

When Clinicians Must Testify in Court

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This month, I'd like to talk about issues that arise when clinicians testify in cases that affect their patients. I won't be discussing legal arguments or judicial decisions. Instead, I will focus on how clinicians can provide accurate and articulate testimony in order to help a judge or jury reach a fair resolution.

Case Example

A few months ago, I had occasion to observe several state hospital mental health professionals as they testified on behalf of their patient in a hearing concerning an overnight pass with his family.

The patient suffered from schizophrenia, had killed his mother while acutely psychotic some 4 years previously, and had been found not guilty by reason of insanity. His pre-incident psychiatric history indicated only three floridly psychotic episodes over approximately 20 years, with most of the time spent in excellent remission with medication. He had had a good work record and no serious social problems for years prior to killing his mother during a rare period of medication noncompliance. After her death, he was psychotic for several weeks in jail, but he responded well to treatment when transferred to a forensic hospital. He tolerated his trial without becoming psychotic and had shown no signs of psychosis in over 3 years of post-trial hospitalization.

The pass had been planned and discussed for weeks. The psychiatrist's pass order was strongly supported by regular staff observations, individual assessments, team meetings with the patient and his family, consultations with senior staff and facility administration, successful off-grounds activities with other patients and staff, and several day-passes with his wife.

The killing had understandably been very big news in the patient's hometown. The investigation and trial were heavily covered by news media, and residents had been shocked and frightened by the stereotype of a "crazy man" who would "kill his own mother." When word of the impending pass found its way back to the patient's hometown, the local prosecutor filed a legal motion to stop it.

The hospital decided to contest the motion, believing that although treatment was court-ordered, the issue was primarily a clinical one. A court hearing was convened in which the treating clinicians would describe their findings, safety considerations, and actions they had taken to achieve a reasonable balance between community safety and their efforts to treat and rehabilitate the patient. The local prosecutor would try to convince the judge that the patient should not be allowed passes. Many members of the treatment team were subpoenaed.

The treating psychiatrist, a competent and kind physician who had done excellent assessments and carefully considered all ramifications of the overnight pass, was the first to testify. After a few easy questions by the patient's lawyer ("direct examination"), it was the prosecutor's turn ("cross examination"). The prosecutor was very adversarial, asking questions rapidly and aggressively, interrupting the doctor, and using every opportunity to convince the judge that this was a violent, dangerous patient who could "snap" at any moment. The psychiatrist, for whom English was a second language, was taken aback by the prosecutor's aggressive, rapid-fire style and, unfortunately, her testimony collapsed. Try as she might, she was simply unable to respond clearly. She became confused on the witness stand and misstated some important information. Afterward, she felt terrible about her courtroom performance and its potential effect on the patient's future care.

The patient's primary counselor testified next. He had definite opinions about what was in his patient's best interest and what constituted the "least restrictive treatment alternative." During cross-examination, he appeared unruffled by the prosecutor's assertive manner and took the opportunity to lecture the prosecutor and

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judge about the philosophy of rehabilitation and the need for graduated privileges to prepare the patient for eventual return to the community. The prosecutor let him talk at length.

The next witness was a psychologist who had provided testing and independent evaluation of the patient. He described at length the various testing instruments used, their validity and reliability, and their application to the patient. When the prosecutor questioned whether the “paper and pencil tests would protect innocent citizens against the sudden rage of a man who has already killed his own mother in cold blood,” the erudite psychologist jumped at the bait. He skewered the prosecutor—he thought—with facts about treatment response and statistical probabilities of recidivism. Then the prosecutor quietly asked two questions: “His mother, who is buried in the ground not 2 miles from this courthouse, is one of those statistics, isn’t she, doctor?” and “One last question, doctor, would you rent this man a room in your house?”

At the end of the hearing, three things were apparent:

1. The clinician-witnesses did not effectively communicate to the court information that might have helped the patient and hospital.
2. The prosecutor used the testimony of the patient’s witnesses (the clinicians) against them and against the patient.
3. Most of the clinicians who testified felt unhappy about the experience, believed they had either harmed or at least not helped their patient, and were embarrassed about their performance on the witness stand.

Discussion

This was a situation that could never have been a “perfect” example of clinical testimony and fair outcome (from the clinicians’ viewpoint) for the patient. The hospital would have had difficulty prevailing in any event, given the killing and understandable community reaction. Witnesses—even clinicians—are never perfect. Nevertheless, there are a few principles that can help clinicians testify more effectively and perhaps be more comfortable in court.

Accept the adversarial system. The courtroom is not a collegial place. It is not a classroom. It is not your element. The people there are not clinicians and, depending on the topic of the case, they are probably not interested in patient care per se. Although most of the people there respect you and your credentials, at least one person, the lawyer for the side opposing those who subpoenaed you, is not your friend. At best, he or she

will try hard to neutralize your testimony and bolster his own case. Once the clinician understands this and accepts his or her role as someone who is there simply to tell the truth and/or express opinions in an articulate manner, the task becomes clearer and often simpler.

You are unlikely to be the lynchpin of the case. Many clinicians believe the judge and jury will be riveted to their seats and hang on every word of psychiatric testimony. There are cases in which psychiatric issues are the crux of the matter being decided. This is true in commitment or competency hearings and may be true in cases addressing malpractice or criminal responsibility. In most other cases, however, juries consider many things besides psychiatric symptoms and listen to lots of nonpsychiatric testimony. Even if psychiatric issues are critical to the case, there may be more than one mental health professional offering testimony, whether as a witness to facts or as an expert.

