The Ethical Dilemmas of Forensic Psychiatry: A Utilitarian Approach

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The problem of defining a set of ethical principles that will guide mental health practitioners in their interactions with patients is not limited to forensic psychiatry. All aspects of psychiatric practice have ethical implications, and these are particularly complex when the psychiatrist's allegiances are not directed entirely toward the patient. Any psychiatric function that obligates the psychiatrist to evaluate patients for purposes that serve the interests of social or private agencies may support actions on the part of agencies that patients perceive as harmful. There are obvious ethical problems for members of a healing profession who participate in activities that may harm their patients. The problems are similar whether that harm is created by courtroom testimony or by virtue of the psychiatrist submitting a written or oral report to an agency.

The first part of this article is an effort to define general principles that might assist psychiatrists in assessing the ethical dimensions of all types of forensic and social functions. In elaborating on these principles, I emphasize that process of procedural aspects of our social and forensic functions must be given special attention in dealing with ethical conflicts. Once defined and discussed, these principles will then be considered as they apply to one of psychiatry's most important social and forensic roles, the involuntary commitment of dangerous patients.

The "Double-Agent" Role

The ethical problems of social and forensic psychiatry were eloquently described by Thomas Szasz in the early 1960s when he distinguished contractual from institutional psychiatry.[1] In contractual psychiatry, patients volunteer for treatment. Nothing is done to or for them without their consent. Information they disclose to psychiatrists is protected from the scrutiny of others. In institutional psychiatry, psychiatrists are employed by the government or some agency. The agency employed psychiatrist relates to a patient primarily to serve some need of that agency. This is the major reason for the physician-patient interaction. In the course of the examination interview, the psychiatrist may have some concern with the needs of the patient. It is never clear, however, where the psychiatrist's allegiances really lie. The psychiatrist may attempt to be the agent of the institution or the state and the agent of the patient at the same time. (Szasz described the psychiatrist in this role as a double agent.) According to Szasz, the psychiatrist will inevitably lean toward meeting the needs of whoever pays his or her salary or fee. This means that the patient may experience harm as a result of participating in the evaluation process.

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Some examples involving use of the double-agent role are interviewing patients for the purpose of civil commitment, examining offenders in the process of sentencing, examining applicants for an insurance policy, or examining students who have been mentally ill to see if they can be allowed to return to school. One of the most significant ways in which the double-agent role differs from the traditional practice of psychiatry is that it is not accompanied by any guarantee of confidentiality. Psychiatrists who take on the double-agent role usually are obligated to report to someone else much of what their patients tell them. As a result of the psychiatrist's findings, the patient may be given a longer prison sentence; may be committed to a mental institution; may be deprived of a job, an opportunity to enter school, or a license to engage in his or her profession. This poses an obvious moral question for the physician who is trained in the doctrine of "primum non nocere."

There are ethical problems other than the risk that the psychiatrist may hurt the patient. Whatever harm results from a psychiatric evaluation is occasioned by the psychiatrist using skills designed to help people. In a commitment evaluation, a sentencing evaluation, or an insurance evaluation, the psychiatrist is obligated to learn about the patient's disability. This can be done only if the patient communicates in a verbal or nonverbal fashion. If the psychiatrist is to report accurately, it is important that the patient's communication be as complete and reliable as possible. The patient must disclose behavior, thoughts, or feelings that would not be revealed in most social situations. To obtain honest self-disclosure, the psychiatrist uses certain skills. He or she tries to be straightforward, friendly, reinforcing, and, above all, empathic. Without use of these skills, the psychiatrist is not much more efficient than a lay person. It is almost impossible for a competent psychiatrist to conduct a psychiatric examination without being selectively reinforcing and empathic. Herein lies the most difficult aspect of the ethical dilemma posed by the double-agent role. Is it morally justified to use skills originally developed for the sole purpose of helping patients in order to derive information that ultimately may be used to hurt them?

