PROPRIETY OF MEDICAL DOMINANCE OF FORENSIC MENTAL HEALTH PRACTICE: THE EMPIRICAL EVIDENCE

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Medically-trained mental health professionals[1] have historically

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1. These will usually be psychiatrists, but because that term includes professionals with varied training and experience, it will not be used here. A psychiatrist is generally a physician specializing in the diagnosis, prevention, and treatment of mental disorders. Usually, a psychiatrist has undergone a three-year period of residency in an accredited facility after graduation from medical school as formal preparation for his or her specialization. Rubin, *Medical and Paramedical Personnel in the Mental Health Field*, in READINGS IN LAW & PSYCHIATRY 22 (1975). The psychiatrist may be "board certified" as a specialist by the American Board of Psychiatry and Neurology. Certification requires completion of an approved residency, two years of clinical practice, and passing of written and oral examinations. *Id.* at 23. But the absence of certification or even failure to complete residency does not prohibit a physician from legally representing him or herself as a psychiatrist. F. MILLER, R. DAWSON, G. DIX & R. PARNAS, THE MENTAL HEALTH PROCESS 23 (1976) (hereinafter MENTAL HEALTH PROCESS). Given that any physician can simply declare him or herself a psychiatrist, the term is best avoided for present purposes.

Other mental health profession terms likewise need careful definition. "Psychologist" is as vague as "psychiatrist"; generally, it means one who practices psychology. "Clinical psychologist," however, may be given a more precise meaning. Most states have procedures for licensing clinical psychologists; such licensure generally demands a Ph.D. degree and a one-year internship involving supervised diagnosis and treatment of mental disorders. *Id.* at 24. Many people who are not clinical psychologists according to this meaning of the term nevertheless are employed as psychologists. Rubin, a physician, notes that "some question" exists as to whether psychologists should provide "independent and medically unsupervised" diagnosis or therapy. Rubin, *supra*, at 25.

Similar uncertainty surrounds the term "social worker." Some states provide for licensing people within this category, but this is done in far fewer jurisdictions than licensure of physicians or clinical psychologists. *Id.* at 26. The Academy of Certified Social Workers, a private organization, offers certification to people who complete a master's degree program in social work, a supervised period of practice, and an examination; people so certified are entitled to use the initials A.C.S.W. after their names. MENTAL HEALTH PROCESS, *supra*, at 24. Nevertheless, many people whose job descriptions are titled "social worker" are not so certified.

A variety of other professions may be involved in the evaluation or treatment of persons suffering from mental disorder, including nurses, who are licensed under state provisions. *Id.* at 25. Probably the most numerous personnel involved in running public hospitals are the attendants or ward staff. Formal qualifications for these positions are seldom firm, and certification is

asserted dominance in the diagnosis and treatment of mental disorders. A 1954 resolution approved by the American Psychiatric Association, the American Medical Association, and the American Psychoanalytic Association noted their traditional medical responsibility for these matters and continued,

> The medical profession fully endorses the appropriate utilization of the skills of psychologists, social workers, and other professional personnel in contributing roles in settings directly supervised by physicians . . . . [W]hen members of these professions contribute to the diagnosis and treatment of illness, their professional contribution must be coordinated under medical responsibility.[2]

Physicians' claim to supervisory and ultimate responsibility for treatment is increasingly being challenged, especially by psychologists. The Fourth Circuit Court of Appeals, for example, recently held that health insurance companies could not limit payment for the services of psychologists to situations in which the bills were submitted through a physician.[3] Other pending litigation seeks to compel hospital accrediting agencies to promulgate standards giving psychologists the same privileges in hospitals as physicians.[4]

The medical profession's continued adherence to the position taken in the 1954 joint resolution was made clear by a recent statement of American Psychiatric Association President Donald Langsley, decrying efforts by nonmedical mental health professionals to develop for themselves treatment roles independent of medical supervision.[5] Acknowledging that psychologists, social workers, and others are appropriate members of a "treatment team," Langsley asserted that "it is [now] more appropriate than ever that the psychiatrist is the member of the team best equipped to perform triage, make differential diagnoses, [and to] plan and render treatment for a variety of psychological and somatic problems."[6] Psychologists, social workers, and nurses have

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not required. California, however, has identified a group of such professionals as "psychiatric technicians" and has regulated entrance into the category. CAL. BUS. & PROF. CODE § 4502 (West 1974).

A recent study of psychiatrists, clinical psychologists, social workers, nurses, and mental health workers posed as one of its objectives a delineation of the treatment roles performed by various types of mental health practitioners. Blum & Redlich, *Mental Health Practitioners*, 37 ARCHIVES GENERAL PSYCH. 1247 (1980). About half of each professional group reported performing some individual psychotherapy. *Id.* at 1251. The authors state that they were aware of a trend towards involving more nonphysicians in providing treatment, but express surprise at the magnitude of the trend suggested by their study. *Id.* at 1252.

2. *Reprinted in* READINGS IN LAW AND PSYCHIATRY, 159, 160 (1975).

3. Virginia Academy of Clinical Psychologists v. Blue Shield, 624 F.2d 476, 485 (4th Cir. 1980), *cert. denied*, 101 S. Ct. 1360 (1981).

4. Langsley, *Viewpoint, A Commentary by APA's President*, PSYCHIATRIC NEWS, Sep. 19, 1980, at 25, col. 1.

5. *Id.*

6. *Id.*

sought opportunities for independent practice out of motivations of "economic gain and financial rewards," he charged, and have used "politics, lawsuits, and Madison Avenue techniques" rather than dispassionate examinations of education and demonstrated competence in striving for such opportunities.[7]

Medical dominance has pervaded forensic mental health practice[8] as well as the provision of mental health treatment. Nevertheless, challenges have been and are currently being mounted to medical dominance of the forensic field. In forensic practice as well as the provision of treatment, Langsley was undoubtedly correct that dispassionate examination of education and demonstrated competence should be relied upon in assessing whether nonmedical mental health professionals should receive some of the prerogatives traditionally reserved for physicians. Although some of the forensic issues have been subjected to

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7. *Id.* Schindler, Berren, & Beigel, *A Study of the Causes of Conflict Between Psychiatrists and Psychologists*, 32 HOSPITAL & COMMUNITY PSYCH. 263 (1981), explored differences in perception between samples of psychiatrists and psychologists concerning actual responsibility for and competency to perform eleven tasks, including evaluation, treatment, administration, and testifying as an expert witness. Members of both groups agreed that psychiatrists presently had primary responsibility for testifying, although psychologists regarded themselves as having greater actual responsibility in other areas than the psychiatrists regarded them as having. *Id.* at 264. In regard to competency, psychiatrists regarded themselves as more competent than psychologists to carry out eight of the eleven activities at issue (including testifying), and psychologists as equally competent in regard to two others; they regarded psychologists as more competent than psychiatrists only in conducting psychological testing. *Id.* Psychologists, on the other hand, regarded psychiatrists as more competent than psychologists only in management of medication. The psychologists saw themselves as more competent to carry out nine of the eleven activities and equally competent in regard to testifying. *Id.* Perhaps understating the ramifications of their data, the authors commented, "The extensive differences found between the perceptions of psychiatrists and psychologists in this study will be difficult to resolve." *Id.* at 265. For present purposes, it is especially interesting to note that although the psychologists were willing to assert greater competence than psychiatrists in most areas, they perceived themselves as only equally competent to testify in expert capacities. This suggests that nonmedical mental health professionals may find medical dominance of forensic work more difficult to challenge than medical control of other areas.

8. Pollack, in *Forensic Psychiatry—A Specialty*, 2 BULL. AM. ACADEMY PSYCH. & L. 1 (1974), explores the definition of forensic practice in the context of psychiatry. Forensic practice, in his view, is best defined by the objectives of the professional. Thus forensic psychiatry is "the application of psychiatry to legal issues for legal ends, legal purposes." *Id.* at 2. It must be distinguished from other areas of practice in which the professional's concern is with furthering therapeutic objectives and values of the medical system. *Id.* Pollack urges that so defined, forensic practice is a "specialty" in the sense that it represents a special field of endeavor with "distinctive characteristics":

> [T]he psychiatric-legal inquiry and interview as well as the psychiatric-legal report are significantly different from the psychiatric-medical inquiry and report, i.e., significantly different from customary psychiatric evaluations directed to treatment ends . . . . [S]uch psychiatric-legal inquiry, evaluation, and report require special education and training to develop the necessary skills for this work.

Id. at 5. Pollack's approach to distinguishing forensic psychiatry from general psychiatry is a reasonable one and is adopted in this article. It is broadened, however, to distinguish nonmedical as well as medical forensic "inquiry, evaluation, and report."

A private organization, The American Board of Forensic Psychiatry, has been formed for, among other reasons, the purpose of certifying psychiatrists in the "specialty" of forensic psychiatry. *See The American Board of Forensic Psychiatry, Inc., 1976*, 4 BULL. AM. ACADEMY PSYCH. & L. 95 (1976).

discussion,[9] there has been little effort to undertake the sort of examination urged by Langsley.

