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Book Review: Involuntary Treatment of the Mentally Ill, by Michael Peszke

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BOOK REVIEW

Involuntary Treatment of the Mentally Ill. By Michael Peszke. Charles C. Thomas, Publ., 1975.

The development of coherent bodies of procedural[1] and substantive[2] mental health case law, coupled with the creation of a meaningful, advocacy-centered mental health rights bar,[3] has been among the most significant system-wide legal developments of the past five to ten years. This new body of judicial decisions and legislative enactments has clearly had a "ripple effect" far beyond the doors of the courtroom and the State House.[4] Mental health reformers have traditionally been philosophers,[5] doctors,[6] penologists,[7] and, simply "reformers."[8] Since lawyers are, regrettably, newcomers to the area of mental health service delivery,[9] it is not surprising that they are now bearing the brunt of much criticism, the significant portion of which emanates from the medical profession. Having been faced with a flood of source books,[10]

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* The views expressed in this article are solely those of the author. A small portion of this review will appear in a forthcoming issue of the JOURNAL OF HOSPITAL AND COMMUNITY PSYCHIATRY.

1. *See, e.g.*, Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated on other grounds*, 414 U.S. 473 (1974), *on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated*, 421 U.S. 957 (1975); Lynch v. Baxley, 386 F. Supp. 378 (M.D. Ala. 1974); Bell v. Wayne County Gen. Hosp., 384 F. Supp. 1085 (E.D. Mich. 1974).

2. *See, e.g.*, O'Connor v. Donaldson, 422 U.S. 563 (1975); Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala. 1972), 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd sub nom.* Watt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

3. *See, e.g.*, NEW YORK MENTAL HYGIENE LAW § 88 (McKinney 1971); N.J. STAT. ANN. §§ 52:27E-21 *et seq.* (Supp. 1976).

4. For discussions of the impact of significant court decisions on patient life at institutions, *see, e.g.*, Ennis, *New York Signs Far-Reaching Consent Decree in the "Willowbrook" Case*, MENTAL RETARDATION AND THE LAW 1 (June 1975); Johnson, *Court Decisions and the Social Services*, 20 SOCIAL WORK 343 (1975).

5. *See, e.g.*, J.S. MILL, ON LIBERTY (1859).

6. *See, e.g.*, I. RAY, A TREATISE ON THE MEDICAL JURISPRUDENCE OF INSANITY (1838).

7. *See* D. ROTHMAN, THE DISCOVERY OF THE ASYLUM, ch. 10 (1971) [hereinafter cited as ROTHMAN].

8. For a discussion of Dorothea Dix, one of the most significant of the nineteenth century reformers, see ROTHMAN, *supra* note 7, at 187-202.

9. For criticisms of the traditional role of attorneys in mental health litigation, *see, e.g.*, Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 TEX. L. REV. 424 (1966); Litwack, *The Role of Counsel in Civil Commitment Proceedings: Emerging Problems*, 62 CALIF. L. REV. 816 (1974).

10. *See* LEGAL RIGHTS OF THE MENTALLY HANDICAPPED (P.L.I. ed. 1973).

supermarket rack paperbacks,[11] scholarly tradebooks,[12] legal case books,[13] and professional journal articles,[14] the doctors are now responding, often with similarly thoughtful works.[15] It is perhaps inevitable that, as part of the new wave of medical writing, at least one doctor has chosen to retrench, take the offensive, and turn the problem around, so as to lay the blame at the feet of the interlopers: the lawyers.

In this specific context, then, Michael Peszke's *Involuntary Treatment of the Mentally Ill*[16] is a work which should be greatly disturbing to mental health professionals and attorneys who deal with the mental health system. The word "disturbing" is chosen carefully: Peszke's central thesis is a philosophically provocative one with certain legitimate underpinnings, but some of his secondary assumptions and corollary theories are nothing less than frightening in their implications.

