

The Ethical Practice of Forensic Psychiatry: A View from the Trenches

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Forensic psychiatrists have been sensitive to the ethical considerations that follow from working at the "interface" of medicine and law. These ethical issues have been discussed both from a theoretical and from a personal perspective.^{1,2} Current ethical theories presuppose a Newtonian, mechanistic model of science that requires pure objective data and a subject/object dualism. This outmoded view encourages philosophers to see values as separate and distinct from the empirical world of facts. As a result, medical ethicists have seen their task as deductively developing absolute principles that they then use to prescribe action guides for physicians. This deductive method, with its acceptance of the fact/value distinction (the "ethical law" that one cannot derive "ought" statements from "is" or descriptive statements), is an explicit basis for a significant portion of Stone's presentation of the "purist" argument that "the forensic psychiatrist outside a therapeutic context is meddling in alien business."

This article describes applied clinical ethics, a new and specific method of identifying and working with ethical problems. Applied clinical ethics is inductive and is based on a twentieth century understanding of science and values that incorporates a Systems Theory framework.^{3,4}

Applied Clinical Ethics: An Interdiscipline

In the past thirty years academic philosophers have attempted to develop secular medical ethics by proposing new rationalistic theories or using existing assumptions. These theories result in abstract rules that are imposed on clinical situations.⁵ For example, starting from the principle of autonomy (the good is the patient's choice) and applying it universally, the following steps are prescribed for physicians when deciding whether a depressed patient should receive electroconvulsive therapy.

1. Is the patient legally competent to make choices?
2. If yes, has the physician fully informed the patient about the procedure and possible untoward effects?
3. If yes, is that documented and has the patient signed the consent form?
4. If yes, the physician is ethical by definition, and the patient's choice is ethical.

This appears to be a simple, clear, and certain formula, but these characteristics are spurious. This formula redefines medicine as the facilitation of individual, relativistic choices and denies significant importance to human-biological values.

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It disallows any considerations of the clinical data in the derivation of the ethical principle.⁶

Psychiatrists, on the other hand, have approached forensic problems from clinical experience and personal ethical sensitivity.⁷ Psychiatrists have relied on the case method, but have lacked a well-developed theory capable of meeting the conceptual objections of traditional ethicists. Applied clinical ethics combines psychiatry and ethics into an interdiscipline. It is based on the case method and not universal rules. This approach is less relativistic than the current procedural ethics by committee or idiosyncratic individual choice.⁸ Based partly on descriptions of good human functioning, applied clinical ethics is an articulation of a medical value system. This value system supplies general content and makes the physician's ethical responsibility much broader than facilitation of patient choice. The physician can and must ethically label choices as good or bad.

Most current ethical theories make an actual interdiscipline of medicine and ethics impossible because these ethical theories are based on deduction and non-empiricism, while medicine is based on induction and empiricism. One cannot have a functional interdiscipline without an agreed-on way of thinking and knowing.⁹ Compounding the difficulty of forging such an interdiscipline is the lethargic pace at which medicine has moved to incorporate twentieth century scientific thought into its understanding of health and disease.¹⁰ In contrast, applied clinical ethics starts with the clinical situation or case, from which problems are identified and working ethical hypotheses developed; it isn't the juxtaposition of two completely separate disciplines or the imposing of categories from deductive theories onto clinical experience.¹¹

Starting with these clinical cases, we propose two major categories: descriptive ethical problem identification (for example, the issue of dual loyalty conflicts between the individual good of the patient and the institutionally defined social good); and hypothetical ethical constructs that aid in understanding and dealing with case issues (for example, a systems perspective as an alternative to the utilitarian definition of good). Our method has identified forensic problems that are either new or infrequently discussed, for example, the inappropriate use of the legal system resulting from deinstitutionalization; countertransference issues; and the distinction between the legal and therapeutic sense of prediction of dangerousness.

We also have used new ethical constructs to analyze previous identified issues, for example, dual loyalty. Dual loyalty previously has been examined using: (1) a Utilitarian ethical system that defines individual good in terms of the aggregate good and assumes all individual good can be translated into social good or (2) an Autonomy or Patients' Rights ethical system, in which the good is defined in terms of individual good. In one, allegiance is given to protecting society and aiding the legal system in its role of protection and punishment. In the other, the psychiatrist at the extreme is advised not to participate in forensic issues or in the courtroom, or at best to manipulate the system for the individual's good in all cases.

