Editor:

I would like to add some missing information to the discussion between Bursztajn *et al.*[1] and Robert Miller[2] of compensation claims and patient care.

Dr. Miller raises the question of the social cost of paying benefits to highly compensated disability claimants whose affective illness is stabilized but whose associated personality disorder urges them to refuse effective psychotherapy. He asks, "What should be the responsibility of a [an insurance] company when an insured individual refuses to cooperate with treatment recommended by treaters or independent evaluators?" He lists court decisions that have supported refusal of benefits based on noncompliance in medical reimbursement and Social Security claims.

There are several answers. One is that disability insurers do stop payments in these circumstances, but disability policies in highly compensated individuals are usually "individual" policies. These policies are not covered by the Employee Retirement Income Security Act (ERISA), and without it, the insurers are wary of the fine points of special "bad faith" and "punitive damages" regulations that apply. So they struggle, but do not act decisively, and react only after many years. By then, the individual's complex work skills are so out of date that there is no possibility of employment that meets the necessary definition of "gainful."

A second answer is that insurers have taken responsibility by changing the wording of newer policies to support appropriate care. In my years of working with a disability insurer writing new policy language, we replaced the words "regular treatment" with "standard treatment" or "appropriate treatment" and added "can work, must work" definitions for partial disability. This wording can support the independent examiner's recommendations, but often the treaters become "advocates." When they will not cooperate any better than the patient, the court is likely to support the treater's opinion over that of an "expert," leaving the insurer never wanting to go to court.

A third problem is harder to describe but has to do with the definitions of disability. In the case Dr. Miller describes, the patient has reached what the insurer would call baseline. Disability in a highly successful person means there has to have been a significant change in the ability to function (or others' tolerance). If a personality disorder is longstanding, it was surely present during the period of work and success, long before the disabling episode of affective illness. But the treater may have seen the patient only after the onset of the Axis I episode. Treatment files with no history abound, and no distinction may have been made between the Axis I and Axis II diagnoses. The treater has come to believe the patient cannot function until he or she is "better than new" and supports disability status based on the ongoing personality problem. The insurer could end benefits then, not because of noncompliance but because the patient has reached baseline. That might actually motivate treatment—or seeking employment. But insurers, uninformed or stymied, do not get records from the primary care physician, records that usually document the existence and impact of the personality disorder long before the episode.

So everybody loses.

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References

1. Bursztajn HJ, Paul RK, Reiss DM, *et al*: Forensic psychiatric evaluation of workers' compensation claims in a managed-care context. J Am Acad Psychiatry Law 31:117–19, 2003
2. Miller RD: Disability and psychotherapy: a response to Bursztajn *et al*. J Am Acad Psychiatry Law 32:197–9, 2004

Editor:

We welcome a chance to expand on Professor Gunn's exposition[1] of the Royal College of Psychiatrists' statement on the death penalty.[2] His analysis is necessarily limited because, not being a member of the Ethics Committee, he was not party to our extensive deliberations on this matter and therefore may have missed the ethics reasoning underpinning the statement.

First, although the statement was due for review because of time elapsed since the last review, the impetus for the review of the previous statement arose from the fact that previous statements gave little in the way of advice to members because it was assumed

that questions of participation in death penalty cases were not at issue in Britain. However, members of our College are involved in capital cases around the globe, and the College was keen to ensure that members are not deterred from being involved in this work. In the interests of justice and beneficence, it is possible to argue that psychiatrists are justified in participating in capital cases. It is the question of the nature and scope of the participation that is at issue, which we hope the revised statement covers.

Second, our College has for some time been actively concerned about the use of psychiatric testimony for nontherapeutic purposes, and expert testimony in any criminal case (whether capital or not) exposes this debate. Under current English law, psychiatrists will be asked to provide opinions that may become the basis for longer than normal sentences in cases of serious violence. There is a strong body of opinion within our College (although, like Professor Gunn, we are unable to quantify it), as clearly there is within the American psychiatric profession, that psychiatrists are justified in providing expert testimony for all parties involved in legal (criminal, civil, and family courts) proceedings, even if that contributes to an outcome that is nontherapeutic or even antitherapeutic. Of course, in the United Kingdom, psychiatric testimony cannot lead to death, and it is true that probably most U.K. psychiatrists would take the view that there is no justification for psychiatric examinations on fitness for execution or for psychiatric testimony that claims as a matter of science that the death penalty is justified in terms of risk.

But some U.K. psychiatrists do want to be able to provide expert testimony to the courts, even when this may result in a nontherapeutic outcome for the defendant. The situation in the United Kingdom is further complicated because expert evidence is routinely asked of forensic psychiatrists who are also in a therapeutic (treating) relationship with the defendant. The roles are not so separate here as they are in the United States.

But the crux of the matter, as we see it, for both the United States and the United Kingdom psychiatric professionals, is that there is a body of psychiatrists, however small, who support the death penalty and the participation of psychiatrists in the legal process of prosecuting crimes.

It is not true that we are united or speak with one medical voice; we do not. We should express and understand the views of those psychiatrists who believe that they can ethically participate in the justice system in nontherapeutic ways, if only so we can rebut their arguments better. It must be generally agreed now that beneficence and nonmaleficence are but two pillars of bioethics and to discount the other two (autonomy and justice), plus scope in the name of plurality, is as arrogant and as wrong as the other wrongs we hastily condemn. C. S. Lewis once said: "Mercy, detached from Justice, grows unmerciful. That is the important paradox."[3] The Ethics Committee of the Royal College of Psychiatrists deliberated long and hard on this matter. We hope that our statement reflects that deliberation. No doubt there will be more to say when we next review it.

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References

1. Gunn J: The Royal College of Psychiatrists and the death penalty. J Am Acad Psychiatry Law 32:188–91, 2004
2. Royal College of Psychiatrists: Psychiatry and the death penalty: revised statement from the ethics sub-committee. Psychiatr Bull 27:396–7, 2003
3. Lewis CS: The humanitarian theory of punishment, in God in the Dock: Essays on Theology and Ethics. Edited by Lewis CS, Hooper WB. Grand Rapids, MI: Eerdmans Publishing Co., 1994, pp 287–300

Editor:

In my Commentary in a previous issue of the Journal,[1] the 13th reference should have been as noted below.[2]

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References

1. Leong GB: Commentary: no rational reasons for changing competency-to-stand-trial standard. J Am Acad Psychiatry Law 32:246–9, 2004
2. Cheatham CS, Litwack TR: Professionals' attitudes regarding whether a New York defendant who delusionally refuses a viable, counsel-recommended insanity defense should be found competent or incompetent to stand trial. J Psychiatry Law 31:433–60, 2003