A Theory of Ethics for Forensic Psychiatry

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This article offers a justification for a set of principles that constitute the ethical underpinnings of forensic psychiatry. Like professional ethics in general, the principles are based on the particular societal functions performed by forensic psychiatrists and result in the intensification of obligations to promote certain important moral values. For forensic psychiatrists, the primary value of their work is to advance the interests of justice. The two principles on which that effort rests are truth-telling and respect for persons. In the same manner as other physicians who perform functions outside of the usual clinical context (e.g., clinical researchers), forensic psychiatrists cannot simply rely on general medical ethics, embedded as they are in the doctor-patient relationship—which is absent in the forensic setting. Indeed, efforts to retain some residuum of that relationship and its associated ethical principles are likely to create confusion in the minds of both forensic psychiatrists and their evaluees and to heighten the problems of double agency. A virtue of this approach is the clear distinction it offers between clinical and forensic roles.

In 1982, at the annual meeting of the American Academy of Psychiatry and the Law (AAPL), Alan Stone posed a stark challenge to the moral legitimacy of forensic psychiatry.[1] Casting a skeptical eye on the ethical principles forensic psychiatrists might use to guide their behavior, Stone rejected them all. The competing possibilities, he charged, were either internally inconsistent or useless in practice. Indeed, so chaotic was the state of ethics in forensic work that forensic psychiatrists "are without any clear guidelines as to what is proper and ethical."

If correct, as Stone's audience grasped immediately, this conclusion has some fairly troubling implications for forensic psychiatry. A field that is unable to distinguish the proper from the improper, the ethical from the unethical, must tolerate all behaviors equally, since no neutral principle exists for accepting some and condemning others. There can be no good practices and no bad practitioners. The formulation of standards of behavior is beyond the profession's reach. It is difficult to imagine another occupation about

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which a similar statement may be made; even thieves, after all, are said to have honor among them. Forensic psychiatry, in this view, is a quintessentially lawless activity.

Had Stone merely been describing the contemporary state of ethics in forensic psychiatry, his portrayal might have been taken as a challenge. Organized forensic psychiatry was relatively young at that point, its major organization, the AAPL, having been founded only 13 years earlier. If insufficient attention had been paid to ethics so far, that was unfortunate, but remediable. But Stone's judgment was more pessimistic still, preempting the possibility of future advances. Not only had no guiding principles for forensic work been identified to date—the task was hopeless. The bedrock principles of beneficence and nonmaleficence, to which medicine had looked historically, were inapplicable outside the clinical realm. Without these compass points to steer by, forensic psychiatry was condemned to wander in an ethical wasteland, permanently bereft of moral legitimacy.

In the years since Stone's speech, many commentators have challenged his nihilism regarding forensic ethics, pointing to principles that might constitute starting points for an ethical framework for forensic psychiatry.[2–4] The AAPL itself has formulated a code for its members that, although far from comprehensive, offers generally accepted guidelines for behavior.[5] The organization has begun issuing opinions of its Ethics Committee to "flesh out" the bare bones of the guidelines, much the way other specialty groups in medicine have done.[6] Indeed, Stone himself, in his more recent writing, seems less despairing of being able to identify some operational principles and is even willing to offer suggestions for minimizing ethical conflicts.[7]

If the situation was never as bleak as Stone's portrayal, and if considerable attention has been given in the intervening years to formulating more clearly the profession's ethical foundations, there is one respect in which we might yet legitimately be criticized. Forensic psychiatry still lacks a *theory* of ethics by which to shape its behavior. By theory I mean the justification of a set of principles that constitute the ethical underpinnings of forensic work, based on which operationalized guidelines can be formulated in a consistent fashion. Such a theory would enable us to resolve conflicts regarding the applicability of various ethical principles to forensic psychiatry, as well as assist us in more precisely crafting ethical guidelines for particular circumstances.

