

Recognizing the Existence of Quack Experts in Forensic Psychiatry and Exploring Hard Truths

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The quack expert pretends to have some peculiar knowledge or skill that the expert does not possess or that may not even exist at all. Within forensic psychiatry, the response to quack experts has been varied and largely ineffective in mitigating their effect. Previous efforts to address quack experts have primarily relied on the courts, sanctions from professional organizations, or state board intervention. A shift to more globally addressing the misinformation itself and creating education of what appropriate testimony entails is likely far more helpful than trying to identify and punish each quack expert. At the individual level, new avenues of intervention include forensic psychiatrists taking advantage of educational opportunities and engaging in self-reflection. At the regional and national level, potential interventions include the American Academy of Psychiatry and the Law's educating courts and attorneys, developing resource documents conveying basic principles of appropriate practice, and expanding peer review.

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"Everybody lies." Starting in 2004, millions of households began to hear this tagline of the popular show *House, MD*, which spoke to the nihilistic belief that, regardless of a person's situation, that person had the capacity to lie.¹ Although this could be viewed as an indictment solely on the patients depicted in each episode, the show just as frequently showcased medical providers manipulating the truth or making outright false statements in an effort to achieve what they believed to be the greater good. In the real world, we would like to believe that doctors adhere to the virtues of honesty and transparency with patients and colleagues. Even more, we would like to believe that, especially within forensic psychiatry, honesty and objectivity is a constant, even when opinions differ on certain details. This, however, is not always the case.

Many colorful terms have developed over the years to describe behavior that is a deceptive misrepresentation of the truth, even if not malicious in nature.²

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But disinformation and fake news have become more and more of a hot topic within our society, as new resources, such as digital news and online social networks, can propagate disinformation rapidly and to a large audience.^{3,4} There are certain arenas where disinformation is not similarly expected. One of those areas is the testimony of experts on a witness stand.

Many forensic psychiatrists have experienced a frustrating occurrence during their careers: when an opposing expert makes outlandish, false statements, often under oath. These statements can run the gamut from mischaracterizing our knowledge of psychiatric illness (usually with statements including the words always or never) to outright claiming special abilities beyond any logical evidence, such as having the ability to read the mind of an evaluatee or being able to predict far-flung future events with 100 percent accuracy. These types of statements often go far beyond a difference of opinion and into the realm of absurdity. In his presidential article from 2013, Charles Scott called for the American Academy of Psychiatry and the Law (AAPL) to recognize the need to strive for scientific truth in forensic psychiatry and minimize the risk for error or bias in expert testimony.⁵ We must also address

situations when the statement is not simply an error. We need to consider our response to experts who testify to false information.

The Ethics Guidelines for the Practice of Forensic Psychiatry, published by AAPL, sought to address at least part of this concern in 2005 by emphasizing that, "When psychiatrists function as experts within the legal process, they should adhere to the principle of honesty and should strive for objectivity" (Ref. 6, p 3). Although this goal is consistent with preventing willful falsehoods, the ethics guidelines then veer into how a lack of objectivity or the introduction of bias could lead the expert to be perceived in a negative light, rather than directly address the problem that an expert could choose to convey false information on purpose. This hesitance to confront the conundrum of false or misleading testimony is consistent within forensic psychiatry. Although many forensic psychiatrists are ready and willing to expose specific falsehoods in court, the available published literature focuses far more on the potential social and professional consequences of challenging an opposing expert⁷ or how experts might be affected internally when their opinions are questioned.⁸

Concerns about unique ethics situations within forensic psychiatry are nothing new. In 1982, Alan Stone challenged the legitimacy of forensic psychiatry during a famous address, with particular concern focused on the ethics guiding the profession.⁹ In 1997, Paul Appelbaum sought to clarify what Stone's characterization of forensic psychiatry could imply for the field:

If correct, as Stone's audience grasped immediately, this conclusion has some fairly troubling implications for forensic psychiatry. A field that is unable to distinguish the proper from the improper, the ethical from the unethical, must tolerate all behaviors equally, since no neutral principle exists for accepting some and condemning others. There can be no good practices and no bad practitioners (Ref. 10, p 233).

Appelbaum then refutes the assumption that forensic psychiatry cannot have its own ethics standards and lays out a framework from which to develop them, which has continued to be a major contributor to ethics in forensic psychiatry to this day.