Peszke, a doctor, approaches the problem of involuntary commitment as a problem of autonomy: while the legal system, he argues, views involuntary treatment with "repugnance,"[17] the medical profession desires to treat, and cure, illness to insure that autonomy "which is [otherwise] impeded and constricted by the coercion of mental illness."[18] Basically, he posits a nearly unresolvable dichotomy between the medical model (mental illness is a disease and the sick should be treated) and what he perceives as the anti-psychiatric, legal model (mental illness does not exist, "[a]ll behavior is under volitional control," and all citizens may behave as they please as long as they "are not in direct confrontation with social goals").[19] In order for involuntary commitment to exist, it must be proved that mental illness exists and that it "affects the decisionmaking process of the organism . . . ."[20] His ultimate thesis is that mental illness does exist as a disease which coerces free will. Because of this coercion, it thus makes neither "moral

11. *See, e.g.*, B. ENNIS, PRISONERS OF PSYCHIATRY: MENTAL PATIENTS, PSYCHIATRISTS AND THE LAW (1972); B. ENNIS & L. SIEGEL, THE RIGHTS OF MENTAL PATIENTS: THE BASIC ACLU GUIDE TO A MENTAL PATIENT'S RIGHTS (1973).

12. *See, e.g.*, R. MARTIN, LEGAL CHALLENGES TO BEHAVIOR MODIFICATION (1975).

13. *See, e.g.*, A. BROOKS, LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM (1974); J. KATZ, J. GOLDSTEIN & A. DERSHOWITZ, PSYCHOANALYSIS, PSYCHIATRY AND LAW (1967).

14. *See, e.g.*, Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960); Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1107 (1972).

15. *See, e.g.*, A. STONE, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION (1975) [hereinafter cited as STONE].

16. M. PESZKE, INVOLUNTARY TREATMENT OF THE MENTALLY ILL (1975) [hereinafter cited as INVOLUNTARY TREATMENT]. Peszke seems to view the legal profession as a one-minded monolith, ascribing the purported public positions of well-known patient advocate Bruce Ennis to all practicing attorneys.

17. *Id.* at vii.

18. *Id.*

19. *Id.* at 74.

20. *Id.* at 55.

[n]or logical sense" to limit involuntary commitment to the dangerous.[21] Although this is, as indicated above, a provocative position, the reasoning process which supports it is less than totally persuasive, while the process by which Peszke rejects what he posits as the contrary view is nothing less than bizarre.

According to Peszke, asylums developed because of the "intuitive conviction of society" that certain persons needed help which "only the medical profession had the tradition, the wisdom, and the humanitarian interest to assume."[22] For many people, he assures us, these asylums were "a perfectly desirable place in which to live."[23] With this background, he sets out the physician's role:

> *For the physician, the patient who comes for help deserves treatment, and if he needs treatment, the physician has a moral and an inherent medical obligation to provide such treatment to the best of his ability.*[24]

As "mental illness is no different from any other form of disease,"[25] treatment should be "as aggressive and comprehensive as is the treatment of heart failure, a bleeding peptic ulcer or hypertension."[26]

Thus, there exist "certain forms of emotional disorders"[27] which "are as much a disease as are multiple sclerosis and cancer!"[28] This sort of mental illness, or psychosis:

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21. *Id.* at 61.

22. *Id.* at 21.

23. *Id.* at 22. For a less sanguine view, *see, e.g.*, ROTHMAN, *supra* note 7, at 283 ("[T]he very elements which contributed to the erosion of a rehabilitative asylum helped to insure the perpetuation of a custodial one"); *see also* F. PIVEN & R. CLOWARD, REGULATING THE POOR 34 n.66 (Vintage ed. 1972), referring to K. DE SCHWEINITZ, ENGLAND'S ROAD TO SOCIAL SECURITY 66 (1943) (a 1767 House of Commons investigation found that only seven of 100 infants born or received into workhouses survived two years).

