Editor:

As the author of the Georgia Court Competency Test,[1,2] I have followed the debate regarding competency-for-trial instruments with some interest over the years. It is within this context that I read the three relevant articles in the fourth issue of the 2002 volume of the Journal.[3–5]

In particular, I would like to speak to the concern raised by Mankad *et al.*[4] that with the limited coverage of the relevant domains offered by existing court competency measures, "One might wonder if standardized tools would ever enhance, let alone replace, the clinical interview with regard to the functional element of adjudicative competence assessment." If I understand properly the thrust of their remarks, the doctors express the concern that such competency assessment devices might usurp the role of the forensic psychiatric interview and interpretation, resulting in a loss of clinical sensitivity followed by expensive remedial evaluations needed to "clean up the mess" left in the wake of the use of such crude devices.

This line of reasoning makes me think that those of us who have been involved in the development of forensic assessment instruments (FAIs)[6] over the years have done a very poor job of explaining to our psychiatric colleagues the uses and limitations of such devices. First of all, they were never intended to replace the overall clinical evaluation of a forensic case. Indeed, it is unethical to base any important decision about a person solely on the results of a psychological test.[7]

FAIs are, in actuality, designed to yield a specific measure or measures of a person's strengths and weaknesses in a specific psycholegal domain. I will use the Georgia Court Competency Test (GCCT) as an example. The GCCT follows closely the *Dusky* standards for trial competency and requires approximately 10 minutes to administer and score. Its prediction of competency/incompetency agrees with the outcome of sometimes lengthy psychiatric evaluations over 80 percent of the time.[2,8,9] Parenthetically, none of the other trial competency instruments has been reported to exceed the hit rate achieved by the GCCT, and all of the others require substantially more time to use in clinical practice. Despite this perhaps impressive hit rate, I have been very careful to advise that the GCCT should never be accepted as the definitive measure of a patient's fitness to stand trial.[2]

I believe that the GCCT, as well as other FAIs, can be used appropriately in a number of ways:

1. As a screening instrument in situations in which many defendants are being processed and there is the need to try to identify rapidly those who are clearly incompetent. While it is acknowledged that the GCCT and other competency assessment devices will make errors in this process, their use should have the effect of lowering the number of incompetent defendants who are mistakenly sped through the system, at the cost of injustice and great subsequent expense to society through the almost inevitable appeal process.

2. The GCCT can be employed as part of the general assessment process to provide some guidance as to the relevant legal issues for the staff to cover.

3. The device can be administered independently of the psychiatric evaluation and the two findings later compared. Should the two results concur, the psychiatrist may take some comfort in the finding that there is an 80 percent chance that an inpatient evaluation would have resulted in the same recommendation regarding the competency issue. Discrepant results would appear to argue for a re-examination of the data at hand.

4. I see no reason why numbers 2 and 3 cannot be combined. In other words, the GCCT can be administered "blind" and then the results added to the psychiatric report after the fact. This alternative use has the advantage of providing numerical scores, which, in surveys, judges have been found to appreciate very much.[10]

Through the use of Strategies 3 and 4, it appears possible to use the MacArthur Competence Assessment Tool, the GCCT, and other FAIs without jeopardizing the integrity of the forensic psychiatric evaluation, as feared by Mankad *et al.* I believe we are indebted to these doctors for raising issues related to the proper use of the evolving set of forensic assessment instruments.

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Editor:

Two articles in recent issues of the journal have used terminology in an incorrect and imprecise manner that deserves comment.

The first of these articles[1] discussed what were termed "factitious disorders" in the context of civil litigation. Since the diagnostic term "factitious disorder" was introduced in DSM-III in 1980, one of the defining characteristics of that diagnosis has been that the individual's goal was to assume the "patient role" only, and that the presentation of psychological or psychiatric symptoms "is not otherwise understandable in light of the individual's environmental circumstances." This specific diagnostic criterion has remained unchanged through subsequent editions of DSM, including the current version published in 2000.

