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while most have highlighted the need for changes in the Part I clinical examination, there is little mention of what changes, if any, can be made to improve the Part II clinical examination.

It is my opinion that, having initiated the change to the OSCE format for the Part I clinical exam, the College would, inevitably have to review the current long case format in the Part II exam. The debate, I hope, will start sooner rather than later.

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Psychiatric secrets of success: who wants to be a specialist registrar?

Naeem's excellent and informative article (*Psychiatric Bulletin*, November 2004, **28**, 421–424) provided useful tips and advice for trainees aiming for higher specialist training as specialist registrars. However, we would like to point out certain factual inaccuracies which require further clarification.

First, the College's *Higher Specialist Training Handbook* (Royal College of Psychiatrists, 1998) clearly states that higher specialist trainees in lecturer posts who do five or six clinical sessions become eligible for a single certificate of completion of training (CCT) (formerly CCST) after 3 years. It is only when they do 4 clinical sessions that the single CCST is after 4 years.

Second, overseas doctors who are non-European Economic Area nationals and do not have indefinite leave to remain in the UK, are also eligible to apply in open competition for type I specialist registrar training programmes leading to CCT (Department of Health, 1998). If appointed, they are provided with a visiting national training number (VNTN). They can then also apply to the Immigration and Nationality Directorate (IND) of the Home Office for permit-free training leave to remain in the UK. This can be further extended by up to 3 years at a time depending on the training needs of the individual and satisfactory progress (UK Visas, 2004). The VNTN automatically becomes a NTN once the doctor gains indefinite right to remain in the UK. Overseas doctors without UK indefinite residence leave therefore are not limited to taking up fixed-term training appointment (FTTA) or type 2 posts, which do not lead to award of CCT, and conversely FTTAs are not limited to overseas doctors without residency rights.

DEPARTMENT OF HEALTH (1998) *A Guide to Specialist Registrar Training*. Leeds: NHS Executive.

ROYAL COLLEGE OF PSYCHIATRISTS (1998) *Higher Specialist Training Handbook*. Occasional Paper OP43. London: Royal College of Psychiatrists.

UK VISAS (2004) *Guidance-Permit Free Employment*. (INF 14). (http://www.ukvisas.gov.uk).

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the college

The psychiatrist, courts and sentencing: the impact of extended sentencing on the ethical framework of forensic psychiatry

Council Report CR129, June 2004

Professor Nigel Eastman, Professor John Gunn and Dr Mike Shooter, on behalf of the Royal College of Psychiatrists, provided a College response to the consultation paper on extended sentences, issued by the Sentencing Advisory Panel in June 2001. This followed a ruling by the Court of Appeal that sentencing guidelines should be issued to judges on the use of extended sentences. Sections 80 and 85 of the Power of Criminal Courts (Sentencing) Act 2000 replaced certain sections, dealing with extended sentences, of two previous acts namely the Crime and Disorder Act 1998 and the Criminal Justice Act 1991. The Power of Criminal Courts (Sentencing) Act 2000 gave powers to courts to impose additional supervision or a longer than commensurate sentence on sexual and violent offenders 'to protect the public from serious harm from the offender'. The College response was met with a wide spectrum of opinion within the Forensic Executive. The Executive therefore determined to have a seminar on the role of psychiatrists in court, concentrating particularly on the use of psychiatric evidence where longer than normal sentences are being considered. That seminar was held on 6 December 2002 at the Commonwealth Institute and involved: the Executive of the Forensic Faculty, the Ethics Committee, Royal College of Psychiatrists and the Confidentiality Committee, Royal College of Psychiatrists.

The seminar was structured around four presentations: In what circumstances should psychiatrists attempt to predict violence by the mentally disordered? Science and ethics, Nigel Eastman; Risk psychiatry and the courts, Tony Maden; Psychiatric evidence in the court room, John O'Grady; Psychiatrists in the court: black robes and white coats, Gwen Adshead.

There followed a wide range of discussion by participants at the seminar. This paper seeks to gather together these presentations and discussions and presents a summary based around various themes. Particular points or views are not credited to any particular person and the four presentations are amalgamated into the body of this report rather than being individually reported.

