The Ethical Boundaries of Forensic Psychiatry: A View from the Ivory Tower

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At a recent meeting of sixty federal judges from around the country, one of the trial judges defined the essence of the distinction between trial and appellate judges. "Trial judges," he said, "are in the front lines of legal warfare, they are foot soldiers involved in the bloody hand-to-hand combat. Appellate judges, in contrast, sit on a safe hill overlooking the battlefield. When the fighting is over, the appellate judge comes down from his position of safety and goes about shooting the wounded." That is my plan of action. Forensic psychiatry is a kind of hand-to-hand combat, and now as never before, the troops are wounded and bloody. Now, after Hinckley, when forensic psychiatrists need encouragement, healing balms, and soothing treatment, I have come down from my ivory tower to "shoot the wounded."

But forensic psychiatrists need not be afraid, I intend only intellectual violence; like the trial judges they will survive to fight again. In fact, though wounded and bloody they are today stronger than ever. The legal assault on psychiatry of the past two decades had one consistent result: it took discretionary authority from the psychiatrist and handed it to the courts. But the courts, in order to take on this burden responsibly, require more (not less) psychiatric testimony. The more they hate us the more they need us. Whatever the reasons, forensic psychiatry seems to be flourishing. There is an array of journals,[1] new organizations, subspecialty boards, a remarkable number of competent practitioners, and an increasingly sophisticated intellectual dialogue. In a stagnant psychiatric economy, forensic psychiatry is one of the few growth stocks.

I am not a forensic psychiatrist. What has kept me out of the courtroom is my concern about the ethical boundaries of forensic psychiatry. Let me state what I think the ethical boundary problems are.

First, there is the basic boundary question. Does psychiatry have anything true to say that the courts should listen to?

Second, there is the risk that one will go too far and twist the rules of justice and fairness to help the patient.

Third, there is the opposite risk that one will deceive the patient in order to serve justice and fairness.

Fourth, there is the danger that one will prostitute the profession, as one is alternately seduced by the power of the adversarial system and assaulted by it.[2]

Finally, as one struggles with these four issues—Does one have something true to say? Is one twisting justice? Is one deceiving the patient? Is one prostituting the profession?—there is the additional problem: forensic psychiatrists are without any clear guidelines

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as to what is proper and ethical, at least as far as I can see. In this regard I comment on (a) the good clinical practice standard, (b) the scientific standard, (c) the truth and honesty standard, and (d) the adversary standard. For now I simply assert that the American Medical Association's Principles of Ethics with Annotations for Psychiatrists are irrelevant. Eventually, I shall test this proposition by examining the ethical complaints voiced against Dr. Grigson's testimony in capital punishment cases. I argue there is no neutral general principle by which Dr. Grigson can be called unethical.

The Basic Question

Do psychiatrists have true answers to the legal and moral questions posed by the law? Immanuel Kant, who after two centuries, is still a dominant figure in the landscape of moral philosophy, had strong opinions about this question. He wrote, "concerning the question whether the mental condition of the agent was one of derangement or of a fixed purpose held with a sound understanding, forensic medicine is meddling with alien business."[3] Kant would give a different meaning to the ancient designation of the forensic psychiatrist as an *alienist*. Kant also wrote, "physicians are generally still not advanced enough to see deeply into the mechanisms inside a human being in order to determine the cause of an unnatural transgression of the moral law."[4]

Kant's opinion was that our science was inadequate, and as to moral questions, alienists were meddling in alien business. A century later, Freud echoed Kant's sentiments in a new vocabulary: "the physician will leave it to the jurist to construct for social purposes a responsibility that is artificially limited to the metapsychological ego."[5] Although after Freud some psychoanalysts attempted to generate a theory of moral responsibility not limited to the metapsychological ego, Freud's most authoritative interpreter, certainly his most orthodox, Heinz Hartmann, in his monograph *Psychoanalysis and Moral Values,*[6] drew a sharp clear line: psychoanalysis could say something about why people come to hold the values and morality they hold but nothing about those values and morals. This purist position of Kant-Freud-Hartmann would suggest that even today the forensic psychiatrist outside the therapeutic context is meddling in alien business.

