Ethics

9

Karsten M. Heil and Charles C. Dike

Clinical Vignette

You are a committee member on your state's medical board. You are asked to review a case of possible unprofessional behavior by a physician who is licensed to practice in your state and decide what sanctions, if any, this physician should incur.

Dr. James, the physician in question, has been practicing medicine for 10 years. A few months ago, the medical licensing board in your state received a complaint by the author of a scholarly article published decades ago. The author is alleging that Dr. James plagiarized one of his articles and claims that this is not the only instance of plagiarism by Dr. James. The board has decided to investigate the claim.

You review extensive evidence which clearly shows that Dr. James plagiarized several scholarly articles when he was a medical student. He took scholarly articles previously published by other researchers, changed data in the articles, and then republished them under his own name in other journals. He did this several times over the span of several years while in medical school, but never repeated this behavior after graduation. A review of his recent clinical work does not reveal any substandard clinical care. In fact, many patients sent in letters to the medical board advocating on Dr. James' behalf stating that he is an excellent doctor and they are very happy with his care.

In considering this situation, would you vote in favor of Dr. James being sanctioned by the medical board? If so, how severe should the sanctions be and what specific sanction(s) would you impose?

K.M. Heil (✉) • C.C. Dike
Law and Psychiatry Division, Department of Psychiatry,
Yale University School of Medicine, 34 Park Street, New Haven, CT 06519, USA
e-mail: Karsten.Heil@yale.edu; charles.dike@yale.edu

T. Wasser (ed.), *Psychiatry and the Law*, DOI 10.1007/978-3-319-63148-6_9

What Really Happened?

In the 1989 case *Alsabti vs. Board*, the Supreme Judicial Court of Massachusetts (the highest court in the Commonwealth of Massachusetts) decided [1] on a very similar issue: Dr. Alsabti graduated from medical school in 1980 and completed his internship at a hospital in Massachusetts. He had not practiced medicine in Massachusetts since completing his internship, but had been practicing medicine in Pennsylvania. Before graduating from medical school in 1979, four scholarly articles in which he was lead or coauthor were published in medical journals. These articles were almost identical to previously published work by other scholars. The differences in the data and wording between the original articles and Dr. Alsabti's articles were minor and considered immaterial by the Massachusetts Board of Registration in Medicine (*the Board*) that was investigating the case. Three of the four articles had been previously published by other authors in different medical journals than the journals Dr. Alsabti published his articles in. The fourth article he published had been filed as part of another researcher's grant application. Dr. Alsabti did not cite the original authors in his manuscripts and could not explain to the *Board* the substantial similarities between his articles and the previously published work. All four of the articles in question were submitted in 1978. Dr. Alsabti argued that he was not enrolled in medical school at that time (it is unclear why he was not enrolled 2 years before graduation), nor was he yet a physician. He also stated that he had not counted the published articles toward any requirements to obtain his medical degree and, therefore, should not be sanctioned by a medical licensing authority. *The Board* received letters from over 20 of Dr. Alsabti's patients describing him in uniformly positive terms. Board members did not challenge his clinical care or professional conduct during his time as a practicing physician.

The Board nonetheless decided to revoke Dr. Alsabti's state medical license after concluding that he lacked the "good moral character" that Massachusetts law required for practitioners of medicine. Board members argued that his misconduct formed a pattern and was not isolated and that he had likely gained a dishonest advantage in employment following medical school due to his misconduct. Further, the Board argued that he had harmed the public by damaging the integrity of the pool of common scientific knowledge by making it appear as though there were more evidence to support the original work he plagiarized than was merited based on the available empirical work of others.

Dr. Alsabti appealed the revocation of his license to the Supreme Judicial Court of Massachusetts, which affirmed *the Board's* decision. The court found the Board's arguments to be sound and, citing prior legal precedents, elaborated on the importance of physicians' integrity [2] and good moral character [3] for the promotion of public health, welfare, and safety. They wrote: "The board was clearly justified in assessing as serious Alsabti's disregard at that time for basic fairness to competitors and for the possible consequences to patients who might be exposed to medical treatment by physicians relying on experiments Alsabti purported to have done but never did." [1]

Testimonials from Dr. Alsabti's patients' were not taken into consideration by *the Board*, and the Massachusetts Supreme Judicial Court held that *the Board* was not required to do so.

