Types of Witnesses

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The usual way in which a psychiatrist might end up in a courtroom is as a fact witness rather than as an expert witness. The role of expert witness is covered in the companion volume, *The Psychiatrist as Expert Witness.* (Please refer to that book for more detailed discussion.)

The essential distinction between the two roles is that the fact witness testifies about matters that he or she has perceived through the senses: seen, heard directly (as opposed to hearsay), touched, tasted, or smelled. Fact witnesses also may, to a limited extent, testify about gestalts that emerge from these immediate observations, such as a syndrome or diagnosis, and about immediate consequences, such as a treatment plan or a therapeutic intervention.

In contrast, an expert witness may draw conclusions from data, including other observers' data; may testify about abstractions, such as the "standard of psychiatric care" in a malpractice case; and may even render opinions about a patient never seen (for example, in a malpractice case about a patient who committed suicide).

As a fact witness, the four typical roles within which you might commonly enter into some form of litigation are as 1) an observer, 2) a treater, 3) a plaintiff, and 4) a defendant. Some representative examples of these fact witness roles follow.

As an observer, you might be a bystander present by happenstance on an inpatient unit, and you might see a fight between someone else's patient and a nurse, or you might observe an interaction involving another patient, nursing staff member, or family member. As an observer type of fact witness, you are a witness in the narrowest focused sense because you just happened to observe (witness) a significant event. A similar sequence of events may bring you into the courtroom setting to report what you saw in the context of some litigation having nothing to do with you.

A common second role for the average psychiatrist is that of treater (more specifically, the nondefendant treater), who has been caring for a patient either *before* a particular claimed injury that has provoked litigation, typically to portray the patient's premorbid state, or *after* a claimed injury to determine the postinjury psychiatric condition in a manner relevant to the claimed damages in the situation. An ethical pitfall concerning testifying about a patient's postinjury psychiatric condition is addressed later in this book in "When Your Patient Sues Someone Else" in Chapter 8.

Third, you might be the plaintiff. You might be suing someone else and might even have grounds to claim your own emotional damages. Using your clinical knowledge, you might describe, as a fact witness, your own symptoms and how they affect your life.

Last, and most regrettably, you might be the defendant against whom the case is brought. For example, as the defendant in a malpractice case in which one of your patients alleges that you did not meet the standard of care, you could state what you saw or observed in this case and what you diagnosed; then, you could report what you did and your rationale for doing it.

To summarize, as a fact witness, you give direct observations, diagnosis, and treatment—what you perceived and did yourself. Essentially, you are reporting narrowly on the results of personal examination of the patient and drawing "conclusions," if any, which adhere closely to those firsthand observations (for example, the patient's diagnosis and prognosis). An ethical tension develops when a fact witness (for example, a treater) is asked to perform the expert witness's role, as reviewed in the next two sections.

Treater versus expert

In general, these two roles—treater and expert—are considered incompatible because the clinical, legal, and ethical mandates are markedly different for them. Because the subject is both important and often confused, I summarize the differences between these two roles in this section, followed by

a detailed analysis in the next section and in Appendix 1 to this book.

First, the expert does not traditionally have a physician-patient relationship with the subject of the expert's examination, who is usually called an examinee. Second, the treater's job is to place the patient's welfare first—to help and to heal—whereas the expert's job is, by testimony, to inform and to teach the judge or jury, regardless of whether the expert's testimony helps or harms the patient. The treater's "client" is the patient; the expert's client is the court. The very need of the treater to help the patient constitutes, from a forensic perspective, a form of bias through lack of the requisite objectivity and investment in the outcome.

Additionally, the expert witness is ethically obligated to warn the examinee that the material emerging from the expert's examination is not confidential and might be used in open court in ways that may or may not benefit the patient. In treatment you can usually promise confidentiality, barring emergent circumstances.

Interestingly, psychologists who are members of the American Psychological Association are ethically obliged to give the client an elaborate protocol of warnings in the first session about all of the possible forms of confidentiality breaches, as well as to tell the patient how to go about complaining regarding presumed ethical breaches. Although I have seen no case directly concerning this point, such a protocol would blur the distinction somewhat between clinical and forensic contexts, because, arguably, the psychologists have given a quasi-forensic warning at the outset.