We suggest that Utilitarian and Autonomy concepts be replaced by General

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Systems constructs. Systems constructs descriptively reflect the inevitable conflict between two different levels of good and suggest homeostatic mechanisms for dealing with such conflicts. General Systems Theory as a model for looking at ethical issues in medicine has important epistemological advantages.¹² It is a descriptively accurate scientific model for the life sciences and enables an ethical analysis to be relevant to the situation, since the situation can be properly understood in its context. Finally, it provides a clear reason for paying attention to important affective components in ethics, for example, compassion and empathy, since in the systems model all levels are equally important.

Clinical Setting

For three years, one of us trained in ethics and one of us trained in psychiatry have conducted a weekly forensic seminar and practicum with PGY-3 psychiatric residents. The individuals examined in the practicum were representative of the individuals referred to the clinic. These weekly meetings took place at the Monroe County Mental Health Clinic for Sociolegal Services. The clinic was established in 1963 by the Department of Psychiatry of the University of Rochester Medical Center and the Monroe County Board of Mental Health to provide consultative and educational services to the courts and probation department.¹³ It is funded by the Monroe County office of Mental Health. It is located in a complex of buildings housing the courts, probation department, district attorney, public defender, police, county jail, and rehabilitative services for inmates of the jail. The clinic receives approximately 800 referrals per year from a number of sources. Since the clinic is part of the mental health system and not part of the legal system, it can establish its own procedures and its own goals. This makes clear the competing value systems of medicine and law while not resolving the conflict between them.

Results and Discussion

Using applied clinical ethics, problem areas were identified from the case log. These are the areas and the ethical constructs that help deal with them:

1. Need for Treatment and Treatability The first two cases involve differing outcomes based on decisions to recommend or not recommend treatment.

Case 1 A single male social worker in his 30s was arrested on charges of Harassment. In an argument with his mother, he claimed ownership of her home, refused to leave, and was threatening to hurt her. She called the police, as she had done many times before when her son had been abusive or threatened to kill her. The court requested a psychiatric examination to determine need for psychiatric hospitalization. On interview he insisted he was going to return home when released. He had a history of outpatient psychiatric treatment. The current crisis was precipitated when a homosexual relationship with a coworker broke up. He found himself without a place to live and demanded he be permitted to take possession of his mother's house. On mental status examination, he appeared to be hostile and aggressive with some grandiosity and a clear feeling of entitlement. His speech was intellectualized; familiar with psychiatric jargon, he

made reference frequently to family dynamics in the interview. Diagnostic impression was Personality Disorder, type undetermined. He did not meet the criteria for involuntary civil commitment. He was not interested in outpatient treatment.

Case 2 A 32-year-old male with a history of psychiatric hospitalization for treatment of schizophrenia, paranoid type, was referred for evaluation of his competency to stand trial and need for treatment. He was being held on charges of Assault, Third Degree for beating family members including his mother and sisters. On interview he talked about being robbed and of a conspiracy against him. He had little understanding of the legal process or ability to work with his attorney. His jail management posed a significant problem because he refused to take medications. The psychiatrist reported to the court that the individual appeared to be incompetent to stand trial and in need of treatment that could not be given in the jail setting. As a result, the defendant was committed to the state hospital for treatment and restoration of his competency to stand trial.

The ethical question in the decision to recommend medical treatment is complex;¹⁴ the forensic situation increases that complexity. In deciding the ethics of intervening, a general rule of thumb has been to determine whether treatment stands a better chance of helping than harming the patient, a harm-benefit assessment or consequentialist perspective in ethics.¹⁵ What is good depends on determining the consequences of a choice, weighing the various consequences in terms of harm or benefit, and selecting that choice whose consequences produce more pleasure than pain, whether in terms of decision theory or hedonic ethics.

In the forensic situation, there are two competing value systems: medical values and legal values. What is legally beneficial to the individual may be therapeutically harmful and vice versa. There may be a conflict between broader individual good and social good. Medicine often serves an excusing function, for example, absence for illness. This occurs in psychiatry, and the forensic situation again complicates it. The excusing function is influenced by seriousness of charges and consequences. Misdemeanor charges are routinely dropped if a patient is civilly committed to a psychiatric hospital. The excusing function that forensic psychiatry provides to achieve the goal of justice in the legal system now must weigh individual need for treatment and treatment goals against the individual's legal goals and the social goals of the legal system.