To be sure, various commentators, myself included, have addressed one or another principle that might constitute components of a theory of forensic ethics.[2–4, 8–10] But none has linked these principles to a more comprehensive schema. I suspect that inarticulated elements of such a theory exist among forensic practitioners. Indeed, it would otherwise be difficult to account for the widespread agreement in the field about so many aspects of forensic ethics.[11, 12] The task that remains is to make explicit those moral judgments that lie just below the surface of consciousness and to provide a justification for them.

I propose in this article to develop the outlines of a theory of ethics for forensic psychiatry. It seems inevitable that such a theory will be in some ways incomplete and that adjustment will be required. The likelihood of some degree of imperfection, however, is insufficient reason to avoid beginning the work.

Why "Professional" Ethics?

In attempting to construct an ethical theory for forensic psychiatry, we must confront a basic question about professional ethics in general. Professionals, whether teachers, engineers, accountants, or psychiatrists, are all members of a broader society. If we accept that certain ethical norms are binding on everyone, what justification is there for allowing discrete occupational groups to create separate rules for themselves? To press the point, if the norms embodied in professional ethics are identical to those more widely subscribed to, there would appear to be little reason to construct a distinct ethical framework for the professions. On the other hand, if professional ethics differ from—and therefore have the potential for being in conflict with—general norms, how can we justify such deviations?

To answer this question requires some reflection on the nature and application of moral principles.* Moral philosophers recognize two types of principles that guide our behavior. Bernard Gert calls them "moral rules" and "moral ideals."[13] Moral rules are generalizable maxims that proscribe behavior likely to cause harm to other people. "Thou shalt not kill" is a classic example of a moral rule. We are always obligated to follow a moral rule, unless, as Gert suggests, "an impartial rational person can advocate that violating it be publicly allowed." Thus, a person who deviates from the moral rule against killing in order to save his or her own life would generally be acknowledged as having engaged in a justifiable violation of the rule.

Violations of moral rules, in fact, are an inevitable consequence of the complexity of life. Situations frequently arise in which two moral rules, each seemingly absolute, are in conflict with each other. Resolving that conflict requires balancing, among other morally relevant factors, the nature of each imperative, the benefits and harms likely to flow from its violation, and the alternative means of achieving the desired end. A parent, for example, who bears a moral duty to care for a child, might be justified in breaking a promise to help a friend move her belongings if the child were sick and needed the parent's care. Keeping promises is a moral rule, but in this context, the moral responsibility to care for a child takes precedence.

In contrast to moral rules, moral ideals "encourage people to act so as to prevent and relieve the suffering of others."[13] Although usually worthy of praise, such behavior is not ordinarily required of persons. Were that not the case, people might well feel morally compelled to expend all of their time and resources helping other people, to the utter neglect of their own aims in life. Giving charity embodies a

* Following the practice of most contemporary ethicists, I use the terms "moral" and "ethical" interchangeably in this article.

moral ideal, usually to be encouraged, but not compelled. The legal philosopher Lon Fuller uses the felicitous term "morality of aspiration" to describe this kind of moral principle, in contrast to the binding "morality of duty."[14] Moral rules generally outweigh moral ideals, but not always; Gert offers the example of a person who, by breaking a promise (thereby violating a moral rule) can save a life (which only represents a moral ideal), in this case the morally appropriate choice.

With this background in moral theory, we can return to the question of how one can justify a distinct code of ethics for any subgroup in society. Clearly, it would be difficult to rationalize any profession's blanket abrogation of moral rules precluding harm to others, and that is not the function of professional ethics. But a society that desires to promote certain important moral values, as the ethicist Benjamin Freedman[15] suggests, might well elect to allow professions dedicated to those values to weight particular moral rules more heavily than others. "Professional morality," in Freedman's words, "sins a sin of zealousness rather than laxity."[15]

For example, to promote the value of health, society might permit physicians to elaborate an ethical code that gave primacy to rules congruent with that purpose. Keeping confidences, which Freedman sees as a corollary of the duty of nonmaleficence (familiar to physicians in its Latin form, *primum non nocere*—first do no harm), may be a moral rule for all people, but for physicians, especially for psychiatrists, it achieves elevated status. Recognition of this can be seen in the recent decision of the U.S. Supreme Court in *Jaffee v. Redmond*, which held that psychiatrists and other psychotherapists could not be compelled to give testimony in federal court when doing so would mean violating the confidences of their patients.[16] The usual primacy of the value of justice, and of the rule that every person must help in the pursuit of justice, even if it requires breaching confidences, was abrogated for the sake of promoting the treatment of persons with mental disorders.

