Forensic Psychiatry: A Subspecialty
The Presidential Address at the Nineteenth Annual Meeting of The American Academy of Psychiatry and the Law

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The implications of the definition of forensic psychiatry are explored, with particular reference to the field as a subspecialty of general psychiatry. The allegation of undue moral uncertainty in forensic psychiatry is denied and the moral issues are revealed to be related to the status of the underlying philosophical disputes. An outline for the organization of the forensic psychiatric assessment is presented. The charge that forensic psychiatry is not as "hard" a science as the other forensic sciences is denied. The administrative and political organizational problems facing the subspecialty are explored. The practitioners in the field are encouraged to recognize that forensic psychiatry is a subspecialty and to work for official subspecialty status. Cautious predictions about the future of the field are provided.

Forensic Psychiatry: A Subspecialty

The American Academy of Psychiatry and the Law has incorporated into its Ethical Guidelines for the Practice of Forensic Psychiatry the definition of the field that previously had been set forth by the American Board of Forensic Psychiatry:

> Forensic psychiatry is a subspeciality of psychiatry in which scientific and clinical expertise is applied to legal issues in legal contexts embracing civil, criminal, correctional, or legislative matters; forensic psychiatry should be practiced in accordance with guidelines and ethical principles enunciated by the profession of psychiatry.

This discussion will consider some of the implications of the definition and

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will explore some of the field's problems and prospects.

The hallmarks of a subspecialty include:

1. The existence of an established and sizable organized body of practitioners of forensic psychiatry.

2. The existence of scientific and clinical data and skills that are unique to the field.

3. The existence of a body of literature that exemplifies a substantial portion of that unique data, and describes or sets forth those unique skills.

4. The existence of subspecialized fellowship training programs designed to impart the unique data and skills to physicians seeking entry into the field.

5. The existence of a recognized organization to certify subspecialty training programs.

6. The existence of a recognized organization to discern competence in the field.

The largest established and organized body of practitioners in the United States is The American Academy of Psychiatry and the Law, which had its inception in 1969. However, note should be made of the prior existence of the Psychiatry and Behavioral Science Section of The American Academy of Forensic Sciences. This Section has been an integral founding constituent of The American Academy of Forensic Sciences since its inception in 1948. Thus, forensic psychiatry can document its organized existence for the past 40 years.

The body of scientific and clinical data and skills that are unique to the field are exemplified, in the United States, by the series of annual programs presented under the auspices of AAPL, although it may be more accurate to say that the data and skills are actually embodied in the practitioners of forensic psychiatry, and are best exemplified by their practice.

The literature in which the data and skills are set forth is varied. In the United States, it includes *The Bulletin of AAPL, The Newsletter of AAPL,* the compilation of landmark cases in mental health and law available through the AAPL Learning Resources Center, and the comprehensive series of books developed by the Tri-State Chapter of AAPL, entitled *Critical Issues in American Psychiatry and the Law* (currently consisting of seven volumes either in print, in press, or in process). Outside of AAPL, there are the books that have received the Guttmacher Award of the American Psychiatric Association, the American Bar Association's *Mental and Physical Disability Law Reporters,* the AAFS's *Journal of Forensic Science,* and many independent publications such as those in the core library recommendations of the Accreditation Council on Fellowships in Forensic Psychiatry.

The existence of subspecialty fellowship training programs is attested to by the Association of Directors of Forensic Psychiatry Fellowships. At the present time, there are 20 programs in the United States and four programs in Canada. A description of each of the forensic psychiatry fellowships is readily obtainable through the Association of Directors of Forensic Psychiatry Fellowships.

The organization to certify the subspe-

cialty training programs is the Accreditation Council on Fellowships in Forensic Psychiatry, which is sponsored by the AAPL and the American Academy of Forensic Sciences, and whose mission has been approved by the American Board of Forensic Psychiatry. The Accreditation Council's actual implementation of an accreditation process has been one of the principle and successful projects of AAPL during my tenancy as President this year.

The organization to identify those practitioners who have demonstrated their competence in our field is the American Board of Forensic Psychiatry, which is sponsored by the American Academy of Forensic Sciences, the Forensic Sciences Foundation, and AAPL. The American College of Forensic Psychiatry provides an alternative means of obtaining certification.