The legal decisionmaking process is becoming more receptive to evaluation and argument based upon empirical research. In *Ballew v. Georgia*[10] the United States Supreme Court cited extensively from jury studies in support of its conclusion that reduction of jury size below six persons was constitutionally unacceptable.[11] As will be discussed below, the pool of empirical information available on the issues of concern here is small and somewhat shallow. This may be because researchers have not perceived courts and legislatures as receptive to the use of empirical research. This hints of the classic chicken-egg situation: Courts and legislatures may be uninterested in empirical research because there is little good quality research available; and efforts to conduct high quality research may be few because mental health professionals perceive legal decisionmakers as uninterested in such research.

This article attempts to evaluate the challenges to medical superiority in forensic mental health practice by dispassionate examination of education and demonstrated competence. First, the traditional manifestations of medical dominance and the challenges to them are surveyed. The available empirical information bearing upon the merits of the challenges to them is then examined. The assumption that medical education justifies medical superiority is also explored, although primary attention is devoted to the issue of demonstrated competence in forensic mental health matters. Finally, some conclusions are made as to the validity and possible diminution of medical dominance in this area, and suggestions are offered to improve the validity of future research.

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9. *E.g.*, Lower, *Psychologists as Expert Witnesses*, 4 LAW & PSYCH. REV. 127 (1978); Miller, Lower & Bleechmore, *The Clinical Psychologist as an Expert Witness on Questions of Mental Illness and Competency*, 4 LAW & PSYCH. REV. 115 (1978); Comment, *The Psychologist as a Expert Witness: Science in the Courtroom?*, 38 MD. L. REV. 539 (1979); Perlin, *The Legal Status of the Psychologist in the Courtroom*, 4 MENTAL DISABILITY L. REP. 194 (1980). *See also* Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 622-24 (1978).

10. 435 U.S. 223 (1978). *Ballew* is discussed in Tanke & Tanke, *Getting Off a Slippery Slope: Social Science in the Judicial Process*, 34 AM. PSYCHOLOGIST 1130 (1979). For general discussions of the use of social science research, *see* Bersoff & Prasse, *Applied Psychology and Judicial Decision Making: Corporal Punishment as a Case in Point*, 9 PROFESSIONAL PSYCH. 400 (1978); Finster, Busch & Hamilton, *The Rationalization of Social Science Research in Policy Studies*, 11 INT'L J. COMP. SOC. 90 (1978); Sperlich, *Social Science Evidence and the Courts: Reaching Beyond the Adversary Process*, 63 JUDICATURE 280 (1980). For an excellent analysis and discussion of the limits of this kind of decisionmaking, *see* Haney, *Psychology and Legal Change: On the Limits of a Factual Jurisprudence*, 4 LAW & HUMAN BEHAVIOR 147 (1980).

11. 435 U.S. 223, 230-39 (1978).

MEDICAL DOMINANCE OF FORENSIC MENTAL HEALTH PRACTICE

Challenges to the more blatant exclusions of nonmedical mental health professionals from forensic mental health practice have had some success, although the more subtle manifestations of medical dominance remain well-entrenched. Medical dominance of forensic mental health practice is manifested in at least three different ways.

First, the formal procedure for a number of judicial inquiries, while not excluding nonmedical practitioners, has demanded participation by physicians and provided them a role dominant to that of nonmedical professionals. Involuntary commitment by certification, for example, has traditionally required physician certification that the proposed patient meets the legal standard for hospitalization. New York's provision for certification by two physicians is a current example.[12] Texas has embodied the requirement of medical participation in the commitment process in its state constitution, which requires "competent medical or psychiatric testimony" for a commitment.[13]

There is a clear trend towards modification of such requirements, but even the recently expanded requirements favor physicians. For example, in 1978, California legislation allowed psychologists as well as physicians to certify a civil patient for fourteen days of additional intensive treatment[14] or examine a criminal defendant claiming the insanity defense.[15] The legislation, however, requires not only that the psychologist be licensed but also that he or she have a doctoral degree in psychology and at least five years of experience in the diagnosis and treatment of mental and emotional disorders.[16]

No analogous requirements are imposed for physicians. Where competency of a criminal defendant to stand trial is at issue, New York provides for an examination by two physicians. Where—but only where—there is reason to believe that the defendant is mentally defective, one of the appointed examiners may be a psychologist.[17] Illinois' new civil commitment procedure permits emergency hospitalization of a patient upon the certification of a clinical psychologist, a "qualified examiner" (who may under some circumstances be a social worker or

12. N.Y. MENTAL HYG. LAW § 9.27 (Consol. 1973).

13. TEX. CONST. art. 1, § 15a.

14. Cal. Stat. 1978, ch. 391, codified at CAL. PENAL CODE § 1027, WELF. & INST. CODE § 5251 (West Supp. 1981). *See generally* Drude, *Psychologists and Civil Commitment: Review of State Statutes*, 9 PROFESSIONAL PSYCH. 499 (Aug. 1978), which reports that 24 of 50 states include psychologists in their commitment statutes. All of the statutory provisions providing for participation by psychologists have been enacted since 1970, he reports, and of those, 13 were passed since 1975. *Id.*

15. CAL. PENAL CODE § 1027 (Deering 1978).

16. *Id.*; CAL. WELF. & INST. CODE § 5251 (West Supp. 1981).

17. N.Y. CRIM. PROC. LAW § 730.20 (Consol. 1972).

nurse) or a physician.[18] But the justification for hospitalization must be confirmed by a psychiatrist, who is required to examine the patient within twenty-four hours of admission and to issue a second certificate.[19] A few provisions, however, appear to aim towards parity between physicians and at least some nonmedically-trained mental health professionals. Commitment pursuant to a court order under the Illinois statute, in contrast to the Texas constitutional provision cited above, requires in-court testimony by one psychiatrist *or clinical psychologist* who has examined the patient.[20]

The second manifestation of medical dominance of the forensic mental health field concerns the legal rules governing qualification of witnesses as experts. These rules to some extent have impeded efforts by nonmedical mental health professionals to provide input into legal decisionmaking. Traditionally, nonmedical practitioners, even if qualified as experts in some matters, were sometimes limited in the issues they could address. *People v. Manning*,[21] decided in 1978, is illustrative. At the defendant's trial for armed robbery, the defense urged that because of a low I.Q. the defendant was not criminally responsible.[22] In support of this, the testimony of a psychologist with a master's degree and five years of experience as a court psychologist was offered to show that tests had been administered to the defendant, that the tests resulted in I.Q. scores of forty-six and sixty-eight, and that his reading ability was that of a second grader.[23] This testimony was excluded.[24] On appeal, based on two independent rationales, no error was found.[25] First, the appellate court reasoned that the witness did not have a doctorate and was not certified as a clinical psychologist under the Illinois certification procedure; thus she was not properly qualified as an expert, assuming some psychologists could be so qualified.[26] In addition, the court characterized as "equally important" the fact that the defense had not represented that a psychiatrist would testify, using the psychologist's testimony as well as other information in forming an expert opinion.[27] The assumption, of course, was that only a psychiatrist was qualified to testify to an expert opinion on the ultimate issue being litigated—the defendant's sanity.[28] Even a properly qualified psychologist

18. ILL. ANN. STAT., ch. 91 1/2, § 3-602 (Smith-Hurd 1979).
19. *Id.* § 3-610.
20. *Id.* § 3-807.
21. 61 Ill. App. 3d 558, 378 N.E.2d 227 (1978).
22. *Id.* at 560, 378 N.E.2d at 229.
23. *Id.* at 561, 378 N.E.2d at 230.
24. *Id.*
25. *Id.* at 565, 378 N.E.2d at 233.
26. *Id.* at 564, 378 N.E.2d at 233.
27. *Id.* at 565, 378 N.E.2d at 233.
28. *Id.* Other recent decisions reflect this same approach. *See* State v. Alexander, 252 La.

could only testify to "factual" information to be used by the psychiatrist in forming that opinion.[29]

Perhaps the most blatant recent decision limiting testimony by nonmedical mental health professionals is *State v. Williams*,[30] a 1976 case concerning the Maryland Defective Delinquency program. The Maryland program provided for examination of certain convicted criminal defendants and for hearings on whether they were "defective delinquents."[31] If this status were affirmed, the defendant was not sentenced under standard provisions but rather was committed for an indeterminate period to a special program at Patuxent Institution.[32] At the hearing on Williams' alleged defective delinquency, the state called a psychologist on the staff of Patuxent.[33] The psychologist testified that the institutional staff had concluded that Williams was in fact a defective delinquent.[34] But when Williams objected to the psychologist testifying to his own professional opinion on that issue, the trial judge sustained the objection.[35] On appeal, no error was found. After reviewing the history of the defective delinquency program and the statutory scheme for it, the court concluded that defective delinquency is a "psychiatric concept" and that its "diagnosis" rests "primarily on psychiatric criteria."[36] Consequently, a psychologist, although otherwise properly qualified as an expert witness, "may not render an opinion on the ultimate issue of defective delinquency."[37] Psychologists are limited—if properly qualified—to testimony concerning their factual findings, tests they may have administered, and personal judgments and interpretations relating to those tests.[38]

Despite these fairly recent examples, some challenges to formal barriers to nonmedical expert opinion on many forensic issues have been successful. The Illinois court that decided *Manning*, for example,

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564, 574-75, 211 So. 2d 650, 654 (1968) (no error in permitting unlicensed practicing psychologist to testify as to psychological tests given defendant but not as expert on defendant's sanity); Commonwealth v. Williams, __ Pa. Super. Ct. __, 410 A.2d 880, 889 (1979) (psychologist, not clinical psychologist, permitted to testify as to tests performed on defendant but not to express opinion as to whether defendant knew nature and quality of his actions at time of crime); People v. Diaz, 70 App. Div. 2d 885, 887, 417 N.Y.S.2d 101, 103 (1979) (psychologist with 27 years experience in testing permitted to testify as to administration and interpretation of psychological tests but not permitted to testify as to opinion, characterization, or interpretation of tests as they applied to defendant's mental condition). Of course, other courts have taken a different approach. *See* cases cited in note 48 *infra*.

