Editor:

The very fact that the article by Schafer[1] attracted four replies published concurrently in that issue probably indicates the collective discomfort of the Journal's readership. Both sides make passionate expositions of their position, but I suspect readers will not have failed to notice the split among the professional affiliations of these authors. I think Dr. Grisso[2] has pointed out most eloquently that psychology, after all, is not a healing profession, and the traditional medical principles of *primum non nocere* and the accompanying paternalism and beneficence do not apply in that context.

I have a similar point to make, although my point is more general, and it may apply to any profession. Dr. Candilis[3] unsurprisingly draws on the American Medical Association (AMA) and World Psychiatric Association (WPA) ethics codes that prohibit participation of physicians in executions. Few would dispute his assumption that such actions undermine the "fabric of social roles" and that of the profession. Now, imagine a rather disturbing hypothetical scenario: A physician licensed in one state surrenders his license before going to another state to moonlight as an executioner where no one knows he is a physician. Would his actions be unethical? By Dr. Candilis's analysis of social contract or social role, perhaps not.

If it is Dr. Candilis's view that professional ethics are a summation of societal expectations, then the erstwhile doctor-turned-executioner would be behaving unethically if he were not to fulfill his professional role as executioner. The point surely must be that we are what we are, not what we once were. If our roles change, the ethics of those roles change. Not to make too fine a point about the distinction between a trade and profession, it is reasonable to argue that a profession gets its societal legitimacy from the existence of a fiduciary relationship. Without such a relationship, there can be no professional obligation. The debate must be about whether the Federal Bureau of Investigation (FBI) agent with a psychology degree was practicing psychology, rather than whether he was a member of the American Psychiatric Association (APA). As Dr. Grisso points out, practicing psychology may mean a number of things. Before we condemn the FBI agent, let us find out, not whether he was a member of the APA, but whether he was playing the role of a clinician. Would it be different if the agent were a sociologist or mathematician who also has a master's degree in psychology? Would he be a psychologist with all the expectations inherent in his societal role or a federal agent with different sets of obligations to society, or is it unreasonable for society to use a body of knowledge for all sorts of purposes?

Of course, if being a physician or a psychologist makes it imperative that we be good human beings, many of us would fail that test. A thus far undetected tax-evading physician can nonetheless be a competent and ethically compliant physician. Can we condemn him on professional grounds or in terms of professional ethics because he has failed to be a better person? Imagine, now, that he is convicted of tax evasion, but his license is not permanently revoked. Would he cease to be a good physician? Do we want our health care professionals to be virtuous or competent? It perhaps would be nice if all of us were better human beings, but the humanness entails some human failings—some more grave than others. Not all of those failings, however, are incompatible with the precise role we play. If it were, the society would grind to a halt.

The pages of this journal have seen many erudite discussions in the past between the ethics of virtue and the ethics of professional actions . I am confident such discussions will continue. This debate has shown that the ethics of virtue cannot always guide us when professional values clash with ordinary morality.

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Editor:

Dr. Sameer P. Sarkar has written an extremely important editorial ("A British Psychiatrist Objects

to the Dangerous and Severe Personality Disorder Proposals") in a recent issue of *The Journal of the American Academy of Psychiatry and the Law*.[1] His concern is fully justified that the White Paper he describes is likely to lead to legislation in England that could result in a blatant misuse and abuse of psychiatry and psychiatrists. As he points out, the legislation would authorize the involuntary indeterminate confinement of persons viewed as having "a dangerous and severe personality disorder" (DSPD). We are increasingly faced with similar problems in the United States as is evident in the effects of laws in many states in connection with the detention of allegedly dangerous sex offenders in maximum security forensic hospitals.

I believe that legislation similar to what is being proposed in England was enacted in Victoria, Australia, following the publication of the recommendations in 1988 of the Law Reform Commission of Victoria.[2] I believe also that experience in Victoria is consistent with the dire consequences Dr. Sarkar predicts will occur in England if the DSPD White Paper recommendations become law.

