Two Cases From the Forensic Files

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High school and college students email me daily wanting to know how they can become forensic psychiatrists (usually saying "psychologist" instead). They've been watching lots of (sometimes pretty non-credible) forensic science on television and they think that's what we do. They just know that's what they want to do with their lives.

CSI Psychiatry. It has a nice ring: Bill Macy as a terse but likable doctor who spends his time ferreting out the truth against impossible odds, then going to court with last-minute information to save the day. His staff is limited to people who look like they just came from a modeling gig (you choose the magazine). Every week a new story, a new mystery. And don't forget those cute little flashlights.

Not likely. But everyone enjoys case histories and they are often instructive. This month's column presents a couple, with the descriptions changed as appropriate for privacy and confidentiality.

Death Behind Bars

Mr. P. was a difficult patient who was also troublesome for the local community, part of an urban center. Like many people with chronic and severe mental illness, he often stopped his medication, became psychotic, and got in some sort of minor trouble with the law. On one of those occasions, he was arrested for misdemeanor assault and jailed pending trial.

A routine jail intake screening for mental problems found Mr. P.'s long history of schizophrenia and noted his treatment at a mental health center. The screener documented his most recent prescriptions, noting that his medications, an atypical antipsychotic drug and a mood stabilizer, had been in his pocket when he was arrested and "processed." They had been taken from him at intake and stored with his other possessions. No medication was prescribed to take their place. An appointment was scheduled with the jail's contracting primary care physician, and Mr. P. was placed in a single cell within view of a security station.

The medical consultation took place a week later, after Mr. P. had been acting bizarrely for several days. The family practitioner's documentation acknowledged notes by jail nursing and custody staff that described Mr. P. standing naked, speaking to people who weren't there, smearing feces, banging his head against his toilet in an attempt "to get a view of the afterlife," and "acting paranoid" during the past few days. His only medication had been p.r.n. dyphenhydramine, which is commonly used in jails in lieu of benzodiazepines or other controlled drugs for its calming and sedative effect. There is no indication that the doctor reviewed Mr. P.'s past records, ordered a psychiatric referral, or tried to contact his previous clinician. He prescribed a low dose of haloperidol and intramuscular haloperidol p.r.n.

The record reflects continuing psychosis, with obvious indications of self-injurious behavior. Mr. P. was not seen again by the physician, who usually visited the jail twice a week. He was monitored to some extent by direct care staff. The haloperidol was offered several times but usually refused; calls to the jail physician resulted in orders to continue to offer the oral medication, but no further visits. About 6 days after being seen by the doctor, Mr. P. loudly demanded his "shot" (the haloperidol). At least 30 minutes later, when custody staff came to escort him to the nursing station to receive it, they found him lying on his cell floor, unresponsive to commands. He was pronounced dead the same day. An autopsy indicated that the cause of death was intracranial bleeding, apparently from repeatedly hitting his head on the toilet and cell wall.

A lawsuit was filed against the jail and county and against the physicians' group that supplied

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contract medical services. The allegations against the jail were that they had not provided sufficient observation nor sought necessary professional help for their inmate. Allegations against the county were the same as those against the jail and also included insufficient funding and provision of mental health services for the jail. The medical group was accused of not providing the services and coverage for which they had contracted, and the doctor was accused of practicing below the standard of care.

The physicians' group and the individual physician settled their cases out of court. The case against the jail and county proceeded on the general theories that they had been negligent in not contracting for adequate medical and psychiatric services and not providing an adequate budget for mental health services, which allegedly resulted in care below the standard for correctional facilities, which in turn caused Mr. P.'s death.

Let's take a look at the standard of care, that level of diagnosis and treatment required of clinicians and clinical facilities. What is the standard of psychiatric care in jails? Can an inmate expect the same level of care in jail as in a hospital? Can a primary care physician be held to a psychiatric standard when treating a psychiatric patient?

The location of care is often less important than the fact that care was promised, in the sense that 1) the jail had care and custody of its inmate, who had no ability to get care for himself; 2) the jail maintained a medical system (including primary care physicians and consulting psychiatrists and other specialists) designed to provide for inmates' needs and represented that the system was adequate for their care and safety; and 3) the jail's clinical agent, a contract physician, formed a doctor-patient relationship with the inmate. The last item is important in that it created a duty of care to which the doctor was required to adhere. Ordinarily, a doctor-patient relationship is established by accepting a patient for care (which the jail doctor did when he agreed to diagnose, treat, and/or follow the inmate). A doctor-patient relationship, or at least a strong duty of care, can also be created by simply accepting a particular responsibility, such as to carry out the clinical requirements of a jail contract which requires that one provide adequate coverage.

