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The Role of the Defense Psychiatrist in Workmen's Compensation Cases

REFERENCE: Parlour, R. R. and Jones, L. R., **"The Role of the Defense Psychiatrist in Workmen's Compensation Cases,"** *Journal of Forensic Sciences,* JFSCA, Vol. 26, No. 3, July 1981, pp. 535-542.

ABSTRACT: Tomorrow's psychiatrist should be more cognizant, competent, and comfortable in forensic science matters. Psychiatric cases are increasingly the subjects of litigation, but justice in the courts depends on able advocacy by all parties. Advocacy for patient-plaintiffs is more similar to customary clinical roles than is advocacy for defendant insurance companies, which nevertheless are as needful of competent psychiatric experts as patient-plaintiffs if justice is to be done. Ironically, defense psychiatrists can do much to help patient-plaintiffs if they understand their roles correctly. Since legal systems are designed to produce justice, not therapy, the forensic competence of future psychiatrists will help to make litigation more therapeutic *and* just for patients. This paper describes the peculiarities of psychiatric work in litigated workmen's compensation cases, focusing on the role of the defense psychiatrist. We will highlight the constructive and therapeutically gratifying potentials of this work. Greater familiarity with the process will help to enlist the interest and participation of psychiatrists in workmen's compensation cases for the ultimate benefit of the patients and improvement of the legal system.

KEYWORDS: psychiatry, workmen's compensation, jurisprudence

Participating psychiatrists must face certain special features of litigation involving workmen's compensation cases. The following items summarize those features:

1. Patients lose legal advantages by getting well.
2. Patients are treated by physicians chosen by the defense and heavily obligated to minimize the defendant's liability; the role of the psychiatrist engaged by the patient's lawyer is usually limited to the task of describing the psychiatric disabilities incurred on the job and does not include treatment.
3. Although the burden of proof is technically on the complaining patient, it actually falls on the defense in psychiatric cases because psychiatric injury is readily claimed while the absence of psychiatric injury is difficult to prove.
4. The allegation of psychiatric injury may be a trump card in the legal tactics; if the defendant will not admit that the patient is physically disabled, then the patient must have a mental disability to explain his complaints.
5. Patients with strong tendencies to restore themselves mentally will be in conflict with

Received for publication 17 Oct. 1980; revised manuscript received 15 Nov. 1980; accepted for publication 21 Nov. 1980.

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their attorneys who know that the fruit of good "lawyering" is a substantial court order, not healthy clients; these patients will sometimes sabotage their lawyers by refusing to be examined by a psychiatrist or by letting it be known that they just want a small settlement to pay off debts or start a business.

6. There are times when a trial of treatment is important for diagnosis, but in the law treatment is an admission of liability and must not begin without special understanding with the court.

7. Lawyers (who habitually discover truth by calling many witnesses) may resist when the psychiatrist wants to see the patient's "significant others" and may even move to prevent such interviews.

8. The job where the patient was disabled may be the most therapeutic activity in his life; delayed return to work for medical or legal reasons usually compounds the psychiatric injury.

9. Physicians are trained to maintain a neutral status as expert witnesses but the adversary system does not function fairly if each side cannot present the facts in the manner most favorable to its respective clients.

The Confused Concept of the "Impartial" Expert

Each side in a lawsuit is entitled to an optimal presentation in court, and yet it has been traditional to teach that medical expert witnesses should hold a neutral attitude in legal proceedings. Exactly what this means is variably explained: a cold, aloof attitude; lack of emotional display; avoiding being seen with representatives of one side or the other; staying out of the courtroom except when actually on the witness stand; trying to accommodate both sides of the dispute by presenting opinions that appear to be impartial but are really compromised constructions; and never looking for evidence outside one's clinical routines.

Our legal system supposes that the truth best emerges in the adversary procedure established by law. It further presumes that each party to a controversy can and will present his position reasonably and effectively. Implicit is the principle that each side is entitled to the most favorable, believable construction and representation of the facts. Regardless of one's personal philosophy about plaintiffs, defendants, government, the insurance industry, the medical or legal profession, or any issue at stake in society, the litigants do not get their fair day in court if their cases are not optimally presented.

