BJPsych Advances (2024), vol. 30, 403–405 doi: 10.1192/bja.2024.9

The treating psychiatrist as expert witness

CLINICAL REFLECTION

Trevor Broughton & Toral Thomas

SUMMARY

Many authors have considered the ethical dilemmas of a doctor being both the treating physician and expert witness in litigation. The debate has often focused on the potential for bias and the adverse impact being an expert witness can have on the therapeutic alliance. Much of this debate seems rooted in the ethic of non-maleficence. In this article we attempt to examine the other end of this ethical quandary. Using a pragmatic approach, we explore these conflicts and consider biases from other sources. Ultimately, taking on the mantle of both roles is becoming increasingly unavoidable. Hence we argue that, although there are challenges, embracing this dual role can be an important part of holistic treatment, risk management and the pursuit of the ethical principle of justice.

KEYWORDS

Ethics; psychiatry and law; consent and capacity; education and training; human rights.

Treating psychiatrists, in our experience, are inevitably being approached to provide evidence about their patients in court across jurisdictions (Taylor 2012). Current guidance from the Royal College of Psychiatrists (Rix 2023: p. 28) and General Medical Council (GMC) to those undertaking witness statements or expert evidence (2023: para 10c) advocates against treating psychiatrists providing expert testimony for litigation involving their patients. The reasoning is often couched as the potential for bias, conflicts of interest, the impact on therapeutic relationships, and ethical dilemmas bound in questions of disposal or culpability. The preferred solution has favoured the use of independent experts. We wish to address a different perspective: that the relative independence of experts has been largely overstated as a ballast to the bias of the treating clinician, and its own potential for harm has been overlooked.

Bias as a two-edged sword

Bias, or an inability to be thoroughly impartial (Niveau 2019), in this debate has been uniquely attributed the treating psychiatrist, with independence seen as conferring a degree of immunity. Regulatory bodies cited above similarly give more weight to the potential for bias within the treating clinician.

The overriding reason why courts seek expert evidence is an acknowledgement that they require assistance in the interpretation of evidence from highly complex specialised disciplines such as medicine (*R v Turner* [1975]). In that respect the role of the expert is more that of an educator or adviser.

In Canada, this issue was addressed in a judicial review of expert witnesses, as part of the Civil Justice Reform Project: 'too many experts are no more than hired guns who tailor their reports and evidence to suit the client's needs' (Osborne 2007: recommendation 9).

Relative bias between treating physicians and independent experts was later argued in the Ontario Court of Appeal in the matter of Westerhof v Gee Estate [2015]. In brief, this was a civil case in which the plaintiff relied on evidence from their treating physician, which had been ruled inadmissible by a lower court. This in effect meant that a plaintiff needed to acquire 'hired gun' expert testimony instead of a family doctor, which, as a barrier to effective justice, prompted the appeal. This decision was critiqued as follows:

> 'Witnesses, albeit ones with knowledge, testifying to opinions formed during their involvement in a matter […] are NOT engaged by a party to form their opinions, and they do NOT form their opinions for the purpose of litigation. As such, they are not engaged by or on behalf of a party to provide opinion evidence in relation to a proceeding' (*Westerhof v Gee Estate* [2015]: para. 82).

This ruling expressed a view that the opinions of treating physicians may be less biased than those of the experts retained for litigation. This is because treating physicians had likely formed a clinical opinion about questions relevant to the court before litigation was the goal.

Closer to home, the findings by the Rt Hon Lord Woolf leading up to the Access to Justice Act 1999 reflected a crisis in civil litigation, where expert evidence was such an unnecessary generator of cost (owing to a large expensive parallel support industry) that it fundamentally undermined access to justice (Woolf 1996: ch. 13). The recommendations

Trevor Broughton and **Toral Thomas** are consultant forensic psychiatrists with Norfolk and Suffolk Secure & Forensic Services, Norfolkand Suffolk NHS Foundation Trust, based at Northside House, Norwich, UK.
Correspondence Dr Trevor Broughton. Email: trevor.broughton@nsft.nhs.uk

First received 10 Nov 2023
Final revision 13 Feb 2024
Accepted 18 Feb 2024

https://doi.org/10.1192/bja.2024.9 Published online by Cambridge University Press

were an attempt to correct what had become the conduct of partisan experts within an adversarial system under the sway of market forces.