Given the basic premise of these purists, the question of the ethical boundaries of forensic psychiatry is vacuous. Psychiatrists are immediately over the boundary when they go into court. It would be rather like asking what the ethical boundary is for an imposter. From this purist perspective the problem is not the adversarial process. It is as absurd for psychiatrists to decide legal-moral questions, questions of social justice, as a friend of the court as it is for them to be adversarial witnesses. The purist position can be reached by different kinds of reasoning.

Intellectually, there seem to be five strands that make up the purist position. I briefly allude to them and suggest their relevance to forensic psychiatry. First, there is the problem of the fact-value distinction. This is the philosophical line followed by Hartmann.[7] The fact-value distinction has regularly been blurred, ignored, or confused in psychiatric testimony about sexual matters, for example, pornography, incest, and sex with children.[8] This fact-value confusion has obfuscated the law and psychiatry literature on child custody.

Second, determinism v. free will. The debate never has been resolved by psychiatrists; it is relevant to every question of volition and responsibility. It is a principal theme in Professor Morse's recent *Virginia Law Review* attack on psychodynamic testimony.[9]

Third, the deconstruction of the self: without the unity of the self, moral reasoning becomes impossible. It is the deepest, most basic theoretical dilemma of modern psychiatry, and it is not just the work of psychoanalysis and the metapsychological ego. It is an issue in behavioral and biological psychiatry. It is specifically relevant to claims about how the law should deal with multiple personality and dissociative reactions.

Fourth, the mind-brain problem:[10] it plagues all our endeavors to account for human actions. It is particularly pertinent to alcoholism, drug abuse, and recent theories of violence. If this is too abstract, think of the *Torsney* case or, more recently, Dr. Bear's attempt to introduce CAT scan evidence in the Hinckley trial. You will see how important the mind-brain problem is to forensic psychiatry. Professor Michael Moore has demonstrated, to my satisfaction, that America's most influential forensic psychiatrist, Isaac Ray, got lost in the mind-brain trap and never got out.[11]

Finally, there is the chasm that has opened up between what Kuhn[12] would call "normal science" and morality, a chasm that characterizes almost all modern thought and particularly the behavioral sci-

ences. That is the chasm forensic psychiatry tries to bridge.

I shall touch on some of these strands, but let me say only that the purist position is not easily dismissed: it raises serious questions about the basic legitimacy of forensic psychiatry. Each forensic psychiatrist may have resolved the five intellectual problems in his/her own mind, but I doubt any of us would claim that forensic psychiatry has achieved a consensus on these issues. The conceptual problems I have outlined, I want to emphasize, are not limited to psychodynamic testimony. They apply equally to behavioral, biological, and social psychiatry. They apply even to what many would consider the hard science part of psychiatry.

Good Cinical Practice Standard

Now it can be argued against everything I have said that it is applicable to everything psychiatrists do and not just to forensic psychiatry. This counterargument leads to the good clinical practice standard, the argument made by my colleague and friend, Andrew Watson. He believes psychiatrists constantly are making value judgments and expressing moral convictions implicitly if not explicitly. He would acknowledge all the difficult intellectual problems I have enumerated, but he would say they are just as relevant to clinical practice as to forensic psychiatry. Finally, he would say, "If we do it in our office why can't we do it in the courtroom?" We even make predictions about future dangerousness in our office. Do we believe in the practice of psychiatry or don't we? I shall accept Dr. Watson's "good clinical practice" argument so we can cross the first boundary into the law.

But I shall take you back almost two centuries to enter the courtroom. From this safe vantage we can consider twisting justice, deceiving the patient, and prostituting the profession. Let me read you the interrogation of a "forensic" psychiatrist that took place in 1801. It is reported by Nigel Walker in his treatise on crime and insanity in England.[13] The trial involved a Jew who had been caught stealing spoons.