THE PSYCHOTHERAPIST IN COURT: SOME COMMON PITFALLS

In psychiatric treatment, perhaps especially in the treatment of trauma victims, it is important for the therapist to believe the patient's story of the traumatic experience. The patient will not feel "joined" or understood without this belief. This technical recommendation to treaters extends, of course, far beyond trauma victims as a specific population. One might argue that all good psychotherapists attempt, through the process of empathy, to see the world through their patients' eyes. This deliberate credulousness (similar to the literary "willing suspension of disbelief") permits the empathic immersion in the patient's experience without which much of the therapist-patient rapport is unattainable and successful psychotherapy is compromised. Similarly, such belief often acts as a kind of advocacy for the patient's view, which may aid in mastery of the traumatic experience. In consultative experience, I find a number of common practical, conceptual, and ethical pitfalls occurring for treating therapists who end up in court, most often through failure to understand the distinction between fact witness and expert witness. The nature of these pitfalls and the means of avoiding them are the subject of this discussion.

Why does this issue about fact witness and expert witness even arise? Consultative experience reveals that two types of attorneys most commonly precipitate this conflict: 1) those who simply do not understand the nature of the conflict and the irreconcilable roles of treater versus expert and 2) those who wish to economize by not hiring a separate expert and by deliberately having the treater do "double duty" (this latter group often also fails to understand the nature of the problem). Thus, in practical terms the treater may be subjected to pressure from the patient's attorney (or, rarely, the patient) to change roles or may simply volunteer to serve an expert function out of ignorance or a wish to advocate on behalf of the patient.

SUBJECTIVE-OBJECTIVE SPECTRUM

An important aspect of the fact-expert dichotomy is that the fact witness's direct observations may be subjective, at least insofar as they are strained through the treater's senses. In contrast, the expert strives for objectivity, which may include paying attention to views opposing those of the patient or discorroborating the latter's claims—two behaviors that would be in ill accord with the treater's role as follows.

The intentional credulousness of the treating therapist is, as previously mentioned, vital. If a patient said, "My mother is a terrible woman," a competent therapist would never reply, "Oh, no, I've met her, and I think she's a fine lady!" The therapist would grasp that the issue in question is the patient's subjective perception, not the mother as she objectively is or the therapist's equally subjective alternative view.

But the same technically valuable credulousness becomes a potential limitation in the courtroom. Treaters are often in danger of failing to appreciate the degree to which their subjective immersion in the patient's experience constitutes an inescapable bias. Especially with trauma victims, therapists are in danger of confusing their therapeutic credulousness with actual knowledge of the external real event or trauma and testifying to that effect.

A specific example is the situation wherein a patient has an exaggerated and idiosyncratic reaction to what might be a minor trauma for the aver-

age person. If a patient claims that his or her life was forever changed by a billboard he or she observed or that a fall on the ice shattered forever his or her faith in a benign universe, the therapist accepts this (at least at first) as an emotionally valid description of an experience—an experience that does not necessarily mean that the patient is entitled to damages commensurate with those extreme feelings, even though the patient is entitled to the therapist's compassion. The expert, in contrast, must bring the issue into perspective with reason, fairness, and foreseeability.

ROLE CONFLICT OF INTEREST

A second pitfall on the subjective-objective axis is the failure to perceive what amounts to a conflict of interest between therapist and expert roles. The best way to grasp this issue is to recall the physician's primary admonition, *primum non nocere*—"in the first place, do no harm." The traditional interpretation of this principle is that the physician pledges to do only those things that will help the patient and, by implication, to refrain from all others that might be harmful. This admonition accords reasonably well most of the time with the role of fact witness.

Unfortunately, if pressed into the role of expert and honoring the new mandate of objectivity, the treating psychotherapist may well testify in ways that do not clearly help the patient or may indeed be harmful. Such an outcome necessarily occurs in a context in which the treater has not warned the patient of this potential outcome or of the use to which the material revealed in therapy may be put. This situation poses an ethical bar to the treater functioning as expert. All forensic examinations, by the way, require a warning at the outset of the interview to inform the examinee of whatever limits of confidentiality or other ethical issues may apply to that interview.

