The Treating Psychiatrist Thrust Into the Role of Expert Witness

Thomas G. Gutheil, M.D.
James T. Hilliard, J.D.

Treating psychiatrists may precipitously and unwittingly be thrust into the role of expert witness because of certain actions they may take on behalf of their patients and may suffer adverse consequences as a result of lack of training and experience. The authors review this problem and suggest means of avoiding the pitfalls involved. Recommendations include warning patients of the uses that will be made of communications between their treaters and third parties, recording the sources of clinical data for use in communications with the legal system, separating the roles of treating psychiatrist and expert witness, and consulting with attorneys or experienced forensic practitioners. (*Psychiatric Services* 52:1526–1527, 2001)

The "fish out of water" plot device is one of the most enduring staples of fiction. However, in the real world few fish feel the absence of familiar water as keenly as does the treating psychiatrist who is thrust unwillingly into the legal system. For most practitioners, going to court for any reason has all the appeal of a root canal without anesthesia (1). We examine how the actions of treating psychiatrists can precipitate them into a medicolegal morass if they do not have the requisite preparation, specialized training, experience, or basic knowledge to function in that role.

***Dr. Gutheil** is affiliated with the program in psychiatry and the law of the Massachusetts Mental Health Center at Harvard Medical School in Boston. **Mr. Hilliard** is with the law firm Connor and Hilliard in Boston. Send correspondence to **Dr. Gutheil** at 74 Fenwood Road, Boston, Massachusetts 02115.*

Illustrative example

Dr. J had been treating Mrs. S for four years with psychotherapy and antianxiety medication. As a result of the empowering effect of the treatment, Mrs. S was able to make the decision to leave her husband, with whom she had what she described as an abusive and ungratifying relationship. The resulting divorce led to a custody battle over their two young children.

One morning Mrs. S's attorney called Dr. J and asked for "a brief note on the therapy" to aid in the custody negotiations. A bit flustered by this intrusion into the clinical setting, Dr. J obtained Mrs. S's permission and looked back over the chart to remind himself of key data. He then drafted a brief letter, as if writing to a colleague, noting Mrs. S's initial complaints about the stresses of raising two small children, her use of diazepam to control her anxiety and to replace her occasional increased use of alcohol, his clinical efforts to help her break out of a masochistic position in her marital relationship, and her efforts to deal with her husband, "a classic abuser." He sent off the note and thought no more about it.

Months later he is stunned to receive a subpoena from Mr. S's attorney, a document that conveys that Mrs. S's attorney has designated him as an expert on custody matters and that his deposition will be taken shortly. During the deposition Dr. J is appalled to hear Mrs. S characterized—supposedly through his letter, now designated as an "expert report"—as an inadequate mother, an abuser of alcohol and prescription drugs, and a paraphilic who enjoys "heavy S and M." The attorney also sneers at Dr. J's cavalier diagnostic assessment of Mr. S as "a classic abuser" in the absence of any examination of him. Much is made of a code of ethics from the American Academy of Psychiatry and the Law, an organization that Dr. J has never heard of. Dr. J wants to say, "That isn't what I meant at all!" but knows that such a statement will carry little weight.

Patients and third parties in litigation

As this illustrative example suggests, therapists sitting in their offices may legitimately venture informal opinions about third parties solely on the basis of what patients tell them, for supportive effect—for example, "It must be difficult dealing with such a narcissistic husband," and "Separating from such a dependent mother must be a real challenge for you." Such pronouncements pose no difficulty when the psychiatrist is operating empathically from within the patient's world view and from no other point of reference, an issue often addressed in so-called recovered-memory cases (2). However, courts focus on more objective evidence, and in this context therapists should use extreme caution—or refuse entirely—when they are asked to give opinions about a patient or a third party, particularly when litigation is involved.

Thus therapists should understand the significant potential for challenge by the court, operating from its different perspective, and should be prepared to defend their expressed clinical opinions on the basis of ap-

propriate and documented facts about the patients they have actually examined. An attempt to help the patient during litigation by rendering an opinion that is without a defensible foundation can subject the therapist to having to defend that unfounded opinion to an adversely affected third party or, should a complaint be lodged, to a licensing board.

