Ethical Issues in Forensic Psychiatry

Minimizing Harm

Robert L. Sadoff

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"The Highest Form of Wisdom is Kindness"

The Talmud

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About the Authors

Robert L. Sadoff, MD

Dr. Sadoff is currently Clinical Professor of Forensic Psychiatry and Director of the Forensic Psychiatry Fellowship at the University of Pennsylvania School of Medicine. Dr. Sadoff received his MD in 1959 from the University of Minnesota School of Medicine and completed his residency in psychiatry in 1963 at UCLA Neuropsychiatric Institute, from which he received a master of science degree in psychiatry. He also attended Temple University School of Law and has taught legal medicine courses at Temple University Law School and at the Villanova University School of Law. He is board certified in psychiatry, forensic psychiatry, and legal medicine, and has added qualifications in forensic psychiatry with the American Board of Psychiatry and Neurology.

Dr. Sadoff is the author of over 90 articles in medical and legal journals and more than 30 chapters in books by other authors, and has authored, edited, or co-authored eight books, including *Forensic Psychiatry: A Practical Guide for Lawyers and Psychiatrists, Psychiatric Malpractice: Cases and Comments for Clinicians*, with Robert I. Simon, MD, *Mental Health Experts: Roles and Qualifications for Court* and *Crime and Mental Illness* with Frank Dattilio, PhD. He has numerous editorial appointments with peer reviewed journals. He has served as President of the American Academy of Psychiatry and the Law, and President of the American Board of Forensic Psychiatry. In addition, he is a Distinguished Life Fellow of the American Psychiatric Association, a Fellow of the American College of Legal Medicine, and a Fellow of the American Academy of Forensic Sciences, as well as a Fellow of the American College of Psychiatrists and The College of Physicians of Philadelphia, for which he serves on the board of trustees.

Dr. Sadoff is the recipient of a number of national and international awards, including the very prestigious Isaac Ray Award from the American Psychiatric Association, the Philippe Pinel Award given by the International Academy of

Law and Mental Health, the Lifetime Achievement Award from the Philadelphia Psychiatric Society, and the Earl Bond Award and the Dean's Special Award from the University of Pennsylvania. In addition, he has been the recipient of the Manfred S. Guttmacher Award from the American Psychiatric Association, and the recipient of the Nathaniel Winkelman Award from the Philadelphia Psychiatric Center. He has also been named repeatedly in the list of *Best Doctors in America* and in *Who's Who in America* and *Who's Who in the World*.

Dr. Sadoff has examined over 10 000 individuals charged with crimes during the past 40 years, and has testified for both the prosecution and defense in criminal cases and for the plaintiff and defense in civil cases in approximately 20 states and several federal jurisdictions. He has served as a consultant to the Norristown State Hospital, the Trenton Psychiatric Hospital, the Harrisburg State Hospital and the Forensic Psychiatric Hospital of New Jersey, as well as the Philadelphia prison system. Dr. Sadoff has been licensed to practice medicine in five states, including Pennsylvania, New York, California, Minnesota, and New Jersey (currently inactive). He has also lectured in nearly all of the states in the United States and in 12 countries worldwide.

John A. Baird, MD, FRCPsych DCH

Dr. John Baird has worked as a forensic psychiatrist in Scotland for over 30 years. He has in the past been a member of the Parole Board for Scotland, and is currently a member of the Parole Board for England and Wales and the Mental Health Tribunal for Scotland. He is an elected officer of the Executive Committee of the Forensic Faculty of the Royal College of Psychiatrists, having served in the past as Secretary and currently serving as Finance Officer. He has served as a member of the Ethics Committee of the Royal College of Psychiatrists. His MD thesis was a study of psychiatric aspects of imprisonment in Scotland.

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Dr. Solange Margery Bertoglia was born and raised in Costa Rica by her Chilean immigrant parents and older brothers. She received her MD degree from the Universidad de Costa Rica, before emigrating to the United States. Dr. Margery completed her psychiatry residency training at Temple University Hospital in Philadelphia. During her residency, she served as a liaison between patients from a primarily Latino community and the Department of Psychiatry. Subsequently, she completed her forensic psychiatry fellowship training at Saint Vincent's Catholic Medical Center in New York City. Dr. Margery has researched and made national and local presentations on a variety of forensic issues, including: sex offenders, competency to stand trial, insanity defense, race and ethnicity, and homicide by adolescents. Dr. Margery is currently on the faculty of Thomas Jefferson University in Philadelphia where she is actively involved in the teaching and development of the forensic psychiatry curriculum.

