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Forensic Psychiatry and Ethics in Psychiatry 36.1 Forensic Psychiatry The word forensic means belonging to the courts of law, and at various times, psychiatry and the law converge. Forensic psychiatry covers a broad range of topics that involve psychiatrists' professional, ethical, and legal duties to provide competent care to patients; the patients' rights of self-determination to receive or refuse treatment; court decisions, legislative directives, governmental regulatory agencies, and licensure boards; and the evaluation of those charged with crimes to determine their culpability and ability to stand trial. Finally, the ethical codes and practice guidelines of professional organizations and their adherence also fall within the realm of forensic psychiatry. MEDICAL MALPRACTICE Medical malpractice is a tort, or civil wrong. It is a wrong resulting from a physician's negligence. Simply put, negligence means doing something that a physician with a duty to care for the patient should not have done or failing to do something that should have been done as defined by current medical practice. Usually, the standard of care in malpractice cases is established by expert witnesses. The standard of care is also determined by reference to journal articles; professional textbooks, such as the Comprehensive Textbook of Psychiatry; professional practice guidelines; and ethical practices promulgated by professional organizations. To prove malpractice, the plaintiff (e.g., patient, family, or estate) must establish by a preponderance of evidence that (1) a doctor–patient relationship existed that created a duty of care, (2) a deviation from the standard of care occurred, (3) the patient was damaged, and (4) the deviation directly caused the damage. These elements of a malpractice claim are sometimes referred to as the 4 Ds (duty, deviation, damage, direct causation). Each of the four elements of a malpractice claim must be present or there can be no finding of liability. For example, a psychiatrist whose negligence is the direct cause of harm to an individual (physical, psychological, or both) is not liable for malpractice if no doctor–patient relationship existed to create a duty of care. Psychiatrists are not likely to be sued successfully if they give advice on a radio program that is harmful to a caller, particularly if a caveat was given to the caller that no doctor–patient relationship was being created. No malpractice claim will be sustained against a psychiatrist if a

patient's worsening condition is unrelated to negligent care. Not every bad outcome is the result of negligence. Psychiatrists cannot guarantee correct diagnoses and treatments. When the psychiatrist provides due care, mistakes may be made without necessarily incurring liability. Most psychiatric cases are complicated. Psychiatrists make judgment calls when selecting a particular treatment course among the many options that may exist. In hindsight, the decision may prove wrong but not be a deviation in the standard of care. In addition to negligence suits, psychiatrists can be sued for the intentional torts of assault, battery, false imprisonment, defamation, fraud or misrepresentation, invasion of privacy, and intentional infliction of emotional distress. In an

intentional tort, wrongdoers are motivated by the intent to harm another person or realize, or should have realized, that such harm is likely to result from their actions. For example, telling a patient that sex with the therapist is therapeutic perpetrates a fraud. Most malpractice policies do not provide coverage for intentional torts. Negligent Prescription Practices Negligent prescription practices usually include exceeding recommended dosages and then failing to adjust the medication level to therapeutic levels, unreasonable mixing of drugs, prescribing medication that is not indicated, prescribing too many drugs at one time, and failing to disclose medication effects. Elderly patients frequently take a variety of drugs prescribed by different physicians. Multiple psychotropic medications must be prescribed with special care because of possible harmful interactions and adverse effects. Psychiatrists who prescribe medications must explain the diagnosis, risks, and benefits of the drug within reason and as circumstances permit (Table 36.1-1). Obtaining competent informed consent can be problematic if a psychiatric patient has diminished cognitive capacity because of mental illness or chronic brain impairment; a substitute health care decision maker may need to provide consent. Table 36.1-1 Informed Consent: Reasonable Information to Be Disclosed Informed consent should be obtained each time a medication is changed and a new drug is introduced. If patients are injured because they were not properly informed of

the risks and consequences of taking a medication, sufficient grounds may exist for a malpractice action. The question is often asked: How frequently should patients be seen for medication follow-up? The answer is that patients should be seen according to their clinical needs. No stock answer about the frequency of visits can be given. The longer the time interval between visits, however, the greater the likelihood of adverse drug reactions and clinical developments. Patients taking medications should probably not go beyond 6 months for follow-up visits. Managed care policies that do not reimburse for frequent follow-up appointments can result in a psychiatrist prescribing large amounts of medications. The psychiatrist is duty bound to provide appropriate treatment to the patient, quite apart from managed care or other payment policies. Other areas of negligence involving medication that have resulted in malpractice actions include failure to treat adverse effects that have, or should have, been recognized; failure to monitor a patient’s compliance with prescription limits; failure to prescribe medication or appropriate levels of medication according to the treatment needs of the patient; prescribing addictive drugs to vulnerable patients; failure to refer a patient for consultation or treatment by a specialist; and negligent withdrawal of medication treatment. Split Treatment In split treatment, the psychiatrist provides medication, and a nonmedical therapist conducts the psychotherapy. The following vignette illustrates a possible complication. A psychiatrist provided medications for a depressed 43-year-old woman. A master’s level counselor saw the patient for outpatient psychotherapy. The psychiatrist saw the patient for 20 minutes during the initial evaluation and prescribed a tricyclic drug, and the patient was prescribed sufficient drugs for follow-up in 3 months. The psychiatrist’s initial diagnosis was recurrent major depression. The patient denied suicidal ideation. Appetite and sleep were markedly diminished. The patient had a long history of recurrent depression with suicide attempts. No further discussions were held between the psychiatrist and the counselor, who saw the patient once a week for 30 minutes in psychotherapy. Within 3 weeks, after a failed romantic relationship, the patient stopped taking her antidepressant medication, started to drink heavily, and committed suicide with an overdose of alcohol and antidepressant drugs. The counselor and psychiatrist were sued for negligent diagnosis and treatment. Psychiatrists must do an adequate evaluation, obtain prior medical records, and understand that no such thing as a partial patient exists. Split

treatments are potential malpractice traps because patients can “fall between the cracks” of fragmented care. The psychiatrist retains full responsibility for the patient’s care in a split treatment situation. This does not preempt the responsibility of the other mental health