It is not an easy ethical (or technical) task to set therapeutic goals based on patient needs and the therapist's realistic evaluation of the potential for change. Setting therapeutic goals is a delicate process of negotiation and judgment. When the forensic element is added, we have again complicated the ethical decision process. Now the establishment of therapeutic goals must take into account the constraints imposed by the legal system since social goals are added to the picture.

When the psychiatric disorder is major and the legal charges minor, therapeutic values determine the outcome. Where the criminal charges are dominant and psychiatry has little to offer, the individual remains within the legal system. Where the individual has a significant treatable psychiatric disorder and there are major criminal charges, both systems have a socially determined obligation to

remain involved, with all the brokering and negotiation between the systems that this state of affairs implies.

For medical values to be weighted heavily in any assessment of consequences where there are major criminal charges, the psychiatric disorder must be serious, and the possibility of treatment must be realistic. The diagnosis of Personality Disorder (as in the first case) may not fit the requirement for seriousness and often has limited possibilities of treatment, which in turn can limit the judge's dispositional choices. In the first case, further outpatient evaluation was suggested, but the excusing function of psychiatry within the law did not come into play. The seriousness of the need for treatment and the prognosis for treatment did not weigh enough in the dynamic balance between medical values and the legal values to recommend inpatient treatment and have the charges dropped. The second case illustrates the outcome where there is a serious illness and the possibility of effective treatment. Ethically, the seriousness of the psychiatric factors and the efficacy of treatment can allow a heavier weighting of therapeutic values.

2. Evaluation Reliability and Validity Recommendations for treatment are based on the ability to assess the clinical situation. The clinic staff involved in making these evaluations and decisions include experienced and inexperienced practitioners. Many disciplines are represented: psychiatry, psychology, nursing, social work. There is an implicit assumption that discipline and experience variations will nevertheless produce a reasonable degree of evaluation reliability, an assumption that should be examined. Since the legal effects of the results of the psychiatric evaluation are important, an ethical problem arises, one demonstrated by the following case.

Case 3 The patient is a 41-year-old divorced, unemployed individual who had been a firefighter. He was arrested on charges of Harassment for threatening and assaulting his mother with whom he had been living for one year following his divorce. He denied the charges. After diagnosing a personality disorder, the staff member doing the initial interview requested a psychiatric consultation. The consultation revealed that the patient had paranoid delusions and a thought disorder. The patient was given a diagnosis of Schizophrenia, paranoid type. He was committed to a state hospital on a two-physician certificate.

While evaluation reliability is always important to the patient, adding the legal factor makes it even more significant. Evaluation reliability is also important in establishing respect for the work of the clinic, and in general, for the perception of psychiatry in the criminal justice setting. Collaboration and consultation reduce error, although they certainly do not eliminate it. When cost-containment concerns decrease psychiatric involvement in a clinic operation, there is a significant risk that evaluation reliability and validity will be impaired. As a result, the ethical problem arises of sacrificing the individual's good to the social good of budget consideration.

3. Prediction of Dangerousness Although the American Psychiatric Association has taken a clear position that psychiatrists do not have special expertise in the prediction of dangerousness, there continues to be pressure from members of the legal system for psychiatrists to supply such predictions. The situation is

confused, we argue, because there is a psychiatric focus and a legal focus for the prediction. The two are not equivalent. We have argued that psychiatric prediction of dangerousness to self or others involves assessment of the presence of a psychiatric illness requiring further inpatient evaluation and treatment that is likely to improve the patient's condition either through crisis intervention or initiation of long-term treatment.¹⁶ The prediction is for the near future.

Legal prediction of dangerousness has serious restraint and punitive consequences for the individual. The courts predict dangerousness in considering bail, sentencing, and probation. For bail, only a preponderance of evidence of dangerousness is required for the judge not to set bail. For sentencing, all that is required is some proof that the particular sentence is "needed." Various mechanisms of appeal are built into the law to compensate for this reduced standard of proof. The rationale of benefit to the patient requires different safeguards than the rationale of social control. Psychiatric prediction is made in response to an immediate situation and can lead to involuntary hospitalization. Legal prediction is made for punishment or social control, for long-range behavior in a variety of environmental situations, and can result in lengthy sentences. The judge's level of proof in sentencing is lower than the psychiatrist's level of proof in cases of civil commitment, but ethically, it could be argued it should be the reverse.

