# Psychiatric training and involuntary commitment

BY SETH E. MANY, M.D.

*This article contrasts through example and discussion a ritual indoctrination versus a rational procedure in the training of the psychiatrist. The use of trainees as professional surrogates, conflict-of-interest problems, and confusion and lack of discrimination between forensic/psychiatric and service/training issues are discussed. The pivotal role of the trainee in the commitment procedure demands immediate relief. Longer-term provision of standards of training and competency is suggested.*

Thomas Szasz has repeatedly detailed the psychiatric arrogation of the police power of the state in the guise of medical/scientific judgments.[1] In *The Second Sin* he tells us "Psychiatric training is the ritualized indoctrination of the young physician into the theory and practice of violence."[2] In the following article I detail and discuss one sense in which this statement is correct. Drawing upon my own experience in the emergency evaluation-for-admissions unit of a psychiatric hospital, I present several cases in which ritual, role playing, and rationalization are explicated in the light of in-training expectations, conflict of interest, and confusion regarding the appropriate application of legal doctrine to specific instances of disturbed behavior.

## Cases in illustration

1. A 25-year-old woman is sent to a psychiatric hospital on a DCS (Director of Community Services) three-day commitment because of "danger to self" (potential for suicide) and "need for psychiatric treatment." The trainee (a resident psychiatrist) evaluates the patient, who has been under the care of a psychiatrist on the faculty of his training program. The faculty member has instituted the proceeding leading to commitment. It is now up to the trainee to decide whether to accept the patient for commitment—*i.e.*, to admit her to the hospital. The trainee examines and talks to the person for 20 minutes, confers with the staff of the special evaluation services, and then calls the DCS for a fuller explanation of certain observations. The trainee, while acknowledging the potential value of hospitalization (acute relief from angry relatives, financial and emotional responsibilities, etc.), believes that her danger-to-self potential is no greater than that of five other prospective admissions who he has sent to outpatient services. However, to avoid a measure of conflict with his own supervisory staff, he offers the patient a "voluntary" admission. She refuses. He then telephones the faculty psychiatrist responsible for initiating the commitment, in order to gain both a longitudinal perspective on the treatment course and a rationale for involuntary hospitalization. He then commits the patient against his own "best" judgment.

2. A 20-year-old male, under the recent care of a local psychiatrist, is taken by his family to the general medical hospital emergency room. There he is seen by two (non-psychiatric) physicians who sign commitment papers for a 30-day involuntary stay. The following symptoms/signs are noted: inappropriate speech and behavior, loose associations, lability of affect, and marked hostility toward the examining physicians. The resident-trainee on duty examines the patient. Noting a substantial potential for dangerous (to others) behavior, he finds the patient to be

mentally ill and in need of psychiatric care. However, the trainee does not find that the patient is likely to benefit from inpatient hospitalization. In fact, the trainee believes it will make him worse. The hostile element appears to be the result, not of "mental illness," but rather a healthy, if injudicious, response to the prospects of involuntary incarceration. However, the trainee notes state "policy" under *Tarasoff*, and with a view to his own liability decides to play it safe and commit the patient.[3]

3. A 55-year-old man is taken by his relatives to the acute care unit of the medical hospital with marked confusion, disorientation, and moderate memory loss of several years' duration. Cleared by that hospital for any acute organic component, the patient is sent on to the state psychiatric facility on a 30-day commitment. The admitting officer (a psychiatric resident-trainee) examines the patient and concludes that he exhibits the signs and symptoms of mental illness with impaired reality testing, impaired social interactions, and marked personal disability with an element of danger (he forgets when he turns on the gas stove, etc.). However, the trainee concludes that no amount of additional inpatient hospital treatment will lead to a probable remission. This conclusion is reached after a review of past (including recent) hospitalizations with inconsequential affirmative results, and also after taking into account a complete diagnostic work-up (a frequent justification for hospitalization) within the past year. The patient is already on low doses of anti-psychotic (neuroleptic/major tranquilizer) medication, adjusted in the outpatient setting available. No intermediate level of service exists. Further, the patient is adamant in his expressed intention to live at home. He has in fact a repetitive history of escape from the very same hospital, during which he makes a beeline for home. He refuses voluntary treatment. In consternation, the resident-trainee calls the psychiatric supervisor, an employee of the hospital to which the patient is to be committed. The supervisor, per telephone, orders the trainee to commit the

patient. The trainee refuses. The trainee is relieved of duty. The patient is committed.

