Professional versus Personal Ethics: Methods for System Reform?

Robert D. Miller, MD, PhD

It has been suggested that changes in, and more vigorous enforcement of, professional ethical codes might lead to significant improvements in the quality of expert testimony by mental health professionals. The author examines the arguments for and against this thesis, and concludes that lack of consensus on controversial issues is likely to impede implementation and enforcement of meaningful ethical codes. He argues that attempts to educate the courts and legislatures through writings, testimony, and interdisciplinary teaching are more likely to be effective for the foreseeable future.

Like the majority of forensic psychiatrists currently in practice, I had no formal training in the subspecialty. I came to the field through necessity, as a reaction to the advent in the 1970s of zealous patient attorneys in the North Carolina civil commitment system who were initially successful in obtaining the release of up to 90 percent of committed patients because of procedural irregularities in the community-based commitment petitions.[1] In order to permit patients to receive appropriate treatment, it was necessary for hospital-based psychiatrists to become sufficiently familiar with the legal system to ensure that commitment petitions could be decided on their merits, rather than on whether all the boxes on the forms had been checked correctly.

There were no forensic psychiatrists practicing in my locality at the time, so I turned, of necessity, to the growing literature on the subject, both for factual information and for the type of experience that psychiatrists are more accustomed to obtaining through personal supervision. Fortunately, a number of experienced forensic psychiatrists had written on various aspects of performing forensic evaluations, and also made regular presentations at professional meetings such as those of the American Academy of Psychiatry and the Law. While not permitting the kind of questioning and immediate feedback available through supervision, these teachings

Dr. Miller is chief psychiatrist, Colorado Department of Corrections; and professor of psychiatry and director, Program for Forensic Psychiatry, Colorado Health Sciences Center. Address reprint requests to: Dr. Miller, Campus Box C-249, 4200 East Ninth Avenue, Denver, CO 80262.

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have been an invaluable source of information and experience for me and for other fledgling forensic psychiatrists as we developed our ideas about how to go about our work.

Dr. Bernard Diamond was one of those scholars and teachers who provided me with such guidance. I met Dr. Diamond personally for the first time a few years ago; but I felt at that time as if I had known him for years. His writings on the general topic of the role of the expert witness, and the ethical questions raised by the assumption of that role, seem to me to be the most well-developed in the literature, and to stimulate meaningful debate rather than to foreclose it.

One does not have to accept all of Dr. Diamond's ideological beliefs (which have the virtue of being explicit, rather than hidden, as they all too often are for other authors), such as his refusal to testify for the prosecution and his belief in the inherent superiority of psychodynamic to biological concepts of mental disorder, to benefit from his experience and views on the general role of the expert witness. The diversity of the articles in this issue is testimony to the richness of Dr. Diamond's writings, and his ability to stimulate serious discussion within and outside of the profession.

Dr. Diamond is best known for his thesis that expert witnesses cannot be impartial in any meaningful sense of that concept, and that they should neither try to be so, nor pretend that they are.[2–5] As that issue will be addressed by others in this issue, I will focus on another recurring theme in Dr. Diamond's teachings, that of using the position of expert to reform expert witness practices, to educate courts and legislatures, and to convince them to change their policies where they conflict with clinical priorities. He has argued that clinical professionals should not permit their expertise to be misused by courts[3,5,6]; and that in fact the expert witness role can (and in his view, should) provide an opportunity to educate courts and legislatures about relevant clinical knowledge and the policy positions based on that knowledge.[3,4,6] He cites the influence of his testimony and writings on such subjects as hypnotically enhanced eyewitness testimony, the prediction of dangerousness, and the misuse of psychoanalytic theory on court decisions.[6]

Several other authors have discussed moral/ethical dilemmas inherent in forensic work. The theme that forensic professionals can (and should) use their expertise and influence to effect changes in the legal systems with which they interact has recently been extended by Stephen Golding,[7] a leading scholar in forensic psychology. He points out that the only justification for experts to come into court is the fact that they are believed to possess information beyond the ordinary knowledge of judges and juries. He then argues that all too often experts testify based on moral convictions rather than scientific data, and are allowed to do so by courts.