Many of our psychiatric colleagues have seen independent experts making significant recommendations on patients under their care based solely on a single brief assessment without full knowledge of the history. Increasingly such assessments are being formally sanctioned owing to poor practice (Rix 2017) or criticised from the bench (*R v Choudhuri* [2019]: paras 81–94) – involving the court directly criticising an expert as having failed to 'grapple with the obvious alternative explanation' in the proceedings, based on a single brief interview.

The consequences not only reflect negatively on the credibility of psychiatrists (*Daggitt v Campbell* [2016]), but may lead to unworkable recommendations owing to a lack of understanding of local service structures or processes.

On the question of reliability, Large et al (2010) in comparing the agreement between treating clinicians and independent experts concluded that 'concerns about bias arising from the nature of a treating practitioner's relationship with a patient may be overstated'. Given that two psychiatrists are often necessary for crucial issues such as hospital disposal, fitness to plead or diminished responsibility, having one independent psychiatrist should balance any perceived bias from the treating psychiatrist.

Ethical dilemmas

The GMC's guidance on good medical practice places the welfare of the patient at the heart of any clinician's concern. With the expert witness's overriding duty being to the court, it would seem impossible to serve two masters – but only if we take the narrow view that assisting a patient by providing unbiased evidence to the court is inevitably harmful. We argue this is not a given. This is because any independent expert must also adhere to good medical practice.

A case could be argued that a sensitive disclosure made prior to litigation was done with an expectation of confidentiality. This is mitigated by the fact that the treating physician cannot undertake expert witness instruction without the patient's consent except under specifically defined exceptional circumstances. We argue that the relative independence of the expert does not resolve the matter either way.

Furthermore, the assumption that there will be a conflict between the interests of the patient, the court and the expert is not inevitable. Objectives often align. When they do, there is clear merit in the court being aware of the specific treatment plan and local resources. Here the treating clinician could have a distinct advantage.

Rupture of the therapeutic relationship

The effectiveness of psychotherapy understandably relies on the relationship with the therapist. Much has been debated over the strain acting as an expert witness may place on the therapeutic alliance. However, in our view this may be overstated.

In England and Wales, the Tier 1 Mental Health Tribunal (MHT) system mandates evidence from the treating clinician. This evidence regularly conflicts with the expectations of the patient, given that they are appealing in pursuit of discharge. The low success rates of appeals to the MHT speaks to this inherent friction (Gosney 2019).

Whenever the distinction between the MHT and other courts is raised, it is often reframed within their different roles, their adversarial versus inquisitorial nature, or the technical role of the responsible clinician. However, in both processes there are conflicting views, a perceived power imbalance, the liberty of the patient at stake and the testimony of the treating psychiatrist likely going against the patient's preferences. Therefore, such differences are largely semantic. Treating clinicians have had to make do with this situation and devise strategies to heal such ruptures when they arise, and have done so successfully.

Conclusions

Current guidance endorsing the virtues of independence over those of treating clinicians has been overstated, in our view. If the aim is to best assist the court, then the treating clinician may in some cases be in the best position to achieve that.

Furthermore, any dilemmas regarding therapeutic relationships and confidentiality can be mitigated by obtaining informed consent from the patient. The patient can object to the report being prepared and psychiatrists undertaking such work should be able to come to a nuanced perspective on whether their therapeutic relationship would be compromised. Treating psychiatrists are not compelled by either party or the court to undertake such work. Gutheil (2009: p. 8) argues this point thus: 'The importance of having a salaried "day job" [...] cannot be overemphasized, because these provide a base of financial stability to turn down cases'.