I find interesting that the Appelbaum article is one of the few mentions of potentially identifying bad practitioners within our field. Often, forensic psychiatrists try to avoid identifying bad behavior within the field, instead assuming that conflicts are simply differences of opinion or that they could be explained

by certain perceptions. To truly define bad practitioners, we need to decide how we would do so. I propose that the concept of a forensic psychiatrist engaging in activity that is morally wrong can be informative. In 2001, Candilis *et al.*¹¹ argued for a model for the professional role that included the idea of personal morality. A test of deciding whether a forensic psychiatrist's behavior is morally wrong could be a reasonably lofty, although still subjective, way to identify a bad practitioner. Consciously deciding to lie about a medical fact or a practitioner's claiming an extraordinary ability would easily fall into the category of being morally wrong. Although this would allow a stark line that experts could avoid crossing, it is difficult (if not impossible) most times to discern the motivation behind these falsehoods or establish that the lying is done consciously. As I will discuss later in this article, such a barrier is not insurmountable, particularly when the focus of proposed interventions is on the behavior itself, not the motivation.

Identifying the forensic psychiatrist engaged in morally wrong behavior raises the closely related question of whether we should be identifying or labeling this behavior at all. In 2013, the AAPL council attempted to address a number of ethics questions posed to the AAPL Committee on Ethics, including one about calling an opposing expert who testifies frequently on the wrong side a prostitute. Although the question itself is not directly applicable to this article, the answer provided valuable information that is. The authors indicated that, although it was inappropriate to call another physician names, there was an ethical duty to strive to expose those physicians deficient in character or competence.¹² I believe that this provides proper justification for identifying that these individuals exist and mitigating their effects on the profession as a whole.

In searching for the proper term for an individual participating in this behavior, there are many potential candidates, including bad expert, bad forensic psychiatrist, and fraud, among others. I propose the use of the term quack expert. An entry defining quackery within the Encyclopedia Britannica is illustrative: "Quackery, the characteristic practice of quacks or charlatans, who pretend to knowledge and skill they do not possess, particularly in medicine. The quack makes exaggerated claims about his or her ability to heal disease, generally for financial gain."¹³

The term quack expert correctly identifies a psychiatric expert who is not only providing a difference

of opinion but pretending to have some peculiar knowledge or skill that the expert does not possess or that may not even exist at all. Under this definition, quack experts may very well believe what they are saying and are just grossly misinformed. This does not exclude them from doing real harm as a testifying expert. If we accept that identifying a quack expert is appropriate, we must consider what can then be done after identification occurs. Typically, the response falls into one of three categories: letting courts come to their own conclusions; reporting the individual to the American Psychiatric Association (APA); or reporting the individual to state boards. In the rest of this article, I delve into each of these options and present the challenges associated with them. Finally, I conclude with potential methods to intervene at the personal, local, and national level.

Reliance on the Courts

The United States and Canada use an adversarial legal system, based in the underpinnings of common law. An adversarial system assumes that trials and hearings are a competitive process, where both sides present evidence and arguments in an attempt to sway a presumably neutral fact-finder.¹⁴ This competitive aspect can be seen in the use of opposing experts in a case to battle through testimony to show that they should be given more credibility by a judge or a jury. In a hypothetically perfect model, the expert with the better facts and opinion would prevail and the fact-finder could easily distinguish who has the more evidence-based, logical opinion.

Reality, however, rarely fits with these pleasant fictions. In my experience, judges and juries often do not make such critical assessments to completely discredit untrue testimony. Take, for example, a case where two experts are testifying about a question related to psychiatry. Expert A provides an evidence-based opinion, which is well reasoned. Expert B provides an opinion without any evidence based on pure conjecture. Although Expert A constructs an excellent argument for why Expert B's testimony should be ignored, the jury sees it differently. The jury sees two individuals with equivalent credentials, because they are both doctors and psychiatrists, and assumes that both are equally competent and honest. Thus, the true opinion must be somewhere in the middle. Even if false and misleading testimony moves the needle in the minds of the fact-finder just a little, irreparable harm is potentially being done to the legal process.

There is a possibility that this false or misleading testimony can be stopped prior to getting to the trial phase of a case. Evidentiary standards established in prior cases, such as *Daubert v. Merrell Down Pharmaceuticals, Inc.*¹⁵ and *Frye v. United States*,¹⁶ can allow for judges to exclude expert testimony prior to getting to the court. Typically, the question of what expert testimony is admissible is based on an analysis of the strengths and limitations of evidence used to support an opinion.¹⁷

Unfortunately, this analysis is sometimes overly simplified by courts when applied to expert psychiatric testimony. For example, the *Frye* standard holds that the scientific principles or methods an expert uses must have general acceptance within the field.¹⁶ I have experienced cases where the sole status of being a psychiatrist is ruled to meet the threshold of being an expert about any psychiatric condition, because it is generally accepted that psychiatrists can diagnose and treat psychiatric conditions. Even when the more stringent *Daubert* criteria are applied, judges are inconsistent on how apt they are to take on the gatekeeping role of excluding expert testimony rather than deferring to the adversarial process.^{18,19}