While trial judges have the authority to ensure that the proposed expert does in fact possess sufficient professional expertise to be able to accurately enlighten the jury, Golding argues that in practice

that responsibility is rarely taken seriously; opposing attorneys and judges most frequently examine mental health professionals only perfunctorily before they are qualified to testify as experts, leaving to cross-examination the more substantive task of exploring the reliability and validity of their testimony. For example, in *Schuster v. Altenberg*,[8] a "duty-to-protect-third-parties" case, the Wisconsin Supreme Court specifically extolled the virtues of cross-examination in revealing deficiencies in expert testimony.

But cross-examination rarely provides any check on witnesses who testify without sufficient scientific foundation for their opinions, since few attorneys or judges have sufficient knowledge of the clinical and research data to examine clinicians effectively. Dr. Golding further points out that neither psychiatry nor psychology has provided courts with effective guidelines concerning the limits of such expertise, which might assist them in limiting inappropriate pronouncements by self-styled experts.

Dr. Golding argues that there is little reason to anticipate that courts will change their practices on their own, since by deferring to clinical expertise, legal decision-makers are thereby able to delegate the difficult moral choices involved in many mental health cases, such as the insanity defense, to clinicians. Therefore, he concludes that the solutions to the problem of inappropriate moral advocacy in court must come initially from the clinical professions themselves. As one approach to reform, he cites extensively from ethical standards for forensic psychology recently adopted by Division 41 of the American Psychological Association, the American Psychology-Law Society, and the American Board of Forensic Psychology.[9]

The standards go beyond existing generic ethical standards to prohibit expert witnesses from speaking to the ultimate legal issues (such as declining to comment on a defendant's criminal responsibility itself); and they call for clinicians to *proactively* provide not only comprehensive data to support their opinions, but national standards by which courts can (and, Dr. Golding argues, ultimately *must*) evaluate both the credentials of proposed experts and the reliability and validity of their subsequent testimony.

Dr. Golding argues that only if expert witnesses are required by their own ethical standards to expose the bases of their expertise and the data upon which their conclusions are based, will courts be forced to deal substantively with the validity of their testimony.

Poythress[10] criticizes the failure (except in high-priced civil litigation or high-visibility insanity cases) of judges and attorneys to force mental health professionals to provide real credentials and appropriate data to back up their opinions. He mentions professional review procedures in Minnesota that review expert testimony in malpractice cases retrospectively for ethical violations and other abuses, and suggests that such a system, if done prospectively, might help deal with the problem.

Poythress also argues that an extensive system of cross-disciplinary education

between law and the mental health professions might be more effective than attempts to control practices in the courtroom. He acknowledges, however, his own experience in training attorneys to represent patients in civil commitment hearings as evidence that training alone will not suffice to change ingrained behavior patterns.

Perlin[11] recognizes the difficulties experienced by the legal system in policing clinical practice, particularly with the current "hands-off" approach in the federal judiciary, but he does not propose that the professionals themselves become active in reforming their practice.

Appelbaum[12] responds to the question of how the ethical psychiatrist can apply his or her skills to the evaluation of persons for the courts (both civil and criminal), knowing that some of those persons will inevitably suffer harm as the result of the evaluations. He argues that although the official medical ethical guidelines no longer prohibit doing harm,[13] general practitioners continue to hold that as an ideal. He then questions whether the same proscription applies (or ought to apply) to forensic psychiatrists and concludes that it does not.

Forensic psychiatrists should certainly help those whom they evaluate where possible and avoid unnecessary harm to them; but beneficence and nonmaleficence cannot occupy the central positions that they do in clinical practice, else the evaluations would lose their value to the legal system, a value based on the premise of objectivity and lack of bias.

Appelbaum points out that we do not expect physicians to act solely out of beneficence toward others outside of the doctor-patient treatment relationship, and that there is therefore no reason for such expectations in the evaluator-evaluee relationship. But if the principles of beneficence and nonmaleficence do not form the basis for forensic ethics, what substitutes can be found?

