

Treating Clinicians and Expert Testimony

Civil and criminal attorneys often refer their clients to psychiatrists or counselors for “treatment” in anticipation of a later report or expert testimony. They may also seek out professionals who have treated the client earlier to help with the legal case. This month’s column highlights the inadvisability—and sometimes impropriety—of a *treating* clinician’s becoming a *forensic* consultant or expert in the same case.

TREATER-EXPERT CONFLICT

Although a clinician may report the “facts” of his or her experience with the patient, given appropriate permission and disclosures, problems arise when a treating professional either 1) fails to disclose to the court the possible conflict of interest involved in having a current or past treatment relationship* (and thus being obligated to protect the patient’s interest) or 2) offers professional opinions about the patient or legal case (in court, professional “opinions” can only be offered by expert witnesses). It is usually inappropriate, and a disservice to the court, for a doctor or therapist to assume the dual role of treater and expert witness.

First, a *treatment* relationship creates a professional, ethical, and legal (or “fiduciary”†) obligation to act in the patient’s best interest both during and after the treatment relationship. Since *forensic* reports and testimony require objectivity regardless of the patient’s wishes or needs, an inherent conflict is created. This conflict is recognized in the ethical guidelines of both the American Psychological Association and the American Psychiatric Association.

*Note that a clinician-patient relationship is formed whenever counseling or treatment is undertaken or anticipated, regardless of who referred the patient.

†A fiduciary is a person or organization who is legally required to put the patient’s or client’s interests ahead of his/its own. Other examples include bank trustees and court-appointed guardians.

Second, the clinician who testifies regarding a current or past patient knows (or should know) that he or she is required to act in the patient’s interest, and may even have a personal affinity for the patient’s viewpoint. This creates a danger of *intentional bias*.

Third, separate from the clinician’s conscious awareness, the obligation to “do no harm” is so keenly felt by ethical practitioners that there is a danger of *unintended bias* toward the patient.

Fourth, when a treating clinician anticipates reporting to a third party (such as a lawyer, court, or insurance company), professional ethics require that this be discussed with the patient as early as is feasible. The awareness of potential disclosure affects the patient’s revelations to the clinician, and thus the validity of any report or testimony.

Fifth, the clinician’s role and training are not forensic. Even when they know litigation is involved, treating clinicians rarely corroborate patient or case information to the same extent as forensic consultants, and usually have not completely disclosed to the patient any responsibility they have to report to a lawyer or court. Further, they often have a limited or simplistic view of the legal case and the rules that govern it, making them vulnerable to forensic misunderstanding and, at worst, manipulation by the attorney.

SPECIAL CIRCUMSTANCES

Civil Commitment Cases

There are a few administrative and legal matters in which treating clinicians may ethically offer professional opinions. In civil commitment cases, one may speak to the need for involuntary hospitalization, but the abridgement of the patient’s freedom has a treatment purpose and is thus in his or her best interest.

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This column contains general clinical and clinical-forensic opinions which should not be construed as applying to any specific case, nor as any form of legal advice.

Reports to Insurance Companies, Utilization Reviewers, or Disability Agencies

Reports to insurance companies, utilization reviewers, or disability agencies create a bit more conflict. It is important that the patient understand and accept the clinician's need to report or divulge information. It is just as important that the clinician be as accurate and objective as possible, and be aware of the various temptations to, for example, cast the patient's behavior and diagnosis in a light that favors reimbursement, or inappropriately emphasize symptoms that support a disability claim. We expect our patients to be honest with us; it is wrong to model dishonesty in our work, even when purporting to help our patients.

Forensic or Correctional Institutions

Mental health professionals who work in forensic or correctional institutions are in a special situation, but are not immune from ethical and fiduciary issues.

A psychiatrist in a state forensic hospital treated a defendant who was incompetent to stand trial. When he became competent, the psychiatrist was subpoenaed to testify in a trial that could have resulted in the defendant's imprisonment or execution. Since the defendant was incompetent when referred to the hospital, and thus was arguably not able to understand any disclosure or disclaimer a clinician might make to him, the psychiatrist was concerned that testifying might be unethical.

The psychiatrist was right to be concerned. Treating mental health professionals cannot change their ethical requirements just because the hospital has a special name like "forensic" or "prison." Although

information concerning what he actually saw or heard ("fact" information) may be elicited from the mental health professional if the court allows it, he is not obligated to offer opinions (an "expert" act) and probably should not do so.