I had an opportunity to analyze the proposals of the Victoria Law Reform Commission when I addressed the 10th Annual Congress of the Australian & New Zealand Association of Psychiatry, Psychology and Law in November 1989. I commented[3] as follows:

> The Commission's recommended definition of mental impairment, including, as it does, "psychopathy," creates a particular danger that lifelong incarceration of many psychopaths with the psychiatrists as involuntary warden, will occur. "Psychopathic disorder," after all, means, according to the Law Reform Commission, "a persistent disorder or disability of mind which results in abnormally aggressive or seriously irresponsible conduct" (Ref. 3, p 42) The Commission applauds the abandonment of mandatory life imprisonment for murder, and why not? It has found a way to bring about life imprisonment by means of an insanity defense imposed on a psychopathic killer whether he likes it or not. The Commission states: "Where serious harm has already occurred and there is evidence that the dangerous conduct will recur and the person is not treatable, it should be possible to order secure detention either in a prison or a psychiatric institution" (Ref. 3, p 33).
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> The Commission recommends that the prosecution retain the power to raise the insanity issue (calling it a "defense" even though it is asserted not by the defendant but by the prosecution) and, moreover, to use as the standard of proof "the balance of probabilities" rather than "beyond a reasonable doubt" (Ref. 3, p 8).
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> Lest there be any doubt that the Commission reform calls for psychiatric imprisonment of certain personality-disordered offenders who become insanity acquittees, let me draw your attention to the fact that the Commission is of the view that courts be given the power to order involuntary detention in institutions for the mentally ill, or for the intellectually disabled, without the agreement of the respective institutional authorities (Ref. 3, p 29). The Commission makes it clear that the insanity route should be used to ensure that the psychopath does not have access to the Victorian law that abolishes mandatory sentences of life imprisonment for murder. The Commission states: "Although they may not be accepted into psychiatric institutions, it is appropriate that psychopaths be regarded as mentally impaired for the purposes of determining their criminal responsibility. Under Recommendation 7, they could be detained in an appropriate part of the prison system" (Ref. 3, p 42).
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> And who, asks the Law Reform Commission, should make release decisions? Not the Mental Health Review Board or the Intellectual Disability Review Panel which currently hear appeals for release in the mental health/intellectual disability system. These bodies, the Commission insists, do not have sufficient experience in dealing with people who have caused criminal harm (Ref. 3, p 33) Not satisfied with the fact that such review groups have shown very pronounced conservatism when it comes to releasing patients who have committed violent acts in the past, whether these individuals had been charged with crime or not, the Commission recommends that an entirely new Special Release Board be created which would include members of the Parole Board who are viewed as having a great deal of experience in release decisions affecting criminal offenders (Ref. 3 p 33). Can anyone doubt that the proposed Special Release Board will disallow the release of certain patients who have been found to be successfully treated or not mentally ill, or both, by the treating psychiatrists and psychologists? The misuse of psychiatry in such circumstances should be readily apparent. For those who may have some lingering doubts of the seriousness of my concern, let me remind them of the provisions of Principle 4 of the Declaration of Tokyo adopted by the World Medical Association in October, 1975: "A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive–whether personal, collective or political–shall prevail against this higher purpose."

Deidre N. Greig has written a book titled *Neither Bad Nor Mad: The Competing Discourse of Psychiatry, Law and Politics*.[4] (I have not yet read the book, because it is not available in the United States.) According to a recent announcement ,[5] it looks at what happened when the government of Victoria "enacted special legislation to detain one person with a severe antisocial personality disorder on the grounds of his presumed dangerousness, despite the fact that he did not fit within the ordinary criteria of mental illness or

criminality." I believe the book reveals the horrific consequences of a DSPD law so feared by Dr. Sarkar.