Appelbaum answers his own question by advancing the general ethical principles of truthfulness and limitation of one's opinions to those for which the existing knowledge base provides support. He could have included the principle of objectivity (included in the existing forensic ethical guidelines of the American Academy of Psychiatry and the Law,[14] which he dismisses as undercutting his point that forensic ethics are distinct from general psychiatric ethics.) Based on his current conceptualization of forensic ethics, Appelbaum rather cavalierly dismisses as misguided those who continue to be troubled by their involvement in cases in which their opinions may cause harm to those evaluated.

Foot[15] discusses types of ethical (or moral—she equates the two terms) questions that can arise for the members of a particular profession: 1) those particular to the profession's practice, and independent of the setting in which the obligations arise; and 2) moral doubts raised about certain institutions or practices themselves, regardless of the professional's participation in it. For example, the American Medical Association's prohibition against physicians participating in executions is of the first type, since capital punishment itself has not

been declared morally unacceptable, either by society at large or by the medical profession.

Type 1 ethical questions can be further divided into two subtypes, those that depend upon the special aims of the profession (such as the aim of preserving life in the AMA example) and those that do not. Certain acts can be justified by arguing that there are roles within a profession that do not fall under a particular aim of the profession. Psychiatric participation in the death penalty process is such a process. Thus, physicians of many types may provide services, not to patients, but rather to institutions such as insurance companies or courts with a legitimate interest in the mental health of persons subject to their practice.

Foot argues that since the primary purpose of medicine (including psychiatry) is to heal patients, it is difficult to create a separate role—as Appelbaum attempts to do[12]—between healer and "forensicist." She acknowledges that Appelbaum is at least open about the differences between the two roles, rather than arguing that the forensic psychiatrist is either healing the world through his activities or responding to the unconscious desire of the criminal for punishment. But she rejects Appelbaum's argument (which would even justify direct participation in an execution) because (unlike military doctors who return soldiers to combat) the *goal* of the system of capital punishment is to kill the person examined by the psychiatrist.

While certain functions (such as treating inmates who are incompetent for execution) should be repugnant, others may actually help defendants, such as evaluating mental state for insanity defenses and capital sentencing hearings. She argues that the Supreme Court's holding in *Ake v. Oklahoma*[16] recognizes the value of such assistance. Appelbaum[17] also discusses the impact of *Ake* on forensic practice; he concludes that the decision does not require the psychiatrist to become an advocate, and that there is no necessary problem with the proposed consultant role. But Rachlin[18] disagrees, holding that the decision appears to permit judges and attorneys to force psychiatrists into such a role.

Foot[15] points out that participation in capital cases raises other ethical problems; even if the law permits testimony as to future dangerousness, clinicians cannot ethically provide such testimony, since their expertise does not extend that far. She also argues that confidentiality cannot be preserved (and regardless of warnings, defendants will believe that what they tell a doctor is confidential).

With this background, I will now examine two controversial forensic issues, to initiate discussion about the efficacy of using professional ethical guidelines as methods for reforming the use of expert testimony.

The Duty to Protect Third Parties as a Paradigm for Discussion

While clinical participation in the death penalty process has resulted in the most fervent rhetoric in the literature because of the high stakes involved, such activity remains quite infrequent and affects a very small number of clinicians

in actual practice. Other issues are much more common, and much more likely to involve general practitioners as well as forensic specialists. Perhaps the most frequent and controversial is the duty to protect third parties from the actions of psychiatric patients. Although the ethical codes of psychiatrists,[13] psychologists,[19] and social workers[20] all contain exemptions from confidentiality requirements if essential to protect the patient or the public, the codes are permissive and assume that confidentiality will be violated only when the danger is clear and imminent.

Following the *Tarasoff* decision from California in 1974–76,[21] mental health professionals in a majority of states have been subjected to court decisions or legislative establishment of an externally mandated duty to protect society from the actions of their patients.[22] These decisions not only place therapists at increased risk for liability but, more importantly, produce significant ethical conflicts between the therapeutic necessity for confidentiality and the low threshold that a number of courts have established for taking action to protect third parties.