These deficits in discerning evidence-based opinions from falsehood and intentional distortions of the truth present a significant challenge for judges and juries, who can be easily influenced by expert testimony, even when based on junk science. One of the most blatant examples of this was the testimony of Dr. James Grigson, a forensic psychiatrist in Texas who often opined that he could predict the future dangerousness of capital defendants. His assertions that he was "one hundred percent sure" that a defendant would reoffend in one case was a stark enough example of expert testimony that is not backed by science that it has become a landmark case taught by forensic psychiatry fellowships throughout the country (Ref. 20, p 880). Juries hearing that an individual is certain to reoffend and kill another person were surely influenced by this testimony; this supports the idea that even allowing the quack expert's testimony to be heard at all by juries can move the needle in a case. This example also illuminates a major concern with the gatekeeping function of courts: almost all of these cases are viewed in a vacuum. Dr. Grigson repeatedly provided similar opinions in other cases, eventually leading to him gaining the moniker Dr. Death. But the previous bias of an expert and testimony in other cases is often not part

of the analysis when determining whether testimony is allowed.²¹ Instead, it is viewed through a myopic lens of determining whether the testimony should be allowed only in the present case, without regard to any historical testimony of the expert. In this way, combatting the quack expert using *Daubert* or *Frye* is a new battle in every case.

Forensic psychiatrists may be able to help by educating attorneys about false information, but this can only go so far if motions to exclude other experts or parts of their testimony are not granted. After all, admissibility challenges are rarely successful, with a success rate of about 30 percent.²² On the witness stand, forensic psychiatrists can try to educate fact-finders on the lack of evidence behind a statement. But this can be difficult when a statement is so outlandish (such as an expert having telepathic powers) that no one has taken the time to develop literature pointing out the absurdity of the idea. It may seem to the savvy forensic psychiatrist that absurd statements can easily be addressed or even ridiculed with common sense. This supposition can lead to frustration. As forensic psychiatrists have years of medical education and experience in psychiatry, their view of what is pure common sense can be skewed, and the lay public may not agree with the matter being as simple as a psychiatrist might think. Currently, there are many examples of nonphysicians (and even some physicians) believing completely ludicrous ideas about medicine simply because those ideas were voiced by a purported expert in the media. Forensic psychiatrists should assume that similar susceptibility to absurd ideas could occur in a courtroom when they are voiced by an expert.

Often, when discussions arise about quack experts, one component of the legal system that is not brought up is civil liability. Because a doctor-patient relationship is not established in the vast majority of forensic cases, the typical liability for bad medical practice does not apply. Instead, most expert testimony is covered by judicial or quasi-judicial immunity, as long as the experts provide opinions they were engaged to formulate and avoid dual agency.²³ This accepted practice within civil law makes the pursuit of a lawsuit an ineffective way to police quackery.

Reliance on the APA

Although AAPL has produced a set of ethics guidelines, enforcement of ethics lapses is routinely

performed through the APA. This arrangement is made possible by the current requirement that AAPL members living in the United States must also be a member of the APA or the American Academy of Child and Adolescent Psychiatry (AACAP), because both of these organizations have the ability to investigate and adjudicate ethics complaints.²⁴ Based on membership data, the majority of AAPL members are also APA members. Thus, the APA is the *de facto* arbiter of ethics complaints against a significant portion of forensic psychiatrists in the United States. But this is not uniform. There are still many AAPL members who are not APA members and, as I will describe later in this section, would not be beholden to any ethics enforcement by the APA.

Ethics guidance followed by the APA is primarily based on *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*,²⁵ and a specific process has been delineated to receive, review, and investigate ethics complaints.²⁶ Section 2 of the Principles document states the following:

A physician shall uphold the standards of professionalism, be honest in all professional interactions and strive to report physicians deficient in character or competence, or engaging in fraud or deception to appropriate entities (Ref. 25, p 2).