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Editor:

I wish to comment on Dr. Sarkar's recent editorial.[1] I was pleased to see an article by a British forensic psychiatrist in your journal. However, there were a number of factual errors in Dr. Sarkar's paper, and I felt he failed to develop any sustained objections to the British Government's recent White Paper.[2] Dr. Sarkar suggests that the proposed legislation will introduce for the first time the possibility of preventively detaining a person who has not been convicted of an offence. This is not true. He himself gives the example of a "Hospital Order with Restrictions Upon Discharge Without Limit of Time" (Sections 37 and 41 of the Mental Health Act 1983, England and Wales). A Hospital Order (S37) can be made in the absence of a conviction. Where a person is found unfit to plead or not guilty by reason of insanity, he may be committed to hospital under an Admission Order with a Restriction Order (Criminal Procedure [Insanity and Unfitness to Plead] Act 1991, England and Wales), and not a S37/41 order as Dr. Sarkar incorrectly states. This is detention on the grounds of dangerousness in the absence of a conviction. Furthermore, patients may be detained on the grounds of the risk they present to others under the civil sections of the Mental Health Act 1983—it is difficult to see why this is not also preventive detention under the guise of treatment, and a minority of patients in High Security Hospitals in England are detained under this legal mechanism, with no conviction for an offence.

Some might argue that psychiatrists have been playing the social role of detaining certain people who are unwanted by society for as long as there has been psychiatry. Certainly the willingness of British psychiatrists to give evidence in court regarding "the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large" (Section 41 of the Mental Health Act 1983) makes it difficult to object to the White Paper's plan to detain people with "dangerous and severe personality disorder" on the grounds that doctors should have no part in preventive detention. And what about the psychiatrist on the parole board?

I believe Dr. Sarkar needs to do more than simply state that "[p]reventive detention is wrong and contrary to the spirit of freedom and liberty." The governments of many democratic countries have thought it necessary, reasonable, and justified to introduce preventive detention legislation, in the form of longer than commensurate sentences for certain offences or certain offenders, for many years, including the United States and Canada (sexual predator legislation), Australia (e.g., Community Protection Act 1990), and the UK (e.g., Prevention of Crime Act 1908). Dr. Sarkar should explain how this could have occurred in all of these countries if it is fundamentally "wrong and contrary to the spirit of freedom and liberty."

Better objections to the British Government's White Paper are to be found in the history of preventive detention legislation.[3] It has failed to work in the way envisaged by the legislators every time it has been drawn up in the past. Why should it be any different this time?

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Reply

Editor:

Dr. Wilson does raise some important ethics questions about the role of psychiatrists in the society. This journal has certainly seen some very interesting debates on that topic. I do agree that psychiatrists may be required to take on roles that are not strictly medical, and the parole board is a good example of that. Currently, there is an ongoing debate in the Forensic Faculty of the Royal College of Psychiatrists (roughly equivalent to the AAPL) about whether psychiatrists should ever participate in non-therapeutic endeavors. This is the old Appelbaum-Stone debate, and Appelbaum's Presidential address[1] in the 1997 AAPL meeting is the clearest exposition of his position in the discussion.

Some of the factual inaccuracies Dr. Wilson mentions are semantic differences only and not inaccurate in spirit or indeed in law. He mentions the Unfitness to Plead or NGRI verdicts. Although technically individuals are not detained under Section 37/41 of the Mental Health Act, as Dr. Wilson himself points out, they are treated as such when they are obliged to obtain permission of the executive branch of the Government for discharge or leave (Home Secretary) exactly like those detained under Section 37/41.[2] Of course, it is also possible under more recent laws (Criminal Procedure [Insanity and Unfitness to Plead] Act 1991) to have a variety of other dispositions following a finding of Unfitness. Hospital Order with restrictions is but only one option available to the sentencing judge. The rarely used provision in the 1983 Act of Hospital Order without a conviction, is actually Section 37(3) of the said Act of a Hospital Order *without restrictions* and not a Section 37/41 as he might have misconstrued. This section states, *inter alia*, "if the court is satisfied that the accused did the act or made the omission charged, the court may, if it thinks fit, make such an order without convicting him."

Just because there are laws worldwide authorizing preventive detention in various guises does not mean it is right.

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