In psychiatric prediction, the most effective safeguards against misuse of the psychiatrist's role in predicting dangerousness and involuntarily hospitalizing a patient are the professional skills and accountability of the psychiatrist and the psychiatrist's fiduciary obligations centered on the individual's good. Two levels of good are involved in legal prediction, individual and social. The social good (social control and protection) has significant support; for this reason the individual good requires legal guarantees and codified safeguards. Despite legal pressure to assign legal prediction of dangerousness to psychiatry, the fact there are two levels of good in this prediction calls for safeguards that are embedded in the legal system.

4. Effects of Deinstitutionalization Paralleling the deinstitutionalization of state hospital patients has been the increase in the number of individuals in jail who have serious psychiatric difficulties. Many of the patients who are released from the state hospitals follow the path of our community's "golden triangle": psychiatric emergency department, state psychiatric hospital, county jail. Not all patients are candidates for community living; their forced exit from hospital settings has added to the number of psychiatrically impaired inmates. Individuals caught in this situation fit this description: there is little legal interest in the case, the arrest is for very minor nuisance crimes, the mental health system has little follow-up time; staffing constraints encourage seeing the problem as the current arrest rather than looking for longer-term solutions.

Case 4 A 27-year-old male was arrested on bank robbery charges. He was diagnosed as retarded (IQ 65) and was cared for at home by his parents until he was orphaned by a car accident. He was admitted to a developmental center where he remained for 13 years until the age of 21. Over his objections, he was forced to leave the institution, with few resources for coping. He soon became

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involved in behavior that led to arrest and incarceration. On interview, he repeated his wish to return to the developmental center where he might once again help patients more impaired than himself. He stated that he robbed the bank in the hope that this would lead to his return to the developmental center. Other attempts to return or be hired to work with those more impaired than himself were unsuccessful. He met criteria for competence to stand trial. The court was informed of this finding and also alerted to the fact of the individual's impaired ability to adapt to life outside the developmental center.

Our cases¹⁶ point out some effects of the deinstitutionalization process. This person is not a typical bank robber and has a poor fit with the legal system. Other deinstitutionalized arrested individuals further highlight the conflict between an autonomy value and medical values based on the best interests of the individual.

5. Legal and Therapeutic Competence Standards The criteria used to determine competence to stand trial are directed to the evaluation of the question: Is this person competent to deal with the issues and situations involved with handling the legal charges he/she faces? The criteria regarding competence to stand trial may be confused with the criteria regarding involuntary hospitalization¹⁷ to the detriment of the individual and the overall functioning of the legal system and the medical system. The cases below illustrate the complex but not rare situation where the individual may be competent to stand trial and requires involuntary hospitalization.

Case 5 A 28-year-old male was arrested on charges of Attempted Murder, Second Degree. He attempted to kill his mother by choking her. He had a history of psychiatric hospitalization in 1975, 1978, and 1979. He was taking Haldol, 10 mg. bid. in jail. During the psychiatric interview, his answers were sparse, monosyllabic, vague, but there were no overt psychotic symptoms. The psychiatric report indicated he was competent to stand trial and in need of treatment.

Case 6 A 25-year-old male who resided at a developmental center and had a fullscale IQ of 61 was interviewed. In that setting he had a history of assaulting staff members and was arrested on charges of Assault, Third Degree for a recent attack. He was examined for competence to stand trial at the request of the judge. Since the charge was straightforward and he understood both the charges and the consequences, he met the minimal standards of competence to stand trial.

At times, the legal system may pressure the forensic psychiatrist to misuse the competence to stand trial evaluation to achieve a legal end. A district attorney may wish to use a competence evaluation to confine someone where there is sparse evidence for conviction. A public defender's agenda may be to hospitalize an individual in order to bolster an insanity defense or permit memories to fade and witnesses to be lost. In these situations, one party is attempting to use psychiatry to gain an unfair advantage (the goal is unethical) and is asking the profession to act in an unprofessional, unscientific way to achieve an end that is not broadly agreed on (the means violate professional values). Both the legal and therapeutic systems are being misused.

The forensic psychiatrist must be alert to the pressures to misuse psychiatry. There are rare cases, however, in which the ostensible "misuse" of psychiatry

may be ethical to avoid a tragic outcome. From an ethical standpoint, professional values are not universal or categorical imperatives. There are infrequent occasions when the means to an end need to be evaluated within the broad context of the end and not restricted to a narrow analysis of the means.