Notwithstanding these qualifications for recognition as a subspecialty, the American Board of Psychiatry and Neurology has deferred deciding whether to recognize forensic psychiatry as a defined area in which "special competence" may be demonstrated. The American Psychiatric Association has yet to respond to a request by the American Board of Forensic Psychiatry to recognize our subspecialty. The Accreditation Council on Graduate Medical Education (ACGME) has declined to undertake the accreditation of subspecialty fellowship training programs in forensic psychiatry. The American Board of Medical Specialties has declined to recognize the American Board of Forensic Psychiatry. How is this diffidence on the part of organized psychiatry and medicine to be understood?

The American Board of Medical Specialties (ABMS) has explained that, among other reasons, they have requirements for subspecialty certifying Boards with which forensic psychiatry does not currently comply. For example, candidates for a certifying Board recognized by the ABMS must be graduates of an ACGME-accredited subspecialty fellowship. The American Board of Forensic Psychiatry does not presently limit candidates for examinations to psychiatrists who have taken fellowships in forensic psychiatry. Further, because the Accreditation Council on Fellowships in Forensic Psychiatry has implemented its processes only this past September 1988, as yet, there are no forensic psychiatry fellowships accredited by any organization.

The ACGME declined to undertake the evaluation of subspecialty fellowships in forensic psychiatry because the field does not meet all of their prerequisites. For example, the ACGME only reviews programs in fields whose certifying Boards are recognized by the ABMS.

Thus, the ABMS requires us to first be possessed of ACGME-accredited fellowship programs, and the ACGME requires us to first be possessed of an ABMS-recognized certifying Board. That there is something intrinsically impossible in these mutually incompatible prerequisites is recognized by all parties, but the policies are not readily modified.

There has been no formal clarification of the basis for postponing a decision by the American Board of Psychiatry and

Neurology. However, it is bound by the requirements of the ABMS. Thus, it would require those psychiatrists who wish to take an examination in order to demonstrate their "special competence" in forensic psychiatry to be graduates of an accredited subspecialty fellowship program.

The APA has not yet replied to the request from the American Board of Forensic Psychiatry that it recognize forensic psychiatry as a subspecialty, so we do not know how that request is viewed. However, we do know that there is general disagreement within the APA regarding the issue of subspecialization in general.

The only new subspecialty recognized by the APA has been geriatric psychiatry. It is rumored that economic factors were a major concern in the APA's decision. Both Internal Medicine and Family Practice, two of the ABMS recognized specialties, had indicated their interest in establishing geriatric subspecialties. There was concern that geriatric Internists and geriatric Family Practitioners might claim behavioral geriatrics was part of their expertise. Failure to recognize geriatric psychiatry as a subspecialty might have resulted in having psychiatry excluded from a major segment of the therapeutic market. At the present time, there is no other area within organized medicine that is staking out a claim on the area of forensic psychiatry, so there is no fiscal or territorial pressure on the APA to recognize our subspecialty quickly.

A distinction must be made, however, between whether or not forensic psychiatry is a subspecialty, and whether or not organized medicine and psychiatry is willing to recognize forensic psychiatry as a subspecialty. In much the same way as the State of Israel exists regardless of whether or not the majority of Arab nations recognize it, and the People's Republic of China existed regardless of recognition by the United States, the subspecialty of forensic psychiatry exists regardless of whether organized medicine and psychiatry recognize it.

Among the obstacles that we face is the lack of understanding among general psychiatrists, and among the public as a whole, of the adversary system in Anglo-American law, which obliges experts in all fields to be pitted against each other in courtroom testimony. Dr. Paul Fink, a President of the American Psychiatric Association, speaking at the opening ceremonies of the AAPL convention in Philadelphia, cited the spectacle of opposing psychiatric experts as a major public relations problem in forensic psychiatry and called upon AAPL to solve it, Even he, apparently, did not realize that the adversary system was intrinsic to our legal system and beyond the capacity of forensic psychiatry to reform.