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Emanuele Valenti holds a Ph.D. from the Universidad Complutense de Madrid, Spain, Department of Preventive Medicine, Public Health, and History of Science under the direction of bioethicist Dr. Diego Gracia. He earned a B.A. in Philosophy from the Universitá degli Studi di Milano, Italy. In Philadelphia, US, he has been research scholar at the Centre for Bioethics, University of Pennsylvania, collaborating in the ScattergoodEthics Program under the direction of Dr. Arthur Caplan. As visiting scholar, Dr. Valenti has participated in An Observational Descriptive Study of IRB Practices project research under the direction of Dr. Charles Lidz in the Center for Mental Health Services Research at the Worcester State Hospital, University of Massachusetts. He has worked as researcher in the Center for Bioethics and Health Governance at the Hospital Policlinico di Milano, Italy, where he has developed a program to promote a good practice of informed consent. His primary research focuses on coercive measures in mental health, and the assessment of the impact of coercion in the decision making capacity of the patient. He is currently working on the reform and harmonization of the European mental health system.

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Ms. Vanderpool, a healthcare attorney, is the Assistant Vice President of Risk Management at PRMS, a company that manages all aspects of a professional liability insurance program for psychiatrists and other mental health professionals. In addition to assisting the Vice President with the development and implementation of risk management services, she staffs the Risk Management Consultation Service Helpline, giving telephone advice on all types of psychiatric risk management issues, and contributes to PRMS' publications and seminars. She is a frequent speaker for a variety of organizations throughout the nation on psychiatric risk management topics and has had risk management articles published in legal and psychiatric journals. Ms. Vanderpool has also developed a particular interest and expertise in the area of forensic liability. Ms. Vanderpool's professional background includes practicing criminal defense, teaching business and legal courses, and managing a general surgical practice. Ms. Vanderpool received her undergraduate degree from James Madison University and her MBA and JD from George Mason University.

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Dr. Barrios graduated in Law from the University of Salamanca (Spain) and is a Juridical Doctor at the University of Alicante (Spain). He has worked in Spanish

penitentiary institutions for over 30 years. His JD thesis was a study on the Juridical Statute of the Patient.

Dr. Barrios is the author of 6 books, over 50 articles published in medical and legal journals, and has contributed 18 chapters to books by other authors.

He has intervened, as a member of the legal expert panel, in the following studies: EUNOMIA (European Evaluation of Coercion in Psychiatry and Harmonisation of Best Clinical Practice, within the Fifth Framework Programme of Research of the European Commission, completed in 2005), EUPRIS (Mentally ill or disordered persons in European prison systems—Needs, Programmes and Outcome, European Commission, completed in 2007), DEMoB.inc (Development of a European Measure of Best Practice for People with Long Term Mental Illness in Institutional Care, European Commission, completed in 2010).

Dr. Barrios is a member of the Geneva International Academic Network on Mental Health, Human Rights and Legislation of the World Health Organization (WHO), and he has collaborated with the Pan American Health Organization (OPS). He is a co-author of the report: "Fundamental Freedoms, Basic Rights and Care for the Mentally Ill" (Council of Europe, 2009–10).

Preface

Isaac Ray

This book is dedicated to the memory of Isaac Ray, the great nineteenth century American psychiatrist who became the father of American forensic psychiatry following the publication of his seminal book, *A Treatise on the Medical Jurisprudence of Insanity*, published initially in Boston, in 1838 [1]. Dr. Ray was instrumental in advocating for the rights of the mentally ill, for protection of those who were less able to protect themselves, and advocated for reforms that are still needed today.