It simply is not true that the end never justifies the means; that is simplistic (it turns on how the ends are defined). Even Kant's ethics that emphasize never lying cannot be universally applied. In the well-known example of saving one's neighbor from being senselessly killed by lying to the group of killers about the neighbor not hiding in one's house, judgments are made about trade-offs of competing good acts and intentions. Forensic psychiatrists have to balance the harm done to professional standing and future professional activity against the certain and immediate severe damage to the individual. Casuistry offers some criteria for this: the purpose or end must be good rather than bad and the good must be agreed on; the means cannot have such bad consequences that these outbalance the good purpose; and no other preferred means to the end can be available.

6. Diagnostic Labels and Social Agency Medical classification aids the clinician in therapeutic planning. Within the legal system, this medical classification provides a starting point for a discussion of signs and symptoms of the illness that may be relevant to the point at issue. At times, whether we favor it or not, the diagnostic label itself will significantly influence the legal process.¹⁸ This case illustrates the fact that the use of psychiatric diagnoses creates two potential problems: the diagnoses may have pejorative connotations; the diagnoses may point to limited treatment possibilities.

Case 7 A county probation officer requested a presentencing evaluation for a 34-year-old male who had pled guilty to the charges of impersonating a physician's assistant. He had a previous history of posing as a pediatrician, a clergyman, and a psychology professor. He had served time in a federal prison for impersonating a clinical psychologist. On interview he was a well-groomed, confident man who had letters of reference from out-of-state psychologists. He also had a very impressive but obviously falsified CV. He also had been charged with homosexual pedophilia but was never convicted. He reported that he had been married and was presently dealing with a homosexual relationship that had broken up. He was diagnosed as having an Antisocial Personality Disorder and Homosexual Pedophilia. He was eager to be recommended for outpatient psychiatric treatment. On the basis of his past unsuccessful psychiatric treatment and lack of current treatable symptomatology, outpatient psychiatric treatment was not recommended.

The diagnoses of Antisocial Personality Disorder and Homosexual Pedophilia, with their negative connotations, are examples of potentially pejorative diagnoses.¹⁹ There is a professional obligation to counteract the stereotypic, pejorative implications of some psychiatric terms and to make efforts to write reports in a way that would decrease the bias members of the criminal justice system may bring to the report. Even where the pejorative implications of a diagnostic label have been minimized, the diagnosis of a disorder with little or no effective treatment may be harmful to the individual's agenda to be assigned treatment rather than punishment.

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The evaluation in this case flowed from the psychiatrist's responsibility to the courts and not to the individual as part of a doctor-patient relationship. By participating in the evaluation, the individual ran the risk of receiving diagnoses and treatment recommendations that did not fit his goals. Clearly informing the individual about the purpose and use of the evaluation, for example, whether or not there is effective treatment will influence the legal outcome and disposition, allows the forensic psychiatrist to diminish the conflicts of double agency.

7. Presence or Absence of a "Patient"/Consultation in Assumed Therapeutic Situation The previous case points to a larger class of issues where agency responsibility, professional responsibility, and the responsibility to the "patient" can conflict.²⁰ This can be expressed in terms of determining if there is a patient and, if so, who the patient is. In Case 7, should concern and responsibility in a social sense (potential harm to young boys, potential harm to the profession being impersonated, community harm) result in society being the patient, in a metaphorical sense? On an *ad hoc* basis, we think the answer could be yes. As a generalized principle, this is not a professional psychiatric role; it involves social control rather than individual therapy or psychiatric expertise. The next three cases highlight situations in which the individual does or does not wish to assume the patient role.

Case 8 A 19-year-old male was charged with Attempted Rape, First, Assault, and Harassment, as a result of his attempt to rape a girl in the ladies' locker room of a local community college. Police have been to the family home on several occasions in response to his rage attacks that involve rampages, yelling and screaming, and paranoid statements about family members. He resisted his family's efforts to have him hospitalized. On interview in jail, he denied any difficulties. Although he demonstrated no formal thought disorder, his past history and the vagueness of his responses led to involuntary hospitalization for further evaluation, where he was subsequently diagnosed as having a Schizophrenic illness.

