
1 Ethical Issues in Forensic Psychiatry in the United States

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1.1 Introduction

The forensic psychiatrist or psychologist works within the judicial system, which is not a therapeutic system. Rather, the judicial system is one that seeks truth and justice, irrespective of harm that may come either to the defendant in a criminal case, or the plaintiff in a civil case or an individual in an administrative legal case.

The criminal justice system seeks to punish those who are guilty of criminal behavior. In civil matters, the court attempts to seek justice by awarding damages to those who have been harmed by others. The court also attempts to identify those who are not harmed, but claim to be. Forensic mental health experts are utilized by the judicial system to aid in the process of discovery and adjudication. Thus, the forensic psychiatrist may find him or herself working within a system that is not therapeutic and may cause significant harm to various individuals. How can the forensic medical expert work within such a system while adhering to the ethical tenets of our profession and not causing harm to those with whom we work?

We have already established that the major ethical issue in medicine is “first, do no harm.” We have also shown that patients are indeed harmed in the name of therapy, even in the course of conducting diagnostic procedures. With the intention of helping patients, we may often harm them. In psychiatry, we have also shown that patients can be harmed either with medication, somatic treatment modalities or even psychotherapy.

In the Preamble to the *Principles of Medical Ethics* of the American Medical Association (AMA), the AMA affirms that “The medical profession has long

subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self"[1]. The following list outlines the major principles that have been adopted by the American Medical Association. They are not considered laws, but are "standards of conduct which define the essentials of honorable behavior for the physician." [1]

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence or who engage in fraud or deception.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patients' confidences within the constraints of the law.
5. A physician shall continue to study, apply, and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
7. A physician shall recognize the responsibility to participate in activities contributing to an improved community.

Clearly, the concept of *primum non nocere* cannot apply to forensic psychiatric practice. There are inherent harms that can be caused either during the examination, the report writing or the testimony given in forensic cases. The forensic examiner must alert the examinee that he will not be treating him, and there can be no traditional doctor-patient confidentiality. In essence, there is no doctor-patient relationship developed, because there is no agreement for treatment. The examiner is appointed either by the examinee's attorney, by an attorney for the other side, or by the judge to conduct the examination. Irrespective of who retains the examiner, he or she may inflict damage on the examinee. Thus, there is no prohibition in forensic cases to not do harm as there is in treatment cases in medicine generally, and in psychiatry in particular.

In many cases, there is harm done in forensic mental health matters. This is usually not intentional harm, but it is harm that is built in to the adversarial system in which the forensic psychiatrist works. We have discussed the bias that may exist that could lead to harmful examinations, harmful statements in the report, or harmful comments during testimony. The purpose of this

presentation is to alert forensic experts about such potential harm and to attempt to minimize, limit, or eliminate, if possible, the harm that can be caused by the forensic expert.

1.2 AAPL Guidelines

Forensic psychiatrists have recognized that they cannot utilize the time-tested ethical prohibition against doing harm as their mantra in ethical practice, but must formulate ethical conditions that are more appropriate to the forensic setting. As a result, the American Academy of Psychiatry and the Law (AAPL) developed a set of guidelines that were initiated in the mid-1970s. The first attempt occurred when three members of the Academy sat down to attempt to formulate guidelines for forensic practitioners.¹ Those guidelines underwent several modifications that were published as official actions of AAPL until the most recent, in 2005, which have been published by the AAPL [2].

In these guidelines, forensic psychiatry is defined as follows: It is “a subspecialty of psychiatry in which scientific and clinical expertise is applied in legal contexts involving civil, criminal, correctional, regulatory, or legislative matters, and in specialized clinical consultations in areas such as risk assessment or employment. These guidelines apply to psychiatrists practicing in a forensic role” [2]. I have defined forensic psychiatry as the subspecialty of psychiatry that deals with people who are involved in legal matters, either criminal or civil. Clearly, the definition in the AAPL guidelines is much more comprehensive, but less understood by juries when the expert is asked to define forensic psychiatry in court.

The AAPL has clearly indicated that their guidelines “supplement the *Annotations Especially Applicable to Psychiatry* of the American Psychiatric Association to the principles of medical ethics of the American Medical Association” [2]. The APA guidelines state clearly that “psychiatrists in a forensic role are called upon to practice in a manner that balances competing duties to the individual and to society. In doing so, they should be bound by ethical principles of respect for persons, honesty, justice, and social responsibility. However, when a treatment relationship exists, such as in correctional settings, the usual physician-patient duties apply” [3]. Generally, the AAPL guidelines comment on issues of confidentiality, consent, honesty, and striving for objectivity, and the qualifications of the expert.

1.3 Appelbaum's Concepts

It should be noted that many of these concepts within the guidelines stem from the brilliant paper of Paul Appelbaum that appeared in the *Journal of AAPL*

¹ In the mid-1970s, Drs. Jonas Rappeport, Irwin Perr, and Robert Sadoff wrote the first draft of what is now the *Ethics Guidelines for the Practice of Forensic Psychiatry* by the American Academy of Psychiatry and the Law, adopted in May 2005.

in 1997, entitled, “A theory of ethics for forensic psychiatry”. In the introduction, Appelbaum states,

This article offers a justification for a set of principles that constitute the ethical underpinnings of forensic psychiatry. For forensic psychiatrists, the primary value of their work is to advance the interests of justice. The two principles on which that effort rests are truth telling and respect for persons [4].

A virtue of this approach is the clear distinction it offers between forensic and therapeutic roles.

Thus, Appelbaum alludes to the issue of working for justice and truth and respect for the individual who is examined. In that context of respect, the forensic expert must tell the examinee who he or she is, whom he represents, what will happen during the examination, what are the consequences to the examinee of such an examination (for example, can the defendant in a capital case, get the death penalty if the defendant cooperates with the forensic psychiatrist appointed by the prosecution?). Nevertheless, the evaluator must give this information to the examinee in order for the person examined to give informed consent for the examination. Anything less would not be respect for the individual examined.

The idea of searching for truth implies a degree of neutrality and objectivity in the examination. The ethics guidelines by AAPL indicate that we should be “striving for” neutrality and objectivity, inasmuch as it may never be totally reached because of the human element of bias, errors, and other factors that cloud the issue and inhibit the totality of objectivity.