This topic highlights a major ambiguity in the author's approach to the subject matter: initially, he notes that "when hospitalization *was* custodial and treatment minimal, then due process protection was imperative." INVOLUNTARY TREATMENT, *supra* note 16, at 10 (emphasis added); elsewhere, he accurately describes many state facilities (in the present tense) as "medieval horrors." *Id.* at 67. Yet, after he describes the rise of the asylum "as a perfectly desirable place," he notes "[t]his is still the case for many . . . ." *Id.* at 22. The conflict between these statements is unresolved, and the issue of the relationship between the presence of adequate treatment and the rate of involuntary commitment, *see e.g.*, STONE, *supra* note 15, at 43, 67, is ignored.

24. INVOLUNTARY TREATMENT, *supra* note 16, at 28. This of course, presupposes a freedom of choice on the part of the patient, a freedom that is totally nonexistent in the case of most involuntary patients, and, in terms of a competitive marketplace, nonexistent for many voluntary patients as well.

25. *Id.*

26. *Id.* For an interesting treatment of the possible psychological origins of all of Peszke's comparative examples, see S. SILVERMAN, PSYCHOLOGIC CUES IN FORECASTING PHYSICAL ILLNESS 211, 335, 357 (1970).

27. INVOLUNTARY TREATMENT, *supra* note 16, at 51. Contrarily, he finds that the "variety of personality disorders and neuroses that have . . . fallen within the purview of psychiatry . . . are not forms of mental illness." *Id.* at 52.

28. *Id.* at 51. The incessant use of misplaced exclamation points in the text is at times a major irritant.

> affects the decisionmaking process of the organism, it affects his mind, disturbs his intellectual ability such as memory, concentration, abstract thinking and judgment, disturbs the process of logical thought, impairs verbal communication, affects the symbolic process and alienates the victim from his environment and from himself.[29]

Coupled with "the genetic biological attributes of the disease process, the fact that [mental illness] can be diagnosed on objective and subjective grounds and that it can be treated most effectively through biological means [thus proving it] to be a disease entity,"[30] leads Peszke to the inescapable conclusion that, when such conditions are present, it is not necessary that dangerousness be a criterion of commitment.[31]

Following this vigorous defense of the medical model, Peszke attacks the corpus of anti-psychiatric criticism and the involvement of lawyers in the entire involuntary civil commitment process, with what must sadly be characterized as vitriol, in a way which reflects a near total miscomprehension of the role of the legal system not just as it relates to psychiatry but as it relates to the entire fabric of American society. The attack is sufficiently inappropriate (and startling) as to call into question the value of the remainder of the author's work.

Peszke suggests that the problem of inappropriate commitments is a minor one: the concern of being " 'railroaded' " is atavistic, and historical evidence is "scanty."[32] The waters have been muddied by the "attorney [who] brings in the philosophy of criminal law,"[33] and who argues that involuntary hospitalization should be limited to the dangerous.[34] He then criticizes a New York Civil Liberties Union legislative memo, which he implicitly assumes speaks for all practicing mental health attorneys. The memo argues that mental illness alone can never be a justifiable reason for involuntary deprivation of a person's liberty and property, to which he responds "Why Not?"[35]

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29. *Id.* at 55.

30. *Id.* at 60.

31. *Id.* at 61. Such a requirement, he finds, would be "like arguing that the concussed victim should be treated if he is causing a nuisance, but otherwise ignored and left alone." *Id.* For a similar articulation of the author's position, see Peszke, *Is Dangerousness an Issue for Physicians in Emergency Commitment?*, 132 AM. J. PSYCHIAT. 825, 827 (1975).

For an analysis of the role of counsel at involuntary civil commitment proceedings and the reactions by psychiatrists thereto, see Wenger & Fletcher, *The Effect of Legal Counsel on Admissions to a State Mental Hospital: A Confrontation of Professions*, 10 J. HEALTH AND SOC. BEHAV. 66, 71 (1969).

32. INVOLUNTARY TREATMENT, *supra* note 16, at 69-70. *Cf., e.g.*, ROTHMAN, *supra* note 7, at 143 ("[O]nce medical superintendents received a patient, they were usually able to separate him fairly systematically from the outside world").