The traditional concept that experts are impartial suggests that when a physician is asked to evaluate a litigated case, he should decide what the outcome should be irrespective of which of the parties has engaged him. A lawyer would presumably have to obtain many such evaluations until he could find an expert whose opinion happens to be advantageous for the client. The cost of obtaining these many opinions would allow justice only for very wealthy clients. Such a construction of "impartial" is clearly impractical and unfair.

What judges and lawyers really want from expert witnesses is "quality advocacy." This also is what persuades juries. Quality advocacy is not really mysterious or difficult, but it is somewhat different from the usual medical report.

The skilled forensic psychiatrist should be capable of giving effective testimony on any side of the issue, plaintiff's, defendant's, or amicus curiae. His opinions should usually differ to some extent depending on who has engaged him. The quintessential standard of quality for the expert witness is that his opinions be scientifically and professionally plausible, reasonable, and sound; other equally sound opinions could be drawn from the same data by other experts. Three other standards of quality are these:

1. Thoroughness and accuracy in compiling the data of the case is greatly appreciated, even if the final conclusions of the report may be controversial.

2. Data must be carefully delineated from conclusions in the report; it is very important to list after each opinion the data supporting that opinion, because it may not be obvious to

the nonmedical person why certain conclusions are reasonable based on the clinical case report.

3. Opinions and conclusions should be directed toward the *legal* issues in the case; in other words, the report should be framed to help the court make the decisions it must make rather than dwelling on issues that are basically of medical interest.

Thus when asked to evaluate cases for litigation the physician should be advised first of the legal questions to be answered by his investigation [*1*]. He can then collect the data and consider how that data may be construed most favorably for the party who has engaged him. Such constructions must meet the basic standard of scientific and professional integrity beyond which there can be honest and respectful disagreement among experts. It is the expert's job not to decide the case as judges and juries do but rather to assure his client's receiving the most favorable presentation of his case that professional ethics allow. This meaning of "impartial" (ethical) is a positive contribution to justice in the final outcome for which there is no alternative [*2,3*].

Other Facets of the Defense Psychiatrist's Role

The most obvious task of the psychiatric expert is to provide professional opinions about cases. But basic to that duty is the collecting of data on which the opinions will be based. Occasionally expert witnesses are asked to give opinions about data that have been collected by others and to some extent this will occur to the defense psychiatrist in workmen's compensation cases. Usually a heavy burden of data-collection and investigation falls on the defense psychiatrist because:

1. The role of plaintiff's psychiatrist is typically limited.
2. The other medical experts have little to say about plaintiffs' psychosocial status.
3. Nonmedical investigators seek and find very limited types of information according to the instructions of their employers.

Thus if the defense psychiatrist does not obtain the data himself or order others to obtain it (insurance adjusters are happy to oblige if told what to look for), the true status of the case will be obscured and the possibility of a just outcome will be reduced.

Ironically, the defense psychiatrist can be helpful to the system by providing information about what the patient *really wants*. This task would be best undertaken by the patient's lawyer, but there are several practical reasons why this may not happen. Lawyers are not always skillful in understanding their clients, and clients are seldom skillful in "talking the lawyer's language." The lawyer may assume the client simply wants as much as he can get.

The expert witness is freer than other participants to introduce certain information into the system. He almost has carte blanche in presenting data about the patient in explanation of his opinions. One type of information that would be otherwise inadmissable concerns the patient's particular financial needs, desires, and hopes. Frequently the patient wants a few thousand dollars to start a business, to get some schooling, to pay off a nagging bill, or to take a trip; he will be perfectly satisfied with such a settlement and a grateful insurance company will be ready to cut its losses if it knows what the patient wants short of a major sum. Thus the defense psychiatrist can smooth the path to settlement even when he cannot win a total release for the insurance company.