As the definition of our subspecialty states, we operate within legal contexts, unlike clinical psychiatry which operates within therapeutic contexts. This difference was articulated often by the late Dr. Seymour Pollack and was the centerpiece of his presidential message, "Forensic Psychiatry: A Specialty," 1974, Volume II, issue number 1, of *The Bulletin of AAPL*. Dr. Pollack particularly stressed that the ends of law are not

identical with the ends of therapeutic medicine in general, and of therapeutic psychiatry in specific. The requirement of work in a legal context faces the forensic psychiatrist with problems that are not readily understood by clinical practitioners.

At the most elementary level, forensic psychiatrists are asked to substantiate and prove the bases for their opinions. How often does a clinical psychiatrist have to provide, on pain of penalties for perjury, a lucid and cogent explication of the processes by which he reached his conclusions? How often does a clinical psychiatrist face the demand that he convince the majority of rational persons listening to his views? To an extent unexperienced in clinical practice, the forensic expert must differentiate between what he sincerely believes, on the one hand, and what he can demonstrate that he knows, on the other hand. The forensic psychiatrist must distinguish between the hard data of our field and the metapsychological theories that purport to explain those data. Further, the forensic psychiatrist is asked to specify the level of confidence that he has in his opinions. In some civil cases decisions are made by a preponderance of the evidence, i.e., beyond 5O percent certainty. In some civil cases decisions are made by clear and convincing evidence, i.e., a greater level of certainty. In all criminal cases decisions are made by proof beyond a reasonable doubt. How often is the clinical psychiatrist required to make such fine delineations as to the certainty of his therapeutic recommendations, let alone to convince impartial hearers that he is correct? Utilization Review or Medical Audit committees are not as demanding as a judge or a jury.

The matter of hard data in psychiatry is one that is greatly misunderstood by the general public and by our medical colleagues. It is commonplace to hear psychiatry being accused of being a less substantial field than orthopedic surgery, for example. However, in fact, the hard data of psychiatry are essentially the same as that of every other field of medicine. All that any doctor fundamentally knows is what he sees, hears, touches, and smells in the course of his evaluation. (It is difficult to conceive of having to taste anything in the course of a medical or psychiatric examination; maybe the home-made cookies presented by a grateful patient are the exception that proves the rule.) All the behavior we observe, all the words we hear, all the handshakes we feel, all the aromas that waft our way, are the hard data of psychiatry. They are just as real as broken bones and must be given the same serious consideration. We do ourselves a disservice to let accusations of soft data go unchallenged.

In terms of the evaluation of the hard data, orthopedists on the witness stand are seen to publicly disagree just as readily as psychiatric witnesses. To disagree about the interpretation of hard data is common. Every doctor who has attended a Clinical Pathology Conference in the course of medical school training will recall that skilled clinicians in medicine and surgery routinely interpret clinical and laboratory findings in dis-

parate ways. There are multiple valid interpretations of the same findings in many instances.

It is often difficult for the public to fathom the bases of our courtroom disagreements. However, we should be clear in our own minds that there are different levels of professional differences. Some disagreements may be about the hard data itself (e.g., he slouched in his chair when he spoke to Doctor A, but he sat with erect posture when he spoke to Dr. B, so they disagree about the nature of his posture). Other disagreements may be about lower level interpretations of the hard data (e.g., Dr. A thought that he spoke softly, but Dr. B thought he spoke at a conversational volume. The doctors have a different threshold for using the term "soft"). Some disagreements are about higher level interpretations of the hard data (e.g., Dr. A thinks the claimant is impaired, but Dr. B thinks the claimant is malingering). Other disagreements are related to the vagueness of the legal criteria used to determine the psychiatric-legal issue (e.g., Dr. A thinks that the proximate cause of the emotional trauma was x, but Dr. B disagrees that x constituted the proximal cause). All of these different types of professional disagreements can occur, but they do not occur because our data are intrinsically soft. Rather, they are the same types of professional disagreements that are seen when orthopedists or any other physicians testify. All physicians will disagree with colleagues from time to time. Our disagreements are visible in the courtroom. Our agreements are not visible to the public because there is little incentive for attorneys to present experts who agree.