Mental health professional organizations have been concerned about these problems but reluctant to take official actions to deal with them. There have been a number of papers in the literature[22] that offer suggestions to therapists as to how to protect themselves from liability. Appelbaum and colleagues[23] review statutes passed by a number of states that limit the scope of the duty to protect, and provide a model statute that they believe balances the needs of therapists to establish effective therapeutic relationships and the needs of society for protection.

Appelbaum[24] characterizes society's desire for protection from mental patients as leading to preventive detention. He argues that if most psychiatrists refused to be used to effect such detention by using solely clinical grounds for hospitalizing and releasing patients, then that would establish the standard of care and could be used to refute claims of liability for preventing their patients' subsequent violent behavior. He suggests that this approach would be even more effective if organized psychiatry promulgated guidelines along this line.

Schopp and Wexler[25] warn the clinical professions against providing guidelines in this area that are too explicit; if such guidelines were to be accepted by courts (and since the legal standard in malpractice cases requires that demonstration that the defendant fell below professional standards in order that liability be found, official professional guidelines would be expected to have considerable weight), they might provide practitioners with effective methods to minimize their liability, but at the cost of significant reduction in clinical flexibility.

Greenberg[26] also disagrees with Appelbaum's proposal. She points out that no consensus exists (or is likely to exist) on when therapeutic purpose is lacking in a particular case. Also, those psychiatrists operating initially on such a concept would face significant liability until the courts became convinced of the standard (if they did at all.) In addition,

Greenberg argues that many psychiatrists *agree* with the tort law that they have a moral duty to society to provide protection from dangerous persons, even if they may not be treatable.

Greenberg offers a counterproposal: under existing circumstances psychiatrists can protect themselves maximally by detaining everyone believed to be dangerous; this will force legislatures and courts to deal with the problem of significant increases in admissions, with the economic and liberty costs involved. She argues that the high rate of concurrence between psychiatric recommendations and court decisions indicates that psychiatrists are using too high a threshold for detaining. She recommends a lower threshold, thus shifting the true decision-making burden to the courts (and ultimately to the legislatures, which set criteria for commitment.) If psychiatrists were to follow her recommendations, Greenberg suggests that they would provide society with valuable data for changing legal standards.

The Insanity Defense

Another area of controversy, particularly after John Hinckley's successful insanity defense,[27] is psychiatric participation in the determination of criminal responsibility. Apart from purely guild concerns for the reputation of psychiatry,[28] a number of experienced forensic professionals have had reservations about offering such opinions well before the Hinckley case.

A number of critics have gone so far as to argue that mental health professionals should avoid involvement in legal matters altogether. Freud, whose theories are still frequently used as the basis for expert opinions on a variety of legal issues, eschewed the legal expert role and advised others to do the same.[29] Perhaps the most extreme position was taken by Szasz in 1963[30]; since his basic theoretical concept is that mental illness does not exist apart from attribution by psychiatrists, it follows that he would argue that mental health professionals have nothing of value to offer the legal system.

Ennis and Litwack[31] and Morse[32] do not go so far as to reject the concept of mental illness, but they argue that the state of psychiatric knowledge in legally relevant areas (particularly diagnosis, prediction of future behavior, and determination of criminal responsibility) is insufficient to provide legally probative information to courts.

Halleck[33] is concerned with the double agentry inevitably involved in much psychiatric expert opinion formation. He proposes separation of the evaluation and treatment roles, with only experienced forensic clinicians allowed to perform legal evaluations. Like other critics, he would prohibit clinicians from predicting dangerousness; and he would also require that all legally relevant decisions (such as commitment and release) by made by courts rather than by clinicians.

Stone[34] also concludes that psychiatrists should not offer expert opinions in court; but he bases his position less on the lack of appropriate psychiatric knowledge than on the argument that the adversary system necessarily degrades the input of clinicians, who

should therefore refuse to participate, and concludes that it is morally inappropriate to base expert opinions on less than scientific data, which are not yet available in the case of psychiatric opinions.