It may be objected that some settlements are based on the poor judgment of the patient who is mentally ill. What is the defense psychiatrist's ethical responsibility to the patient-plaintiff? The defense psychiatrist has a duty to the insurance company that hires him to provide it the best defense possible within ethical and scientific standards. He also has a duty as a physician not to harm and to be constructive if possible. In spite of the cautious nature of insurance adjusters, they usually cooperate when informed that the patient is really mentally ill and in need of treatment.

The defense psychiatrist may aid the processing of workmen's compensation cases by doing what is therapeutic for the patient, remembering the adversary role to which his report may be assigned in the courtroom. The patient and his significant others need instructions about how to help themselves. They typically suffer from loss of self-esteem when they cannot function in ways that formerly brought satisfaction. They have not found alternative activities appropriate to their remaining personality assets. The alert physician will identify his patient's strengths as carefully as his psychopathology and will use this information for diagnosis, therapy, and prognosis. It is important to consider that symptoms may reflect an unrelated psychiatric disorder, such as a major depression, not a sequela of personal injury.

Thus the defense psychiatrist serves as investigator, reporter, facilitator of communication within the artifices of the legal system, skilled diagnostician, and practical therapist. Since the role of the plaintiff's psychiatrist may be limited in the legal process, this participation of the defense psychiatrist is doubly important.

Management of the Initial Interview

Seldom in ordinary psychiatric practice is the initial interview so fraught with tension, suspicion, and hostility as the first meeting of the plaintiff-patient and the defense psychiatrist. The patient's attorney has usually advised his client to regard the defense psychiatrist as a clever inquisitor who is trying to gather proof that the patient is malingering and who is trying to avoid giving the treatment the patient needs and deserves. Because of the nature of the system, this orientation is largely correct. The patients are often embittered toward the insurance carrier and its agents who have typically deceived or otherwise thoroughly disappointed and disillusioned them by the time psychiatric referral is made. Surprisingly, such a setting does not preclude therapeutic results; in fact, skillfully handled, there are some distinct advantages to this situation.

The initial interview should be long enough to get well into the patient's psychosocial history, to discover additional sources of documentation to be pursued, to identify the patient's significant others and to begin involving them in the case, to identify the basic diagnostic questions in the case so that required tests and consultations can be obtained by the time the written report is required, and to define an initial therapeutic plan that will help to clarify the diagnostic issues and give the patient and his significant others specific duties by mutual consent, a treatment contract.

Such an interview should have a marked impact on the patient. He should now see that something is being done about his case. He has contacted a person who is willing to make and keep promises to perform and to give straight answers, a person who responds to telephone messages (unlike many plaintiffs' attorneys and most insurance adjusters). This impact encourages realistic openness by the patient to help achieve the best possible understanding of the case, overcoming much of the initial negativism.

A significant factor in successful first interviews is the patient's surprised gratification, which may put him off guard to some extent and allow more truth to emerge than perhaps his lawyer would like. If there is a second interview, the patient is likely to return with renewed cynicism and silence induced by his legal advisor. Frequently, second appointments are simply not kept on advice of the lawyer whose objective is the maximum possible award.

The goal of achieving a large settlement is commonly not only wrong, based on the facts, but also often detrimental to the patient's health because it promotes more or less permanent disability. Unfortunately, the system does not reward lawyers for promoting their clients' health.

Despite these unfavorable factors in the litigation process, effective psychiatric diagnosis and treatment can be done. The defense psychiatrist must be thorough, because his main hope of obtaining a good result is his superior fund of information about the patient. The patient's attorney and psychiatrist tend to be brief and perfunctory in their work because they

frequently cannot be sure of full compensation for their efforts. The defense psychiatrist is hired by a responsible insurance company, which pays its consultants promptly, win or lose. Whereas the plaintiff's psychiatrist may spend 30 to 60 min in the initial interview, the defense psychiatrist should spend 2 to 4 h for the first interview and arrange additional interviews if necessary for thorough diagnostic study.