Others have argued that the guidelines should be more compelling and eliminate the words “striving for” and push for total objectivity and neutrality.² It would be nice to have such an ideal situation, but if it cannot be implemented, then it is an ideal that is not practical. We should set the goals for guidelines in ethics in forensic psychiatry to those which can be practiced and implemented.

Thus, in my opinion, Appelbaum has laid the groundwork for the guidelines that have evolved through several modifications of the AAPL Committee on Ethics [2]. The 2005 guidelines are workable, practical, and should be recognized as the accepted ethics for forensic psychiatrists conducting their examinations, preparing their reports, and offering testimony that affect individuals involved in the judicial system.

1.4 Confidentiality

The guidelines refer to confidentiality, which is an ethical proposition within medicine generally. I have often found the guideline for confidentiality in general medicine to be honored more in the breach than in its acceptance. Psychiatrists tend to be more protective of the privacy of their communications with their patients than physicians in general. In forensic work, there is a limitation to confidentiality that must be discussed with the examinee at the outset of the examination. The

² Personal communications from several members of AAPL.

examinee must be told that there will be a report prepared and sent to the retaining attorney, whether it be the defendant's own attorney, or the prosecutor in criminal cases, or the plaintiff's attorney, or the defense attorney in civil cases.

There are a number of attempts to invade the privacy or confidentiality of these medical records. For example, the examinee has often asked that a copy of the records be sent to him or her. I have never sent records directly to the individual examined for a number of reasons. First, the patient may not be able to accept the concepts without being harmed, unless they are read to him and explained to him by his therapist. By definition, I, the forensic examiner, am not his therapist and cannot accept the role of explaining my observations, impressions, or opinions to him in a therapeutic context, because that would blur my role. I have sent the records, when requested with a signed release of information to the individual's therapist, who can then discuss the report with the individual in a therapeutic context.

Generally, I send the report only to the retaining attorney and know that the attorney will be distributing the report to others, and may even send it directly to the attorney's client. If that is the case, the attorney then assumes responsibility for the consequences of his distributing the report. A number of attorneys will refuse to give the report to their clients, believing the client is too fragile or may "freak out" when reading the report. A number of examinees have called to try to get the report directly from me when they cannot get it from their attorney. It is always good conduct and a wise decision to call the attorney to determine why he or she does not send the report directly to the person examined. One of the reasons is the fragility of the examinee, but another may be that the client has not paid the attorney's bill, and the attorney is withholding the report until he is paid. We would not want to interfere in any way with the attorney-client relationship by providing the report in such cases where the client has not been faithful to his own attorney.

At some later date, on a post-conviction appeal (PCRA) an attorney may request the records in order to show that his client did not have effective assistance of counsel and his conviction should be overturned. In those cases, a subpoena will be issued to the forensic expert to receive his report and any supporting data that was utilized in reaching his opinions. How long should the psychiatrist retain his records? My practice is to strip my file after the conclusion of the case in chief. I keep the records that I generated for 7–10 years, and then discard them, because the law allows us to do so. However, for the first 10 years, I will keep my report and correspondence in the file that may be necessary for some future use. Sometimes, I receive requests for records that are 20 or 30 years old, and I just don't have them. I often assume that attorneys will keep the supporting data they have sent to me for my review. However, the original attorney may not wish to cooperate with the appellate attorney who is criticizing his work. That becomes an issue between the attorneys and the forensic psychiatrist should not be placed in an awkward position to intrude on that relationship.

In summary, it is wise to restrict the distribution of the report from the forensic psychiatrist only to the retaining attorney, who will then distribute it according to

his or her legal requirements. It is also essential that the examinee be alerted to the limitation on confidentiality since most individuals believe that what they tell a psychiatrist is secret or private, and that cannot be the case in forensic work.

1.5 Informed Consent

The next ethical issue is that of consent, and that involves alerting the evaluatee about what will be done with the information gleaned and what effect it will have upon the person examined. In addition, I may need to testify at a hearing or in court about what I learned in the course of the examination. The examinee should be told that such disclosure may need to occur and that I could not keep secret what he told me. He needs to be forewarned about what would happen to the information so that he can give proper informed consent to the examination.

It is also important that the information given to the person examined before he or she divulges any information should include what possible consequences could occur to him or her in that particular case. An example is the case of *Barefoot v. Estelle* [5], a Texas case in which the Supreme Court overturned the guilty verdict because the expert who gave the information to the defendant did not divulge that his testimony could result in the defendant receiving the death penalty.

People have a right not to cooperate with the forensic psychiatrist, and many will not do so for a number of reasons. I have had individuals balk at speaking with me because they were told by their attorney that I was a neurologist and not a psychiatrist. They asked the question, "What does my attorney think, I'm nuts?" They refuse to cooperate until they have a chance to talk with their attorney and clarify the reason for the examination and my role. Sometimes, when visiting an individual in prison, the defendant will not speak with me unless his attorney is present, and that needs to be arranged at some later date. I always give the defendant the benefit of the doubt and allow him to refuse to cooperate until his attorney is alerted and they can work out a solution that is least harmful to the defendant.

1.6 Competency

The issue of competency to consent is raised in the AAPL guidelines. Sometimes, the defendant, in a criminal case, or the plaintiff, in a civil case, is not competent to give consent to the examination. In those cases, there should be others at the examination to give consent for the individual examined. For example, in a civil case, the individual examined may be so injured that the brain damage limits his ability to cooperate or to even give consent to the examination. The examination may be conducted in order to determine his competency in this matter, and the extent of damage that can be assessed if permission is given by a legally appointed surrogate or a guardian.

In criminal cases, the issue of competency is often assessed at various stages of the criminal proceedings. A person who is not competent to stand trial may be competent to give consent to the examination in order to determine his competency

to proceed. In the event that he is not competent to give consent, his attorney should be present to protect his rights.

A clear example of this occurred about 30 years ago, in Philadelphia, when three mental health professionals were appointed by the court to evaluate a criminal defendant for the prosecution. There were two psychiatrists and a psychologist, all of whom had experience in working in the criminal justice system. In those days, the defendant did not have to cooperate with experts for the prosecution even if he planned to present an insanity defense. In this particular case, the defendant, standing 6' 7" and weighing over 300 pounds, was very specific in his statement to the three of us, that he refused to cooperate with the court-appointed experts for the prosecution and respectfully would not give any statement to us. The two psychiatrists were prepared to leave when the psychologist inappropriately (and, in my opinion, unethically and foolishly) challenged the defendant, who was sitting with his attorney and with us in a private room. The psychologist said that if the defendant did not speak with us, the psychologist might consider him to be incompetent and he would, therefore, be detained in the mental health system indefinitely until he could cooperate and could be deemed competent to proceed.