The forensic psychiatric historian, Dr. Jacques Quen, in a paper entitled, "Isaac Ray: Have We Learned His Lessons?" [2] cites Overholser and Weihofen, who summarized Isaac Ray's philosophy as "doing as little harm to the mentally ill as possible." The authors quote Ray as stating, "In the first place, the law should put no hindrance in the way of the prompt use of those instrumentalities which are regarded as most effectual in promoting the comfort and restoration of the patient. Secondly, it should spare all unnecessary exposure of private troubles, and all unnecessary conflict with popular prejudices. Thirdly, it should protect individuals from wrongful imprisonment" [3].

Although Ray was most concerned about commitment of the mentally ill and the manner in which the mentally ill were treated in judicial decisions in court cases, his concern about doing little or no harm is the basic theme of this book, in which I hope to illustrate means by which we may limit or minimize the inherent harm in the practice of forensic psychiatry.

Primum Non Nocere

The concept of *primum non nocere*—first, do no harm—is the basis for ethical medical practice and treatment in psychiatry. However, it cannot, and does not,

apply to forensic cases where there is no doctor-patient relationship and the forensic psychiatrist may indeed cause harm to the examinee. Consider, for example, the psychiatrist hired by the prosecution in a capital murder case. His or her assessment of the defendant may lead to a verdict of guilty and subsequent death penalty. Consider also the role of the treating psychiatrist on death row, treating a psychotic prisoner who has deteriorated and requires medication and further therapy in order to improve to the point where he or she may be competent to be executed. Consider also the plaintiff in a civil matter who has been emotionally harmed as well as physically damaged in an accident or incident at work. Consider the forensic psychiatrist working for the defense in that case who may minimize the damage or find no significant mental illness caused by the accident in question.

Forensic psychiatrists work in three major areas in assessment of individuals in civil or criminal cases. First, they are involved in examining the defendant in a criminal case, or the plaintiff in a civil matter. Secondly, they are responsible for writing a report to the court or to an attorney regarding their findings, which would include not only the psychiatric examination, but also the review of extensive records and interviewing collaborative individuals, when necessary. Third, they may be required to testify at deposition and/or at trial. Harm may come to the individual examined at any or all of the three levels of work: examination, report writing, and/or testimony.

Personal Concerns

I have been practicing psychiatry for over 45 years, 25 years of which have been exclusively in forensic work. During the past many years I have seen over 12 000 individuals, either in civil or criminal cases, in a variety of different circumstances. I have worked for both defense and prosecution in over 10 000 criminal cases, and either for the defendant or the plaintiff in over 2000 civil cases. In addition, I have been asked by judges to evaluate and assess individuals in both criminal and civil matters and have worked in a number of administrative cases involving patients' rights, competency, and other forensic psychiatric issues.

I have been concerned about the manner in which individuals, families, or groups of people have been assessed and the conclusions that have been drawn depending on the needs of the attorney. I have seen testimony that has been slanted, unscientific, and based on inadequate evidence or which is contrary to the facts proven. Perhaps, adversaries of mine in specific cases may have felt the same about my assessments or my testimony. Nevertheless, it is an issue that forensic psychiatrists, attorneys, judges, and other concerned citizens need to address as the practice of forensic psychiatry has grown and proliferated over the past several decades. We now have formal accredited training programs in forensic psychiatry. We have board certification that originated with the American Board of Forensic Psychiatry and which culminated in the acceptance of forensic psychiatry as a subspecialty of psychiatry by the American Board of Psychiatry and Neurology. We have recertification of these boards in forensic psychiatry to insure high quality of professional behavior.

I have been struck with the manner in which colleagues and adversaries have approached their professional responsibilities. I have witnessed destructive and biased attitudes toward various criminal defendants and plaintiffs in civil cases that are unnecessary and harmful. I have witnessed psychiatrists becoming adversarial in order "to win" cases. I have seen professional psychiatrists testify to speculative rather than evidence-based or scientific matters. And I have also seen our colleagues testify on matters for which they have no expertise and very little experience. One psychiatrist even admitted that he did not know the legal criteria for assessing competency in a particular criminal case. Nevertheless, he speculated on the issue based on his medical diagnosis rather than applying the medical observations to the legal standards.