Structuring the Referral

Referrals need to be structured very carefully to minimize misunderstanding by patients who are often inclined to use any excuse to avoid the interview. Fortunately the insurance carriers usually pay the psychiatrist for missed appointments, but the psychiatrist should not contribute to this problem. The time and place of the appointment should be clearly stated. Directions to the appointment place and the doctor's telephone number are helpful. Patients should be instructed to bring all medicine bottles they have been using; this procedure helps the psychiatrist get accurate information about the patients' prescriptions and about the names of the doctors in the case, data the patients often forget to give otherwise. The family doctor's records, school records, employees' personnel files, criminal records, and military records are commonly overlooked sources. Frequently, the investigation of obscure or indirect sources of information results in a major break in the case, that is, the finding of substantial data supporting a legal defense theory of the case.

Patients and their attorneys are frequently surprised that the significant others of the patient are expected to participate in the psychiatric interviews. These sources provide important information about the causes of the patient's trouble—by what they say, by what they do not say, and by what they are willing to do as members of the treatment team. Their failure to attend psychiatric appointments is also informative.

Occasionally, patients will bring the whole family, including little children who may disrupt the proceedings. It is very worthwhile to observe these interactions firsthand for a while. When the value of these observations no longer exceeds the trouble, the spouse and children can be excused while the remainder of the examination is completed. At the end of the interview, the spouse and children might be recalled to double-check certain points.

It is very important to have the insurance carrier's complete file available for review prior to the first interview. If the file has not arrived in time for study, the first interview should be postponed. All sources of information should be carefully documented in one's notes so they can be readily found on the witness stand and accurately reflected in the final report.

Language problems are occasionally a factor. In all such cases the insurance carrier will arrange for an interpreter, especially if the examiner insists. Even if the examiner considers himself proficient in a foreign language, it is often desirable to retain the interpreter. His presence usually does not inhibit patients' self-expression. On the contrary, it usually helps patients feel more comfortable in the psychiatrist's office.

Diagnostic Treatment Trials

Insurance companies do not complain about paying for long psychiatric workups, especially if the resulting report is rich in data about the patient. Usually the defense psychiatrist is authorized to spend as much time as necessary and to order any necessary tests for diagnostic purposes. He is not always authorized to refer to other specialists or to initiate treatment until he justifies this to the insurance agent after seeing the patient. Sometimes the insurance company is uneasy about assuming liability by authorizing a trial of treatment. Yet such treatment trials are truly necessary as diagnostic procedures in many cases, and most judges are sophisticated enough to understand this. If the defense psychiatrist's report clearly states that these treatment measures were necessary for diagnosis, there is usually no problem about erroneous assumption of liability.

Prescribing antipsychotic or antidepressant medications is a familiar diagnostic approach. Various trial treatment techniques will prove valuable in many cases. The patient's sincerity, his motivation to better his own condition, is an important consideration from both psychiatric and legal viewpoints. Patients can be given various "homework assignments" based on their needs and their goals [*4*]. Examples include physical exercises, academic pursuits, attendance at social or Alcoholics Anonymous meetings, writing, and following time budgets (advance planning of daily activities) [*4*]. Treatment contracts that encourage constructive activity will reduce inappropriate dependency and raise self-esteem [*4*]. Significant others need practical advice as much as the patient does to develop new patterns that ameliorate rather than aggravate disability.

Follow-Up and Formulation

After the initial interviews, the defense psychiatrist will follow up on the data sources revealed thus far. He will get the insurance company to do the perfunctory obtaining of records. He may recommend that certain kinds of surveillance be done by hired investigators. Contacting those who know the patient will usually best be done by the psychiatrist himself because others are not so well trained at obtaining the necessary information. If the spouse was not brought to the interview, a special effort should be made to contact him or her. Anyone who knows the patient's behavior patterns might be contacted. Discovering the true state of affairs ultimately serves the best interest of all concerned.