Lessons from the Case: Ethics, Morality, Law, and the Medical Profession

One of the major reasons for investing the government with the power to decide who can and cannot practice as a physician is the protection of patients from incompetent providers who might harm their patients. Dr. Alsabti's medical skills were not questioned in this case however. Instead, his unethical behavior itself, which was also illegal in Massachusetts, was deemed to be damaging to the public's health, welfare, and safety. The damage was viewed as so severe that the loss of his medical license—the ultimate power a state licensing board has—was deemed appropriate.

There is copious debate in philosophy about the delineation of ethics and morality. One useful way to think about the difference is to think of morality as the personal understanding of right and wrong, and of ethics as a more systematized way of thinking about how our understanding of right and wrong should guide individual and group behavior [4]. The relationship between law and ethics is complex. While there is great overlap, they are not interchangeable—what is ethical may be illegal and vice versa. For example, civil protests by a psychiatrist may be illegal if there is a law banning protests, but it may not be unethical, especially if the protests are in support of patients. On the other hand, as a psychiatrist engaging in a sexual relationship with a patient's consenting adult relative would not be illegal, but it would be considered unethical. In Dr. Alsabti's case, his behavior was both unethical and illegal.

As demonstrated by *Alsabti vs. Board* above, unethical behavior by physicians can have severe professional consequences. In the USA, each state has jurisdiction over the licensure of medical professionals practicing in its territory. It is therefore important to keep in mind that while many of the laws and rules governing licensure are very similar between states, they are not the same. Alsabti's plagiarism contravened the "good moral character" that Massachusetts law requires physicians to possess in order to gain or maintain their state medical license. Courts interpreting legal standards such as "good moral character" can rely on their own understanding of such terms but can also look at what they perceive the ethical standards of the group in question (here physicians) to entail. Nongovernmental entities such as specialty boards, e.g., the American Board of Psychiatry and Neurology (ABPN), also require high standards of ethical behavior from everyone seeking or holding a certification and have procedures to sanction unethical behavior up to the revocation of board certification [5]. Likewise, professional bodies, such as the American Medical Association (AMA), American Psychiatric Association (APA), and American Academy of Psychiatry and the Law (AAPL), publish and regularly update codes of ethics that are held as binding for physicians [6], psychiatrists [7], and forensic psychiatrists [8], respectively.

These associations have very little formal power to sanction offending members other than revoking their membership, which, unlike state medical licenses or board certifications, is generally not required for clinical practice. Indirectly however, being sanctioned by a professional organization could have significant consequences for practice and could embolden a complainant to seek redress through litigation in civil court. Additionally, physicians who practice in subspecialty areas cannot afford to ignore their ethical guidelines even if they do not belong to the subspecialty organization. For example, in one such case in 1996, the Supreme Judicial Court of Massachusetts held that the ethical guidelines of AAPL applied to a psychiatrist specializing in adult and child and adolescent psychiatry who was practicing in a forensic role, even though the psychiatrist was not board certified in forensic psychiatry and not a member of AAPL [9].

In this chapter, we will highlight ethical guidelines relevant to the practice of psychiatry in general, as well as introduce those specific to forensic psychiatry. We will discuss some of the key ethical issues addressed by the AMA, APA, and AAPL ethical codes.

Principles of Medical Ethics As Applicable to Psychiatry

The ethics of medical practice date back to the classical Hippocratic Oath (said to have originated in the late fifth century BC) that, to this day, guides the ethical practice of physicians in one form or another. The bond between the physician and patient is highlighted by quotes from the text such as: "I will keep them (the sick) from harm and injustice," and "Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves" [10].