Changes in Psychiatry

Psychiatry is a changing and evolving specialty of medicine. When I began my career in 1960, the emphasis was on psychodynamics, and Freud was still a very prominent influence in the training programs. During the past five decades, we have seen a major shift from psychoanalytic concepts to cognitive behavioral matters in psychotherapy and to chemical imbalance in our diagnoses, and the use of various medications to treat major mental illnesses. Psychopharmacology has become a major subspecialty of psychiatry. In addition, we have developed various techniques to diagnose brain problems, including MRI, PET scan, and CAT scans. Neuropsychological testing has been shown to be effective in the diagnosis of functional organic conditions that may not be revealed on more grossly sensitive tests that pick up only structural organic damage.

We have brought the newer scientific psychiatry into the courtroom when testifying for individuals revealing significant mental illness or brain damage that affected behavior in criminal or civil cases. As a result of the transitions within psychiatry, the law has made further demands on our scientific acumen by such cases as Daubert [4] and Kumho [5], demanding scientific-based testimony rather than speculative "junk science." The judge has become the gatekeeper for various types of testimony that may be harmful to an individual as it reveals prejudice or bias rather than scientific methods.

Bias in Forensic Psychiatry

Several decades ago, one of the early leaders in forensic psychiatry, Bernard Diamond, pointed out, in his historic paper on "The Fallacy of the Impartial Expert" [6], that all of us have our biases that need to be considered in forensic cases.

The major ethical prohibition in medicine has been *primum non nocere*—first, do no harm. Paul Appelbaum [7] and others have shown that forensic psychiatrists have a different ethical standard when conducting assessments, or even in testimony, because the nature of our work cannot guarantee that no harm is done to the individual. Rather, he has developed concepts of respecting the integrity of the evaluee (the defendant in a criminal case, or the plaintiff in a civil case), and

considering beneficence or non-maleficence. Others have debated with Appelbaum on these concepts, most notably Alan Stone [8] pointing out glaring differences. This book will attempt to present the major issues that arise for forensic psychiatrists practicing in this very complex and controversial field where harm may occur.

Medicine in General

It is well known that in medicine generally, physicians attempt to treat or cure illnesses by utilizing treatments that may be harmful to patients. However, physicians are clearly aware that in many cases, in order to help their patients, they must first cause pain either through surgery, through various medications or chemotherapy, or other procedures. Even in psychiatry, we have learned that various medications given to improve psychotic conditions may cause harmful side effects such as tardive dyskinesia. We have recently found that some antidepressants may also lead to diabetic conditions. Clearly, electroshock treatment which has been helpful for severe depression has caused many patients fear, anxiety, and harm. We have seen the effects of lobotomy on various patients who were not amenable to treatment by other methods, such as psychotherapy, medication, or even electroshock treatment. All of this is performed in order to help our patients who depend upon us for scientific and accurate information and effective therapy.

Benjamin Rush is considered the father of American psychiatry, and his portrait appears on the seal of the American Psychiatric Association. It should be noted that Benjamin Rush, in all his greatness as a physician and the author of one of the earliest textbooks on psychiatry in America, entitled, *Medical Inquiries and Observations Upon the Diseases of the Mind* [9], used leeches for bloodletting as a means of treating his patients. It is well known that some patients did not do well from such harmful treatments. We learn as we go, and sometimes we have learned that the treatment that was once thought to be helpful and successful was not scientifically based and proved to be harmful.

We have mentioned surgery as a means of helping others that may be harmful. The surgery may result in a painful after-effect, but pain is not necessarily harmful, and we must consider harmful as having long-term side effects. The short-term downside from surgery that leads to long-term cure or improvement is certainly worth the discomfort. When I speak of harm, I am talking about long-term harm that can be either avoided or minimized through careful planning and application of ethical principles outlined by the American Academy of Psychiatry and the Law [10]. However, even following these principles may not eliminate or minimize harm that is inherent in the system.

I am not advocating that the harm can be totally eliminated, because I know that is impossible in the adversarial system in which forensic psychiatrists work. However, there are means by which harm may be minimized if care is taken during the assessment, the report writing, and the testimony phase of the proceedings.

This book will analyze the ethical issues affecting forensic psychiatric practice, especially those promulgated by the American Academy of Psychiatry and the

Law. Within those guidelines, we will look at individual bias, vulnerability of the examinee, and potential harm to the mental health professional. The book will discuss each of the procedures of the forensic expert separately with respect to minimizing harm.