Moreover, as Gert indicates, professional codes of ethics may transform the goals of moral ideals into moral rules, binding on the members of a profession.[13] Relieving pain is one such moral ideal, the goal of which becomes a duty incumbent on physicians, nurses, and other health professionals when they accept responsibility for a particular patient. This is a second way in which professional ethics "sins a sin of zealousness," in Freedman's term.

How do we know on which moral rules a profession should confer preeminence or which moral ideals should be translated into duties? The answer should be fairly apparent by now. Creating an ethical code for a profession must begin with identification of the values that society desires the profession to promote. Of course, those values must in themselves be morally legitimate. Health is such a value; discrimination on the basis of race, religion, or sexual orientation is not. Then, relative dominance is conferred on those moral rules that support that value, and the moral ideals that act similarly may be transmuted into binding duties. If

the work is undertaken correctly, the ethics of any profession differ from ethical standards more generally applied only insofar as is necessary to advance the value in question.[17]

The Necessity for a Distinct Set of Ethics for Forensic Psychiatry

Even with the justification clear in our minds for professional ethics in general, there is an additional obstacle that must be overcome before we can outline the principles of ethics for forensic psychiatry *per se*. It might be objected that a framework to guide the ethical thinking of forensic psychiatrists already exists. Since every forensic psychiatrist is a physician, and the principles of medical ethics are widely subscribed to by members of the profession, the work of elaborating a distinct set of ethical principles for a medical subspecialty is unnecessary. To discern the moral obligations of forensic psychiatrists, or of physicians in any other role, we need only examine the principles of medical ethics.

As a rejoinder to this claim, I note that the assumption that all activities of physicians must be governed by the same ethical principles is clearly fallacious. The ethics of medicine, focused as they are on the principles of beneficence—to do good for one's patients, whenever one can—and nonmaleficence—to avoid doing harm if at all possible—derive from the usual clinical setting.[18] When patients come to physicians for diagnosis and treatment of medical problems, patients seek and are appropriately reassured by physicians' nearly single-minded fidelity to their interests. Fried refers to this as the principle of "personal care."[19] This commitment to personal care has served medicine well, and it constitutes the bedrock on which the structure of medical ethics has been constructed.

Imagine for a moment, however, a physician who selects by chance for his or her patient a medication of uncertain efficacy at a dosage that bears no relation to the patient's own needs, all the while refusing to tell the patient which medication the patient is actually receiving. Indeed, the physician herself remains deliberately ignorant of what the patient is taking, complicating evaluation of the patient's situation, including puzzling changes in the patient's state, which may or may not be due to medication side effects. To what extent does this behavior measure up to the usual standards of ethical medical care? Not in the least. Are we then willing to condemn the physician's actions as unethical? Perhaps not quite yet. Indeed, we might conclude that the physician is acting ethically after all.