29. 61 Ill. App. 3d at 564, 378 N.E.2d at 233.
30. 278 Md. 180, 361 A.2d 122 (1976).
31. *Id.* at 180, 361 A.2d at 123.
32. *Id.*
33. *Id.*
34. *Id.* at 181, 361 A.2d at 124.
35. *Id.*
36. *Id.* at 187, 361 A.2d at 126.
37. *Id.*
38. *Id.* at 187-88, 361 A.2d at 126-27.

appears to have reversed its position the following year. *People v. Lewis*[39] held that a properly qualified psychologist could express an expert opinion concerning a criminal defendant's competency to stand trial.[40] Further, at least when offered on some issues, psychological testimony is admissible even if the witness is not a licensed clinical psychologist.[41] The trial judge, explained the appellate court, should admit the testimony if it appears that the witness's background of training and experience is sufficient to qualify him or her as an expert on the subject or issue under inquiry.[42]

Undoubtedly the leading decision eliminating formal barriers to nonmedical testimony is *Jenkins v. United States*,[43] in which the United States Court of Appeals for the District of Columbia found error in a trial judge's exclusion of psychological testimony that the defendant had been insane at the time of the crime charged.[44] The American Psychiatric Association filed an amicus curiae brief urging that the existence of mental illness, its diagnosis, and its relationship, if any, to the defendant's particular conduct at issue were medical issues about which only a medically-trained person was qualified to assert an expert opinion.[45] The brief characterized the issue before the court as "of grave concern" to psychiatrists and the association.[46] Further, it cited extensively from and relied heavily upon the joint resolution that asserted the united front of American medicine against efforts of nonmedical mental health professions to develop independent roles in mental health areas.[47]

Perhaps the challenges to formal limits on nonmedical testimony have been so successful that forensic mental health testimony can no longer be accurately characterized as dominated by medical professionals. Relying heavily upon *Jenkins*, Perlin recently asserted that "legal barriers to [psychological] testimony have virtually disappeared."[48]

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39. 75 Ill. App. 3d 560, 393 N.E.2d 1380 (1979). *But cf.* People v. Strange, 81 Ill. App. 3d 81, 400 N.E.2d 1066 (1980) (only qualified psychiatrist may testify on opinion as to sanity of defendant; therefore, defendant's motion to call psychologist on issue was properly denied).

40. 75 Ill. App. 3d at 563, 393 N.E.2d at 1383.

41. People v. Lewis, 75 Ill. App. 3d 560, 563, 393 N.E.2d 1380, 1383 (1979).

42. *Id.*

43. 307 F.2d 637 (D.C. Cir. 1962).

44. *Id.* at 643.

45. Brief for the American Psychiatric Association at —.

46. *Id.* at —.

47. See text & note 2 *supra*.

48. Perlin, *supra* note 9, at 194, 195; *see, e.g.*, United States v. Portis, 542 F.2d 414 (7th Cir. 1976) (psychologist with three degrees and extensive experience permitted to testify to opinion on defendant's sanity); United States v. Riggleman, 411 F.2d 1190 (4th Cir. 1969) (nature and extent of knowledge rather than claim to title determine competency and clinical psychologist with doctorate permitted to give expert opinion); People v. Crawford, 66 Mich. App. 581, 239 N.W.2d 670 (1976) (psychologist competent to give expert testimony concerning defendant's competency to stand trial); State v. Bush, 260 N.W.2d 226 (S.D. 1977) (clinical psychologist qualified to express opinion as to defendant's mental state at time of alleged criminal act); Rollins v. Commonwealth,

This is probably an overstatement, however. As Miller and others have noted, *Jenkins* held only that a trial judge may not decline to qualify a witness as an expert solely on the ground that the witness is a psychologist rather than a psychiatrist.[49] Whether to qualify a witness as an expert, however, is widely recognized as a matter within the broad discretion of trial judges.[50] Considering the matter at issue and the particular witness's training and experience, a trial judge even in those jurisdictions that follow the literal holding of *Jenkins* may well decline to qualify at least some nonmedical mental health professionals as experts and remain within the area of legitimate discretion that prevents the action from constituting error on appeal.[51]

A third way in which medical dominance of forensic mental health practice has been manifested is the subtle depreciation of the credibility of nonmedical personnel. This is reflected in lawyers' preference of medically-trained witnesses. Attorneys not infrequently appear willing to utilize nonmedically-trained witnesses only when no physician witnesses favoring their position are available. Techniques used by lawyers in efforts to impair the credibility of nonmedical mental health professionals often show the same orientation. A nonphysician-witness's lack of medical training is developed and emphasized in cross-

207 Va. 575, 151 S.E.2d 622 (1966), *cert. denied*, 386 U.S. 1026 (1967). Some appellate courts have set out guidelines for use by trial courts in deciding whether psychologists should be qualified as experts. For example, in State v. Robertson, 108 R.I. 656, 278 A.2d 842 (1971), the court indicated that generally trial judges should require a Ph.D. in clinical psychology, a showing that the witness is a diplomat of the American Board of Examiners in Professional Psychology, and postdoctoral experience including substantial experience in a hospital or clinical setting in association with psychiatrists or neurologists. *Id.* at 662-63, 278 A.2d at 846. On remand, the witness involved in the case was not permitted to testify. *See* State v. Robertson, 111 R.I. 402, 303 A.2d 361 (1973). It is significant that a large number of courts perceive no need to regulate or guide the exercise of trial judges' discretion in determining whether physicians should be qualified as experts in matters related to mental disorder.

49. Miller, Lower, & Bleechmore, *supra* note 9, at 121.

50. McCORMICK ON EVIDENCE 30 (E. Cleary ed. 1972).

51. The ability of other mental health professionals to qualify as experts on matters relating to mental disorders is less established. For example, courts are split concerning social workers. *Compare* People v. Parney, 74 Mich. App. 173, 253 N.W.2d 698 (1977) ("forensic" social worker not qualified as expert on competency to stand trial) *and* Commonwealth v. Roy, 2 Mass. App. 14, 307 N.E.2d 851 (1974) (social worker could not testify as to defendant's mental status) *with* Custody of a Minor, 377 Mass. 876, 393 N.E.2d 379 (1979) (expert testimony by psychiatric social worker in termination of parental rights case was proper) *and* People v. Giles, 192 Colo. 240, 557 P.2d 408 (1976) (psychiatric social worker may give opinion testimony as to person's mental condition) *and* State v. McDonald, 89 Wash. 2d 256, 571 P.2d 930 (1977) (psychiatric social worker with three and one half years of clinical experience properly permitted to testify as expert; any deficiencies in professional schooling may be compensated for by clinical experience and objections go to weight rather than admissibility of testimony). Nurses have not fared well in the courts. *See* State v. Williams, 309 So. 2d 303 (La. 1975) (psychiatric nurse properly precluded from giving expert testimony on sanity); State v. Shipman, 568 S.W.2d 947 (Mo. App. 1978) (testimony by defendant's mother, a nurse, as to defendant's ability to distinguish right from wrong not admissible as expert opinion). In regard to other mental health personnel, *see* Smith v. State, 141 Ga. App. 720, 234 S.E.2d 385 (1977) (psychology technician with B.A. in psychology who had satisfied all state requirements for administering tests, interviewing patients, and submitting evaluations to a clinical psychologist for approval was not qualified as expert in interpretation of psychological tests and could not express opinion on defendant's sanity).

examination. The witness is sometimes compelled to acknowledge that he or she is prohibited by law from using some common treatment techniques such as medication, for example. The inference is that the witness is a distinctly second-class treatment professional. The lawyer who discovers that an opposing psychologist or social worker unsuccessfully attempted to enter medical school before pursuing his present profession may pursue this issue in an effort to convince the judge or jury that the witness himself believes that medical training is superior to other forms of education and practice.