Once the direct patient care has been critiqued, and assuming the inmate's death was caused by inadequate care, can some of the responsibility for not meeting the relevant standard be placed at the feet of nonclinical parts of the organization, such as the jail or county administration? That is, can an agency be held liable for a doctor's and staff's mistakes?

The short answer is yes, it can. One avenue to liability (remember, I'm not a lawyer) is something called *respondeat superior*, a very old legal doctrine that says the boss—the "master" in the old days—is responsible for the acts of his servants (masters were usually "he" in those old days). In general, people who are injured by a negligent employee of a company or agency need not seek redress solely from the employee (who usually doesn't have much money)—the company takes the hit so long as the negligence occurred as part of the scope of the person's employment.

Doctors and other independent practitioners are a bit of a special case. Since we are expected to exercise appropriate clinical judgment regardless of employer rules, employer liability is sometimes modified (and sometimes diluted) by our personal "discretionary" duty.

But what about doctors who are contractors, not employees (sometimes referred to as "independent contractors")? Companies and agencies that contract with doctors rather than employing them often do so, at least in part, to shield themselves from liability. Such contracts usually specify that the doctor (or other contractor) represents himself as qualified, promises to meet the requirements of the job (in this case, jail psychiatric coverage and inmate care), and agrees that his work is his responsibility rather than that of the contractee (agency or company). The agency hopes the "independent contract" will separate the doctor from it in case of a malpractice accusation.

The jail or county administration might be held responsible for the doctor's negligence in direct care if it can be shown that they contracted negligently with him, or failed to provide things necessary (or agreed to) for adequate patient care. If, for example, they credentialed him in spite of known problems, misled him about the patient load, or didn't keep promises to provide and fund an acceptable support staff or patient care environment, then a doctor who performed reasonably under adverse conditions may be able to defend himself against accusations of malpractice (or at least dilute his liability).

Finally, what about the argument that the jail physician was not a psychiatrist, and thus should not be held to the standards of a specialty in which he was never trained? After all, he never suggested to anyone that he was a psychiatrist. (Let's set aside for the moment the question of whether a family physician without access to psychiatric consultation should have treated Mr. P. in the same way.)

My view, and that which has been held by several courts, is that once a nonpsychiatric physician recognizes a significant psychiatric problem (or should have recognized it), he or she has two choices: 1) seek psychiatric consultation or referral, or 2) diagnose and treat the psychiatric condition. If the primary care physician chooses the latter, the patient has a right to assume the doctor knows what he or she is doing, and that the care will meet the applicable psychiatric standard. The decision to offer such specialty care is the doctor's and must be made in the patient's interest; the patient is often not in a position to evaluate whether or not a separate specialist is needed.

Those who see this as an unfair burden on primary care doctors (who, after all, treat lots of psychiatric symptoms and disorders) might think of it in the following way, and perhaps examine their own practices accordingly. Psychiatry is a specialty that requires years of post-MD/DO training. Assessment and treatment—especially of severe and/or subtle psychiatric disorders—very often require such additional training and experience. Seen the other way, if a psychiatrist chooses to diagnose or treat a mental patient's infection, thyroid condition, or chest pain, for example, the psychiatrist is (usually, though perhaps not always) representing to the patient that he or she can do so competently and that referral to another clinician is unnecessary. The patient is entitled to rely on the psychiatrist for that assurance, since the patient has no duty to be his own doctor. If the psychiatrist then misses something important and the patient is damaged as a result, the psychiatrist may well be liable for the damage.

A Depressing Lawsuit Appeal

Ms. J. was a very successful investment advisor and salesperson. She was well established in her professional community and trusted by her clients, many of whom had invested millions of dollars through her. Some of Ms. J.'s clients lost large sums of money when a particular investment offered by her employer, a large national firm, proved unprofitable. Ms. J. alleged that she lost both business and friends because her firm encouraged her to tout a stock that they knew was a poor investment (a stock that was allegedly profitable for them but not for the clients). She sued the firm for damages, won at the trial level, and was awarded several million dollars. She did not collect any money at that time, however, because payment was delayed pending the investment firm's appeal for a new trial. The firm's appeal was successful and a new trial was scheduled.