## Discussion of cases

Case 1 illustrates the subordination of the trainee's judgment to that of the supervisor *after* all other attempts to justify involuntary admission have failed. In the absence of imminent danger he is, on his own, unable to certify the commitment. Given this circumstance and the pressure from other sources (*i.e.*, the Director of Community Services and the faculty member who has instituted commitment) to admit, the ritual "voluntary" admission is proferred. Having failed in this maneuver to salve conscience, moral authority is abrogated by recourse to the "judgment of the superior." This is also called "carrying out orders," although the disguise of supervision is a workable counterpart, infrequently revealed. This case also examines the conflict-of-interest issue involved in having training faculty members initiate commitments.

Case 2 examines several issues of continuing forensic uncertainty. What if the predictable outcome of hospitalization is "no improvement" or "worse"? Can hospitalization be justified because both the state and the trainee wish to "play it safe"? And can this form of "preventive detention" be justified if the potential for inflicting harm is *not* the result of the disease? In this instance, the trainee's own needs for professional "safety" take precedence over his own conclusions drawn from the psychiatric evaluation.

Case 3 represents some of the issues previously outlined: namely, conflict of interest (the supervisor is also an employee of the hospital) and vague or conflicting standards of commitment (*i.e.*, the "need" for hospitalization versus the imperative for the "least restrictive environment"). It also examines a default mode of operation that may significantly

alter commitment decisions on the part of the trainee. If, after thorough evaluation, the trainee believes that a patient does not meet the criteria for commitment, yet recognizes the probable outcome of censure or dismissal from his position, he will quite likely opt for commitment. The controlled supervisory setting, proclaimed by some as a solution to the problem of insufficient expertise in the emergency evaluation of the patient, deepens the dilemma.[4] The appropriate resolution of the conflict between duty (obeying the implication of clinical judgment) and self/professional preservation (obeying the command of a supervisor) requires greater, not lesser, autonomy in practice.

All three cases reveal a peculiar psychiatric defect: the habitual reliance by the examiner upon sources of data contaminated by and interlocking with the self-interests of persons who wield substantial power over the patient, on the one hand, and the trainee's career course, on the other. Yet these and similar cases undeniably require the expert, coordinated attention of persons responsible for the disposition of emotional and behavioral disturbance. The permanent destruction of another person's legitimate freedom and useful social role is at stake. From the perspective of the trainee, which mistakes are the more harmful? Those that place the patient in jeopardy? Or those that disable fellow staff, cohorts, supervisors, faculty, and institutions of employment?

## General discussion

Review of the historic application of the law regarding civil commitment reveals the abuse of powerless people: women, children, immigrants, the retarded, the impoverished, and the marginally productive—disturbed and disturbing persons who have constituted a relatively clear subculture within an industrially organized society.[5] But while political and economic factors are frequently held accountable for this

abuse at the macrotheoretic level, underlying social and psychological dynamics are less frequently explored. In particular, the unique role of the trainee in the rituals and rationalizations of civil commitment, serving as surrogate and scapegoat, has not been addressed.

Thomas Scheff, in *Being Mentally Ill: A Sociological Theory*, undertakes a brief discussion of the "socialization of the staff member" relative to the professional career.[6] He neglects comment, however, on the special juridical/medical role cast upon the trainee in civil commitment as well as in other forensic psychiatric procedures. Illich (*Medical Nemesis*) notes that one of the first laws to establish mandatory medical certification was an edict issued in 1776 by the Empress Maria Theresa. She commanded the court physician to certify fitness to undergo torture so as to ensure valid testimony.[7] Illich also does not appear to recognize that in many instances the power of the medical institution is exercised through trainees.

As a matter of institutional politics and economics, trainees with the least experience are most likely to be thrust into the commitment role.[8] Faculty psychiatrists, as well as resident psychiatrists further into training, frequently have the power and status to avoid such assignments. The necessity for nighttime coverage, the complexity of criteria for admission, the omnipresent issue of civil liability, and the significant potential for personal harm in an unrestrained, sometimes uncontrollable context, make this among the least popular of psychiatric positions. It is the exception to find tenured faculty out on this front line. Other factors, such as professional role choices, conscious ethical decisions in regard to public versus private sector practice, and supply and demand disincentives, also determine the allocation of trained psychiatric personnel.[9]

The influence of the workplace environment should not be ignored. Such variables as available and allocated time for

psychiatric examination; pressure of other waiting patients or referral staff; an information and disposition base which rapidly contracts during evenings, nights, and weekends; and a variety of other human-dependent variables are the shifting contingencies which shape actual decisions.