A better course for hospitals that are routinely required to provide forensic reports and expert witnesses is to employ a separate professional for forensic assessment, reports, and testimony. Such professionals avoid forming a clinician-patient relationship (e.g., do not prescribe, treat, or give clinical advice). They should be qualified to do forensic evaluations, clearly identify themselves and their roles to the "evaluatee" (n.b., not "patient") whenever the person is seen, and assess the evaluatee's competence to understand the disclosure.

Rural Settings

I am often asked about rural settings that have forensic needs but only one mental health professional qualified to offer expert opinions to a court. Although most communities have at least one doctoral-level mental health professional near enough to meet clinical needs, it may be difficult to find another one who meets both criteria for forensic matters: absence of past or present clinical relationship and qualification to work as a forensic expert. Of the two requirements, the absence of current or past relationship is arguably the more important. In most cases, the court's primary need is for an objective clinician, not necessarily one who understands legal nuances. The dual treater-testifier role can almost always be avoided by finding a non-treating professional a few miles away.

Child Custody Evaluations

A recent survey by our office confirmed that child custody evaluations are particularly vulnerable to bias and inappropriate reports or testi-

mony. The general principles of forensic work are highlighted in the cauldron of divorce, acrimony, the child's needs, and sometimes manipulation and intrigue. My opinion is simple: *Treating clinicians, especially parents' therapists, should not offer clinical or legal opinions in custody matters.* They should not ignore subpoenas to provide *factual* information, but should refrain from offering opinions about custody. The mother's, father's, and child's therapists must be as free as possible to provide treatment, and their patients must feel as little fear or implication that the therapist will help or hinder their custody wishes as is possible in such an emotionally laden setting. A separate professional, well qualified in child psychology or psychiatry and child custody settings, should see *all* parties (never just one parent, for example) in an evaluation, not a "helping," format. Protecting the interests of the child requires reviewing the records of other professionals' therapy sessions; however, this must be done with the knowledge that treating clinicians' notes are often biased toward one parent or the other.

FORENSIC QUALIFICATIONS

Placing clinicians into forensic roles when they do not have considerable, relevant forensic and clinical experience can, of course, be problematic. The forensic expert should usually have a terminal degree in his or her field (MSW, PhD, MD with psychiatric training) and be generally familiar with the legal issue at hand.

A man was convicted of murdering his ex-wife and sent to prison. The killing occurred in his home. The woman's family sued to recover damages from his homeowner's insurance by alleging that his act arose out of mental illness and was thus not really a "murder." The perpetrator had no history of mental ill-

ness and had not pursued any defense of incompetence or non-responsibility. Videotapes of him being interviewed by police within an hour of the killing showed no indication of significant mental impairment, nor did psychiatric interviews for the defendant in the civil lawsuit.

Although the plaintiff's attorneys could find no psychiatrist or clinical psychologist who would say the perpetrator was legally insane at the time of the killing, they retained a local family counselor. The counselor, while perhaps a good therapist, had no forensic experience and did not have a license to diagnose or independently treat severe mental illness in that state. His report nevertheless contained diagnoses and sweeping statements to the effect that the very fact that the perpetrator killed someone defined him as legally insane.

The report was easily rebutted by a forensic psychiatrist testifying for the insurance company, and the family counselor was somewhat embarrassed by the whole affair.

her carry out legitimate obligations to the court.

THE LAST WORD

Once the role of "treater" has begun, your duty to the patient's interest is clear, compelling, and (barring protecting someone from imminent harm) permanent. It is very difficult to serve the patient and the court at the same time.

IS THERE A NEED FOR SPECIAL ETHICAL GUIDELINES IN FORENSIC MATTERS?

The extent to which forensic mental health professionals are subject to clinical ethics (especially in criminal cases) is a matter of some debate. Absence of a clinician-patient relationship deals with the issue of fiduciary duty, but does not exempt us from the ethics of our profession. Some scholars, notably Dr. Paul Appelbaum, have described forensic roles and settings which, they believe, deserve special ethical guidelines. Such exceptions, while not allowing the forensic psychiatrist or psychologist to shed completely the mantle of "clinician," do let him or