At that point, Ms. J. alleged that the appeal itself had added to her damages, and that the firm's appeal represented bad faith, delayed her payments, ruined her family financially, and caused great emotional damage. She sought treatment for depression allegedly related to those losses and the lengthy appeal process, said that she had become mentally disabled and unable to work, and asked her treating psychiatrist to be an expert witness on her behalf. The company asserted that it was merely exercising its options under the law, that she was able to work, and that evaluation by their forensic psychiatrist indicated that although depression appeared to be present, it was not severe enough to be disabling.

Ms. J.'s medical records and her psychiatrist's deposition showed that her psychiatric treatment bills were unpaid, and implied that the psychiatrist, a family friend, expected to be paid only if and when Ms. J. won her suit and collected her judgment. The psychiatrist's deposition also revealed that he had "loaned" Ms. J. several thousand dollars. He described the money as a loan that he didn't expect to be repaid. Further research, however, revealed that the loan had been arranged through a mechanism called judgment "factoring." The psychiatrist had given Ms. J. about $10,000, which was to be repaid several-fold if the case were won but not repaid at all if it were lost.*

Ms. J.'s attorneys retained a forensic psychiatrist in addition to the clinician who had been treating her. The forensic psychiatrist saw her briefly, appears to have accepted her version of the situation at face value, reported that she was completely mentally disabled, and testified at trial that the investment firm had caused the disability. After that testimony, however, the company's lawyers presented records and other convincing evidence that, in contrast to her claims, Ms. J. had earned considerable money during the course of the litigation and, further, had successfully hidden it from her attorneys and from her side's forensic psychiatrist (who had just testified to her company-caused disability and poverty). The jury deliberated for a short time and found for the investment firm.

*In *factoring*, a plaintiff offers measured parts of a potential judgment to buyers at a substantial discount, a sort of speculative investment or "bet" on the outcome of the case. The practice is legal when properly done, but participation by an expert witness is unethical.

This case was not primarily about the clinical standard of care, but rather emotional damages, boundary issues for a treating psychiatrist, and the quality of a forensic evaluation. In retrospect, it seems clear that Ms. J. exaggerated (at best) her claim of emotional damages, and both her treating psychiatrist and her side's forensic evaluator were rather gullible in accepting her complaints at face value. The treating psychiatrist, a kind person who felt he was helping a patient and friend, was vulnerable to being manipulated by someone whose presentation was complicated by litigation, and crossed a substantial clinical boundary when he lent or gave the patient money.

That boundary was crossed in two ways: by allowing the patient to defer payment for services until after the trial with the tacit understanding that the debt would be forgiven if she lost, and by purchasing a portion of the potential lawsuit award. The former might not be a significant issue were it not for the fact that the treating psychiatrist also agreed to testify on her behalf (although such an arrangement could affect the patient's care and treatment response in any event). The latter—participation in "factoring"—is likely to cause problems in treatment, made worse by the doctor's anticipation of being an expert.

The treating psychiatrist's offer to testify on the patient's behalf in spite of various conflicts of interest raised several ethical and legal issues (not the least of which was the contingency arrangement in which only if the patient won would he would be compensated for his expert and clinical services and have his $10,000 repaid with enormous interest). These were pointed out by the firm's psychiatric expert during his own deposition. Perhaps as a result, the treating psychiatrist was never called to testify. The various problems associated with having treating clinicians offer expert testimony have been discussed in a previous column and elsewhere.[1–4]

It is difficult to reconstruct the work of the forensic psychiatrist who worked with Ms. J.'s lawyers; however, she may have performed an incomplete evaluation. In any event, her very strong testimony that Ms. J. was completely disabled and impoverished by her job loss and the ensuing lawsuit appeal was not consistent, in the court's view and that of the firm's psychiatrist, with most of the facts of the case. Had she (the forensic psychiatrist) done a more thorough evaluation and/or been more conservative in her testimony, she might not have appeared unprepared upon learning the truth about Ms. J.'s abilities and finances.

The Last Word

Be aware that a physician's duties of care in non-hospital institutions, such as jails and prisons, are very similar to those in hospitals, even when conditions are poor. When working with patients who are (or may become) involved in litigation, be extra cautious about diagnoses and whether or not you choose to work with the patient's attorney. Litigation adds new motivations to the patient's complaints, and often new impediments to recovery.

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