The Szaszian position on this question is a clear and resounding "No." I and others have adopted more of a compromise position.[2,3] The common argument of those of us who urge a more temperate approach is that each double-agent role should be evaluated on its own merits. Such evaluation requires the use of some type of conceptual framework that helps the psychiatrist consider which factors must be evaluated in each role. The easiest way to develop such a framework is to first examine the potential harms and benefits of double-agent roles in general. Specific roles can then be evaluated in terms of their possible harms, their benefits, and to what extent the process by which they are entered into can be modified so as to maximize benefit and minimize harm.

Reducing Harm and Increasing Benefits

There are certain general advantages to the double-agent role. First of all, society may be helped by knowing more about its deviant citizens and sometimes

only psychiatry can provide the kind of help that society is looking for. Second, the patient may be helped. There are many instances in which society and the patient can be helped at the same time. Certainly, many patients who are involuntarily committed are later grateful for what has been done to them. It can even be argued that a person who is given a longer prison term as a result of psychiatric intervention may be spared the aversive consequences that would follow committing a new crime, including the possibility of an even longer period of incarceration. Help also may be provided in the course of the evaluation interview. A skilled psychiatrist may be able to comfort or counsel a patient in the course of a single examination. Third, the double-agent role can be helpful to the psychiatric profession. It can provide psychiatrists with power, a certain amount of prestige, and, at times, considerable financial remuneration.

The most serious objection to any double-agent role is, of course, the harm it may cause to the patient. There also may be harm to the psychiatric profession. Insofar as psychiatrists begin to be looked on as agents of oppression rather than as helping individuals, their public image suffers. There also may be significant harm to the doctor-patient relationship. This may be both specific and general. A patient may be aware that he or she may be harmed by the doctor's actions and will not fully cooperate. Or the patient actually may experience harm as a result of the double-agent role and will not trust that doctor in subsequent interactions. In both instances the patient's treatment is compromised, and a specific harm is created. Other patients who begin to learn about and fear this apparent psychiatric duplicity will come to distrust any psychiatrist who takes on an institutional role and perhaps all psychiatrists. This is a general harm that can be created.

There are certain procedural aspects of institutional psychiatric practice that have significant potential harmfulness. The manner in which these roles are assumed can have enormous influence in increasing or decreasing their risks. Double-agent roles are least controversial under the following conditions:

1. The psychiatrist has a clear idea of what kind of evaluation is being requested. It would seem that such clarity would be routine. Unfortunately it is not. Legal and social agencies often are unclear as to why they request a psychiatric evaluation.[4] Sometimes it is the psychiatrist who is confused. Psychiatrists still confuse requests to evaluate competence to stand trial with requests for evaluation of insanity. Most disturbing, psychiatrists not uncommonly will predict dangerousness when such a prediction is not even called for.[5] The harm engendered by such lack of clarity has been poignantly illustrated in the *Smith v Estelle* case in which a psychiatrist's prediction of dangerousness made in the course of a competence evaluation was later used to justify a capital sentence.[6] Social agencies and courts should define as specifically as possible what information they are looking for. Psychiatrists should ascertain they understand the request and should respond to it as precisely as possible. They should not provide information unrelated to the issue consideration.

Clarity is, of course, increased when the terms used in the agency's request are defined as precisely as possible. Two examples of words usually not defined or defined imprecisely are "dangerousness" and "treatability." Dangerousness in

our society has become almost a term of art and can refer to any undesirable conduct from having a greater than average tendency to shoplift to having qualities that lead to a high probability of committing homicide. Treatability implies many goals ranging from reducing chances of recidivism, to removing symptoms, to restructuring the personality. To the extent these terms are not defined, psychiatrists must construct their own definitions. The predictions they make based on these private definitions are not likely to provide the social or forensic agency with meaningful information.

