Letters to the Editor

Only letters that are responsive to articles published in previous issues of the *Journal* will be accepted. Authors of these published articles are encouraged to respond to the comments of letter writers.

Editor:

Dr. Appelbaum's paper, "A Theory of Ethics for Forensic Psychiatry" (Paul S. Appelbaum, 25:233–47, 1997) gives a scholarly and thoughtful analysis of the ethical foundations of forensic psychiatry. It forges new ground and is a significant contribution to the field insofar as it proposes fundamental principles to underlie forensic ethical guidelines. Dr. Appelbaum, whom I consider a friend and a serious ethics scholar, should be congratulated for extending the limits of the debate. In accordance with his hope that it will "provide a stimulus for a thorough examination of the ethical foundations of our behavior," I accept his invitation and enter the debate to clarify and defend what Dr. Appelbaum calls the "mixed model" and present some of my perceptions.

Dr. Appelbaum is in error when he states that the surveys of forensic psychiatrists fail to "show support for the principles of clinical ethics in forensic psychiatry." In fact, a survey of AAPL forensic psychiatrists specifically and unequivocally shows that most are of the opinion that "medical and psychiatric ethics remain a consideration when performing a forensic evaluation" and that "as a physician, a forensic psychiatrist owes some responsibility both to an evaluee and to society regardless of who pays the fee."[1]

The ethical principles of truth telling and respect for persons proposed by Dr. Appelbaum are good principles for forensic psychiatric purposes, and I would support their adoption as two underlying principles; but they are not sufficient. I agree on the need for some differentiation of ethical principles applicable to physicians according to the specific functions they are performing, but traditional medical ethics, with a foundation dating back to Hippocrates, is the unifying thread that encompasses all roles in which medical skills are used by physicians. It has served our profession well and should not be discarded. I agree with most forensic psychiatrists who, according to the survey results, consider medical ethics applicable to forensic work and are of the opinion that physicians retain some responsibility to an evaluee regardless of who pays the fee.

To say that traditional medical ethics remains relevant when performing forensic functions does not mean, as Dr. Appelbaum suggests, that it can take center stage and become primary or that it can dictate the forensic opinion. To the contrary, in my conceptualization at least, it means that in extreme circumstances in which the potential harm is so disproportionate that it would preclude truth telling

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(honesty and striving for objectivity), the forensic psychiatrist should turn down the case.

In an era in which managed care has placed profit as its primary motive and goal, it is particularly problematical to suggest that psychiatrists ever eschew medical values when they use medical skills in their consultation to other systems. Dr. Appelbaum's example of the research psychiatrist to whom science is the primary value and goal is a good illustration of my point. In research, medical values are secondary but can outweigh research scientific responsibilities when the harm is too great. If a research subject develops serious problems as a result of a research study, it is the medical researcher's ethical duty to take the patient out of the study because of the overriding patient welfare concerns.

Although not mentioned or referenced in Dr. Appelbaum's paper, the highly respected forensic psychiatrist Bernard Diamond, MD, was a strong and even extreme proponent of what Dr. Appelbaum has called the "mixed model." Dr. Diamond's view of a forensic psychiatrist's proper role was to consult to the legal system solely in ways consistent with and supportive of traditional medical values, including trying to change the law through cases in which new legal criminal defense theories were developed and through legislative testimony to influence the law to be more helpful to individuals and to society, consistent with medical values.[2] Aspects of his approach have analogies to the legal concept of therapeutic jurisprudence. To Dr. Diamond, medical values are essential when consulting to the legal system, but honesty and truth are equally important in the legal arena.[3] Since he considered lying and distorting the truth unethical, he would turn down the majority of cases in which his services were requested, because either the attorney wanted to use legal tactics or technicalities to obscure the truth or honesty did not justify a helpful opinion. He therefore was an extreme proponent of both the whole truth and traditional medical duties in the forensic realm. Dr. Jay Katz, in support of telling the whole truth, has recommended that forensic psychiatrists use "disciplined subjectivity".[4]