The Oath further defines this relationship as including a commitment to: beneficence (doing the best physicians can for the patient's benefit), non-maleficence (keeping the patient from harm), and justice (protecting the patient's legal and civil rights). It also states that these commitments should not be influenced by the patients' socioeconomic status, race, ethnicity, or gender ("be they free or slaves"). Hence, the Hippocratic Oath established the primacy of the patient's benefit in all physician–patient interactions.

Since the formation of the American Medical Association in 1847, American physicians have been guided by a Code of Medical Ethics to which physicians commit themselves as members of the medical profession [6]. The code, comprised of the principles of medical ethics, and the opinions of the AMA's Council of Ethical and Judicial Affairs (CEJA), is updated regularly to address the changing nature of medicine and was last updated in June 2016.

The AMA's principles of medical ethics [6] begin by reminding physicians of the ethical "responsibility to patients first and foremost, as well as to society, to other health professionals, and to self." These principles "are not laws, but standards of conduct that define the essentials of honorable behavior for the physician." They are

the foundation of the ethical guidelines for all specialty medical organizations. The principles state that a physician shall:

1. Provide competent and compassionate care, and respect human dignity and rights.
2. Uphold the standards of professionalism, be honest, and report physicians who are incompetent or deficient in character.
3. Respect the law but also seek to change laws that are contrary to the best interests of patients.
4. Safeguard patients' privacy within the constraints of the law.
5. Continue to further their knowledge and remain committed to medical education.
6. Be free to choose whom to treat and in which setting they want to practice, except in emergencies.
7. Participate in activities that improve the community and public health.
8. Regard responsibility for the patient as paramount.
9. Support access to medical care for all people [6].

These principles of medical ethics can be summarized as reflecting the following four ideals—justice (fairness), beneficence (benefitting the patient), non-maleficence (do no harm), and autonomy (respect for persons). The AMA ethical rules are far reaching and their application in individual cases can be quite complicated. They would be difficult to interpret for and apply to the practice of psychiatry without further elaboration. As a result, the APA developed annotations to the principles of medical ethics that are applicable to psychiatry [7]. For ease of discussion, we have grouped psychiatrists' ethical guidelines into three areas: (1) the physician–patient relationship, (2) psychiatrists' relationships with other providers and third parties, and (3) other ethical duties of psychiatrists.

The Physician–Patient Relationship

The physician–patient relationship is the cornerstone of psychiatric practice. As noted in the APA Commentary on Ethics in Practice (Topic 3.1.1), "Patients often lack medical expertise and sometimes struggle with symptoms that adversely affect their autonomous decision-making; the psychiatrist is responsible for rendering medical care in the patients' best interest while respecting the patient's goals and autonomy." The relationship is a "collaborative endeavor between two autonomous individuals… every effort should be made to have the relationship begin by mutual consent" [11].

Important elements of this relationship include:

- All treatment should be voluntary and provided only after the informed consent of the patient has been secured, except in emergencies or when a patient lacks the

capacity to give informed consent to treatment. Even when such exceptions apply, it is unethical to certify the necessity of involuntary treatment or detention without a personal examination of the person in question.