The defense psychiatrist will want to discuss the case with other physicians, especially the family doctor, who typically has not been consulted about the injury being litigated. On the contrary, patients are early directed to medical consultants chosen by the lawyers on either side, so the family doctor is often left out. Even so, the family doctor may have important observations to make about the litigated injury because he has been consulted simultaneously about other problems and because of his knowledge of the patient's history before the injury; more important may be his insightful observations about the patient's family and other psychosocial circumstances. The family doctor's records give a valuable longitudinal picture of the patient's past. Besides professionals, the defense psychiatrist should consult friends, family members, lodge or union brothers, people at work, anyone for whom the patient has provided a name and phone number or address when referrals are requested early in the initial interview.

In most of his cases, the defense psychiatrist will have more than one contact with the patient to observe the effects of medication and treatment regimes and to evaluate the sincerity of the patient and his significant others. Treatment plans and other prescriptions should be freely modified as indicated by the progress of the case. Sometimes patients will decide not to make another appointment but are willing to be checked by telephone. Sometimes one might even phone a patient who said not to call; usually even such unsolicited calls are appreciated by patients. At any rate these follow-up data often prove very important in the final formulation of the case.

Formal Treatment

Sometimes the case is first referred to the defense psychiatrist at the point where the defendant insurance company has been ordered to provide treatment. In such cases it will not be necessary to discuss with the defendant the need for several interviews of the patient although defendant will often ask for a preliminary unwritten diagnostic opinion after the first or second interview. In these "true" treatment cases, patients come expecting treatment (not just diagnosis); they should not be disappointed by the defense psychiatrist. This is not to say that he should do whatever the patient demands, but rather that he produce a working diagnosis and ample treatment proposals for the patient and his significant others. He should also allow time to work through some of the objections that will be made by those who come not expecting to do anything, expecting rather to be taken care of in the passive model.

In all of his commitments to the patient, the defense psychiatrist should perform meticulously. The paradoxical bond of trust between the patient and the defense psychiatrist is an invaluable ingredient in resolving the case on a reasonably equitable basis. If a particular promise cannot be kept, the patient should be notified of that fact promptly and an alternative plan should be negotiated. These reports to the patient by the psychiatrist provide additional opportunities to gain understanding of the case.

If the patient refuses reasonable prescriptions for medicine or action, or fails to carry out commitments without a valid explanation, empirical evidence is provided for opinions about future treatability, about the patient's sincere motivation, about all aspects of the case. The usual forensic science diagnostic report lacks such data about responses to treatment, yet there seems no good reason for these omissions. The defense psychiatrist has a significant role to play in seeing that the reasonable benefits of the system are provided to deserving patients. Offering more healthful mental sets and lifestyles in an otherwise bleak and bitter contest helps patients eventually achieve even higher levels of functioning; exposing the fraudulent abuse of the system by the malicious and misled also helps to prevent chronic disability.

Formulating the Report

Credibility in forensic psychiatry depends, among other things noted above, on dependability with regard to timely reports. Courts and lawyers are not unreasonable in this regard; if there is a valid reason for delay, a written statement to this effect and a proposed completion date will almost always suffice. In those uncommon cases where a report is needed before the psychiatric study can be completed, one should submit a preliminary report that clearly states the most likely conclusion based on present evidence and the likelihood of forthcoming evidence changing these conclusions. The legal process is fully capable of comprehending such a report and the tentative spirit of its submission. Extensions of deadlines will normally be granted if requested in a timely manner.

Occasionally one sees forensic science reports written in the anamnestic style, apparently unorganized by the examiner. The value of this style will be wasted on lawyers, judges, and juries unless it is accompanied by an extensive explanation. Such reports make their authors appear lacking in the logical organization of data and conclusions valued in the legal system. One may use anamnestic interviewing techniques at various times when it is likely to be productive, while taking a more directive role in the interview at other times, but anamnestic reports should not be written unless they are specifically required.

