

The Treatment-Forensic Interface

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This month's column is about maintaining a separation between some kinds of forensic work and providing general patient care for the same patient/evaluee. It has been a long time since I focused on this topic in this column,¹ but the issue remains very relevant. In a perfect world, the multifaceted conflict of interest between objective forensic work and the obligations of a doctor-patient relationship would never occur. In the real world, however, such conflicts happen all the time, and while they are sometimes harmless, they can also create big problems.

Note that I am not implying that "forensic" practice doesn't include clinical work. There are many clinical aspects of forensic work, just as patient care has a number of points of interface with the legal system. The point of this column is recognizing potential conflicts and separating those that are manageable from those that are likely to interfere with both our duties and the fair outcome of legal or administrative procedures.

The Physician-Patient Relationship

Once a psychiatrist or other physician has established a clinical relationship with a patient, the patient's interests must be the paramount concern in virtually all of that doctor's behavior that may affect the patient. One can think of a very few exceptions to this principle, such as preventing injury to others or reporting some kinds of criminal activity, but even those rare examples can often be couched in terms of benefit to the patient.

A doctor-patient relationship is very easy to form. Direct treatment is the paradigm that usually comes to mind, but a clinical consultation, patient-centered examination, or even a telephone call may create a duty that quickly becomes *fiduciary*, or nearly so (that is, carrying the legal expectation that the patient's interest will come before all else).

When we perform a forensic or administrative task, we are usually acting on behalf of someone, or something, other than the patient. An assessment for a court, whether requested by an attorney, government agency, or the court itself, assumes acceptance of a duty to one or more third parties (e.g., the lawyer, agency, or court). Assessments for disability, civil commitment, child cus-

tody, competence to make a will or handle one's other affairs, fitness for duty, eligibility for a license or permit of some kind, and the like, all rely upon a duty of honesty and objectivity on the part of the evaluator. That expectation, by someone other than the patient, that your evaluation, findings, and opinions will be professional and objective is critical to the fairness and accuracy of whatever legal or administrative process is being pursued.

When we accept an evaluating role outside the strict clinical needs of our patients, in which some third, non-clinical party will use our findings and opinions to make a judgment that affects the patient, we automatically encounter a conflict of interest. On the one hand, the patient has every right to expect us to act in his or her best interest. On the other hand, the court, agency, or other third party is entitled to assume that we offer our results with skill and objectivity, without regard to any significant conflict that may govern, or at least affect, the outcome. The third parties rarely understand the strength of the duty we have to our patients and are often in danger of basing important decisions on information fraught with clinician bias.

Doctors, too, rarely comprehend the many sources of their bias. Most simply say to themselves (and believe) that they can somehow manage the potential for conflict of interest and provide objective findings or testimony.

Denial is a wonderful thing. Sometimes, particularly in some administrative situations, the bias is manageable or sufficiently slight that its relevance is limited. Occasionally, most of the significant sources of conflict can be discerned by the psychiatrist, who may try to allow for them as he or she completes, for example, an insurability form or a report to a licensing board about a colleague-patient's ability to practice safely. But the more one understands the breadth and number of opportunities for bias, the more one is likely to appreciate the

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differences between the role of treater and that of evaluator or expert, and confine oneself to one or the other with regard to a given individual.

Sources of Bias or Conflict of Interest

A wealthy man was involved in a rancorous divorce. His attorney called his psychotherapist to help in the case and to testify about his patient's competence and vulnerability during a time when he made certain very extravagant gifts. The treating psychiatrist had received over \$100,000 from the patient for psychotherapy over many years. He charged the attorney (and was paid) over \$100,000 for expert witness services during the long and expensive divorce process. He testified that he would also probably treat the patient for months or years in the future and expected to be paid by him commensurate with his services.

This admittedly extreme (but actual) example illustrates the many reasons that such dual relationships are not advisable. Some of the following points may appear redundant, but note the attention to whether or not the psychiatrist's behavior is intentional.

- As already mentioned, the doctor-patient relationship creates a professional and ethical obligation to act in the best interests of the patient. The patient has a right to rely on this attitude in the doctor both during and after treatment. That's a cornerstone of the patient's ability to work in therapy free of concerns about future divulging of confidences, betrayal, or exploitation.* Forensic consultation or testimony, on the other hand, requires objective comment regardless of the patient's needs or wishes.
- Having spent time working with the patient, sometimes intimately, clinicians often feel a personal affinity for the patient's viewpoint. Knowing that he or she is professionally and ethically required to act in the patient's interest, the clinician is thus in danger of intentional bias in favor of the patient.
- Separate from physicians' conscious awareness of a duty or wish to act in their patients' interests, the obligation to "do no harm" is keenly felt by ethical practitioners. Even when they try to be objective in forensic reports or testimony, there is a danger of unintended bias toward their patients.
- Separate from the "do no harm" ethic mentioned above, clinicians' countertransference feelings can create bias either for or against the patient. Subsequent clinician behavior (e.g., wording a report or letter in a biased way) may be intentional, but the reasons for it are often unconscious.
- Our ethical principles require that when a treating psychiatrist or psychotherapist believes it may later become necessary to comment to a third party (such as an employer or insurance company), this is to be discussed fully with the patient as early as is feasible. Clinicians should know that awareness of the probability of disclosure affects the patient's conversations and revelations to some extent, and this, in turn, affects the validity of any forensic participation.

