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HEALER, WITNESS, OR DOUBLE AGENT? REEXAMINING THE ETHICS OF FORENSIC PSYCHIATRY

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In recent years, psychiatrists have become ever more prevalent in American courtrooms. Consequently, the issue of when the usual rules of medical ethics should apply to forensic psychiatric encounters has taken on increased importance and is a continuing topic of discussion among both legal and medical scholars. A number of approaches to the problem of forensic psychiatric ethics have been proposed, but none adequately addresses the issues that arise when a forensic encounter develops therapeutic characteristics. This article looks to the rules governing the lawyer-client relationship as a model for a new approach to forensic psychiatric ethics. This new model focuses on the expectations of the evaluee and the ways in which the evaluating psychiatrist shapes those expectations to determine how and when the rules of medical ethics should apply to forensic psychiatric encounters.

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I. INTRODUCTION

When a clinically trained psychiatrist takes the stand in a court of law, the psychiatrist enters territory that is strewn with ethical hazards. A testifying psychiatrist arguably serves two masters: the legal duties imposed on witnesses in court and the obligations of medical ethics that all physicians must follow. Consequently, to practice forensic psychiatry is to choose a path of "moral adventure."[2] This adventure once captured the attention of many scholars and practitioners,[3] but scholarly attention on the matter has largely tapered off since the early 1990s, despite the increasing use of psychiatrists in courtroom settings.

The most vexing ethical problem in forensic psychiatry arises when a forensic psychiatric encounter takes on therapeutic characteristics. Distinguishing "forensic" psychiatric encounters from "therapeutic" encounters is not as simple as it might seem at first blush. Even though forensic psychiatric evaluations are often conducted outside traditional clinical settings,[4] the person performing the forensic psychiatric evaluation may also be the caregiver of the person being assessed.[5] At least one study suggests that psychiatrists performing forensic evaluations often fail to inform evaluees of the limits of confidentiality with respect to forensic evaluations.[6] Moreover, the growing therapeutic jurisprudence movement consciously focuses on the interaction between mental health and the law, and courts that have adopted the tenets of therapeutic jurisprudence often play a therapeutic role in the lives of the

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[2] Alan A. Stone, *The Ethics of Forensic Psychiatry: A View from the Ivory Tower*, *in* LAW, PSYCHIATRY, AND MORALITY 57, 73 (1984) (hereinafter "Stone, *Ivory Tower*").

[3] *See, e.g.*, *Id.*; Paul S. Appelbaum, *A Theory of Ethics for Forensic Psychiatry*, 25 J. AM. ACAD. PSYCHIATRY L. 233, 245 (1997) (hereinafter "Appelbaum, *Theory of Ethics*"); Thomas Nilsson et al., *The precarious practice of forensic psychiatric risk assessments*, 32 INT'L J. L. PSYCHIATRY 400, 404-05 (2009).

[4] Authors discussing forensic psychiatric encounters have used both "clinical" and "therapeutic" to describe psychiatric encounters marked by a traditional doctor-patient relationship. *Compare* Appelbaum, *Theory of Ethics*, *supra* note 3, at 233, *with* Alan A. Stone, *Revisiting the Parable: Truth Without Consequences*, 17 INT'L J.L. & PSYCHIATRY 79, 80 (1994) (hereinafter "Stone, *Truth Without Consequences*"). In this article, the term "therapeutic" will be used to describe the types of interactions associated with the doctor-patient relationship, whereas "clinical" will be used to describe the setting and context in which therapeutic interactions typically occur. Thus, a psychiatrist who treats a patient in his private practice forms a therapeutic relationship with that patient, and the office visits in which the psychiatrist evaluates that patient take place in a clinical setting. A key argument in this article is that while nearly all clinical encounters are therapeutic, therapeutic relationships can nonetheless form even in non-clinical settings.

[5] Indeed, such a relationship could be viewed as desirable, since clinical experience with evaluees helps improve the quality of forensic assessments. *See* Nilsson et al., *supra* note 3, at 405.

[6] Richard Robinson & Marvin W. Acklin, *Fitness in Paradise: Quality of Forensic Reports Submitted to the Hawaii judiciary*, 33 INT'L J. L. PSYCHIATRY 131, 135 (2009) (reporting a survey of forensic reports in which only 24% of the reports "included a complete statement that the limits of confidentiality were explained to the defendant"); *Id.* at 136 ("66% of reports fail[ed] to document the ethically mandated notice of limits of confidentiality . . . .").

defendants that appear before it.[7] Each of these factors blurs the line between the forensic and the therapeutic in the context of the legal system.

Moreover, even if an encounter could be described as plainly and purely forensic at the outset, an ostensibly forensic encounter may – and sometimes does – take on therapeutic characteristics. In such cases, the examining psychiatrist can become a "double agent," facing a conflict between his forensic duty to seek and report his honest opinion on the subject's mental state and his duty as a physician to act in the best interest of his patient.[8] When that occurs, the psychiatrist is faced with the inescapable question of whether and how the traditional obligations of medical ethics should apply.[9]

This article will describe and analyze three previously proposed approaches to that question and the closely related question of when and how a doctor-patient relationship can form in the context of a forensic psychiatric evaluation. It will also explain why each of these prior approaches does not sufficiently address the issues that arise when a forensic encounter takes on therapeutic characteristics. Finally, it will propose a new approach that draws inspiration from the rules governing the lawyer-client relationship.

Part II will present a parable told by Alan Stone that illustrates the dilemma that forensic psychiatrists often encounter. Part III will begin with an examination and critique of the most completely developed of the prior approaches – Paul Appelbaum's theory of forensic ethics, which draws a firm line between therapeutic and forensic encounters and holds the ethical duties governing the former to be inapplicable to the latter. The remaining sections of Part III will examine two other proposed approaches, one of which identifies the use of medical skill and/or judgment as the decisive factor, and the other of which asserts that the process of psychiatric evaluation is non-invasive and thus does not trigger the duty of obtaining the evaluee's informed consent.[10]

Part IV will suggest a new approach based on the rules governing the lawyer-client relationship. This approach provides a renewed focus on the expectations of the evaluee and the ways in which the evaluating psychiatrist shapes those expectations. The key inquiry under this approach is whether the psychiatrist's actions during the evaluation led the evaluee to reasonably believe that the evaluating psychiatrist was acting as his physician.[11] In assessing the reasonableness of the evaluee's belief, the focus should be on what, if any, psychiatric methods or technique were used that led the evaluee to form that belief.[12]

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[7] Specialized courts for veterans, drug users, and perpetrators of domestic violence have sprung up in recent years, many of which formulate and monitor treatment programs for offenders that appear before them. *See generally* Bruce J. Winick et al., *Dealing with Mentally Ill Domestic Violence Perpetrators: A Therapeutic Jurisprudence Judicial Model*, 33 INT'L J. L. PSYCHIATRY 428 (2010).

[8] *Id.*

[9] Of particular import in forensic psychiatry are the ethical duties of beneficence (acting in the patient's best interests), non-malfeasance (doing no harm to the patient), confidentiality, and informed consent.

[10] This approach does, however, leave as an open question the applicability of other principles of medical ethics. *See infra* Part III.B.

[11] Applebaum, *Theory of Ethics*, *supra* note 3.

[12] *See infra* Part IV.B.

The effectiveness of pre-evaluation warnings and waivers should also be evaluated based on a standard derived from legal ethics, namely the rules governing advance waivers of conflicts of interest, which can be invalidated if the client is not likely to understand the waiver at the outset or if a material change occurs in the circumstances or expectations surrounding the relationship.[13] Thus, the lawyer-client based approach, unlike the approaches previously proposed, would be based on evaluees' perspectives and interpretations of the psychiatric encounter rather than those of psychiatrists, lawyers, or society at large.

II. THE ARMY SERGEANT PARABLE

Four years before he described forensic psychiatry as a "moral adventure," Stone related a story that epitomized the ethical tension that forensic psychiatrists can face.[14] The central character in Stone's parable was an African-American supply sergeant in the United States Army who was accused of stealing large quantities of Army supplies.[15] Many of the stolen goods were of no use to the sergeant, and a civilian psychiatrist was prepared to testify at court-martial that the stealing was due to "unconscious and irresistible impulses" caused by kleptomania, which was recognized as a mental disorder in the DSM-III, the then-current version of the Diagnostic and Statistical Manual of Mental Disorders.[16] The Army, unhappy with this result, sent the sergeant to be evaluated at one of its hospitals by Stone, who was then employed as an Army psychiatrist.[17] During the psychiatric evaluations that followed, Stone repeatedly informed the sergeant that anything he revealed to Stone could be used against him at a court-martial.[18] According to Stone, the sergeant took these warnings "rather impassively."[19]

During the course of three weeks of psychiatric evaluation sessions, the sergeant revealed to Stone the story of his life.[20] Despite being a well-educated and highly intelligent man, the sergeant had trouble finding a suitable job after graduating college, and ended up enlisting in the Army.[21] The sergeant then spent most of his twenty-year Army career facing daily racial discrimination and answering to white superiors who were less educated and less intelligent than he was.[22] Stone concluded that the bitterness that the sergeant felt over this lifelong predicament caused the sergeant to

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[13] *See infra* notes 107-110 and accompanying text.