professionals involved in the patient’s treatment. Section V, annotation 3 of the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry, states: “When the psychiatrist assumes a collaborative or supervisory role with another mental health worker, he/she must expend sufficient time to assure that proper care is given.” In managed care or other settings, a marginalized role of merely prescribing medication apart from a working doctor–patient relationship does not meet generally accepted standards of good clinical care. The psychiatrist must be more than just a medication technician. Fragmented care in which the psychiatrist only dispenses medication while remaining uninformed about the patient’s overall clinical status constitutes substandard treatment that may lead to a malpractice action. At a minimum, such a practice diminishes the efficacy of the drug treatment itself or may even lead to the patient’s failure to take the prescribed medication. Split-treatment situations require that the psychiatrist remain fully informed of the patient’s clinical status as well as the nature and quality of treatment the patient is receiving from the nonmedical therapist. In a collaborative relationship, the responsibility for the patient’s care is shared according to the qualifications and limitations of each discipline. The responsibilities of each discipline do not diminish those of the other disciplines. Patients should be informed of the separate responsibilities of each discipline. The psychiatrist and the nonmedical therapist must periodically evaluate the patient’s clinical condition and requirements to determine whether the collaboration should continue. On termination of the collaborative relationship, both parties treating the patient should inform the patient either separately or jointly. In split treatments, if the nonmedical therapist is sued, the collaborating psychiatrist will likely be sued also and vice versa. Psychiatrists who prescribe medications in a split-treatment arrangement should be able to hospitalize a patient if it becomes necessary. If the psychiatrist does not have admitting privileges, prearrangements should be made with other psychiatrists who can hospitalize patients if emergencies arise. Split treatment is increasingly used by managed care companies and is a potential malpractice minefield. PRIVILEGE AND CONFIDENTIALITY Privilege Privilege is the right to maintain secrecy or confidentiality in the face of a subpoena. Privileged communications are statements made by certain persons within a relationship—such as husband–wife, priest–penitent, or doctor–patient—that the law protects from forced disclosure on the witness stand. The right of privilege belongs to the patient, not to the physician, so the patient can waive the right. Psychiatrists, who are licensed to practice medicine, may claim medical privilege, but privilege has some qualifications. For example, privilege does not exist at all in military courts, regardless of whether the physician is military or civilian and whether the privilege is recognized in the state in which the court martial takes place. In 1996, the United States Supreme Court recognized a psychotherapist–patient

privilege in Jaffee v. Redmon. Emphasizing the important public and private interests served by the psychotherapist–patient privilege, the Court wrote: Because we agree with the judgment of the state legislatures and the Advisory Committee that a psychotherapist-patient privilege will serve a “public good transcending the normal predominant principle utilizing all rational means for ascertaining truth”… we hold that confidential communications between a licensed psychotherapist and her patients in the course of diagnosis or treatment are protected from compelled disclosure under Rule 501 of the Federal Rules of Evidence. Confidentiality A long-held premise of medical

ethics binds physicians to hold secret all information given by patients. This professional obligation is called confidentiality. Confidentiality applies to certain populations and not to others; a group that is within the circle of confidentiality shares information without receiving specific permission from a patient. Such groups include, in addition to the physician, other staff members treating the patient, clinical supervisors, and consultants. A subpoena can force a psychiatrist to breach confidentiality, and courts must be able to compel witnesses to testify for the law to function adequately. A subpoena ("under penalty") is an order to appear as a witness in court or at a deposition. Physicians usually are served with a subpoena duces tecum, which requires that they also produce their relevant records and documents. Although the power to issue subpoenas belongs to a judge, they are routinely issued at the request of an attorney representing a party to an action. In bona fide emergencies, information may be released in as limited a way as feasible to carry out necessary interventions. Sound clinical practice holds that a psychiatrist should make the effort, time allowing, to obtain the patient's permission anyway and should debrief the patient after the emergency. As a rule, clinical information may be shared with the patient's permission—preferably written permission, although oral permission suffices with proper documentation. Each release is good for only one piece of information, and permission should be reobtained for each subsequent release, even to the same party. Permission overcomes only the legal barrier, not the clinical one; the release is permission, not obligation. If a clinician believes that the information may be destructive, the matter should be discussed, and the release may be refused, with some exceptions. Third-Party Payers and Supervision. Increased insurance coverage for health care is precipitating a concern about confidentiality and the conceptual model of psychiatric practice. Today, insurance covers about 70 percent of all health care bills; to provide coverage, an insurance carrier must be able to obtain information with which it can assess the administration and costs of various programs. Quality control of care necessitates that confidentiality not be absolute; it also requires a review of individual patients and therapists. The therapist in training must

breach a patient's confidence by discussing the case with a supervisor. Institutionalized patients who have been ordered by a court to get treatment must have their individualized treatment programs submitted to a mental health board. Discussions About Patients. In general, psychiatrists have multiple loyalties: to patients, to society, and to the profession. Through their writings, teaching, and seminars, they can share their acquired knowledge and experience and provide information that may be valuable to other professionals and to the public. It is not easy to write or talk about a psychiatric patient, however, without breaching the confidentiality of the relationship. Unlike physical ailments, which can be discussed without anyone's recognizing the patient, a psychiatric history usually entails a discussion of distinguishing characteristics. Psychiatrists have an obligation not to disclose identifiable patient information (and, perhaps, any descriptive patient information) without appropriate informed consent. Failure to obtain informed consent could result in a claim based on breach of privacy, defamation, or both. Internet and Social Media. It is imperative that psychiatrists and other mental health professionals be aware of the legal implications of discussing patients over the Internet. Internet communications about patients are not confidential, are subject to hacking, and are open to legal subpoenas. Some psychiatrists have blogged about patients thinking they were sufficiently disguised only to find that they were recognized by others, including the involved patient. Some professional organizations have electronic mailing lists in which they ask advice about patients from their colleagues or make referrals and in so doing provide detailed information about the patient that can easily be traced. Similarly, using social media to communicate about patients is equally risky. Child Abuse. In many

states, all physicians are legally required to take a course on child abuse for medical licensure. All states now legally require that psychiatrists, among others, who have reason to believe that a child has been the victim of physical or sexual abuse make an immediate report to an appropriate agency. In this situation, confidentiality is decisively limited by legal statute on the grounds that potential or actual harm to vulnerable children outweighs the value of confidentiality in a psychiatric setting. Although many complex psychodynamic nuances accompany the required reporting of suspected child abuse, such reports generally are considered ethically justified. HIGH-RISK CLINICAL SITUATIONS Tardive Dyskinesia It is estimated that at least 10 to 20 percent of patients and perhaps as high as 50 percent of patients treated with neuroleptic drugs for more than 1 year exhibit some tardive dyskinesia. These figures are even higher for elderly patients. Despite the

