

Forensic Pitfalls

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The lives of forensic psychiatrists are complicated and subject to stressful experiences because they have elected to interact with a social system very different from their own. This article presents discussion of these frequently troublesome areas commonly encountered by forensic psychiatrists in trying to respond to the law's requests and needs without sacrificing their medical integrity: (1) legitimate definition of expertise; (2) reasonable medical certainty; (3) generally accepted standard of care. They are explored with emphasis on the exercise of self-assessment by the involved forensic psychiatrists lest their incautious application of knowledge and expertise become pitfalls of their own making.

The lives of forensic psychiatrists are complicated and subject to stressful experiences because they have elected to interact with a social system very different from their own; differing in the counterpart missions, responsibilities, concepts, vocabularies, and ethics of the legal and medical systems. However, when so inclined, most of us can learn to adapt, to alter some of our medically ingrained attitudes and beliefs, and, with a foot in each camp, to maintain adequate personal and professional balance—even, possibly, to enjoy some of the attendant challenges.

You have become familiar with potential pitfalls in forensic practice, and ways to avoid them: the law's need for us to prognosticate; the issue of patient confidentiality; the medically unaccustomed but legally necessary skepticism in dealing with some interviewees; the

contentious and sometimes abrasive operations of the adversary system.

Based on my assumption that you have come to grips successfully with these and similar problems, I shall not pursue them further. Instead, I shall discuss briefly some points that I recurrently find continually troublesome and that require my constant vigilance: What is my legitimate area of expertise and how can I contain myself within it; do I limit my medical and legal conclusions "within reasonable medical certainty"; am I a genuine authority regarding a "generally accepted standard of care?"

The primary reason I sometimes find these questions vexatious is that the law gives us few guidelines or definitions. It is left to us to understand, explain, and decide how to function with relevance to a legal context. In other words, we are expected to engage in a constructive self-scrutiny, acquire knowledge, exercise self-discipline, and be ready to describe and demonstrate our clinical assets and limitations and document our pro-

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nouncements about "reasonable medical certainty" and "accepted standard of professional practice."

Contemplation of our legitimate areas of expertise brings to mind first the frequency with which we are pressured, cajoled, and persuaded to express opinions on what are properly legal issues. You are acquainted with this potential pitfall. I should mention one small element of the large topic which we dare not ignore: an honest self-evaluation of what we know, probably know, or just generally think we know concerning psychiatric practice. Psychiatrists who consider themselves informed on most aspects of our specialty, when anticipating the spotlight of direct and cross-examination, should carefully review what their verifiable areas of competence are. Can I expound authoritatively on organic versus psychogenic amnesia; sequelae in adulthood of childhood learning disability; the physiological effect of two marijuana cigarettes; fugue states, depersonalization phenomena, temporal lobe seizures, Capgras Syndrome—and their likely effects on particular episodes of a litigant's behavior?

With the passage of years I find myself now turning down more legal cases than formerly. The change has doubtless developed from my reaction to certain uncomfortable occasions in court, from scrupulous appraisal of my clinical limitations, and from the accumulated wisdom of experience. Here are a few case examples:

A male college student was arrested and charged with three counts of rape. From my diagnostic evaluation, I concluded that he had

a multiple personality disorder. Personality A was an undistinguished college student making average grades. Personality B was a rapist of coeds. Personality C was a somewhat visionary, talented, artist. I conferred and commiserated with the attorney over how he could argue that Personality A, his client's basic identity, should not be held responsible for the behavior of Personality B. In passing, I informed him that I could not address that issue. I also informed him I had never treated a multiple personality patient and had no firsthand experience with rehabilitation or cure. I could only review the literature and report what others said, and we agreed I might be a vulnerable witness. I was able to refer him to a diagnostic and therapeutic authority on multiple personality, and thus felt I had discharged my obligation to the lawyer and his client.

A depressed patient was admitted to the open psychiatric unit of a general hospital. A psychiatrist prescribed antidepressant medication and suicidal precautions. The patient was to be checked by the nursing service every half hour; his whereabouts were to be known at all times. However, he left the ward unobserved, found a door with a defective lock, went up the stairs, found an unlocked door, and jumped from the roof to his death. The consequent law suit against the hospital did not include the psychiatrist as a defendant. I told the attorney who consulted me that I had a general knowledge of hospitals' standard means of suicide prevention but I was not a hospital administrator, engineer, maintenance man, or security guard. I had never really studied door locks, patient-proof screens, lighting, and similar security measures. The attorney thanked me sincerely, and I did not hear from him again.

"Reasonable medical certainty" is a very uncertain concept, mostly a legal fiction.¹ Still, we are confronted with it regularly; and, since it is designated "*medical* certainty," we are supposedly aware of what it entails. It is not absolute scientific certainty; it is merely reasona-

ble. We clinicians may feel on relatively safe ground by invoking "more likely than not" or "probable" as opposed to "possible." If these rational criteria do not satisfy the law's search for certainty, that is not our affair—although the law may try to make it so. It is important for us to adhere to the adjectival "medical" that gives us a stabilizing point of reference. We may then conclude that the application of reasonable and consensually validated clinical judgment in a given case will suffice.

