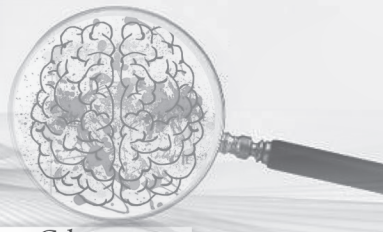

Chapter

1

Introduction

Forensic psychiatry is the branch of medicine that deals with disorders of the mind and their relation to legal principles. The word "forensic" means belonging to the courts of law. Psychiatry and the law intersect when dealing with the social deviants who, by violating the rules of the society secondary to some presumed or proposed mental disorder, adversely affect the functioning of the community.

The social deviant is a potential threat to the safety and the security of other people. The "legalization" of psychiatry has led to increasing practice of defensive medicine. Defensive practice converts patients into litigants. Clinicians have to defend themselves. Patients readily sense the shift from the clinician's interest in the patient to the clinician's self-protection. The patient's feeling triggers litigation. The therapeutic alliance is broken.

On a sheet with his letterhead a psychiatrist typed a warning to the employer that his patient, John Jones, had expressed the desire to kill him (the employer). He sent the letter by first-class mail, not express or registered, and he addressed it not to the employer but to the personnel department of the company. Subsequently liability, suit for breach of confidentiality was faced by him. He wondered, "but I was only doing what the law requires of me"!

HISTORY OF FORENSIC PSYCHIATRY

Indian legal system is by and large based on the British legal system. The role of law in the development of modern psychiatry was extensive, particularly after the 18th century and reflected both a growing public awareness of problems raised by mental disorder and community's need to express and enforce measures to manage the problems. Religion and utilitarian philosophies were influential in English public life during the 19th century and coloured the contemporaneous calls for the reforms of asylums, prisons and the legal system. Thus the English Act of 1774 was replaced sequentially by the Country Asylum Act 1808, then by the English Lunacy Act 1853, then by the Lunacy Act 1891, and later by the Mental Health Act 1959 in order to make fresh provisions for treatment and care of mentally disordered; provisions were made for informal admission of mentally ill to any hospital or nursing home without application or order for detention. Now the primary concern was the welfare and treatment of the individual patient which was left to the doctors, social workers and hospital managers. The Act was further amended in 1983. As far as the European countries are concerned, the literature claims about the relationship between law and psychiatry even in Greece and Rome 2000 years ago in a limited way. By the 14th century, the legal

status of the insane person was well defined, two issues central to the forensic psychiatry of today were already being discussed: the responsibility of the mentally ill person and the way he should be dealt with within the community. In the 17th century, a very elaborate medicolegal perception of the individual has been achieved. It was the judge who decided whether the individual was insane and it was his (individual's) relatives who asked that he be placed in custody. In 1808, the term 'Psychiatric' appeared for the first time. Among the achievements at that time, first was the separation of mentally disordered from other prisoners while second was the creation of asylums and reorganization of the existing institutions. By early 20th century, the use of psychiatric experts and the general influence of psychiatry in the criminal justice system were enhanced.

Coming to the Indian scenario, even though diagnosis and treatment of mental illnesses have been well documented in Ayurveda, Charak Samhita and Susruta Samhita, etc. the legal aspects pertaining to the mental illnesses have not been mentioned anywhere in the ancient Indian literature before the arrival of the British. The first lunatic asylum was established by the British at Calcutta in around 1787. The purpose of these asylums was not the care and treatment of the mentally ill but to shut them off in places far away from towns to rid the society of them, while at the same time protecting them against themselves. Law relating to the custody of lunatics and management of their estates was introduced in India through three separate acts viz. Lunacy (Supreme Court) Act 1858, The Lunacy (District Courts) Act 1858, and the Lunatic Asylum Act 1858. The Acts were modified in 1883 and more elaborate instructions and guidelines for admission and treatment of lunatics were outlined. A central supervision of the mental hospital was established in 1906. This was brought out in the form of the Indian Lunacy Act of 1912. In 1920, the names of all lunatic asylums were changed to mental hospitals and the control of mental hospitals was shifted from prison authorities to civil surgeons.