possibility for many tardive dyskinesia–related suits, relatively few psychiatrists have been sued. In addition, patients who develop tardive dyskinesia may not have the physical energy and psychological motivation to pursue litigation. Allegations of negligence involving tardive dyskinesia are based on a failure to evaluate a patient properly, a failure to obtain informed consent, a negligent diagnosis of a patient's condition, and a failure to monitor. Suicidal Patients Psychiatrists may be sued when their patients commit suicide, particularly when psychiatric inpatients kill themselves. Psychiatrists are assumed to have more control over inpatients, making the suicide preventable. The evaluation of suicide risk is one of the most complex, dauntingly difficult clinical tasks in psychiatry. Suicide is a rare event. In our current state of knowledge, clinicians cannot accurately predict when or if a patient will commit suicide. No professional standards exist for predicting who will or will not commit suicide. Professional standards do exist for assessing suicide risk, but at best, only the degree of suicide risk can be judged clinically after a comprehensive psychiatric assessment. A review of the case law on suicide reveals that certain affirmative precautions should be taken with a suspected or confirmed suicidal patient. For example, failing to perform a reasonable assessment of a suicidal patient's risk for suicide or implement an appropriate precautionary plan will likely render a practitioner liable. The law tends to assume that suicide is preventable if it is foreseeable. Courts closely scrutinize suicide cases to determine if a patient's suicide was foreseeable. Foreseeability is a deliberately vague legal term that has no comparable clinical counterpart, a common-sense rather than a scientific construct. It does not (and should not) imply that clinicians can predict suicide. Foreseeability should not be confused with preventability, however. In hindsight, many suicides seem preventable that were clearly not foreseeable. Violent Patients Psychiatrists who treat violent or potentially violent patients may be sued for failure to control aggressive outpatients and for the discharge of violent inpatients. Psychiatrists can be sued for failing to protect society from the violent acts of their patients if it was reasonable for the psychiatrist to have known about the patient's violent tendencies and if the psychiatrist could have done something that could have safeguarded the public. In the landmark case Tarasoff v. Regents of the University of California, the California Supreme Court ruled that mental health professionals have a duty to protect identifiable, endangered third parties from imminent threats of serious harm made by their outpatients. Since then, courts and state legislatures have increasingly held psychiatrists to a fictional standard of having to predict the future behavior (dangerousness) of their potentially violent patients. Research has consistently demonstrated that psychiatrists cannot predict future violence with any dependable accuracy.

The duty to protect patients and endangered third parties should be considered primarily a professional and moral obligation and, only secondarily, a legal duty. Most psychiatrists acted to protect both their patients and others threatened by violence long before Tarasoff. If a patient threatens harm to another person, most states require that the psychiatrist perform some intervention that might prevent the harm from occurring. In states with duty-to-warn statutes, the options available to psychiatrists and psychotherapists are defined by law. In states offering no such guidance, health care providers are required to use their clinical judgment and act to protect endangered third persons. Typically, a variety of options to warn and protect are clinically and legally available, including voluntary hospitalization, involuntary hospitalization (if civil commitment requirements are met), warning the intended victim of the threat, notifying the police, adjusting medication, and seeing the patient more frequently. Warning others of danger, by itself, is usually insufficient. Psychiatrists should consider the Tarasoff duty to be a national standard of care, even if they practice in states that do not have a duty to warn and protect. Tarasoff I. This issue was raised in 1976 in the case of Tarasoff v. Regents of University of California (now known as Tarasoff I). In this case, Prosenjiit Poddar, a student and a voluntary outpatient at the mental health clinic of the University of California, told his therapist that he intended to kill a student readily identified as Tatiana Tarasoff. Realizing the seriousness of the intention, the therapist, with the concurrence of a colleague, concluded that Poddar should be committed for observation under a 72-hour emergency psychiatric detention provision of the California commitment law. The therapist notified the campus police, both orally and in writing, that Poddar was dangerous and should be committed. Concerned about the breach of confidentiality, the therapist's supervisor vetoed the recommendation and ordered all records relating to Poddar's treatment destroyed. At the same time, the campus police temporarily detained Poddar but released him on his assurance that he would "stay away from that girl." Poddar stopped going to the clinic when he learned from the police about his therapist's recommendation to commit him. Two months later, he carried out his previously announced threat to kill Tatiana. The young woman's parents thereupon sued the university for negligence. As a consequence, the California Supreme Court, which deliberated the case for the unprecedented time of about 14 months, ruled that a physician or a psychotherapist who has reason to believe that a patient may injure or kill someone warn the potential victim. The discharge of the duty imposed on the therapist to warn intended victims against danger may take one or more forms, depending on the case. Therefore, stated the court, it may call for the therapist to notify the intended victim or others likely to notify the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances. The Tarasoff I ruling does not require therapists to report a patient's fantasies; instead,

it requires them to report an intended homicide, and it is the therapist's duty to exercise good judgment. Tarasoff II. In 1982, the California Supreme Court issued a second ruling in the case of Tarasoff v. Regents of University of California (now known as Tarasoff II), which broadened its earlier ruling extending the duty to warn to include the duty to protect. The Tarasoff II ruling has stimulated intense debates in the medicolegal field. Lawyers, judges, and expert witnesses argue the definition of protection, the nature of the relationship between the therapist and the patient, and the balance between public safety and individual privacy. Clinicians argue that the duty to protect hinders treatment because a patient may not trust a doctor if confidentiality is not maintained. Furthermore, because it is not easy to determine whether a patient is sufficiently dangerous to justify long-term incarceration, unnecessary involuntary hospitalization may occur because of a therapist's defensive practices. As a result of such debates in the medicolegal field,