- The care provided to patients should be competent. This means psychiatrists should not provide services for which they are not qualified. If necessary, the psychiatrist should consult with, or refer the patient to, a more qualified colleague.
- Treatment should be based on the best available evidence and science. When established treatments have failed, psychiatrists may offer nonestablished or novel interventions. Risks and benefits of treatment, risks and benefits of alternatives to such treatments, as well as risks and benefits of no treatment must be discussed with the patient to empower the patient to be able to provide informed consent. Offering treatments that lie outside of the scientific consensus, such as unapproved chemical compounds, is problematic except within the context of a clinical study.
- Because of the highly personal and intensely emotional nature of the physician–patient relationship in psychiatry, proper boundaries should be maintained at all times. Engaging in any form of sexual intimacy with one's patient or former patient is unethical (and in some States illegal). This ethical injunction extends to a patient's close relatives and friends.
- Address boundary and privacy issues when using the internet or other electronic communication technologies. Psychiatrists should inform patients of the appropriate use of these technologies. Their use in emergency situations, if applicable, should be discussed and documented. Psychiatrists should be alert to the risk of HIPAA (The Health Insurance Portability and Accountability Act of 1996) violations when using technology to transmit patients' personal information. Likewise, the dangers of boundary violations are high when patients' access a psychiatrist's personal information through shared websites such as Facebook, or other means of communication. Due to rapidly advancing and changing technologies, the ethics in this area are likely to evolve. Psychiatrists should remain vigilant when using new media and technology and consult APA ethical guidelines as necessary.
- It is ethical to charge for missed appointments or appointments not canceled within a stipulated period in advance as long as that policy was communicated to the patient beforehand.
- It is paramount that patients' privacy be protected. Further, any clinical information used in teaching or scholarly writing must be disguised to effectively conceal patients' identities. However, in certain clinical situations, breaking confidentiality is not only permissible but required. For example, when a patient's behavior presents a high risk of danger to the patient or other persons, breaking confidentiality is permissible to avert danger.
- It is ethical to refuse psychiatric treatment of persons who are not suffering from a mental illness amenable to treatment.
- If a patient's care is transferred to another provider, the psychiatrist should cooperate with the patient's request to share information with and release files to the new provider [7, 11].

Important ethical issues that frequently come up during clinical training include: maintaining boundaries, when to break confidentiality, and how to handle situations where involuntary treatment or detention may be warranted.

Maintaining clear boundaries with your patients is meant to protect both you and the patient from harm and increase chances of treatment success. Empathic and compassionate care should not be confused with becoming emotionally involved with a patient. An emotionally involved psychiatrist could refrain from asking a patient uncomfortable questions or providing vital but distressing information to the patient for fear of hurting the patient's feelings, situations that could be harmful to the patient in the long run. On the other hand, the quality of care provided by psychiatrists is positively influenced by empathy, compassion, and the establishment of clear boundaries between the psychiatrist and the patient. Where these boundaries lie in individual cases is often nuanced and may be influenced by culture and personal style. There are some hard lines, however. For example, sex with a current or former patient is unethical in all circumstances. According to the APA, sex with a former patient is always unethical regardless of how much time has elapsed since treatment was discontinued. Although some scholars disagree with this stance [12], there is currently no wiggle room for psychiatrists practicing in the USA.

Another important issue of great concern involves accepting large financial gifts from current or former patients—it is generally viewed as unethical and should be avoided.

With regard to confidentiality, psychiatrists owe an ethical obligation not to reveal a patient's personal information without the patient's informed consent, as well as a legal duty to protect a patient's privacy (APA Commentary on Ethics in Practice, Topic 3.2.1 [11]). For example, when discussing cases with colleagues not involved in a patient's care, it is important to maintain privacy by effectively disguising the patient's identity even if the clinical case is somewhat altered in the process. Unlike ethical obligations, there are substantial differences in the legal duty to protect a patient's privacy depending on the jurisdiction a psychiatrist is practicing in, as well as the role the psychiatrist is serving (for example, treating psychiatrist versus forensic psychiatric evaluator). These legal obligations are discussed in greater detail in this text's chapter on confidentiality.

Involuntary treatment or detention is one of psychiatry's most controversial topics, not the least because of the historically rampant abuse of involuntary treatment procedures by psychiatrists.

Psychiatrists recognize that enforced treatment contains an inherent tension among several ethical values: respecting the individual's autonomy, providing care for that individual, and protecting the community (APA Commentary on Ethics in Practice, Topic 3.2.5 [11]). In psychiatric emergencies, such as threats of harm to oneself or others, the psychiatrist has an ethical obligation "to ensure the safety of the public or the care and protection of patients through involuntary psychiatric treatment" (ibid). Making use of involuntary treatment modalities requires sensitivity on the part of the psychiatrist to balance these competing values. When involuntary treatment is imposed, it should "ensure the least restrictive clinically appropriate alternative and, to the extent possible, respect the informed consent process and the

patient's decision-making capacity" (ibid). However, there are several notable psychiatrists who disagree with the concept of involuntary treatment or commitment (Thomas Szasz is a well-known example [13]).