In 1946, the Health Survey and Development Committee, popularly known as the 'Bhore Committee' was asked to survey mental hospitals. As it reported that majority of the mental hospitals in India were quite out-dated and were not designed for curative treatment of the inmates, the Mental Health Act was enacted in 1987 and enforced from 1993. Again after 20 years, it has been revised as the Mental Health Care Act 2010 and its implementation is under process. It aims to provide access to mental health care for persons with mental illness and to protect and promote the rights of persons with mental illness during the delivery of mental health care.

PSYCHIATRISTS AND THE COURTS

The complexity of medicolegal matters is divided into two sides, which pull away from each other trying to place the truth in the hands of the fact finder (the judge or the jury). The clinician gets exposed to merciless cross-examination, feels fear, revulsion, and dismay. These feelings are tempered somewhat by insights into the process. From the clinician's viewpoint an important distinction must be made regarding the clinician's role as a witness.

WITNESS OF FACT

The witnesses' input—the facts—are his direct observations and material from direct scrutiny. A witness of fact may be a psychiatrist who reads portions of the medical record aloud to bring it into the legal record and thus make it available for testimony. Any psychiatrist at any level of training can have that role.

EXPERT WITNESS

In contrast, a psychiatrist under certain circumstances may be qualified as an expert. The qualifying process, however, consists not of popular recognition in one's clinical field but of being accepted by the court and both sides of the case as suitable to perform expert functions. Thus the term "expert" has particular legal meaning and is independent of any actual or presumed expertise the clinician may have in a given area. The clinician's expertise is elucidated during direct examination and cross-examination of the clinician's education, publications, and certifications. In the context of the courtroom, an expert witness is one who may draw conclusions from data and thereby render an opinion—for example, that a patient meets the required criteria for commitment or for an insanity defense under the standards of a jurisdiction. Expert witnesses play a role in determining the standard of care and what constitutes the average practice of psychiatry.

COURT-MANDATED EVALUATIONS

In some cases the judge asks clinicians to be consultants to the court, which raises the issue of for whom the clinicians work. Because clinical information may have to be revealed to the court, clinicians may not enjoy the same confidential relationship with their patients in those situations that they have in private practice. Clinicians who make such court ordered evaluations are under an ethical obligation and, in some states, a legal obligation to so inform the patients at the outset of the examinations and to make sure that the patients understand that condition. Such court-mandated evaluations were supported by the Supreme Court of the United States in Ake *vs* Oklahoma. The Court held that, when a state allows a defense of sanity, it must provide funds for a psychiatric expert for an indigent defense. Such an expert may be part of the defense if appropriate.

COMPETENCE TO BE EXECUTED

A new area of competence to emerge in the interface between psychiatry and the law is the question of the patient's competence to be executed. The requirement for competence is thought to rest on three general principles. First, the patient's awareness of what is happening is supposed to heighten the retributive element of the punishment. Punishment is held as meaningless unless the patient is aware of what it is and to what it is a response. The second element is a religious one; competent persons about to be executed are thought to be inthe best position to make whatever peace is appropriate with their religious beliefs, including confession and absolution. Third, the competent person about to be executed preserves until the end the possibility (admittedly slight) of recalling some forgotten detail of the events of the crime that may prove exonerating.

DURHAM RULE

In the Durham case, Judge Bazelon expressly stated that the purpose of the rule was to get good and complete psychiatric testimony. He sought to release the criminal law from the theoretical straitjacket of the M'Naghten rule. However, judges and juries in cases using the Durham rule became mired in confusion over the terms "product", "disease" and "defect." In 1972, some 18 years after the rule's adoption, the Court of Appeals for the District of Columbia, in United States *vs* Brawner, discarded the rule. The court—all nine members, including judge Bazelon—decided in a 143-page opinion to throw out its Durham rule and to adopt in its place the test recommended in 1962 by the American Law Institute in its model penal code, which is the law in the federal courts today.