The Jews of the London community had set up a society for visiting the sick and doing charitable deeds. The society employed a Dr. Leo who three times testified at the Old Bailey on behalf of his Jewish patients. On all three occasions, his patients had been accused of shoplifting. This was his third appearance. First Dr. Leo was questioned by the court.

> **Court:** Are you particularly versed in this disorder of the human mind?
>
> **Leo:** I am.
>
> **Court:** Then you are what is called a mad doctor?
>
> Walker adds, "no doubt there was laughter in the court at this sally."]

Then he was cross-examined by the prosecutor.

> **Prosecutor:** Have you ever given evidence before?
>
> **Leo:** [Walker adds, "almost losing his temper."] I believe that I have. Is that any matter of consequence?
>
> **Prosecutor:** Upon your oath, have you or have you not been examined as a witness here before?
>
> **Leo:** I never took any notice.
>
> **Prosecutor:** Have you not been here twice?
>
> **Leo:** Yes.
>
> **Prosecutor:** Have you not been here more than three times?
>
> **Leo:** I cannot say.
>
> **Prosecutor:** Have you not been here before as a witness and a Jew physician, to give an account of a prisoner as a madman, to get him off upon the ground of insanity?

The nastiness with which Dr. Leo was treated by these English contemporaries of Immanuel Kant cannot be attributed to their intellectual position, but they strike two notes that resonate even today in the halls of Congress and our state legislatures. Namely, that the psychiatrist is a bad joke in the courtroom, and that forensic psychiatrists are there to get defendants off.[14]

The question I would pose to Dr. Watson is, what could he say today in defense of Dr. Leo's testimony? He could tell the prosecutor (as I would) that antisemitism was vile and repugnant in an officer of the court. But could he argue, given the primitive state of psychiatry in 1801, that Dr. Leo had a good clinical understanding of what he called "the mania" of his patient for stealing spoons? Could he say that his purpose in testifying was other than to help a fellow Jew escape what the

law of the day considered just punishment, twisting justice and fairness to help his patient and prostituting his profession to do it?

Dr. Watson might say my example is ridiculous and farfetched, but I ask him and those who share his views to imagine some psychiatric historian two hundred years from now examining the good clinical practice and the clinical diagnostic concepts advanced by the psychiatrists on either side of the Hinckley trial. Is there much chance that the historian of our profession would conclude that those psychiatrists, to use Kant's language, "saw deeply into the mechanisms inside the human being in order to determine the cause of an unnatural transgression of the moral law"?[15] Or would the historian more likely comment on the primitive state of clinical psychiatry in 1982, its incomplete understanding of the brain and the mind and its bizarre diagnostic categories as set out in DSM III?

Standards of Science

Another of my friends and colleagues, Loren Roth, is of the view that what should guide the ethical forensic psychiatrist is his/her commitment to the standards of science. As I understand his view, he wants to set a higher standard than Watson's "good clinical judgment." I think Loren shares my view that "good clinical judgment" is a precariously egocentric standard.

I once did some empirical research on humor. It turned out that of 280 students 280 thought they had a very good sense of humor.[16] Similarly, it seems to me every psychiatrist thinks he/she has very good clinical judgment. Dr. Roth wants to find a brighter line. He would limit his testimony to what he knows to be scientific. Based on that standard, he would not allow forensic psychiatrists to answer ultimate legal questions that have no scientific answers. But I claim that if forensic psychiatrists limited themselves to the standards of bench scientists, not only would they not testify about ultimate legal questions, but also their lips would be sealed in the courtroom.

Psychiatry is still closer to social science than to physical science, and Max Weber's statement about social science applies to us. We must expect what we believe to be right soon will be proved wrong.[17] It is no disgrace to work at a primitive science. As Jonas Rappeport asks, "Are we embarrassed to let the public know that the state of our art is such that we do not know everything and that there are different schools and theories in psychiatry?"[18] The hubris in psychiatry has come from passing it off as certainty or claiming that we know things beyond a reasonable doubt.