One of the important ethical standards of the APA is the requirement that a psychiatrist may certify a patient for involuntary commitment or treatment only after he or she has personally evaluated the patient [7]. Psychiatry residents, depending on their licensing status and the jurisdiction in which they practice, often have the legal authority to certify a patient for involuntary commitment. Residents can find themselves in clinical situations where other medical staff—even more senior colleagues—sometimes pressure residents to certify a patient for involuntary commitment without a personal examination of the patient. Residents have both a legal and an ethical obligation to resist such pressures.

Psychiatrists' Relationship with Other Providers and Third Parties

The nature of psychiatric practice often requires that psychiatrists work with colleagues from different disciplines who have their own ethical obligations. In addition, an increasing number of psychiatrists do not work directly with patients but with third parties such as insurance companies, the legal system, the military, and medical providers, where psychiatrists serve as consultants in an integrated care setting, and so on. These situations create unique challenges that require psychiatrists to develop clear ethical guidelines to protect patients and society. Important considerations include:

- Referrals to other providers, psychiatric or otherwise, should only be made to persons who are competent to deliver the necessary treatment.
- Consultants should only be given information relevant to the specific situation (the "minimum necessary" information needed to provide competent consultation).
- Information provided to other health providers, employers, insurance companies, or other third parties must be truthful.
- Progress notes should only contain the information necessary to ensure good continuity of care. Including nonessential information in progress notes can put the patient's privacy at risk and make successful continuity of care more difficult.
- A psychiatrist can be reimbursed for providing supervision to other providers (e.g., by charging an hourly rate or a flat fee for the supervision).
- Fee splitting, where other providers pay a percentage of their fees to a referring or consulting psychiatrist, is unethical. The concern with fee splitting is that it could lead to an increase in inappropriate referrals to the provider as the referring psychiatrist would obtain financial benefit with each referral (and thus would be incentivized to increase the number of referrals made).
- If a psychiatrist takes on a supervisory role for non-physician professionals (or medical trainees), the psychiatrist must ensure that he or she spends adequate

time to ensure effective supervision; the psychiatrist cannot act as a mere figurehead. Further, matters requiring professional medical judgment must not be delegated to nonmedical professionals (e.g., delegating the decision about what medication to prescribe to a social worker).

- Psychiatrists are mandated to protect patients from impaired or incompetent physicians and non-physician mental health professionals. If possible, these issues should first be addressed through informal processes. If those efforts are unsuccessful, psychiatrists should address the issue through other appropriate channels such as the state's impaired physician program, the state medical board, the chief of the service/hospital, hospital medical staff procedures, or other available routes. (APA Commentary on Ethics in Practice, Topic 3.3.5 [11]).
- Relationships with pharmaceutical and other industries should be handled with caution. At a minimum, potential conflicts of interests must be disclosed to patients and in public speeches and writings, even if the psychiatrist feels that these are inconsequential [7, 11].

Some of the ethical duties listed earlier provide a unique challenge to medical students and trainees because of the power differential they face relative to their supervisors. A related problem is the case of a supervisor who is intoxicated or otherwise not providing competent care. While the power differential makes it especially difficult for trainees to report unethical and/or incompetent behavior of supervisors, they are nonetheless obligated to do so. Every training program should have procedures in place that encourage trainees to report unethical behavior of supervisors without fear of retribution.

In recognition of these challenges, it is the ethical responsibility of psychiatrists to ensure that trainees are treated with respect in an environment conducive to learning. It is not ethically permissible for a supervisor to sign notes or orders written by trainees absent a supervisory relationship.