Some years ago, another President of the American Psychiatric Association, Dr. Alan Stone, addressed the AAPL convention and declared that our field was a "moral minefield." He suggested that there were intrinsic ethical difficulties in our work and implicitly applauded our courage in being undeterred by them. What are these ethical problems that are unique to our work? First, there is the basic fact that the ends of law and the ends of therapeutic medicine are not the same. As a result of working in legal contexts, forensic psychiatrists are asked to put their duty to our society ahead of their duty to the individuals who compose our society. For example, our therapeutic duty is *primum non nocere*; first do no harm. However, when we offer the opinion that a given defendant is competent to stand trial, and our opinion is accepted by the Court, the defendant may regard the consequences of our work to be harmful. Similarly, when we offer the opinion that a claimant does not meet the level of impairment required to receive Social Security Disability benefits, and the U.S. government's Social Security administration accepts our view, the claimant may feel that we have harmed him. However, if we always provided answers to legal questions that served the interests of the persons being evaluated, we would be of no value in legal contexts, and the society in which we live would be harmed. Obviously, there are occasions when the interests of the person being evaluated

are consonant with the interests of society, and in such cases there is no such ethical tension as in the examples that I have just cited.

The forensic psychiatrist must be prepared, in a way that the clinical psychiatrist often is not prepared, to choose between the well-being of the person he is asked to examine and the well-being of the society as a whole. It is an ethical problem that is not unique to our field. In military psychiatry, the physician is required to place the interests of the nation ahead of the interests of the individual being examined. For example, it may be necessary for the military psychiatrist to declare that an enlisted person is malingering to avoid the dangers of combat. By making such a finding, the military psychiatrist puts the well-being of the person being examined at a lower priority than that of the society as a whole, which must be able to call upon its citizens in its own defense. Similar considerations regarding the duty to society being given priority over the duty to individuals apply to those situations in which clinical psychiatrists, like all other physicians, are obliged to report gun-shot wounds and child abuse. Thus, there is nothing that is intrinsically alien to medicine or to medical ethics in our field.

Beginning students of moral philosophy are soon made aware of the fact that some ethical tensions are derived from basic conflicting moral theories, i.e., from the fact that there is no fundamental agreement regarding what constitutes moral behavior. Thus, a major portion of the "moral minefield" is due to the nature of philosophy itself, rather than to forensic psychiatry. In gross over-simplification, there are two major schools of moral philosophy in our Western culture. The first, the deontologic school, holds that there are some core rules of moral obligation that are binding on all persons. Perhaps the leading spokesman for this school is the German philosopher, Emmanuel Kant. The second, the consequentialist or utilitarian school, holds that what makes some behavior right is its desirable outcome. The leading proponents of this school are the Englishmen Jeremy Bentham and John Stuart Mill. To take an extreme example of the disagreement between the two schools, let us examine the issue of whether it is ever right to punish someone who has committed a crime. The deontological school would suggest that a person who has done something good deserves a reward and a person who has done something wrong deserves punishment. For the deontologic moral philosopher, punishment of a criminal offender is a moral imperative and failure to punish a criminal would itself be morally wrong. The utilitarian school would suggest that punishment has a deterrent effect on the perpetrator and on other potential perpetrators of criminal acts; because the consequences of punishing criminals are beneficial to society the punishment is justified.

On the surface, it would seem that deontological and consequentialist moral philosophy complement each other. However, on closer study, it becomes apparent that the two can lead to major disagreements. For the deontolog-

ical school, it is an imperative to punish a moral wrong-doer regardless of the practical consequences, e.g., no matter what the cost, no matter what the difficulty, even if it required the entire Gross National Product for 100 years to fund the search for one offender. On the other hand, for the utilitarian, it may be more important that some person be designated as the criminal offender and receive publicized punishment, so that other potential criminals will be deterred, even if the person who is being punished is not the person who actually committed the crime. The deontologists would say that the utilitarians are doubly immoral because they are punishing an innocent person and because they have allowed the truly guilty party to escape.

The utilitarians would say that the deontologists are immoral because they are wasting the resources of society on a Quixotic project, thereby diminishing what remains to be used to better that society. It would be nice to report that there is some easy way to resolve the fundamental differences between the deontologists and the utilitarians, but no mutually acceptable resolution has been found since the beginning of Western civilization, and no one expects a solution to be found in the foreseeable future.