[14] *See* Alan A. Stone, *Presidential Address: Conceptual Ambiguity and Morality in Modern Psychiatry*, 137 AM. J. PSYCHIATRY 887, 887-88 (1980) (hereinafter "Stone, *Presidential Address*").

[15] *Id.*

[16] *See* AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL 293 (3d ed. 1980).

[17] *Id.*

[18] *Id.*

[19] Stone, *Presidential Address*, *supra* note 14, at 888.

[20] *Id.*

[21] *Id.*

[22] Stone, *Truth Without Consequences*, *supra* note 4, at 81.

develop "a sense of entitlement and reparation" that led the sergeant to steal whatever and whenever he could "in protest of the racist world that had deprived him of his hopes."[23] Unfortunately for the sergeant, this sense of entitlement did not constitute a recognized mental illness. Stone testified against the sergeant at trial, and the sergeant was convicted and stripped of his pension and "everything else of value he had accumulated in his lifetime."[24]

Given the harsh potential and eventual outcomes of his court-martial, one might think that the sergeant would have been more circumspect about the revelations that he made to Stone, particularly given Stone's repeated warnings that anything the sergeant said could be used against him. Nevertheless, the sergeant revealed much to Stone during the course of their sessions, and "the narrative that emerged from more than ten hours of interviewing could not have been more incriminating."[25] Stone later ascribed the sergeant's willingness to reveal so much of his past to Stone's use of countertransference to "demonstrate [his] capacity to empathize across the barriers of race and to find a way to communicate with this Black man."[26]

Thus, the Army psychiatrist who had established an emotional rapport across the racial divide ended up being the principal witness against the sergeant and ultimately an agent of the sergeant's conviction. Stone felt that he had betrayed the sergeant, and soon came to recognize the source of this sense of betrayal: "[A]though legally and technically the sergeant had been warned and had given informed consent . . . I had unwittingly used my therapeutic skills to extract from him damaging personal revelations. The forensic evaluation had developed into a therapeutic encounter and I had become a 'double agent.'"[27]

III. PROPOSED APPROACHES AND THEIR DRAWBACKS

The "double agent" problem that Stone describes arises because it is not inherently clear whether psychiatrists are bound by the rules of medical ethics when they conduct a forensic evaluation. Perhaps even more fundamentally, the line between forensic psychiatry and therapeutic psychiatry is itself quite blurred. A number of scholars have written articles suggesting how psychiatrists should approach the rules of medical ethics in the context of forensic psychiatric evaluations. It is less clear, however, what characteristics make an encounter "forensic" rather than therapeutic in nature.

A. Approach One: Forensic Psychiatric Evaluations as Inherently Non-Therapeutic

Paul Appelbaum proposed the most completely developed theory to date regarding the ethics of forensic psychiatric evaluations.[28] Appelbaum argues that forensic psychiatric evaluations are not therapeutic encounters at all because they do not serve traditional medical ends, and that the traditional ethical rules imposed on physicians

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[23] Stone, *Presidential Address*, *supra* note 14, at 888.

[24] *See* Stone, *Truth Without Consequences*, *supra* note 4, at 81.

[25] *Id.*

[26] *Id.* at 80.

[27] *Id.*

[28] *See* Appelbaum, *Theory of Ethics*, *supra* note 3.

therefore do not apply.[29] In their place, Appelbaum suggests the implementation of a distinct theory of forensic psychiatric ethics based on the principles of "truth-telling" and "respect for persons."[30] By "truth-telling," Appelbaum means that the primary mission of the forensic psychiatrist is to give an honest evaluation to the court, both in terms of his opinion of the evaluee and the limitations of his testimony.[31] Of course, all witnesses – expert or not – testify under oath and subject to the penalty of perjury if they do not tell the truth. Consequently, it is difficult to discern what the practical effect of imposing an ethics-based "truth-telling" duty would be.

By "respect for persons," Appelbaum means being candid with evaluees about the nature of the encounter and the limitations on confidentiality and other duties of medical ethics.[32] Here too, it is not clear how this prong of Appelbaum's ethical theory provides forensic psychiatrists with any additional ethical duties beyond those already expected of non-physicians. Indeed, Appelbaum himself seems to imply that "respect for persons" stems not from an ethical duty specific to forensic psychiatrists or even testifying physicians generally, but rather from the type of ordinary morality expected of every member of society.[33]

Moreover, even if one were to accept that "truth-telling" and "respect for persons" are the proper ethical guideposts for forensic psychiatrists – an issue that remains controversial among scholars and practitioners[34] – Appelbaum's theory faces two obstacles. First, in order to accept and implement Appelbaum's theory, one must be able to draw a clear line between therapeutic and non-therapeutic encounters.[35] Second, adherents must accept that when an encounter is (or is primarily) forensic in nature, the traditional rules of medical ethics should not apply.[36] Both of these propositions are highly questionable.

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[29] *See* Appelbaum, *Theory of Ethics*, *supra* note 3; Paul S. Appelbaum, *The Parable of the Forensic Psychiatrist: Ethics and the Problem of Doing Harm*, 13 INT'L J.L. & PSYCHIATRY 249 (1990) (hereinafter "Appelbaum, *Problem of Doing Harm*").

[30] *See* Appelbaum, *Theory of Ethics*, *supra* note 3, at 239-43.

[31] *Id.* at 240. For general criticisms of Appelbaum's focus on truth-telling, *see, e.g.* Stone, *Truth Without Consequences*, *supra* note 4, at 84-87; M. Gregg Bloche, *Psychiatry, Capital Punishment, and the Purposes of Medicine*, 16 INT'L J.L. & PSYCHIATRY 301, 320-23 (1993) (hereinafter "Bloche I").

[32] Appelbaum, *Theory of Ethics*, *supra* note 3, at 241-43.

[33] *See Id.* at 242 ("[F]orensic psychiatrists – not as professionals, but as citizens – have the same duties as other people to act nonmaleficently . . . [a]ssisting in the torture or abusive interrogations of prisoners would fail [to promote the aims of forensic psychiatry] not as a matter of professional ethics, but by virtue of ordinary moral reasoning.").

[34] Some psychiatrists have asserted that Appelbaum's view on the role of forensic psychiatrists "has not gained wide support in the forensic psychiatric community." Stone, *supra* Nilsson et al., note 3, at 405 n. 3. In a review of scholarship on the ethics of forensic psychiatry, however, Dr. Glenn H. Miller stated that "Appelbaum identified the intuitive ways American forensic psychiatrists think" and that "forensic psychiatrists are all Appelbaumians." Glenn H. Miller, *Alan Stone and the Ethics of Forensic Psychiatry: An Overview*, 36 J. AMER. ACAD. PSYCHIATRY & L. 191, 192 (2008), *available at* http://www.jaapl.org/cgi/content/full/36/2/191.

[35] *See* Appelbaum, *Theory of Ethics*, *supra* note 3.

[36] *Id.*

1. Therapeutic and Non-Therapeutic Encounters: A False Dichotomy?

Appelbaum's insistence that forensic evaluations are different in kind from clinical evaluations lies at the very heart of his theory of forensic ethics.[37] In Appelbaum's view, since forensic evaluations are meant to serve the ends of justice rather than the ends of clinical medicine, the ethical rules governing the practice of medicine in the clinical setting simply do not apply.[38] Most critically, Appelbaum asserts that "[w]hereas clinical medical ethics are rooted in a physician-patient relationship, no such nexus is established in the forensic setting."[39] Thus, Appelbaum believes that a psychiatrist can comfortably don either of two hats – one of a therapist, and the other of a forensicist – and keep those hats ethically distinct.[40]

Even at the outset of the encounter, however, there is nothing inherently "forensic" about performing a psychiatric evaluation of an individual in order to determine a person's mental state. Evaluation and diagnosis are integral components of clinical medicine,[41] and the tasks of making a diagnosis and describing the implications of that diagnosis are defining features of practicing medicine.[42] Indeed, Appelbaum himself seemed to concede this much in a book he co-authored, where he characterized psychiatric evaluations as a "routine . . . part of [medical] care" and referred to the subjects of such evaluations as "patients."[43] Thus, a binary approach to the question of whether the rules of medical ethics apply seems inapt in the context of psychiatric evaluations. Even in non-clinical settings, psychiatrists can and do use therapeutic

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[37] *See* Appelbaum, *Theory of Ethics*, *supra* note 3, at 237-39.