Tancredi and Weisstub[35] criticize Stone's conclusions on several grounds. They point out that he never provides a definition of morally acceptable behavior by which to judge the activities he criticizes. They argue that he does not adequately distinguish between the actions of individual practitioners and the practice of the profession as a whole. More substantively, they challenge Stone's assumption that "science" equals data acquisition (actively disputed by a number of historians of science), and that such data-based analysis (by which Stone concludes that psychiatry has little to offer the courts) is necessarily of a higher order than "taste" or "aesthetics," in which categories Stone places current psychiatric knowledge. They point out that morality itself is not subject to data-based analysis, and therefore expert opinions based on experience other than research data are not necessarily immoral.

Several mental health professional organizations have taken official positions on the insanity defense following the Hinckley trial. The American Psychiatric Association[36] proposed: 1) eliminating the volitional prong of the American Law Institute insanity test in those jurisdictions (including the federal courts) that employ it; 2) banning expert testimony on the ultimate issue of criminal responsibility; 3) recognizing that insanity acquittees, if they have committed violent crimes, are not equivalent to civil committees, and should not be released as easily when imminent dangerousness can no longer be *proven*; and 4) adopting an external parole board model (such as Oregon's Psychiatric Security Review Board) for release determinations.

The American Medical Association initially adopted a position statement calling for the total abolition of the insanity defense. After considerable negotiation with the American Psychiatric Association, the two organizations issued a joint statement[37] which claimed that there was little difference between them in the concerns that motivated either to address the issue, or in the policy objectives that each sough to promote. Both started from the proposition that, as a matter of sound public policy, the criminal justice system must seek to assure a reasonable balance between the public's legitimate interest in protection from potentially violent offenders, and the mentally disordered defendant's entitlement to fast and humane treatment. Beyond this primary concern, the associations were also concerned with the establishment of an appropriate role for physicians in the process. The statement held that when physicians become too caught up in the adversary process, they bring disrepute upon themselves and upon their professions.

Given the impetus of the public reaction to the Hinckley case in the generation of the American Psychiatric Association's position, it has been criticized by Diamond[6] and Perlin[38] as self-serving guild protection. Stone[34] points out that

the new guidelines would have made no difference in the outcome of the Hinckley case itself. Rogers[39] criticized both the American Psychiatric Association and the American Bar Association for advocating the removal of the volitional prong based on conclusions that determinations of volition were less reliable than determinations of cognition. He stated that there was little empirical evidence to bolster their assertions and cited various research, which at best does not support the proposition that it is easier to provide meaningful expert opinions on cognition than on volition. He argued that an examination of both is necessary in every situation, regardless of the legal criteria used.

The American Psychological Association also issued a position statement on the insanity defense.[40] It eschewed the politically popular pressure to advocate limiting or abolishing the defense, but rather called for empirical research into the bases for offering opinions on each prong, and also for the effects of expert testimony on jury deliberation.

Internal Implementation of Ethical Standards

As applied to psychiatry, Dr. Golding's proposals would require the American Psychiatric Association to establish specific, and enforceable, ethical guidelines for forensic practice that address controversial subjects such as addressing ultimate legal issues, proactive disclosure of limitations of the bases of expert opinions, and offering opinions on subjects (such as the prediction of future dangerousness). The Ethics Committee of the American Academy of Psychiatry and the Law has been attempting to devise such standards and to convince the APA to incorporate them into its Annotations to the AMA Ethical Principles, without much success. Now that forensic psychiatry has been officially recognized as a subspecialty by the APA, this resolution might be significantly facilitated.

Currently, the American Academy of Psychiatry and the Law has decided not to attempt to enforce its ethical guidelines (which are narrower in scope and much less detailed than those for forensic psychology). A major factor in this decision has been a reluctance to face costly litigation from disciplined practitioners, which would inevitably result from such enforcement.[41] This decision has been repeatedly criticized within the Academy[42] and also in published articles.[12]

The ethical guidelines of the National Organization of Forensic Social Work[43] are similar to those of forensic psychiatry and psychology; but, like those codes, they are largely general in nature and do not provide any mechanism for enforcement. The Ethical Code of the American Academy of Forensic Sciences,[44] which includes forensic psychiatrists, psychologists, and social workers, is so vague as to be of no practical use: as long as experts do not misrepresent their credentials or make deliberate misstatements of fact, the Academy considers their testimony ethical. The other major forensic interdisciplinary professional organization, the International Acad-

emy of Law and Mental Health, has not promulgated ethical guidelines.