It should be noted that there are disagreements within each of the major schools. Deontologists disagree regarding which rules are morally binding. For example, is it more important to always tell the truth or to always punish criminal offenders? If always telling the truth were to make it impossible to always punish criminal offenders, would that justify sometimes not telling the truth or would that justify sometimes not punishing criminal offenders? Utilitarians disagree regarding which consequences are more important than others. For example, would it be better to spend scarce resources to improve health care for society, or to improve police and criminal justice programs. How does one evaluate whether a healthy society is better than a safe society? Thus, apart from the differences between the deontologists and the utilitarians, there is plenty of room for dispute within each of the two philosophical positions.

All moral issues are contaminated by these philosophic disagreements. Thus, it is no surprise that forensic psychiatrists can be caught on the horns of moral dilemmas. What is important is that the forensic psychiatrist should be able to recognize what the nature of the moral problem is. Is it that the requirements of law are different from the requirements of medicine? Is it that the requirements of deontology are different from the requirements of consequentialism? Is it that there is a disagreement about the prioritization of moral obligations? Is it that there is a difference regarding how to evaluate the practical consequences of mutually exclusive moral choices and actions? Sometimes, in the course of careful philosophical analysis it becomes possible to detect imperfect reasoning from agreed upon premises, and to resolve the disagreement. Sometimes, the level of disagreement can be agreed upon, even if the dispute can not be resolved, thereby narrowing the scope of the dispute.

The thrust of my argument is that

forensic psychiatry is not a "moral minefield," rather it is that moral discourse is itself a morass of unresolved conflicts. In much the same way that it is not fair to blame the adversary system of Anglo-American law on us, it is unfair to blame lack of moral unanimity on us. It is perhaps incumbent upon the forensic psychiatrist to have some understanding of the roots of moral disputes, if only so as to clarify that the problem rests with philosophy rather than with forensic psychiatry.

The fundamental method of organizing data in forensic psychiatry is not the same as that used in clinical psychiatry. This is because a large part of the data that must be considered in forensic psychiatry is outside of the consideration of clinical psychiatry. For example, the legal issues themselves are myriad. In family and domestic relations laws one must consider such issues as juvenile delinquency, child custody, parental fitness, children in need of supervision, abrogation of parental rights, spouse abuse, child neglect, abandonment of children, adoption, and foster care. In criminal law one must be mindful, among other things, of competence to stand trial, competence to waive representation by counsel, competence to be sentenced, competence to be executed, of guilty but mentally ill (GBMI), diminished responsibility, and the verdict of not guilty by reason of mental disease or mental defect. Within civil law, the issues include involuntary psychiatric hospitalization, rights to refuse treatment, informed consent, competence to participate in do-not-resuscitate decisions, testamentary capacity, competence to become engaged, married, or divorced, contractual capacity, disability compensation, and medical malpractice. None of those psychiatric-legal issues fits into the traditional medical framework of chief complaint, history of the present illness, past pertinent history, physical findings, mental status, laboratory reports, and differential diagnosis.

For every one of the psychiatric-legal issues there are a wide array of legal criteria. Those criteria may be in legislated statutes, in case law determinations by the courts, in administrative codes established by the executive branch of government or in private contracts (e.g., insurance policies). Just to complicate matters, each of the 50 states and the federal jurisdiction has its own distinct set of laws, cases, codes, and valid contracts. While the issues may remain the same, thanks to our federal system of legally independent states, the criteria that are used to decide the issues are a hodgepodge. As before, such legal matters do not readily fit into the standard data organization framework used in medicine.

Different from clinical medicine's focus on a present condition that is the concern of the patient, is the fact that in forensic medicine the focus may be on the past (e.g., was the person competent to consent to the treatment provided?) or on the future (e.g., will it be safe to transfer this person acquitted by reason of mental disease to a less secure psychiatric facility?). Further, the person who is the focus of the examination may have no complaint; the inquiry comes from a third party whose own health is not under consideration at all. These contin-

gencies are not part of the routine clinical psychiatric data collection format.

Forensic psychiatry has its own conceptual framework for the organization of the data that is germane to its practice. It is a framework designed to deal with the fact that the method of data organization in forensic psychiatry differs both from that of medicine and from that of law. It is derived from the fact that some special framework is needed to work at the interface between the two fields. In general, forensic psychiatry applies a four step process:

1. What is the specific psychiatric-legal issue?
2. What are the legal criteria that determine the issue?
3. What are the relevant psychiatric-legal data?
4. What is the reasoning process used to reach a conclusion?