[38] *See id.* at 239 ("Forensic psychiatrists . . . like all other physicians whose roles may sometimes depart from the paradigm of the treatment setting, require a distinct set of ethical principles to guide their work.").

[39] *Id.* at 238.

[40] Stone, *supra* note 4, at 82. Appelbaum discusses a third "hat" – that of the researcher – as an example of a setting in which physicians use their medical skills but where the standards of medical ethics that govern the traditional doctor-patient relationship do not apply. *See* Appelbaum, *Theory of Ethics*, *supra* note 3, at 237-38. Appelbaum asserts that "research physicians" are not bound by the traditional clinical duty of loyalty to individual patients but do take on additional ethical obligations. Certainly, entire independent books, articles, and interpretations of ethical guidelines can be and have been written on the ethical obligations physicians working in the research setting. *See, e.g.*, ROBERT J. LEVINE, ETHICS AND REGULATION OF CLINICAL RESEARCH (1981); Ad Hoc Committee on Medical Ethics, *American College of Physicians Ethics Manual Part II: Research, Other Ethical Issues, Recommended Reading*, 101 ANNALS INTERNAL MED. 263, 263-64 (1984); Lois Snyder & Paul S. Mueller, *Research in the Physician's Office: Navigating the Ethical Minefield*, 38 HASTINGS CTR. REP. 23 (2008). These issues are beyond the scope of this article. Once again, however, it is worth noting that unlike the stringent rules concerning informed consent that are imposed on physicians conducting clinical research, Appelbaum's ethical framework does not appear to impose *any* additional ethical obligations on forensic psychiatrists beyond those already imposed on all expert witnesses.

[41] *See, e.g.*, Gregory Dolin, *A Healer or an Executioner? The Proper Role of a Psychiatrist in a Criminal Justice System*, 17 J. L. & Health 169, 212 (2004).

[42] *E.g.*, *id.* at 210-11.

[43] *See* THOMAS GRISSO & PAUL S. APPELBAUM, ASSESSING COMPETENCE TO CONSENT TO TREATMENT: A GUIDE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS 83 (1998).

techniques, and the line between a "forensic" encounter and a "clinical" one is too blurry to take an all-or-nothing approach to applying the traditional principles of medical ethics.

Furthermore, even if one were to concede that a psychiatric evaluation could be construed as merely and purely forensic at the outset, the encounter still might take on therapeutic characteristics as the evaluation process progresses. This is the critical point of Stone's parable involving the black Army sergeant. When an encounter initiated for forensic purposes begins to take on therapeutic qualities, does it not make sense that at least some of the ethical rules governing therapeutic encounters should then attach, even though the evaluations are being conducted in an ostensibly non-clinical setting?

Appelbaum's answer to this question seems to be that so long as the psychiatrist follows the "respect for persons" prong of his theory of forensic ethics, the psychiatrist need not worry about evaluees misconstruing the nature of the encounter – or at least, the psychiatrist need not worry about any additional ethical obligations attaching as a result of such a misconstruction.[44] According to Appelbaum, physicians need only act "to negate the risks associated with [their] role" by:

> undercut[ting] subjects' beliefs that [psychiatrists], acting in the usual way that physicians act, are placing subjects' interests above all other considerations. Although allowing subjects to hold such beliefs might be an effective means of gathering information, it is inherently deceptive and exploitive, and fails to respect subjects as persons.[45]

Consequently, Appelbaum asserts that so long as forensic psychiatrists "make clear to the subjects of their evaluations who they are, what role they are playing in the case, the limits on confidentiality, and – of particular importance – that they are not serving a treatment function," the requirement of respecting persons is met, and the rules of medical ethics need not attach.[46] At that point, the psychiatrist has discharged his function, and it is thereafter up to the evaluee to decide whether to "withhold cooperation from the evaluation – albeit often at some cost."[47] Put another way, Appelbaum seems to propose that so long as the psychiatrist makes reasonable efforts to notify his evaluees that he is not performing a therapeutic function, he need not be bound by any subsequent belief that the evaluees hold regarding the nature of a particular encounter.

This approach is unduly formalistic. In effect, it deems the mere provision of an explicit disclaimer sufficient to ensure that the encounter remains purely forensic without placing any restrictions on the subsequent use of psychiatric skills and tactics to gain the patient's cooperation. If the evaluator uses his skills as a psychiatrist to gain the trust and cooperation of the evaluee, the evaluee might reasonably believe that the encounter has become therapeutic in nature notwithstanding earlier

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[44] *See* Appelbaum, *Theory of Ethics*, *supra* note 3, at 240-43.

[45] *Id.* at 241.

[46] *Id.*

[47] *Id.* at 241-42. Appelbaum stresses that the evaluee can withhold his *cooperation* but not his *consent*, since obtaining the actual consent of a forensic evaluee generally is not necessary. *Id.* at 242.

disclaimers to the contrary. This is precisely what occurred in Stone's evaluation of the sergeant – the sergeant was notified at the outset that Stone was not acting as a therapist, but Stone's use of his psychiatric skills led the sergeant to make unguarded disclosures.[48] Appelbaum's approach does not explain why the provision of reasonable notice should be sufficient if the psychiatrist's subsequent actions directly undercut that notice and the encounter begins to take on therapeutic characteristics.

To draw an analogy with criminal procedure, the Supreme Court has held that the provision of otherwise valid and sufficient *Miranda* warnings does not immunize police from a finding of Fifth Amendment violations where the police's actions render the *Miranda* warnings ineffective, such as when officers employ "technique of interrogating in successive, unwarned and warned phases."[49] The reasoning behind such a rule is that in such circumstances, the suspect is likely to experience "bewilderment" regarding the effectiveness of the rights being read to him, and might "reasonably infer" that the new Miranda warning does not apply to incriminating statements made during unwarned phases of the interrogation.[50] Similarly, psychiatric evaluees might be bewildered if a psychiatrist begins using psychotherapeutic techniques after telling the evaluee that the encounter was non-therapeutic, and the evaluee might reasonably infer that the earlier warnings regarding the non-therapeutic nature of the encounter no longer apply.

Furthermore, and perhaps more importantly, in many cases there is some question as to whether even repeated disclaimers could be sufficient to make the evaluee truly understand that the physician evaluating him is not bound by the usual ethical obligations of physicians. First, "[c]ulturally shaped expectations of professional benevolence, encouraged by a clinician's empathic manner, may engender feelings of trust and, later, violation" even in supposedly non-therapeutic encounters.[51] Thus, it might be difficult for an evaluee to tell which 'hat' the psychiatrist is wearing regardless of whether the psychiatrist uses techniques designed to establish transference or countertransference, or other quintessential psychiatric techniques.

This possibility grows even stronger when there is some question as to the evaluee's competence, which is often the case with the subject of a forensic psychiatric evaluation. Indeed, psychiatrists are usually called in to perform a forensic evaluation precisely because someone has questioned the evaluee's competence, or at least his mental state. If a person such as Stone, who has devoted a considerable portion of his career to the study of medical ethics, can find it difficult to distinguish which 'hat' a psychiatrist is wearing during an evaluation, how likely is it that a potentially incompetent evaluee can tell? Even if the psychiatrist minimized his use of psychiatric techniques after the disclaimer, how could the psychiatrist know that such an evaluee understood the disclaimer itself? It does not appear that Appelbaum has addressed these issues in his explanation of why providing notice as part of respecting persons is sufficient to entrench an encounter as a purely forensic one.

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[48] *See* Stone, *supra* note 14, at 888.

[49] *See* Missouri v. Seibert, 542 U.S. 600, 609-11 (2004).

[50] *Id.* at 613.

[51] M. Gregg Bloche, *Clinical Loyalties and the Social Purposes of Medicine*, 281 J. AM. MED. ASS'N 268, 273 (1999) (hereinafter "Bloche, *Clinical Loyalties.*").

2. The Relevance of Medical Ethics in Non-Clinical Settings

Well before he laid out his own theory of forensic ethics, Appelbaum stated that "psychiatrists operate outside the medical framework when they enter the forensic realm, and the ethical principles by which their behavior is justified are simply not the same."[52] Indeed, Appelbaum has stated that if forensic psychiatrists were constrained by the traditional medical principles of beneficence and non-malfeasance, "their evaluations would be worthless to the courts."[53] Consequently, Appelbaum argues that the traditional rules of medical ethics *must* be abandoned in forensic settings.[54] However, even if one were to accept that a clear line could be drawn between forensic and therapeutic encounters, it does not necessarily follow that the principles of medical ethics should be discarded in forensic settings.