since 1976, the state courts have not made a uniform interpretation of the Tarasoff II ruling (the duty to protect). Generally, clinicians should note whether a specific identifiable victim seems to be in imminent and probable danger from the threat of an action contemplated by a mentally ill patient; the harm, in addition to being imminent, should be potentially serious or severe. Usually, the patient must be a danger to another person and not to property; the therapist should take clinically reasonable action. HOSPITALIZATION All states provide for some form of involuntary hospitalization. Such action usually is taken when psychiatric patients present a danger to themselves or others in their environment to the extent that their urgent need for treatment in a closed institution is evident. Certain states allow involuntary hospitalization when patients are unable to care for themselves adequately. The doctrine of parens patriae allows the state to intervene and to act as a surrogate parent for those who are unable to care for themselves or who may harm themselves. In English common law, parens patriae ("father of his country") dates to the time of King Edward I and originally referred to a monarch's duty to protect the people. In US common law, the doctrine has been transformed into a paternalism in which the state acts for persons who are mentally ill and for minors. The statutes governing hospitalization of persons who are mentally ill generally have been designated commitment laws, but psychiatrists have long considered the term to be undesirable. Commitment legally means a warrant for imprisonment. The American Bar Association and the American Psychiatric Association have recommended that the term commitment be replaced by the less offensive and more accurate term hospitalization, which most states have adopted. Although this change in terminology does not correct the punitive attitudes of the past, the emphasis on hospitalization is in keeping with

psychiatrists' views of treatment rather than punishment. Procedures of Admission Four procedures of admission to psychiatric facilities have been endorsed by the American Bar Association to safeguard civil liberties and to make sure that no person is railroaded into a mental hospital. Although each of the 50 states has the power to enact its own laws on psychiatric hospitalization, the procedures outlined here are gaining much acceptance. Informal Admission. Informal admission operates on the general hospital model, in which a patient is admitted to a psychiatric unit of a general hospital in the same way that a medical or surgical patient is admitted. Under such circumstances, the ordinary doctor–patient relationship applies, with the patient free to enter and to leave, even against medical advice. Voluntary Admission. In cases of voluntary admission, patients apply in writing for admission to a psychiatric hospital. They may come to the hospital on the advice of a personal physician, or they may seek help on their own. In either case, patients are admitted if an examination reveals the need for hospital treatment. The patient is free to leave, even against medical advice. Temporary Admission. Temporary admission is used for patients who are so senile or so confused that they require hospitalization and are not able to make decisions on their own and for patients who are so acutely disturbed that they must be admitted immediately to a psychiatric hospital on an emergency basis. Under the procedure, a person is admitted to the hospital on the written recommendation of one physician. After the patient has been admitted, the need for hospitalization must be confirmed by a psychiatrist on the hospital staff. The procedure is temporary because patients cannot be hospitalized against their will for more than 15 days. Involuntary Admission. Involuntary admission involves the question of whether patients are suicidal and thus a danger to themselves or homicidal and thus a danger to others. Because these persons do not recognize their need for hospital care, the application for admission to a hospital may be made by a relative or a friend. After the application is made, the patient must be examined by two physicians, and if both physicians confirm the need for hospitalization, the patient can then be

admitted. Involuntary hospitalization involves an established procedure for written notification of the next of kin. Furthermore, the patients have access at any time to legal counsel, who can bring the case before a judge. If the judge does not think that hospitalization is indicated, the patient's release can be ordered. Involuntary admission allows a patient to be hospitalized for 60 days. After this time, if the patient is to remain hospitalized, the case must be reviewed periodically by a

board consisting of psychiatrists, nonpsychiatric physicians, lawyers, and other citizens not connected with the institution. In New York State, the board is called the Mental Health Information Service. Persons who have been hospitalized involuntarily and who believe that they should be released have the right to file a petition for a writ of habeas corpus. Under law, a writ of habeas corpus can be proclaimed by those who believe that they have been illegally deprived of liberty. The legal procedure asks a court to decide whether a patient has been hospitalized without due process of law. The case must be heard by a court at once, regardless of the manner or the form in which the motion is filed. Hospitals are obligated to submit the petitions to the court immediately. RIGHT TO TREATMENT Among the rights of patients, the right to the standard quality of care is fundamental. This right has been litigated in highly publicized cases in recent years under the slogan of "right to treatment." In 1966, Judge David Bazelon, speaking for the District of Columbia Court of Appeals in Rouse v. Cameron, noted that the purpose of involuntary hospitalization is treatment and concluded that the absence of treatment draws into question the constitutionality of the confinement. Treatment in exchange for liberty is the logic of the ruling. In this case, the patient was discharged on a writ of habeas corpus, the basic legal remedy to ensure liberty. Judge Bazelon further held that if alternative treatments that infringe less on personal liberty are available, involuntary hospitalization cannot take place. Alabama Federal Court Judge Frank Johnson was more venturesome in the decree he rendered in 1971 in Wyatt v. Stickney. The Wyatt case was a class-action proceeding brought under newly developed rules that sought not release but treatment. Judge Johnson ruled that persons civilly committed to a mental institution have a constitutional right to receive such individual treatment as will give them a reasonable opportunity to be cured or to have their mental condition improved. Judge Johnson set out minimal requirements for staffing, specified physical facilities, and nutritional standards and required individualized treatment plans. The new codes, more detailed than the old ones, include the right to be free from excessive or unnecessary medication; the right to privacy and dignity; the right to the least restrictive environment; the unrestricted right to be visited by attorneys, clergy, and private physicians; and the right not to be subjected to lobotomies, electroconvulsive treatments, and other procedures without fully informed consent. Patients can be required to perform therapeutic tasks but not hospital chores unless they volunteer for them and are paid the federal minimum wage. This requirement is an attempt to eliminate the practice of peonage, in which psychiatric patients were forced to work at menial tasks, without payment, for the benefit of the state. In a number of states today, medication or electroconvulsive therapy cannot be forcibly administered to a patient without first obtaining court approval, which may take as long as 10 days.

