# Commentary: A Judiciary Point of View

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The involuntary admission of the mentally ill to a mental institution is most probably perceived by the psychiatric community as a medical need no different from any other field of medicine.

Even before citing a judicial point of view, it is not necessary to hold medical or judicial opinions to grasp the main difference: Patients in an overcrowded internal medicine ward understand and admit that they are sick and that their hospitalization — unless they are unconscious — is with their full consent. Involuntary admission is by definition against one's will. Another difference is that in the overcrowded internal medicine ward, the medical staff does not hold keys to the locked doors, and the patient can leave the ward and simply walk around the hospital or even walk out.

The Israeli judiciary is not different from the western systems which regard the person's freedom as a constitutional right. Accordingly, the U.S. Supreme Court has expressed its opinion by saying: "There can be no doubt that involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the State cannot accomplish without due process of law" (1). The Israeli courts' opinion is along the same lines and can be found in many court cases dealing with involuntary psychiatric admissions. A representative statement for such courts' opinion was expressed in a Tel Aviv court case: "Not in vain set the legislature paragraph 35b (in the statute for the treatment of the mentally ill), stating that the main goal of admitting the sick to a hospital is for medical treatment. Hence, one cannot hospitalize a person in a hospital for the purpose of community or self protection, unless it is strictly in accordance with this statute. By that, the legislature has expressed a firm standpoint that has replaced the past paternalistic approach, that regarded the duty of society to care for the weak and helpless, as an independent goal, which overrules the individual will" (2).

## Is There Really a Language Gap?

We do not share the authors' view regarding the "binary" difference between the medical and the judicial languages. It is not an issue of language but rather a matter of different tools used for the decision-making process. The doctor should take into consideration a wide spectrum of medical anamnestic data necessary to make a differential diagnosis, to rule out different diagnostic options and then to come to a decision regarding the appropriate treatment. The judicial system has to take into consideration a wide spectrum of evidence and circumstances before it reaches a decision regarding the dangerousness of the mental patient.

Indeed, psychiatrists' medical experience enables them to better predict future behavior of mental patients. However, they, too, have to rely on past evidence and circumstances, which they have not necessarily witnessed. There is no question that qualified physicians can make a diagnosis of mental disease based on an examination of the patient. If they do not, though, collect sufficiently accurate evidence of past behavior and evidence of recent incidents that brought such a patient to the hospital, how can they make a positive *dangerousness diagnosis* with such certainty?

Like any medical specialty, psychiatric specialists should be sure that the reports of relatives, neighbors, police officers or any person about the patient behavior are accurate. The tools the internist uses to diagnose renal failure are laboratory tests. The tools of the psychiatrist to diagnose dangerousness are the reports of the patient's behavior. As the internist cannot rely on inaccurate laboratory equipment, so the

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psychiatrist should not rely on inaccurate reports and testimonies. One may argue that there is a difference, though, between medicine and the judiciary, in interpretation and evaluation: In emergency cases when a doctor suspects a myocardial infarct or acute appendicitis and has no laboratory or accurate diagnostic tools to verify such diagnosis, he/she must regard such suspicion as an emergency case. The judiciary, on the other hand, still needs evidence.

However, evidence is evidence for both specialties. Even the suspicious physician has to rely on some evidence before he diagnoses MI, such as chest pains, sweating, etc., or lower abdominal pains, tenderness, rebound, etc., in the case of appendicitis. The same is true for the psychiatrist: When a patient is admitted to the ER, the attending physician should have at least some evidence to reach a diagnosis of suspected *dangerousness*. So too the judicial experts: They have to be presented with at least some evidence for deciding that there is dangerousness and a legal justification for deprivation of freedom.

The above may lead to the conclusion that the two systems, the psychiatric and judicial, are not that far apart. Both need accurate and satisfactory information of evidence for reaching a decision, or at least *some* evidence to raise a suspicion and both should not be satisfied unless they can rest assured that such information is fully reliable.