Both Stone and M. Gregg Bloche cite the public criticism of Dr. Grigson, a psychiatrist whose testimony helped send dozens of criminal defendants to death row, as an example of the public belief that the principles of medical ethics should not be wholly discarded in the forensic setting.[55] Appelbaum might respond by saying that Grigson's testimony was unacceptable not because he failed to follow the dictates of medical ethics, but rather because his testimony was based on an insufficient scientific basis, and thus failed the requirement of "truth-telling." However, the singling out of Grigson for criticism must stem from more than a belief that Grigson was dishonest or untruthful in his testimony; after all, exaggeration in expert witness testimony is hardly a fault unique to Grigson.

Instead, the strongest criticisms of Grigson stemmed from a belief "that Grigson, a physician, was successfully helping . . . send individuals to their deaths."[56] The image of a doctor even indirectly aiding an execution was simply too much for many scholars and laypeople to bear.[57] One must assume that it was a similar impulse that led the American Psychiatric Association to unequivocally state in its annotations to the American Medical Association Principles of Medical Ethics that psychiatrists should not participate in executions.[58] In the eyes of both professional and lay critics, Grigson was still supposed "to be wearing the medical mantle of beneficence and non-malfeasance in the courtroom," despite the fact that he was outside the usual clinical setting.[59]

Similarly, the criticism recently leveled at psychologists who participated in the interrogation of detainees in the War on Terror illustrates how members of the broader

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[52] Appelbaum, *supra* note 29, at 258.

[53] Appelbaum, *Theory of Ethics*, *supra* note 3, at 239.

[54] *See id.* at 237-39.

[55] *See* Stone, *supra* note 4, at 87-88; Bloche I, *supra* note 31, at 337-42.

[56] Stone, *supra* note 4, at 88.

[57] *See, e.g.*, Bloche I, *supra* note 31, at 337-42 (discussing the importance of doctors avoiding even the "*impression* that the doctor is working *primarily* for the executioner" (emphasis in original)); Dolin, *supra* note 41, at 211-16.

[58] *See* AM. PSYCHIATRIC ASS'N, THE PRINCIPLES OF MEDICAL ETHICS: WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY, princ. 1, annot. 4 (2006).

[59] Stone, *supra* note 4, at 88.

public as well as many professionals[60] expect mental health professionals to follow their codes of ethics even when working in non-clinical settings. The American Psychological Association amended their Code of Ethics in 2002 to state that psychologists may, in effect, ignore their usual ethical principles when those principles are in irreconcilable conflict with "law, regulations, or other governing, legal authority."[61] This amendment has been tied to the actions of some psychologists in assisting interrogators in settings such as Guantanamo Bay and Abu Ghraib.[62] In some instances, interrogators "play[ed] direct roles in breaking detainees down. The psychologists were both treating the detainees clinically and advising interrogators on how to manipulate them and exploit their phobias, according to complaints later lodged by some of the detainees' lawyers."[63]

The American Psychiatric Association rejected the path of its identically-initialed counterpart. As the president of the psychiatrists' association stated in 2006:

> When I read in the *New England Journal of Medicine* about psychiatrists participating in the interrogation of Guantanamo detainees, I wrote to the Assistant Secretary for Health in the Department of Defense expressing serious concern about this practice. In mid-October I found myself on a Navy jet out of Andrews Air Force Base, along with the top health leadership in the military and other leaders from medical and psychological organizations, on a 3-hour trip to Guantanamo Bay. . . . We were introduced to two psychologists on these teams, and we asked pointed questions about their practice and involvement in giving advice during interrogations. We were reassured repeatedly that although there may have been various "stress techniques" used in the past on detainees, today's interrogations focused on building rapport with detainees, as positive relationships were much more effective in gaining good information than anxiety-inducing stress that could rapidly evolve into frank torture.
> Not good enough. . . . I told the generals that psychiatrists will not participate in the interrogation of persons held in custody. Psychologists, by contrast, had issued a position statement allowing consultations in interrogations.
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> If you were ever wondering what makes us different from psychologists, here it is. This is a paramount challenge to our ethics and our Hippocratic training. Judging from the record of the actual treatment of detainees, it is

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[60] *See Redline Comparison of APA Ethical Principles of Psychologists and Code of Conduct, December 1992 and December 2002*, AM. PSYCHOLOGICAL ASS'N, at 3, *available at* http://www.apa.org/ethics/code/92-02codecompare.pdf (accessed May 20, 2017).

[61] *Id.*

[62] JANE MAYER, THE DARK SIDE: THE INSIDE STORY OF HOW THE WAR ON TERROR TURNED INTO A WAR ON AMERICAN IDEALS 196 (2008).

[63] *Id.*

> the thinnest of thin lines that separates such consultation from involvement in facilitating deception and cruel and degrading treatment.[64]

This is not, of course, meant to imply that the ethical waters are just as murky for a mental health professional evaluating someone for the purposes of a legal proceeding as they are for a mental health professional playing a role in the interrogation of a detainee. But the broader issue of whether psychiatrists should be held to their ethical principles in ostensibly non-clinical settings looms large in both instances, just as it does in discussions of Dr. Grigson. Likewise, the description of psychologists "treating detainees clinically" and "advising interrogators on how to . . . exploit their phobias"[65] illustrates the difficulty in drawing a line between "clinical" and "non-clinical" situations.

It is unwise to dismiss criticism of Grigson or the detainee psychologists as the symptom of the general public simply failing to understand the role of mental health professionals in non-clinical settings. Indeed, with respect to detainee interrogations, one may reasonably assume that public outrage would have been heightened further had the assisting professionals been psychiatrists – and thus subject to the Hippocratic oath – rather than psychologists. A number of scholars have noted that professionals and laypeople alike often view physicians as bound by medical ethics whenever they use the judgment and skill of a physician.[66] The ethical rules governing professions cannot exist in a vacuum isolated from public perception, and a great many observers from both inside and outside the medical profession believe – and will continue to believe – that physicians should adhere to the foundational principles of medical ethics in non-clinical as well as clinical settings. Psychiatrists cannot afford to simply ignore such perceptions.[67]

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[64] Steven S. Sharfstein, *Presidential Address: Advocacy as Leadership*, 163 AM. J. PSYCHIATRY 1711, 1713 (2006), *available at* http://ajp.psychiatryonline.org/cgi/content/full/163/10/1711 (accessed May 20, 2017).

[65] Mayer, *supra* note 62, at 196.

[66] *See* PHILIP J. CANDILIS ET AL., FORENSIC ETHICS AND THE EXPERT WITNESS 11-12 (Andrew Szanton ed. 2007) (collecting sources). This approach is discussed at length *infra* at Part III.A.

[67] *See, e.g.*, *id.*; Stone, *supra* note 4, at 88 (suggesting that public pushback stemming from existing social perceptions of the proper role of a physician "would have important professional consequences if forensic psychiatrists were to adopt Appelbaum's approach"). It should be noted that in some societies and legal systems, public perception of the role of psychiatrists may differ considerably. A recent article on forensic psychiatry in China indicates that in China's legal system, the lines between the clinical/therapeutic and forensic spheres of psychiatry are more clearly delineated. *See generally* Junmei Hu et al., *Forensic psychiatry in China*, 34 INT'L J. L. PSYCHIATRY 7 (2011). When engaged to provide opinions in legal proceedings in China, "[a] forensic psychiatrist is not just a medical doctor but a finder of truth." *Id.* at 9. While most forensic psychiatrists "carry out clinical work in other settings," forensic psychiatrists in China do not carry out "[t]reatment interventions." Organizations contracted to provide forensic opinions are expected to "be essentially impersonal and provide neutral assessment of any client." *Id.* at 9-10. Of course, public *perception* of the role of psychiatrists in China may differ from the legal responsibilities of forensic psychiatrists described in this article. The article suggests, however, that both the public perceptions and legal responsibilities of psychiatrists may vary between different legal systems and cultures.

B. Approach Two: Use of Medical Skill and Judgment

Another approach that has been adopted by some scholars is to view the rules of medical ethics as applicable whenever physicians make use of their professional knowledge, skills, and/or judgment.[68] As Bloche noted, "[s]ociety – and the legal system – look to forensic psychiatrists *because of their physicianhood*, not merely because they possess technical expertise."[69] Since forensic psychiatrists are hired precisely because of their status as medical experts in their field and because of the high esteem in which physicians generally are held, they are acting within their role as medical professionals and must be governed by the rules of medical ethics.[70] The primary justification for this view is that society at large expects physicians to retain some medical values even when they are acting in ostensibly non-clinical settings.[71]

One potential problem with this approach stems from the ambiguity surrounding what exactly constitutes the use of medical "skill" or "judgment." It is relatively easy to state that a physician who prescribes a drug for a diagnosed illness uses his medical judgment and skill while one who sets a listing price for the sale of his house does not. However, what if a cardiologist suggests to her friends over dinner that they increase their daily intake of potassium based on a study that she had recently read in a medical journal that potassium deficiency could contribute to heart disease? What about a family physician who recommends a particular antihistamine to a casual acquaintance he sees wandering the allergy medicine section of a pharmacy? In both cases, the physician is arguably using his or her medical knowledge, skill, and/or judgment, but it would seem unusual to characterize these encounters as creating a "doctor-patient relationship" in the traditional sense.