RIGHT TO REFUSE TREATMENT The right to refuse treatment is a legal doctrine that holds that, except in emergencies, persons cannot be forced to accept treatment against their will. An emergency is defined as a condition in clinical practice that requires immediate intervention to prevent death or serious harm to the patient or another person or to prevent deterioration of the patient's clinical state. In the 1976 case of O'Connor v. Donaldson, the Supreme Court of the United

States ruled that harmless mentally ill patients cannot be confined against their will without treatment if they can survive outside. According to the Court, a finding of mental illness alone cannot justify a state's confining persons in a hospital against their will. Instead, involuntarily confined patients must be considered dangerous to themselves or others or possibly so unable to care for themselves that they cannot survive outside. As a result of the 1979 case of Rennie v. Klein, patients have the right to refuse treatment and to use an appeal process. As a result of the 1981 case of Roger v. Oken, patients have an absolute right to refuse treatment, but a guardian may authorize treatment. Questions have been raised about psychiatrists' ability to accurately predict dangerousness to self or others and about the risk to psychiatrists, who may be sued for monetary damages if persons who are involuntarily hospitalized are thereby deprived of their civil rights. CIVIL RIGHTS OF PATIENTS Because of several clinical, public, and legal movements, criteria for the civil rights of persons who are mentally ill, apart from their rights as patients, have been both established and affirmed. Least Restrictive Alternative The principle holds that patients have the right to receive the least restrictive means of treatment for the requisite clinical effect. Therefore, if a patient can be treated as an outpatient, commitment should not be used; if a patient can be treated on an open ward, seclusion should not be used. Although apparently fairly straightforward on first reading, difficulty arises when clinicians attempt to apply the concept to choose among involuntary medication, seclusion, and restraint as the intervention of choice. Distinguishing among these interventions on the basis of restrictiveness proves to be a purely subjective exercise fraught with personal bias. Moreover, each of these three interventions is both more and less restrictive than each of the other two. Nevertheless, the effort should be made to think in terms of restrictiveness when deciding how to treat patients. Visitation Rights Patients have the right to receive visitors and to do so at reasonable hours (customary

hospital visiting hours). Allowance must be made for the possibility that, at certain times, a patient's clinical condition may not permit visits. This fact should be clearly documented, however, because such rights must not be suspended without good reason. Certain categories of visitors are not limited to the regular visiting hours; these include a patient's attorney, private physician, and members of the clergy—all of whom, broadly speaking, have unrestricted access to the patient, including the right to privacy in their discussions. Even here, a bona fide emergency may delay such visits. Again, the patient's needs come first. Under similar reasoning, certain noxious visits may be curtailed (e.g., a patient's relative bringing drugs into the ward). Communication Rights Patients should generally have free and open communication with the outside world by telephone or mail, but this right varies regionally to some degree. Some jurisdictions charge the hospital administration with a responsibility for monitoring the communications of patients. In some areas, hospitals are expected to make available reasonable supplies of paper, envelopes, and stamps for patient's use. Specific circumstances affect communication rights. A patient who is hospitalized in relation to a criminal charge of making harassing or threatening phone calls should not be given unrestricted access to the telephone, and similar considerations apply to mail. As a rule, however, patients should be allowed private telephone calls, and their incoming and outgoing mail should not be opened by hospital staff members. Private Rights Patients have several rights to privacy. In addition to confidentiality, they are allowed private bathroom and shower space, secure storage space for clothing and other belongings, and adequate floor space per person. They also have the right to wear their own clothes and to carry their own money. Economic Rights Apart from special considerations related to incompetence, psychiatric patients generally are permitted to manage their own financial affairs. One feature of this fiscal right is the requirement that patients be paid if

they work in the institution (e.g., gardening or preparing food). This right often creates tension between the valid therapeutic need for activity, including jobs, and exploitative labor. A consequence of this tension is that valuable occupational, vocational, and rehabilitative therapeutic programs may have to be eliminated because of the failure of legislatures to supply the funding to pay wages to patients who participate in these programs. SECLUSION AND RESTRAINT Seclusion and restraint raise complex psychiatric legal issues. Seclusion and restraint have both indications and contraindications (Table 36.1-2). Seclusion and restraint have

become increasingly regulated over the past decade. Table 36.1-2 Indications and Contraindications for Seclusion and Restraint Legal challenges to the use of restraints and seclusion have been brought on behalf of institutionalized persons with psychiatric illnesses or cognitive disabilities. Typically, these lawsuits do not stand alone but are part of a challenge to a wide range of alleged abuses. Generally, courts hold, or consent decrees provide, that restraints and seclusion be implemented only when a patient creates a risk of harm to self or others and no less restrictive alternative is available. Table 36.1-3 lists additional restrictions. Table 36.1-3 Restrictions for Seclusion and Restraint INFORMED CONSENT Lawyers representing an injured claimant now invariably add to a claim of negligent performance of procedures (malpractice) an informed consent claim as another possible area of liability. Ironically, this is one claim under which the requirement of expert testimony may be avoided. The usual claim of medical malpractice requires the litigant to produce an expert to establish that the defendant physician departed from accepted

medical practice. But in a case in which the physician did not obtain informed consent, the fact that the treatment was technically well performed, was in accord with the generally accepted standard of care, and effected a complete cure is immaterial. As a practical matter, however, unless the treatment had adverse consequences, a complainant will not get far with a jury in an action based solely on an allegation that the treatment was performed without consent. In the case of minors, the parent or guardian is legally empowered to give consent to medical treatment. By statute, most states, however, list specific diseases and conditions that a minor can consent to have treated—including venereal disease, pregnancy, substance dependence, alcohol abuse, and contagious diseases. In an emergency, a physician can treat a minor without parental consent. The trend is to adopt the so-called mature minor rule, which allows minors to consent to treatment under ordinary circumstances. As a result of the Supreme Court’s 1967 Gault decision, all juveniles must now be represented by counsel, must be able to confront witnesses, and must be given proper notice of any charges. Emancipated minors have the rights of an adult when it can be shown that they are living as adults with control over their own lives. Consent Form The basic elements of a consent form should include a fair explanation of the procedures to be followed and their purposes, including identification of any procedures that are experimental, a description of any attendant discomforts and risks reasonably to be expected, a description of any benefits reasonably to be expected, a disclosure of any appropriate alternative procedures that may be advantageous to the patient, an offer to answer any inquiries concerning the procedures, and an instruction that the patient is free to withdraw patient consent and to discontinue participation in the project or activity at any time without prejudice. Some theorists have suggested that the form can be replaced by a standardized discussion that covers the issues noted above and a progress note that documents that the issues were discussed. CHILD CUSTODY The action of a court in a child custody dispute is now predicated on the child’s best interests. The maxim reflects the idea