The ramifications of terminology lead in many directions. I wish to discuss only one. It is wise to assume that the adversarial philosophy pervades all the psychiatrist's contacts with attorneys and their clients and that the psychiatrist is being employed to further legal goals. We need to be ever cognizant of the subtle persuasiveness, if not seductiveness, of the law's adversarial process. It behooves us to be as clear, as the present state of the art allows concerning the bases for our opinions. Can we present a particular opinion supported by sound medical data, or are we offering an emotionally tinged personal value judgment?² The difference may not be obvious.

Is the medical evidence plentiful, clear, and concordant; or is it sparse, arguable, and conflictual? In the latter case lies the danger. It allows unwary or uncritical practitioners to testify in a manner supportive of their personal convictions. Does my opinion merely seem rational, or is it actually supported by replicated findings? The process of self-disciplined introspection is seldom

enjoyable, but it is essential to good forensic practice, not only in the service of professional integrity, but also as a defense against aggressive cross-examination.

The recent increase in medical malpractice suits referred to forensic psychiatrists at the Menninger Clinic has been surprising, averaging 12 cases a year. A major number of these litigations name psychiatrists, psychologists, social workers, nurses, and/or psychiatric institutions as defendants. The ultimate question posed is "Did the practitioner/institution deviate significantly from a generally accepted standard of professional care?" On that issue the law has left us mostly to our own counsel, expecting us to define and administer proper professional functioning.

In traditional practice this was not onerous. There was only one standard of care: what was best for the patient.³ However, in today's overpopulated world, judicial, economic, political, medical, legal, and social developments have made the standard of care issue a can of worms.⁴ Let us examine a specimen contributed to the can by the mental health field. Again it will require an exercise in self-scrutiny.

I have concluded that there are several accepted standards of care in the mental health field. What is the appropriate, consensually approved standard for a private psychiatric hospital, a psychiatric unit in a general hospital with no resident psychiatrist, the alcohol and drug abuse service in that same hospital, a public mental hospital, a community mental health center, or a solo private

practitioner? Can I comment authoritatively on all those operations? I have decided that I cannot.⁵

I was asked to participate in a class action suit against a state hospital. The institution operated an acceptably staffed admission service, a short-term treatment unit, and an adolescent unit. However, only one psychiatrist was assigned to the building housing 600 chronic patients. This discrepancy was so flagrant, I felt I could say it fell well below acceptable standards. Suppose, however, the hospital had been able to assign three psychiatrists, or four, to the 600 patients? Would that be minimally acceptable? According to what standard? In that eventuality I might have bowed out to someone more knowledgeable of the nation's public hospitals. Four psychiatrists for 600 patients would not be tolerated under the Menninger Hospital's requirement of one psychiatrist for 20 patients, but is such coverage relevant to the purpose of a state hospital? Probably not.

Legal actions involving community mental health centers have particularly distressed me. As you know, the typical center is staffed by psychologists and social workers, with a part-time consulting psychiatrist. An egalitarian philosophy prevails; all professionals are judged equal regardless of graduate degree. Supervision is minimal and accountability neglected. The center serves clients, not patients, and is concerned with that vague entity termed mental health.

I have some familiarity with centers. I was clinical director of one center and served on the board of directors of an-

other. In the past I have evaluated centers throughout the country. Still, in retrospect, I have to question my participation in some of the litigations which have occurred. A person in treatment commits suicide, or rapes someone in the community. A staff member engages in a sexual indiscretion with a client. Initially confident in working with such a case, I frequently become uneasy as the details and the questions unfold.

Was the psychologist adequately trained; was supervision effective; what clinical skills should a social work therapist possess; should the consulting psychiatrist have been more available and accessible; was there proper communication between therapist and prescribing physician? what do I really know about the standard of care appropriate to require of a community mental health center? The fuzziness I have observed of administrative structure, lines of communication, supervision, professional expectations, and clinical responsibilities in some centers makes me wish I had reserved my can of worms analogy for this spot. My current rule of thumb, if the center's psychiatrist is not named a defendant in the legal complaint, is to advise the attorney to seek consultation with someone practicing in a center.

I have had to acknowledge that in our expanded field, there are several standards of care practiced and rarely can they be conveyed from one setting or institution to another. I have perforce assessed my experience, knowledge, and biases and as a consequence been prompted to alter certain of my current professional involvements.

We psychiatrists are supposedly adept at introspection, probably to a greater degree than other professionals. We have been trained to grapple with the multiple manifestations of transference and countertransference and with our own neurotic tendencies. We may resist continuing postgraduate self-scrutiny, but it is particularly important in forensic practice because our foibles, biases, laxities, or incautions are especially vulnerable to public attention. An aphorism attributed to John Larsen states that the amateur knows what he can do; the professional knows what he cannot do. If we fail to base our habitual performance on the dictum that implies, we risk

being trapped in pitfalls of our own making.

References

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