At that point, I intervened, telling the psychologist, with great passion, that he must retract his statement, apologize to the defendant, and that we would leave peacefully and not make any further threats. I was not only concerned about the unethical manner in which he threatened the defendant, but I was also concerned about our physical safety. The psychologist was easily convinced that it was in everyone's best interest for him to apologize and for us to withdraw before there was violence. I also added to the defendant that we were sorry about the psychologist's comments and that we would not, and could not, make any statement about his competency. We would merely report to the judge that the defendant "respectfully refused to cooperate with us." It would then be up to the judge to determine the next step in the proceedings.

The AAPL guidelines commentary on informed consent discusses various exceptions and special cases. They note that, in particular situations, "such as court-ordered evaluations for competency to stand trial or involuntary commitment, neither assent nor informed consent is required. In such cases, psychiatrists should inform the evaluatee that if the evaluatee refuses to participate in the evaluation, this fact may be included in any report or testimony. If the evaluatee does not appear capable of understanding the information provided regarding the evaluation, this impression should also be included in any report and, when feasible, in testimony" [2].

1.7 Presence of Legal Counsel

Further to the commentary, the guidelines note that "absent a court order, psychiatrists should not perform forensic evaluations for the prosecution or the government on persons who have not consulted with legal counsel when such persons are known to be charged with criminal acts; under investigation for criminal or quasi-criminal conduct; held in government custody or detention; or

being interrogated for criminal or quasi-criminal conduct, hostile acts against government, or immigration violations. Examinations related to rendering medical care or treatment, such as evaluations for civil commitment or risk assessments for management or discharge planning, are not precluded by these restrictions. As is true for any physician, psychiatrists practicing in a forensic role should not participate in torture” [2].

The long statement precluding assessment of individuals in quasi-criminal situations from being evaluated without the advice of legal counsel stems from examples of individuals who were examined by forensic psychiatrists upon arrest and before counsel could be obtained. Without the advice of counsel, a number of these individuals gave statements they would not have given had they been properly advised by their attorneys. The prohibition to forensic psychiatrists is that we do not cooperate with the state inappropriately by tricking or deceiving the individual before he has proper advice from his attorney so that he can be protected under the law and the Constitution. Psychiatrists should not be agents of the state in promoting deception or torture in order to get information from the defendant. This would be clearly unethical. However, individuals newly arrested, who have serious mental problems, may be in need of emergency treatment, which is appropriate and may be given. Those treating psychiatrists should then be precluded from ever testifying against the defendant at a later date.

1.8 Objectivity, Honesty, and Neutrality

Under the concept of striving for objectivity and neutrality, the commentary indicates “The adversarial nature of most legal processes presents special hazards for the practice of forensic psychiatry. Being retained by one side in a civil or criminal matter exposes psychiatrists to the potential for unintended bias and the danger of distortion of their opinion. It is the responsibility of psychiatrists to minimize such hazards by acting in an honest manner and striving to reach an objective opinion.” [6].

The early attempts by the AAPL Committee on Ethics to develop guidelines also included concepts of neutrality, honesty, and striving for objectivity when conducting forensic psychiatric examinations. The committee recognized that one could not always achieve total neutrality or objectivity, but at least the attempt was made to strive for such an ideal. The committee was clearly influenced by Bernard Diamond’s seminal paper on the “Fallacy of the impartial expert” [7], recognizing that all assessors have inherent biases that need to be recognized. Seymour Pollack [8], one of the early pioneers in modern forensic psychiatry, had cautioned that recognizing our biases is important, and they must be “put on the table” when we are involved in forensic cases.

1.9 Cultural Differences

Ezra E.H. Griffith, in his article, “Ethics in forensic psychiatry: A cultural response to Stone and Appelbaum” [9], focuses on the cultural differences and critiques

Stone and Appelbaum positing the notion that it is important for the assessor to have a cultural knowledge of the person being interviewed and evaluated. He has stated that it would be more equitable for the African American criminal defendant to be examined by an African American forensic psychiatrist, who would understand the nuances of his cultural situation, rather than by a Caucasian forensic psychiatrist, who may not have understanding of the cultural background.

Griffith continues by stating, "I'm concerned about the unwitting collusion to exclude the voices of the non-dominant groups . . . A theoretical ethics framework is not persuasive if it merely brings orderliness into the sustained interaction of dominant and non-dominant group members, while preserving the traditional higher ethical relationship between the groups" [10].

Ciccione and Clements [11] support the notion that there are cultural differences that must be accounted for in the ethical principles governing forensic psychiatry and forensic examinations.

Hicks, in his paper, "Ethnicity, race, and forensic psychiatry: are we color blind?" [12] advises that forensic psychiatrists and psychologists should consider race, ethnicity, and culture when performing evaluations for legal purposes and when providing treatment to the special populations with whom they work. Hicks notes, "Findings in several studies have shown that African Americans are more often diagnosed with psychosis and whites with mood disorders in emergency rooms and at hospitalization . . . elderly African Americans are more frequently given diagnoses of psychotic disorders and dementia . . . than are elderly whites."

Hicks is also concerned about the assessment for dangerousness and states that psychiatrists show a higher level of "dangerousness" with minorities than with whites. He declares, "There is an imprecision and ample room for clinicians' bias to influence the decisions with serious consequences. According to the 1990 General Social Survey of Public Perceptions, respondents were more likely to identify African Americans and Hispanics as prone to violence" [13].

As an example of the disparity from a racial standpoint, Lykken states, "From 1973 to 1980, cases involving an African American defendant and white victim were more than seven times more likely to result in the death penalty than cases involving a white defendant and an African American victim" [14]. He also notes that there is an unfairness in the diversion of offenders to substance abuse and mental health treatment between and among whites and African Americans. He concludes that studies have shown that white adolescents with behavioral problems "tend to end up in the mental health system, whereas African American adolescents exhibiting similar behavior end up in the criminal justice system." Lykken is also concerned about the expert witness in examining a person of different ethnic or racial background and states, "The forensic evaluator may experience fear, unease, or identification with the subject. The subject may be more suspicious and mistrustful of a white evaluator, who might be perceived as an instrument of the majority-dominated justice or mental health systems. The subject may also have unrealistic expectations of favorable treatment from an evaluator who belongs to an ethnic and minority group" [14].