that a natural parent does not have an inherent right to be named a custodial parent, but the presumption, although a bit eroded, remains in favor of the mother in the case of young children. As a rule, the courts presume that the welfare of a child of tender years generally is best served by maternal custody when the mother is a good and fit parent. The best interest of the mother may be served by naming her as the custodial parent because a mother may never resolve the effects of the loss of a child, but her best interest is not to be equated ipso facto with the best interest of the child. Care and protection proceedings are the court's interventions in the welfare of a child when the parents are unable to care for the child. More fathers are asserting custodial claims. In about 5 percent of all cases, fathers are

named custodians. The movement supporting women's rights also is enhancing the chances of paternal custody. With more women going to work outside the home, the traditional rationale for maternal custody has less force today than it did in the past. Currently, every state has a statute allowing a court, usually a juvenile court, to assume jurisdiction over a neglected or abused child and to remove the child from parental custody. It usually orders that the care and custody of the child be supervised by the welfare or probation department. TESTAMENTARY AND CONTRACTUAL CAPACITY AND COMPETENCE Psychiatrists may be asked to evaluate patients' testamentary capacities or their competence to make a will. Three psychological abilities are necessary to prove this competence. Patients must know the nature and the extent of their bounty (property), the fact that they are making a bequest, and the identities of their natural beneficiaries (spouse, children, and other relatives). When a will is being probated, one of the heirs or another person may challenge its validity. A judgment in such cases must be based on a reconstruction, using data from documents and from expert psychiatric testimony, of the testator's mental state at the time the will was written. When a person is unable to, or does not exercise the right to, make a will, the law in all states provides for the distribution of property to the heirs. If there are no heirs, the estate goes to the public treasury. Witnesses at the signing of a will, who might include a psychiatrist, may attest that the testator was rational at the time the will was executed. In unusual cases, a lawyer may videotape the signing to safeguard the will from attack. Ideally, persons who are thinking of making a will and believe that questions might be raised about their testamentary competence hire a forensic psychiatrist to perform a dispassionate examination antemortem to validate and record their capacity. An incompetence proceeding and the appointment of a guardian may be considered necessary when a family member is spending the family's assets and the property is in danger of dissipation, as in the case of patients who are elderly, have cognitive disabilities, are dependent on alcohol, or have psychosis. At issue is whether such persons are capable of managing their own affairs. A guardian appointed to take control of the property of one deemed incompetent, however, cannot make a will for the ward (the incompetent person). Competence is determined on the basis of a person's ability to make a sound judgment —to weigh, to reason, and to make reasonable decisions. Competence is task specific, not general; the capacity to weigh decision-making factors (competence) often is best demonstrated by a person's ability to ask pertinent and knowledgeable questions after the risks and the benefits have been explained. Although physicians (especially psychiatrists) often give opinions on competence, only a judge's ruling converts the opinion into a finding; a patient is not competent or incompetent until the court so rules. The diagnosis of a mental disorder is not, in itself, sufficient to warrant a finding of incompetence. Instead, the mental disorder must cause an impairment in judgment

for the specific issues involved. After they have been declared incompetent, persons are deprived of certain rights: they cannot make contracts, marry, start a divorce action, drive a vehicle, handle their own property, or practice their professions. Incompetence is decided at a formal courtroom proceeding, and the court usually appoints a guardian who will best serve a patient's interests. Another hearing is necessary to declare a patient competent. Admission to a mental hospital does not automatically mean that a person is incompetent. Competence also is essential in contracts because a contract is an agreement between parties to do a specific act. A contract is declared invalid if, when it was signed, one of the parties was unable to comprehend the nature and effect of his or her act. The marriage contract is subject to the same standard and thus can be voided if either party did not understand the nature, duties, obligations, and other characteristics entailed at the time of the marriage. In general, however, the courts are unwilling to declare a marriage void on the basis of incompetence. Whether competence is related to wills, contracts, or the making or breaking of marriages, the fundamental concern is a person's state of awareness and capacity to comprehend the significance of the particular commitment made. Durable Power of Attorney A modern development that permits persons to make provisions for their own anticipated loss of decision-making capacity is called a durable power of attorney. The document permits the advance selection of a substitute decision maker who can act without the necessity of court proceedings when the signatory becomes incompetent through illness or progressive dementia. CRIMINAL LAW Competence to Stand Trial The Supreme Court of the United States stated that the prohibition against trying someone who is mentally incompetent is fundamental to the US system of justice. Accordingly, the Court, in Dusky v. United States, approved a test of competence that seeks to ascertain whether a criminal defendant "has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him." Competence to Be Executed One of the new areas of competence to emerge in the interface between psychiatry and the law is the question of a person's competence to be executed. The requirement for competence in this area is believed to rest on three general principles. First, a person's awareness of what is happening is supposed to heighten the retributive element of the punishment. Punishment is meaningless unless the person is aware of it and knows the

punishment's purpose. Second, a competent person who is about to be executed is believed to be in the best position to make whatever peace is appropriate with his or her religious beliefs, including confession and absolution. Third, a competent person who is about to be executed preserves, until the end, the possibility (admittedly slight) of recalling a forgotten detail of the events or the crime that may prove exonerating. The need to preserve competence was supported recently in the Supreme Court case of Ford v. Wainwright. But no matter the outcome of legal struggles with this question, most medical bodies have gravitated toward the position that it is unethical for any clinician to participate, no matter how remotely, in state-mandated executions; a physician's duty to preserve life transcends all other competing requirements. Major medical societies, such as the American Medical Association (AMA), believe that doctors should not participate in the death penalty. A psychiatrist who agrees to examine a patient slated for execution may find the person incompetent on the basis of a mental disorder and may recommend a treatment plan, which, if implemented, would ensure the person's fitness to be executed. Although room exists for a difference of opinion regarding whether or not a psychiatrist should become involved, the authors of this text believe such involvement to be wrong. Criminal Responsibility According to criminal law, committing an act that is socially harmful is not the sole