2. The information requested by the agency is of a variety that the psychiatrist is able to obtain on the basis of his or her clinical skills. In general, psychiatrists are skilled in evaluating the personality structures and emotional cognitive capacities of their patients. They have less skill in evaluating specific task-oriented capacities such as capacities to drive, to be a student, or to be an air traffic controller. Because they usually are not experts in fields such as education, driving, or air traffic safety, they cannot do much more than speculate as to how various emotional or cognitive incapacities are likely to influence the patient's task performance.

Psychiatrists also have quite limited skills in predicting future violence. There are circumstances in which they can predict the probability of violence on the part of a given individual living in a given environment over a given time span.[7] As a rule, however, psychiatrists do not have sufficient clinical skills that allow for a meaningfully accurate prediction of violence. Many of the predictions of violence they are asked to make (usually framed in the context of predicting dangerousness) are beyond their clinical expertise.

3. The psychiatrist's report is not a de facto mandate for an administrative decision. Agencies must make difficult decisions as to whether to allow their clients certain privileges (such as entering a university or being given a driver's license). Courts must decide difficult issues such as competence to stand trial, dangerousness, or insanity. Many moral, social, and political considerations go into these decisions. Too often, agencies or courts try to bypass the moral and social dimensions of decision making by simply accepting the recommendations of the psychiatrist. This makes the psychiatrist more of an ethical decision maker than an expert. Psychiatric participation in double-agent roles is least controversial when the psychiatrist's report or testimony is scrupulously reviewed by social or judicial agencies and when it is weighed as only one of many factors involved in making a final decision.

4. Patients are provided with thorough information as to the process and potential outcome of the interview. Many individuals who are subject to the double-agent role do not know that the doctor is also obligated to an agency. They may view the physician solely as their helper and not as a person who can do them harm. Sometimes they may know that the doctor is functioning in a double-agent role but may be so accustomed to viewing doctors as helping individuals that they may suppress their awareness of the agency employed psychiatrist's function. Many psychiatrists, including myself, have admonished psychiatrists who function in this role to explain clearly to their clients all the potential risks of com-

munication or noncommunication in the interview process.[8] Patients so informed are unlikely to perceive themselves as having been misled into revealing information that is later used against them.

The Ethics of Civil Commitment

I would like to apply the criteria I have listed to one specific social and forensic role: the psychiatrist's involvement in civil commitment of patients dangerous to others. Much of what I say probably is relevant to other forms of civil commitment, but the case is much easier to make when considering the dangerous mentally ill. The statutes that control them were not drafted with beneficence toward patients in mind. The psychiatrist who participates clearly is involved in a social control function.

I wish to emphasize that I am not arguing against civil commitment. I believe society has a right to involuntarily detain individuals who are mentally ill and dangerous to others. My primary concern is with the current psychiatric role in that process of detention. I will argue that in its current use the role does not effectively serve the interests of either the patient, society, or the psychiatrist and that participation in this role seriously compromises the ethical position of the psychiatrist.

There are several ways in which the psychiatrist becomes involved in detaining the dangerously mentally ill. Sometimes a psychiatrist in a walk-in or emergency clinic interviews a patient who has voluntarily appeared or who comes under duress from the family, and the psychiatrist reluctantly concludes that the patient is a severely ill person who could do harm to others. The patient may reject the psychiatrist's recommendation for voluntary hospitalization. In this situation the psychiatrist usually has begun the interview in an empathic manner. The issue of involuntary commitment is not raised until the patient has been substantially exposed to an empathic interviewer and has probably disclosed a great deal of information about himself or herself. There is no semblance of informed consent here. Once the psychiatrist appreciates that commitment is necessary, there must be a considerable amount of maneuvering to preserve the safety of all involved parties. Often the patient is not told he or she is to be committed until security officers have been notified. This is hardly a gratifying medical function and is painful to all involved.

More commonly, the psychiatrist in the emergency room is presented with a patient brought by the sheriff, and the initial petition for commitment has been made by family, friends, or social agencies. Here, the psychiatrist may provide a brief explanation of the purposes of the interview, but it is usually not very elaborate. A more serious problem for all concerned parties is that the psychiatrist's evaluation in the emergency room situation is hampered by a very confusing factual situation. The petition form may simply say that the patient threatened to kill his wife. The patient may deny this.