Other Duties of the Ethical Psychiatrist

- When working in an organized system of care, the psychiatrist must communicate to the patient certain requirements of the organization such as treatment restrictions or triage protocols. The psychiatrist must also help identify treatment alternatives outside of their own system of care if it is more beneficial (or more affordable) for the patient's treatment.
- It is unethical for a psychiatrist to publicly offer a professional opinion on persons (including public figures) whom the psychiatrist has not personally examined and from whom the psychiatrist has not obtained authorization to disclose a professional opinion about their behavior, including their mental state. This is called the Goldwater Rule (named after Barry Goldwater, U.S. presidential candidate in 1964, whose mental state many psychiatrists publicly opined about without having performed a direct psychiatric examination of Mr. Goldwater).

- Law breaking that bears directly on a psychiatrist's practice, such as falsifying medical records, submitting a false bill, and providing false documents to excuse a patient from obligations, is unethical. However, breaking laws that bar civil protests may not be unethical, even if illegal.
- Psychiatrists should not contribute to discrimination based on ethnic origin, race, sex, creed, age, socioeconomic status, or sexual orientation.
- Psychiatrists should not participate in legally authorized executions.
- Psychiatrists should not participate directly or indirectly in interrogations of those detained by law enforcement or intelligence agencies [7, 11].

Ethical Guidelines for the Practice of Forensic Psychiatry

The American Academy of Psychiatry and the Law's (AAPL) ethical guidelines begin by noting that the unique intersection of psychiatric practice and the law exposes forensic psychiatrists to many potential conflicts. AAPL ethical guidelines define forensic psychiatry as "a subspecialty of psychiatry in which scientific and clinical expertise is applied in legal contexts involving civil, criminal, correctional, regulatory or legislative matters, and in specialized clinical consultations in areas such as risk assessment or employment." These ethical guidelines apply to all psychiatrists practicing in a forensic role. They are intended to "supplement the Annotations Especially Applicable to Psychiatry of the American Psychiatric Association to the Principles of Medical Ethics of the American Medical Association" [8].

The traditional physician–patient relationship is different in a forensic psychiatric context. Consider the case of a forensic psychiatrist hired by a defense attorney or the court to evaluate an individual accused of a criminal offense. Here, the psychiatrist's primary duty is to the hiring attorney or the court and not the defendant. This is very different from traditional psychiatric practice in which the psychiatrist's primary duty is to the patient. However, if the defendant expresses suicidal or homicidal ideation during a forensic evaluation, the psychiatrist must shift focus, put on a doctor–patient hat, and act to protect the defendant and others from harm. This careful balancing of roles highlights the need for additional ethical structures when engaging in forensic psychiatric practice.

One of the paramount issues at play in forensic psychiatry is managing dual agency (serving two agencies or serving in two roles at the same time), given the prominent role of third parties in forensic assessments. Other core ethical principles that are crucial to forensic psychiatric practice and further described in the AAPL guidelines include informed consent, confidentiality, honesty, and striving for objectivity.

Dual Agency

The multiple overlapping roles that forensic psychiatrists serve lead to competing commitments and obligations. Psychiatrists practicing outside of a forensic context have a primary, but not absolute, duty to their patient. However, forensic

psychiatrists do not act within a traditional physician–patient relationship in much of what they do. For example, psychiatrists working in a forensic hospital or correctional facility are often asked to provide reports to the courts and may testify in court in cases involving their patients. Their testimony (and reports) could help or harm their patients. In these complicated circumstances, when a treating psychiatrist provides information in court on a patient's diagnosis, treatment provided, and response to treatment only, the psychiatrist is serving as a fact witness, as they are solely testifying about their past experiences working with the patient in a clinical setting. However, when the same psychiatrist forms an opinion regarding the patient's dangerousness or risk of engaging in criminal behavior based on psychiatric data and the additional collateral information available, the psychiatrist is acting as an expert witness (as they are using their psychiatric expertise to form an opinion about the patient) and, in this case, has now become a dual agent, working both for the patient and the legal system. AAPL ethics recommend that treating psychiatrists should avoid acting as forensic experts in relation to patients they are treating (whenever possible) in order to avoid inherent biases that could influence their opinion. It is, however, not unethical to do so and may be necessary in certain situations (e.g., if the psychiatrist is practicing in a rural area without proximally located colleagues who could perform the forensic evaluation instead). The psychiatrist must carefully balance these competing roles without acting unethically. Similar role conflicts often arise with psychiatrists working in correctional and military settings where there are limits on what kind of information can be kept confidential between the psychiatrist and the patient.

