

Presidential Address, 1989: Thoughts for the Next 20 Years

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I want to talk today about some things I think are important in the field and practice of forensic psychiatry. I wish I were as scholarly as some of our past presidents, who gave us definitive historical treatises or research from the cutting edge of medical science.

Instead, I'm a working stiff, whose usefulness may lie in having worked at various levels in several different psychiatric settings, forensic and others. I'd like to share some thoughts from clinical, academic, and forensic arenas, as well as from our colleagues, patients, clients, supporters, and detractors.

The result will be personal, perhaps to the point of self-centeredness. It will be serious, even for an organization that sometimes takes itself *too* seriously. It will also be unadulterated, with little homage to diplomacy but lots of respect for those who try to do what's right.

Doctors

I want to talk first about doctors. You've heard of doctors; they've been in all the papers (perhaps unfortunately!). Doctors are what we *are*. We have a rich diversity of interest, profession, and experience; but AAPL members are all physicians, fully trained in the medical specialty of psychiatry.

It saddens me to see AAPL members

who follow some other medical doctors in eschewing the mantle of physician. I am not speaking so much of leaving clinical practice, but rather of leaving behind one's medical *identity*, and the bases of what it means to be a physician. The changing of a few superficial trappings or behaviors, as in advertising or creative business practices, is not the important thing either. The critical matter is the denying of the reasons, for the foundations of, those medical traditions.

I believe fervently that the price of denying those foundations—foundations of ethics, relieving pain, impartial rendering of care, and doing no harm—is no more nor less than the loss of one's physicianship. What a terrible price to pay. How can anyone who isn't a doctor understand what it is like to be one; and how can a layman possibly comprehend the loss that comes when we give up that identity?

I think the loss is always there for those who must—or choose to—leave medicine after coming this far. We see obvious symptoms, and sometimes lethal depression, among physicians forced out of the field by, for example, disability or loss of license.

Voluntary leaving, perhaps through retirement, takes its toll as well. How

many colleagues do you know who are content with life without medicine, even in their 80s or 90s? For example, Dr. Cecil Wittson, a psychiatrist who was a university chancellor two decades before Dr. Keith Brodie, retired at age 68 and developed a new and successful career as an architectural consultant, but continued to be a regular fixture at departmental Grand Rounds for another decade or so. I'm sure each of you knows a similar story.

What does all this have to do with forensic psychiatry? Well, it suggests two things. One is related to those who focus their careers on self-aggrandizement and/or financial success at the expense of medical ethics or medical career.

The other is a concern that comes to mind whenever I see AAPL members becoming so involved in the *legalistic* aspects of issues that they seem to separate themselves from any semblance of physicianship. Sometimes there is an ethical issue involved, perhaps a sacrificing of honesty or objectivity in the service of some legal concept or adversary proceeding. At other times, there is no ethical issue, but just an inexorable movement out of medicine, into the law, with an attempt to say to oneself, "It's OK to deny the medical canons so long as I choose appropriate legal ones."

I don't believe it is that easy. I don't even believe it is *possible* in many cases, without a loss of identity that will eventually affect the physician adversely. Please note that just now I am expressing concern for the *doctor*, not for the legal case, patient or profession.

I used to do a little work in the area

of terrorism and hostage situations. Several of us worked with an APA task force for a few years, dealing with law enforcement, training, negotiation, "mindset," victims, and the like. We came to lots of conclusions, some more useful than others. One of the most important was that a physician, psychiatrist or not, cannot set aside the *mantle* of physician, even in the service of some other high calling.

This group and others with whom I have worked have studied cases in which doctors were asked to trick hostage-takers, to drug them, for example, or make them more vulnerable to a police sharpshooter. We interviewed many physicians who were involved in law enforcement consultation, who then became more and more like the police officers or paramilitary persons with whom they associated.

We saw doctors experience three kinds of vulnerability: (1) very stressful environments, (2) great situational pressure to assume police-like roles, and (3) seduction into personal bailiwicks of fantasied or neurotic power, even paranoia. The first—the stress of terror-violence or hostage situations—is self-evident, but let me give some examples of the other two types of vulnerability.

One is a classic: the prison or concentration camp physician who finds himself treating captives so that they may later be tortured (or tortured further). Most of the time, in most countries, correctional psychiatry takes the form of straightforward medical care. Sometimes, however, it has directly to do with restoring an inmate's suitability for public display, punishment, or execution.

Under some drastic circumstances, the doctor may feel that using his medical knowledge for purposes of, for example, extracting information or even torture is a patriotic duty. In my view, this is never the case.

The third category of vulnerability with respect to doctors and law enforcement or military medicine has to do with both the seductiveness of so-called "power" and the neurotic vulnerability of the physician. For most of us, law enforcement consultation, for example, is an interesting job with considerable social utility. We often enjoy a little vicarious notoriety, but keep it under control as we work, and after we go home.

A few clinicians, though, identify so much with the consultee that they begin to believe they should compromise their medical foundations by "becoming" policemen. I know two psychiatrists who carry concealed pistols, not for protection, but because they have conveniently convinced themselves that being armed is part of their job. I asked one's agency head whether *any* physician consultants or physician employees were expected to carry arms, or whether it was even remotely recommended. It was not.

In another community, a psychiatrist who was part of a local volunteer police group dropped by one of his own hospital wards one night after duty, wearing his law enforcement uniform. He only reluctantly checked his revolver when the nurse on duty demanded it.