The issues raised were profoundly complex and, not surprisingly, where issues of personal morality and ethics were concerned, there was a wide variation in individual executive members' response. There was a common feeling of intense unease in relation to our work with courts and public protection agencies. What clearly emerged was that there is no current adequate ethical framework to address the profound issues we face in our interface with public protection/criminal justice system. This is of very particular concern to forensic psychiatrists but we believe that the issues we face, because of our day-to-day interaction with the criminal justice system, will not be confined to forensic psychiatrists only but will be of concern to all psychiatrists. There was representation from the Child and Adolescent Faculty at our meeting and they confirmed that child psychiatrists equally face profound ethical dilemmas in their everyday work, particularly when issues of child protection reach the courts. These concerns are likely to be amplified greatly for all sections of the College if the proposals of the new Mental Health Bill reach Parliament and eventually form the basis of a new Mental Health Act.

Why are there ethical dilemmas?

The basic dilemma that faces forensic psychiatrists is their dual role. Most forensic psychiatrists act as catchment area forensic psychiatrists responsible for comprehensive services to a specified geographical area, and with gatekeeping functions in regard to secure services (both National Health Service and private). However, in the interaction with the criminal justice system, the forensic psychiatrist is also responsible to courts and other criminal justice agencies when they provide reports on their behalf.

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Traditional medical ethics assumes a confidential individual centred doctor–patient relationship. However, when working with the courts (or other criminal justice agencies, including multi-agency public protection arrangements [MAPPAs]) there are also responsibilities that have to be discharged in regard to the courts or other agencies. The patient is not necessarily a free agent in that there is always a degree of coercion in their agreement to undergo a psychiatric assessment for court purposes. The introduction of longer than normal sentences and sentencing criteria that explicitly use psychiatric diagnoses, such as discretionary life sentences, place psychiatric testimony at the centre of sentencing decisions by the courts. MAPPAs expect psychiatric services to be active partners in risk decisions and to share information with other agencies where there are significant issues of public protection involved. What is clear is that neither traditional medical ethics nor the advice produced by the Royal College of Psychiatrists (2004) in *Good Psychiatric Practice* are adequate to address the ethical dilemmas involved in the practice of forensic psychiatry (and other branches of psychiatry).

Case law in British courts has gradually defined a role for psychiatric evidence when courts make decisions to impose longer than normal sentences. For example, Lord Lane in Wilkinson (R. *v.* Wilkinson 1983) stated that a discretionary life sentence 'was reserved broadly speaking, for offenders who, for one reason or another, cannot be dealt with under the Mental Health Act [1983] yet whose mental state makes them dangerous to the life or limb of members of the public'. The criteria for a discretionary life sentence include that the offence must be grave enough to require a very long sentence, the offender must be a person of mental instability who presents a grave danger to the public and that it must appear that the offender will remain unstable and a potential danger for a long or uncertain time. Many other examples could be given but the point to note is that these guidelines, laid down through successive judgements, require psychiatric evidence in court on diagnosis, prognosis and associated risk. Gradually, these judgements have resulted in legislation that allows longer than normal sentences to be imposed. The Criminal Justice Act 1991 gave the courts powers to impose longer than normal sentences for offenders convicted of violent or sexual offences. Section 4(1) of that same Act includes a statutory requirement to obtain a medical report on an offender 'who is or appears to be' mentally disordered. This present seminar arose from a decision by the Court of Appeal to issue guidance for judges on the use of extended sentences under Section 85 of The Powers of Criminal Courts (Sentencing) Act 2000. That discussion document involved mention of mental disorder and the use of psychiatric evidence in order to assist the courts in determining the 'correct' sentence. Recent publication of the Sexual Offences Act 2003 further extends the role of psychiatrists in court, as evidence will be required on the state of mind of the defendant and the victim in order for the criteria for conviction to be fulfilled.

Extended and discretionary life sentences are about deactivating the risk posed to others, not changing it. A convicted person's claim to justice (in terms of fairness and equality) is overridden by the larger social group's claim for self-protection and forms the justification used to underpin these sentences. The argument is strictly utilitarian and therefore relies heavily on good quality evidence for its moral coherence.