One of the many uses of this outline is that it can reveal where problems exist. In many instances, what is revealed is that the problem is with the legal system, rather than with forensic psychiatry. In some instances the problem occurs at the first step of the outline; judges and lawyers erroneously ask the wrong questions and then complain about the answers that they receive. For example, the Court may ask if a defendant is competent to stand trial, but the real question may be whether the defendant is able to remain acquiescent while his lawyer enters into a negotiated plea bargain on his behalf. In other instances, the problem occurs at the second step of the outline; the criteria set forth in the law are insufficiently specific. For example, who really knows precisely what is meant by "the best interests of the child" when custody issues must be considered? In some instances, the problem occurs at the third step in the outline; judges may insist that we provide answers to questions that are beyond current psychiatric knowledge. A good example of this problem occurred when the United States Supreme Court decided that psychiatrists could legally express an opinion regarding the future dangerousness of persons, notwithstanding the fact that the American Psychiatric Association had filed an *amicus curiae* brief to the effect that such predictions were beyond the scientific competence of psychiatrists. Finally, the problem may be at the fourth step in the outline; the attorney examining the psychiatric expert witness may (on direct examination) not set forth a series of questions that permit the forensic psychiatrist to demonstrate the rational argument leading from the data to the conclusions or, alternatively, the opposing attorney (on cross-examination) may have prevented the psychiatric expert witness from responding fully and cogently to the questions being posed. After all, once we are on the witness stand, we are largely dependent on lawyers to facilitate and permit the presentation of the logical connections between our data and our opinions.

Much of the difficulty that the medical profession and the general public have in appreciating forensic psychiatry is due to blaming our field for problems that derive from other disciplines. The adversary system comes from Anglo-American law; it is not the creation of

forensic psychiatry. The "moral minefield" is derivative from irreconcilable conflicts within the main stream of Western civilization's moral philosophies. The lack of clear and stable legal criteria for specific legal issues is attributable to social policy decisions made by legislators, judges, and executive administrators.

Given the various problems that cause misunderstanding and misappreciation of forensic psychiatry, what can be done, and what does the future hold for our field? Several cautious predictions are possible. First, the trend towards formal postresidency training in forensic psychiatry is likely to continue. The time will come when any forensic psychiatrist who is not a graduate of an accredited fellowship program will be as dubious a practitioner as a physician who specializes in mental disorders but who has never graduated from a residency in psychiatry. Second, the trend towards recognizing board certification in forensic psychiatry as an important credential for practitioners is likely to continue. Eventually all practitioners will be expected to be certified in forensic psychiatry and the absence of such certification will be grounds to question the qualifications of a witness seeking to provide expert testimony. Third, the importance of educating the general public, the nonforensic general psychiatrists, the specialists in our own field, and the attorneys will continue. AAPL will have an increasingly important role to play as our field continues to mature and its importance is further recognized. Fourth, research in forensic psychiatry will have to increase substantially, so that the scientific data base upon which our opinions rest can become more firm. It has been suggested that many of the questions that we are asked in court are not answerable from current clinical and research data (e.g., what percentage of patients with command hallucinations actually obey the commands? Do psychotropic medications work as effectively when administered involuntarily as they do when the patient actively cooperates with the treatment? What factors are related to future dangerous behavior?)

Looking into a crystal ball is always a risky project, sometimes the future is cloudy, sometimes the seer has poor eyesight, sometimes the sphere slips and the shattered shards are undecipherable. These predictions may more likely represent the expectations, perhaps even the hopes, for the field, rather than a guaranteed surety. What we, the current generation of forensic psychiatrists, do in the present is the key to the evolution of forensic psychiatry in the future. If we recognize that our field has become a subspecialty in psychiatry, and if we act accordingly, then the future of our field is secure. If we are uncertain ourselves, if we falter in our organizational efforts and our commitment to expand the scientific and clinical bases of our work, then the responsibility for delaying general appreciation of our field will rest with us. The future of our subspecialty is in our own hands. It is our task to be worthy of that opportunity.