Of course, lawyers' choices of witnesses and cross examination techniques are related to what they perceive as judges' and juries' attitudes regarding the credibility of variously trained mental health professionals. Whether judges and juries actually harbor a preference for witnesses with medical backgrounds has not been empirically examined. Nevertheless, the presumed existence of such a preference constitutes an important part of the conventional wisdom of law practice. Since there are very few written embodiments of the reactions of judges and juries to trial level presentations, there is little material to draw upon in an effort to investigate the accuracy of the conventional wisdom. However, a 1973 opinion of the Texas Court of Criminal Appeals, *Hogan v. State*,[52] reflects what is widely regarded as the judicial attitude. Prior to his trial for murder, Hogan moved for examination by a specifically named psychologist.[53] The motion was granted, and the psychologist examined Hogan and testified at his trial that Hogan had been insane at the time of the killing.[54] Nevertheless, Hogan was convicted and subsequently appealed.[55] He urged that he had a due process right to an opportunity to prepare an adequate defense and that the trial court, by giving him access to only a psychologist on the issue of sanity, deprived him of that right.[56] The appellate court cited with apparent approval its comment almost twenty years earlier that a psychiatrist is "certainly best qualified to pass upon a question of mental illness," but that a properly trained and experienced psychologist should, if offered, be qualified as an expert upon that issue.[57] Then—almost begrudgingly, one senses—the court reviewed the qualifications of the psychologist who had examined and testified for Hogan and concluded that providing Hogan with only his services did not amount to a deprivation of due process.[58]

52. 496 S.W.2d 594 (Tex. Crim. 1973).
53. *Id.* at 596.
54. *Id.*
55. *Id.* at 595.
56. *Id.* at 596-97.
57. *Id.* at 597; *see* Watson v. State, 161 Tex. Crim. 5, 8, 273 S.W.2d 879, 882 (1954).
58. 496 S.W.2d at 596.

Thus, to some extent there has been erosion of traditional medical dominance of the forensic mental health area. Formal legal barriers to qualifying nonmedical mental health professionals as expert witnesses have been reduced and perhaps almost eliminated under certain circumstances. Nevertheless, medical dominance of many statutory schemes for evaluating proposed patients in commitment proceedings, criminal defendants for competency to stand trial, and related matters appears still well-entrenched. Perhaps more importantly, there remains a subtle attitude that nonmedical opinions are less credible than ones offered by medically-trained persons. The trend appears quite clearly to be towards further erosion of medical dominance. The propriety of this trend and of its relatively slow pace should be evaluated, as Langsley suggested, by means of dispassionate examination of education and demonstrated competence.[59] This is undertaken in the next section.

EMPIRICAL EVIDENCE OF MEDICAL DOMINANCE

To what extent is medical dominance of forensic mental health practice justified by *empirical evidence* of superior education and greater demonstrated competence? Several sub-inquiries are addressed separately here. First, to what extent is medical dominance justified by medical training? Second, to what extent have medically-trained forensic practitioners demonstrated greater competency in forensic matters? Third, is the manner in which medically-trained mental health professionals provide evidence during litigation superior in the sense that it is more thorough?

A. *Medical Training and the Presumption of Forensic Expertise*

Langsley expressed the often unarticulated assumption that medical training in itself better equips a mental health professional to accurately address forensic matters.[60] Courts sometimes give effect to this attitude by regarding medical education alone as sufficient for qualification as an expert on forensic matters.[61] This attitude can be evalu-

59. *See* text & note 6 *supra*.

60. *Id.*

61. *See* Cody v. State, 259 Ind. 570, 290 N.E.2d 38 (1973) (medical doctor need not have more training, experience, or qualifications than general practitioner to testify as to examined person's sanity), *cert. denied*, 416 U.S. 960 (1974); Lux v. Mental Health Bd., 202 Neb. 106, 274 N.W.2d 141 (1979) (general practitioner's qualifications sufficient to permit opinion on mental condition; Schenck v. Roger Williams Gen. Hosp., — R.I. —, 382 A.2d 514 (1977) (cardiologist's lack of training or experience in psychiatry might affect weight of testimony as to patient's psychiatric problems, but not admissibility of testimony as to those problems).

Some decisions, however, have rejected this approach. *E.g.*, State v. McSpaddin, 341 So. 2d 868 (La. 1977) (trial judge properly permitted psychiatric resident to testify as to expertise in general medicine but not as psychiatrist); Commonwealth v. Roy, 2 Mass. App. Ct. 14, 307 N.E.2d

ated by analyzing the role of forensic coursework in medical education and assessing physicians' understanding of legal issues which arise in forensic practice.

Vann and Morganroth interviewed seven psychiatrists who regularly performed competency examinations at a New York psychiatric hospital.[62] When asked to state the standard for competency to stand trial, only two could correctly do so.[63] One psychiatrist confused the competency standard with the Durham definition for legal insanity,[64] while four others viewed legal incompetence as synonymous with the presence of a psychosis.[65] Wexler and Scoville reported a similar finding in their study of the civil commitment process in Arizona.[66] These authors interviewed a psychiatrist who regularly prepared physician's certificates and gave testimony in probate court; he indicated that the M'Naghten rule for criminal insanity was the criterion he used in forming his opinions for the commitment proceedings.[67]

Another study, of somewhat larger scale, revealed glaring weaknesses in psychiatrists' examinations and reports to the referring courts concerning defendants' competence to stand trial and legal insanity. McGarry reviewed 130 such reports;[68] he found neither any reference to the defendant's competency to stand trial nor any evidence that an appraisal had been made of the legally relevant behaviors.[69] Opinions concerning legal insanity could be perfectly predicted from clinical diagnoses, indicating that clinical criteria, and not the relevant legal criteria—which was incompletely articulated in each psychiatric report—had been applied by the medical examiners.[70]

Apart from these empirical findings, reports concerning the availability of forensic training—or, more importantly, the lack thereof—in medical schools and psychiatric residency programs confirm that forensic work is a specialty area not routinely addressed by medical education.[71] Individual psychiatrists have undoubtedly distinguished

851 (1974) (third-year psychiatry resident not qualified to testify to psychiatric diagnosis); State v. Arpin, — R.I. —, 410 A.2d 1340 (1980) (trial judge has discretion to require medical doctor to demonstrate specialized training and practical experience in area of psychiatric disorder before permitting expert testimony).

62. Vann & Morganroth, *Psychiatrists and the Competence to Stand Trial*, 42 U. DET. L.J. 75 (1964).

63. *Id.* at 84.

64. *Id.*

65. *Id.*

66. Wexler & Scoville, *The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1 (1971).

67. *Id.* at 65.

68. McGarry, *Competency for Trial and Due Process Via the State Hospital*, 122 AM. J. PSYCH. 623 (1965).

69. *Id.* at 626.

70. *Id.*

71. *See* Barr & Suarez, *The Teaching of Forensic Psychiatry in Law Schools*, 122 AM. J.

themselves in applying their medical/psychiatric knowledge to legal matters. But the assumption that all medically trained individuals necessarily possess such expertise is at best dubious.

The anecdotal nature of these reports and the lack of control groups of nonmedical mental health examiners prohibits interdisciplinary comparisons on knowledge and performance variables. It is likely, however, that a presumption of forensic expertise applied to any mental health degree or profession would be unjustified. As two recent commentators suggest, "the presence of an M.S.W., an M.D., or a Ph.D. degree merely insures that one completed a course of graduate work; it should not be taken for granted as evidence of forensic expertise."[72]

B. *Demonstrated Competence in Forensic Matters*

A second more difficult issue concerns the comparative accuracy of judgments by medical and nonmedical health professionals on questions raised in legal proceedings. Investigating this matter involves numerous and complex problems.

1. *Methodological Problems.* Direct evaluation of the accuracy of judgments is, of course, difficult or impossible because of researchers' inability to identify a correct judgment. Consequently, researchers resort to comparing medical and nonmedical professionals to determine how consistent their forensic opinions are. This is an obvious compromise. A showing of consistency between medical and nonmedical mental health professionals does not establish that either (or actually both) are accurate. More important for present purposes, evidence of inconsistency does not firmly establish that either group is more accurate than the other. Given traditional deference to psychiatric views, however, there is a significant danger that any evidence of differences in judgment will uncritically be taken as indicating that the nonmedical mental health professionals are less accurate than the medically-trained evaluators.

Other problems arise from the wide variety of questions asked of mental health professionals in legal contexts. One type concerns matters that are primarily clinical in nature, such as questions concerning the existence, treatment and prognosis of mental disorders. Another type concerns matters of legal but not necessarily direct clinical significance; these include questions of a subject's ability to understand pend-

PSYCH. 612 (1965); Sadoff, Thrasher & Gottlieb, *Survey of Teaching Programs in Law and Psychiatry*, 2 BULL. AM. ACAD. PSYCH. & L. 67 (1974).

72. Hattaway & Poythress, *A Mental Health Critique of People v. Parney: Medical and Nonmedical Expertise on Competency to Stand Trial*, 56 MICH. ST. B.J. 784 (1977).

ing criminal charges, the likelihood of a subject committing a serious assault, or the subject's suitability as a parent. A final type of inquiry concerns "ultimate" legal issues, such as a criminal defendant's competency to stand trial or insanity at the time of the crime. Comparative analysis of studies is often difficult because the studies fail to distinguish among these questions or even to make clear what sorts of questions are being studied.[73] Obviously, good research requires comparisons of performance concerning questions of the same type.