Although this focus on honesty could easily be a basis for a violation when a quack expert provides false information during testimony, forensic subjects are not specifically delineated within the document. This leads to a set of regulatory standards that may not properly evaluate potential unethical expert witness testimony.²⁴ Furthermore, these guidelines that are nonspecific to forensic psychiatry may not even be applied by someone who practices forensic psychiatry, leading to further imperfect fit.²⁴ This is not to say, however, that the APA is completely unable to understand the problems inherent with quack experts and testimony. In the case of Dr. Grigson, he was expelled from the APA and the Texas Society of Psychiatric Physicians in 1995, in part because of his assertions that he could predict future violent acts with 100 percent certainty.²¹

The APA has attempted to address a few topics within forensic psychiatry, within a document labeled *Opinions of the Ethics Committee on The Principles of Medical Ethics*.²⁷ But the questions and answers within this section do not seek to directly address the possibility that a quack expert might provide false testimony on the witness stand. Rather, the

majority of the questions and answers focus on concepts of dual agency and involvement in cases where the death penalty is a factor. One section does mention the concept of a physician dealing honestly with patients and colleagues; however, the advice centers around the requirement to strive to render an objective opinion.²⁷ The concept of striving is a concern, as it allows for wiggle room in an area of patently false statements and does not seek to address willful misinformation.

If the APA does identify unethical behavior, there are a variety of outcomes available, including reprimand, suspension, and expulsion.²⁶ Unfortunately, this highlights a significant shortcoming of reliance on the APA in this area: the penalties revolve around being an APA member. In fact, prior to investigating a claim, the APA first reviews whether the accused psychiatrist is an APA member. If not, the APA cannot pursue the complaint or take further action. Physicians are not required to be a member of the APA to practice psychiatry. Thus, a quack expert wishing to avoid the scrutiny of the APA altogether could simply choose not to be a member of that organization. As a concrete example of this, I return to Dr. Grigson. After Dr. Grigson was expelled from the APA in 1995, he continued not only to practice psychiatry but to testify about the future dangerousness of defendants on behalf of the state.²¹ This represents a significant pitfall of relying on the APA alone to police quack experts.

Reliance on State Medical Boards

State medical boards are a potential avenue to address unethical and dishonest behavior from a forensic psychiatrist and have multiple advantages, including considerable resources, investigative power, and significant punishments (such as excluding an individual from practicing within the state).²⁴ In 2024, the Federation of State Medical Boards reported that state medical boards took disciplinary action against 3,023 physicians from across the country.²⁸ Depending on the state, frequent causes for discipline include negligence or incompetence, abuse of alcohol or other drugs, inappropriate prescribing practices, inappropriate contact with patients, and fraud.²⁹ Board actions, however, are not uniform between states. There is significant variation in the use and form of medical board disciplinary actions, depending on the state in which a physician practices.³⁰ Even if a physician is disciplined by a state medical board, the effect on recidivism is unclear. In a study from Grant and Alfred,³¹ there was a significantly high rate of

recidivism among sanctioned physicians. Although this could indicate that sanctions are ineffective, it does not account for the overall threat of board sanctions that prevents physicians from acting inappropriately in the first place.³¹

Although much of the literature on the effectiveness of state medical boards focuses on physicians in general, there is evidence that some differences exist for psychiatrists. A study in California in 2001 found that psychiatrists were significantly more likely than other physicians to be disciplined for sexual relationships with patients. Charges for negligence or incompetence were about the same between psychiatrists and other physicians.³² This suggests an even bigger problem than previously mentioned in this article with reliance on the APA. The questions being decided by state medical boards are not specific and tailored to psychiatry. Instead, concerns regarding competence in the field are being determined by a variety of professions, including nonpsychiatrists. If questions about ethics are not being addressed by psychiatrists, there is little hope that questions specific to forensic psychiatry as a subspecialty are being considered.

Some states have statutes addressing standards for expert witnesses, but this is not the norm. Instead, when state medical boards do address forensic psychiatry, it is often in the context of regulating out-of-state physicians providing expert work within the state.³³ This is not to say that state medical boards never address other concerns within forensic psychiatry. In the case of *Salerian v. Maryland State Board of Physicians*, the Court of Special Appeals of Maryland reviewed a case in which a psychiatrist was engaged in expert work and consequences were levied by the state board for his conduct.³⁴ Although this is an example of an appellate case involving forensic psychiatry, the courts did not directly address any claims of purposeful misdirection in testimony. Rather, the conduct under scrutiny involved confidentiality, dual agency, and whether forensic psychiatry was the practice of medicine. If state medical boards are not equipped to deal with the nuance of forensic practice, then it is unlikely they will make efforts to regulate the content of testimony. This encourages bad experts to simply avoid falling afoul of any blatant violations, such as having a sexual encounter with an evaluatee or practicing medicine without a license, but still gives them latitude at the state level to provide false or misleading testimony.