Even if professional organizations were willing to be more assertive in enforcing their ethical codes, there are significant obstacles preventing the establishment of sufficiently detailed codes to address the issues discussed above, and of ensuring that behavior proscribed by such codes is reported to ethics committees. Diamond[45] has distinguished between professional ethics (those principles accepted by a majority of a profession) and personal ethics (those held by individual members of that profession.) He clearly realizes that personal ethics should not be binding on others; he recognizes, for example, that his strong belief that expert witnesses cannot (and should not) be "impartial," in any meaningful sense of that word,[5] has been rejected by all professional organizations.

Issues such as participation in capital cases and prediction of dangerousness continue to be too controversial for official consensus to develop. It is also unclear if refusing to accept official position statements (such as those discussed above) would constitute unethical conduct. For example, are psychiatrists who continue to address the volitional prong of the insanity defense, in those states which retain it, practicing unethically?

My personal experience has been that the American Psychiatric Association's Ethics Committee has been reluctant to provide definitive opinions in situations in which psychiatrists are called upon by their jobs to behave in ethically questionable ways. In one case, the Ethics Committee held that it was *not* unethical for a psychiatrist to be forced to serve as a hearing officer in release hearings whose outcome was predetermined by the state Department of Health and Social Services.[46] More recently, the Committee opined that it was *not* unethical for a psychiatrist to be responsible for the treatment of nearly 200 forensic patients at a state mental hospital.[47]

Even when ethical guidelines are unequivocal, such as the American Psychiatric Association's proscriptions against any sexual contact with patients,[48] against pre-arraignment forensic evaluations,[49] and against fee-splitting,[50] significant numbers of psychiatrists continue such practices. And since many of these practices do not violate any legal ethical codes, courts still welcome such testimony.

Although the APA's ethical guidelines state that psychiatrists should strive to report suspected ethical violations, the current chair of the APA Ethics Committee reports that to his knowledge there have been no complaints against psychiatrists for failing to report unethical behavior in their colleagues, although a forthcoming issue of the Committee's Newsletter will be devoted to the topic.[51]

A number of other efforts are being made by psychiatric professional organizations to address perceived problems associated with expert testimony internally. While these efforts do not directly invoke ethical guidelines as their authority, many are in fact supported by ethical guidelines requiring competent testimony that is not significantly influenced

by the wishes of the retaining party. One of the chief reasons for the establishment of the American Board of Forensic Psychiatry (and of similar boards in psychology and social work) was to improve the quality of expert opinions rendered to courts and other decision-making bodies. Unfortunately, the certifying methods used by such boards limit their abilities to police effectively the activities of those who are seeking certification or who are already certified.

As part of its examination process, the American Board of Forensic Psychiatry does review reports submitted to courts (selected by the candidate), but has no ability to monitor ongoing practice; certification can be withdrawn only after the American Psychiatric Association has taken comparable action. Only a small fraction of practicing forensic psychiatrists have sought certification, and many who have established credentials with courts have chosen not to seek certification; therefore, lack of certification has not yet achieved much significance as a measure of expertise in courts, and the direct authority of the Board is limited to a small number of psychiatrists. It is certainly possible that when the American Board of Psychiatry and Neurology assumes the certifying function, more psychiatrists will sit for examination and the new board will have more effects; but given the current ineffectiveness of the current board in policing post-certification behavior, it is unlikely to cause significant change in courtroom practices.