The difference that makes a difference between clinical practice and forensic practice sometimes has been discussed under the heading of the psychiatrist as a double agent. I do not want to rehearse that discussion, although I think it a valuable way to analyze these problems. Rappeport's solution to the thorny dilemma of examining a patient for the other side is for the interviewer to recognize the potential for abuses of confidentiality and always to inform the patient which side he or she is serving.[19] But I agree with Seymour Halleck that informing the examinee of the fact that you are a double agent is necessary but not sufficient to resolve the conflict of interests. There are two reasons: I put off one until my discussion of Dr. Grigson and capital punishment, the other is as follows. Skilled interviewers like Drs. Halleck, Roth, and Watson will create a relationship in which the examinee can readily forget he/she has been warned.

It is no accident that good clinicians often are emotionally seductive human beings inspiring personal trust. Emotionally seducing a schizophrenic to reach the patient in his/her autistic withdrawal may or may not be bad technique but it is certainly easier to justify as a parameter of treatment than as a method of obtaining information to determine whether he/she should have visitation rights with his/her children.

The crucial word for me is "justify": when the psychiatrist's goal is to do the best he/she can to ease the patient's suffering, he/she has a powerful justification. It is the justification for every physician who did not wait for science and theory to be perfected. Do whatever you can to help your patient and *primum non nocere,* first of all do no harm.[20] These contradictory claims constitute the ethical dialectic of the physician's practice. We have not yet found the synthesis of this thesis and antithesis; our fate is to struggle with this contradiction. But as physicians we know what the ethical struggle is. We know the boundaries of the ethical debate. When we turn our skills to forensic psychiatry, when we serve the system of justice, we can no longer agree on the boundaries of the debate.

Action on Behalf of Defendants

A few words about the adversary system and how it bears on my subject. Let me return to Dr. Leo at the Old Bailey in 1801.

Dr. Leo is typical of a certain kind of psychiatrist who goes to court. The psychiatrist who knows very little about the law but who goes to court out of sympathy for a client or for a cause. To some forensic psychiatrists these are the real villains, the amateurs who do not recognize that forensic psychiatry is a subspecialty. But it is not the amateur's naiveté about the law that interests me; rather, it is his/her impulse to help the patient or to serve some cause the patient presents. The amateur is still trying to act according to the basic ethical calling of the physician: trying to relieve suffering, still struggling within the ethical dialectic of the healer.

It is my impression that this impulse has not been limited to amateurs. Many distinguished forensic psychiatrists have felt more comfortable acting on behalf of criminal defendants. Indeed it seems there is a very comfortable ideological fit between being a forensic psychiatrist and being against capital punishment; being therapeutic rather than punitive; being against the prosecution and what was seen as the harsh status quo in criminal law. This ideological fit has begun to come apart in recent history, but during the days when David Bazelon and American psychiatry had their love affair, the fit was real. Those were the halcyon days when the concept of treatment and the concept of social justice were virtually indistinguishable.

Here we confront a still-lingering confusion in the enterprise of forensic psychiatry. The problem is that helping the patient, which is the ethical thesis of the practitioner, becomes the ethical temptation in the legal context. What principle does the forensic psychiatrist have to restrain himself/herself against this temptation? What is equivalent to the therapist's antithesis of do no harm, particularly when he/she is cajoled by the lawyers, dazzled by the media spotlight and paid more than Blue Cross Blue Shield allows? I have suggested I believe Dr. Watson's good clinical practice is a precariously egocentric standard for self-administered ethical restraints. One only needs to hear forensic psychiatrists criticizing each other's ethics to see how precarious it is. Dr. Roth's scientific standard would, in my opinion, lead to a vow of silence.