In addition, there is substantial disagreement as to which type of question is best suited or even acceptable for analysis.[74] Legal "purists" argue that questions concerning ultimate legal issues are inappropriate because they call upon the mental health professional to make legal judgments, tasks properly performed only by triers of fact.[75] But practicing lawyers and judges may evaluate situations differently and accept or even demand responses to such questions. Evaluations of the practical role that mental health professionals perform thus might focus on responses to questions bearing directly upon legal standards.

This, however, raises additional problems. Responses to such questions may not lend themselves to the sort of evaluation necessary to conduct comparative analysis. It is widely recognized that ultimate conclusions on certain legal matters such as criminal commitment and

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73. Poythress, *A Proposal for Training in Forensic Psychology*, 34 AM. PSYCHOLOGIST 612 (1979), discussed this confusion of criteria and concepts:

> Perhaps the most publicized example of such confusion is Rosenham's (1973) article on "Being Sane in Insane Places," in which the terms *insane* and *mentally ill* are used interchangeably throughout without any evidence of an appreciation for the distinction between the two. The most intricate example of confusing concepts, however, may come from Salmon (1975). In an article ostensibly having to do with the issue of competency to stand trial, the following language is found: A review of empirical data on mental competency examinations is enlightening. The examination of the accused is extremely brief. One study found that the average time spent for mental examinations was 9.2 minutes. "It appears in practice that the alleged mentally ill is presumed *insane* and bears the burden of proving his *sanity* in the few minutes allowed to him." (p. 741; italics added) The author's quote is from Szasz's (1965, p. 73) *Psychiatric Justice*, which reported data on the duration of clinical interviews of proposed patients in *civil commitment* hearings. So what we have in the end are data about *civil commitment* examinations, couched in the language of *insanity*, put forth to serve the author's point about the nature of *competency* evaluations.

Id. at 614-15.

74. For a fairly liberal definition of the "proper" domain of expert testimony, see Nash, *Parameters and Distinctiveness of Psychological Testimony*, 5 PROFESSIONAL PSYCH. 239 (1974). Contrast this with the radical position of Morse, *supra* note 9, and with a middle-ground position of Bonnie & Slobogin, *The Role of Mental Health Professionals in the Criminal Process: The Case for Informed Speculation*, 66 VA. L. REV. 427 (1980).

75. Dix, *Mental Health Professionals in the Legal Process: Some Problems of Expert Dominance*, 6 L. & PSYCH. REV. 1, 6-7 (1981), argues that permitting experts to testify in terms of some legal standards obscures ambiguities in the legal standards and removes pressure upon courts to address and resolve these ambiguities. Gass emphasizes the danger of unwarranted generalization of expertise, that is, the danger that the expert will uncritically and perhaps even unconsciously be credited as an expert in the interpretation of the legal language. Comment, *supra* note 9, at 595. Obviously, mental health professionals have no such expertise and few if any would claim it.

responsibility involve not only factual conclusions but also moral or ethical concerns, and therefore may not lend themselves to objective comparative analysis.

Other methodological problems also exist. Because of wide variation among jurisdictions in definitions of legal criteria, comparison of studies is risky. Special problems exist in regard to ultimate legal issues which, of course, address the potentially varying standards for competency and insanity.[76] In addition, variations in legal standards may affect mental health professionals' response to questions regarding clinical and nonultimate legal matters. Changes in the legal standard may be viewed by clinicians as requiring changes in clinical focus or methods and the result may be differences in response to what may appear superficially to be objective factual inquiries.

Further, the great diversity of approaches to understanding and explaining human behavior makes comparative evaluation difficult.[77] This diversity does not occur along professional training lines; explanatory theories used by medical mental health professionals do not greatly differ from those of other mental health professionals. But as a result, at least some of any variation among professionals' performance that might be disclosed by research might be due less to differences in professional skills than to differences in conceptual orientation.[78]

2. *Available Studies*. Evaluation of the comparative accuracy of different mental health professionals on issues relevant to legal matters therefore presents substantial difficulty. These difficulties must be considered in interpreting and assessing the studies that examine the demonstrated competence of various mental health professionals. Newsom-Smith and Hirsch have compared the judgments of social workers with those of psychiatrists on a number of questions related to the clinical assessment and management of suicidal patients.[79] In addi-

76. *See* Saver & Mullins, *The Insanity Defense: M'Naghten vs. A.L.I.*, 4 BULL. AM. ACAD. PSYCH. 73 (1976).

77. *See generally* I COMPREHENSIVE TEXTBOOK PSYCHIATRY II, ch. 8-11 (2d ed. 1975) (various essays on theories of personality and psychopathology, including Freudian School, Cultural and Interpersonal Psychoanalytical Schools, and Schools Derived from Psychology and Philosophy). *See also* Meehl, *Psychology and the Criminal Law*, 5 U. RICH. L. REV. 1, 7 (1970). Medically-trained mental health professionals are sometimes more than other professionals identified with psychoanalysis, a specific theoretical conception of the mental apparatus and a method of treatment first developed by Sigmund Freud. Most but not all practicing psychoanalysts are also physicians. *See* Rubin, *Medical and Paramedical Personnel in the Mental Health Field*, in READINGS IN LAW AND PSYCHIATRY 22, 25 (rev. ed. 1975). But the apparently increasing proportion of medically-trained mental health professionals who do not adhere to psychoanalytic theory or treatment methods suggests that this is no longer an appropriate basis for distinguishing medical and nonmedical mental health professionals, if indeed it ever was.

78. *See* text & notes 102-05 *infra*.

79. Newsom-Smith & Hirsch, *A Comparison of Social Workers and Psychiatrists in Evaluating Parasuicide*, 134 BRIT. J. PSYCH. 335 (1979).

tion, the researchers compared the two groups' opinions on one legally related matter—suicide potential—and one ultimate legal question—appropriateness of inpatient care and commitment.[80] Sixty parasuicidal admissions to a hospital were independently examined by a social worker and a junior psychiatrist.[81] On the essentially clinical question of whether mental illness was present, the two groups differed significantly. Social workers found mental illness possibly or definitely present in sixty-five percent of the cases; psychiatrists found it in forty-three percent.[82] The overall rate of agreement on this question was reflected by a Kappa of .198, a relatively low rate of agreement.[83]

No basis existed for determining which patients were in fact mentally ill, so no appraisal of the comparative accuracy could be made.[84] The existence of inconsistency between the two groups is a basis for legitimate concern, even if the study provided no basis for even speculating as to which group was more accurate. There was, however, perfect agreement between the two groups in identifying cases of severe psychopathology.[85] This indicates a strong tendency of the two groups to agree concerning cases at one end of the spectrum.

The suicide potential of the patients, a legally relevant issue, was appraised by both the social worker and psychiatrist groups. Similar estimates of the proportion of subjects regarded as suicide risks in the near future were obtained; psychiatrists identified sixty-five percent of the sample as posing such a risk, while social workers identified seventy percent as doing so. Agreement over specific cases was not reported. Follow-up, however, proved social workers slightly more accurate in predicting future parasuicidal behavior than the psychiatrists. Seven subjects were found to have made subsequent nonfatal attempts, while one subject successfully committed suicide. The social workers had identified the suicide and six of the attempters as high risks; the psychiatrists had placed the suicide and five of the attempters within this category.[86]

Finally, the study addressed the two groups' judgments on the clinical propriety of inpatient care for the conditions diagnosed and the

80. *Id.* at 337.
81. *Id.* at 336.
82. *Id.* at 337, Table I.
83. *Id.* Table II.
84. *Id.* at 338.
85. *Id.* Table III.
86. *Id.* at 340. The differences were not statistically significant. Given the small number of subjects involved and the small differences noted, there is probably no statistically significant difference. But the finding is suggestive. It is widely assumed that psychiatric judgments are more accurate. So long as a difference is in the opposite direction, that assumption could not be supported even if the number of subjects was astronomical.

legal propriety of imposing such care involuntarily on the patients.[87] The researchers provide some basis for evaluating the accuracy of the commitment judgment by enabling comparison of the judgments of both groups with the ultimate decision whether to commit the patients. Social workers regarded inpatient treatment as clinically appropriate for forty-five percent of the sample; they concluded that commitment was indicated in only four cases, or seven percent of the group. In contrast, the psychiatrists indicated a clinical preference for inpatient care for only twenty-seven percent of the patients. But they decided that commitment was justified in seven cases, constituting twelve percent of the group. Actually, only one patient was so detained and this patient had been identified as justifying involuntary care by both groups. Thus, both social workers and psychiatrists overpredicted the justification for compulsory treatment. The tendency was, however, more pronounced in the psychiatrists.

Newsom-Smith and Hirsch concluded that "the results demonstrate that social workers assess parasuicide as safely and reliably as do junior psychiatrists."[88] Given the conventional wisdom that psychiatrists' evaluations are superior to those of nonmedical examiners in forensic matters, this conclusion is significant. Not only were psychiatrists not demonstrably better than social workers in assessing suicide potential, they were in fact slightly less accurate than social workers, although not to a degree that statistical significance was obtained. But the two groups were significantly inconsistent in identifying the presence of mental illness, in assessing the clinical desirability of inpatient care, and in evaluating the justification for compulsory inpatient care. It is especially interesting that the psychiatrists expressed a clinical preference for inpatient treatment much less frequently than the social workers and concluded that compulsory inpatient treatment was justified more often than did the social workers.[89]

Levinson and Ramsay investigated the ability of nonmedical Mental Health Associates (MHAs) to make legally relevant assessments

87. *Id.* at 337, Table I.