33. INVOLUNTARY TREATMENT, *supra* note 16, at 75. The philosophy referred to is that of "innocent until proven guilty, therefore free of mental illness until proven to have it!" *Id.*

34. *Id.* at 76.

35. *Id.* at 77.

Peszke further criticizes the memo's use of the due process clause as an argument against such involuntary hospitalization, a clause which he suggests refers only to criminal matters.[36] He concludes that the NYCLU "appear[s] to assume . . . that a psychotic, troubled individual would prefer to stay that way rather than to get better."[37]

From this relatively narrow set of premises, Peszke moves to the real target of his assault: the entire legal profession. Relying heavily on De Toqueville's writings,[38] the author states his central thesis:

> I posit that the legal profession wishes to claim exclusive control over all social and political aspects of life in the United States. Hence, in this area of social implication of medical practice—namely, involuntary hospitalization and the issues of informed consent stemming from it—the attorneys have challenged medicine and have extended their professional interest![39]

Because the judiciary "is not under the control of any group except of the legal profession," Peszke questions "whether the United States is really a democracy."[40] Finally, he suggests that, in the long run, the issue of involuntary commitment may be the Maginot Line for the future of the American people: "It may be that the issue of the mentally ill is the place to stop the growing tyranny of law . . . ."[41]

Peszke suggests that "much of the agitation . . . directed at the medical profession and psychiatry . . . has to do with the legal profession's wishing to establish its own control over this very powerful social tool."[42] He characterizes the legal attitude towards the mentally ill as "one of extreme naïveté, exaggerated ideological concern mixed with complete and absolute disinterest;"[43] he follows up this nearly incomprehensible definition by suggesting that, whereas an attorney would be unlikely to use his judgment, for instance, "in the interpretation of the figures for calculating the construction of a bridge, . . . it is quite clear that the average attorney is convinced that his own judgment, his own expertise, and his own professional background is sufficiently expert to enable him to make judgments on intrapsychic and interpersonal behavior."[44]

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36. *Id.* *Contra*, note 62 and accompanying text *infra*.

37. INVOLUNTARY TREATMENT, *supra* note 16, at 79.

38. Ironically, speaking recently at a Princeton University conference on institutional issues, Dr. David Rothman referred to De Tocqueville to a completely contrary end:

> De Tocqueville came here to see the prisons and thought the United States was the wave of the future, but, as it has turned out, all that we did was to move the whipping post inside and invent more gadgets to go with it.

N.Y. Times, Apr. 5, 1976, at 35, col. 7 (New Jersey ed.).

39. INVOLUNTARY TREATMENT, *supra* note 16, at 93.

40. *Id.*

41. *Id.* at 94.

42. *Id.* at 95.

43. *Id.* at 98.

44. *Id.* at 100.

These astonishing arguments are then, curiously, followed by a short inconclusive chapter discussing comparative studies of involuntary treatment in other countries, and by suggestions for the future which include such reasonable recommendations as the need for the medical profession to formulate ethical standards,[45] creation of a mental health tribunal to review cases following emergency detentions,[46] the discontinuation of rural based psychiatric facilities,[47] centralization of urban emergency reception centers,[48] and "a good five-dollars-an-hour psychotherapist."[49] On the other hand, Peszke also suggests, albeit sardonically, that if the legal profession feels that its "inherent constitutionally given right to protect the freedom of citizens . . . give[s] [it] . . . a 'first crack' at a patient, then, indeed in those jurisdictions *the medical profession should leave the emergency room and psychiatric problem to the attorney*."[50]

He concludes by returning to a few final anti-legal salvos: many of the attorneys practicing mental health law exhibit "naïveté and arrogance" while failing to come up with practical or constructive alternatives;[51] the average doctor perceives the average attorney "as a man who will distort the truth,"[52] as one whose scholarship shows "gross ignorance or even a conscious malevolence and dishonesty alien to worthy scholarship;"[53] and, finally, the law student's interest in law and psychiatry is not "to learn the strength and attributes of the legal profession or to study human problems," but "to learn how to pick holes and to show the psychiatrist up in court."[54]