The most common dual agency issue that occurs in general psychiatric practice involves completing Social Security (or private insurance company) disability forms for patients. Others include Workmen's Compensation forms and fitness for duty evaluations. In these situations, treating psychiatrists are asked to state their professional opinion regarding their patient's ability to perform certain tasks, armed with only that information provided by the patient. The ethical values of honesty and striving for objectivity call for an unbiased assessment of the patient's ability, a very difficult task indeed, especially if the psychiatrist's opinion conflicts with the patient's desire. The risk of rupturing the therapeutic alliance is high.

Informed Consent and Confidentiality

Unlike traditional psychiatric practice, what is discussed between a forensic psychiatrist and an evaluee is generally not protected by traditional physician–patient confidentiality. If the psychiatrist is hired by the evaluee's own attorney, their discussions may be protected by an extension of the attorney–client privilege referred to as the "work product rule," but this does not keep the information private from the hiring attorney or his/her co-workers. In addition, whatever information the evaluee presents may be discussed in open court or at deposition (a legal process where sworn testimony is provided to attorneys without a judge or jury present. Such testimony may or may not be subsequently presented at a court

hearing). The evaluee may be unaware of these potential disclosures before agreeing to a forensic evaluation. It is, therefore, the duty of the forensic evaluator to ensure the evaluee understands the limited nature of confidentiality in these assessments. The psychiatrist must inform the evaluee that the psychiatrist performing the evaluation is hired by a named third party (e.g., an attorney), the reason for the evaluation, and the limits of confidentiality described earlier. This should be done at the beginning of any forensic evaluation, with reminders during the assessment as necessary. Without these warnings, any consent given to the psychiatrist would not be considered an informed consent.

Honesty and Striving for Objectivity

The unique adversarial nature of the US legal system which pits two opposing sides against one another creates inherent tensions for a psychiatrist hired by one side in a legal dispute. The desire to "win" the case increases the potential for unintended bias in psychiatrists practicing in US court systems, different from other countries without an adversarial judicial process [14]. Several of the ethical rules described earlier are meant to protect the forensic psychiatrist from becoming a "hired gun"—an expert who will say whatever is helpful to the party who hired him/her. However, some unconscious bias is inevitable in any forensic evaluation. The US legal system attempts to balance this by allowing experts to be retained by both sides and by holding forensic experts to ethical standards such as those described by the APA and AAPL.

A psychiatrist who strives for objectivity would render an honest opinion based on a personal examination of an individual, interview of all collateral sources as available and necessary, and review of all pertinent data related to the case. In addition, the psychiatrist should not alter or distort his/her professional opinion in support of the retaining attorney and should not agree to payment that is contingent on the outcome of the case. Further, the psychiatrist should state the limits of his/her opinion as necessary. For example, if the evaluee (or collateral sources) could not be interviewed after an "earnest effort" [8] to do so, it should be stated in the report because the absence of this information could limit the conclusions drawn from the evaluation.

Other Ethical Issues Pertinent to Forensic Psychiatry

- It is unethical to conduct a psychiatric evaluation of an individual charged with a crime before the person has had access to legal counsel, except in medical emergencies for the purposes of treatment.
- Forensic psychiatrists may not bully, be rude, or use name-calling to obtain information from evaluees. However, persistent questioning about inconsistencies and the exploration of areas that make the evaluee uncomfortable are ethical and often warranted in forensic evaluations.

- In cases where a psychiatrist is asked to assess material relevant to a legal case (such as medical records, correspondence, or police interrogation videos) but has not examined the evaluee in person, any opinion rendered must be qualified, indicating in reports and testimony that there was no personal examination.
- It is unethical to change diagnoses or other major findings in a forensic report upon the request of an attorney in order to strengthen a case. It is permissible, however, to accept requests for changes in phrasing that make the expressed opinion clearer or more easily understandable to a nonpsychiatric audience.
- It is unethical to claim expertise in areas where one does not have actual knowledge, skills, and experience [7, 8].