For in our example, the physician is caring for the patient as part of a research protocol. The procedure involves comparing the efficacy of two medications, assigned at random, and administered on a double-blind basis. Dosages are determined in advance and standardized, to permit clearer estimation of the comparative efficacy and side effects of the medications. Although the research physician has turned aside from medicine's usual dedication to patients' interests (we might more accurately refer to patients here as "research subjects"), he or she would not be condemned for this behavior. Rather, it would be generally acknowledged that

the ethics of the research setting differ substantively from those that apply in ordinary clinical work.[19]

This premise is true in two respects. Certain obligations that usually would be binding in clinical medicine are abrogated in research studies. Research physicians are expected to give primary attention to the production of valid, generalizable data, rather than to meeting patients' individual needs. They may even subject patients to procedures that are unlikely to benefit them and hold some degree of risk, if that course advances the research.[†] Beneficence and nonmaleficence toward the individual patient are not their principal obligations. On the other hand, although research physicians might not owe primacy to patients' interests, they assume additional duties, including the obligation of obtaining a valid informed consent from their research subjects, which involves disclosure of just how the research process differs from ordinary clinical care. The justification of their behavior is based, in part, on their subjects' knowing and voluntary acceptance of these altered conditions of treatment.

Differentiation of ethical principles applicable to physicians according to the functions they are performing is in keeping with the rationale we considered above for the existence of professional ethics as distinct from general ethical norms. To determine which moral rules and ideals a group of professionals ought to observe with particular zealousness, we look to the values that society desires that profession to promote. It is not unusual, however, for professionals to be charged with pursuing different values at different times, depending on the roles they are fulfilling. A physician may work in a general outpatient clinic in the morning, where fidelity to patients' interests (that is beneficence and nonmaleficence) is the over-riding moral imperative. Later in the day, he or she may move to a research unit, where the advancement of knowledge, rather than the pursuit of health, takes priority. There is no reason to be uncomfortable with the notion that as one's role changes, so also do the ethics to which one is committed.

A similar argument, it should be evident by now, can be made for forensic psychiatry. Whereas clinical medical ethics are rooted in a physician-patient relationship, no such nexus is established in the forensic setting.[9‡] Forensic psychia-

[†] Of course, in keeping with generally accepted ethical principles, the degree of risk to which subjects are exposed must be proportionate to the expected benefits of the research; and if unexpected harms occur or it becomes clear that subjects are foregoing important benefits, research projects may be stopped prematurely to protect subjects' interests.

[‡] When I speak of forensic psychiatry and the forensic setting, I refer to the evaluation of subjects for the purpose of generating a report or testimony for an administrative or legal process. This is in keeping with Pollack's well-known definition of forensic psychiatry as "the application of psychiatry to legal issues for legal ends."[20] This is distinct from other functions that persons who consider themselves forensic psychiatrists sometimes fulfill, such as treatment of persons in the correctional system. Psychiatrists providing such treatment fill a role much closer to the one usually played by physicians, and thus—although the particular circumstances of, for example, prison psychiatry, may alter some of the usual ethical rules (e.g., concerning confidentiality) observed in a general treatment setting—they are more tightly bound by the duties associated with beneficence and nonmaleficence. The ethics of correctional psychiatry would benefit from a careful analysis, but I do not intend to offer one in this article.

Forensic psychiatrists sometimes also act as consultants to attorneys, assisting them with strategic and tactical decisions, but not directly testifying themselves. In a brief treatment of this role, I have suggested that its

trists who conduct evaluations for legal purposes do not enter into a physician-patient relationship, and therefore the ethical principles that apply in the latter situation are different from those in the former. As numerous commentators have recognized, were forensic psychiatrists to be charged with pursuing subjects' best interests and avoiding harm—as are their clinical colleagues—their evaluations would be worthless to the courts.[4, 22] They would be no more than advocates: junior lawyers doing their best to win a case for their clients. Inherent in the value of the forensic evaluation for the courts is the idea that information adverse to the subject's interests might well be derived from the evaluation and that the forensic expert will truthfully present such data when they are relevant to the legal issue at hand.

Forensic psychiatrists, therefore, like all other physicians whose roles may sometimes depart from the paradigm of the treatment setting, require a distinct set of ethical principles to guide their work. There is no shame in this reality, just as clinical researchers ought to feel no compunctions about observing a code of ethics distinct to their role. Indeed, Stone recognized the inevitability of this conclusion in his chastisement of forensic psychiatry for lacking ethical bearings.[1] His error came in suggesting that it is not possible to identify an alternative set of principles to take the place of those that function in the clinical realm. It is to that task that I now turn.

