Forensic Training in Family Practice Residencies

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Knowledge and skill in forensic medicine are important in primary care not only for defensive purposes but also because of potential therapeutic value in patient care. The major role in future mental health services envisioned for primary care physicians makes such training especially important. A national survey of family practice residency programs reveals that 47 percent of programs do not address forensic aspects of medical practice. A model forensic medicine curriculum is described that would require minimal adjustment of existing programs. The need for inclusion of forensically qualified clinicians in training programs for primary care physicians is evident.

It has been argued that knowledge of the legal implications in the practice of medicine "makes a physician a more effective healer and investigator. Ignorance of the law puts both patients and providers in potential jeopardy."[1] Since 60 percent of mental health care is delivered at the primary care level,[2] it is especially important that family physicians understand the ways and degrees in which forensic matters impinge on medical practice, both from a regulatory and from a clinical standpoint.[3] Physicians without forensic training tend to regard the legal framework as a burden mindlessly imposed by ignorant and self-serving politicians. In truth, however, the threat of professional liability suits makes medical practice perilous to the legally naive, especially with regard to current mental health services.[3] In rural areas in particular, the family physician is commonly the only psychiatric service readily available and potentially the most influential advocate regarding public health programs and standards of care in treatment facilities for the mentally ill (eg, group homes, convalescent hospitals, community mental health centers, and even jails).

Although laws are not designed to be therapeutic, the knowledgeable physician can enhance his therapeutic effectiveness by the creative application of the legal framework to clinical work. Many a patient, unmoved by kindness, reason, insight, pleading, past experience, medication, and the whole catalogue of clinical art, will be motivated by being warned of the legal consequences of his maladaptive behaviors. A civil commitment hearing for a potentially dangerous person can be very therapeutic, even if the petition is denied. The physician's failure to file such a petition because of unfamiliarity or discomfort with the legal process may make him a malpractice defendant. The threat of prosecution for child abuse can make family counseling much more productive.[4,5] Helping a hopelessly estranged married couple draw up

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a sound divorce agreement is a simple treatment tactic that has led to many successful reconciliations and many less-tortured divorces. Informed by the family physician, judges can draw up amazingly therapeutic conditions of probation. Being legally informed and reasonably comfortable in the justice system brings a new dimension of satisfaction and competence to the physician's work.

The traditional principle of physician-patient secrecy has become increasingly complicated by exceptions, eg, the statutory requirements to report contagious disease, suspicious wounds, and family violence[6] and the legal duties to warn potential victims[7] and to respond to subpoenas, issued with increasing frequency in today's litigious social climate.[8] For the family physician, confidentiality has always been a paradox, especially in rural communities where few secrets are hidden. The irony is that so many patients are in psychological trouble at least partly because of too little openness with significant others,[9] and the enlightened involvement of significant others in treatment plans is essential.[10] The wise family physician has had to work around these opposing principles with little specific training in forensic medicine. Doubtlessly, practical forensic medicine has always been taught to some extent without being so identified.

Recent data on violence emphasize the critical role of primary care physicians in violence prevention. In Brown's study,[11] more than one half of the convicted murderers interviewed had made an office visit to a nonpsychiatrist physician, usually for psychosomatic complaints, within two months before their crimes. Similarly, over 70 percent of a sample of suicide victims had consulted a nonpsychiatrist physician during three months before their demise, 62 percent within 30 days, and 18 percent within 24 hours.[12] Chronic medical illness is a definite contributing factor in a substantial percentage of suicides and suicide attempts.[13]

In their role as health supervisor to entire families, family physicians are in a unique position to detect and intervene in cases of spouse and child abuse.[14-16] Physicians should be aware not only that spouse abuse exists, but that it is probably more prevalent than is currently recognized.[6] In fact, the National Institute of Mental Health found that severe spouse beatings occur in at least 5 percent of the nation's households.[17] In a study by Gayford,[18] 70 out of 100 battered wives were on antidepressants prescribed by physicians, not one of whom suspected the true cause of the problem. Increasingly, laws and statutes regulating physician responsibility in cases of domestic violence are being enacted, following the model of child abuse legislation now a reality in all 50 states.[6] These laws require that a physician report suspected cases of child abuse to either police or designated social agencies; in many states, failure to report child abuse makes the physician an accomplice, liable to prosecution.[6] Obviously, as Petro et al[6] observed, "new sanctions against domestic violence are forcing a substantial change in the physician's legal and social responsibilities, as well as altering the fundamental sanctity of physician-patient confidentiality." Increased awareness of violence in primary care practice may lead to improved violence prediction and prevention generally.[19] Recognition of violence potential in patients will be less threatening to primary physicians trained in the management of violence, an essential component of which is a working knowledge of commitment law and procedure.

The family physician, involved with patients throughout the life cycle, expects to be involved at life's end, a time when bequests are belatedly made. Knowledge of legal criteria for making wills is critical on such occasions.