Case 9 A 40-year-old separated mother of four children was arrested on charges of Burglary First, Attempted Arson, Criminal Mischief Second, and Assault Second when she broke into her ex-husband's trailer. After her release on those charges, she returned to jail to visit her boyfriend. Upset at not being permitted to visit with him, she created a disturbance and was arrested on charges of Obstructing Governmental Administration and Criminal Mischief, Third Degree. Although she had a past history of both inpatient and outpatient treatment, she did not see herself in need of treatment. She viewed the court-requested evaluation for competence to stand trial and need for treatment as a waste of time and of no use to her. During the interview she was hostile and withholding. She was found competent to stand trial and not requiring inpatient psychiatric treatment.

Case 10 A 22-year-old single male was charged with Unlawful Imprisonment when he took a female social worker prisoner in her car and made her drive around the city. She escaped from the car when it stopped at an intersection. On examination he was an unkempt, hostile individual who did not wish to participate in the evaluation. He said he already had one label as criminal and didn't want to have another as a mental patient. He was aware of his legal situation and

stated that the psychiatric evaluation could do nothing to help him in this legal situation. He had alcohol on his breath and was under the influence of alcohol in the judgment of the interviewer. The interviewer had carefully informed him of the purpose of the examination and who had requested it, and that the clinic would be making a report to the judge. He still refused to participate. At his request, the interview was terminated and no recommendation for psychiatric treatment was made.

This pretrial and sentencing situation can be risky for psychiatrists. Identifying an inmate as a patient can have consequences both at trial and at sentencing. Individuals can attempt to be labeled patients in order to manipulate the excusing function of psychiatry. On the other hand, the psychiatrist may be unwilling to see the individual as a patient in order to "protect" society. More problematic is seeing both society and the individual as patient and being trapped in a dual-loyalty situation. It is good ethical practice to identify the patient and to be clear about who that is. More than one patient (dual loyalty) sets up a problem in ethics that is structurally not resolvable in any ideal way. Where possible, the dual-loyalty situation is best avoided, but we argue that in medicine in general and in forensic psychiatry in particular, this is not always the best ethical choice.

There is also an ethical question about how patienthood is to be determined and by whom. Case 10 addressed the individual's choice of patient status. Is patienthood determined by the therapist, by the patient, or in an interacting relationship? Autonomy ethics tends to assume the patient makes the choice of patienthood. This has several weaknesses, and in psychiatry its problems are most apparent. A therapeutic interaction seems to be the best model for assigning patient status. The model involves the expert's knowledge and responsibility, affective components such as the therapeutic alliance, negotiating the patient role with the individual, and reevaluation by the psychiatrist and patient as the treatment proceeds. Most ethical models of the physician-patient relationship, even the contractual one, miss the real clinical situation. The legal context complicates this therapeutic model. If the loyalty is to be to the referral agent, then the presence of a therapist, a clinic setting, and a therapeutic vocabulary does not necessarily lead to a physician-patient relationship. The individual being evaluated can miss this sophistication, unless fully informed of the actual relationship. There is an ethical need, then, to make the legal context clear, to counteract the too-easy assumption that patient status has been given. And there is also an ethical option, because of the legal agenda, for the individual to choose not to be a patient, where there may not be such an option in the therapeutic context.

8. Countertransference with Forensic Populations Countertransference is a technical and ethical issue in general psychiatry. Frequently it is a more troublesome issue with the clinic population (that routinely includes murderers, child molesters, rapists, con artists, and arsonists, as well as generally violent individuals).¹ We have argued elsewhere that empathy and concern for the welfare of the individual are basic components of the medical system, that an ethical system is better grounded in these affective elements than in reason, utility, or intuitive rules or rights.¹⁶

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The legal value system with its concepts of accountability, intent, and punishment is closely related to ethical systems that see autonomy as paramount. Autonomy based ethics implies making informed choices, responsibility as a necessity for human dignity, a sufficient degree of freedom that punishment makes rational sense, and a heavy emphasis on cognitive and rational decision making. The therapeutic value system incorporates determinism, dynamic understanding of conflict and intent, and the possibilities of change and growth. Accepting responsibility is part of change and growth, not in the judgmental sense of being accountable and punishable but in the therapeutic sense of having the ability to monitor one's behavior and gain control over its overall direction. This therapeutic value system is a part of naturalistic ethics, emphasizing the affective character of ethics.