You can't shed your MD, and you shouldn't compromise it without ex-

pecting serious problems. My advice: Don't do it.

Public Service

Let me mention another medical tradition that lies near the heart of who we are: Public service. AAPL members have for years pressed themselves to offer care and time to indigent persons and in public facilities such as prisons and forensic hospitals. We have had committees and task forces on the subject.

I'd love to have 20 or 30 of you come to work in any part of our Texas MH/MR system, but especially in one of the most neglected corners of the public sector, correctional psychiatry and the rehabilitation of the criminally mentally ill.

Denmark's Georg Stürup, honorary Golden Apple recipient and author of *Treating the Untreatable*, described his life's work with criminals to Elise and I a few years ago. He said, over and over and in many ways, "Don't forget these people. They have no one, yet they *are* people. They are desperately lacking and in terrible pain. Those who understand this are so rare: you must not turn your back on them."¹

As a matter of fact, *many* of our members toil in those fields, full-time or part-time. Still, the public perception that forensic psychiatrists aren't clinical physicians—which is sometimes true, of course—contributes to a general reputation for self-centered practice. We should continue to spend some AAPL resources to highlight public needs, to encourage psychiatrists and other mental health professionals to meet those

needs, and to publicize our good works as both a showcase for AAPL and a model for others.

The “Stigma” of Our Work

That reminds me of the topic of stigma. I’m talking about *our* stigma, not that of being a patient; about the occasional temptation almost to *apologize* for our work.

When people ask what I do in forensic psychiatry, I am sometimes tempted to explain the inherent judicial fairness in litigants’ access to forensic psychiatric consultation, the need for psychiatric expertise in the court’s search for truth, the difference between the “hired gun” role and that of objective advocate or disinterested medical expert, and my own balance of consultation to defense and to plaintiff or prosecutor.

Maybe I just have a need to be liked, but the current climate of criticism and public misunderstanding of what we do, and the fact that a few psychiatrists and others—even AAPL members—are hired guns, lead me to make my position clear. I’m not comfortable merely saying my job is “legal” or “part of the system” or “there’s nothing wrong with it,” and I’ll bet many of you feel the same way.

Recent Converts

Our training and ethics are particularly relevant when one considers the many psychiatrists and other clinicians who are leaving clinical practice for forensic medicine. Most of the ones who have talked with me about our subspecialty seem to be looking into forensics for the wrong reasons.

They are hassled by the competition

of practice. They feel put upon by third party payers and regulators. They are (often unreasonably) frightened by the threat of malpractice suits. They are sometimes not the best of clinicians, and feel—often unconsciously—inadequate in patient care.

Such rapid converts are attracted to several things in forensic practice, some realistic and some not. They may like the idea of seeming to be an authority, of reviewing colleagues’ work, but they rarely say so. Although they outwardly envy the forensic subspecialist’s knowledge of court procedures and sometimes misunderstand the difference between ourselves and attorneys, they almost never feel a need for additional training before taking on forensic referrals. They sometimes want to skim the “cream” of record review and high fees without considering *pro bono* work or how their lack of expertise might hurt a lawyer or client. They very often ask for referrals before they develop that expertise.

The “Market”

The forensic “market,” if you will, is becoming more sophisticated in its requests for our services. Driven first by suspicion of our motives, the public, lawyers, and judges have started to pay more attention to our credentials and backgrounds. They keep track of relevant cases, and often of individual psychiatrists’ involvement in them. They don’t always trust our memories of “what cases have you testified in, Doctor?” but consult computer banks and transcripts of past testimony. This is especially true in repetitive kinds of liti-

gation, such as asbestosis cases, in which inconsistencies in physician testimony from case to case are easily spotted and exploited by experienced law firms.

Some of the most useful legislation regulating civil forensic testimony relates to the use of outside experts in malpractice litigation. Texas has just joined several other states in requiring that testifying expert physicians have recent practice experience in the field and area in which they are rendering opinions. Although I hear guild-mentality complaints about such safeguards from some forensic physicians, it seems to me a reasonable limitation.

I just used the phrase "guild-mentality." Let me mention an AAPL project sometimes criticized as self-serving, but which is in truth an effort to educate the public to important facts. I am referring to our bringing to professional and lay groups information that clearly delineates the qualified forensic psychiatrist from members of other disciplines who may—knowingly or not—misrepresent their abilities. We must continue to highlight the differences between ourselves and, for example, psychologists or clinical social workers. They do not

share many of our areas of expertise, our breadth of professional viewpoint, or, in many cases and perhaps most important, our long-standing traditions of medical ethics.

Conclusion

And so we return to traditions and ethics. They are, I feel, even more important than factual knowledge in separating us from nonphysicians. These traditions are not, as commonly misconstrued by laypeople and malpractice plaintiffs' lawyers, simply traditions of the "old boys' club" or doctors' "conspiracy of silence." Rather, these are the admonitions of Hippocrates and Ochsner, of Freud and Menninger. They are the *marrow* of what it means to be a physician and a psychiatrist—what it means to ourselves and to those whose pain we try to alleviate.

Don't let it go, my friends. Don't compromise the medical part of your being. And may the next 20 years of the American Academy of Psychiatry and the Law be marvelous.

Reference

1. Reid WH, Dorr D, Walker J. I., *et al.* (eds.): *Unmasking the Psychopath: Antisocial Personality and Related Syndromes*. New York, W.W. Norton, 1986