Psychiatry is a medical discipline and psychiatrists are first and foremost doctors, both in their technical training and in the ethical core within which they work. Society's expectation of psychiatrists to provide evidence in court that will inform sentencing may be seen as being at variance with the proper role of medically qualified psychiatrists. Many psychiatrists would then argue that their role should be confined solely to consideration of therapeutic benefit to the patient. Others, however, may see themselves as not only doctors but also as citizens participating in society's laws and structures. Some may see themselves as filling a public health role in preventing violence. The European Convention of Human Rights not only provides rights for individuals but also a right for individuals to be protected from harm that may arise through the action of others. Psychiatrists may therefore see themselves as having a duty to participate in procedures that provide that human right to be protected from harm from others.

What emerges from this brief discussion of the interplay between psychiatric evidence and extended sentencing is the need to have an ethical framework that will provide psychiatrists with robust guidance on how to act properly as doctors when providing evidence in court where non-welfare decisions may be made, such as extended sentences or discretionary life sentences.

Duties to third parties

The core purpose of medicine is the identification and treatment, or at least amelioration, of human pain, disease and distress. For many medical conditions, it is convenient to consider the pathology as existing within the individual and to treat accordingly. However, for mental disorders, that disorder exists in the context of relationships, family, workplace and society. There is a known association (ignoring for the purposes of this argument any issues of causation) between mental disorder and violence. A violent act carried out in the context of mental disorder will have effects, not only on that individual, but upon their family, the victim, the victim's family and wider society. The European Convention of Human Rights acknowledges this in the statement that there is a human right to be protected from known risk from others. Is it therefore part of the core purpose of the medical specialty of psychiatry to identify, treat or, at least, ameliorate the effect of and consequences of violence associated with mental disorder? Some would argue that this approach would extend to the point of there being a public health perspective on the prevention of violence within populations of people who are mentally disordered. Such an approach seems explicit in the provisions of the proposed new Mental Health Act that might allow for the detection of people with mental disorder who pose a significant risk to others, not necessarily on the basis of benefit to them, but on the management of their condition to prevent violence. This is an issue that is wider than the issue of psychiatric involvement in giving evidence to court, impacting, as it does, on core mental health legislation and society's expectation of psychiatrists. The breadth or limits of psychiatrists' duty to third parties is in urgent need of clarification within the overall framework of medical ethics.

Breadth or limits of the psychiatrist's welfare role in court

A court request for a psychiatric report on a defendant, who potentially faces a longer than normal sentence, may not simply be a request for an opinion on a welfare disposal but also an opinion on mental disorder and risk that may then justify a longer than normal sentence. If the defendant is deemed to be mentally disordered and a welfare disposal under the Mental Health Act 1983 recommended, then the defendant can be seen to have benefited from the report. In that case, there would be no significant ethical issue involved. On the other hand, if that same defendant is seen and deemed to be mentally disordered but no welfare disposal is recommended, that same medical opinion may be used by the court to justify a longer than normal sentence. Where there is no doubt and a thorough examination is carried out in hospital under Section 38 of the Mental Health Act 1983, the court is likely to have even greater detail on diagnosis and risk. If such a report concludes that the

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defendant (usually someone with personality disorder) is 'untreatable', the justification for longer than normal sentence may be that much greater.

Given these dilemmas, the first question is whether or not to assess the individual (that is, whether to 'engage'). For some, there will be no limit imposed upon them arising from the nature of the request, even if that request is being directed solely at public protection. This would be based either upon adoption of what has become termed the 'forensicist' position (that is, in so doing, you are not acting as a doctor and therefore can be involved ethically in giving evidence in court that may result in enhanced punishment or preventative detention). Although it is a neat solution to the ethical dilemmas involved in court work, such an extreme position is unlikely to be acceptable to forensic psychiatrists in this College. The arguments are complex but essentially it is difficult to see how a doctor can be other than a doctor when examining a defendant. There can be no escape from the ethical demands of being a medical practitioner. American commentators have recognised this and some, such as Alvin Stone (1984), have concluded that forensic psychiatrists cannot operate within a framework of medical ethics. It is by no means certain that this will be accepted by the whole profession as is evident by the knowledge that doctors might consider participation in the risk assessment board in the Scottish judicial system where that role is explicitly one of risk assessment for judicial purposes only.