Possibilities

The current state of addressing false statements from psychiatric experts has failed to adequately

mitigate this problem. Reliance on the courts understanding complicated psychiatric questions or on other organizations properly policing unethical behavior has not had a meaningful impact on how quack experts choose to practice in our communities. Because these current methods are not working, something else must be done. As with many initiatives targeting a change in a widespread practice, three levels of intervention are possible: individual, local, and national.

Individually, forensic psychiatrists have a wealth of resources to make sure they remain current with the state of the field and avoid functioning as a quack expert. AAPL has enhanced the ability of members and the public to access guidelines in a variety of areas, including practice resource documents,³⁵ virtual AAPL presentations,³⁶ and other ongoing educational activities. Remaining up to date on the literature provides a solid foundation for identifying evidence to use in opinions rather than simply believing in a concept.

Self-reflection can be helpful when developing an opinion. Even the simple question of, "What evidence do I have to back up this statement?" can be an exercise to avoid treading outside of bounds. If the answer includes some basis for the opinion based on facts, literature, or even practice experience, the expert is likely on good footing. If the answer is some variation of "Because I said so," caution is advised. Consultation with a respected colleague in forensic psychiatry may also be an option if self-reflection presents a challenge for the expert. Despite the utility of these suggestions on an individual level, none of these suggestions will affect the expert who decides to willfully lie. Instead, a more local and national approach external to the expert is likely needed.

Local interventions are likely most effective with attorneys and courts. Educational seminars to teach how evidence-based opinions are reached and the pitfalls of false statements can be invaluable to help better develop the gatekeeping function courts possess before testimony even arrives at a trial. In particular, education outside of a specific case may be most effective, because it will allow a broader discussion, without the competitive stakes involved in an adversarial process. Judges and bar associations are frequently looking for educators to help them better understand psychiatry and demystify the method by which we provide expertise. Although this is a local intervention, AAPL could play a significant role in this space by providing vetted speakers or recorded

seminars to these local groups to ensure that those educating attorneys and courts are competent and ethical.

It may be enticing to attempt to identify quack experts locally and encourage their exclusion from the legal process. But there is often not a mechanism to do this officially, and trying to do so may be fraught with legal and social peril.⁸ Instead, it is far easier to identify problematic behavior and educate the local court system on being vigilant for it across the board, not with just one person. For example, if there is a concern about an expert making predictions claimed to be always 100 percent accurate, a better tactic may be to educate judges on how those types of predictions are problematic and not supported by evidence or the literature. This can achieve the same effect of a response targeted to an individual, as it will discourage the behavior among the local expert community at large.

For a national response, AAPL is uniquely poised to influence education meant to reduce the effect of quack experts. A renewed focus on developing, publishing, and educating on ethics standards within forensic psychiatry can provide a foundation for forensic psychiatrists to point to when false statements are made. In addition to enhancing general ethics principles, identification of specific false statements and providing commentary on the lack of evidence behind them can create literature that forensic psychiatrists can use to refute bad testimony. An example of this was the Ethics Questions and Answers document produced by the AAPL Committee on Ethics and adopted by the AAPL Council, which was published in 2013.¹² Although it may sound strange to produce written documentation to refute absurd notions, such as the ability of a psychiatrist to read the minds of others, the creation of documents to clarify such basic questions may assist in minimizing the use of these false statements.

Peer review is another area in which AAPL already has a framework that could be expanded. The peer review committee is often thought of by members during the AAPL annual meeting, when recorded testimony is submitted by a brave individual and a panel of experts provides critique in front of an audience, but this need not only be a once per year occasion. Expansion and advertisement to members of this opportunity, so that submission and feedback could occur more regularly throughout the year, could be a vital resource for those seeking to

improve their practice and avoid quackery. I recommend that, initially, this process remain voluntary, as a means to make peer review a more regularly accepted occurrence. A more prescribed process could be considered in the future, if it were deemed necessary by members of AAPL.

Increasing the visibility of AAPL on a national stage will enhance the impact of such education. Too often, forensic psychiatrists have to explain repeatedly what AAPL is and why recommendations from the organization are so important. Connections with outside groups, such as legal and judicial organizations, can increase the recognition of AAPL as a leader within this field, whose statements on ethics and proper practice should be considered when analyzing whether an expert is providing false information.

Minimizing the harm that quack experts can cause to the profession and the legal system is not an easy task. I believe that the difficulty and complexity of this topic is one of the reasons that it is not often confronted directly within our profession. It is possible, however, that by shifting away from attempting to blame and penalize the individual quack expert directly, we can accomplish more to change this behavior throughout our legal system. In the suggestions I have laid out, both the individual forensic psychiatrist and AAPL play an important role in addressing this problem directly. Everyone has the potential to be a quack expert. Perhaps we can make it far less enticing to do so.

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