What is to be done with such a concoction of polemic, misunderstanding and anger, especially when it is obviously written seriously and when it is coupled with suggestions which do, when they stand alone, make sense?[55]

At the outset, Peszke's comments on the ramifications of the involvement of lawyers need a speedy rebuttal on a factual level. The problem of inappropriate commitment is *not* a historical curiosity—contemporaneous studies have shown that significant percentages of state hospital patients (the number varies from 43% to 68% to 75%) could be safely treated elsewhere.[56] Also, and perhaps just as significantly,

45. *Id.* at 114. *Cf. In re* Quinlan, 70 N.J. 10, 46-51, 355 A.2d 647, 667-69 (1976).
46. INVOLUNTARY TREATMENT, *supra* note 16, at 12.
47. *Id.* at 125.
48. *Id.*
49. *Id.* at 126.
50. *Id.* at 115 (emphasis added).
51. *Id.* at 133.
52. *Id.* at 134-35.
53. *Id.* at 135. Here he refers specifically, but not by name, to Ennis.
54. *Id.* at 136.
55. See, *e.g.*, text accompanying notes 45-49 *supra*.
56. *See, e.g.*, T. SCHEFF, BEING MENTALLY ILL 168 (7th ed. 1973) (the presence of

studies nearly unanimously show that psychiatrists are no more accurate in predicting dangerousness than are nonpsychiatrists.[57] The argument that the attorney "brings in the philosophy of the criminal law"[58] is similarly misplaced: it is rather, the existence of legislative statutory enactments which permit involuntary hospitalization in the first place (in the absence of which the issue would never arise). Certainly, not even Peszke would suggest that the psychiatric profession, acting *ultra vires*, has the inherent right to establish inpatient hospitals (presumably state funded and run) to which persons can be sent without legal recourse. It is unthinkable that such power can legitimately exist without the assent of the people as reflected in the actions of the individual state legislatures.[59]

Peszke's rhetorical "Why Not" (in responding to the NYCLU criticism of hospitalization on the basis of illness alone) ignores political reality by sidestepping the historic decision of the United States Supreme Court in *O'Connor v. Donaldson*,[60] which finally and forever put to rest the question of the justiciability of treatment issues.[61] Also,

43% of patients in hospitals studied could not be explained in terms of their psychiatric condition); Abraham & Bucker, Preliminary Findings from Psychiatric Inventory, 1971 (unpublished) (68% of patient population at St. Elizabeth's Hospital in Washington not considered dangerous to themselves or others); Mendel, *Brief Hospitalization Techniques*, 6 CURRENT PSYCHIATRIC THERAPIES 310 (1966) (75% of patients studied with diagnosis of schizophrenia could be suitably discharged), *all cited in* Ferleger, *A Patients' Rights Organization: Advocacy and Collective Action by and for Inmates of Mental Institutions*, 8 CLEARINGHOUSE REV. 597 n.1 (1975). *See also* Dixon v. Weinberger, 405 F. Supp. 974 (D.D.C. 1975), in which a Federal judge in Washington, D.C., ordered St. Elizabeth's Hospital to devise a plan by which it could release 43% of its inpatients to less restrictive, more appropriate community facilities.

57. *See, e.g.*, AMERICAN PSYCHIATRIC ASSOCIATION, CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL 23-30 (1975); Cocozza & Steadman, *The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence*, 29 RUTGERS L. REV. 1084 (1976); Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693, 749 (1974) (no evidence found that a psychiatrist can predict dangerousness more than a lawyer); Rappeport, Lassen and Gruenwald, *Evaluation and Follow-up of Hospital Patients Who Had Sanity Hearings*, CLINICAL EVALUATION OF THE DANGEROUSNESS OF THE MENTALLY ILL 89 (Rappeport ed. 1969) ("The comparison between court released and hospital released adjustment rates shows no significant difference in the predictive accuracy of either institution").