Various formats of forensic science reports are recommended in the literature. Some of these styles appear unduly redundant and pretentious. The courts have always said they want good psychiatric work, not specialized reports. The following order of reporting is recommended:

(1) patient's name and case number;
(2) the origin of the report and the legal issues to be addressed;
(3) sources of documentation upon which the report is based;
(4) persons interviewed and the dates;
(5) patient's age, sex, race, occupation, and marital status;
(6) a description of the precipitating events;
(7) a full description of the complaints, history of the present illness, and review of systems and life history;
(8) mental examination;
(9) diagnoses and the manifestations of these diagnoses, including precipitating and predisposing causes, severity, and prognosis with and without appropriate treatment; and
(10) opinions on the specific legal questions at issue, including the reasoning and relevant data for each opinion.

A Plea for Reform of the System

Case after case comes to the defense psychiatrist too late. Reversible symptoms and conditions have gone untreated too long. Patients who thought the legal system would provide medical care, like private medical care, have become thoroughly disillusioned and highly bitter toward the insurance carrier and its doctors who give one examination after another but little or no treatment. Insurance agents have been hard to reach by phone, undependable in keeping commitments to patients, frequently slow, and inefficient in processing claims.

Usually the psychiatric referral is made after nonpsychiatric management of the case has gone sour. By this time psychopathologic mechanisms have become well established and are compounded with hostility engendered by the awkwardness of the system. The patients' attorneys, either because of ignorance about how to be helpful or simply because of their zealous playing of the adversary role, tend to aggravate the situation.

Probably half of the disability finally adjudicated is psychiatric although often not so diagnosed. Easily half of the psychiatric disability ultimately seen by the defense psychiatrist is the product of the legal system. Usually the psychiatrist can make a substantial impact on these cases, but more bitterness and suffering could be avoided and better final results obtained if intervention by the defense psychiatrist occurred early in the proceedings. This assertion is based partially on a more favorable experience with a small percentage of cases referred early because the insurance company recognized the needs. In these cases where the insurance company provided prompt, dependable, and ample services because it identified with the distress of the patient (the reasons for such occasional empathy remain obscure but fascinating), the suffering and worry of patients and their families were minimized, physical conditions were promptly ameliorated, unnecessary mental illness was avoided, and the entire process had a refreshing, cooperative, and wholesome flavor. Contrast this with the usual situation where the insurance company drags out the process, hoping that patients will weary of the struggle and settle at a low figure. In such cases months of diagnostic procedures can go by before treatment is begun, and psychiatry is sought only after nonpsychiatric management is failing.

The niggardly defense philosophy that gives service to patients only when compelled by the court is not inherent or necessary under the existing legal structure. In fact, this philosophy is forcing legislative revisions that wipe out certain traditional privileges of the defense. For example, in California, patients have recently been granted greater access to doctors of *their own* choosing to obtain treatment [5]. Based on limited present experience it is predicted that an aggressive therapeutic philosophy including early psychiatric assessment by insurance carriers would cost no more in the long run; at the same time it would greatly reduce morbidity, and prevent medical and legal complications, and enhance the achievement of justice.

References

[1] Parlour, R. and Jones, L. R., "Theories of Psychiatric Defense in Workmen's Compensation Cases," *Bulletin of the American Academy of Psychiatry and the Law*, Vol. 8, Sept. 1980, p. 3.
[2] Diamond, B. L., "The Fallacy of the Impartial Expert," *Archives of Criminal Psychodynamics*, Vol. 3, Spring 1959, pp. 221-236.
[3] Diamond, B. L. and Louisell, D., "The Psychiatrist as an Expert Witness: Some Rumination and Speculations," *Michigan Law Review*, Vol. 63, June 1965, pp. 1335-1354.
[4] Parlour, R., "Some Behavioral Techniques in Community Psychiatry," *American Journal of Psychotherapy*, Vol. 29, No. 1, Jan. 1975, pp. 79-91.
[5] California Labor Code, § 4600 (1977).

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