We would suggest that medical experts, as well, use binary tools in making a diagnosis and deciding on treatment. Indeed, a disease can be classified as mild, moderate, severe or even life threatening. When it comes to diagnosis, however, the patient has to meet certain criteria to rule out most of the differential options and then has to meet certain criteria to justify one or another treatment modality. The judicial system functions in a similar way, only with different diagnostic tools. A person's state of mind can vary, even according to the judiciary. Only at a certain point, though, he becomes legally incompetent or dangerous, just like the patient who becomes eligible to a certain treatment at a certain point.

As far as involuntary commitment is concerned, both the judiciary and the medical officers should ask the same "binary" question: Is the patient eligible to be free or should he be deprived of freedom for the purpose of getting medical treatment?

Our view is that in reality there is no language gap between the medical and judiciary systems. At the moment of decision, both make "either/or" decisions in an unavoidable binary manner.

## Involuntary Hospitalization

### A. Criticism of court decisions

We agree with the authors' criticism regarding the court decision to release from hospital a schizophrenic patient who had tried to have her teeth extracted because of hallucinations. We agree that self mutilation does represent dangerousness for self, even when it is not life threatening. It is a pity that the state did not appeal to the Supreme Court so that the judicial and medical community could have obtained a binding precedent. On the other hand, one should not conclude that such an extreme court decision represents a judicial consensus. As the authors note, not all court cases have rejected decisions for involuntary commitment.

### B. Examples of unjustified involuntary admittance

There are, unfortunately, numerous examples of unjustified involuntary admittance cases, where people had been confined in a mental institution on insufficient grounds or even lack of evidence for dangerousness. One does not have to be a physician or a legal expert to understand that involuntary admittance can be abused by interested elements that may be in a better position when the patient — their relative or neighbor — is kept away and is not around. By this we do not mean to condition the involuntary admittance by insisting that relatives or neighbors should file a complaint and make a statement to the police prior to every involuntary admittance order. However, we would expect the referring physician to at least request that such relatives or neighbors be personally interviewed by him/her before making a decision of involuntary admittance. Indeed, a psychiatrist is not an expert on police investigation, although he is expected to have enough knowledge and experience in human behavior to use common sense and judge whether such family members are reliable.

Another example can be rooted in superficiality of officials, such as police officers, social workers,

etc., as presented in a Jerusalem court case when the court released a schizophrenic patient from hospital. The court preferred to accept her version rather than the police which did not bother to supply evidence, either to the District Psychiatrist or to the court, not even a written report of the incident in the police station, which had been the reason for the police request for involuntary admittance (3).

In another Tel Aviv court case, the District Psychiatric Committee (DPC) decided to prolong involuntary commitment of an uncooperative psychotic patient, who used verbal violence toward her parents, removing different items from the house and practiced unprotected sex with people she met in the streets. The court held that the committee did not specify what evidence was examined, why only verbal violence represented dangerousness, why the removal of different items from the house without damaging anybody was dangerous and why sexual proclivity was regarded as dangerousness justifying urgent admission (4).

Cases such as the above do not reach the courts and are dealt with by the DPCs. Quite often a psychotic patient is admitted not because of a recent violent or dangerous act, but merely because of family or neighbors' reports of "worsening" in his disease and the mere potential for dangerousness. In some cases the patient may be in a quiet state, however, when he has a "history" of even one violent act, even when such an act took place years before, he may be considered "dangerous" unless proven otherwise.

Another example is when family members want to make sure that their incompliant son/relative is properly treated and use quasi-dangerous "stories" in order to convince the system to hospitalize him/her. Although they may mean well, and believe they do it for the benefit of the sick person who refuses treatment, this is an unjustified coercive admission.

We would expect the admitting psychiatrist to make efforts to minimize such unjustified acts by at least asking the patient's companion more questions, using common sense and, most importantly, being fully and honestly convinced that the medical consideration for involuntary hospitalization outweighs the basic human right for freedom.

Guidance of the doctor's prediction of dangerousness as a reason for involuntary admission has been well set by the Jerusalem District Court: "It is not enough that the medical authority assumes or believes that the patient is dangerous. It should ***be convinced***. That conviction is not by any means the private and personal state of mind (feeling) of the treating physician, since it should be available for judicial criticism. Such conviction should be measured within an objective base so that when examined, the convinced physician shall be able to convince others" (5).