Human-dependent variables are not just supervisory and hierarchical. Trainees, especially early in the training process, may be significantly influenced by permanent, non-psychiatric staff attached to special "evaluation" units. This is the analog of the dependency that interns in general hospital emergency room settings develop with respect to nursing staff, looking to them for guidance and direction. The non-psychiatric evaluation staff may have substantial experience but only marginal accountability regarding civil commitment decisions. This same staff may hold the key to a work interruption for an evening meal, or a decent, uninterrupted night's sleep. Contrariwise, they may add to the difficulties and frustration inherent in an immense bureaucratic ritual. Furthermore, this same staff may provide on-the-job performance evaluations of the psychiatric trainee to the trainee's supervisors. The decision to commit may thus be passed on to the non-psychiatric staff, in much the same way that the well-trained certified psychiatrist passes the buck to the trainee.

Legal tradition does not permit the physician to prevail over the patient's prohibition, even when procedures are construed by the physician as necessary.[10] Involuntary treatment has been permitted only by court order in situations where constitutional guarantees of freedom have conflicted with the state's interest in the preservation of life. This continuing prohibition is nowhere more evident than in a patient's refusal of medically necessary procedures (*e.g.*, a transfusion) when supported by an appeal to the exercise of religious freedom.[11] Yet even this freedom may be curtailed. Beecher notes the "great ethical problem" arising in the case of a child of a Jehovah's Witness or a Witness "too ill to

make a rational decision."[12] In the latter instances, the trustee/guardianship relationship of the state to the patient may assume priority over First Amendment guarantees of freedom. But *who* is to decide that the state's interests are to prevail contrary to the Bill of Rights? Is this an appropriate task for a physician with no formal legal training? Is it a job for a trainee with no special psychiatric qualifications?

In *Addington v. Texas*, the U.S. Supreme Court held that the criminal standard of proof, guilt "beyond a reasonable doubt," is not applicable to the civil commitment of the dangerously insane. Basing its decision upon uncertainties in psychiatric diagnosis, it rejected the civil standard of "preponderance of evidence" in favor of "clear and convincing proof."[13] Given the attention of the Court to difficulties inherent in valid and reliable psychiatric diagnosis and predictions of dangerousness, is it likely that the Court would sanction such determinations by persons with little or no formal postgraduate training in the specialty of psychiatry? Or by persons typically unemployable (in many states) as qualified psychiatrists? Furthermore, despite a common law tradition permitting the testimony of any licensed physician as a competent witness concerning insanity, such testimony is neither sought nor desired in the court setting without the professional training and background appropriate to the specialty of psychiatry.[14] Thus the current practice of permitting trainees to render the final judgment regarding civil commitment does not permit the patient access to the Fourteenth Amendment guarantees of due process and equal protection of the laws.

It is generally acknowledged that even trained psychiatrists may experience substantial professional difficulty and uncertainty in dealing with forensic psychiatric issues.[15] Special issues of psychiatric paternalism,[16] psychiatric liability,[17] and the psychiatric assessment of dangerousness[18] exemplify these conditions. Recent reviews of admissions for psychiatric emergencies demonstrate the problematic and difficult

nature of diagnosis, treatment, and prognosis in this particular circumstance.[19]

Special attention has been drawn to deficiencies in didactic preparation, supervision, and clinical exposure,[20] and the primary role of incompletely trained personnel in the delivery of emergency psychiatric care.[21] Yet while civil commitment adds a special dimension to an already problematic psychiatric procedure, and is the forensic procedure most common in psychiatric practice, the foregoing studies do not distinguish between voluntary and involuntary admission with respect to the unique role of the psychiatric trainee.

Tancredi is an important exception. In his recent paper on legal and ethical issues in emergency psychiatry and crisis intervention, his discussion of the suicidal patient draws out the issue of whether a resident "at this stage in his training lacked the requisite skill . . . to provide reasonable psychiatric treatment and care for this patient." Citing *Cohen v. New York State*, a suit involving a suicide under the direct care of a resident-trainee, he emphasizes the necessity of "appropriate supervision" by the psychiatrist who has delegated care to those in training.[22] However, Tancredi does not extend the discussion to the issue of civil commitment, nor does he appear to recognize the implications from the perspective of a patient being examined by an inadequately prepared professional. Furthermore, as previously noted, increased supervision may have a deleterious effect upon the assumption of clinical and ethical responsibility by the trainee.