Psychiatrists who would argue for an ethical framework giving primacy to the twin bedrocks of traditional medical ethics, namely beneficence and non-maleficence, can argue coherently that it is not part of their social role to assist the state in pursuing public protection where there is no medical condition that can be treated in the individual who poses a threat. Put simply, doctors properly use medical skills towards medical purposes and not towards punishment and public protection. It is clearly part of medicine's duties to treat an individual's mental disorder and thereby to improve public welfare as a knock-on effect. Following that argument, psychiatrists can conclude that it is not ethically part of medicine to assist the courts in increasing punishment and public protection by applying medical skills to such a purpose.

A less extreme version of the 'forensicist' position would be that doctors operate in court within the general ethical framework of justice ethics. Such a view might conclude that it is in everybody's interest that there is good quality evidence before the court in relation to making just decisions. It is unjust for only one side to have access to evidence that is relevant. What conclusions a professional reaches in regard to ethical duties in relation to others, as in the previous section, would be relevant to this argument. A defendant may argue that they have a fundamental right to have medical evidence presented in court in order for just decisions to be made regarding a sentence. Society may argue that the human rights of others to be protected from risk requires courts to consider the association between mental disorder and violence in making decisions on sentences. Following that argument, to effectively withhold evidence from the court would be deemed unethical as such a stand would undermine the proper application of justice.

A further position that could underpin an ethical framework for forensic psychiatrists' involvement in court might rest upon an alibi that, whatever the court's stated purpose, there must always be some possibility of finding a disorder and a disorder that is treatable. Given that, at the point of accepting papers from court, it will be impossible to determine in advance whether such a conclusion could be reached, it could be assumed that there is always some prospect of individual welfare thus placing no ethical limit upon medical assessment for the criminal justice system.

Others operating from an ethical framework based on traditional medical ethics would require there to be some prospect of individual health benefit, or at least welfare, in order for the assessment to be ethically acceptable. A further extension of this position might be to act only for the defence when clearly the assessment is within a framework of potential benefit to the defendant. An ethical framework for this position would require consideration of the consequences of not carrying out an evaluation. These may include depriving defendants of a court report that might have led to a welfare disposal, providing evidence of the absence of mental disorder that could mean that a longer than normal sentence would not be passed or there being a lack of availability of mitigating findings.

A further issue to be considered is at what point mental disorder and risk should be considered when a defendant moves through the criminal justice system. Parole decisions and discretionary life panels often routinely request medical reports in determining suitability for early release or release on a life licence. Some prisoners may find that a psychiatric assessment is carried out near to the point of their release from prison if they are considered to be at high risk. They may then have the double jeopardy of not only receiving a prison sentence but then being transferred to hospital at the end of the sentence. There may be an ethical argument for ensuring that disagreements regarding mental disorder and risk are considered early on at the point of sentencing when the court, rather than doctors, can decide these issues.

Reporting findings: mental disorder and risk

Once an assessment has taken place, the findings will be presented to court. These findings will relate the presence or absence of mental disorder, assessment of risk and translation of medical findings into legal language (e.g. psychopathic disorder within the Mental Health Act 1983, abnormality of mind for a plea of diminished responsibility). Except for the extreme 'forensicist' position in the USA, more psychiatrists agree that there is no room for psychiatric evidence in the absence of mental disorder. The problem then is how narrow or wide to define that term 'mental disorder'. Mental disorder is not a neutral term but has a high 'value' component, exemplified by the diagnosis of personality disorder. Can one comment, for instance, on a defendant with abnormal personality traits not amounting to a clear diagnosis of personality disorder? Such evidence might be relevant, for example, in considering a community rehabilitation order or as mitigating circumstances for sentencing. Is paedophilia in the absence of other mental disorder a condition that psychiatrists can properly present evidence for to the court?