The ambiguous nature of what constitutes the use of medical skill and judgment leads to a second difficulty with this approach. As with Appelbaum's focus on the initial objectives of the encounter, the medical skill or judgment standard is an all-or-nothing approach. One might reasonably argue that the principles of beneficence and non-malfeasance should attach in some way to both of the scenarios described in the previous paragraph. For instance, many people would believe that the cardiologist in the former scenario had violated her responsibilities as a physician if, at the time she gave the casual advice, she knew that increasing intake of potassium would actually *increase* the risk of heart disease. It seems somewhat harsh, however, to imply the existence of a full doctor-patient relationship – with the attendant ethical and legal duties relating to loyalty and confidentiality – in either situation. It would be more appropriate to adopt instead an approach that would require the attachment of some ethical duties relevant to the particular situation, but not the full set of ethical rules that physicians must follow with their patients.

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[68] *See* CANDILIS ET AL., *supra* note 66, at 12.

[69] Bloche I, *supra* note 31, at 324 (emphasis in original).

[70] *See, e.g.*, *id.*; CANDILIS ET AL., *supra* note 66, at 12.

[71] *See, e.g.*, *id.* at 11-12; Bloche I, *supra* note 31, at 324-26. There may at least some circumstances where the public is actually *more* keen than psychiatric professionals to see traditional rules of medical ethics broken in order to prevent harm to others. *See* Myriam Guedj et al., *Is it acceptable for a psychiatrist to break confidentiality to prevent spousal abuse?*, 32 INT'L J. L. PSYCHIATRY 108, 111-13 (2009).

Finally, the basis for the medical skill and judgment approach appears to be detached from the perspectives of the individual evaluee and psychiatrist, and instead is based on general societal expectations regarding the responsibilities of physicians. While public perception inevitably plays some role in setting the ethical rules for all professionals, the purpose of the traditional rules of medical ethics is to ensure that physicians look after the interests of individual patients.[72] Consequently, one should take into account the expectations and perspective of the evaluee/patient in determining when a doctor-patient relationship forms and what rules of medical ethics should attach.

C. Approach Three: Psychiatric Evaluations as "Routine, Non-Invasive Procedures"

In terms of one of physicians' ethical duties – that of obtaining patients' informed consent – Paul Appelbaum has suggested an alternative way of viewing competency evaluations. A book on performing competency evaluations that Appelbaum co-authored with Thomas Grisso states that "when patients come for medical care . . . they or their appropriate surrogates consent at the outset to the performance of routine, non-invasive procedures that are part of that care," including psychiatric assessments of competency.[73] Thus, obtaining a patient's consent to a competency evaluation is unnecessary and would be akin to seeking consent before performing such mundane procedures as taking a patient's blood pressure.[74] Grisso and Appelbaum explicitly limit this proposition to those cases where psychiatric patients are presented for treatment by themselves or their families, a situation markedly different from court-ordered forensic evaluations.[75] Even given that limitation, however, the proposition that psychiatric competency evaluations are routine and non-invasive is questionable.

First,probing someone's thoughts and decision-making processes with pointed questions is a much more personal type of evaluation than taking someone's blood pressure or testing someone's reflexes. Consequently, assessing someone's decisional capacity and performing other psychiatric evaluations is more stressful for the subject than other common types of routine medical examinations. Furthermore, the mere fact that an assessment is being performed is an indication to the evaluee that someone is questioning his mental state and/or mental capacity, which can be a distressing realization in and of itself.

The results of a psychiatric competency evaluation could also lead to embarrassment and significant adverse consequences in both the employment and personal life of the evaluee due to the social stigma associated with a finding of impaired mental state.[76] In this regard, the performing of a competency evaluation

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[72] *See, e.g.*, CANDILIS ET AL., *supra* note 66, at 3; Bloche, *Clinical Loyalties*, *supra* note 54, at 268.

[73] GRISSO & APPELBAUM, *supra* note 43, at 83.

[74] *Id.*

[75] *Id.*

[76] *See, e.g.*, James T.R. Jones, *Walking the Tightrope of Bipolar Disorder: The Secret Life of a Law Professor*, 57 J. LEGAL EDUC. 349, 350 ("The stigma against people who have a mental illness is so great that job applicants with [bipolar disorder] fear to disclose it to potential employers; indeed, 'some vocational rehabilitation counselors . . . actually encourage their

could be more closely analogized to the administering of an HIV test, for which informed consent is nearly always required and confidentiality rules are strictly enforced due to the social stigma that accompanies public knowledge of a positive result.[77] An evaluee's awareness of the social consequences of a finding of incompetence or mental illness likely would add further stress to the encounter.

As mentioned above, the situation envisioned for the approach described by Grisso and Appelbaum was that of a private evaluation performed at the behest of the evaluee or his "appropriate surrogates" rather than a court-ordered forensic evaluation.[78] However, Grisso and Appelbaum's justification for not obtaining consent was based less on precisely which party requested the evaluation than on the supposedly "routine" and "non-invasive" nature of the evaluation. For the reasons stated above, that basis is inadequate, and if Grisso and Appelbaum applied this view of competency assessments to assessments whose results could be revealed in court, the above objections would become even stronger. Since any psychiatric evaluee could face potentially dire consequences depending on the outcome of the assessment, forensic evaluees almost certainly experience even greater stress connected to the assessment than individuals undergoing truly "routine" examinations.[79]

IV. LOOKING TO THE LAWYER-CLIENT MODEL

A few observations can be made in light of these prior approaches. First, none of the approaches directly account for either the evaluee's expectations and beliefs regarding the nature of the evaluation or the effect that the psychiatrist's actions during the course of the forensic evaluation might have on those expectations and beliefs. The preamble to the American Medical Association's Principles of Medical Ethics – and, by extension, the American Psychiatric Association's annotated version of the Principles – states that "a physician must recognize *responsibility to patients first and foremost*, as well as to society, to other health professionals, and to self."[80] Since the primary purpose of the rules governing the doctor-patient relationship is to protect the interests of the patient, it follows that any standard for determining when such a relationship forms should place considerable weight on the perspective of the putative

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clients to hide prior hospitalizations or to devise strategies for covering gaps in employment caused by mental illness.'") (internal citations omitted).

[77] *See, e.g.*, N.Y. PUB. HEALTH LAW § 2781 (McKinney 2010) ("[N]o person shall order the performance of an HIV related test without first having received the written or, where authorized by this subdivision, oral, informed consent of the subject of the test . . . ."); *id.* at § 2782 (generally prohibiting the disclosure of "confidential HIV related information"). Even when an HIV test is "routine" and initiated by a health-care provider, the patient's informed consent must be obtained and confidentiality is guaranteed. *See, e.g.*, *id.* at §§ 2781-82; Rahul Rajkumar, *A Human Rights Approach to Routine Provider-Initiated HIV Testing*, 7 YALE J. HEALTH POL'Y, L. & ETHICS 319, 325 (2007).

[78] GRISSO & APPELBAUM, *supra* note 43 at 83

[79] It is also worth noting that Grisso and Appelbaum refer to evaluees as "patients," which implies that a doctor-patient relationship exists on some level between the evaluator and evaluee. *See* GRISSO & APPELBAUM, *supra* note 43, at 83.

[80] THE PRINCIPLES OF MEDICAL ETHICS Preamble (Am. Med. Ass'n 2010), *available at* http://www.psych.org/MainMenu/PsychiatricPractice/Ethics/ResourcesStandards/Principles-of-Medical-Ethics-2010-Edition.aspx?FT=.pdf (emphasis added).

patient.[81] A system for determining which rules of medical ethics apply during forensic evaluations thus should give considerable weight to: 1) the perspective and expectations of the evaluee; and 2) the actions taken by the evaluating psychiatrist that shape the evaluee's perspective and expectations.

Furthermore, none of the previously proposed approaches consider the possibility that the attachment of the rules of medical ethics should be something other than an all-or-nothing affair. Given the ambiguous boundary between forensic and therapeutic encounters, it makes more sense to view the formation of a physician-patient relationship during the course of a psychiatric encounter as movement along a continuum ranging from a purely forensic relationship to a fully therapeutic relationship, and to attach only some obligations of medical ethics to relationships that fall in between those two extremes. The rules governing the lawyer-client relationship provide a model that includes all of these essential features.