Principles of Ethics for Forensic Psychiatry

Recalling that the underlying premise for all professional ethics is that society has an interest in advancing certain important moral values, we must begin by asking which values forensic psychiatry is intended to promote. It seems clear that society prizes psychiatric testimony in court because of its potential to advance the interests of justice: the fair adjudication of disputes and the determination of innocence or guilt. Psychiatrists provide information that helps the courts to determine who ought not to be tried at a given point in time, because they are incapable of assisting in their defense; who should not be punished for the acts they have committed, because they lack moral responsibility; who have been subject to psychological injury as the result of others' negligence; and who are so impaired as to be reasonably unable to work. Testimony on these and other subjects is sought from forensic experts because jurists believe that when they are in possession of that testimony they are better able to reach accurate judgments on these very difficult issues.

If justice is the value to be advanced by forensic psychiatrists, what does that imply about the ethical principles that should guide their work? Two primary ethical principles can be derived from this functional analysis. A strong hint with regard to the first principle comes from the oath to which witnesses swear as they prepare to testify: ". . . to tell the truth, the

ethical contours may differ somewhat from the ethical parameters associated with the role of expert witness.[21] Although a more detailed consideration of this function is warranted, that is not the focus here.

whole truth and nothing but the truth."[23] *Truth-telling* is the first principle on which the ethics of forensic psychiatry rest. As I have suggested elsewhere, "[t]he primary task of the psychiatrist in the courtroom is to present the truth, insofar as that goal can be approached, from both a subjective and an objective point of view."[24]

Subjective truth-telling implies something akin to the concept of honesty, i.e., saying what one believes to be true. Is this enough, however, for the forensic expert? What about the forensic psychiatrist who, willfully or by neglect, remains ignorant of the professional literature, knowledge of which might well alter the opinions he or she provides? What about the expert who, although truthful in his or her testimony, as far as it goes, fails to tell the court that his or her conclusions are based on a theory held by only a small minority of peers, or that much evidence exists contradicting the conclusions reached? When the courts ask forensic psychiatrists to tell "the truth, the whole truth . . .", I submit that they are asking for something more.

Here is where the objective component of truth-telling comes into play. The psychiatric witness who is being objectively truthful will acknowledge, insofar as possible, the limitations on his or her testimony, including those due to the limits of scientific or professional knowledge, as well as those specific to a particular case (e.g., due to inability to locate records or directly to examine the subject of the evaluation).[25] Moreover, when the witness' testimony is based on an idiosyncratic theory or interpretation of the literature, the minority status of those views will be made clear. Failure to do so, deliberately or by neglect, will mislead finders of fact about the *prima facie* weight they should give to the expert's testimony and violate the obligation of truthfulness.

Although of critical importance, expressing the limits on one's testimony is not always a simple matter. Forensic psychiatrists operate in an adversarial system in which the attorneys who have hired them may have strong interests in minimizing the extent to which they express uncertainty about their own opinions or about the state of knowledge in the field.[25] Since attorneys and not witnesses are in control of courtroom testimony, questions may be framed in a way so as to discourage experts from making such remarks. But expert witnesses are not helpless in this regard. Experts can set as a condition of their participation an agreement by the attorneys who engaged them to allow them to state the essential limits on their testimony. An expert's ultimate recourse is always to walk away from a case if he or she feels that continued participation will compromise professional ethics.

The second moral rule on which the ethics of forensic psychiatry rests is *respect for persons*. Were truth the only desideratum of the justice system, the police would be permitted to torture suspects to obtain confessions and to search premises on the mere suspicion that illegal activity is occurring. Courts could compel defendants to testify, even against their interests, and district attorneys could reopen the prosecution of acquitted defendants when new, apparently incrimi-

nating evidence became available. Under the American constitutional system, none of this is permitted. Rather, we temper our justice system's pursuit of truth with the recognition that sometimes other values must take precedence. Although one might conceptualize the values underlying the exclusion of probative evidence in a variety of ways, I think it is fair to construe them as representing society's commitment to a respect for persons, even when those persons are suspected of having committed crimes.

