Editor:

The *Journal* contained a fascinating narrative from David Menkes, MD, PhD,[1] about an expert who listened to a telephonic deposition without announcing his presence, while e-mailing suggestions to the deposing attorneys as to what lines of inquiry to follow. In their detailed and thoughtful commentary, Candilis and Martinez[2] demonstrated, citing multiple authorities, that the "silent" expert witness violated standards of ethics from a whole series of perspectives. However, the latter authors did not address the court's response, which was to defeat the motion *in limine* to exclude the silent expert's testimony, although the expert admitted on cross the truth of the scenario. The court's response deserves some commentary of its own.

Dr. Menkes describes the judge's reaction as follows:

> The judge opined that the eavesdropping "may not be very nice" but disputed the contention that it represented unlawful interception of communication on the basis that it was "for the purpose of court proceedings" [Ref. 1, p 241].

For perspective on the possible rationales of the court's view, note that experts may be asked to supply guidance to retaining attorneys about cross-examination of opposing experts' opinions, not to mention participating as rebuttal witnesses in frank attempted refutation of those opinions. In a recent trial in which this author was an expert, a "litigation consultant" sat behind the opposing attorney's table and regularly passed slips of paper with apparent suggestions to the cross-examining attorney; however, this occurred in full view of the judge and jury. Comparably, attendees at deposition of whatever status are customarily reported as "also present." Neither of these benign contexts, however, applies in the instant case.

My suggestion here—unfortunately unprovable without specific data—is that the judge's response rested on several legal "dynamics," as it were, beyond the remark attributed to columnist George Will, "The judge will do what the judge will do." This is the apparent wish by some judges to "get it all in and sort it later." One result of this view is seen in privilege arguments, where the exceptions seem to swallow the rule.[3] A second is the concern, in a homicide case, that a claimed failure of a "speedy trial" will raise difficulty further along the way. A third is the basic distrust[4] of experts (shown in some parts of the legal system) that would lead a judge to consider an expert's violation of his own ethical code an irrelevancy, or at least a harmless error.

I would be interested in other views, especially that of Dr. Menkes, as to what the underlying reasoning might have been.

Thomas G. Gutheil, MD
Professor of Psychiatry and Co-Founder
Program in Psychiatry and the Law
BIDMC Department of Psychiatry
Harvard Medical School
Boston, MA

References

1. Menkes DB: The silent expert. J Am Acad Psychiatry Law 34: 240–1, 2006
2. Candilis PJ, Martinez R: Commentary: the higher standards of aspirational ethics. J Am Acad Psychiatry Law 34:242–4, 2006
3. Gutheil TG, Appelbaum PS: Clinical Handbook of Psychiatry and the Law (ed 3). Baltimore: Lippincott Williams & Wilkins, 2000
4. Gutheil TG: Testimony, necromancy and basic distrust. AAPL Newsletter 25:1–4, 2000

Reply

Editor:

I am grateful for Dr. Gutheil's trenchant summary[1] of a key ethics question arising from my original case[2]—namely, on what basis the judge decided not to sanction the deceitful expert. On reviewing the case documentation, I discovered that attorneys for the defendant had also submitted a second motion *in limine* with further argument to exclude the expert (anonymized transcript follows).

> Defendant's Second Motion *In Limine* or to Strike Motion *In Limine* to Preclude Testimony of XX, MD
>
> The Defendant, by and through undersigned counsel, pursuant to State DD.R.Crim.P. 3.190(a), hereby moves the Court to enter its Order precluding the State from making reference in opening statement or closing argument to, or seeking admission in evidence of, any testimony by XX, M.D. In support thereof, the Defendant states:
>
> 1. The State has listed as a witness XX, M.D., to testify in response to one aspect of the defense of temporary insanity raised in this case.
>
> 2. In reviewing certain materials pertinent to Dr. XX's involvement in this case, his billing records include an entry stating that he had attended by telephone the telephonic deposition

of David Menkes, M.D., Ph.D., taken by the State on October 23, 2003. *See* Exhibit "A," attached hereto.

3. During Dr. Menkes' deposition, those present, either in person or by telephone, were asked to identify themselves. *See* Exhibit "B," attached hereto, at 5-7 (excerpt of portion 2 of Dr. Menkes' deposition). The individuals who identified themselves or otherwise were identified at that time were Mrs. AA and Mrs. BB, counsel for the State, Mr. CC, counsel for the Defendant, the court reporter and the witness. Dr. XX failed to state his presence at that time or at any other time during Dr. Menkes' deposition, and the fact that he was listening on the telephone was not in any other manner disclosed to all parties to the telephonic deposition, including by counsel for the State.