Similarly, Griffith states, “Expert witnesses must be vigilant in monitoring their own potential biases. The ethnicity of the forensic psychiatrist, the ethnicity of the subject and the interaction between dominant and non-dominant ethnic groups in the justice system may all affect an examiner’s neutrality in complicated ways” [9]. In summary, Griffith is concerned that the non-dominant minority defendant in a criminal case may be harmed if he is examined by an insensitive, dominant forensic psychiatrist who is not aware of the cultural nuances that may significantly affect the examination and the legal conclusions.

In his discussion of the bias that may be inherent in our work, and especially when there is a cultural difference, Silva states, “We need to be able to view the total environment, perhaps as seen by those whom we examine rather than by those who have taught us the abstract system of justice and truth. We need to understand the issues that face the defendant or the plaintiff and how they view our role and our conclusions” [15].

Reid, in his paper, “Ethics and forensic work” [16], discusses various ethical issues for the forensic psychiatrist and is primarily concerned about bias. He states we should do our best to recognize and set aside our significant biases. His major concern is knowingly allowing bias to control testimony. Reid declares, “Bias for a particular view or opinion is just as problematic as bias against it, and arguably more subtle. The witness stand is not the place to express your philosophy nor to allow your philosophy to shape, substantially at least, your opinions in a case . . . Testimony is rarely an appropriate vehicle for pressing one’s personal or philosophical views” [16].

Reid is also concerned about the psychiatrist working outside of his area of expertise. He writes about a young psychiatrist who had accepted a forensic referral and “told the attorney calling him that he understood the general rules of forensic work.” During deposition on cross examination, “he was asked if he had taken notes during the many hours of interviewing various people. The expert said he had, but that he had shredded his notes upon receiving the deposition subpoena.” Reid notes that this “was not only imprudent, but arguably an illegal act that belied the witnesses’ earlier representation to the authority that he was competent to be an expert. His testimony ruined his usefulness in the case and wasted the attorney’s and the plaintiff’s time and money” [17].

1.10 Competency

These issues raise the question of the expertise of the forensic examiner. There are a number of general psychiatrists who become involved in legal matters without proper training or experience. Some do not know the specific criteria required for determining a person’s competency since the determination will vary depending on the reason the person is examined. For example, one may be competent for one particular event, but not for another.

An example that I often use is the elderly female who is examined in a nursing home for competency to prepare a will. The woman may be competent to prepare her will or sign the will inasmuch as she understands generally how much money

she has and to whom she can leave the money if she chooses. However, she may not know what things cost, she may be of weakened intellect and be victimized by designing persons who may steal from her because she is not competent to handle her own affairs. Thus, one should always pose the question about competency: competent for what purpose?

With respect to competency, there are varying rules that govern one's examination and expert opinion. They vary in different jurisdictions and, of course, they vary depending on the purpose of the examination. As an example, New Jersey has specific criteria for competency to stand trial,

"No person that lacks capacity to understand the proceedings against him or to assist in his own defense shall be tried, convicted, or sentenced for the commission of an offense so long as such incapacity endures."

A person shall be considered mentally competent to stand trial on criminal charges if the proofs shall establish:

- that the defendant has the mental capacity to appreciate his presence in relation to time, place, and things;
- that his elementary mental processes are such that he comprehends;
- that he is in a court of justice charged with a criminal offense;
- that there is a judge on the bench;
- that there is a prosecutor present who will try to convict him of a criminal charge;
- that he has a lawyer who will undertake to defend him against that charge;
- that he will be expected to tell to the best of his mental ability the facts surrounding him at the time and place where the alleged violation was committed if he chooses to testify and understands the right not to testify;
- that there is or may be a jury present to pass upon evidence adduced as to guilt or innocence of such charge or, that if he should choose to enter into plea negotiations or to plead guilty, that he comprehend the consequences of a guilty plea and that he be able to knowingly, intelligently, and voluntarily waive those rights which are waived upon such entry of a guilty plea; and
- "that he has the ability to participate in an adequate presentation of his defense."³

1.11 Clinical Case Examples

In keeping with the cultural differences that may result in harm if one does not understand cultural nuances, I can offer two examples from my own practice.

In one case, I was asked to examine a criminal defendant in another country who had a different culture and a different language from my own. He had been charged with murder. I had no knowledge of his culture and told the defense attorney that before becoming involved in the case, I would need to study the culture of that country. Indeed, when there, I not only examined the defendant for several hours over many days, but I also interviewed the elders of his culture

³New Jersey Statutes 2A:163-2, Model Penal Code: 4.04 Amended 1 1979, c. 178, sec. 13.

and had a mock jury of them to determine their cultural view of the defendant's behavior. That was extremely helpful in reaching my opinion that I rendered in a report to the defense attorney.

In another case, in examining, for the prosecution, a woman who had been charged with the death of her newborn baby (neonaticide), I determined that the woman had just come from Mexico, did not speak English, and had been in the United States less than a week when the baby was born and had died. In the course of conducting the examination after about one hour, the Spanish-English translator said to me, "I don't know who I'm speaking with." By that, she meant the defendant had switched, as in dissociative identity disorder (DID), and had become an alter who spoke in a different tone, using a different approach that was not consistent with what had occurred during the first hour of the examination. I immediately stopped the examination and called the prosecutor, telling him that I could not continue in the best interest of justice, because one would need to have a Spanish-speaking forensic psychiatrist in order to determine the nuances of the mental disorder that appeared to be occurring at that time. I never did learn whether she had a DID or what the legal outcome of the case was, but I felt that it was necessary in order to avoid further harm to the defendant (and to justice), that I recuse myself from the case.

With respect to bias, another case occurred in which I was asked by a criminal defense attorney to examine his client, who was a purported Skinhead who had killed his family. I suggested to the attorney that it would not be appropriate for me to conduct the examination, because I could not do it without some prejudice or bias that might affect my objectivity or neutrality. He asked why, and I told him that I was certain that his client would not wish to be examined by a Jewish forensic psychiatrist and that I would have feelings about his view of life and his animosity toward me and my people as well. I suggested we try to find an ethnically neutral forensic psychiatrist (which we were able to do, but only with great difficulty).