The following points are relevant to a doctor who is primarily a forensic evaluator but also provides treatment:

- If the initial referral is forensic, the forensic professional may do an incomplete clinical evaluation, and/or may not document the evaluation, history, symptoms, diagnoses, treatment plan, and prognosis as completely or objectively as would a clinician whose sole purpose is treatment.
- If the initial referral is clinical but the role later becomes forensic, the doctor's diagnostic attention, treatment, and/or documentation of care may change, to the detriment of the patient's clinical needs.
- A forensic expert who is treating a litigant may unconsciously (without overt malicious intent) create incomplete or skewed treatment documentation. He or she knows that the notes are very likely to be revealed during litigation. There may be a subtle wish or impulse to support the attorney's case, or to please the attorney.
- A forensic expert who is treating a litigant may unconsciously (without overt malicious intent) a) create findings that support the legal case, b) obscure findings that might refute the attorney's case, c) avoid (or fail to encourage) certain assessment and treatment procedures (e.g., to keep the patient from improving and decreasing damages), and/or d) fail to refer the patient/evaluee to a nonforensic clinician when necessary.
- A forensic expert who is treating a litigant could consciously (with overt intent) abbreviate or skew treatment documentation or diminish or change treatment or procedures in the ways described above.
- A forensic expert who is treating a litigant could consciously (with overt intent) use a nominal "treatment" relationship to prevent a legitimate treatment situa-

*For a good discussion of this issue from the viewpoint of the damage to treatment that such conflict can cause, see Strasburger et al., 1997.²

tion. That is, by controlling the documentation of clinical care, an unscrupulous expert may be in a position to control, if he or she chose to do so, opposing counsel's access to accurate clinical information.

- A forensic expert who is treating a litigant could consciously (with overt intent) collude with the litigant to misrepresent symptoms, diagnoses, treatment response, or disability (note that this can occur with nonforensic clinicians as well, usually out of a misguided effort to help the patient).

Administrative Evaluations and Progress Reports

Some of the most common evaluation situations in ordinary psychiatric practice involve administrative reports or letters. These may be used by patients to establish eligibility for disability or other insurance benefits, fitness for duty, or criteria for some form of license or certificate (e.g., a driver's license, pilot's certificate, handgun permit, or professional license). Let's look at several scenarios with the assumption that the doctor decides to provide the assessment and/or report—although this is often a bad idea.

What if my patient requests a letter or report? Such requests come in a variety of contexts, from the strictly practical to those full of ambiguity or psychological meaning. Patients may couch such requests in a simple "I need this" context (e.g., "they won't let me back on the loading dock without a note from you" or "my probation officer wants a letter saying my drinking is under control"). Sometimes it's a request or demand to negotiate on the patient's behalf (e.g., "my lawyer wants to talk to you" or "I'm supposed to get a custody evaluation; will you do it?"). At the least, the clinician is placed "on the spot."

Sometimes, especially when the task seems straightforward (such as merely quoting from one's records or endorsing a clinical finding), it is reasonable to accept the request and move on in treatment. At other times, however, if one considers participating at all, one should be prepared for a substantial discussion in which the understanding is clear that if one accepts the task, it will be separated as much as is feasible from the treatment, and the results will be communicated to the relevant person or agency independent of the patient. Further, one should often not accept the patient's version of the third party's request. In all but the simplest of situations, get permission from the patient to contact the employer, school, probation officer, attorney, or other party and determine both the context of the request and exactly what is being sought.

That doesn't mean that the process should be hidden from the patient. A thorough discussion of the implications of the letter or report is important, as well as an exploration of what it is likely to contain and the possible outcomes. Both patient and clinician should understand, however, that this is a notification and discussion, not a negotiation of the findings or opinions to be expressed.

What if the patient wants to review the letter before it is submitted? I often hear of well-meaning clinicians who work with the patient to compose letters or reports on their behalf, or allow the patient to review drafts before they are submitted. *Although this sounds therapeutic, it is almost universally a mistake, and it substantially threatens the doctor's forensic or administrative objectivity.* Administrative or forensic assessment is a professional task. It is not negotiation and, regardless of one's wish to adapt it to the therapeutic purpose of the relationship, it is not intended to be part of the treatment enterprise. Attempts to combine the two are very likely to damage the validity of the opinion.