This becomes even more important when one considers the question of reporting findings on risk. This paper cannot examine in detail the very complex arguments regarding the validity of risk assessment. There appears to be a consensus view among British forensic psychiatrists that clinical assessment has an ethically justifiable edge over other risk measures because they are individually sensitive and dynamic. Actuarial risk measures should therefore be presented in the context of a clinical assessment. The other side of this argument is not often discussed, namely whether clinical assessment without actuarial risk assessment in tandem can be ethically justified. Risk assessment essentially leads to probability statements about future behaviour. Clinical risk assessment (especially when combined with actuarial) is better than chance in assessing future risk but falls far short of near certainty predictions. When a risk assessment is being carried out within a risk management paradigm where that estimate can be continuously adjusted according to changing circumstances or response to treatment, then the modest ability to predict future risk is less problematic. In the court context, decisions are dichotomous (for example, Mental Health Act 1983 disposal *v.* prison sentence). Risk assessment is, in that context, a one-off assessment not open

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to continuous refinement. For the judicial system, there is the ethical issue of whether sentencing based on such probability data is just. Given case law and statute on longer than normal sentences and discretionary life sentences, it is hard to see how courts can escape sentencing decisions based on probability assessments of risk. Does that bring with it an ethical obligation on psychiatrists to participate in justice decisions by making available to the court their assessments of risk where the defendant has mental disorder? Those arguing from a societal perspective with its duties to third parties could argue that unjust decisions are inevitable if psychiatric evidence on mental disorder and risk is not available at the point of sentencing. This opens up the issue of who owns medical information and what rights society has to expect doctors to participate in the court process. This is discussed below.

The courts have a further option in the case of personality disorder to make use of a hybrid order under Section 45 of the Mental Health Act 1983. This blurs further the role of psychiatric evidence and risk assessment as it explicitly requires consideration of both a prison and hospital component to the defendant's care.

In the Scottish jurisdiction, for high-risk defendants likely to attract longer than normal sentence or discretionary life sentence, the proposed new risk assessment board, which will presumably involve psychiatrists, seems explicitly to adopt this position. For those who would argue for an ethical framework that limits psychiatric involvement to welfare considerations, this position would be unacceptable as it would clearly place no limit on the types of defendants or prisoners who might be subjected to medical comment on their risk. A coherent argument against the presentation of psychiatric evidence to courts where longer than normal sentences are considered can be put forward on the basis of, first, the ethical obligation on doctors to adopt a welfare role in relation to those they evaluate, and second, risk assessment can only be adequately reliable and valid if it is conducted within an ongoing clinical and therapeutic context. This latter argument could lend support by suggestion that the person evaluated thereby becomes a 'patient' and therefore it is only ethically justifiable to present findings of risk to the court where there is some prospect of benefit to the assessee.

The increasing availability of treatment options within prisons brings further dilemmas for the psychiatrist. Those treatment options include:

- Dangerous and severe personality disorder prison-based programmes
- Expanding availability of therapeutic community places in prisons
- Programmes such as the Cognitive Enhanced Thinking Programmes.
- Sexual Offender Treatment Programmes (not available in the National Health Service [NHS] except in special hospitals)
- Substance Misuse Treatment Programmes.
- Possibility of transfer from prison to hospital for specific treatment but with eventual return to prison to complete sentence.

If the welfare of the prisoner is the prime medical consideration, should the psychiatrist in their opinion and risk assessment address options for treatment in prison?

One further consideration with regard to risk assessment is whether risk assessment can be considered a medical investigation, for which valid informed consent is necessary. This is discussed further below.

Who owns medical information?

In considering whether it is ethically justifiable for psychiatrists to give expert testimony, which may have as its endpoint a decision by the court to have a longer than normal sentence, one consideration is whether the state has a valid claim on expert testimony. The state does take an interest in the regulation of medical people. Nazi doctors were condemned for using their medical skills for political purposes, as were Soviet psychiatrists. It is therefore hard to argue that the professional's expert knowledge is private to the doctor to be used only as they see fit. There is both social and legal condemnation of doctors who use their medical knowledge for morally unacceptable purposes. The operation of the General Medical Council, although independent of the state, is regulated by parliamentary statute. Does it follow from the state's interest in medical matters, that the state has a legitimate claim to medical skills and knowledge in the operation of justice and, hence, for sentencing purposes?