1.12 Evidence-Based Psychiatry

Further, the guidelines indicate that the work of forensic psychiatrists should be based upon evidence that can support their opinions. The guidelines state, "They communicate the honesty of their work, efforts to obtain objectivity, and the soundness of their clinical opinion, by distinguishing, to the extent possible, between verified and unverified information as well as among clinical 'facts,' 'inferences,' and 'impressions'" [2].

Several cases have emerged, including *Daubert* [18] and *Kumho* [19], replacing *Frye* [20] in some jurisdictions as standards for presenting testimony in court. Generally, these cases require the judge to be the gatekeeper to limit testimony to that which is based on scientific evidence and not "junk science." The testimony also must be helpful to the trier of fact, whether it be judge or jury.

1.13 Personal Examination

The commentary of AAPL guidelines also indicates a very basic statement, “Psychiatrists should not distort their opinion in the service of the retaining party” [2]. Honesty, objectivity, and the adequacy of the clinical evaluation may be called into question when an expert opinion is offered without a personal examination. The guidelines indicate that an opinion may be rendered on the basis of other information if a personal examination is not available. But the guidelines state, “Under these circumstances, it is the responsibility of psychiatrists to make earnest efforts to insure that their statements, opinions, and any reports or testimony based on these opinions, clearly state that there was no personal examination and note any resulting limitations to their opinions” [2].

Case examples in which a person may not be examined include complex domestic relations cases in which certain individuals or children may not be examined. Sometimes, the examiner in a child custody case is retained by either the mother or father, and the opposite parent refuses to cooperate with that examiner unless he or she is court-ordered. The commentary of AAPL guidelines specifies custody cases which may be very difficult, and in which the psychiatrist must disclose the basis for his opinion and the limitations of the opinion when a full examination could not be conducted [2].

Another example is that of a will contest in which the decedent is evaluated for mental state at a previous time, but, of course, is not available for a direct examination. In those cases, the guidelines indicate that a clear statement must be made about the limitations of the assessment, because no direct examination was made.

1.13.1 Case Example

A man was killed in an automobile accident, and the question was raised whether or not he experienced pain and suffering before he died. The police reports were inadequate to determine whether he suffered prior to his death. In order to attempt to answer the question, I spoke to family members about the kind of person he was and how he viewed his life. I also reviewed the accident scene reports and forensic pathology reports that indicated the victim was conscious prior to his death. Because of his consciousness prior to death and the type of individual he was, it was my opinion, within reasonable medical certainty, that he did experience pain and suffering prior to his death. However, I had to declare in my report and in my testimony that my opinions were limited because I did not examine the individual about whom I was giving an opinion. My opinions were based primarily on reports of others and written reports of professionals.

In another similar matter, there was an airplane crash in which several people were killed, others were badly injured, and many others “walked away without a scratch.” In attempting to assess pain and suffering prior to death, it was necessary to review the forensic pathology reports indicating the passengers were conscious

for two minutes prior to their death. Utilizing the scientific evidence of the forensic pathologist, I was then able to interview a number of the survivors and their anxiety and other feelings that they experienced prior to the crash, at the time of the crash, and following the crash. I was able to divide the time around the crash into 10 different periods during which the survivors experienced various emotions. Utilizing those data and the forensic pathology reports, I was able to give an opinion, within reasonable medical certainty, that the 10 people who died experienced various emotions, including pain and suffering, for the two minutes they were conscious prior to their losing consciousness and their death. In both cases, it was important to verify in the report that the opinions were based on various information that I had without a direct examination of the victims.

1.13.2 Competency in a Wills Case

In a wills case, in which the records were evaluated after the death of the testator, I noted the examining psychologist reached the opinion that the testator had been depressed and, as a result of depression, was subject to undue influence by others due to a weakened intellect. However, there was a scrivener of the will who testified at deposition that the testator was competent at the time of the writing of the will. The attorney, who was the scrivener, testified that she had tried to influence the decedent into changing her will, but the testator was insistent on having the will written her way. She resisted all efforts to change her mind and, despite her depression, was not of a weakened intellect.

One may give more weight to the opinion of the psychologist who conducted the examination of the testator before she died rather than to a forensic psychiatrist who reviews the records after death and had no opportunity to conduct a face-to-face examination. However, the psychologist reached the opinion not only that the testator was depressed, but also that she had a weakened intellect and was the victim of undue influence by specific others wishing to challenge the will. Therefore, he opined that she was incompetent to write this will at that particular time. However, he did not take into account the testimony of the scrivener of the will, whose testimony indicated the strength of the mental state of the testator, which belied the opinion that she was of “weakened intellect.”

It has been my experience that we should stay within the limits of our expertise, and not become adversarial in order to effect a particular conclusion in such cases. For example, we should not reach the conclusion that the person was unduly influenced, as that is a legal conclusion. We should limit our testimony to the opinion that the testator had a particular diagnosis of depression and that, as a result of that diagnosis, she was more susceptible to influence by particular others who had a close relationship with her. We do not really know whether she was unduly influenced, as that casts an aspersion on the person accused of unduly influencing her. That may have occurred, but it is not a psychiatric or psychological opinion. It is a legal conclusion.

1.14 Fees

The guidelines distinguish between retainer fees, which are ethical and appropriate, versus contingency fees, which undermine honesty and efforts to attain objectivity, and which should not be accepted [2].

Ethical questions arise beyond the issue of retainer v. contingency fees. Should psychiatrists charge first class accommodations when they travel? Should they allow themselves to be “wined and dined” by the retaining attorney? Gutheil [21] raises the question of travel expenses when one is busy enough to have more than one case away from home. How does one split the expenses and the time for the fees charged? Some psychiatrists have been known to “double bill,” that is, to bill two different attorneys for the same time that was spent. That would be unethical and should be discouraged. Can a psychiatrist charge a daily fee when he travels? What about charging for overnight when one is sleeping? Should the psychiatrist charge for meals and other expenses on the road that he would normally have even if he were home?