What if the patient is no longer under your care? The caveats mentioned above usually apply to former as well as current patients. In most cases (but not all), neither the doctor nor the patient anticipates a forensic purpose during treatment. That being true, the clinical work probably did not involve the kinds of assessment and research usually associated with an administrative or forensic question (such as whether or not the patient would later be eligible for a job driving a truck or responsible for some allegedly criminal act).

What if the patient's lawyer contacts you for a letter or report? The lawyer's objective is to win the case. In most situations, he or she has little interest in psychiatric ethics, the doctor-patient relationship, potential conflicts of interest, or even the patient's clinical course (unless it is relevant to the legal case). You must weigh the various options and pitfalls before deciding what to do. Sometimes it helps to explain the clinical and ethical issues (which include whether or not you are capable of answering the query, or of being objective). Usually, the lawyer already understands all that. He or she is simply looking for something to help the case. Bias may be present, but it is often irrelevant from the attorney's point of view ("how can this doctor help my case?").

I suggest that treating clinicians be cautious when deciding what they can or cannot do for patients' attorneys, tell lawyers of ethical or objectivity problems, refrain from becoming an "expert" witness (i.e., one who

offers opinions as contrasted with simple factual information), and protect their patients' well-being. Lawyers can be pushy, and very convincing (after all, it's what they do for a living). Act in moderation.

What if the patient wants to see the report after it is submitted? I believe that when an independent evaluator does an assessment and writes a report as an agent of a third party such as a lawyer or judge, the evaluatee probably has no right to receive a copy from the evaluator. Evaluatees often ask to discuss one's findings, or for a copy of the report. I rarely discuss my findings directly with evaluatees outside the lawyer's presence, and almost always refer them to their attorney, who will share the information as he or she believes proper. If I am working for the side opposing the evaluatee, such a discussion (between the evaluatee and me) is likely to be improper. In any event, the findings, which are usually preliminary and don't reflect other aspects of the case or proceeding, may be misunderstood, with unfortunate consequences.

When the evaluatee is also one's patient, however, it is difficult (and sometimes inappropriate) to keep the findings from him or her. First, the notes and findings may be construed as part of the clinical record, and thus available to the patient unless you can show that they are likely to harm the patient. Second, communication is very important to treatment. It would seem odd to expect openness and honesty from one's patient while refusing to discuss a report that affects him or her. Finally, the evaluation process, and its results, can rarely be separated from the treatment process. Addressing the facts, confronting the issues, and discussing the attendant feelings and their meanings would be logical to most treaters.

All of this adds further opportunity for bias and conflict of interest when evaluating or reporting about one's patient to a third party or agency. It seems obvious that when the evaluator knows he or she must continue to see the evaluated patient and discuss or explain evaluative findings in treatment sessions, the objectivity of the evaluation process, and especially of the findings, is likely to suffer.

Each of the above questions becomes far easier to answer when the administrative or forensic activity—evaluation, letter, report, or testimony—is done by someone else. First, when that happens, the outcome is far less likely to be biased. Second, the impact and meaning of the independent evaluator's findings, as well as the outcome of the proceedings (whatever it may be), are much easier to examine during treatment. Third, the

patient retains a relatively undamaged clinical relationship which can be used to manage and accept the result.

Child Custody and Fitness to Parent

Child custody and matters of ability to parent (e.g., to regain custody or visitation after children have been removed from the home) deserve special mention. Such issues often arise in the course of treatment. Handling them properly is critical for all concerned.

The most common situation is one in which a patient asks the psychiatrist or therapist (who has usually been seen for some issue separate from custody or parenting) to write a report, or work with his or her lawyer, in order to help the patient gain custody. The bottom line is simple, and I cannot think of an exception: *Do not offer opinions about child custody or a patient's ability to safely parent his or her children unless you have the requisite training, have performed the appropriate evaluation of all available relevant parties, and are free of significant bias for or against the evaluatee(s).*

Child custody and parenting evaluations are highly specialized. Both, but custody assessments in particular, require procedures, expertise, and experience that are different from those expected in routine clinical work.^{3,4} The potential for bias among treating clinicians (often very harmful bias) is substantial. When one considers that the safety and welfare of children is among the most crucial issues we encounter, it becomes very important that treating clinicians continue their work and leave the evaluations to independent, experienced (often child-trained and forensically skilled) colleagues.

The Last Word

When you are in a treatment role, keep the patient's care your primary concern. Be cautious about anything that may interfere with it, and be aware that the clinician-patient relationship often creates a substantial conflict with respect to other roles you may assume.

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