Paul Applebaum MD has suggested the standard of truth should govern the forensic psychiatrist. In a moral dialogue this is a very appealing standard, but like Kant's categorical imperative it is much more convincing as an abstract statement than useful as a practical guide to conduct. I assume Applebaum's standard of truth is not the same one I raised at the beginning of this article: the truth in an absolute sense. That kind of absolute truth keeps the psychiatrists out of the courtroom. What Applebaum means, I think, is closer to honesty; the forensic psychiatrist must honestly believe what he/she says and should not allow his/her views to be distorted. He/she should be an honest, good clinical practitioner. Let us consider how this standard fares in the adversarial context.[21]

Adversarial System

The adversarial system requires psychiatrists for both sides. That was one complaint against the old lineup of concerned psychiatrists for the defense: psychiatry was not being fair to the adversarial system. My late friend and colleague Seymour Pollack was particularly concerned about this issue,[22] and even Judge Bazelon lamented there were not good psychiatrists on both sides. Bazelon wanted psychiatrists to recognize and to accede to the higher ethical framework of the adversarial system's search for justice.[23] He failed to consider how the psychiatrist would square the ethical imperative of his/her healing profession with the adversarial goals of the prosecution.

To illuminate that problem I want to examine what I take to be the most challenging case: Dr. Grigson's practice of testifying for the prosecution in capital punishment cases, such as *Barefoot v. State*. I disagree with those who claim such testimony is unethical.[24] By that I mean it does not violate the APA's canons of ethics as I would interpret them, it does not violate the good-clinical-practice standard, and it does not violate the truth-as-honesty standard. It may violate Roth's scientific standard, but again I claim that almost everything but a vow of silence would violate his standard.

The practice in question is as follows. The defendant has been found guilty of a capital offense. The court then hears testimony from Dr. Grigson who has never personally examined the defendant. Grigson is asked a series of hypothetical questions relevant to the defendant's history and criminal behavior. His

answers expressed with great clinical conviction are that such persons are sociopaths, they are and will be very dangerous, and they do not experience remorse. Dangerousness and lack of remorse are two of the criteria relevant to the death penalty.

Now what is unethical about such testimony? I assume Grigson believes what he is saying. One certainly has no basis to assume otherwise just because he testifies for the prosecution in favor of the death penalty. I assume he is as honest, sincere, and committed to the good clinical practice standard as the forensic psychiatrists who testify against the death penalty or who go around the country urging verdicts of not guilty by reason of insanity. After all, Dr. Grigson and the other psychiatrists testify under oath sworn to tell the truth.[25]

I may not have done justice to Applebaum's standard; he may have been thinking along different lines (I shall return to this matter of sworn testimony). But if I have made my friends into straw men, it was to make clear that my ideas are part of an intellectual dialogue with them.

Let me turn briefly and finally to examine Grigson's testimony in light of the APA's own principles of ethics. Here the language is specific. What annotations could one cite if one wished to make an ethical complaint against the pro capital punishment psychiatrist? One might allege that he gave diagnostic opinions about a patient he never examined.

The relevant annotation, annotation 3 of section 7, clearly is not aimed at courtroom testimony. It was added by the APA after the Goldwater fiasco.[26] Hundreds of psychiatrists were willing to fill out questionnaires and diagnose Barry Goldwater as mentally ill during the presidential elections of 1964. The incident embarrassed the psychiatric establishment, and they added this annotation. I opposed this change at the time as a denial of free speech and of every psychiatrist's God-given right to make a fool of himself or herself. If the psychiatric establishment banned everything that embarrassed them, they would ban forensic psychiatry. And if annotation 3 of section 7 were strictly enforced, forensic psychiatrists could never give public lectures in which they discussed the relevant clinical aspects of Hinckley, Sirhan, Poddar, Torsney, and so on. Furthermore, if Grigson violated annotation 3, then it is also regularly violated when forensic psychiatrists routinely answer hypothetical questions about testamentary capacity.