These are questions that have not really been addressed by forensic psychiatrists traveling to examine individuals and to testify when away from home. There is also the question raised by the American Medical Association as to whether testifying in court is the practice of medicine [1]. Does a forensic medical expert need a medical license to testify in a state away from home? Some states require that one have a license in order to come to their state to conduct an examination or even to testify. Reid has conducted a survey of the various states that require licensing [22]. I do not know of any psychiatrist who has been arrested on charges of “practicing medicine without a license” for traveling to another state in order to testify. There has been one instance of a psychiatrist from a neighboring state who came in frequently to testify for the defense in criminal cases. Prosecutors became upset with him and demanded that he have a license in their state in order to come in and testify for the defense in various cases. They threatened to have him arrested for practicing medicine without a license, but he was able to obtain proper legal consultation and finally did get a license to practice medicine in the neighboring state, avoiding further legal difficulty and subsequent prosecution.

These issues of fee structure and testifying in states in which one is not licensed to practice medicine raise the question of doing harm to the forensic expert. May the expert testify in a state in which he is not licensed without being arrested for “practicing medicine without a license?” Will the expert incur harm to his or her reputation by overcharging the client for expenses on trips in which he or she travels in order to conduct examinations or to testify in different states? Most forensic psychiatrists never have to raise these questions as they are not called upon to conduct examinations away from home or to testify across the country. However, there are a handful of “super experts” who are nationally and internationally known and are often involved in very high profile cases that have national exposure. It is especially important in these cases for the expert to conduct

himself or herself according to the ethical guidelines of AAPL in order to avoid bad publicity or cast aspersions on himself and, of course, also on the profession of forensic psychiatry.

1.15 Forensic v. Treatment Role

In accordance with the paper, “On wearing two hats” [23], the guidelines state that, “Psychiatrists who take on a forensic role for patients they are treating may adversely affect the therapeutic relationship with them. Treating psychiatrists should, therefore, generally avoid acting as an expert witness for their patients or performing evaluations of their patients for legal purposes” [2].

Appelbaum [24] points out the inherent dangers for the treating psychiatrist when demands are made of him to prepare a report for a legal or bureaucratic agency about information regarding his patient. One wishes to do no harm, or as little harm as possible.

Appelbaum continues questioning, “How ought a treating psychiatrist respond when a patient or the patient’s lawyer requests that the psychiatrist prepare a report on the patient’s suitability for custody of a child or agree to testify on the degree of emotional harm the patient suffered in an automobile accident?” [24]. Appelbaum suggests “An offer can be made to help identify another clinician to perform the forensic evaluation . . . If framed properly, this response can have a powerful positive effect on the psychiatrist-patient relationship” [24].

Strasburger [23] and colleagues note it is not always possible to respond in this manner. Some agencies, such as the Social Security Administration, require statements from treating psychiatrists in adjudicating patients’ disability claims. Appelbaum responds, “Failure to comply, at least at present, endangers patients’ access to financial support to which they may be entitled. Moreover, in some circumstances including rural areas, there may be no other psychiatrist to whom to turn for the forensic evaluation” [24]. Appelbaum suggests discussing the problem frankly with the patient so the patient is not misled about the nature of the relationship he has with his therapist.

An example from my practice involves two of my former students who had moved to New York after training at the University of Pennsylvania. A New York attorney asked me to evaluate one of his criminal defendants, which I did and referred for treatment, giving the names of both of my former students who were practicing in New York City. The patient chose one of them for treatment, and the prosecutor chose the other (coincidentally) to conduct an examination.

The case came to trial, and the court deemed not only should I testify, but also the treating psychiatrist should testify as well. There I am in court with my two former students and now cherished colleagues, both on opposite sides. The matter was handled as pleasantly as possible, but it was important, for the outcome of the case, for the court to hear the testimony of the treating psychiatrist. Although it did have some impact on future treatment, it did not destroy the doctor-patient relationship. Treatment did continue after the hearing and did so in a positive, constructive manner.

So it is possible not to be harmful to the patient, who happens to be involved in a legal matter, for his psychiatrist to testify for him. If the testimony is conducted in a sensitive and proper manner, the doctor-patient relationship need not be negatively affected or destroyed.

1.16 Dual Role and Agency

Stone [25] critiques the question of the dual role of the forensic psychiatrist as a major concern and an ethical violation. He advocates forensic psychiatrists not working in the field because, he argues, one cannot act ethically according to the guidelines, especially if one testifies for the patient he is treating. Stone is also concerned about the dual role the psychiatrist may have when working for the prosecution in criminal cases. He notes that individuals usually see psychiatrists as helping individuals and, indeed, the forensic psychiatrist appointed by the prosecution may, in fact, be harmful to the defendant. Even discussing and disclosing his role and for whom he is working, as Appelbaum advocates, and which is part of the ethical guidelines for forensic psychiatrists, may be forgotten by the evaluatee in the course of a lengthy and “seductive” examination. Thus, the evaluatee may give information to the very nice and cooperative forensic psychiatrist who, in turn, may use that information against the defendant and harm him.

Stone finds Appelbaum’s “Standard of Truth and Justice” more an “appealing abstraction” than a useful guide to ethical conduct in the forensic setting [25]. Stone believes that ethical behavior derived from the principles of serving truth and justice do not effectively deal with forensic psychiatry’s ethical dilemma. He raises the issue of the seductive power of the forensic psychiatrist to induce inappropriate trust in an evaluatee. Giving the needs of social justice primacy over helping patients, in doing no harm, Stone has argued that forensic psychiatrists lose their ethical compass.

It should be noted that the AAPL honored Professor Stone by having him lecture at their annual meeting on October 22, 1982. His remarks, entitled, “The ethical boundaries of forensic psychiatry: A view from the Ivory Tower,” were published in the Bulletin of AAPL in 1984. The article was republished a quarter century later [26].

Paul Appelbaum, of whom Stone was critical, entitles his response to Stone’s article, “Ethics in forensic psychiatry: Translating principles into practice” [27]. Stone has referred to Appelbaum’s position as the “Standard position for ethics in forensic psychiatry.” Appelbaum indicates that Stone’s position has changed over 25 years when he states, “He appears to have backed away from the blanket assertion that there are no ethics principles by which the practice of forensic psychiatry can be governed, although he remains skeptical that any of the current approaches, including the Standard Position, address in practice the ethical challenges of forensic work.” Appelbaum summarizes by stating that “Although the ethics challenges cannot and should not be denied, a reasonable set of ethics principles to guide forensic practice exists and, in fact, has been implicit in the work of forensic psychiatrists for many years.” He believes we can “legitimately

offer useful information to the courts,” and that we have “a modest role, perhaps, but not one to be scorned” [27].

