibness to talk a traffic policeman out of a ticket; in a foreign country this becomes a task far less likely to succeed.

Similarly, in the foreign land of the courtroom, the setting is different, as are the assumptions and the culture. The witness, then, should attempt to familiarize herself with these cultural determinants as thoroughly as possible in advance to permit making a useful contribution not only to the case, but to the role of the psychiatric profession in due process.

IV. PITFALLS

A. REMAINING THE CLINICIAN

As in the cases reviewed in Chapter 6, the clinician may be tempted to act the part of a lawyer for the duration of the courtroom experience. This temptation should, of course, be resisted because no other person is in a position to consider and attend to the clinical issues.

B. MAINTAINING HUMILITY

A number of factors conspire to encourage an attitude of humility in the clinician bound for court: the imprecise nature of the clinical field, the "foreign land" of court, the need for the expert's testimony to inform the court, and the importance of avoiding alienating the jury by the use of jargon, pomposity, or self-righteousness.

C. TAKING IT PERSONALLY

The best witness is the calm, dispassionate witness off whose back rolls the most barbed, scathing, and defamatory harangue.

D. SELLING THE POINT

Expert witness ethics permit advocacy for one's opinion, but not for one's attorney or that side of the case. The expert should maintain objectivity and nonpartisan neutrality, while preserving the effectiveness of testimony.

V. CASE EXAMPLE EPILOGUE

The colleague whom the therapist consults in part confirms the bad news. She must honor the subpoena, he says, even if that involves cancelling a number of appointments. On the other hand, if she is asked to testify as an expert witness on the impact of the accident on her patient's mental state, the therapist is entitled to reimbursement of a reasonable expert's fee.

With regard to her fear of damaging her patient, either by provoking a termination of the relationship or by revealing sensitive information, the forensic psychiatrist she consults has equally gloomy news. He explains that, unless state law stipulates otherwise, all citizens are required to testify about any information that might be relevant to a given case. Although this state has a statute that provides for limited psychotherapist-patient privilege in civil cases, it does not apply to cases in which the plaintiff raises the issue of psychological damages. Therefore, if it were specifically requested, the therapist might have to provide detailed information about her patient's life. The consultant reviews with her the legal issues involved in tort suits, especially the points that the lawyers questioning her would be seeking to prove.

From the tone of the therapist's questions, however, the consultant senses that she is asking for something beyond just information. Because in her training she had never been prepared for courtroom testimony, and after entering practice she has assiduously avoided cases in which she might be called to testify, he assumes that she is quite anxious about the unfamiliar courtroom setting. He offers to tell her something about what to expect in court, how court procedures work, and some of the simple things that she could do, such as carefully preparing her testimony in advance, that might make the experience easier for her. He directs her to readings that outline techniques of coping with cross-examination and point to likely lines of attack. In addition, he suggests that once she knows what she intends to say, they sit down together and role-play, he playing judge and lawyer, and she rehearsing her testimony.

At the role-playing session, the consultant surprises his colleague with the vigor of his attack on her credentials and background, but she stands her ground and answers to the point. The consultant explains that this may occur in the courtroom setting, where the opposing side may attempt to discredit the testimony by discrediting the witness.

In court the therapist is, indeed, forced to discuss her patient's life and background in detail and to give an opinion on whether, in a hypothetical case, the personality of a woman with a background similar to the patient's could have changed markedly after the accident. Because she honestly believes that this outcome is unlikely in this case, and so states, her own patient's attorney attempts to tear down her credentials and to suggest that her theoretical claim is unsupported by empirical data. Although shaken by this attack from an unexpected quarter, the therapist is able to answer most of the questions confidently, because she has reviewed the literature relevant to her presentation before coming to court. The issue of her patient's extramarital affair is never raised.

The therapist cannot say afterwards that she enjoyed the experience, but she does believe that because she presented the information in a reasonable and knowledgeable way, she is satisfied with her performance.