Discussion

Stone questions the possibility of synthesizing therapeutic values and justice values in the practice of forensic psychiatry. The arguments he presents to demonstrate the boundary problems of forensic psychiatry are in the tradition of philosophers who have similarly contrasted the therapeutic society with the just society, mistakenly thinking that one can be achieved without the other.²¹ The practical ethical issues we have identified in forensic psychiatry reflect the charge of giving expert assistance in both the therapeutic society and the just society. Trying to be clear about ambiguous philosophic terms such as responsibility, autonomy, free will, and forming intent, becomes even more important and problematic in this context, because the goals of healing and the goals of punishment are so different.

Although it is easy to understand why some suggest abandoning the project,^{22,23} this action would ignore psychiatric illness in the legal context and abandon individuals to a Draconian system. To be a just society there must be more than a *lex talionis* and efficient control of its members. If justice is more than social control, it must be concerned with issues of intent, appropriate punishment, and the social effects of unnecessarily sacrificing individual interests. These are the issues an excusing function addresses. One can argue such a function is both in conflict with and essential to the goals of justice. The expertise of the psychiatrist is a requisite for justice to operate in the real world: following the spirit as well as the letter of the law.

The value systems and goals of psychiatry and law are significantly different. Working in a setting that calls for a balanced tension can be disturbing to those who want a neat ethical system with ideal resolutions to problems, but this does not express the human social condition, as Freud pointed out in *Civilization and Its Discontents*.²⁴ How can a psychiatrist provide the information about human behavior that is essential to actual justice while not compromising the medical value system? We suggest, as a partial solution to this difficult assignment, that close attention be paid to the forensic setting. The setting itself can influence decisions and generate ethical problems.²⁵

The fact that the sociolegal clinic described earlier in this article is part of the mental health system and not an arm of the legal system provides the independence needed to define the nature and limits of the psychiatric intervention and to avoid becoming solely an agency advocate. The clinic is set up along the lines of a community mental health center. Of course, there is a potential for abuse in psychiatric consultations to the legal system that this structure does not fully resolve; however, the free-standing situation does make it possible for the clinic to refuse an unreasonable request from the legal system. In those rare instances, where the two systems have been in serious conflict over a jailed individual's treatment, the clinic has withdrawn from the individual's care to emphasize its view that the minimal acceptable medical care could not be provided within the legal system's restrictions or requirements. At times, individuals have entered outpatient treatment at the clinic either because of the nature of the psychopathology or patient preference. This outpatient relationship is bound by all the ethical obligations present in the doctor-patient relationship. As a practical matter, members of the clinic are rarely (from our experience, less so than other clinical staff and psychiatrists in the community) called on to testify or provide clinic records about these treatment situations.

The clinic should combine its independent structure with sensitivity to the distinct possibility that an evaluation may not be in the best legal interest of an individual, and respect the individual's noncooperation as a practical and ethical choice. As Stone pointed out, psychiatrists working in a forensic setting may have to make choices between the individual's best interests, in the traditional Hippocratic sense, and societal goals and obligations. A structure that permits forensic psychiatrists to define and make clear to all parties concerned which of the competing values will prevail in any given forensic evaluation is a partial solution to the dual-loyalty concern.

Systems theory points out that there is no ideal solution to this problem of dual loyalty, a problem of ethics at two levels. The workable solution or synthesis in ethical theory and in clinical practice is to find a balance of power between social and individual good and to determine on an *ad hoc* basis which allegiance will prevail.²⁶ The next step is for the psychiatrist to make clear to all parties concerned where loyalty is being placed. This solution is basically the same approach the clinician uses in balancing his goals of benefiting the patient and doing no harm. The purist position of intervention without harm immobilizes the physician; in like fashion the purist position of devotion only to the good of the identified patient immobilizes forensic psychiatrists. The purist position does not achieve its aim to benefit the individual and harms the individual and society. Under German Law those individuals who survived Nazi Germany's concentration camps are permitted to sue for compensation for disabilities arising from the horror of their internment. If psychiatrists were to decide to abandon the forensic arena (not examine or testify for the lawyers of the survivors or the lawyers of the government), they would not be meeting the individual or societal good. Avoiding potential dual-loyalty situations is not always possible or desirable.