Griffith summarizes his position about Stone when he states, “I believe that Stone’s original thoughts about ethics in forensic psychiatry, while provocative and even unnerving to his audience 25 years ago, have had a profound influence on forensic psychiatrists. The field has advanced on many fronts in the past two and a half decades” [28].

Stone’s remarks at the 2007 meeting of AAPL were not published in that special edition of the *Journal*, so Stone published his current comments in the *Journal of Psychiatry and Law*, “Ethics in forensic psychiatry: Re-imagining the wasteland after 25 years” [29]. He summarizes by stating, “While at present there exists no uniform ethical guideline, forensic psychiatrists now have many options for moral guidance in the courtroom, and this situation is the beginning of ethical development for the profession.” Basically, Stone elaborates on his epistemologic concerns about the ethics in forensic psychiatry. He refers to a recent book entitled, *Forensic Ethics and the Expert Witness*, (which he refers to as FEEW) [30] by Candilis, Weinstock, and Martinez who have been frequent contributors to the literature of ethics in psychiatry and forensic psychiatry and have done considerable research in the field. Their book, published in 2007, is a treatise on the ethical issues facing the forensic psychiatrist and expert witness. However, they do not focus on the utilization of such ethics in order to diminish the harm inherent in our work.

By contrast, this book is not a treatise on ethics in forensic psychiatry. It is about minimizing harm to those populations that are served in the legal system in administrative, civil, and criminal legal matters. Therefore, a full presentation on the Appelbaum–Stone debate is not appropriate here. However, utilizing the concepts of ethics in forensic psychiatry and how they differ from those in medicine and psychiatry generally, is helpful in understanding the purpose of this presentation.

It has always been my contention that one can get much more information from an examinee by a positive, pleasant approach than by being seen as “the enemy.” When I am asked to see a defendant by the prosecution, in a criminal case, or the plaintiff by the defense attorney in a civil case, I understand that the individual may be on guard and reluctant to discuss the matter with me. I am very open with the individual, telling him who I am, whom I represent, what I will do with the information, and how it may affect him. All of this is done according to the format of the AAPL ethical guidelines [2]. However, Stone is correct in that the giving of this information can be very “seductive” and put the examinee off guard, so that he will tell me more than what he would want to or was prepared to, until he faced such a pleasant and open interviewer. Stone is also correct in that physicians are seen as helping individuals even though, in this situation, they may be harmful to the evaluatee. This is one of the inherent harms built into the adversarial system in which forensic psychiatrists work on a daily basis.

Berger [31] is also concerned about ethical issues in forensic psychiatry and the matter of dual agency. He states that dual agency occurs when “a company psychiatrist owes a treatment duty to his patient—an employee of the same company—and a simultaneous obligation to the company to return the patient to work immediately.” He also states there are other situations of dual agency, including “A military psychiatrist owes a treatment duty to his enlisted patient and a simultaneous duty to the military to maintain security.” He further notes, “A jail psychiatrist owes a treatment duty to his inmate patient (who is awaiting his trial) and a simultaneous duty to the state to get a confession from the inmate.” Also, “A state-employed psychiatrist owes a duty to the best interest of his death row patient and a simultaneous job assignment to get the execution done.” He states clearly, “The two roles of the psychiatrist in these examples conflict with each other.” Berger is concerned that as a therapist, the psychiatrist obtains information that can be used to relieve the patient’s suffering, but the forensic psychiatrist uses his knowledge base for legal purposes. Berger concludes that “The ethical principle guiding forensic psychiatry is honesty, but a psychiatrist’s honest conclusion does not always serve the best interest of the patient” [31].

Berger’s examples are of people who worked for different agencies, and he stresses the job and the treatment requirements, but also the need to report to an employer about the function of the person being treated. Another example comes from a case evaluation when a judge was cited for inappropriate behavior on the bench and was told that in order to keep his job, he had to undergo treatment for several months by a psychiatrist selected by the Board of Judges. The treatment lasted for a full year. The question for the treating psychiatrist was how much he should reveal to the Board about what he learned in the course of treating the judge. Did he obtain information during treatment that would negatively affect people coming to court when the judge sat on the bench? Does the psychiatrist owe a duty, not only to his patient, but also to the community-at-large to prevent an erratic judge from retaking the bench when he may cause harm to particular individuals who come before him?

Many of us find these same questions occur when we treat individuals on probation or parole. We are asked to treat the individual primarily to keep him or her out of prison and working effectively in the community. We may also be asked to evaluate or treat people on bail awaiting trial in order to help them with their mental illness so they may be more effective at their trial, and also that they may not require hospitalization if they are found not guilty by reason of insanity or if they are found to be guilty but mentally ill and in need of treatment.

The question always arises: How much does one reveal, in the course of treatment, to the authorities, who require a regular report about the patient in treatment? This is clearly a dual role for the treating psychiatrist, who may have forensic experience. Can such a treatment be harmful to the patient if too much is revealed to the authorities? The issue here is use of good judgment in giving information that is required, but not excessive information that may prove harmful to the patient at some later time.

1.17 Deception and Forensic Practice

Bringing the matter closer to the present, Janofsky [32], in a recent article in the *Journal of AAPL* entitled, “Lies and coercion: Why psychiatrists should not participate in police and intelligence interrogations,” starts by saying, “Direct or indirect participation of the psychiatrist with police, military, or intelligence personnel when interrogators use deception or psychological or physical coercion violates basic principles of ethical forensic psychiatric practice.” He notes that the Appellate Court decisions have repeatedly found “that it is acceptable for police to use artifice, deception, trickery, or fraud during the course of an interrogation” [33]. He notes that psychiatrists must not engage in similar techniques, because they are unethical.

One of the examples here is the use of DNA on death row inmates to show that they could not have committed the crime for which they were convicted and sentenced to death. One case involved a man who had spent 15 years on death row after confessing to a crime that he did not commit. It was shown that the confession was made illegally through coercion and that DNA revealed his innocence and that his confession was not valid. I was asked to evaluate him to determine why he would give a confession to a crime that he did not commit. He indicated to me, on examination, that he had been coerced by the police and that he was told that if he confessed, they would let him go. At some point, he believed that to be the case rather than using logic that police would not let him go after confessing to murder. However, he was not in a logical frame of mind at the time that was offered to him.