Current guidance, in our view, has not fully appreciated the benefits of expert evidence from treating clinicians, nor grappled with the issue of 'hired gun' experts, which we have sought to re-balance in this article.

The final arbiter in any area of litigation is the court. Courts have been known to form views

BJPsych Advances (2024), vol. 30, 403–405 doi: 10.1192/bja.2024.9

contrary to medical evidence. Where proceedings may result in a punitive outcome for the patient, this would follow a democratic mandate from parliamentary lawmakers on the appropriate means to deal with law-breaking. Portraying the expert's participation as invariably conflicting with their duty towards non-maleficence would ultimately mean that no psychiatrist (regardless of their independence) should participate in any criminal proceedings as a matter of principle. The independence of the expert does not shield them from this ethical quandary.

Psychiatrists are usually comfortable being key decision makers in the clinical arena. This is decidedly not so in court. The struggle psychiatrists experience in this role may reflect an inability to shed the mantle of decision maker (or *responsible* clinician) and rather being relegated to the role of an expert adviser. Ultimately the court, as the true decision maker, will need the highest-quality evidence to fulfil its mandate. We argue that the treating psychiatrist could be in the best position to provide this level of data.

Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

Author contributions

This article was written jointly, with both authors contributing content, references and shaping the arguments put forward. The text was agreed as representing the combined views of both authors.

Funding

This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

Declaration of interest

None.

References

General Medical Council (2023) *Providing Witness Statements or Expert Evidence as Part of Legal Proceedings*. GMC (https://www.gmc-uk.org/-/media/gmc-site/ethical-guidance/mdg-2023/providing-witness-statements-or-expert-evidence-as-part-of-legal-proceedings-english.pdf).

Gosney P, Lomax P, Hooper C, et al (2019) Current appeal system for those detained in England and Wales under the Mental Health Act needs reform. *Journal of Medical Ethics*, **45**: 173–7.

Gutheil TG (2009) *The Psychiatrist as Expert Witness*. American Psychiatric Publishing.

Large M, Nielssen O, Elliott G (2010) The reliability of evidence about psychiatric diagnosis after serious crime: part II. Agreement between experts and treating practitioners. *Journal of the American Academy of Psychiatry and the Law Online*, **38**: 524–30.

Niveau G, Godet T, Vollm B (2019) What does impartiality mean in medico-legal psychiatry? An international survey. *International Journal of Law & Psychiatry*, **66**: 101505.

Osborne CA (2007) *Civil Justice Reform Project: Summary of Findings & Recommendations*. Ministry of the Attorney General, Ontario (www.attorneygeneral.jus.gov.on.ca/english/about/pubs/cjrp).

Rix K, Eastman N, Haycroft A (2017) After *Pool*: good practice guidelines for expert psychiatric witnesses. *BJPsych Advances*, **23**: 385–94.

Rix K, Eastman N, Adshead G, et al (2023) *Responsibilities of Psychiatrists Who Provide Expert Evidence to Courts and Tribunals (College Report CR193)*. Royal College of Psychiatrists.

Woolf H (1996) *Access to Justice: Final Report to the Lord Chancellor on the Civil Justice System in England and Wales*. Department of Constitutional Affairs (https://webarchive.nationalarchives.gov.uk/ukgwa/20060213223540/http://www.dca.gov.uk/civil/final/contents.htm).

Taylor PJ, Graf M, Schanda H, et al (2012) The treating psychiatrist as expert in the courts: is it necessary or possible to separate the roles of physician and expert? *Criminal Behaviour and Mental Health*, **22**: 271–92.

Cases

Daggitt v Campbell [2016] ONSC 2742.

R v Choudhuri [2019] EWCA Crim 2341.

R v Turner [1975] QB 834.

Westerhof v Gee Estate [2015] ONCA 206.