Editor:

In his recent editorial on the medication of criminal defendants (J Am Acad Psychiatry Law 29:136–7, 2001), Dr. Slovenko rejects any course of action other than medicating the individual in question. His recommendation that the treating psychiatrist “...let the chips fall where they may,” and follow the adage, “whatever will be, will be...” does not inspire confidence in his assessment of his treatment choice’s consequences. In fact, several factors complicate the scenario that Dr. Slovenko appears to find so simple.

First, contrary to Dr. Slovenko’s assertion that “The physician’s task is to treat the suffering irrespective of what the future may hold,” the physician’s task is to collaborate with the patient in the treatment of suffering. A patient may have a perfectly logical reason to refuse treatment—in this case fear of the death penalty—which the physician must respect. I myself have had several patients who have refused the medication I have offered to relieve their suffering, despite the fact that I knew what was best for them. And yes, a court-ordered medication would allow the physician to medicate the patient while remaining within ethical boundaries. But incompetence to proceed with trial does not imply incompetence to refuse medication. In an easily imaginable hypothetical case, an incompetent-to-stand-trial defendant might be found by a judge to be quite competent to make medication decisions.

Second, a defense attorney’s suggestion that a jury should see a defendant in the “true,” unmedicated state is not incredible, but quite reasonable. Dr. Slovenko is correct in pointing out that the mentally ill and unmedicated defendant’s behavior on the witness stand does not necessarily correlate with his unmedicated behavior at the time of the crime, but the jury is supposed to use eyes and ears to make just such an assessment.

Third, Dr. Slovenko’s assertion that juries are less likely to find a “crazy-looking” defendant not guilty by reason of insanity (NGRI) because they do not want him back on the streets, is unsupported by any data that I know of. In any case, defense attorneys should be allowed to recommend whatever strategy they think will serve, based on their understanding, their client’s best interests.

As physicians, we must consider the consequences of various treatment alternatives, talk with patients about those consequences, and respect their choices. This applies to the prison psychiatrist as well.

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Editor:

The recent article on recovered memory by Cannell et al.¹ and subsequent discussions by Davis et al.² and Barden,³ although probably fairly predictable, were also fascinating and frightening. They stimulated a series of reflections on matters indirectly, if at all, addressed:

1. Because memory responds to attention and therapy inevitably directs attention (e.g., by asking questions, even open-ended ones), all therapy is “recovered memory therapy.”

2. “Recovered” and continuous memory can be true, false, a mixture, or—as Binder’s important article⁴ describes—a mix of documented factually accurate and psychotic content.

3. The present dearth of senior clinicians who practice or even understand serious psychotherapy is one of the tragedies of our profession at this time.

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References
In *State v. Eppinger*, the Ohio Supreme Court considered procedural issues related to Ohio’s version of “Megan’s Law.” The Court appeared to be concerned with the procedural protections provided by the statute. The Court also appeared to be bothered by the trial court’s stated preference for the testimony of a gypsy over that of a mental health professional in attempting to predict the likelihood of engagement in sexually oriented offenses in the future.

The Court noted the problems inherent in predicting future behavior of a sexual offender and referred to this as “an imperfect science.” The Court stated that such a prediction was required by statute and testimony by a mental health professional or other expert might be the best way to assist the trial court in that determination.

The Court also noted the statutory factors that the trial court must consider in making a sexual offender classification, such as the defendant’s age, prior criminal record, use of drugs or alcohol to impair the victim, and the presence of mental illness in the defendant.

The Ohio Supreme Court’s decision in *State v. Eppinger* requires trial courts in Ohio to review several factors when making a sexual offender classification. Some of these factors have not been shown to predict recidivism. The Court appears to be comfortable in allowing, but not requiring, the testimony of mental health professionals on the issue.

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