At this point the psychiatrist is in the unfortunate position of trying to investigate whether a violent act did occur. The wife may have disappeared by the time the patient has arrived at the evaluation center. The police may simply note that

the patient has always been a peaceful citizen. If the other criteria of civil commitment are met, the psychiatrist is, in effect, placed in the role of becoming a detective. The psychiatrist has no particular skill in this role and is further handicapped by an absence of investigatory resources. Telephone calls may be made trying to gain information as to exactly how the patient did behave. These time-consuming operations often reveal little. The psychiatrist has no certainty as to the reliability or even the identity of the person who is called. The psychiatrist who becomes involved in the difficult process of trying to gain facts about past behavior may also find there is no one to be called. Here, the only source of information is a client who has no wish to be cooperative. I believe this kind of detective role, especially one that imposes so many handicaps on the seeker of truth, is inappropriate for a member of a helping profession.

Whether serving as both petitioner and examiner or simply as an examiner in the commitment process, the psychiatrist is called on to make a judgment whether the patient is mentally ill (and this part is usually easy) and whether the risk of that patient being dangerous is sufficient to justify his or her restraint. The latter task is made somewhat easier in states where dangerousness is at least defined as a threat of bodily harm, or an attempt to inflict bodily harm. Even when dangerousness is defined, however, the statutes provide little guidance as to what degree of probability the patient will commit a violent act constitutes dangerousness.

There may well be good reasons for keeping such statutes vague. In every instance when an individual is civilly committed as dangerous to others, some decision must be made as to whether the type of harm that individual threatens, and its likelihood of occurring in a given time frame, is sufficiently threatening to society to justify restraining that individual. The public's interest in self-protection must be balanced against a need to consider the individual's rights. Society must decide how many it will restrain unnecessarily to protect us from the one person who might hurt us. This is purely a moral and political issue that must be left to the conscience of the community.

It is the vagueness of the term dangerousness that allows the court to interpose community values on the commitment process. In this sense, dangerousness does not exist and cannot exist until it is legally designated. If the psychiatrist signs a form stating that he or she believes an individual is dangerous before the court has decided that individual is dangerous, the psychiatrist can only be guessing as to the conscience of the community. The psychiatrist is then assuming the role of the judge rather than that of the medical expert.

In dealing with emergency room commitments, the psychiatrist is, in effect, invested with a great deal of judicial power. It can be argued the psychiatrist's initial recommendations to detain a patient until a hearing can be held are reviewed by a magistrate. In most states, this is a perfunctory review. It is extremely uncommon for a magistrate to overturn a psychiatrist's recommendation for initial restraint. Until a formal hearing is held, the psychiatrist is, for the most part, the patient's sole judicial tribunal. Psychiatrists naturally abhor such a role and avoid it when they can. Most frequently the role is thrust on those who might be considered the underclass of the psychiatric profession. The overwhelming

majority of commitments in the United States are done by psychiatric residents and public sector psychiatrists who often are foreign medical graduates.

Once the initial petition for commitment has been sustained, hospital psychiatrists also may become involved in the process of commitment. Sometimes they may be asked to testify at the formal hearing as to the patient's current mental status. In addition, any psychiatrist who is caring for the hospitalized patient has the legal power to release the patient at any time in the process of commitment. This means that the psychiatrist who may be treating the patient has a tremendous degree of control over the patient's freedom. Such power may impair the doctor's and patient's capacity to form a therapeutic relationship. On the one hand, the psychiatrist is telling the patient to be open, honest, and frank. On the other hand, to the extent that the patient has recovered his or her sanity, the patient will appreciate that honest self-disclosure to the physician may put him or her in jeopardy of continued deprivation of freedom. This situation impairs, sometimes drastically, the quality of therapy that can be performed with civilly committed patients.