Task forces of the Council on Psychiatry and Law and the Commission on Judicial Action of the American Psychiatric Association and of the American Academy of Psychiatry and the Law are currently examining transcripts of expert testimony, which is thought to be a more appropriate measure of practice than written reports, which are often purposefully edited to reveal little of the bases for the opinions rendered. These groups are in the early stages of their work, and it has not yet been determined what will be done with any recommendations they make; but they have the potential to be made available to courts and legislatures as standards of forensic practice. Another task force of the Council on Psychiatry and Law has prepared a report on the use and misuse of psychiatric diagnoses in court,[52] which will also be made available to attorneys and judges to assist them in making optimum use of psychiatric expert testimony. As forensic psychiatry becomes an official subspecialty of the APA, such standards may take on greater weight with external regulatory bodies.

Another way in which the clinical professions can affect practice of forensic specialists is through training. Until recently, most forensic clinicians learned on the job, or through apprenticeship under an experienced teacher. Over the last decade, however, the number of formal forensic fellowship programs has grown to over twenty, and many have received accreditation based on strict educational criteria. With official recognition of forensic psychiatry as a subspecialty by the American Psychiatric Association, which will ultimately require completion of an accredited fellowship

program for certification, the number of such fellowships and thus of more thoroughly trained graduates, can be expected to increase. As such graduates become more numerous, it is to be hoped that the relevant research data and collective experience of leaders in the forensic field will achieve greater penetration into everyday practice than is currently the case.

External Implementation of Ethical Standards

In the absence of greater professional consensus, it seems unlikely that the proposals by Diamond, Golding, and others that forensic mental health organizations use their ethical codes to raise the standards in those professions will have a significant impact on everyday practice. Such efforts, however, may become increasingly effective as lobbying tools for use in courts, and particularly in legislatures.

While the influence of the mental health professions on courts has waned considerably since the halcyon days of the *Durham* rule,[53] and the current conservative Supreme Court majority has not been particularly receptive to input from organized psychiatry,[11,54] when the clinical and judicial agendas coincide there is still room for effective input, as can be seen in a number of decisions based on the Supreme Court's holding in *Youngberg*[55] that professional judgment is presumptively valid. In addition, although the Supreme Court has rejected the American Psychiatric Association's position that clinicians cannot predict long-term dangerousness,[56,57] at least two lower courts have accepted the evidence presented in barring such psychiatric testimony.[58,59]

Several states have passed legislation requiring that expert witnesses in medical malpractice cases spend the majority of their time in direct clinical practice. These laws have been passed in order to ensure that testifying physicians actually have the necessary ongoing experience in clinical practice to justify their being qualified as experts, and to discourage physicians from specializing is testifying in malpractice cases. Although clinical support may well have been forthcoming for guild reasons and is still widely circumvented in practice,[60] it is still an example of potential cooperation.

This principle appears equally valid in other areas of forensic psychiatry, such as determinations of competency to stand trial, criminal responsibility, psychic trauma, and child custody. No professional organization has suggested such requirements; and with the percentage of members the majority of whose practice is testifying, it is not likely to be forthcoming in the near future. Nevertheless, it is a concept worth considering; those practitioners who spend a majority of their time in testifying are more vulnerable to pressures to satisfy attorneys retaining them than are those whose basic income is derived from clinical practice.

Legislatures have generally been more receptive to clinical input than have courts, perhaps because they are more used to dealing with special interest groups, and also because they are more willing to base decisions on data rather

than on principle. A good example of such receptivity is the fact that over a third of state legislatures have passed legislation limiting the scope of court decisions holding therapists liable for the behavior of their patients[23]; psychiatric input has been crucial to the passage of such legislation.[61]

Conclusions

Until a new generation of forensic psychiatrists, trained in comprehensive fellowship programs, becomes a majority in forensic practice, it would appear that the most effective course of action would be for professional organizations and their leaders to concentrate their efforts on legislatures rather than courts. While the APA's Judicial Council has been increasingly active over the past decade in drafting *amicus* briefs to courts, it has been less active in providing information and positions to legislatures, although it is currently involved in the issue of psychologists obtaining hospital admission and prescribing privileges. Since legislative deliberations tend to be more predictable than court decisions and most state psychiatric organizations have active legislative committees, efforts in this area would seem to be a more productive expenditure of professional time at this time.

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