The scope of forensic psychiatry will be developed from the standpoint of administrative, civil, and criminal cases. The practical issues involved in conducting forensic psychiatric assessments under various conditions will be presented as will special considerations, such as bias, minimizing harm, developing a therapeutic approach, and elaborating on various vulnerable individuals who are frequently examined in forensic cases. These include juveniles, mentally retarded, autistic, sexual assault victims, the elderly, the organically damaged, the psychotic, and the mentally disabled prisoners. The ethical issues in conducting forensic psychiatric examinations and presenting psychiatric testimony in court will also be examined and discussed. Cases illustrating the difficulties involved will punctuate the presentation. Harm may also come to the non-vulnerable defendant or plaintiff in legal cases. We need to minimize the harm that comes to these individuals as well whenever possible. Selecting the vulnerable populations does not imply that we are not concerned about the general populations as well. There are those individuals, primarily in civil cases, who are the victims of harassment, discrimination, and prejudice. These are individuals who may not have specific diagnostic entities that place them in the vulnerable categories. However, they may develop psychiatric syndromes or illnesses as a result of the alleged harassment, discrimination or bias. We also see individuals who are victims of accidents with physical and mental injuries, but who do not have a predisposing illness or psychiatric syndrome.

In criminal cases, we may be asked to examine victims of crime who are not in the vulnerable categories. These are people who may have been shot during a robbery or a kidnapping and may require psychiatric assessment as a result of the injuries sustained in the criminal case.

In administrative matters, we may be asked to evaluate professionals who have been accused of negligence in their work or we may need to assess competency of individuals facing administrative matters. In all of these cases, we need to be careful in our assessment, report writing, and testimony in order to minimize harm.

Any ethical issue pertaining to vulnerable populations applies to all individuals seen in forensic mental health matters. The system has inherent difficulties that may bring harm to those involved that we may be able to mitigate whenever possible. There are situations in which harm will occur to those who have transgressed, and that is a justifiable harm or punishment. However, we are more concerned about innocent people who may be victimized even more because of the legal situation in which they are involved. The very act of filing a lawsuit, with all its ramifications and consequences, affects both plaintiffs and defendants. We must do all we can to minimize harm to all populations, but the vulnerable ones listed above will be stressed since they represent individuals who are most likely to be harmed in the legal system if special care is not taken by the forensic psychiatrist to minimize such harm.

The original manuscript for this book did not include the perspective from Europe and the United Kingdom. Reviewers recommended that we include ethical issues in forensic psychiatry from a more global perspective than just from the United States.

Dr. John Baird, a forensic psychiatrist from Scotland who has had experience in working in the United Kingdom, comments on the differences between the practice of forensic psychiatry in the United Kingdom and the United States. His presentation is from a more systemic view, utilizing different organizations that monitor the practice of forensic psychiatry. In both the United Kingdom and Europe, individual forensic psychiatry appears to be secondary to the institutional application of principles to the mentally disabled within the legal system.

Both Dr. Baird and Dr. Valenti, a forensic psychiatrist and ethicist, present the changes that have occurred in both systems that promote the welfare of the individual involved in the legal system. Dr. Baird focuses on minimizing the harm from the perspective of the forensic psychiatrist and Dr. Valenti on human rights for this same population.

Dr. Valenti presents the very complicated system in the European Union that comprises a number of different countries and cultures and legal systems that have attempted to unify their ethics as regards the mentally ill within the judicial system. Dr. Valenti does not focus particularly on minimizing harm, but does relate the newer ethical principles that affect the mentally ill within the court system in the European Union. He points out that the reforms that have occurred in the last several years have helped the human rights of such people and thus harm to them is minimized. Ideally, an attempt is sought to unify the variety of systems in order to promote human rights and thus minimize harm.

The theme of this book is to minimize the harm inherent in forensic psychiatric practice. Clearly, the intent is to minimize the harm to plaintiffs or defendants, but also to the expert witness as well. Donna Vanderpool, an attorney and risk manager, provides comprehensive coverage of potential liability to expert witnesses, especially those in medical malpractice cases. She points out the inconsistencies of a number of Appellate Court holdings and illustrates the complexity of the emerging liability cases against expert witnesses.

