AAPL: Ask the Experts-2014

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Neil S. Kaye, MD, and Bob Sadoff, MD will answer questions from members related to practical issues in the real world of Forensic Psychiatry. Please send question to nskaye@aol.com.

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Q.: In the course of a defense IME, I have serious concerns about the safety of the examinee. Although he denies acute suicidality, he appears depressed, psychotic, and is on a low dose of a SSRI and no antipsychotic medication. According to the IME contract I have sign, I am not allowed to discuss my findings with anyone. What do I do?

A. Kaye.:

Before a person can become a good forensic psychiatrist, she must first be a good clinical psychiatrist. As such, even when we are working with our "forensic hat" on, the need to be respectful of life and to act to preserve life cannot be ignored. Your duty as a physician trumps the duty of your role as a forensic evaluator. Therefore, intervention is appropriate and necessary. Although Tarasoff was a California State case involving expressed violence toward a third party, the courts rationale in that matter (and subsequent similar rulings by other Statate's courts) gives us guidance, consistent with medical ethics, and forms the basis of my opinion.

Your actions must demonstrate an effort to preserve life. You could ask the evaluee to call a family member or friend and to have them come to the office to pick up the evaluee and take her to the hospital. This could include insisting that the evaluee reveal her thoughts to this third party in your presence. You could contact the evaluee's own attorney, explain the situation, and ask her to come to the office to get her client. Or, you could take action consistent with your State's involuntary evaluation/admission process, and involved the police/mobile crisis if necessary.

A. Sadoff.:

In this case, I agree 100% with Neil Kaye. We are physicians first and forensic experts as a result of our clinical expertise. We must always keep the welfare of the patient/examinee foremost in our concerns rather than the adversarial position of the legal case. I have discussed this in my book “Ethical Issues in Forensic Psychiatry: Minimizing Harm” in which I caution our colleagues to minimize the harm we can create by virtue of the power we have in our forensic roles.

The writer of the forensic question poses but one of many such ethical conundrums we may face in our work. How much of an adversary are we and how much a physician? We cannot adhere to the age-old maxim of “primum non nocere” or “first do no harm” because we can and do harm the plaintiff in a civil case when working for the defense and we can harm the defendant when working for the prosecution in a criminal case. But we can limit the harm or minimize it by careful, ethical consideration of each case on which we work.

Clearly, the instant case is one in which we are obliged as physicians to help the examinee irrespective of which side is paying the bill. I agree with Dr. Kaye’s list of potential interventions. I have used many of his suggestions in the course of my work and find that calling the examinee’s attorney to help calm the patient is very effective. If there is a contract limiting one’s choices, I opt for calling the retaining attorney for permission to act in the patient’s behalf.

Take Home Point:

Forensic psychiatry has long held that there is no doctor-patient relationship in the performance of a forensic evaluation. While this argument could be pushed to include the absence of any duty to protect the person or the public from expressed/planned violence, even when self-directed, this path is ill advised. The AMA has complicated this matter by adopting a position that forensic evaluees are patients, albeit with different rights.

This is not the time to pick nits. Rather this case confronts us with the simple issue of doing the right thing. Acting to save a life will always be seen as the right choice.