4. Dr. XX was not entitled to attend and be present during the deposition of another witness in this case under State DD.R.Crim.P. 3.220(h) and R.Civ.P. 1.310. *See also, Palm Beach Newspapers, Inc. v. Burk,* 504 So.2d 378, 381-82 (State DD 1987) (criminal discovery depositions are not open to attendance by the public).

5. The surreptitious eavesdropping by Dr. XX on the deposition of Dr. Menkes violates §90.616, State DD. Stat. (2003), the rule of sequestration of witnesses, in that the rule provides for the exclusion of witnesses from hearing the testimony of other witnesses, on request of a party, except under circumstances not applicable to Dr. XX. Furthermore, the failure of the State and of Dr. XX to indicate his presence prevented counsel for the Defendant from invoking §90.616, State DD Stat. (2003), to exclude Dr. XX from applying to the Court for relief.

6. The surreptitious eavesdropping by Dr. XX during the deposition of Dr. Menkes was accomplished with his knowing involvement, the knowing involvement of the State and, as acknowledged by the State during proceedings before the Court on February 3, 2004, was affirmatively accomplished by the conduct of the State.

7. Such surreptitious, deceptive conduct and concealment further potentially implicates Rules 4-8.4(c) and (d) and 4-3.4 of the Rules Regulating the State DD Bar. The failure to disclose Dr. XX's eavesdropping served no purpose other than to deceive the Defendant, her counsel and the deponent.

8. By this motion, the Defendant further reasserts the grounds for the same relief asserted in Defendant's Motion in Limine to Preclude Testimony of XX, M.D., served on January 30, 2004.

WHEREFORE, the Defendant respectfully requests this Honorable Court to enter its Order in limine precluding the State from making reference in opening statement or closing argument to, or seeking admission in evidence of, any testimony of XX, M.D.

Respectfully submitted,
ATTORNEY FOR DEFENDANT

Implications

The judge's decision to deny the original[2] and this further motion *in limine* is puzzling, given the strong legal and ethical arguments to sanction the expert.[1–3] Although his reasons for allowing the expert's testimony are unknown, a contributing factor may have been the nature of the case, that of a high-profile double filicide. Considerable public and media interest in such a grisly scenario may have added to the momentum for a quick resolution.

In any event, the judge's decision not to sanction the deceitful expert devalues the role of expert testimony in this case and perhaps generally. In highly emotive cases such as this one, it could be argued that disinterested and ethical expert opinion is of particular importance in ensuring a fair trial.

David B. Menkes, MD, PhD
Waikato Clinical School
University of Auckland
Hamilton, New Zealand

References

1. Gutheil TG: Letter. J Am Acad Psychiatry Law 34:569, 2006
2. Menkes DB: The silent expert. J Am Acad Psychiatry Law 34: 240–1, 2006
3. Candilis PJ, Martinez R: Commentary: the higher standards of aspirational ethics. J Am Acad Psychiatry Law 34:242–4, 2006

Editor:

The article "Mental Health Care In Juvenile Detention Facilities: A Review," by Desai et al.[1] was well written and timely, drawing attention to neglected clinical and forensic issues. In two sections, Psychotropic Medications, and Medication Management, the authors present an overview of existing limited national data regarding patterns of psychotropic medications use in juvenile detention facilities nationwide, and considerations for the continuation of and initiation of psychotropic medications for incarcerated juveniles. The authors did not mention a developing area for forensic psychiatrists—requests to render opinions regarding standards of care and practice in juvenile correctional facilities (i.e., suicide litigation, medical malpractice, class action/federal conditions of confinement litigation, or accepted standards of medical practice for state medical licensure and other regulatory/oversight matters).

The authors also did not report the accepted practice of reassessing recent psychotropic medication regimens, and when indicated, holding or discontinuing one or more psychotropic medications. Some examples of clinical situations to consider holding or not reinitiating one or more psychotropic medications include pregnancy in females, medication noncompliance, lack of youth assent/parental informed consent, recent substance abuse, and the

need for clinical reassessment of the youth in a contained, structured setting. The need to use psychotropic medications in a safe and appropriate manner and only as part of a comprehensive treatment plan is particularly important due to recent controversies regarding psychotropic medication use in nonincarcerated youth in state custody.