Hypotheticals

Testifying to hypothetical questions in court is not unethical, at least as I interpret the language and the history of annotation 3 of section 7. The procedure is used by Grigson, of course, to escape the double-agent conflict I mentioned earlier. Without examination of the patient, there is no doctor-patient relation, no false expectation, no deception, and no conflict of interest. To object to Grigson's procedure is to attempt to deprive the prosecution of a legitimate adversarial witness. I claim we have no general neutral principle for doing that.

I believe we have the intuition that such testimony in death penalty cases is unethical because of our basic practical ethical guideline to do all we can to ease the suffering of our patients. Ironically, this basic guideline is no longer part of the AMA's ethical guidelines. Nor is "first of all do no harm." If we were to take this guideline very seriously, how could we ever be zealous advocates for the prosecution in death penalty cases, and if the legal system thought we were bound by this practical ethical guideline, how could we serve the adversarial system of criminal justice?

When we object to the ethical conduct of Grigson as the prosecution's expert, . . it is because we want to have our cake and eat it too. We want to be doctors who are healers, and we want to serve the adversary system. My colleague Laurence Tancredi has commented that to many moral philosophers, justice is itself a beneficence. I am sure he is correct, but justice is a beneficence to a society of unidentified persons. In contrast, the doctor's practical ethical duty is to ease the suffering of particular identified patients. Medicine has not yet solved the problem of how to balance the particular good of the identified patient against the general good of the unidentified masses. We lose our practical ethical guideline when we try to serve such greater good.

Consider in this regard the Soviet psychiatrists whom we have condemned for the unethical political abuse of psychiatry. If one has a dialogue with these Soviet forensic psychiatrists, one of the first points they make is that the revolution is the greatest good for the greatest number. The greatest piece of social justice in the twentieth century is the greatest beneficence imaginable. It is when they act in the service of that beneficence that we believe their ethical compass as psychiatrists begins to wander. The scandals in medical research in this country demonstrate the

same theme.[27] The advancement of science is a noble goal; you may prefer it to the revolution, or the American system of justice, but when doctors give it greater weight than helping their patients or doing no harm, they lose their ethical boundaries.

It is sometimes said by forensic psychiatrists that all the supposed ethical problems I have recited here do not exist because I have failed to recognize the avowedly adversarial nature of forensic testimony. These forensic psychiatrists would argue that they openly accept the fact they have been selected in a biased fashion to be partisan expert witnesses. They have no ethical problems because they openly accept the responsibility of putting forward the best possible case for their side. Furthermore, they could argue that the ethics of such adversarial testimony is in fact intelligible as it is for lawyers. But their assumption must be that this practice is ethical because, just as is the case with lawyers, it is understood by all the participants in the system of justice and no one is misled.

Partisan Truth

But does the jury clearly understand this partisan role? After all, they watch as the forensic psychiatrist takes an oath to tell the truth, the whole truth, and not the partisan truth. The psychiatrist does not begin his/her testimony by revealing to the jury that he or she has been retained to make the best case possible. Rather, he or she is introduced to the jury with an impressive presentation of distinguished credentials to establish expertise, not partisanship or bias. Nor does the judge instruct the jury they should keep in mind in weighing the expert testimony that the forensic psychiatrists have a responsibility to be biased. Until there is this kind of candor in the courtroom, it will be impossible to sweep the ethical problems of psychiatry under the rug of intelligible adversarial ethics.

None of these are simple matters, and I do not mean to suggest they are—or that I have any answers. What I have tried to suggest from my vantage in the ivory tower is that it seems none of us has the answers. Forensic psychiatry is caught on the horns of an ethical dilemma. It is a painful position to be in, but the greater danger is to think you have found a more comfortable position, that you can simply adjust to the adversarial system or remain true to your calling as a physician. The philosophers say life is a moral adventure; I would add that to choose a career in forensic psychiatry is to choose to increase the risks of that moral adventure.

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