Although Peszke concedes that there is a "certain amount of accuracy, *if not always of good taste*," INVOLUNTARY TREATMENT, *supra* note 16, at 76 (emphasis added), in this position, he demurs to it. His fallback position remains that dangerousness should not be the key determinant in involuntary hospitalization decisions. *Id.* at 76-77.

58. *Id.* at 75. See note 33 *supra*.

59. See, *e.g.*, N.J. STAT. ANN. §§ 30:4-23 *et seq.* (Supp. 1976).

In *Briggs v. Mandel*, Docket No. 115A/40/A-54664 (Md. Balt. County Cir. Ct., Feb. 28, 1975), the court ordered that state's Office of the Public Defender to assign counsel to represent indigent persons subject to involuntary civil commitment, noting that, if a plan was not implemented to provide such services within a four-month period, no person could be involuntarily committed without such counsel after the cut-off date. Slip op. at 16.

60. 422 U.S. 563 (1975).

61. The Supreme Court characterized the position similar to Peszke's as "unper-

his suggestion that the "life, liberty or property" due process clause applies only to criminal matters is, of course, absolutely and unequivocally wrong.[62] These examples are not isolated; they are indicative of the biases which color his entire approach.[63]

The author's final attacks on what he apparently sees as the psychopathology of the attorney's personality require little comment except as they, again, reflect his curious scholarship. In explaining why lawyers feel they can preempt psychiatrists, Peszke notes, "[m]any [attorneys] have taken psychology and sociology courses which have exposed them to certain levels of thinking in the area of the social sciences."[64] His explanatory footnote asserts:

> It has been commented that at the undergraduate college level, courses in sociology and psychology are taught by young, often quite radical faculty, who are very venomous in their condemnation of society in general and medicine in particular.[65]

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suasive," and added:

> Where "treatment" is the sole asserted ground for depriving a person of liberty, it is plainly unacceptable to suggest that the courts are powerless to determine whether the asserted ground is present.

Id. at 574 n.10.

62. At the outset, the distinction between criminal, quasi-criminal and civil proceedings is no longer a meaningful one when issues such as liberty are involved. *See, e.g., In re* Gault, 387 U.S. 1 (1967). Beyond this, of course, the due process clause clearly applies to civil law in matters involving duration of commitment of the mentally ill, Jackson v. Indiana, 406 U.S. 715 (1972); treatment of the mentally ill, Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala. 1971), 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd sub nom.* Wyatt v. Aderhold, 503 F.2d 1305 (5th Cir. 1974); and the full range of other matters in which a person's "life, liberty, or property" is involved. *See, e.g.*, Fuentes v. Shevin, 407 U.S. 67 (1972); Goldberg v. Kelly, 397 U.S. 254 (1970); Cafeteria and Restaurant Workers Local 473 v. McElroy, 367 U.S. 886 (1961).

63. Thus, his attempts at distinguishing the attorney-engineer relationship from the attorney-psychiatrist relationship, INVOLUNTARY TREATMENT, *supra* note 16, at 100, are similarly misplaced. Federal Judge David Bazelon, one of the giants in the field of legal psychiatry, has put the issue in proper perspective by noting:

> [D]iffidence in the face of scientific expertise is conduct unbecoming a court. Very few judges are psychiatrists. But equally few are economists, aeronautical engineers, atomic scientists, or marine biologists. For some reason, however, many people seem to accept judicial scrutiny of, say, the effect of a proposed dam on fish life, while they reject similar scrutiny of the effect of psychiatric treatment on human lives . . . . [I]t can hardly be that we are more concerned for the salmon than the schizophrenic.

Bazelon, *Implementing the Right to Treatment*, 36 U. CHI. L. REV. 742, 743 (1969). He continues:

> When the limited function of a judge in reviewing administrative determinations is borne in mind, there seems little to distinguish psychiatry from, say, radio broadcasting. No judge would claim the ability to prescribe a particular therapy for a "chronic undifferentiated schizophrenic." But neither would any judge allocate frequencies to avoid interference. That is not his task in either case; his role rather is to determine whether a capable expert has studied the problem fully and reached a defensible result.