Practitioners should be aware that the more helpful to their patients their letters or reports may be, the greater the likelihood that an opposing attorney will want to depose them and call on them at trial. Practitioners should also be aware that although being named as an expert in litigation usually requires an agreement between the retaining attorney and the expert, a misguided attorney may list the treating therapist as an expert witness without even informing the therapist. In general, patients should be encouraged to first discuss with their own attorney any possible communications between the therapist and the court.

Most important, the treating psychiatrist's appearance in court can have extremely destructive effects on the treatment relationship. Resulting negative transference can destroy the therapy, especially because the therapist's comments on the stand may be felt as more personally wounding or painful than the testimony of an expert who is more remote from the patient's clinical care (3). This problem can and should be brought to the attorney's attention.

Attorneys' efforts

A patient's attorney may attempt to thrust the patient's therapist into the role of expert to save money, for convenience, or on the basis of an assumption that a particular therapist is more favorable to the patient's side of the case. In such cases the psychiatrist should not assume that the attorney is using good judgment; the attorney may not grasp how the psychiatrist's patient-centered perspective, usually attained without comprehensive review of records or depositions, is easily impeached.

Legal pressures aside, forensic objectivity, which may differ from necessary therapeutic subjectivity, and honesty—"the whole truth"—are critical to the rendering of a legally relevant opinion or the provision of a letter to a third party about a patient. It is also important that psychiatrists avoid rendering an opinion or a diagnosis concerning even their own patient when they have not had an opportunity to fully evaluate or examine that patient on the particular issues they have been asked to discuss. For example, a therapist treating a patient for depression may know all there is to know about the patient's condition and family history of affective disorder but may never have specifically examined the patient's parenting abilities, which are relevant in a custody battle.

Recommendations

We offer four recommendations to psychiatrists who want to avoid the pitfalls of their role as expert witnesses.

First, patients have the right to know what use will be made of communications between their therapists and other parties. It is vital to inform patients whenever confidentiality does not apply. Court proceedings are usually much more open than therapeutic work.

Second, clinicians should develop the general habit of recording the sources of clinical data—for example, "The previous record notes . . . ," "The patient reports . . . ," and "Nursing staff observed . . . ," but this source-conscious approach is absolutely essential in communications to be used in the legal system, where the speaker or the source of information must be identified.

Third, the roles of treating psychiatrist and expert witness should usually be separated, because they have different clinical, legal, and ethical requirements (4). A surprising number of attorneys do not understand this point or do not choose to be influenced by it. As noted, caution must be used to clarify which factual data come solely from the patient.

Finally, psychiatrists who face involvement with the legal system should not be reluctant to seek consultations about court communications or appearances from attorneys or experienced forensic practitioners (5). The attorneys who are retained by local district branches may be particularly familiar with psychiatric issues in court. Similarly, discussion with a forensic practitioner may more efficiently help to clarify the pitfalls that are relevant to the particular issue being litigated.

In summary, an educated fish, oriented to the differing assumptions and approaches of the legal context, may find the legal waters less threatening and less harmful to the patient who is involved in litigation. ♦

References

1. Gutheil TG: The psychiatrist in court: a survival guide. Washington, DC, American Psychiatric Press, 1998
2. Simon RI, Gutheil TG: Clinically based risk management principles for recovered memory cases. Psychiatric Services 48:1403–1407, 1997
3. Melton GB, Petrila J, Poythress NG, et al: Psychological evaluations for the courts, 2nd ed. New York, Guilford, 1997, pp 41–45
4. Strasburger LH, Gutheil TG, Brodsky A: On wearing two hats: role conflict in serving as both psychotherapist and expert witness. American Journal of Psychiatry 154: 448–456, 1997
5. Gutheil TG: The psychiatrist as expert witness. Washington, DC, American Psychiatric Press, 1998