Her intent is to educate expert witnesses to prevent damage or harm to themselves in the course of their work in conducting forensic examinations, writing reports, and testifying in court. As she points out, the harm that may come to a defendant or plaintiff could result in retaliation against the expert for causing such harm. She demonstrates the areas of duty the expert has to the examinee and the areas of liability that may exist for the expert professional. Finally, she presents important guidelines and recommendations for the expert in order to prevent or minimize harm.

The motivation to write this book was the presentation of the Isaac Ray Award given by the American Psychiatric Association in 2006, which required my preparing lectures on important issues in forensic psychiatry. Thus, I decided that the important message for the Isaac Ray Lectures should be a reiteration of Ray's

concerns about minimizing harm to vulnerable mentally ill patients and applying his recommendations to the forensic psychiatric profession.

In summary, the purpose of this book is to illustrate the ethical and practical issues that affect forensic psychiatric practice. The question is not what we do, but how we do it, and under what standards, ethical guidelines, and personal values that contribute to the total picture. It is hoped that by such presentation and discussion, vast improvements in the manner in which forensic psychiatry is practiced will occur, resulting in less harm to the examinee and greater credibility to the examiner and our role within the judicial system. Despite the fact that we cannot always adhere to the doctrine of *primum non nocere*, we can minimize the harm caused inherently by the adversarial system in which we participate.

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Acknowledgments

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Next, I thank the Isaac Ray Committee of the American Psychiatric Association for the honor of receiving the Isaac Ray Award in 2006, prompting me to write this book in honor of Isaac Ray. It was my dear friend, Dr. Kenneth Weiss, forensic psychiatrist and psychiatric historian, who led me to the writings of Isaac Ray on minimizing harm to the vulnerable mentally ill in our hospitals. I also wish to thank Dr. Marla Isaacs, forensic psychologist, whose sensitivity in examining a vulnerable child in a very difficult domestic relations case stimulated my thinking about minimizing the harm in the work we do in forensic psychiatry.

I am especially grateful to my two original mentors in forensic psychiatry, Melvin S. Heller, MD, whose enthusiasm and ebullience heightened my interest in this very challenging field, and his colleague at Temple University, the late Professor Samuel Polsky, whose brilliance in the field was matched only by his expansive teaching of courses in law and mental health. I thank my dear friend, Professor Michael Perlin, of the New York Law School, with whom I have worked for over 35 years in many capacities and who has always instilled in me a concern and care for the mentally ill and the mentally disabled. He has fought for their welfare through his work as a public defender in Trenton, New Jersey, as the mental health advocate for New Jersey and through his extremely prolific writing on the legal issues affecting the mentally disabled.

I want to thank all of my teachers and all of my students from whom I have learned more, I suspect, than what I taught them. I am also grateful to my many colleagues in forensic psychiatry, and especially those active in the American

Academy of Psychiatry and the Law whose work I have quoted in this book and whose thinking and creative ideas have stimulated the concepts presented herein. Toward that end, I am especially grateful to Drs. Paul Appelbaum, Richard Ciccone, Thomas Gutheil, Jonas Rappeport, Robert Simon, Robert Weinstock, and Robert Wettstein for their prolific writing and special concerns for ethics in forensic psychiatry and for the welfare of those we serve.

The concept that I present in these pages would not be complete without the addition of Donna Vanderpool's chapter. She is an attorney working in risk management who has given us the legal perspective of forensic psychiatric practice that may be harmful to the practitioner. I am most grateful for her significant contribution to this book.

The early reviewers of the manuscript suggested that I include a European perspective on ethical issues in forensic psychiatry. I am most grateful to Dr. Emanuele Valenti, MBe, PhD, who has contributed a significant chapter on the European perspective and to Dr John Baird for his chapter on forensic psychiatry in the United Kingdom. John Baird, from Scotland, has been a regular speaker at our Seminar in Forensic Psychiatry at the University of Pennsylvania. Finally, I thank my colleague and friend, a regular participant in our Seminar in Forensic Psychiatry at the University, Dr. Solange Margery Bertoglia, for contributing a chapter on immigrants as a vulnerable population. Dr. Margery, who hails from Costa Rica, has experienced the view of the immigrant as well as worked with immigrants within the forensic field. I am very grateful to Solange for her important contribution to this book.