It is therefore incorrect, as did the authors of this article, to refer to "factitious physical disorders" in the context of civil litigation, as such a diagnosis is invalid with reference to the DSM diagnostic criteria. If, as the article argues, in some instances "the individuals. . .produce the signs and symptoms consciously," then they are engaging in illness deception in the context of litigation, and if a judge or jury is satisfied that they are doing this deliberately for the purpose of obtaining a monetary benefit then a finding of fraud might be the outcome of such a legal decision.

The second article describes five cases of what the authors referred to as "malingering by proxy."[2]

In all five cases, excessive quantities of prescribed substances were obtained or sought under the pretext that they were required for administration to companion animals. The substances involved were clorazepate (Tranxene), an anabolic steroid, a thyroid supplement, an opioid, and amitriptyline. The authors of this article described the seeking of such drugs from veterinarians on the pretext that the carers needed them for their animals as "a form of malingering."

Dorland's Illustrated Medical Dictionary defines malingering as "the willful, deliberate and fraudulent feigning or exaggeration of the symptoms of illness or injury, done for the purpose of a consciously desired end."[3]

While the behavior of the pet owners described by LeBourgeois *et al.*[2] was deceptive and undertaken for the apparent purpose of "a consciously desired end," namely obtaining a prescribed substance, it is in my view incorrect to describe it as malingering. The term "malingering" was originally used in the 18th century to refer to the feigning of illness as a means of avoiding military service. More recently, it has been used to refer to persons subject to military law.[4]

Malingering has thus been used to refer to the behavior of an individual who falsely pretends to be suffering from sickness or disability or exaggerates the effects of any such health-related problem. Deception or imposition of the type described by LeBourgeois *et al.*[2] is exactly that—it is not malingering because it does not involve feigning or exaggeration of symptoms—that is, the subjective experience of the person's state of ill health.

What the authors refer to as "malingering by animal proxy" is quite different from so-called "factitious disorder by proxy" (such as Munchhausen's syndrome by proxy) in which symptoms are frequently induced in the (usually) child, and the carer's involvement with the medical profession meets a psychological need.

In my view the use of terms such as "malingering by proxy" and "malingering by animal proxy" is incorrect and should be avoided. Where deception is

used to obtain prescribed drugs, it should be characterized by that term.

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Editor:

Bursztajn *et al.*[1] offer two composite case vignettes of lost compensation claims. They attempt "to illustrate how a psychiatric worker's compensation evaluation can be helpful when the forensic evaluator [independent medical examiners or examinations; IMEs] has an awareness of the social context of primary medical and mental health care in today's managed-care-dominated health care environment." Proposing that such evaluations can be helpful in individual cases and useful for educating both primary care clinicians and employers, the authors emphasize that these evaluations are no substitute for primary clinical care and mental health referral and treatment.

Unfortunately, though their goal is meritorious, their suggested path to get the patients off disability more quickly by referral to psychiatrists is not. Ironically, rather than exploring the health care access problems of their hypothetical patients in the managed care environment, the IMEs adopted a methodology similar to that used by the managed care industry to limit care, by suggesting frail alternatives to the care patients were already receiving.

The first patient, suffering from suspiciousness and stigma (already attending a clinic for "work stress") ended up accepting from the IME a recommendation for psychiatric referral; the second patient, "learn[ed] from the independent medical examiner that he was depressed. . .and he could benefit from psychiatric treatment [although he had no mental health coverage!]."

Aside from the problematic method of medical case presentation by creating composite stories, the authors suggest that their invented cases indicate: (1) that these claimants needed treatment for their "psychopathic disorders"; (2) that the cases give evidence of "inappropriate claims"; and (3) that a forensic IME evaluator should make suggestions "tactfully" or otherwise "to help the examinee make behavioral changes." Without support in their hypotheticals, the authors conclude from their "composite stories" that the claimants "made inappropriate claims and lost not only their claims but also the opportunity for adequate treatment for their psychopathic disorders" (Ref 1, p 118).