Indeed, even the court did not specify what "being convinced" is. We would recommend, however, that if, after a self-questioning process, a psychiatrist is satisfied that he would have made, under similar circumstances, the same decision for involuntary admittance of a close friend or family member, then he has sufficient conviction and has made the right decision in accordance with medical ethics.

**In conclusion:** The involvement of the judicial system in involuntary admission processes is necessary due to the real possibility of abuse or even misconduct of third parties which may mislead the attending psychiatrist into mistaken decisions.

### C. The liability of psychiatrics

The authors point to the fact that contrary to the judiciary and the District Psychiatrists, who have procedural immunity, the treating psychiatrist can be held liable for harm caused by a mental patient who has been released prematurely. Along the same lines he may be held liable for unjustified involuntary "confinement." Such liability is not unique to psychiatry; all medical specialties may be held liable for mistaken or unjustified medical decisions — although not every such decision is considered malpractice. The answer to this difficult question, which is within the domain of tort law, is in the unavoidable medical malpractice insurance.

We agree that a psychiatric hospital is not a penitentiary and that protection of the safety of the community is a social rather than a medical issue. This is also reflected in the guiding Supreme Court ruling, where Chief Justice Aharon Barak ruled that the period of criminal involuntary commitment of a mentally non-liable person under a court order should be proportionate to the criminal act with which he was charged. After such a period, changing his criminal

involuntary commitment into a civil one, if he is still in need of supervision and treatment in a closed ward, should be considered (6).

We also agree that the District Psychiatrist should not be the law enforcing agent for the police, when a person does not comply with a court order for involuntary outpatient clinic treatment. Accordingly, we would urge legislators to change paragraph 15(5), "The statute for the treatment of the mentally ill," which gives the District Psychiatrist the authority to involuntarily admit such non-compliant persons. According to our view, the District Psychiatrist should inform the police or the Attorney General, who are the ones to enforce the court order.

### The representation of involuntarily committed patient by an attorney

The opinion that the judiciary is excessively or perhaps unjustly involved in medical decisions for involuntary admittance has been expressed (7). The role of the representing attorney is not to question the medical diagnosis or treatment. His/her role is to check the existence of legal prerequisites for involuntary admittance and whether the data and evidence for *dangerousness*, on which medical decisions regarding involuntary admissions have been made, are valid ones. Also, such an attorney can compare the in-hospital medical records with the hospital request to prolong involuntary commitments by three to six months. From personal experience as chairman of DPCs I can bring cases — though not too frequently — where the request for hospitalization prolongation for three to six months specifies that the patient's behavior in the ward is unstable, irritable and even violent, while the medical charts or the nurses' reports testify to the contrary.

We do not agree with the statement that "the legal model views hospitalization strictly as denial of patient's rights and freedom." Rather, **the legal system *does approve* involuntary hospitalization for the right people who meet the prerequisite for such hospitalization**. People who are involuntary hospitalized due to insufficient or unconvincing evidence of dangerousness do not meet the statutory criteria and, therefore, their rights and freedom are abused.

### References

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## Authors' Response

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Wolfman asks: "How can psychiatrists make a positive diagnosis of dangerousness with so much certainty?" The answer is that they cannot. The medical profession relies heavily on probabilities and assessment. When a physician is unsure of the diagnosis he usually watches the patient for a few days until the clinical picture becomes clearer. We do not send the patient away for unavailability of enough evidence. "Some evidence" seems sufficient for a physician to suspect the beginnings of a severe disorder, although it may not be fully developed as yet. "Some evidence" is, however, not enough for the judicial system.

Furthermore, Dr. Wolfman seems to ignore the fact that the goal of a civil involuntary hospitalization is to **prevent the possible danger** rather than to take action after its harmful results. How, then, can a psychiatrist "be convinced and be able to convince others" if the dangerous behavior has not occurred yet?