criterion of whether a crime has been committed. Instead, the objectionable act must have two components: voluntary conduct (actus reus) and evil intent (mens rea). An evil intent cannot exist when an offender's mental status is so deficient, so abnormal, or so diseased to have deprived the offender of the capacity for rational intent. The law can be invoked only when an illegal intent is implemented. Neither behavior, however harmful, nor the intent to do harm is, in itself, a ground for criminal action. M'Naghten Rule. The precedent for determining legal responsibility was established in 1843 in the British courts. The so-called M'Naghten rule, which, until recently, has determined criminal responsibility in most of the United States, holds that persons are not guilty by reason of insanity if they labored under a mental disease such that they were unaware of the nature, the quality, and the consequences of their acts or if they were incapable of realizing that their acts were wrong. Moreover, to absolve persons from punishment, a delusion used as evidence must be one that, if true, would be an adequate defense. If the delusional idea does not justify the crime, such persons are presumably held responsible, guilty, and punishable. The M'Naghten rule is known commonly as the right–wrong test. The M'Naghten rule derives from the famous M'Naghten case of 1843. When Daniel M'Naghten murdered Edward Drummond, the private secretary of Robert Peel, M'Naghten had been suffering from delusions of persecution for several years, had complained to many persons about his "persecutors," and finally had decided to correct the situation by murdering Robert Peel. When Drummond came out of Peel's home,

M'Naghten shot Drummond, mistaking him for Peel. The jury, as instructed under the prevailing law, found M'Naghten not guilty by reason of insanity. In response to questions about what guidelines could be used to determine whether a person could plead insanity as a defense against criminal responsibility, the English chief judge wrote:

1. To establish a defense on the ground of insanity, it must be clearly proved that, at the time of committing the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, he did not know he was doing what was wrong.
2. Where a person labors under partial delusions only and is not in other respects insane and as a result commits an offense, he must be considered in the same situation regarding responsibility as if the facts with respect to which the delusion exists were real. According to the M'Naghten rule, the question is not whether the accused knows the difference between right and wrong in general; rather, it is whether the defendant understood the nature and the quality of the act and whether the defendant knew the difference between right and wrong with respect to the act—that is, specifically whether the defendant knew the act was wrong or perhaps thought the act was correct, a delusion causing the defendant to act in legitimate self-defense. Jeffery Dahmer (Fig. 36.1-1) killed 17 young men and boys between June 1978 and July 1991. Most of his victims were either homosexual or bisexual. He would meet and select his prey at gay bars or bathhouses and then lure them by offering them money for posing for photographs or simply to enjoy some beer and videos. Then he would drug them, strangle them, masturbate on the body or have sex with the corpse, dismember the body, and dispose of it. Sometimes he would keep the skull or other body parts as souvenirs.

FIGURE 36.1-1 Cases of persons in the legal system. A. Harry K. Thaw. In 1908, Thaw, a millionaire playboy, was convicted of killing architect Stanford White at Madison Square Garden in New York

City. He was found legally insane and sent to a mental institution from which he was ultimately released in 1924. He died in Florida in 1947 at the age of 76 years. B. Winnie Ruth Judd. Known as the “trunk murderess” of the early 1930s, Judd was saved from execution by a sanity hearing. She was committed in an Arizona state hospital from which she made her seventh escape in 1962. She was found in 1969 working as a receptionist. An Arizona Board of Pardons and Parole recommended her freedom in 1971. She died in 1998 at age 93 years. C. Dan White. The former San Francisco supervisor killed San Francisco mayor George Moscone and supervisor Harvey Milk at City Hall in 1978. White’s “Twinkie defense” helped reduce his crime from murder to manslaughter, for which he served 5 years. White committed suicide a few days after he was released from prison. D. John Hinckley, Jr., who attempted to assassinate President Ronald Reagan in 1981, was declared not guilty by reason of insanity. He is currently a patient in a mental hospital in Washington, DC. E. Serial killer Ted Bundy exhibited antisocial behavior at its most extreme and dangerous.

Bundy was executed in Florida in 1989 after confessing, without showing any remorse, to the murder of 36 women. (Some authorities estimate the number was probably closer to 100.) F. Jeffrey Dahmer. His murder trial for the deaths of 17 young men and boys gained widespread notoriety after accusations of cannibalistic practices were made. Dahmer was killed in prison by a psychotic inmate in 1994. (Figure A, courtesy of United Press International, Inc.; Figures B to F courtesy of World Wide Photos.) On July 13, 1992, Dahmer changed his plea to guilty by means of insanity. That Dahmer could plan his murders and systematically dispose of the bodies convinced the jury, however, that he was able to control his behavior. All of the testimony bolstered the notion that, as with most serial killers, Dahmer knew what he was doing and knew right from wrong. Finally, the jury did not accept the defense that Dahmer experienced a mental illness to the degree that it had disabled his thinking or behavioral controls. Dahmer was sentenced to 15 consecutive life terms or a total of 957 years in prison. He was killed by an inmate on November 28, 1994. Irresistible Impulse. In 1922, a committee of jurists in England reexamined the M’Naghten rule. The committee suggested broadening the concept of insanity in criminal cases to include the irresistible impulse test, which rules that a person charged with a criminal offense is not responsible for an act if the act was committed under an impulse that the person was unable to resist because of mental disease. The courts have chosen to interpret this concept in such a way that it has been called the policeman-atthe-elbow law. In other words, the court grants an impulse to be irresistible only when it can be determined that the accused would have committed the act even if a policeman had been at the accused person’s elbow. To most psychiatrists, this interpretation is unsatisfactory because it covers only a small, special group of those who are mentally ill. Durham Rule. In the case of Durham v. United States, Judge Bazelon handed down a decision in 1954 in the District of Columbia Court of Appeals. The decision resulted in the product rule of criminal responsibility, namely that an accused person is not criminally responsible if his or her unlawful act was the product of mental disease or mental defect. In the Durham case, Judge Bazelon expressly stated that the purpose of the rule was to get good and complete psychiatric testimony. He sought to release the criminal law from the theoretical straitjacket of the M’Naghten rule, but judges and juries in cases using the Durham rule became mired in confusion over the terms product, disease, and defect. In 1972, some 18 years after the rule’s adoption, the Court of Appeals for the District of Columbia, in United States v. Brawner, discarded the rule. The court—all nine members, including Judge Bazelon—decided in a 143-page opinion to throw out its Durham rule and to adopt in its place the test recommended in 1962 by the American Law Institute in its