Take Home Messages

– Professional bodies such as the AMA, APA, and AAPL set forth ethical codes of conduct. They do not carry the direct force of law, but nonadherence to them can lead to severe professional and legal consequences including loss of medical licensure and board certification. These potential sanctions may be imposed even if one is not a member of any of these professional organizations, so it is important for all psychiatrists to familiarize themselves with these guidelines.
– All psychiatrists are physicians first and all forensic psychiatrists are psychiatrists. That is why multiple codes of ethics often apply simultaneously to the same individual.
– Tread carefully when you observe unethical behavior of others as you are obligated to address it and to report it if the problem persists. It is advisable to familiarize yourself with the reporting procedures of your training program and institution.
– Forensic psychiatrists, especially when acting as forensic evaluators, face unique ethical challenges arising from their special role and the lack of a typical physician–patient relationship. Forensic psychiatrists should strive for honesty and objectivity and resist pressures to sway their opinion in favor of the hiring party.

References

1. Supreme Judicial Court of Massachusetts. Alsabti vs. Board of Registration in Medicine, 404 Mass. 547. 1989. http://masscases.com/cases/sjc/404/404mass547.html. Accessed 18 Apr 2017.
2. Supreme Judicial Court of Massachusetts. David A. Levy vs. Board of Registration and Discipline in Medicine, 378 Mass. 519. 1979. http://masscases.com/cases/sjc/378/378mass519.html. Accessed 18 Apr 2017.
3. Supreme Judicial Court of Massachusetts. Sherwin H. Raymond vs. Board of Registration in Medicine, 387 Mass. 708. 1982. http://masscases.com/cases/sjc/387/387mass708.html. Accessed 18 Apr 2017.
4. Gert B, Gert J. The definition of morality. In: Stanford Encycl. Philos. 2016. https://plato.stanford.edu/entries/morality-definition/. Accessed 18 Apr 2017.

5. American Board of Psychiatry and Neurology – Policies. https://www.abpn.com/about/policies/. Accessed 18 Apr 2017.
6. Council on Ethical and Judicial Affairs. American Medical Association. Code of Medical Ethics. 2016. https://www.ama-assn.org/about-us/code-medical-ethics. Accessed 18 Apr 2017.
7. American Psychiatric Association. The principles of medical ethics with annotations especially applicable to psychiatry. 2013. https://www.psychiatry.org/FileLibrary/Psychiatrists/Practice/Ethics/principles-medical-ethics.pdf. Accessed 18 Apr 2017.
8. American Academy of Psychiatry and the Law. Ethics guidelines. 2015. http://www.aapl.org/ethics.htm. Accessed 18 Apr 2017.
9. Supreme Judicial Court of Massachusetts. Sugarman vs. Board of Registration in Medicine, 422 Mass. 338. 1996. http://masscases.com/cases/sjc/422/422mass338.html. Accessed 18 Apr 2017.
10. Edelstein L. The Hippocratic Oath: text; translation, and interpretation. In: Cross cultural perspectives in medical ethics. 2nd ed. Baltimore: The Johns Hopkins; 1943. p. 3.
11. American Psychiatric Association. APA Commentary on Ethics in Practice. 2015. https://www.psychiatry.org/FileLibrary/Psychiatrists/Practice/Ethics/APA-Commentary-on-Ethics-in-Practice.pdf. Accessed 18 Apr 2017.
12. Appelbaum PS, Jorgenson L. Psychotherapist-patient sexual contact after termination of treatment: an analysis and a proposal. Am J Psychiatry. 1991;148:1466–73.
13. Szasz T. Involuntary mental hospitalization: a crime against humanity. In: Biomedical ethics and the law. Boston, MA: Springer; 1976. p. 151–71.
14. Timmerbeil S. The role of expert witnesses in German and U.S. civil litigation. Annu Surv Int Comp Law. 2003;9:163. Article 8.