In reviewing the process of civil commitment, it is useful to reflect on the inconsistent manner in which the court apportions power to psychiatrists. Psychiatrists are given power to release any patient at any time. They are given a great deal of power subject only to the approval of a magistrate to restrain patients until a formal hearing is held. They are given much less power in the process of formally committing patients at the time of the judicial hearing. It seems courts have less trust in psychiatrists' judgments that result in patients being deprived of liberty (the exception here is when psychiatrists' recommendations for detention prior to a formal hearing are only briefly reviewed by a magistrate) than they do in psychiatrists' judgments that result in the release of potentially dangerous patients.

Is it possible that the courts are more interested in protecting the rights of patients than in protecting the public? It would seem unlikely that society would take such a cavalier attitude toward its own protection. Certainly, current practices save money insofar as they allow one professional to make judicial as well as treatment decision, but is this savings worth the risk to public safety? A possible consideration here is that our courts are relying on psychiatrists to be more conservative in releasing than in hospitalizing patients. One reason the courts may anticipate such conservatism is that the fear of being sued for releasing a patient who later harms someone is quite prevalent (and realistically so) among psychiatrists.

Summary

How does the current role of psychiatrists in the commitment of dangerous patients stack up in terms of its potential harmfulness to all concerned parties?

1. Do current statutes provide clear criteria for the determination of dangerousness? The answer is a definite no. Often even definitions of mental illness in commitment statutes are unclear insofar as they include elements of dangerousness to self or others.

2. Do psychiatrists have skills enabling them to determine whether individuals should be committed as dangerous? The answer is a qualified but definite no. Psychiatrists, as noted, have some skills in predicting violence. The best they can do, however, is to make a probability statement as to the likelihood a violent act will occur in a given period of time under certain circumstances. Usually that probability is quite small. It also should be emphasized that the factual or data base on which predictions of dangerousness are made in the civil commitment process is likely to be inadequate.

3. Is there sufficient judicial review of the psychiatrist's reporting so as to ascertain he or she does not become a de facto decision maker? The answer is that this is true only in certain aspects of the commitment process. Most of the time the psychiatrist assumes unwanted and unnecessary power.

4. Is good informed consent provided in the commitment process? Most of the time it is not.

5. Is it likely the current system of commitment provides maximum protection for the rights of patients and the safety of other citizens? There is no definitive way of answering this question absent research comparing the current system with a different one. It would seem likely, however, that commitment based on imprecise requests for information, on misguided perception of expertise, on blurring of expert and social roles, and on insufficient attention to informed consent cannot be very efficient in protecting either patients or society.

6. Does the current commitment process complicate the subsequent treatment of patients? It is reasonable to assume that in situations in which the doctor has total control over the patient's freedom, therapeutic trust and rapport are compromised.

7. Does the current commitment process harm the image of psychiatrists? It is hard to see how it could avoid hurting our image. Many of the most powerful attacks on the profession of psychiatry are based on a critique of the civil commitment role.

8. Does the role give psychiatrists power? Yes, but that power is accompanied by responsibilities that make psychiatrists more susceptible to lawsuits.

9. Does it give psychiatrists prestige or money? No.

On the basis of this review and summary, it would appear that the current role of psychiatrists in civil commitment of dangerous patients creates too many harms and too few benefits to be ethically justified.

Proposals for Change

While the ethical problems involved in the psychiatrists' participation in the civil commitment process never can be eradicated, they certainly can be minimized by adhering to procedures that provide greater protection for all concerned parties. The following recommendations for statutory change illustrate this point:

1. Psychiatrists should be allowed to petition for the commitment of patients suspected of being both mentally ill and dangerous to others if their patients do not enter the hospital voluntarily. This petition should not be viewed as a formal psychiatric examination. Once it is made, the petitioning psychiatrist should have

no further role in the commitment process. (In this role the psychiatrist's function would be similar to that of any other citizen. The ethical problems raised around the issue of informed consent, however, still remain.)