If one accepts that the state has a valid claim on expert testimony, who then sets the limits on the use of medical knowledge by the state, especially where the state acts repressively towards its citizens? To work ethically in a system where the state has a valid claim on expert testimony requires a just state to underpin the practice of justice.

If the doctors accept an ethical position in which they participate in court proceedings without taking the stance that they will do so only where there is a benefit to the welfare of the patient, this raises the issue of the appraisee's consent to such procedures. One argument may be that, as long as the psychiatrist explains to the person assessed what the parameters of their meeting are and attempts to be as objective as possible, there is no violation of a duty to the assessee. The counter argument is that, notwithstanding an attempt by a psychiatrist to explain their position, the appraisee may find it extremely difficult to treat the doctor as other than a doctor and psychiatrists will not be able to eliminate a 'therapeutic' aspect to their assessment. These considerations argue powerfully for there to be a reasonable separation between the evaluation role and treatment role. Within a British system where the forensic psychiatrist may be acting as a catchment area psychiatrist and gatekeeper to facilities, it is not possible for there ever to be a complete separation between the evaluation and treatment roles. Defendants required by the court to have a psychiatric report before sentencing are in a situation where there is a great deal of coercion involved in their 'consent' to a psychiatric report.

The arguments rehearsed above on the presentation to court on risk assessment findings leads to consideration of whether risk assessment should be considered a medical investigation and therefore require the assessee to give informed valid consent to that investigation being conducted. Given the level of coercion involved in a defendant being required by the court to undertake a psychiatric evaluation, the practical implications of refusal to participate in a risk assessment, merits consideration.

Training and regulation of doctors

The complex issues raised in this paper, ranging as they do from technical issues, such as a proper application of risk assessment methods, to ethical concerns around the role of the psychiatrist in court, make a powerful argument for these issues to be addressed formally during the training of psychiatrists. Competencies for providing psychiatric reports to court and giving evidence should form part of the training of all psychiatrists but, most particularly for child and adolescent psychiatry and forensic psychiatry.

The regulation of expert witnesses in court is a complex subject and is being addressed for non-medical experts. Appraisal and revalidation of psychiatrists is at a relatively early stage of development. The College should address how to incorporate into appraisal and revalidation competency to provide evidence in court. Much court work is category 2, which falls outside normal NHS work, or can form part of a psychiatrist's private practice. There is a danger that court work

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routinely will not be addressed at appraisal and revalidation.

Conclusion

Much of the divide among forensic psychiatrists regarding their role rests on the extent to which individual forensic psychiatrists understand their responsibilities towards third parties where there is concern about interplay between mental disorder and risk. Those forensic psychiatrists who would understand their duties as arising both from their responsibilities as doctors and as participants in society structures on laws, might argue that there is an ethical obligation to provide medical evidence to courts, including their professional opinion on risk. Others would confine their role to a welfare role and only involve themselves in such work where there is a realistic prospect of benefit to the patient. Such diversity in practice and underlying ethical framework raises profound issues for forensic psychiatrists.

This paper has not sought to reach a definitive conclusion on an ethical framework for psychiatrists' participation in court work (and increasingly in other structures within the criminal justice system and public protection systems). Instead the breadth and diversity of opinion is highlighted together with underlying beliefs and ethical frameworks. Specialist registrars in training who commented on these ethical issues concluded that defendants are most likely to be fairly treated by psychiatrists who are painfully aware of the tension inherent in trying to reconcile conflicting ethical imperatives. It follows that the training of tomorrow's forensic psychiatrists must incorporate training on ethics to ensure that practitioners have a particular awareness of the profound ethical dilemmas that are integral to forensic work.