88. *Id.* at 341.

89. A. Berman & R. Cohen-Sandler, Suicide and Malpractice: Expert testimony and the "Standard of Care" (unpublished paper, earlier version presented at annual meeting of American Association of Suicidology, Albuquerque, N.M., April 24, 1981), examined the responses of psychologists, psychiatrists, and social workers to a hypothetical case concerning a patient at significant risk for suicide. They looked specifically at the percent of professionals of each type who viewed the handling of the hypothetical case as "unacceptable" and who mentioned various factors in defining the patient as a suicide risk. Psychologists were significantly more critical of the overall case management of the hypothetical patient. But overall, the authors concluded, the three professions did not differ in their evaluation of the case and only minimal variations appeared in the factors emphasized by the three groups in evaluating the patient's risk.

of subjects' dangerousness.[90] The MHAs were nonprofessional mental health workers with at least one year's experience in mental health service working under the supervision of a psychologist. A major part of their task consisted of home visits that often involved assessment of the subjects' dangerousness. Follow-up interviews were conducted for fifty-three subjects whose propensity for dangerous behavior had been assessed by an MHA. Two evaluations were made under different criteria for identifying actually dangerous persons. One used a broad standard, under which a subject was classified as dangerous if the subject either engaged in acts endangering the well-being of others or threatened such actions. The other used a narrow standard requiring actual acts of this sort.

The MHAs predicted that seventeen of the fifty-three subjects (32%) would be dangerous. Only nine of the seventeen (53%) of those predicted were determined to have actually been dangerous under the broad standard. Under the narrow standard, only five of the seventeen (29%) of the predicted group were proven in fact to be dangerous.[91] The authors noted that MHAs appeared unable to predict dangerousness to an extent significantly better than "the flip of a coin."[92] Nevertheless, when the accuracy of the MHAs was compared with that of psychiatrists and other mental health professionals in other studies, the MHAs turned out to be no worse as predictors than psychiatrists or other more highly trained mental health professionals.[93] The authors concluded: "[O]ur results suggest that psychiatrists may not necessarily be the optimal personnel to make predictions of dangerousness. Dangerousness is not a medical category and psychiatrists seem to have no special insight into its prediction. The testimony of other, nonmedical personnel, might be more seriously considered by the courts."[94]

A study by Roesch compared judgments concerning the ultimate legal question of criminal defendants' competency to stand trial.[95] One set of judgments consisted of those made by volunteer workers at community agencies in North Carolina. These volunteers were not medically trained, of course, and most had no formal credentials in other disciplines or professions. All, however, had been instructed on the matter of competency to stand trial and on the use of the Competency

90. Levinson & Ramsay, *Dangerousness, Stress, and Mental Health Evaluations*, 20 J. HEALTH & SOC. BEHAVIOR 178 (1979).

91. *Id.* at 182, Table 1.

92. *Id.* at 182.

93. *Id.*

94. *Id.* at 185.

95. Roesch, *A Brief, Immediate Screening Interview to Determine Competency to Stand Trial: A Feasibility Study*, 5 CRIM. J. & BEHAVIOR 241 (1978). The study is also reported in Roesch, *Competency to Stand Trial: An Analysis of Legal/Mental Health Issues and Procedures and a Proposal for Change*, 4 SOC. ACTION & L. 39 (1978).

Assessment Instrument.[96] The other set of judgments was those made by the staff of a state hospital to which the subjects were later admitted. These judgments were made only after thorough evaluation of the patients by the staff. The judgment was greatly influenced by the view of the admitting psychiatrist and therefore can fairly be regarded as a medical judgment.[97]

Roesch reported overall agreement of ninety percent between the nonmedical volunteers and the psychiatrically-dominated staff.[98] The small ten percent of cases in which disagreement existed cannot be viewed as adversely reflecting upon the quality of the volunteers' decisionmaking. The two evaluations were made at different times, and different clinical pictures presented by defendants at different points in time have been identified as a major cause of unreliability in competency assessment.[99] Moreover, the two assessments used vastly different methods. The nonmedical volunteers used a brief screening interview, while the hospital staff used data from observations and testing procedures over a longer period of time.[100] The small rate of disagreement does not suggest that the volunteers were less able to accurately assess competency.

Badger and Shore[101] conducted two studies, both of which focus upon consistency in making the ultimate legal judgment concerning whether to civilly commit a person. The first study consisted of fifty-seven actual commitment cases in which two examiners had interviewed each proposed patient and rendered opinions to the commitment court. In twenty-eight cases, one of the examiners was a physician and the other was not; in twenty-nine cases, both examiners were physicians. The physician-nonphysician combination reached agreement in twenty-six of the twenty-eight cases (93%); they recommended commitment in twenty (77%) of the twenty-six cases on which they reached agreement. The physician-physician pairs reached agreement in twenty-eight of their twenty-nine cases (97%); commitment was

96. *See* Competency to Stand Trial and Mental Illness (DHEW Pub. No. 73-9105, 1973). The C.A.I. is a 13-item rating scale for use by the examiner. The items include relevant factors such as the defendant's "appraisal of available legal defenses" (item 1), and "appreciation of range and nature of possible penalties" (item 8). The examiner rates defendants' degrees of incapacity from 1 (totally impaired) to 5 (no impairment) on each item. *See* Competency to Stand Trial and Mental Illness, Appendix B (DHEW Pub. No. (ADM) 74-103, 1973).

97. Though the inpatient workup included psychiatric interviews, psychological tests, and family interviews (among other things), the defendants' competency status was highly predictable using only the initial psychiatric interview. Roesch, *supra* note 95, at 40 (second study).

98. *Id.* at 246 (first study).

99. See Goldstein & Stone, *When Doctors Disagree: Differing Views on Competency*, 5 BULL. AM. ACAD. PSYCH. & L. 90 (1977).

100. The average length of stay was 17 days.

101. Badger & Shore, *Psychiatric and Nonmedical Decisions on Commitment*, 137 AM. J. PSYCH. 367 (1980).

recommended in twenty-two (79%) of the twenty-eight cases where agreement was reached. The minimal variation between the results in the two categories strongly suggests that the nonphysicians performed similarly to, and at least no less accurately than, the physicians. Unfortunately, no effort was made to compare the examiners on their judgments of clinical matters (the existence of mental disorder) or of legally relevant matters involved in the cases (such as the dangerousness of the proposed patients).

The second Badger and Shore study compared the reactions of medical and nonmedical professionals to a series of five short and largely nonclinical case vignettes. The vignettes were apparently written to reflect varying symptoms and degrees of dangerousness. The percentages of each group recommending commitment were compared. The percentage of nonphysicians (psychologists and social workers) recommending commitment was very close to that of physicians recommending commitment for four of the five vignettes. The fifth vignette was apparently designed to present the most questionable case for commitment. Four of the twenty-one physicians (19%) recommended commitment; only one of the nineteen nonmedical professionals, or five percent, recommended this result.

Despite the failure of Badger and Shore themselves to stress this, the responses to the fifth vignette appear especially significant. The responses suggest, of course, a stronger tendency on the part of medically trained professionals to commit, a finding consistent with the Newsom-Smith and Hirsch study.[102] This tendency may be explained in terms of an attributional bias held by medically trained persons that encourages them to seek explanations for problems within the medical-disease model.[103] Psychologists and perhaps other nonmedically trained persons may be more open to nondisease explanations for such situations and thus be less likely to urge hospitalization. Experimental evidence suggests that acceptance of a nondisease explanation renders persons less inclined to attribute behavior to mental illness.[104] The competing explanatory theories for human behavior[105] and the general absence of precision in social sciences tend to confirm that this tendency towards commitment is related to differences in the training and philosophy of various mental health professions rather than to varied ability or competence. Further, it is important to note that while more physicians

102. See text following note 87 *supra*

103. *See* Antonio & Innes, *Attribution Biases of Psychiatrists and Psychologists*, 43 PSYCHOLOGIAL REP. 1149 (1978).

104. *See* Farina, Fisher, Getter & Fischer, *Some Consequences of Changing People's Views Regarding the Nature of Mental Illness*, 87 J. ABNORMAL PSYCH. 272 (1978).

105. See text & note 77 *supra*.

than nonphysicians recommended commitment in response to the fifth vignette, over eighty percent of the physicians did not urge commitment. The general medical consensus, then, was consistent with the position taken by ninety-five percent of the nonphysicians. This suggests that noncommitment was the "correct" response, but that more physicians than nonphysicians erred. If the variation reflects inaccuracy, it more likely was inaccuracy by a minority—although a substantial one—of the physicians.