2. Once the petition has been filed with the clerk of court, the sheriff should be instructed to bring the patient to a forensic psychiatrist employed by the state. The forensic psychiatrist must provide the patient with full informed consent as to the nature of the examination. Under no circumstances should this psychiatrist institute any type of treatment (absent a life-threatening emergency) either during or after the examination. The psychiatrist should be a fully trained professional who is paid a substantial fee for conducting the examination. Once the examination is completed, the psychiatrist's report must immediately be presented to a judicial officer who is on call 24 hours a day.

3. The psychiatrist's report should be restricted to listing evidences of mental illness, evidences of potential violence, and a probability statement as to the likelihood that the individual would be violent in a certain period of time under various circumstances. The psychiatrist should make no statement as to the patient's dangerousness. The ultimate decision for even the initial brief detention must be made by a judicial officer, who will conduct a relatively formal hearing.

4. No psychiatrist who is treating a patient should be allowed to testify at the patient's commitment hearing. Only forensic psychiatrists employed by the state for this specific purpose should be allowed to testify at any commitment hearing.

5. No treating psychiatrist should have the power to release a committed patient. Only the court should have this power after having heard the opinions of state-employed forensic psychiatrists. Again, the state-employed psychiatrist in this situation should be paid an adequate fee.

The above recommended changes provide certain advantages to all concerned parties. First, they define each participant's role accurately and honestly. No professional is required to go beyond his or her expertise. Decisions are made by judicial agencies. Second, they are likely to result in improved treatment of civilly committed patients, since treating physicians will have nothing to do with restraining patients. Third, they should enhance the image of psychiatry. Fourth, by putting this function in the hands of skilled forensic psychiatrists, residents in psychiatry would be relieved of a painful and unrewarding task. Fifth, they allow psychiatrists to collect money for a service that is now provided free of charge. Sixth, they would curtail malpractice suits against psychiatrists for releasing patients who harm others. (A judge who releases a patient who commits harm cannot be sued.)

An obvious disadvantage of these changes is that they would require much more of the courts. Some judicial officers, just like physicians, would have to be on call 24 hours a day. This would add extra economic costs to the process. Paying for forensic psychiatrists is also likely to add to the economic burden. Finally, it is likely that new costs would be incurred as a result of an increase in the number of judicial procedures. All the additional costs, however, might be more than balanced by the savings associated with a more efficient system. The

long-range benefits to patients and society might make the overall increase in costs trivial.

Conclusion

The analysis I have presented of psychiatrists' role in the civil commitment of dangerous patients can be applied to every controversial, social, and legal role psychiatrists assume. Usually, such analysis will suggest changes that make for a less conflictive ethical role. Sometimes these changes can be negotiated between the examining psychiatrist and the agency to which he or she reports. Sometimes they require legislative intervention. Psychiatrists cannot, as a rule, control the conditions by which they function in social and forensic roles. They can, however, define conditions under which their services are likely to create the least harm and do the most good. To the extent they do this and also seek to create these conditions, they will begin to resolve many of the ethical problems of psychiatric practice.

References

1. Szasz T: Law, Liberty and Psychiatry. New York, MacMillan, 1963
2. Halleck SL: The Politics of Therapy. New York, Science House, 1971
3. Robitscher J: The Powers of Psychiatry. Boston, Houghton Miflin, 1980
4. Farmer L: Observation and study: Critique and recommendations on federal procedures. Unpublished report, Federal Judicial Center, Washington, DC, 1977
5. Geller S and Lister E: The process of criminal commitment for pretrial psychiatric examination: An evaluation. Am J Psychiatry 135:53-60, 1978
6. Smith v Estelle, 78-1839, Fifth Circuit Court of Appeals, September 31, 1979
7. Monahan J: The clinical prediction of violent behavior. Crime and Delinquency Issues, U.S. Department of Health and Human Services, Rockville, MD 1981
8. Halleck SL: Psychiatry and the Dilemmas of Crime. New York, Harper and Row, 1967 □