A. Drawing Inspiration from the Lawyer-Client Relationship

The relationship between an attorney and his client is similar to the relationship between a psychiatrist and his patient in a number of ways. The fundamental ethical duties of both types of professionals are broadly analogous, with confidentiality and informed consent ranking high on the obligations placed on lawyers and psychiatrists alike.[82] Furthermore, as with all professionals, clients often approach both types of professionals in order to seek advice on how to solve particular, difficult problems in their lives. For lawyers and psychiatrists, prospective clients are often emotionally upset both about the underlying problem that led them to seek professional services and their inability to resolve it on their own.[83] Prospective clients often approach a lawyer as much out of a desire to talk through their problems with someone as out of a need to acquire a professionally-provided resolution to the problem.[84] Indeed, some have suggested that lawyers should acquire a basic understanding of psychological theory – including child development, transference and countertransference, and differential diagnosis of certain mental illnesses – in order to effectively practice

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[81] *Id.* One might reasonably question whether the interests of the patient *should* be the controlling purpose of the ethics rules governing doctor-patient relationships generally or psychiatrist-patient relationships in particular. Answering that fundamental question is beyond the scope of this article, but a couple short observations are in order. First, regardless of whether the interests of patient *should* be paramount in medical ethics, there is little question that they *are* paramount under the prevailing rules of medical ethics in the United States today, as the Preamble to the Principles demonstrates. Second, the ethical tension that forensic psychiatrists face when confronted with the "double agent" problem identified by Stone stems from the perception that serving the ends of the adversarial legal system is a betrayal of the individual evaluee, not a betrayal of broader categories of people or society.

[82] *Compare* MODEL RULES OF PROF'L CONDUCT 1.2 & 1.6, *with* THE PRINCIPLES OF MEDICAL ETHICS: WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY annots. to princ. 4 (Am. Psychiatric Ass'n 2006).

[83] *See, e.g.*, L.O. Natt Gantt, *More Than Lawyers: The Legal and Ethical Implications of Counseling Clients on Nonlegal Considerations*, 18 GEO. J. LEGAL ETHICS 365 (2005).

[84] *See, e.g., id.*

certain types of law.[85] Moreover, there is significant literature devoted to how attorneys can most effectively represent with clients with diminished capacity, which is the subject of Model Rule 1.14.[86]

Thus, just as in psychiatric evaluations, the widely varying and frequently changing expectations that a prospective legal client might have make it difficult to determine when exactly an encounter between a lawyer and a potential client creates a formal "lawyer-client relationship." Courts and bar associations have generally confronted the difficult issue of the formation of lawyer-client relationships by focusing on the presence (or absence) of the quintessential elements of lawyering. Section 14 of the *Restatement (Third) of The Law Governing Lawyers* (hereinafter "*Restatement*") states that:

> A relationship of client and lawyer arises when:
> (1) a person manifests to a lawyer the person's intent that the lawyer *provide legal services for the person*; and either
> (a) the lawyer manifests to the person consent to do so; or
> (b) the lawyer fails to manifest lack of consent to do so, and *the lawyer knows or reasonably should know that the person reasonably relies on the lawyer to provide the services . . . .*[87]

Comment e to § 14 further expands on subsection (1)(b) by explaining the importance of the client's expectations in determining whether and when a lawyer-client relationship arises:

> Even when a lawyer has not communicated willingness to represent a person, a client-lawyer relationship arises when the person reasonably relies on the lawyer to provide services, and the lawyer, who reasonably should know of this reliance, does not inform the person that the lawyer will not do so. In many such instances, the lawyer's conduct constitutes implied assent. In others, the lawyer's duty arises from the principle of promissory estoppel, under which promises inducing reasonable reliance may be enforced to avoid injustice. In appraising whether the person's reliance was reasonable, courts consider that *lawyers ordinarily have superior knowledge of what representation entails and that lawyers often encourage clients and potential clients to rely on them*.[88]

As for what exactly constitutes "legal services," courts and commentators have largely approached the problem by focusing on the lawyer's provision of legal advice or assistance and the client's reasonable reliance on that advice or assistance. In what

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[85] *See* Pauline H. Tesler, *Collaborative Law: A New Paradigm for Divorce Lawyers*, 5 Psychol. Pub. Pol'y & L. 967, 988 (1999).

[86] *See, e.g.*, David M. Boulding & Susan L. Brooks, *Trying Differently: A Relationship-Centered Approach to Representing Clients With Cognitive Challenges*, 33 INT'L J. L. PSYCHIATRY 448 (2009).

[87] RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 14 (2000) (hereinafter "RESTATEMENT") (emphasis added).

[88] *Id.*

has become a widely-quoted formulation of the rule governing the formation of the lawyer-client relationship, the Iowa Supreme Court held in the 1977 case *Kurtenbach v. TeKippe* that a lawyer-client relationship arises when "(1) a person seeks advice or assistance from an attorney, (2) the advice or assistance sought pertains to matters within the attorney's professional competence, and (3) the attorney expressly or impliedly agrees to give or actually gives the desired advice or assistance."[89] The phrasing has been adopted as case law by many states,[90] and the legal encyclopedia *American Jurisprudence* quotes it verbatim in its entry on the creation of the lawyer-client relationship.[91] The focus on the giving of legal advice as sufficient to infer the creation of a lawyer-client relationship stems from the widespread perception among lawyers and laymen alike that the very essence of lawyering is the provision of legal advice and the formulation of a course of action to resolve the client's problem.[92]

Both the *Restatement* and the ABA's *Model Rules of Professional Conduct* (hereinafter "*Model Rules*") provide that lawyers owe some duties to prospective clients even if no lawyer-client relationship ultimately forms. Model Rule 1.18(b) states that "[e]ven when no client-lawyer relationship ensues, a lawyer who has had discussions with a prospective client shall not use or reveal information learned in the consultation" where the information could not be used or revealed with respect to an actual former client.[93] The Restatement also states that the ethical duty of confidentiality applies to information learned from prospective clients[94] and that the protection of the attorney-client evidentiary privilege extends to prospective clients.[95] Furthermore, the Model Rules and the Restatement both state that a lawyer cannot represent a potential new client whose interests are materially adverse to those of a former prospective client, if the potential client's case is substantially related to the matter about which the former prospective client approached the lawyer.[96] Thus, the attachment of a lawyer's ethical duties is not all-or-nothing, and some duties attach even if a full, formal lawyer-client relationship never actually forms.

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[89] Kurtenbach v. TeKippe, 260 N.W.2d 53, 56 (Iowa 1977). For the applicability of each of these elements in the forensic psychiatric context, see *infra* Part IV.B.

[90] *See, e.g.*, State *ex rel.* Stivrins v. Flowers, 729 N.W.2d 311, 341-42 (Neb. 2007); Herbert v. Haytaian, 678 A.2d 1183, 1188 (N.J. 1996); Bays v. Theran, 639 N.E.2d 720, 723 (Mass. 1994).

[91] *See* 7 Am. Jur. 2d Attorneys at Law § 137 (2008).

[92] *See generally* MODEL RULES OF PROF'L CONDUCT Preamble ¶ 2 ("As advisor, a lawyer provides a client with an informed understanding of the client's legal rights and obligations and explains their practical implications . . . . As an evaluator, a lawyer acts by examining a client's legal affairs and reporting about them to the client or to others."). *See also id.* ¶¶ 8-12 (discussing how lawyers' ethical obligations stem from the need to preserve public confidence in the legal system and the legal profession).

[93] MODEL RULES OF PROF'L CONDUCT R. 1.18(b) (2010) (emphasis added).

[94] *See* RESTATEMENT § 15(1)(a).

[95] *See id.* § 70.

[96] *See id.* § 15(2); MODEL RULES OF PROF'L CONDUCT R. 1.18(c).

B. Applicability to Doctor-Patient Relationship

The applicability of the second of the three *Kurtenbach* elements to the forensic psychiatric setting is relatively clear, since the entire reason that psychiatrists are asked to perform forensic evaluations is that such evaluations are believed to be within psychiatrists' professional competence. The first and third elements, however, require some explanation. For the first element, while court-ordered forensic evaluations and many other forensic encounters do not start with the evaluee "seeking advice or assistance from" the psychiatrist, an analogous situation arises when the evaluee starts to think of the psychiatrist as his doctor. Such a belief might be formed due to the evaluee's misapprehension of the nature of the encounter, the psychiatrist's use of therapeutic techniques ordinarily associated with clinical encounters, or some combination of the two. In such situations, the evaluee likely would expect the evaluating psychiatrist to be bound by the same ethical obligations as a clinical physician even though the evaluee may never seek medical advice *per se*. Where the psychiatrist fails to dispel this expectation but nonetheless continues the evaluation, it could be said that the psychiatrist has impliedly agreed to the creation of a therapeutic relationship with the evaluee, thus fulfilling an expectation analogous to that contemplated by the third element of the *Kurtenbach* approach.