VI. ACTION GUIDE

A. CHECKLIST FOR PREPARING TO TESTIFY IN COURT

1. *Review* relevant data, charts, and records in detail.
2. *Interview* directly the patient, witnesses, caretakers.
   a. *Alert* patient and others to agency and purpose of interview.
   b. *Explain* that judge or jury, or both, make actual decision.
   c. *Include* formal mental status examination.
3. *Record* results of above determinations for court, then *condense* into easily carried notes.
4. *Review* pertinent current literature on contested subject, especially papers you have written.
5. *Prepare* the attorney.
   a. *Educate* attorney about clinical elements of case.
   b. *Correct* unrealistic expectations:
      i. Lie detection by clinician
      ii. Evocation of speech from mute patient
      iii. Retrospective assessment of state of mind long before evaluation

   - iv. Attempts to subvert opinion
   - v. Absolute diagnosis

6. *Avoid* absolute and invariant conclusions in report.

B. CHECKLIST FOR WRITING FORENSIC REPORTS

1. *Plan* (or outline) the structure and content of the report well in advance.
2. *Include* all materials and information to support each of your conclusions.
3. *Ensure* that the report can stand alone, without need for additional appendices; quote and cite only the relevant elements of the database.
4. *List* all documents and resources reviewed as the database, including interviews.
5. *Describe* the reason (occasion or referral) for your role in the legal proceeding (e.g., requested by plaintiff's attorney to review case).
6. *Present* your conclusion, clearly identified, in the relevant statutory language, either at the beginning or end of your report.
7. *Describe* the supporting data that validate each of your conclusions.
8. *Proffer* any alternative scenarios that derive from contested facts.
9. *Identify* any constraints (time, financial, inadmissibility) on your evaluation and resulting limitations on your data.
10. *Consider* presenting opposing views and rebuttals (subject to your retaining attorney's approval).
11. *Refrain* from writing a report if none is requested or if instructed not to do so by the attorney.
12. *Discuss* changes in wording with the attorney; in general, accept requests for minor changes, condensation, or corrections of statutory language; reject requests for substantive revisions of opinions.

C. CHECKLIST FOR TESTIFYING IN COURT

1. *Recall* role of witness: to inform the court.
2. *Clear* sufficient time in schedule to permit unhurried participation in proceedings; bring work or reading.
3. *Present* testimony clearly, audibly, and comprehensibly; avoid jargon.
4. *Attempt* to have impressive credentials spelled out and entered into the record.
5. *Avoid* responding to discrediting cross-examination as personal attack.
6. *Recall* the stages of presentation: direct examination, cross-examination, redirect, recross.
   - a. *Anticipate* attorney's laying a foundation.
   - b. *Move* readily with questions into the new "what if" situation.
7. *Attend* to specific question and remain within its scope in answering.
8. *Accept* that "I don't know" is perfectly appropriate answer.
9. *Remember* concept of reasonable medical certainty.
10. *Describe* data first, interpret meaning or conclusions later.
11. *Tell* truth as best able, regardless of side of case.
12. *Delay* a moment before answering to permit reflection, weighing of answer, and objection by counsel.
13. *State* when question cannot be answered.
14. *Remain* alert to context, direction, and implications of question.
15. *Beware* of qualifying phrases, metaphors, and analogies.
16. *Exercise* consideration for patient's presence by judicious choice of language; educate attorney about impact of testimony on subject.
17. *Remain* alert to attorney's maneuvers:
   - a. Focusing attack on fee
   - b. Use of "always" and "never"
   - c. Series of lulling questions with a sudden reversal
   - d. Use of literature as authority
   - e. Inaccurate quotations
   - f. Simple harassment

  g. Implication of "coaching"
  h. Incomprehensible questions

18. Above all, *remain* cool under fire.

VII. SUGGESTED READINGS

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B. EXPERT WITNESSES AND FORENSIC PRACTICE

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3. Gutheil TG, Simon RI. *Mastering forensic psychiatric practice: advanced strategies for the expert witness.* Washington, DC: American Psychiatric Publishing, 2002.
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