Certainly, offering these composites as having any evidence of "psychopathic disorders" is patently false, and treatment recommended for such assumed diagnoses would be misleading, if not harmful.[2] Although the authors apparently believe otherwise, neither example demonstrated "inappropriate claims," other than from the IME's socioeconomic and preferential psychiatric referral stance.

Most important, an IME is supposed only to determine whether a patient is (still) disabled, not what treatment would limit the total cost to society for such a disability.[3] Regarding the patient-physician relationship in the context of work-related and independent medical examinations, AMA Opinion E-10.03, says, in pertinent part:

> Before the physician proceeds with the exam, he or she should ensure to the extent possible that the patient understands the physician's unaltered ethical obligations, as well as the differences that exist between the physician's role in this context and the physician's traditional fiduciary role. . .*IMEs are responsible for administering an objective medical evaluation but not for monitoring patients' health over time, treating patients, or fulfilling many other duties traditionally held by physicians*. Consequently, a limited patient-physician relationship should be considered to exist during isolated assessments of an individual's health or disability for an employer, business, or insurer [emphasis added].[4]

Moreover, nowhere in their article do the authors indicate whether the hypothetical patients were informed of their legal right to have present someone they have brought to record the examination content.

Ethics Opinion 10.03 goes on to say:

> The physician has a responsibility to inform the patient about important health information or abnormalities that he or she

discovers during the course of the examination. In addition, the physician should ensure to the extent possible that the patient understands the problem or diagnosis. Furthermore, when appropriate, the physician should suggest that the patient seek care from a qualified physician and, if requested, provide reasonable assistance in securing follow-up care.

It should be obvious that this part of the opinion was neither meant to suggest referring patients of primary care doctors to psychiatrists, nor to consider and then monitor health care economic or access problems. Moreover, it is difficult to imagine how such a forensic psychiatrist IME would answer a claimant's question: "But what about my primary care doctor?" From an ethics standpoint, it is widely accepted that using for referrals a patient's probable transference to the IME, based on apparent authority, is an unethical intervention, especially when taken advantage of by a nontreating psychiatrist. It suggests undue influence and, to the rest of medicine, would have the appearance of impropriety.

It is irrefutable that an "independent medical examination" is generally ordered by some employer, agency, insurance company, or governmental payer for the sole purpose of assessing whether disability payments can be ended without violating the contract made with the worker. Because common law accepts that a worker's compensation contract is one that "adheres" to the one who wrote it—that is, it is prepared by one party, to be signed by the party in a weaker position, as with all insurance disputes—it is traditionally looked at by the adjudicator in the light least favorable to the profferer. Using an IME to make referrals is not a way to end "managed-care domination."

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Reply

Editor:

Dr. Schoenholtz's letter raises important questions about how the dual agency of managed health care interacts with the potential dual agency engendered when forensic psychiatrists are asked to offer opinions as to optimal treatment and the prognosis with current treatment. (The term dual agency refers to what some call a role or mission conflict in which a professional has duties toward separate agents with potentially conflicting interests.)[1] These issues, some of which we have addressed in earlier publications,[2,3] form the subtext of our current work.[4] Although forensic psychiatrists have pioneered in exploring what objectivity means in medicine and mental health, with the advent of managed health care, all of American medicine confronts the pitfalls of dual agency.

Under California law, workers' compensation evaluations necessarily address the matter of treatment recommendations. California Workers' Compensation Appeals Board (WCAB) regulation 10606(j) states: "These reports should include where applicable. . .[the] treatment indicated." Also, the standard, formal, accepted medical-legal evaluation referral letters contain the request: "Regarding medical treatment: a) Is the treatment which has been provided reasonable and necessary to cure or relieve the effects of industrial injury? b) What further medical treatment is reasonable and necessary?" The more informal cover letters often include the question: "Any treatment recommendations?"