1.18 Expert Qualifications

Finally, the guidelines refer to qualifications of the expert witness, and the commentary states, “When providing expert opinion, reports, and testimony, psychiatrists should present their qualifications accurately and precisely. As a correlate to the principle that expertise may be appropriately claimed only in areas of actual knowledge, skill, training, and experience, there are areas of special expertise, such as the evaluation of children, persons of foreign cultures, or prisoners, that may require special training or expertise” [2].

The special expertise is addressed in a book prepared by Drs. Dattilio and Sadoff about the roles and qualifications of mental health experts [34]. The book is designed to alert attorneys to the different backgrounds, education, training, and expertise of the various types of mental health experts, including psychiatrists, psychologists, social workers, and others.

Wettstein [35], in his chapter in the *Ethics Primer* of the American Psychiatric Association, discusses ethics in forensic psychiatry, and summarizes very nicely the issues of double agency and striving for objectivity and honesty. All of these are important considerations, since they go to the ultimate issue of limiting harm we do in our work in forensic psychiatry.

1.19 Ethics in Forensic Psychiatry

Weinstock has summarized an annotated bibliography on “Ethics in forensic psychiatry,” in 1995 [36]. His article annotates the work of Pollack and Diamond, Appelbaum, Rosner, and Miller, and others who have worked in preparing the ethical guidelines that ultimately became the guidelines of AAPL in 2005. Furthermore, Weinstock, along with Leong and Silva [37], conducted a survey of AAPL members to determine their opinions on the inclusion of various controversial ethical issues for forensic psychiatrists. Members of AAPL appeared to appreciate the need to consider traditional Hippocratic values as at least one consideration in their functioning as forensic psychiatrists [37]. They appeared to balance their duties to an evaluatee with duties to society and the legal system, and to appreciate the responsibilities of multiple agency. Support was shown for interpreting ambiguities in AAPL’s current guidelines and the directions indicated by most of the survey’s proposed guidelines.

The authors of the survey conclude that AAPL members clearly consider medical ethics relevant in their functioning as forensic psychiatrists. They recognize that they have multiple duties and obligations, and on occasion, they may act as double agents, or even multiple agents with multiple allegiances. The authors state, “In treatment as well as forensic situations, allegiances should be made clear. Forensic psychiatrists appear in practice to be following the balancing methods proposed by psychiatrist Edward Hundert to cope with conflicting obligations by weighing opposing values (even if not consciously), or utilizing a method similar to ethicist Baruch Brody’s Model of Conflicting Appeals. In general, they do not follow any single rule or allegiance absolutely” [38].

Thus, as forensic psychiatrists, we are bound by ethical principles not only of the American Medical Association, the American Psychiatric Association, but also of the AAPL. Because there are issues of double or multiple agency built into the work of the treating psychiatrist, Appelbaum states, “If we are serious about ridding ourselves of the problem with double agency, we must begin with a code of ethics to which we adhere. When we allow therapeutic principles to creep into our thinking, we open the door to profound confusion over the psychiatrist’s role” [27].

Appelbaum clearly distinguishes between treatment psychiatry and forensic psychiatry regarding ethical issues. His treatise implies that if we follow the ethical issues of forensic psychiatry, that is, respect for the individual and seeking truth and justice, we send a message to the system about our function within it. This is not to say that following the ethical guidelines of the AAPL will necessarily diminish the harm that exists within the system, but it is working in the right direction.

In commenting on Stone’s thesis, Dike [39] asks, “Is ethical forensic psychiatry an oxymoron?” in which he cites a paper that I wrote in 1984, “Practical ethical problems of the forensic psychiatrist in dealing with attorneys” [40], in which I indicated that attorneys who vigorously represent the interests of their clients “may make demands on forensic psychiatrists that are either inappropriate or potentially

unethical from a medical-psychiatric standpoint. They may insist that psychiatrists alter, omit, or delete information that may ultimately transform reports in favor of the attorney or patient/client.” Dike notes that although my views seem to support Stone’s concern that forensic psychiatrists may be cajoled by attorneys to “twist” the rules of justice in fairness to help their client, I did not see this as a reason to boycott the courts, but rather “as an indication that ethics’ guidelines should be developed” [41].

Dike notes that psychiatrists, as all doctors, “take an oath to do no harm.” Stone wondered whether patients may not be deceived consciously or unconsciously “and ultimately harmed, in the quest to serve justice when psychiatrists participate in the legal arena. On the other hand, the distress of cognitive dissonance that may occur in forensic psychiatrists may cause some to alter or ‘twist’ justice in favor of their patients (in order to do no harm)” [41].

Dike, in continuing to quote my earlier paper, reminded forensic psychiatrists that I was cognizant of the limits of individual expertise and of our profession. He notes, “If our personal biases or any information that may impair our effectiveness to the retaining attorney, the ethical forensic psychiatrist should express them to the retaining attorney especially if there is a likelihood that the biases will influence our opinion” [41].

Dike concludes, with respect to the role of the forensic psychiatrist and his place within the judicial system, as follows: “Eradicating forensic psychiatry would adversely affect the goals of achieving fairness and justice in our society. Expert opinion or testimony that leads to the hospitalization and treatment of individuals with serious mental illness in lieu of their incarceration in prison, serves not just the individual but also society at large” [41]. Dike notes that what is needed is a set of guidelines that would be pragmatic and that is tailored “to the current state of knowledge of the science of psychiatry, not to the emotional responses of those who would criticize the program” [39].

1.20 Summary

In summary, we have a very complex set of ethical guidelines and issues for the forensic psychiatrist that tend to evolve over time and with experience. We cannot use the same guidelines in forensic work as we do in treatment psychiatry. We are not there to help the individual, but to evaluate honestly and with objectivity. We can also be therapeutic in our evaluations, if we wish, in terms of helping the individual get through a very difficult evaluation that is necessary, but does not need to be destructive or damaging.

We must keep in mind that the thesis of this book is not to describe the ethical principles of medicine and psychiatry and how they differ from forensic psychiatry, but how we are guided in our work in forensic psychiatry to minimize the harm to the people we serve. Clearly, the focus is on seeking justice and respect for others. In this sense, according to Appelbaum and others who support his original and creative ideas, we can minimize harm, but not necessarily eliminate it, by adhering to accepted ethical principles.

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