Id. at 745. *See also* Bazelon, *Psychiatrists and the Adversary Process*, SCIENTIFIC AM., June 1974, at 18, 23.

64. INVOLUNTARY TREATMENT, *supra* note 16, at 100.

65. *Id.* at 105 n.8.

Similarly, in ascribing a desire to "show the psychiatrist up in court"[66] to the nascent law student, Peszke quotes what he passes off as a "verbatim piece of advice to an attorney acting on behalf of an incarcerated patient."[67]

> If there is a hearing before a neutral psychiatric arbiter, concentrate all of your effort into getting him or her incensed with the inadequacy of the hospital psychiatrist, the facility and the treatment resources. This may not be hard to do in many cases; the hospital psychiatrist is likely to be foreign, poorly trained, under-staffed and over-worked. The board psychiatrist will probably be much more 'established' and orthodox. Put him in the position of either having to endorse what the hospital wants to do—of having to underwrite obvious inadequacy or of being willing to go after the inadequacies himself on behalf of the patient.[68]

This quotation, however, is wrenched out of context. The author's point was to show how a competent psychiatrist can effectively cross-examine an *incompetent* psychiatrist.[69] Sadly, Peszke misses the main thrust of the article he uses to support his contention.

This is a troubling work, in the same way that a bad performance of Wagner's *Götterdämmerung*, for example, is more troubling than a bad pop music concert. Expectations are so much higher and so much more can go wrong. The work becomes in the long run little more than an anti-lawyering polemic; if Dr. Peszke were treating a patient who spoke as author Peszke writes, it is inconceivable that he would not make note of the full range of ego defenses used: projection, defensiveness, denial, fixation, just to name a few.[70] Peszke has attempted to produce a manifesto by which the medical profession can defend itself against the misguided and ill-fated onslaughts of the law. Although his articulation of the medical position is not unreasonable (given his basic assumptions), and some of his recommendations do make sense, his underlying misconceptions make this work, for want of a better word, a potentially dangerous one.

This book may be just the tip of an iceberg of anti-lawyering works by medical professionals, or it may be aberrational. It is especially

66. *Id.* at 136.
67. *Id.* at 140 n.10.
68. *Id.*
69. See Silverberg, *The Civil Commitment Process: Basic Considerations*, 1 LEGAL RIGHTS OF THE MENTALLY HANDICAPPED 103, 110 (P.L.I. ed. 1973). The author of that article, former head of the Patients' Advocacy Service at St. Elizabeth's Hospital, is currently chairman of the American Bar Association Commission on the Mentally Disabled.
70. See, *e.g.*, C. BRENNER, AN ELEMENTARY TEXTBOOK OF PSYCHOANALYSIS 88-107 (1955); C. HALL, A PRIMER OF FREUDIAN PSYCHOLOGY 85-97 (1954); J. PAGE, PSYCHOPATHOLOGY 12-13 (4th ed. 1973). To be more colloquial, as an ancient proverb goes, he who is able to see a fly on someone else is often unable to see an elephant on himself.

disconcerting at a time when a significant number of psychiatrists are producing books[71] and articles[72] which are aimed at lessening discord between the professions and when doctors and lawyers are finally coming together professionally and regularly to discuss mental health problems.[73] Dr. Peszke expresses a point of view that is evidently a popular one with more than several doctors; hopefully, his professional brethren will deal with it in a somewhat more dispassionate manner than that in which it was written.

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71. *See* note 15 *supra*; R. SADOFF, FORENSIC PSYCHIATRY (1975).

72. *See, e.g.*, Kopolow, *A Review of Major Implications of the* O'Connor v. Donaldson *Decision*, 133 AM. J. PSYCHIAT. 379 (1976).

73. In March 1976, the Menninger Foundation and the American Bar Association Commission on the Mentally Disabled, for instance, co-sponsored a National Conference on the Legal Rights of the Mentally Disabled.