I agree with Dr. Appelbaum and not Dr. Diamond insofar as truth telling should have primacy over traditional medical responsibilities in the forensic realm. I also agree with Dr. Appelbaum that ethical truthful forensic opinions can do harm to evaluees, and the potential for such harm is what makes forensic opinions useful. In agreement with Dr. Diamond, however, medical values should not be discarded but should play a significant but, in my opinion, secondary role in the balancing process. In some situations the legal system requires forensic psychiatrists to perform roles that are so contrary to traditional medical values that the balance should swing so that medical values equal and thereby conflict with the obligation towards truth. Because of this conflict, the only ethical solution is for psychiatrists to refuse to perform the role and to turn down the case.

An example of a situation in which concern for medical values should lead to nonparticipation is the penalty phase of a

capital case if the psychiatrist were asked to provide irrelevant but truthful personal *ad hominem* data, so that rather than address the facts, the district attorney could use the information unfairly to discredit a defense expert's testimony. Perhaps it should be unethical for psychiatrists to provide information or testimony supporting aggravating circumstances at the penalty phase of a capital case to procure a death penalty, especially in case of a disproportionately severe sentence. Personal beliefs about the death penalty are irrelevant. Problems arise out of professional traditional medical ethics considerations. Another survey of forensic psychiatrists showed that 63.7 percent agreed with the need to treat death penalty cases differently from other cases because of their special seriousness and only 20.7 percent disagreed.[5] Consideration of medical values provides the best justification for the current APA and AMA prohibition against physicians giving a lethal injection to carry out an execution[6] as well as the APA and AAPL prohibitions against performing prearraignment evaluations.[6, 7] The survey of AAPL forensic psychiatrists[1] showed strong support for considering prearraignment examinations unethical. Since the APA bases its ethical principles and annotations on medicine, retention of these values provides a basis for the APA to enforce forensic ethics.

Dr. Appelbaum's principle of truth provides a rationale for the existing AAPL ethical guideline requiring honesty and striving for objectivity.[7] Striving for objectivity was included in recognition of the necessity to make efforts to be objective and not accept an honest but subjective truth consistent with inevitable biases. Dr. Appelbaum's principle of respect for persons, though admirable, unfortunately is not always a primary concern for the legal system. For example, excessive punishment for a particular offense or accepting confessions dictated by delusions can be viewed as violating respect for persons. It could also potentially violate respect for persons if a psychiatrist facilitates such sentences and procedures. I wish Dr. Appelbaum had clarified further the parameters that he proposes for the principle of respect for persons. Does he consider it to have equal value with truth? Does it ever necessitate a refusal to assume certain forensic roles? What happens if the legal system wants psychiatrists to do things the profession considers a violation of respect for persons? Dr. Appelbaum presents an intriguing concept, and I hope he will give further details. Since over the years I have agreed with most of Dr. Appelbaum's opinions on practical ethical issues and have been impressed by his insight and capacity for ethical analysis, I suspect that despite some theoretical differences we would agree on many more practical ethical facets than we would disagree.

Dr. Appelbaum appropriately calls attention to the serious danger of forensic psychiatrists becoming confused and believing they are in a treatment capacity when performing a forensic function, with a significant risk of misleading defendants. Empathy that is appropriate in a treatment capacity can be insidious in the forensic context. For example, telling a defendant when performing an evaluation

for the prosecution that you can understand why he/she wanted to kill the victim can mislead the defendant into thinking you are sympathetic and in a traditional medical role. Dr. Appelbaum is right about the ethical need to clarify the forensic role, and AAPL ethical guidelines also require such clarification to a defendant.[7] There is a strong risk, if forensic psychiatrists act as if they are still wearing a medical hat, that evaluees also could become confused.