Ethical Guidelines

The value system of medicine, with its full description of the human organism, in addition to its situational quality, also calls for an emotive grounding for a medical ethical system. This emotive grounding is not "doing what feels good" or "doing what you feel like doing." It is not pure subjectivism in opposition to pure objectivism. Indeed, there is no pure subject and no pure object. The emotive component of a naturalistic ethic provides the basis for a workable ethical theory. Ethics in general depend on an affirmation of life and feelings of care for others (the capacity for mature object-relations). Without this affective part of human nature, values cannot begin. Aristotle recognized this essential element but lacked the biological and psychological data we now have to substantiate his model of the good man, without whom ethics is not possible. Ethics is not rational decision making alone or doing good by avoiding contradictions. It is more than fairness or consistency.²⁷

The practice of forensic psychiatry, like the practice of general psychiatry or the practice of general medicine, is most effectively and humanely done using a situational ethics. At times situational ethics is erroneously portrayed, as an "anything goes" ethics. But situational ethics is not cultural relativism; it is not tolerance of all choices; it is not devoid of working generalizations and rules of thumb.²⁸ What situational ethics provides is a method for selecting guidelines that adequately deal with clinical realities. If no guidelines seem to adequately fit the situation, new ones should be developed. The real situation should not be twisted to fit a rule, nor should terrible consequences be accepted in the name of rule following, nor should we assume that an ethical generalization is good for all time and all places.

Based on the collected cases, we make the following suggestions:

1. Abstract, deductive generalizations work poorly in medicine, which is inductive. Confidentiality, for example, is a workable rule developed from numerous case experiences that illustrated the need for trust in a therapeutic relationship. It is not a theoretical good-in-itself, aside from the situation. When we start trying to apply categorical principles such as "The Principle of Confidentiality," we end up doing situational ethics and might as well have started from the clinical situation.

2. The ethicists' notion of rights and autonomy are not the relevant ethical issues in the clinic and fail to describe the clinical experience. Besides being philosophically indefensible, if we stopped and thought about them, such ethical concepts aren't much help with the clinical realities. Alternative ethical systems are available that should be considered, for example, a naturalistic ethics based on affirmation of life, empathy, and norms of adaptive growth.

3. Respect for individuals is a more useful concept than rights and autonomy concepts in the development of a medical ethic. However, we must redefine respect for individuals to include empathy and concern for the individual's best interest, rather than only respect for reason. This translates respect into the tradi-

tional expectation that the physician brings a fiduciary responsibility to the doctor-patient relationship.

4. The therapeutic value system deals with values of compassion, norms of well-functioning, and goals of healthy growth and development. These medical goals and values must be maintained by physicians working with the legal system, both to be true to their medical identity and to assist in the legal goal of justice.

Conclusion

We have proposed the development of an interdiscipline, applied clinical ethics, and used it to investigate ethical issues in a forensic psychiatric clinic. Applied clinical ethics is built on the data and norms of the life sciences, which are both scientific and valuational. Incorporating General Systems Theory, applied clinical ethics is emotive as well as cognitive ethics. Starting with clinical cases, ethical problems were identified and ethical constructs for analysis of issues were developed.

Ethical choices are influenced by context. The clinic setting (in the criminal justice complex) and the clinic organization (part of the mental health system) were discussed as functionally decreasing some of the conflicting issues that emerge from different value systems and problems of dual loyalty.

Ethical concerns and pitfalls abound in forensic psychiatry. Attempts to deal with these ethical concerns have been based on traditional approaches that have been inadequate to the task. We have discussed the working model of applied clinical ethics as a method for uncovering, articulating and studying ethical issues and as a method for arriving at workable solutions. We retain the psychiatrist's clinical approach and further develop the psychiatrist's personal ethical sensitivity with the incorporation of more sophisticated ethical theory. In the last three decades, philosophers and other professional ethicists have proposed systems that remove these clinical value issues from the clinical context and place them within preestablished ethical theories. The use of these preestablished ethical theories, which are imposed on the clinical experience, have affected medicine by shaping public policy, regulations, and legal restrictions. Clinical value issues cannot be successfully taken from the clinical context and be judged meaningfully by *a priori*, rationalistic, absolute, and antiquated ethical theories. The use of these theories to analyze the ethical issues in forensic psychiatry has been detrimental to an adequate understanding of the problems. Applied clinical ethics provides the benefits of a language with which to fully discuss the clinical realities and ethical choices. It uses a methodology that is consistent with the clinical method of patient care, thus providing the needed common language to advance patient care in both a technical and ethical sense. Applied clinical ethics strengthens forensic psychiatry's ability to define the ethical behavior of its practitioners.

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