Lawyers often tell witnesses that their testimony is crucial, for example that the case hinges on one’s psychiatric testimony. If that motivation serves to make the witness review the patient’s record carefully and take his or her role seriously, that’s fine. But one should resist the temptation to feel too self-important. That keeps one’s ego in check and removes some of the pressure to “perform.”

Don’t take it personally. The other side’s lawyer is not your friend, but he or she is not really your enemy either. He sees you as an enemy of his case. In that light, it is his job, and his ethical responsibility, to try to defeat the enemies of his case. If you take his questions or implications as a personal affront, you make his job easier.

Avoid witness “gamesmanship.” Psychiatrists are pretty smart. We also think of ourselves as good with people, great communicators, and intuitive. Surely we can figure out what’s happening during an opposing lawyer’s questioning, anticipate where the lawyer is going, and cut him off at the pass. While we’re at it, why not lighten things up with a little sarcasm when the attorney for the other side misunderstands some point or mispronounces “trichotillomania”?

Don’t try it.

First, it’s not becoming to treat a trial as a showcase for one’s own ego. That is not why you’re there, and other things are far more important. As if that weren’t reason enough, it turns out that opposing lawyers are pretty smart too. They have almost always studied the

topic at hand very well and routinely already know the answer to every question they ask. If you feel you're jousting for position in a sort of debate, and particularly if you feel you're winning, you are probably falling into a verbal trap. Just answer the questions, express your opinions, and be polite.

Plain anxiety, performance anxiety, and preparation.

Some people just hate public speaking. Unfortunately, that's part of the definition of testimony. Most trials and hearings are conducted in public, and the testimony is recorded, warts and all, for anyone to read at a later time. Clinicians are usually treated courteously, but many of us get nervous when we realize that we are about to be questioned in public.

Part of the answer lies in *preparation*. Testimony is not a memory test—that may be reassuring—but it is important to know the details of the case and related clinical concepts. Review the chart, and perhaps relevant principles of the person's differential diagnosis and treatment plan, the night before.

Some witnesses treat testimony as if it were an oral Board exam. It isn't, but rehearsal may reduce anxiety and increase the clarity of testimony. Repeated exposure to court or a court-like environment may help as well. Some large hospitals, such as state forensic hospitals, have mock-trial practice for their staff who are likely to be called to testify about evaluations and treatment. A nearby department of psychiatry or psychology may have a forensic program where you can practice testimony. A facility attorney or colleague may be willing to play the part of a cross-examining lawyer, perhaps with more gusto than you will find at the trial itself.

Consider seeking out a colleague who is experienced at testifying. Most of us still get nervous at times, but we'll try to demystify the process for you.

My March, 2006 column in this journal¹ discussed some short books that contain lots of tips about testimony. If you are called to court often, or are anguishing over future testimony, consider getting one or more of these resources (see bibliography below). Many medical centers and local medical libraries also have copies.

Get a good night's sleep. This applies particularly to expert witnesses and those who are defendants in a malpractice suit. If you are someone who obsesses over whether or not you have covered every nuance in your preparation, stop. Resist the temptation to stay up late. A rested witness is far more effective (and comfortable) than one who has stuffed that last morsel of data into his or her brain at 2:00 AM.*

Preparation may not address all the causes of one's anxiety, especially those that are related more to personal characteristics (e.g., neuroses and personality traits) than to knowledge. I occasionally hear of clinicians who take a small dose of a beta blocker or an anxiolytic before going to court. A little propranolol may be helpful for some, I suppose, but I don't recommend benzodiazepines, particularly during pre-testimony review or conferences.

Linguistic or cultural disadvantages. International medical graduates (IMGs) may be at a disadvantage, or may feel at a disadvantage, in court because of their language or cultural backgrounds.^{2,3} Over the years, I have observed a variety of court appearances by IMGs, including excellent testimony, witnesses who did not realize that an accent or their difficulty with idioms interfered with their effectiveness or credibility, witnesses who believed they would perform badly or be misunderstood but who did a fine job, and witnesses who were so flustered by their own expectation of poor performance (e.g., who assumed their "foreign" characteristics would embarrass them) that they were almost immobilized during the experience.

It seems to me that IMG issues should be treated just as one does other factors (such as anxiety or other potential vulnerabilities in the courtroom) when one chooses a practice. Some practice settings involve little chance of court testimony; others are much more likely to include situations of civil commitments, competency evaluations, child custody matters, and the like that will lead to court appearances from time to time. The practical aspects of job description and assignment should be considered by both the doctor and the administrator or supervisor.

Can clinicians simply avoid testifying altogether?

Probably not. Although some jobs entail a greater chance of going to court than others, virtually every treating clinician will eventually be called to describe what he or she has done or observed in the course of patient care. Sometimes the probability is obvious, such as when treating a patient in a forensic context. Sometimes it's simply the luck of the draw. Eventually, some of your current or past patients will almost certainly get into some sort of legal trouble, go through a divorce or child custody battle, allege malpractice, have criminal charges filed against them, or become involved

*Judges occasionally fall asleep during testimony. Witnesses should not.

in the judicial system in some other way. In some of those cases, you will be asked to tell what you know or have observed about the patient, either in court or in a quasi-court setting such as a deposition. Sometimes you can discuss or negotiate your participation with the attorney(s). At other times you have no choice but to appear at the appointed time and answer the questions that will be asked. Previous columns that discuss topics such as the effect of testifying on the doctor-patient relationship and conflicts of interest between one's obligations to the patient and to the court are listed in the bibliography.

The Last Word

Whether or not one works in a "forensic" setting, those of us who assess and treat patients with severe and chronic mental illness occasionally end up in court. Be sure you understand the questions; tell the truth; be very concise; remember that the legal process is generally adversarial, not collegial; don't lecture unless asked; and don't take it personally.

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