That is why it should be clear to a forensic psychiatrist when performing an evaluation that medical values operate only in the decision whether or not to take the case and in aspects peripheral to the assessment. Once a forensic role, with its potential for harm, is considered ethically appropriate and an evaluation is performed, only truth (honesty and striving for objectivity) and, to use Dr. Appelbaum's term, respect for persons should operate in the assessment and testimony. In accordance with the sentencing commission's recommendation,[8] medical values should operate regarding factors other than the opinion itself. An additional reason to support the "mixed" framework is that even though doctor-patient responsibilities are secondary in forensic work and truth has primacy in any evaluation, claiming no doctor-patient responsibilities at all might result in findings of types of negligence other than malpractice. Some doctor-patient relationship is necessary for negligence to be malpractice and for malpractice insurance clearly to apply. If, instead, other types of negligence are found, malpractice insurance might not provide any protection.[9]

Dr. Appelbaum suggests that treating psychiatrists have duties only to their patients and forensic psychiatrists have duties only to truth telling and respect for persons. That statement does not consider the fact that treating psychiatrists currently clearly follow a "mixed model." Although treating psychiatrists have primary duties to patients, they also have secondary duties to society, potential victims including victims of child abuse, and even the legal system. Treating psychiatrists can be used in many states to testify against their patients in a criminal trial for child abuse and forced to reveal information disclosed in therapy despite expectations of confidentiality. Another example can be found in a California case in which a psychiatrist was used by the prosecution to testify against a patient who had come for help in controlling aggressive impulses. This information was used to prove premeditation and to obtain a death penalty at the penalty phase for the patient after he killed his girlfriend, yet this procedure was approved by the California Supreme Court. For some inexplicable reason, the treating psychiatrist, rather than maintaining a primary duty to the patient, cooperated willingly with the prosecution, and objections to violation of confidentiality and privilege were raised only by the defense attorneys.[10]

All psychiatrists have mixed duties. I find no persuasive reason for forensic psychiatrists to be the lone exception insofar as they consult to the legal system as opposed to some other system with differing values. It would set a dangerous

precedent that could encroach into consultations to other systems, including managed care. I hope Dr. Appelbaum would reconsider this aspect of his proposal in light of these real threats.

Dr. Appelbaum has made an important contribution to the debate on forensic psychiatry's foundations and has proposed two significant fundamental principles. However, it would be a serious error to forego medical ethics completely when consulting to any other system, whether it be the courts, the legislature, managed care, schools, or doing research to advance science. In our current era with its increasing attacks on medical professionalism, it is essential to retain medical values as at least a factor, albeit usually secondary, whenever psychiatrists consult to any other system, including the legal system.

I appreciate Dr. Appelbaum's invitation for discussion of his theory. His proposal, although erudite, thoughtful, and convincing in many respects, in certain other aspects is a minority view. It should be carefully scrutinized and modifications considered. Purity no longer is possible in any psychiatric role. My concerns reflect survey findings that most AAPL forensic psychiatrists also wish to retain medical ethics as at least one consideration in forensic psychiatric practice.

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References

1. Weinstock R, Leong GB, Silva JA: Opinions by AAPL forensic psychiatrists on controversial ethical guidelines: a survey. Bull Am Acad Psychiatry Law 19:237–48, 1991
2. Diamond BL: The forensic psychiatrist: consultant versus activist in legal doctrine. Bull Am Acad Psychiatry Law 20:119–32, 1992
3. Diamond BL: The psychiatric expert witness: honest advocate or "hired gun"?, In Ethical Practice in Psychiatry and the Law. Edited by Rosner R, Weinstock R. New York: Plenum Press, 1990, pp 75–84
4. Katz J: "The fallacy of the impartial expert" revisited. Bull Am Acad Psychiatry Law 23: 141–52, 1992
5. Weinstock R: Controversial ethical issues in forensic psychiatry: a survey. J Forensic Sci 33:176–86, 1988
6. American Psychiatric Association: Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry. Washington, DC: APA, 1995
7. American Academy of Psychiatry and the Law: Ethical guidelines for the practice of forensic psychiatry—1987 (rev 1989, 1991, and 1995 In Membership Directory). Bloomfield, CT: AAPL, 1997, pp X–XIII
8. Task Force on the Role of Psychiatry in the Sentencing Process: Psychiatry in the Sentencing Process. Washington, DC: American Psychiatric Association, 1984
9. Weinstock R, Garrick T: Is liability possible for forensic psychiatrists? Bull Am Acad Psychiatry Law 23:183–93, 1995
10. People v. Wharton, 809 P. 2d 290 (Cal. 1991)