Whatever position individual forensic psychiatrists take on their role within courts, there does appear to be a certain amount of common ground. Forensic psychiatrists in the College consider themselves first and foremost as doctors and would not accept the forensicist position adopted in the USA. There is acceptance that defendants in court will see the psychiatrist primarily as a doctor and expect that psychiatrists act within some framework of medical ethics. There is wide agreement that psychiatrists should only provide evidence to court where there is mental disorder, although the boundaries of mental disorder are by no means clear. There is wide acceptance of the need, as far as possible, to separate out court appraisal and treatment roles. There is an emerging consensus that only clinical risk assessment can be considered as ethically acceptable. The other side of the argument, that is whether it is ethically acceptable to provide a clinical risk assessment without incorporating actuarial risk assessment merits further debate.

Further considerations

The seminar did not consider international codes and practices. These need to be considered as work proceeds. Some doctors regard medicine as owing allegiances to standards and codes that transcend national legislation. Indeed there is a move within the international community for this to happen on a much broader front than within medicine.

Further work needs to be done on:

- What are the duties of psychiatrists towards third parties in relation to the prevention of harm to third parties where there is some association between risk and mental disorder?
- Consideration of who owns medical information in the sense of whether there is a legitimate call on medical expertise in the courts by the state.
- Guidance on consent to court reports and, hence, consent to complete or partial disclosure of findings.
- Consideration of whether risk assessment can be considered to be a medical investigation and as such, requiring the same rigour in obtaining full consent as other medical investigations that may carry significant risks of harm to the patient. It is questionable whether defendants in court understand that risk assessment may be used for decision-making in court outside of the medical context.
- Incorporating international codes and practices into a College ethical framework.
- Addressing awareness of ethical dilemmas and competency in court work into the training of specialist registrars.
- Examining how competency in court work can be incorporated into continuing professional development, appraisal and revalidation.

R. v. Wilkinson [1983] 5 CR AppR(s) 105.

ROYAL COLLEGE OF PSYCHIATRISTS (2004) *Good Psychiatric Practice* (2nd edn) (Council Report CR125). London: Royal College of Psychiatrists.

STONE, A. A. (1984) The ethical boundaries of forensic psychiatry – a view from the ivory tower. *Bulletin of the American Academy of Psychiatry and the Law.*

Annual elections – Council and the Court of Electors

Notice to Members and Fellows

Members are reminded of their rights in connection with the forthcoming elections for the vacancies on the Court of Electors and Council. There are 5 vacancies on the Court of Electors. There are vacancies for 2 Fellows and 3 Members on Council.

The nominating meeting of the Council will be held on 24 January 2005 and the last date for receiving nominations from the membership will be Wednesday 23 February 2005. Nomination forms are available from Andrea Woolf: e-mail: awoolf@rcpsych.ac.uk

The relevant Bye-laws and Regulations are printed below. Please note that constitutional changes are currently under consideration, and that the terms of office listed below may be altered.

Bye-law XXI – the Court of Electors

2. The Court of Electors shall be composed of:
   (a) The President, Dean and Registrar, each of whom shall be an ex-officio member of the Court of Electors; and
   (b) Fifteen Electors who shall be chosen in the manner hereinafter prescribed from amongst the Fellows.
4. At the first meeting of the Council in alternate years after the name of the President for the next ensuing College year has become known, the Council shall nominate a sufficient number of candidates for appointment as Electors to ensure an election, which will be held by a postal ballot of all Members of the College in the manner prescribed by the Regulations. Additional nominations may be lodged with the Registrar between the beginning of the then current calendar year and the end of four clear weeks after the meeting of the Council above referred to. No such nominations shall be valid unless it be supported in writing by twelve Members of the College and accompanied by the nominee's written consent to serve if elected.

Regulation XIX – the Council

2. Elections shall be held in alternate years to ensure that there are not less than six elected Members of Council and no more than six elected Fellows of the Council subject to the overall condition that no elected Member or Fellow shall serve on Council for more than six years in that capacity without a break of at least one year. At its first meeting in each alternate College year after the name of the President for the next ensuing College year has become known, the Council shall nominate the necessary number of Members and Fellows of the College to ensure that there are no more than six elected Fellows and not less than six elected Members serving on Council. Any nominee who is proposed and seconded and gives his or her consent in writing to

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