MODEL PENAL CODE

In its model penal code the American Law Institute recommended the following tests of

criminal responsibility: (1) Persons are not responsible for criminal conduct if at the time of such conduct, as a result of mental disease or defect, they lacked substantial capacity either to appreciate the criminality (wrongfulness) of their conduct or to conform their conduct to the requirement of the law. (2) The term "mental disease or defect" does not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct.

Subsection I of the American Law Institute rule contains five operative concepts: (1) Mental disease or defect, (2) Lack of substantial capacity, (3) Appreciation, (4) Wrongfulness, and (5) Conformity of conduct to the requirements of law. The rule's second subsection, stating that repeated criminal or antisocial conduct is not of itself to be taken as mental disease or defect, aims to keep the sociopath or psychopath within the scope of criminal responsibility.

RESPONDENT SUPERIOR

The Latin phrase respondent superior expresses the axiom, "Let the master answer for the deeds of the servant". That doctrine holds that a person occupying a high position in a chain or hierarchy of responsibility is liable for the actions of a person in a lower position. A typical example is the psychiatric attending physician who supervises a resident. By the same reasoning, when a state hospital, for example, is named in a lawsuit, the list of cited defendants may extend upward to include the commissioner of mental health and the governor of the state. After the traditional first response, the attorneys usually weed out the irrelevant defendants.

Firstly, consultation from outside the line of clinical responsibility often does not fit the model. The consultant is an adviser, not a superior. Secondly, the question of the particular defendant's authority (whether that person can hire and fire, censure, or control subordinates in the system) is relevant to the assignment of blame. Thirdly, as a rule, psychiatrists should remove themselves from situations in which they bear responsibility (liability) for the practice of other professionals but cannot control the activities of those persons or perform their own assessments of the patients. In addition, psychiatrists should clarify ambiguities of responsibility at the point of entry into a system.

SEXUAL RELATIONS WITH PATIENTS

Although maintaining sexual relations with patients is not a common form of malpractice, it is not rare enough. The most common form is heterosexual relations occurring in an outpatient context between a male therapist and a female patient, but all other permutations have come to light and to litigation.

Sexual relations with a patient is considered a breach of the fiduciary (trust-based) relationship of physician to patient and a negligent failure by the physician to work correctly with transference and counter transference issues in a manner consistent with the standard of care. The usual harms identified are the failure to provide treatment during the affair, the misuse of time that might be spent in treatment elsewhere, the creation of severe difficulties for future therapy, and the direct emotional harms of guilt, depression, anxiety, shame, humiliation, and suicidal intent.

Sexual relations with a patient under any circumstances (usually including ex-patients) is unethical, a deviation from the standard of care, and, therefore, proscribed. Many social activities that are not overtly sexual are highly suspect (one famous case involved a therapist's taking tea with a patient). As a form of liability prevention, such activities should also be avoided.

SUICIDE AND SUICIDAL ATTEMPTS BY PATIENTS

Suicide and suicidal attempts are the most frequent causes for lawsuits against psychiatrists. An estimated one out of every two suicides leads to a malpractice action. Psychiatrists may be charged with negligence because they did not properly control a patient under treatment; such negligence causes injury, and the suicidal behavior must have been predictable. The psychiatrist may be judged with malpractice, in decreasing order of culpability, during the patient's hospitalization, while the patient is out of the hospital on a pass, and during outpatient treatment. Supervision is greatest during hospitalization, and supervision is least during outpatient treatment.

NEGLIGENT TREATMENT

Typical claims allege inadequate or insufficient treatment (under-treatment), excessive or overly aggressive treatment (over-treatment), and variations on the theme of improper treatment, such as using the wrong medication, failing to anticipate or respond to side effects appropriately, and creating iatrogenic harms or addictions.

PREVENTING LIABILITY

Preventive approaches: (1) Clinicians should provide only those kinds of care that they are qualified. They should take reasonable care of themselves; they should treat their patients with respect; (2) The documentation of good care is a strong deterrent to liability. A clinician who takes the trouble to obtain a consultation (second opinion) in a difficult and complex case is unlikely to be viewed by a judge careless or negligent; (3) The informed-consent process involves a discussion of the inherent uncertainty of psychiatric practice and helps prevent a liability suit.