Do the fundamental principles of beneficence and objectivity necessarily collide when the forensic psychiatrist makes treatment recommendations to the retaining party or (if the retaining party is the insurance company) when the forensic psychiatrist receives permission from both sides to make recommendations directly to the patient or the patient's treating clinician? When does such permission have to be sought explicitly? When is it implicit? When can it be said to be unreasonably withheld? And what should a forensic psychiatrist do if it is withheld?[1]

Although one wants to avoid the normative fallacy of inferring what clinical practice ought to be from workers' compensation presentations in regions dominated by managed health care, it is important to extend our understanding of the latter reality through further empirical study. We are currently

preparing for submission for publication the results of an exploratory study based on the presentations of workers' compensation claims for evaluation to the practice of one forensic psychiatrist (D.M.R.).[5] Since practices vary across states and populations and according to the goals and contracts of referral sources, we welcome critics of our work to join us as collaborators in a more representative cross-regional set of forensic practice studies.

Composite cases are commonly used to protect patient confidentiality and to illustrate "classic" presentations in medical teaching and texts. The medical mind learns well when thinking about cases, as opposed to principles.[6,7] Those cases typically are composites, which allow for inclusion of the most significant features. Reliance on such paradigm cases is likely to increase, given computer-based "virtual" patient teaching methods and Health Insurance Portability and Accountability Act (HIPAA) protections of patient confidentiality.

Finally, intrusion into the forensic psychiatric examination by a representative of the examinee can be destructive to the goal of objectivity, for which, according to standard practice and the American Academy of Psychiatry and the Law (AAPL) Ethics Code, all forensic psychiatrists should strive for.[8] Professional organizations in related disciplines, such as the American Academy of Clinical Neuropsychology, have made strong policy statements discouraging the participation of nonobjective observers in forensic examinations.[9] The presence even of tape recorders has been shown to be enough of a distraction to result in a significant decline in performance on setting-sensitive neuropsychological tests such as those measuring memory. On the other hand, motor performance is relatively insensitive to the presence of recording devices.[10] Such findings support forensic psychiatrists' customary precautions against the distorting influence of third parties. They also indicate why similar precautions are not needed in other kinds of forensic medical examinations that evaluate relatively setting-insensitive (e.g., motor) performance measures.

An even more intriguing implication of such findings is that not only the forensic, but also the clinical evaluation of psychiatric impairment may be particularly sensitive to third-party interference and therefore may need special protection to attain the desired validity. It may be essential for any forensic psychiatric evaluation of clinical care to ask, on a case-by-case basis, whether managed care restrictions and record requirements are in evidence. If so, did they drive history-taking, mental status observations, diagnostic formulations, and treatment plan recommendations to the detriment of the patient's care?

California state law recognizes that the nature of the forensic psychiatric examination, unlike other medical examinations (e.g., orthopedic), makes it inappropriate to have a third party present. Thus, under California law, a patient can have a witness in any examination except a psychiatric one. This provision reflects a realistic concern that the presence of nonobjective third parties is likely inadvertently to turn a forensic psychiatric examination from an objective evaluation into a *de facto* attorney coaching session, a rehearsal, or a setting-driven repeat of a deposition or a narrative previously given to the attorney.

In other states, if necessary, psychodynamically informed judges usually heed motions to protect forensic psychiatric examinations from being tainted by an examinee's or attorney's insistence on manipulating the setting. Similarly, mental health notes are afforded a greater degree of protection from intrusion by the legal system under the *Jaffee v. Redmond* Supreme Court decision.[11] Unfortunately, however, clinical mental health practice is not similarly protected from the intrusive influence of managed health care organizations.

Like medical education in general, forensic psychiatric education can benefit from additional inquiry into how to achieve and maintain diagnostic objectivity in the face of third-party influences ranging from managed health care restrictions to the process constraints inherent in the workers' compensation system. Carefully designed empirical studies, conducted with mutual consent, can avoid the pitfalls of intrusion and promote forensic psychiatric inquiry, teaching, and research. Moreover, forensic psychiatry's long experience of seeking objectivity amid conflicting interests can be of enormous value to clinicians newly confronting third-party intrusion in managed care-influenced clinical practice.[12]

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