The second Badger and Shore study is subject to some significant criticism on methodological grounds. The use of written vignettes presented the professionals with a fixed clinical picture of the subject. Secondhand descriptions of patients often give clinical impressions different than those formed by a professional on the basis of personal interviews.[106] Perhaps, then, the vignettes artificially created some of the agreement between the two groups. It remains possible that one group or the other might possess skills concerning interviewing patients and assessing the rough data derived from these interviews that would have resulted in the demonstrated superiority of either physicians or nonphysicians. To the extent that is true, however, there is no reason to assume that it would be the medically trained persons who would possess these superior skills.[107]

A final study comparing ultimate issue opinions was undertaken by Poythress and Petrella,[108] who reviewed the outcome of seventeen criminal trials in which the insanity defense was asserted and opposing expert testimony given. In each case the testimony of a clinical psychologist was opposed by at least one physician or psychiatrist. The decision of the trier of fact was used as a criterion for evaluating the accuracy of the insanity opinions offered by the opposing experts. In fourteen of the seventeen cases, the trier of fact returned a verdict consistent with the opinion of the clinical psychologist.

This appears, at first blush, to be the most compelling of the interdisciplinary studies of relative accuracy of judgments because it used actual courtroom data and evaluated accuracy rather than simply agreement. There are, however, several methodological problems with the study that require consideration. One is that the opposing experts

106. See Stein, Karasu, Charles & Buckley, *Supervision of the Initial Interview: A Study of Two Methods*, 32 ARCHIVES GENERAL PSYCH. 265 (1975).

107. It is interesting to note that responding to such vignettes is not unlike responding to hypothetical questions in the courtroom context. Perhaps the results of the Badger and Shore study are most directly applicable to the comparative performance of physicians and nonmedical professionals in responding to these types of courtroom inquiries.

108. N. Poythress & R. Petrella, The Quality of Forensic Examinations: An Interdisciplinary Study (unpublished paper presented at American Psychology-Law Society Convention, 1979, in Baltimore, Md.).

may have differed in actual or perceived trustworthiness. All of the psychologists were employed by a forensic hospital and had examined the defendant at the request of the courts. None of the psychologists had been privately retained by either side. In contrast, all of the medical witnesses had been privately paid by one of the parties. This may, of course, indicate that the psychologists were more objective and thus more credible than the physicians. In addition, the medical witnesses were subject to impeachment as having an interest in the litigation, and thus—whatever their actual credibility—the physicians may have been perceived by the triers of fact at less credible than the psychologists.

A second problem is that the trier of fact obviously did not reach a verdict independently of the testimony. Thus the accuracy criterion—the verdict of the trier of fact—was not independent of the testimony and may not be a reliable criterion for use in evaluating accuracy. Despite these methodological concerns, however, the study constitutes strong ammunition for those challenging medical superiority.

C. *Quality of Testimony and Reports*

Finally, the quality of information provided by medical and nonmedical persons in legal proceedings must be considered. Where the expert actually appears in court and testifies, of course, this input is determined in large part by the lawyers and judge. But much input from mental health professionals is not in terms of such in-court testimony but rather through the much less formal and structured means of a report to the court. Important decisions are often made on the basis of these reports, and they constitute a type of input justifiably closely scrutinized. The objective of the report, of course, is to provide the court with sufficient information on which to make an independent judgment. If the report is conclusory, the judge can merely accept or reject the expert's conclusion on little more than faith. On the other hand, to the extent that the reports reveal the nature and means of evaluation on which they are based, they also provide a basis for assessing those evaluations. There is, therefore, reason to inquire as to the comparative performance of medical and nonmedical mental health professionals by examining the reports they submit to the courts. There appears to be only one interdisciplinary study bearing on this question.

Poythress and Petrella studied the thoroughness of the written reports provided by five persons in each of three mental health professions: psychiatrist, psychologist, and social worker.[109] All the individuals had been certified to perform competency evaluations at a

109. *Id.*

forensic hospital. The study provided a basis for evaluation of the clinical examinations underlying the written reports.

A detailed report by each examiner fully describing his assessment permitted consideration of the thoroughness and quality of the examinations. Thoroughness of the underlying evaluation was assessed by a number of unobtrusive measures, including case documentation of use of outside sources of information about the defendant (contact with attorneys, family members or friends, witnesses or jail personnel, and similar persons; requests for professional consultation, such as EEG or psychological testing) and quantity of information obtained and recorded by the examiner (number of typed lines under various report headings, including social history, mental status, and competency opinion). Psychiatrists made fewer inquiries of or referrals to outside sources than either of the nonmedical disciplines.[110] There were significant differences in the length of the case records; the psychiatrists' case records contained less information in each category measured.[111]

Quality of the reports and evaluations was assessed by having three legal "consumers"—a trial court judge, a prosecuting attorney, and a law professor—perform ratings of court reports prepared by the psychologists, psychiatrists, and social workers whose work samples had been selected for investigation. All remarks on the court reports which might have identified the discipline of the person who had prepared the report were removed to ensure the ratings performed by the legal expert were blind ratings. The legal experts worked independently and rated each of thirty reports (ten per discipline) on several variables important in forensic evaluations, including the examiner's awareness of relevant legal criteria, the adequacy of the clinical basis for the legal opinion offered, and the use of understandable language rather than clinical jargon. The reports of the two nonmedical groups were consistently rated as highly as, or higher than, the reports of the psychiatrists.

Poythress and Petrella conducted a similar study in the area of legal insanity. Using similar methodology, case records by psychologists and psychiatrists (but not social workers) were reviewed for unobtrusive measures of quantity or thoroughness and were blindly rated for quality by a trial judge and a prosecuting attorney. The results were quite similar to those obtained in the competency study. Psychol-

110. Forty cases per discipline were randomly selected for scrutiny. Psychiatrists documented 24 contacts with outside sources of information about the client; psychologists and social workers, in comparison, made 32 and 40 such contacts, respectively.

111. Quantity of information was measured by the number of typed lines in the clinical notes. Psychiatrists' notes averaged, over 40 randomly selected cases, 90.9 typed lines. The clinical notes of psychologists and social workers, in contrast, averaged 144.7 and 122.7 typed lines, respectively.

ogists' reports reflected a more thorough effort, both in use of outside sources of information about the defendant and in quantity of information recorded. On qualitative measures the reports of psychologists were rated as favorably as those of psychiatrists.

When report input was evaluated by legal consumers, then, input provided by nonmedical professionals was found equal to or better than the input provided by psychiatrists. Reports by nonphysicians were more detailed and extensive and thus provided a more satisfactory basis for legal decisionmaking. Insofar as the reports permitted assessment of the underlying evaluation conducted by the professionals, the legal consumers consistently rated those evaluations by nonmedical personnel as high as or higher than the evaluations by the psychiatrists. This blind—and therefore, in Langsley's terms, dispassionate—examination of the demonstrated competence of medical and nonmedical forensic practitioners to provide satisfactory reports to the courts on competency and insanity found no support for the traditional assumption that medically trained examiners are more competent than nonmedical examiners.

CONCLUSION AND IMPLICATIONS FOR FUTURE RESEARCH

Empirical studies lending themselves to a dispassionate examination of educational advantage and demonstrated competency of physicians in forensic work are few in number. In part because of difficulties inherent in this sort of research, those studies that do exist have significant methodological defects. Clearly, there is a need for additional research. Before addressing the conclusions that can be drawn from available research, it is worthwhile to examine what available studies (and their defects) suggest about future research.

A. *Implications for Future Research*

First, attention should be devoted directly to matters that are important because they relate to issues posed by the law. Much of the problem with drawing forensic conclusions from social science research is that the research was not undertaken for that purpose, and therefore does not attempt to directly and comprehensively address legal concerns. The studies by Poythress and Petrella[112] and that by Levinson and Ramsay[113] are exceptional in their explicit effort to answer questions posed by legal concerns. The study by Newsom-Smith and Hirsch is more typical because it addresses matters of legal concern

112. See text & note 108 *supra*.
113. See text & note 90 *supra*.

almost incidentally. As a result, no effort was made to develop full information on such matters as comparative accuracy on the propriety of compulsory hospitalization. Given the increasing importance of empirical information in the resolution of legal issues, legal researchers should regard matters as deserving of inquiry because, and perhaps only because, they are legally relevant. This will encourage researchers to seek information most responsive to the legal inquiry.

Second, the different kinds of judgments made in forensic practice should be distinguished and specifically addressed. Failure to do so makes evaluation of results difficult or impossible. Newsom-Smith and Hirsch successfully distinguished judgments on clinical facts (the desirability of hospitalization), legally relevant facts (suicide potential) and ultimate legal issues (propriety of compulsory hospitalization). The differences in the two groups' approaches to the clinical fact of hospitalization desirability and the legal issue of propriety of compelled hospitalization makes clear the need to separate types of issues.

Research on the efforts of forensic mental health professionals to address ultimate legal inquiries is clearly desirable. Substantial criticisms exist concerning the desirability and legal propriety of posing questions to mental health experts in terms of ultimate legal issues.[114] Those objecting to such inquiries stress the danger that conclusory responses of mental health professionals will covertly convey opinions as to how to resolve the numerous legal ambiguities that exist in almost every ultimate legal standard.[115] Evidence of how professionals with different training respond to such questions would be useful; it is important to address more than this, however. The study by Badger and Shore is an example of failure to devise a research design comprehensive enough to enable the results to be used for issues such as those of concern here.[116] The authors examined only various mental health professionals' responses to the ultimate legal question of whether commitment was appropriate. No effort was made to inquire as to why these responses varied. That is, the authors did not examine how each professional interpreted the legal standard or resolved potential subissues such as diagnosis of mental illness or assaultiveness. As a result, it is impossible to evaluate the significance of the consistencies and inconsistencies among the professional judgments. To the extent that inconsistencies were shown, they may have been due to different perceptions of the legal standard rather than differences in clinical skills or professional judgment. To the extent that consistency was demonstrated, the

114. See text & notes 74 & 75 *supra*.
115. See note 75 *supra*.
116. See text & note 101 *supra*.

study leaves open the possibility that offsetting inconsistencies in skill and perception of the legal standard may have been present.