There were a number of references and citations that I was not able to find, but with the help of attorney Tina L. Mazza Ralls, Esquire, I could complete the citations and references. I am grateful to Ms. Ralls for her scholarship and her expertise in the law that is so essential to the accuracy of these references. My dear friend and colleague and co-author of other books on forensic mental health, Dr. Frank Dattilio, clinical and forensic psychologist, reviewed a number of chapters and helped clarify ethical issues relating to forensic psychology. For that I am most grateful.

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Introduction

Robert L. Sadoff

Medicine is the profession that involves the treatment of illness and research in preventing and treating illnesses. Psychiatry is the specialty of medicine that treats mental and emotional illnesses, organic brain syndromes, and physical illness with emotional manifestations. Forensic psychiatry is the subspecialty of psychiatry that deals with people who are involved in legal matters, either criminal or civil. Treatment psychiatry (sometimes erroneously referred to as clinical psychiatry, since forensic psychiatry is also clinical) involves the treatment of individuals with mental or emotional illness.

Forensic psychiatry in America typically does not deal with treatment except in correctional institutions and forensic psychiatric hospitals, but rather with clinical assessment of individuals in criminal or civil cases. The forensic expert may be called either by the prosecution, the defense or the court in a criminal case, or by the plaintiff, the defense or the court in a civil case, or by either side in an administrative legal case. It is usually best for the forensic expert not to be the treating psychiatrist. The goal of treatment is to help the patient, and the goal of forensic psychiatry is to seek justice and truth while respecting the rights of those who are examined [1].

First, Do No Harm

The ethical credo for treating physicians is *primum non nocere*—first, do no harm. Doctors are not supposed to intentionally or negligently harm patients they treat. Their goal is to alleviate suffering and pain while treating the medical condition. However, it is well known that in the course of treating particular illnesses, patients do suffer as a result of the treatment.

For example, in surgical procedures, patients have pain during the procedure even though they are anesthetized and will have pain following the procedure, requiring analgesic medication, which sometimes can be taken to excess and lead to addiction or habituation. Sometimes the surgical procedure inadvertently or unintentionally results in further damage to the patient. For example, abdominal operations sometimes lead to adhesions, which cause further complications in the future. Surgeons always advise their patients that major operations could result in serious complications or even death. Certainly, neurosurgical operations of the brain could lead to problems of mentation or cognition or even movement of limbs. Nevertheless, the option is either to operate with the risks that are usually known (and some that are unknown or unexpected) or to suffer from the pain and complications of the illness. Often, this is a very difficult choice for many patients who have learned to live with the symptoms of their illness and are uncomfortable making a choice about the unknown that may occur following surgical treatment.

Intentional Harm

Medical treatment then can be painful or harmful even though the intention is to relieve pain and alleviate suffering; never should the doctor intentionally inflict harm on his or her patient.

Of course, there are unusual and rare circumstances when physicians have been found to betray the confidences of their patients or to intentionally inflict harm for reasons that are outside the scope of medical practice. One psychiatrist treating a patient for depression gave whopping doses of lithium for bipolar disorder that caused kidney failure. It was later learned, in the criminal trial, that the psychiatrist wanted to kill the patient in order to free the patient's wife, with whom he had fallen in love, to marry him. This type of intentional harm is extremely rare, but when it occurs, it is a breach of trust between the patient and the doctor and should never be tolerated.

Confidentiality

In psychiatry, maintaining confidentiality is extremely important to the welfare of the patient. Talking about patients' illnesses outside the consultation room could lead to damage or harm to the patient by loss of job, loss of reputation, or other complications that may have been unforeseen by the loose lips of the treating psychiatrist.

There are regulations that guide the release of information about patients. Generally speaking, the treating psychiatrist should never reveal any information about his or her patient without proper legal release such as a court order. Even a subpoena may not be sufficient to release information, unless the court orders it following a hearing. Thus, in psychiatry, maintaining confidentiality is a priority that is rarely violated or breached. However, in general medicine, doctors frequently talk about their patients without concern about the information that is revealed. Especially in high profile individuals, physicians may be very proud of the fact