These rules governing the lawyer-client relationship suggest at least three possible approaches for determining when a psychiatrist-patient relationship forms. The first approach would be to use the presence of a forensic evaluee's reliance on either medical advice or assistance (*e.g.*, prescribing drugs as part of a treatment plan) as the key factor in determining whether a psychiatrist-patient relationship exists. This approach might make sense for most fields of medicine, but its utility is somewhat doubtful in some types of clinical psychiatric practice, particularly those involving psychoanalysis and talk therapy. As described above, the evaluee may come to think of the psychiatrist as his doctor without ever doing anything that would constitute "seeking medical advice." Furthermore, the verbal exchanges between an evaluee and his psychiatrist alone might be seen as sufficient to establish a relationship even if the psychiatrist never prescribes any medications or provides any treatment plan, since the interaction itself can be the core of a psychoanalytic or psychotherapeutic relationship.[97]

A second approach suggested by the lawyer-client model is to distill the essential elements of the traditional psychiatrist-patient relationship (in the same way that the provision of legal advice or assistance has been deemed essential to the lawyer-client-relationship) and then use the presence or absence of those essential features as the guideposts for determining whether such a relationship exists. The use of this approach in psychiatric settings prompts the question of what exactly constitutes the "essence" of a psychiatric encounter. This question is not a simple one due to the enormous variety of clinical settings in which psychiatrists practice and the wide range of analytic and therapeutic techniques that psychiatrists use. Indeed, it seems a virtual impossibility to focus on any single action or class of actions as the "essence" of psychiatric practice. Thus, as with the "medical advice or assistance" approach, the diversity of psychiatric methods and practices makes it difficult to devise rules based upon the "essential features" of psychiatry.

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[97] *See, e.g.*, HEINRICH RACKER, TRANSFERENCE AND COUNTERTRANSFERENCE 23-70 Int'l Universities Press (1995) (discussing classical techniques of psychoanalysis).

The final approach would be to focus on the reasonable expectations of the evaluee and the psychiatrist's efforts to affirm or dispel those expectations. A rule embodying this idea could be written to parallel the current § 14 of the *Restatement's* rules governing the lawyer-client relationship:

> During the course of a psychiatric evaluation, a doctor-patient relationship forms between the psychiatrist and the evaluee when:
> The evaluee forms a reasonable belief that the evaluating psychiatrist is acting as his or her physician; and
> (a) the psychiatrist explicitly affirms the evaluee's belief; or
> (b) the psychiatrist fails to disaffirm that belief and the psychiatrist knows or reasonably should know that the evaluee reasonably believes that the evaluating psychiatrist is acting as his or her physician[98]

If these requirements are met, the psychiatrist could not later disclaim the existence of the relationship by arguing the encounter was initiated for forensic purposes.

Using the "reasonable evaluee" as the focus of the inquiry would provide a number of advantages. By placing the focus on the perspective of the evaluee rather than on the perspective of the psychiatrists, it upholds the evaluee's dignity and remains true to the patient-centric ethos of the medical profession. Since the focus is not solely on subjective expectations but rather on reasonable beliefs, however, the inquiry would remain objective – an essential feature since some psychiatric evaluees suffer from mental disorders that may lead them to form unreasonable beliefs.

When determining whether the evaluee's belief is reasonable and whether the psychiatrist reasonably should be aware of that belief, the inquiry should focus on the various techniques and actions that a psychiatrist might use that could lead an evaluee to believe that the psychiatrist was acting as his doctor. For example, if the psychiatrist provided an outpatient treatment plan in order to treat a mental disorder that the psychiatrist detected during the course of the evaluation, the psychiatrist's conduct would signal to a reasonable evaluee that the evaluating psychiatrist had begun acting as his physician. Since the key perspective is that of the evaluee rather than the psychiatrist, the fact that the evaluating psychiatrist never consciously intended to form a doctor-patient relationship with the evaluee is not determinative. Instead, the inquiry focuses on the psychiatrist's actions and how a reasonable evaluee would interpret those actions.

The rule also should be written so that the attachment of medical ethics rules is incremental rather than all-or-nothing. A full therapeutic relationship with all the attendant ethical duties could be implied if, as described above, the evaluee's belief arose after the psychiatrist prescribed a drug or treatment plan. In such cases, the full panoply of medical ethics rules would attach. The psychiatrist should refuse to testify if doing so would be harmful to the evaluee-patient's interests, and courts that recognize a doctor/patient privilege could exclude the psychiatrist's testimony if the evaluee-patient invokes the privilege.[99] On the other hand, if the belief arose after the use of psychiatric skills designed to establish analytic transference and/or countertransference (as with Stone and the sergeant), only a subset of the ethical duties

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[98] *Cf.* RESTATEMENT, *supra* note 87.

[99] In such cases, of course, another psychiatrist who has not established a therapeutic relationship with the evaluee could be brought in to conduct the forensic psychiatric evaluation.

required in full therapeutic relationships would attach. For instance, the psychiatrist might only be required to maintain a limited duty of confidentiality – *e.g.*, being allowed to reveal information learned during the course of the evaluation only to the court and attorneys of record.

The creation of the physician-patient relationship during the course of an ostensibly forensic evaluation and the attachment of ethical duties thus could be viewed as movement along a continuum rather than the crossing of a bright line. This approach seems appropriate given the fluid and potentially ambiguous nature of psychiatric evaluations.[100] This would parallel in some ways the legal ethics approach towards individuals who consult with an attorney but do not become "full" clients. The attorney owes such individuals a duty of confidentiality and a limited duty of loyalty, but not the full panoply of ethical duties that attach in a true lawyer-client relationship.[101]

C. Conflicts of Interest and Advance Waivers and Warnings

The "double agent" problem that forensic psychiatrists face can also be analogized to another concept in lawyer-client relationships – conflicts of interest.[102] As a general rule, a lawyer faced with a conflict of interest must withdraw from his representation of the client or clients whose representation creates the conflict of interest. In many cases, however, lawyers may proceed with a representation despite the existence of a conflict of interest provided that each client (or former client) provides informed consent, thereby waiving his right to conflict-free counsel.[103]

One of the most difficult questions regarding conflict waivers is the extent to which clients may provide advance waivers, whereby the client agrees to waive conflicts of interest that may arise in the future. Clients cannot possibly anticipate all possible conflicts that may arise during the course of a lawyer's representation. If a conflict arises that the client did not or could not anticipate at the time he agreed to the waiver, he may attempt to question the validity of the earlier waiver. The issue then becomes whether the client's past waiver or present wishes should be determinative.

In that respect, advance waivers of conflicts of interest can be analogized to advance directives for treatment, a topic familiar to psychiatrists.[104] As with clients who agree to advance waivers, a key question that arises with advance directives is whether a directive should apply if circumstances change in a manner that the patient did not anticipate at the time he signed the directive.[105] Important issues with both

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[100] *See supra* notes 34-43 and accompanying text.

[101] See *supra* notes 78-81 and accompanying text.

[102] Under the *Model Rules*, a conflict of interest exists if "the representation of one client will be directly adverse to another client" or if "there is a significant risk that the representation of one or more clients will be materially limited by the lawyer's responsibilities to another client, a former client or a third person or by a personal interest of the lawyer." MODEL RULES OF PROF'L CONDUCT R. 1.7.

[103] *See* MODEL RULES OF PROF'L CONDUCT r. 1.7(b); MODEL RULES OF PROF'L CONDUCT r. 1.9(a)-(b).

[104] *See, e.g.*, Richard L. O'Reilly, *The Capacity to Execute an Advance Directive for Psychiatric Treatment*, 31 INT'L J. L. & PSYCHIATRY 66-71 (2008).

[105] *Id.* at 69.

types of documents include the interplay between whether the patient/client anticipated the altered circumstances, whether following the directive remains in the best interests of the patient/client, and whether the patient's/client's present or past expressed wishes should control.[106] Similar considerations are at play in a forensic psychiatric encounter when an evaluating psychiatrist disclaims the ordinary rules of medical ethics and informs the evaluee that he is not acting as the evaluee's doctor. If a therapeutic relationship begins to form later in the evaluation process, one may reasonably question whether the psychiatrist's "advance disclaimer" was sufficient to relieve him of his usual duties as a physician.