model penal code, which is the law in the federal courts

today. Model Penal Code. In its model penal code, the American Law Institute recommended the following test of criminal responsibility: Persons are not responsible for criminal conduct if, at the time of such conduct, as a result of mental disease or defect, they lacked substantial capacity either to appreciate the criminality (wrongfulness) of their conduct or to conform their conduct to the requirement of the law. The term mental disease or defect does not include an abnormality manifest only by repeated criminal or otherwise antisocial conduct. Subsection 1 of the American Law Institute rule contains five operative concepts: mental disease or defect, lack of substantial capacity, appreciation, wrongfulness, and conformity of conduct to the requirements of law. The rule’s second subsection, stating that repeated criminal or antisocial conduct is not, of itself, to be taken as mental disease or defect, aims to keep the sociopath or psychopath within the scope of criminal responsibility. Guilty but Mentally Ill. Some states have established an alternative verdict of guilty but mentally ill. Under guilty but mentally ill statutes, this alternative verdict is available to the jury if the defendant pleads not guilty by reason of insanity. Under an insanity plea, four outcomes are possible: not guilty, not guilty by reason of insanity, guilty but mentally ill, and guilty. The problem with guilty but mentally ill is that it is an alternative verdict without a difference. It is basically the same as finding the defendant just plain guilty. The court must still impose a sentence on the convicted person. Although the convicted person supposedly receives psychiatric treatment, if necessary, this treatment provision is available to all prisoners. Some famous cases of persons declared not guilty by reason of insanity are illustrated in Figure 36.1-1. OTHER AREAS OF FORENSIC PSYCHIATRY Emotional Damage and Distress A rapidly rising trend in recent years is to sue for psychological and emotional damage, both secondary to physical injury or as a consequence of witnessing a stressful act and from the suffering endured under the stress of such circumstances as concentration camp experiences. The German government heard many of these claims from persons detained in Nazi camps during World War II. In the United States, the courts have moved from a conservative to a liberal position in awarding damages for such claims. Psychiatric examinations and testimony are sought in these cases, often by both the plaintiffs and the defendants. Recovered Memories

Patients alleging recovered memories of abuse have sued parents and other alleged perpetrators. In a number of instances, the alleged victimizers have sued therapists who, they claim, negligently induced false memories of sexual abuse. In an about-face, some patients have recanted and joined forces with others (usually their parents) to sue therapists. Courts have handed down multimillion dollar judgments against mental health practitioners. A fundamental allegation in these cases is that the therapist abandoned a position of neutrality to suggest, persuade, coerce, and implant false memories of childhood sexual abuse. The guiding principle of clinical risk management in recovered memory cases is maintenance of therapist neutrality and establishment of sound treatment boundaries. Table 36.1-4 lists the risk management principles that should be considered when evaluating or treating a patient who recovers memories of abuse in psychotherapy. Table 36.1-4 Risk Management Principles for Cases of Recovered Memories of Abuse in Psychotherapy Worker’s Compensation The stresses of employment can cause or accentuate mental illness. Patients are entitled to be compensated for their job-related disabilities or to receive disability retirement benefits. A psychiatrist is often called on to evaluate such situations. Civil Liability Psychiatrists who sexually exploit their patients are subject to civil and criminal actions

in addition to ethical and professional licensure revocation proceedings. Malpractice is the most common legal action (Table 36.1-5). Table 36.1-5 Sexual Exploitation: Legal and Ethical Consequences REFERENCES Adshead G. Evidence-based medicine and medicine-based evidence: The expert witness in cases of factitious disorder by proxy. J Am Acad Psychiatry Law. 2005; 33:99–105. Andreasson H, Nyman M, Krona H, Meyer L, Anckarsäter H, Nilsson T, Hofvander B. Predictors of length of stay in forensic psychiatry: The influence of perceived risk of violence. Int J Law Psychiatry. 2014. [Epub ahead of print] Arboleda-Florez JE. The ethics of forensic psychiatry. Curr Opin Psychol. 2006; 19(5):544. Baker T. The Medical Malpractice Myth. Chicago: University of Chicago Press; 2005. Billick SB, Ciric SJ. Role of the psychiatric evaluator in child custody disputes. In: Rosner R, ed. Principles and Practice of Forensic Psychiatry. 2nd ed. New York: Chapman & Hall; 2003. Bourget D. Forensic considerations of substance-induced psychosis. J Am Acad Psychiatry Law. 2013;41(2):168–173. Chow WS, Priebe S. Understanding psychiatric institutionalization: A conceptual review. BMC Psychiatry. 2013;13:169. Koh S, Cattell GM, Cochran DM, Krasner A, Langheim FJ, Sasso DA. Psychiatrists' use of electronic communication and social media and a proposed framework for future guidelines. J Psychiatr Pract 2013;19(3):254–263. Meyer DJ, Price M. Forensic psychiatric assessments of behaviorally disruptive physicians. J Am Acad Psychiatry Law. 2006;34:1:72–81. Reid WH. Forensic practice: A day in the life. J Psychiatr Pract. 2006;12(1):50. Rogers R, Shuman DW. Fundamentals of Forensic Practice: Mental Health and Criminal Law. New York: Springer Science + Business Media; 2005. Rosner R, ed. Principles and Practice of Forensic Psychiatry. 2nd ed. New York: Chapman & Hall; 2003. Simon RI, Shuman DW. Clinical-legal issues in psychiatry. In: Sadock BJ, Sadock VA, Ruiz P, eds. Kaplan & Sadock's Comprehensive Textbook of Psychiatry. 9th edition. Vol. 2. Philadelphia: Lippincott Williams & Wilkins; 2009:4427. Simon RI, ed. Posttraumatic Stress Disorder in Litigation. 2nd ed. Washington, DC: American Psychiatric Publishing; 2003. Simon RI, Gold LH. The American Psychiatric Publishing Textbook of Forensic Psychiatry. Washington, DC: American Psychiatric Publishing; 2004. Studdert DM, Mello MM, Gawande AA, Gandhi TK, Kachalia A, Yoon C, Puopolo AL, Brennan TA. Claims, errors, and compensation payments in medical malpractice litigation. N Engl J Med. 2006;354(19):2024–2033. Wecht CH. The history of legal medicine. J Am Acad Psychiatry Law. 2005; 33(2): 245.

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