In contrast, the study by Levinson and Ramsay avoided any danger that the results would be affected by the mental health professional's personal interpretation of the ambiguous legal standard of "dangerousness."[117] Rather, the researchers used two specific and different standards, one requiring actual assaultive behavior and the other covering threatened as well as actual assaults. As a consequence, there is no danger that their results are contaminated by inconsistencies in the meaning of dangerousness and thus the results can be applied to contexts in which either definition is appropriate. Finally, future research will benefit by increased efforts to study accuracy of judgments as opposed to consistency. Elusiveness of correct answers poses significant problems, of course, but efforts should be made to overcome these. Newsome-Smith and Hirsch, for example, could have undertaken to evaluate the extent to which members of both groups' studies accurately identified the one actual suicide and the seven near suicides as appropriate subjects for compulsory admission.[118] Badger and Shore could have delved into the propriety of commitment in any of the situations presented to the subjects studied; the "case" in the final scenario presented to the subjects apparently was inappropriate for commitment and responses favoring commitment were at least arguably wrong, but this is never specifically addressed.[119]

Poythress and Petrella, in one part of their study, evaluated the accuracy of practitioners by comparing their conclusions with those reached by the triers of fact in the litigation.[120] Despite the problems in this measure of accuracy, the study reflects a creative effort to find a standard for judging accuracy. In the other part of their study, however, they examine only the adequacy of reports on their faces. While this is an important concern, the extent to which a facially adequate report accurately reports reality is, of course, of equal importance.

Whatever its defects, the available empirical information unquestionably casts strong doubt upon the propriety of medical dominance in forensic mental health work. Poythress and Petrella's study convincingly demonstrates that the facial thoroughness and quality of reports by nonphysician mental health professionals are at least equal to those of psychiatrists. Moreover, there is substantial evidence of consistency between the judgments of medical and nonmedical mental health professionals on legally relevant matters as demonstrated by Newsom-

117. See text & note 90 *supra*.
118. See text & note 79 *supra*.
119. See text & note 101 *supra*.
120. See text & note 108 *supra*.

Smith and Hirsch (identification of severe psychopathology), Roesch (competency to stand trial), and Badger and Shore (propriety of civil commitment).

Researchers have exposed some troubling evidence of inconsistencies between medical and nonmedical judgments. Newsom-Smith and Hirsch found disagreement on the presence of mental illness, desirability of inpatient care, and necessity for compulsory admission. The Badger and Shore study's report of disagreement on the fifth vignette[121] is also curious. Nevertheless, in light of the general trend of the results, these inconsistencies cannot fairly be assumed the result of greater accuracy on the part of the medically trained persons.

Those studies attempting to directly address comparative accuracy show nonmedical personnel as accurate as—or more accurate than—medically trained persons. Newsom-Smith and Hirsch demonstrated similar accuracy on suicide potential, and Levinson and Ramsay did the same on assaultiveness. Poythress and Petrella's study suggests that nonmedical experts may be more accurate than psychiatrists in determining criminal defendants' responsibility.

B. *The Future of Medical Dominance of Forensic Practice*

The present state of the evidence confirms the desirability of changing existing legal barriers to encourage participation in forensic issues by nonphysician mental health professionals. The imposition of stringent limits upon nonphysician mental health professionals as expert witnesses and the limitation of the types of issues which they can address seem clearly unwarranted. Moreover, imposing specific requirements such as the California five-year experience requirement only upon nonphysician mental health professionals seems unjustified.[122] Evidence also casts considerable doubt upon the desirability of giving medically trained personnel a dominant or reviewing role where other mental health professionals are permitted to have input into the decision. Thus, requirements such as in the Illinois mental hospital admission process that a physician confirm the conclusion of a nonphysician mental health professional[123] seem inappropriate.

The nonmedical professions involved in mental health work need to work to alter the legislative and judicial processes by which barriers to nonmedical input are formulated and modified.[124] Presentations to

121. See text & notes 102-05 *supra*.
122. See text & note 14 *supra*.
123. See text & note 19 *supra*.
124. An example of medical and legislative cooperation is described in Victoroff, *Collaboration Between Ohio Psychiatrists and the Legislature to Update Commitment Laws*, 134 AM. J. PSYCH. 752 (1977).

legislative committees need to include careful documentation by empirical information. Individuals or associations must be prepared to participate in litigation involving such matters. The decision of the Maryland court that defective delinquency is exclusively a medical concept was almost certainly a result of uninformed judicial intuition rather than a full and informed consideration of the value of nonphysician input into the evaluation process.

The attitude that medical opinions are inherently more accurate or at least more persuasive is more difficult to attack. There exists a need to change judges' and jurors' perception of medical superiority in many forensic areas. Since the task would be facilitated by more vigorous efforts on the part of lawyers to persuade triers of fact that nonmedical witnesses are credible, lawyers first must be convinced that testimony by nonmedical mental health professionals can be presented in such a manner as will render it as credible as medical testimony. Several possible approaches to the problem might be considered.

First, nonmedical witnesses should be prepared to assert and defend their expertise and professional credibility. Nonphysicians need to be prepared to document in court the consistency of medical and nonmedical judgments in forensic areas. Lawyers, of course, need to be prepared to establish the credibility of their nonmedical witnesses by eliciting this information.[125] In appropriate circumstances, this expertise and credibility should be developed as part of the direct examination of the witness or even while qualifying the witness as an expert. The witness should make certain that the lawyers understand the kinds of responses the witness can give and the authority that the witness can cite in support of his or her professional credibility. Knowing that "good" answers will be forthcoming is—or should be—a prerequisite to posing questions in court. Obviously, this approach demands a good working relationship and exchange of information between the mental health professional and the lawyer.

Second, nonphysician witnesses should undertake training and preparation designed specifically to increase their skill as witnesses. The credibility of some medical witnesses often arises not from their professional qualifications or clinical skills but rather from their experience as witnesses and their composure on the stand. In-service training, perhaps including mock courtroom presentations, should be designed to develop similar skills in nonphysicians. Part of this preparation process may involve changing nonphysicians' self-image. Perlin

125. This might be done during voir dire of an expert or during the direct examinations of that expert. *See generally* Cameron, *The Mental Health Expert: A Guide to Direct and Cross Examination*, 2 CRIM. L.J. 299 (1979).

and others have noted that at least some of nonphysicians' problems in the courtroom can be traced to the witnesses' own perception of themselves as inferior to physicians.[126] Such self-perceptions are likely to become apparent to the judge or jurors and impair the witnesses' credibility. After all, who should know better than the witness how credible his or her testimony is? Modification of this self-image may be a difficult matter, especially in a program, institution, or society that accords a high degree of professional and social status to the practice of medicine. But the task must be undertaken. Development of a respectable body of empirical evidence supporting nonphysicians' claim to equal expertise should greatly assist this process.[127]

The third way in which nonmedical mental health experts' credibility can be enhanced is by increased efforts to use nonmedical personnel in courtroom contexts. Undoubtedly a significant part of nonphysicians' credibility difficulties is that their participation in litigation is unusual. The more frequent nonphysician testimony becomes, the less likely judges and jurors are to view it with skepticism. Greater reliance upon nonphysicians may, in fact, enhance the effectiveness and efficiency of the delivery of mental health care. Given the high salaries that physicians command in most situations, greater reliance upon nonphysicians can be expected to reduce the demand for expensive medical staff positions or at least free the time of physicians for other tasks for which they have unique qualifications.[128]

126. Perlin, *supra* note 9, at 194, 197.

127. The recent formation of the American Board of Forensic Psychology and its preparation for designating those who pass certain examinations as diplomats may be a useful move in this direction. *See* Kurke, *Forensic Psychology: A Threat and a Response*, 11 PROFESSIONAL PSYCH. 72 (1980). The development of this program appears to have been in part at least a response to the formation of the American Board of Forensic Psychiatry and its program of national certification of forensic psychiatrists. *Id.*

128. There may be other, less direct, benefits from efforts to attack the presumption of medical superiority. As the acceptability of nonphysician expert testimony on forensic mental health issues increases, trial judges may be more inclined to limit cross examination and impeachment that focuses upon such witnesses' absence of medical training. This is likely to be a long time in developing, however. Where there is no testimony in a case supporting the proposition that medical training confers greater relevant skills, at least prolonged inquiry concerning the absence of such training may be characterized as a "know-nothing appeal to ignorance" and cut short. But at least where an opposing witness is willing to testify that medical training better equips one for forensic work than other mental health professional backgrounds, trial judges are unlikely to prohibit inquiry into and argument based upon the absence of a medical doctor's degree.