Status of Current Forensic Training

Clearly family physicians will be ill-prepared to exercise optimally their medical and legal responsibilities if those who direct their education fail to incorporate forensic issues. To assess the true status of forensic training in particular and mental health training in general, the psychiatry faculty at the College of Community Health Sciences, The University of Alabama, conducted in the Spring of 1981 a survey of psychiatric training in family practice residency programs nationally. Sixty-four percent of the programs returned completed questionnaires; the geographical distribution and the distribution of program types represented by the returned questionnaires resulted in distributions nearly identical to the survey population, allowing inferences to family practice residencies in general. In addition to questions related to faculty composition and curriculum design,[25] curriculum content areas were listed. Forty-seven percent of the responding programs, in which 43 percent of

the current residents are in training, report that forensic aspects of medical practice are not included in their curriculum; deinstitutionalized mental patients are not addressed in 54 percent of programs affecting 49 percent of residents. It is thought that one explanation lies in the fact that, as Barr and Suarez discovered in a 1965 survey,[20] "in medical schools, where the curriculum is already bulging, forensic psychiatry is thought to be too specialized a field."

The surprisingly high percentage of existing programs reporting no training in forensic medicine may be misleading in part, not accounting for incidental coverage of the field in other contexts. Not long ago forensic psychiatrists themselves had a very narrow legalistic focus that seemed far removed from everyday medical work. More recent burgeoning of case law and statutes affecting medical practice and concomitant development of clinical interest in the interaction of law and medical practice have made forensic medicine a subject of immediate and daily concern. To trust the learning of this essential material to footnotes and chance observations in the study of other subjects is no longer sufficient. Family physicians cannot be considered properly prepared for their major responsibility in providing mental health services without formal and systematic training in forensic medicine. Fortunately, a large and growing number of informed psychiatrists are available to provide this training as full-time, part-time or volunteer faculty. Involvement of experienced family physicians is needed to ensure relevance of the teaching to the realities of family practice.

A Proposed Curriculum in Forensic Medicine for Family Physicians

The following curriculum is proposed as a minimum program of forensic medicine training. Faculty should be clinicians skilled in therapeutic applications of law, not just legally trained, but clinically experienced. This curriculum calls for 15 hours of didactic seminars; as about one third of this material is ordinarily taught in practice management courses, this curriculum requires only 10 additional didactic hours. Ninety percent of the practical training involves merely additional forensic emphasis to standard clinical training activities. Thus, implementation of this curriculum should not cause major scheduling adjustments. Many programs might find it necessary to recruit additional faculty who are forensically skilled clinicians.

Didactic Seminars With Appropriate Reading Assignments

1. General description of the legal system: history, structure, function (1 hour)
2. The trial process: ordinary and expert testimony, due process, strengths and weaknesses of the adversary system (1 hour)
3. Preparation for trial and appearance as an expert witness (1 hour)
4. Recognition and management of violence toward others and suicide: family violence, law and procedures for civil commitment (2 hours)
5. Physician-patient confidentiality: ethics, law, exceptions, therapeutic management of confidentiality paradox. Management of clinical records and training of office staff (2 hours)
6. Patients' rights: rights of voluntary patients (confidentiality, informed consent, improper advances, abandonment, licensure-credentials, standard practice, experimentation); rights of involuntary patients and abridgment procedure, in hospitals, jails, and prisons; Good Samaritan law (2 hours)
7. Professional liability law and procedure: prevention, insurance, special doctrines, defense (1 hour)
8. Other torts: elements of tort, types of damages, types of defenses, workers compensation (1 hour)
9. Family laws: without marriage, marriage, divorce, child custody, responsibilities of parents and children (1 hour)
10. Criminal law and procedure: competency for trial, insanity and other defenses, juvenile court (1 hour)
11. Testimentary capacity: elements, proofs, clinical procedures (1 hour)
12. Contractual competency: general application, application to medical practice, consent for treatment of minors, guardianship (1 hour)

Practical Training

1. Supervised participation in two court hearings as an expert witness
2. One half-day visit to a jail or prison that has an active medical and psychiatric program

3. Establishment of a well-considered system of medical record keeping utilized throughout the three-year residency and regularly audited for forensic validity by experienced faculty

4. During the already scheduled three- to four-month rotation in an active emergency service, emphasis on recognition and management of violence

5. One-month rotation in the receiving unit of a state hospital (mentally ill or mentally retarded) with teaching emphasis on forensic medical and psychiatric aspects

6. Part-time coverage, over a six-month period, of a convalescent facility with forensic medical and psychiatric emphasis by supervision

7. Workup of ten disability evaluation cases with forensic emphasis by supervisor; one half of these cases should have psychiatric disability

8. Supervised participation as expert witness in one will contest

9. During the already scheduled month-long rotation in a community mental health center, emphasis on forensic medical and psychiatric aspects of formerly committed patients

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