Here too, one can look to the rules governing the lawyer-client relationship as a model. In the legal world, the prevailing approach to advance conflict waivers focuses on whether the client was likely to understand the nature of potential future conflicts at the time the client provided consent.[107] Courts and ethics codes generally focus on two factors: 1) the degree of specificity provided in the waiver about the potential conflicts and attendant risks, and 2) the reasonable expectations that the client might form therefrom with regard to future conflicts, which turns largely on the client's sophistication and experience with legal services.[108] Later-arising changes in the circumstances or expectations surrounding the representation can nullify the effectiveness of the advance waiver:

> If a material change occurs in the reasonable expectations that formed the basis of a client's informed consent, the new conditions must be brought to the attention of the client and new informed consent obtained. If the new conflict is not consentable, the lawyer may not proceed.[109]

Where a non-consentable conflict arises, the lawyer must withdraw from representing the client in order to avoid violating his ethical duties.[110]

For these reasons, lawyers are well-advised to maintain an open line of communication with clients regarding potential conflicts, even when an advance waiver is already in place. In fact, some courts have held that lawyers should go back and obtain a second waiver from the client if a conflict actually arises, even though such a rule largely nullifies the purpose of obtaining an advance waiver in the first

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[106] In the case of advance directives, there is the additional complicating factor of whether the patient has the capacity to make decisions as to medical treatment, which also is an issue with forensic psychiatric evaluees. Thus, any adaptation of the rules governing advance conflict waivers to the arena of forensic psychiatry must take into account the increased possibility of diminished capacity.

[107] *See* MODEL RULES OF PROF'L CONDUCT r. 1.7 cmt. 22; RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS §122 cmt. D (AM. LAW INST. 2000).

[108] *See supra* note 91.

[109] RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS §122 cmt. D (AM. LAW INST. 2000). Comment 22 to Model Rule 1.7 similarly provides that "advance consent cannot be effective if circumstances that materialize in the future are such as would make the conflict nonconsentable" under Rule 1.7(b). *See* MODEL RULES OF PROF'L CONDUCT r. 1.7 cmt. 22.

[110] *See* MODEL RULES OF PROF'L CONDUCT r. 1.16(a)(1).

place.[111] The extra protection provided to clients who agree to such waivers is justified because the relationship between lawyer and client is fiduciary in nature and not merely a contractual arrangement[112] – a feature that is also true of doctor-patient relationships.[113]

Ordinarily, psychiatrists performing court-ordered forensic evaluations need not obtain their evaluees' informed consent before performing a forensic evaluation, and the relationship between a forensic psychiatrist and an evaluee does not implicate fiduciary duties. However, even Appelbaum concedes that a forensic psychiatrist must at least warn evaluees that he is not acting as the evaluee's physician.[114] Furthermore, an evaluating psychiatrist is in a far better position than his evaluee to discern the nature of their relationship and his knowledge of his ethical and legal obligations. Consequently, principles similar to those governing advance waivers in the attorney-client context can also be used to analyze the adequacy of forensic psychiatrists' warnings to evaluees.

Specifically, forensic psychiatrists should be required to make a reasonable effort to make their evaluees aware that some of the traditional rules of medical ethics do not apply to the forensic evaluation, including and especially limitations on the traditional duties of beneficence, non-malfeasance, and confidentiality. Drawing from the *Model Rules'* approach to advance conflict waivers, the adequacy of these warnings should be analyzed by reference to: 1) the degree of specificity used in describing the limitations and 2) to the evaluee's sophistication and suspected mental state. For instance, when disclaiming the duties of beneficence and non-malfeasance the psychiatrist should first explain those duties in terms that the evaluee is reasonably likely to understand.

Furthermore, changes in the evaluee's expectations regarding the nature of the encounter and the relationship between himself and the evaluating psychiatrist might nullify the effectiveness of earlier warnings. Just as attorneys are not immune from future conflict of interests simply because they obtained an initial waiver, psychiatrists should not be immune from all requirements of medical ethics if they give an initial warning and then engage in conduct that establishes a therapeutic relationship with the evaluee. When a psychiatrist becomes aware that the evaluee's expectations have changed, he should provide further warnings to dispel the altered expectations regarding the encounter. This, perhaps, is where Stone crossed an ethical boundary in his evaluation of the sergeant; once the sergeant's expectations changed, Stone apparently made no effort to reemphasize and clarify the nature of their relationship. In some sense, by continuing the evaluation without ensuring that the sergeant still understood the obligations that Stone owed (and did not owe) to him, Stone was 'leading the sergeant on' by taking advantage of the sergeant's altered expectations.

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[111] *See* Pamela Phillips, *Advance Conflict Waivers: How to Make Them More Enforceable*, *in* PRACTICING LAW INST., Handling Intellectual Property Issues in Business Transactions 463 (2007).

[112] *E.g.* Worldspan, L.P. v. Sabre Group Holdings, Inc., 5 F.Supp.2d 1356, 1358 (N.D. Ga. 1998).

[113] *E.g.* U.S. v. Brogan, 238 F.3d 780, 783 (6th Cir. 2001) (listing the doctor-patient and lawyer-client relationships as two of the classic examples of fiduciary relationships).

[114] *See* Appelbaum, *Theory of Ethics*, *supra* note 3, at 241.

Of course, given the mental state of many forensic psychiatric evaluees, there will be cases where even repeated warnings cannot suffice to bring the evaluee's expectations back in line with those that the forensic psychiatrist attempted to establish at the beginning of the evaluation process. When that occurs and the requirements for the creation of a doctor-patient relationship have been met,[115] the psychiatrist should thereafter adhere to the rules of medical ethics.[116] If such adherence proves impracticable or insufficient to cure the ethical problems created by the evaluee's altered expectations, the psychiatrist should halt the evaluation process. This can be analogized to the situation where a nonconsentable conflict of interest arises in an attorney-client relationship, thus requiring the attorney to withdraw from the relevant representation(s) notwithstanding the existence of advance waivers.[117]

V. CONCLUSION

"While general psychiatry has been circumscribed from the vast influence it once had, forensic psychiatry has instead been entrusted with more and more authority during latter decades."[118] Thus, the applicability of the traditional rules governing medical ethics in forensic psychiatric encounters has become an increasingly important topic of discussion for the past four decades, and is likely to remain a hotly disputed issue for decades to come. Until now, the importance of the perspective and expectations of forensic evaluees has largely been ignored in the search for suitable approaches to the subject.[119] Furthermore, scholars have largely failed to recognize that, given the fluid nature of forensic psychiatric evaluations, rigid approaches that

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[115] *See supra* Part IV.B.

[116] *See Id.* As described in that section, the doctor-patient relationship should be viewed as points along a continuum, and if the rules are written to reflect this view, the psychiatrist might only be required to adhere to a subset of the ethical rules that attach in full therapeutic relationships.

[117] Ordinarily, attorneys must withdraw from representing the relevant client(s) if continued representation would violate the ethical rules governing conflicts of interest, even if the attorney had already secured an advance waiver with the clients' informed consent. *See supra* notes 96-97 and accompanying text.

[118] Henrik Anckarsäter et al., *Mental Disorder is a Cause of Crime: The Cornerstone of Forensic Psychiatry*, 32 INT'L J. L. & PSYCHIATRY 342, 347 (2009).

[119] This could be viewed as being part of a broader problem with a legal system that generally discounts the rights and perspectives of people suspected of mental illness, perhaps most notably by ordering forced medication and commitment when mental health professionals deem it appropriate. *See generally, e.g.*, Ragnfrid Eline Kogstad, *Protecting Mental Health Clients' Dignity – The Importance of Legal Control*, 32 INT'L J. L. & PSYCHIATRY 383 (2009). Moreover, at least some psychiatric scholars have suggested that active participation in the legal system may be *inherently* incompatible with medical ethics because it reinforces "a system where mentally disordered offenders are systematically treated less favourably than other offenders" despite the fact that modern science does not sufficiently support "a presumption that people who commit crimes under the influence of mental disorders are generally more dangerous than other offenders." Nilsson et al, *supra* note 2, at 404-405. Under such a view, forensic psychiatry presents two separate ethics problems – one concerning professional ethics (the subject of this article), and the other concerning social justice. *Id.* The crux of the latter ethical dilemma is that even encounters that are clearly non-therapeutic might nonetheless violate medical ethics because the legal system itself systematically favors outcomes that are not in the best interests of persons with mental disorders. *See id.*

require either the attachment of all rules of medical ethics or else the attachment of none at all are woefully out of place in the forensic setting. Perhaps if Stone had the benefit of a more flexible and evaluee-focused ethics model such as the one proposed in this article, he could have better navigated the "double agency" problem that arose with the Army sergeant.

If there is one lesson that should be learned from the prior approaches to the question of medical ethics in forensic settings, it is that the issues surrounding forensic psychiatric encounters do not lend themselves to quick and easy-to-remember formulations. If this article achieves its goal, however, scholars and practitioners alike will take greater notice of the importance of flexibility and the need to weigh the expectations of evaluees when choosing whether and when to adhere to the traditional rules of medical ethics during forensic psychiatric evaluations.