Editor:

In his dissertation of a "Theory of Ethics for Forensic Psychiatry" (Paul S. Appelbaum, 25:233–47, 1997), Dr. Appelbaum addresses what he and other forensic scholars perceive as double agency when a psychiatrist utilizes therapeutic principles in doing a forensic evaluation. Dr. Appelbaum states that a truth-searching approach should be devoid of the use of any healing principles in order that the patient be not deceived or betrayed into an unfavorable forensic outcome.

I submit that efforts to eliminate therapeutic principles such as empathy, rapport and transference from a forensic evaluation inevitably truncates the search for truth and honesty which are pivotal to Dr. Appelbaum's hypothesis. Any honest understanding of aberrant or maladaptive human behavior requires not only the gathering of all sources of information, thorough examination and observation of the patient, but empathic interaction so as to erase psychological mechanisms which might distort the underlying clinical truth. There are erroneous forensic evaluations, premised upon an approach that the expert steer clear of any therapeutic contamination, an example of which I shall cite.

Some months ago, a 24-year-old black male with a history of Schizo-Affective Disorder was apprehended driving under the influence of alcohol. Because of the history of mental illness, he was sent for competency examination prior to trial. The forensic expert evaluating the patient for the State documented a mental status of sluggish manner, poor eye contact, difficulty performing simple tasks of attention and concentration, and appearing confused. The expert observed difficulty in the patient processing information adequately and appearing not to sufficiently understand the prosecution process and the legal system. The expert determined that the patient lacked a rational and factual understanding of the charges against him. An opinion that the patient was incompetent to stand trial was rendered.

The defense attorney subpoenaed the treating psychiatrist, who outlined treatment for schizophrenia over a period of six years, with adequate remission of psychotic symptoms and compliance with antipsychotic medication. Utilizing a therapeutic approach, the treating physician was able to demonstrate that anxiety produced a mask of confusion when the defendent was examined and found incompetent. The patient, a timid personality, had become overwhelmed by a forensic evaluation devoid of therapeutic rapport.

In all disciplines of medical practice including medico-legal practice, understanding of symptoms is diagnostically imperative. Practicing in Southern Africa, I misdiagnosed young Zulu women presenting with pelvic pain as having urinary tract infection. An African colleague, familiar with Zulu culture enlightened me to explore the symptom of pelvic pain. I discovered that, with many of these women, the clinical problem was infertility. For these young women, it was painful that they did not have children. How much more important is the meaning of symptoms in a forensic context when camouflage of the truth, by failure to therapeutically explore, may result in erroneous conclusions. Separating the therapeutic role from the forensic role denies the ethical practice of forensic psychiatry a valuable diagnostic tool.

The argument that a combined truth-searching and therapeutic role represents double agency is rebuttable when the forensic psychiatrist advises the patient of the exceptions and limitations of confidentiality. A "favorable" forensic outcome for the patient is not necessarily free of harm. "Favorable" forensic out-

comes resulting from incomplete diagnostic exploration may exert a haunting effect upon the forensic searcher of truth. I ponder how John Hinckley and his family now feel, he facing possible indefinite commitment in a mental hospital because expert forensic psychiatrists provided the impetus for a successful insanity defense.

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