Adequate training and preparation for the complex evaluation, diagnostic, and social judgments involved in the commitment process cannot be resolved either by appeals to a quantitative increase in supervision, or by a further delay in the process of professional maturation whereby a physician is deemed qualified to render such judgments. Rather, what is needed is the development of a reasonable, competency-

based educational process in which a hierarchy of skills may be identified and assimilated at a pace commensurate with the development of psychiatric expertise in general. In other words, the most difficult, problematic, and complex psychiatric procedures should be in the domain of the expert, not the trainee. This should be required if for no other reason than the protection of the patient from our best intentions unleavened by either knowledge or experience. Until that time, patients should not be coercively subjected to any such procedures carried out by trainees, supervised or not.

## Summary

Civil commitment cases from actual experience in a psychiatric training program are detailed and discussed. In most cases the resident–trainee performs a crucial task as surrogate for staff and faculty psychiatrists. The provision of service and support for institutions and their employees, in the name of career training, helps to disguise the nature of a decision-making process based upon a ritual indoctrination in the exercise of psychiatric power.

Through the operation of the training role, not only does the resident in-training psychiatrist allow the faculty/staff a safe distance from the difficult and complex issues at the interface of law and psychiatry, but also mistakes in judgment may be transformed into pedagogical issues, with the patient assuming the lifelong burden of errors made in the name of "training."

The civil commitment procedure may include the ritual reading of "rights," provisions for early hearing, and an independent watchdog system designed to afford the patient who protests early recourse to constitutionally protected rights. Actual rights can rarely be asserted until after the damage has been done, if at all.

This article addresses flaws in a system which uses the in-training psychiatrist as a link in the chain of commitment. It does not argue for or against civil commitment in general. Nor does it address the potential for wrongful commitment under circumstances of trainee fear, exhaustion, emotional lability, or negligence. Simply put, psychiatric trainees play a role which their professional superiors do not want, and for which the trainees are, at best, poorly prepared. It is the patients as citizens who suffer the abuse.

## Suggestions

1. The situation described calls for immediate relief. No person in training should perform a professional role for which he or she is ill-prepared. No citizen should be subject to the possible deleterious consequences of such performance. The involuntary commitment of any person by any other person in training should cease forthwith.

2. Training of physicians in issues specifically relevant to civil commitment should precede responsibility for commitments. Such training should be both pedagogic and experiential. The appropriate role is not surrogation, but subrogation—*i.e.*, an apprenticeship taken with experts in the field. Appropriate training must include preparation for and exposure to the complex issues at law raised by the commitment procedure.

3. A reassessment and rank ordering of the various tasks of psychiatry, with a view to their difficulty, consequences, and necessity for special expertise, should be made. This would form the basis on which minimal criteria (and hence verifiable competency) in the performance of specific forensic psychiatric tasks could be postulated for the purpose of training.

## Notes

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2. T.S. Szasz, *The Second Sin* (Garden City, N.Y.: Anchor, 1973), p. 72.

3. Tarasoff v. Regents of the University of California, 131 Cal. Reporter 13 (1976).

4. J.R. Hillard, G.J. O'Shanick, and J. Houpt, "Residency Training in the Psychiatric Emergency Room," 139 *American Journal of Psychiatry* 236-38 (1982).

5. A. Deutsch, *The Mentally Ill in America* (Garden City, N.Y.: Doubleday, 1937); R. Caplan and G. Caplan, *Psychiatry and the Community in Nineteenth Century America* (New York: Basic Books, 1969).

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9. S.E. Many, "Psychiatrists, State Hospitals, and Civil Rights," 80 *New York State Journal of Medicine* 1873-77 (1980); see also "Letters to the Editor," 81 *New York State Journal of Medicine* 725, 816 (1981).

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11. H. Beecher, "Scarce Resources and Medical Advancement," in *Experimentation With Human Subjects*, ed. P.A. Freund (New York: Daedalus Library, Braziller, 1969), pp. 66-104.

12. *Id.* at 91.

13. Addington v. Texas, 99 S. Ct. 1804 (1979).

14. B. Ennis and R. Emery, *The Rights of Mental Patients*, ACLU Handbook (New York: Avon, 1978).

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18. R. Simon and W. Cockerman, "Civil Commitment, Burden of Proof, and Dangerous Acts: A Comparison of the Perspective of Judges and Psychiatrists," 5 *Journal of Psychiatry & Law* 571-94 (1977).

19. B.M. Ianzito, J. Fine, and J. Pestana, "Overnight Admission for Psychiatric Emergencies," 29 *Hospital & Community Psychiatry* 728-30 (1978).

20. Hillard et al., *supra* note 4.

21. Knesper et al., *supra* note 8.

22. Tancredi, *supra* note 15, at 802.