ECONOMIC BIAS

Another potential pitfall in the treater's serving as expert flows from monetary considerations. Civil litigation usually involves damages. Practically speaking, *damages* means an amount of money considered by the decision maker to represent adequate compensation to the plaintiff for the injury in question. In psychiatric malpractice cases, for example, the money is often earmarked for payment of the therapy that the patient needs to overcome the emotional injuries allegedly caused by the defendant in the case. Under those circumstances, the expert receives only a fee and thus has no financial interest in the outcome of the case; that is as it should be.

The treater, in contrast, *has* a direct financial incentive to be generous at best (or inflationary at worst) in defining the estimated damages, because that money will go directly to the treater to fund the treatment. Although it is theoretically quite possible for a treater to remain free of bias under those circumstances, the appearance of conflict of interest is damaging to the credibility of the plaintiff and hence to the strength of the case, if any.

DETERMINING THE STANDARD OF CARE

A central element in malpractice cases is the question of *negligence,* usually defined in terms such as a failure to render care at the level of the average reasonable practitioner. Whether care meets this standard is an expert question or conclusion; depending on jurisdiction, the standard may be determined by regional practice ("locality rule") or national practice as conveyed by national journals and meetings. Focus on the average maintains fundamental fairness; it would be inappropriate to hold all practitioners to the level of the best and fault them for falling below that. A conclusion that an expert might draw in a typical malpractice case is that the care delivered to the plaintiff in the case did or did not meet the standard of care. Most malpractice cases require that the expert demonstrate at some point how he or she has become aware of the standard of care, especially if the expert practices in a different setting. Access to the standard may come to the expert by wide teaching or consultation experience, organizational meetings, conferences, and seminars; peer review activities both for quality of care and for journal articles; and similar sources. This knowledge base validates the expert's opinion.

A pitfall for the treater concerning standard of care is an egocentric view: "The way I do it is the right way, and other ways are below the standard of care." This simplistic formulation misses the pluralistic nature of modern psychiatry.

HINDSIGHT BIAS

Hindsight bias is the principle that retrospective vision is 20/20 because the events have already occurred. When the psychotherapist is treating a patient whose previous treater was negligent, it is easy for the current treater to forget that he or she already knows the outcome (by hindsight) of the alleged negligence. However, knowing the outcome by hindsight does not necessarily mean that—in the "foresight view" of the previous treater—the outcome was foreseeable. The legal notion of fore-

seeability is essential to the finding of negligence: could the harm have been foreseen under ordinary circumstances?

A particularly common pitfall is the subsequent treater's beliefs that his or her present knowledge of the patient is superior to that of the previous treaters, even when the patient earlier had different symptoms or a different condition. Again, the hindsight bias reveals itself: "I know what the outcome is, so I know retrospectively what they should have seen." Such a view is unfair to the previous treaters and slights the real and palpable data—much of it subjective and flowing from being in the actual room and observing the patient before one's eyes—to which a contemporary treater has access.

As it is with diagnosis, so it is with treatment. A subsequent treater must weigh into his or her potential second-guessing of previous therapy the many uncertainties and ambiguities that may have been present then but are now dimmed in the glare of hindsight and knowledge of certain outcomes.

GOAL-DIRECTED TESTIMONY AND THE PULL OF POLITICAL ACTIVISM

The final pitfall represents a serious confusion of the political with the clinical and legal.

> A treating therapist, serving as a plaintiff's expert in a sexual misconduct case, stated (under oath in deposition, incidentally) that she diagnoses all alleged victims of sexual misconduct as suffering from posttraumatic stress disorder, whether or not they meet the criteria, in order to ensure compensation for these patients.

Although one might understand the spirit of such a position, one might also reflect on how such abuse of the diagnostic process may backfire, decreasing the credibility of this expert's testimony to the detriment of the patients.

CONCLUSION

Although the courtroom may be perceived as a hostile environment by many clinicians, treating psychotherapists are increasingly called on to enter those precincts and give testimony. This review is intended to highlight common pitfalls for treaters entering into this "foreign country." The major pitfalls addressed in this chapter include differences between fact and expert witnesses, conflicts of roles and interests, subjective and objective viewpoints, foresight and hindsight, and political contamination of the process. Armed with caveats derived from these discussions, the clinician may gain not only increased comfort but also increased effectiveness as a witness in court.

NOTES