Apart from these issues related to psychotropic medication, the authors state that there is no widely accepted or published best practice standards of behavioral health care in juvenile detention settings (page 209). The American Academy of Child and Adolescent Psychiatry did release the practice parameter for the Assessment and Treatment of Youth in Juvenile Detention and Correctional Facilities in 2005.[2,3]

Joseph V. Penn, MD, CCHP
Clinical Assistant Professor
Brown University Medical School
Providence, RI

Christopher R. Thomas, MD
Professor and Director of Child Fellowship Program
University of Texas Medical Branch
Galveston, TX

References

1. Desai RA, Goulet JL, Robbins J, *et al*: Mental health care in juvenile detention facilities: a review. J Am Acad Psychiatry Law 34:204–14, 2006
2. Penn JV, Thomas CR: AACAP Work Group on Quality Issues: Practice parameter for the assessment and treatment of youth in juvenile detention and correction facilities. J Am Acad Adolesc Psychiatry 10:1085–98, 2005
3. Penn JV; Use of Psychotropic Medications with Incarcerated Youth; Standards for Health Services in Juvenile and Confinement Facilities. Chicago: National Commission on Correctional Health Care, 2004, pp 263–5

Reply

Editor:

It was with interest that we read the letter to the editor regarding our article entitled "Mental Health Care in Juvenile Detention Facilities: A Review."[1] In particular, we would like to commend Drs. Penn and Thomas on their work in developing a practice parameter for the assessment and treatment of youth in juvenile detention and correctional facilities. This document was released after our paper was already in press. However, it represents an important step forward in establishing guidelines for the treatment of vulnerable youth while detained.

With respect to the issue of psychotropic medications, such agents are a critical component in the treatment of this population. Consulting psychiatrists clearly play a major role in the reassessment of previously prescribed medications and in utilizing additional medications when indicated. At times, changes to existing medication regimens may be essential. However, we want to emphasize that considerable caution is needed when making such changes within a detention setting, because of the short and unpredictable lengths of stay, as well as the potential absence of adequate follow-up care or lack of follow-through with available care once the youth leaves the detention facility.

Forensic psychiatrists interested in participating in the development of policy, practice guidelines, and accepted standards of medical practice in these settings will find their efforts much needed. They would do well to familiarize themselves with these settings as well as the practice parameter issued by the American Academy of Child and Adolescent Psychiatry and authored by Drs. Penn, Thomas, and their colleagues. It is only with continued attention to proper standards of good clinical care, as well as more research and development of effective and appropriate interventions, that the serious mental health and substance abuse needs of this vulnerable population can be addressed.

Rani A. Desai, PhD, MPH
Joseph L. Goulet, PhD, MS
Judith Robbins, LCSW, JD
John F. Chapman, PsyD
Scott J. Migdole, LCSW
Michael Hoge, PhD
Yale University School of Medicine
New Haven, CT

Reference

1. Desai RA, Goulet JL, Robbins J, *et al*: Mental health care in juvenile detention facilities: a review. J Am Acad Psychiatry Law 34:2:204–14, 2006

Editor:

I read with interest and great appreciation the discussion[1] and commentary[2] concerning psychiatric

advance directives (PADS) in the *Journal*. Many colleagues will be shocked to learn that the American Psychiatric Association Board of Trustees and Assembly have taken the concept beyond acceptable limits.

They recently approved a Position Statement on Mentally Ill Prisoners on Death Row that laudably calls for

> . . .the sentence of death to be reduced to a lesser punishment when the prisoner is found to have a mental disorder or disability that significantly impairs his or her capacity to understand the nature and purpose of the punishment, or to appreciate the reason for its imposition in the prisoner's own case.

However, in its Commentary, the Statement expresses the view that it is ethical to treat an incompetent death row inmate to render him competent to be executed when that inmate, at a time when he was competent, had made out an advance directive that he be treated should he become incompetent. The purported intent of the APA Statement is to respect the dignity and autonomy of the prisoner by honoring his wish to be executed.

I consider such treatment as carrying autonomy beyond its legitimate interests. To comply in such a request, the physician is cooperating formally with an act that is intrinsically wrong—namely, any active, direct cooperation by a physician in the act of execution. I believe that the Board inadvertently took a position that constitutes APA participation in executions in violation of the code of medical ethics.

Abraham L. Halpern, MD
Professor Emeritus of Psychiatry
New York Medical College
Valhalla, NY

References

1. Swanson J, Swartz M, Ferron J, *et al*: Psychiatric advance directives among public mental health consumers in five U.S. cities: prevalence, demand, and correlates. J Am Acad Psychiatry Law 34:43–57, 2006
2. Schouten R: Commentary: psychiatric advance directives as tools for enhancing treatment of the mentally ill. J Am Acad Psychiatry Law 34:58–60, 2006