The implications of the moral rule of respect for persons differ for the various actors in the criminal justice system, because their roles place them at risk for violating this principle in different ways. For the police, their entitlement to use physical force to protect social order creates the risk that unnecessary force may be used.[26] For prosecutors, the discretion afforded in deciding what charges to file or whether to seek the death penalty creates the potential for the intrusion of illegitimate factors such as the defendant's race or sexual orientation into their decisions.[27] In the case of forensic psychiatrists, the major risk is that subjects of forensic evaluations will assume that an evaluating psychiatrist is playing a therapeutic role and, therefore, that the usual ethics of the clinical setting apply. "This person is a physician," they may reason. "Surely she is here to help me, and at least will do me no harm. I am safe in speaking freely about whatever I choose."

Respecting persons means acting to negate the risks associated with one's role. Thus, the police must avoid use of unnecessary force, and prosecutors must strive to exclude racial and other personal characteristics of defendants from influencing their decisions. Forensic psychiatrists, in turn, must undercut subjects' beliefs that they, acting in the usual way that physicians act, are placing subjects' interests above all other considerations. Although allowing subjects to hold such beliefs might be an effective means of gathering information, it is inherently deceptive and exploitive, and fails to respect subjects as persons.

Forensic psychiatrists, to avoid violating the rule of respect for persons, must make clear to the subjects of their evaluations who they are, what role they are playing in the case (including which side they are working for), the limits on confidentiality, and—of particular importance—that they are not serving a treatment function.[28] Just as in the research setting, where the fidelity of a physician to the interests of the research subject is similarly altered, care must be taken to insure that the subject is aware of the different parameters of this situation.[§]

This dimension of the obligation to respect persons sometimes goes by the rubric of "informed consent." Insofar as use of that phrase implies an identity with informed consent in clinical contexts, I think the term is misleading. Subjects often submit to forensic examinations under coercion and, in some settings, forensic

[§] A variety of suggestions have been made as to how to respond if it appears that the subject has not grasped the difference between a forensic and a clinical evaluation, or loses an appreciation of the differences during the course of the evaluation. These suggestions range from reinforming the subject, to stopping the evaluation, to consulting with the subject's attorney or the judge, to excluding any testimony derived from the evaluation.[7, 28, 29]

psychiatrists may perform their assessments even over the objections of the evaluee (e.g., a competence to stand trial evaluation of a belligerent prisoner). To refer to these situations as embodying informed consent distorts the accepted meaning of the term. Nonetheless, subjects at a minimum can elect to withhold their cooperation from the evaluation—albeit often at some cost[‖]—and respecting them as persons means giving them sufficient information to allow them to decide whether or not to do so.[¶]

Respect for persons also underlies the adherence of forensic psychiatrists to maintaining the confidentiality of the evaluation, except to the extent that disclosure is necessary to fulfill the forensic function. Even when a blanket warning is given that nothing said by the subject will be considered confidential, the implication is that information may be revealed as part of the legal process. Outside that process, however, as in conversations with the news media, revelation of the information communicated by the subject manifests a serious lack of respect for the subject as a person.

Between them, truth-telling and respect for persons appear to provide sufficient foundation for most generally accepted ethical intuitions regarding the behavior of forensic psychiatrists, including those embodied in the AAPL guidelines. But are they the only moral rules or ideals to which forensic psychiatrists must be sensitive? What about beneficence and nonmaleficence, for example, those mainstays of medical ethics? Here, it is important to return to the general justification for professional ethics. Recall that although a code of professional ethics may intensify the obligation of professionals to uphold particular moral rules or ideals, it cannot entirely negate their duty to conform to the moral rules (usually injunctions not to harm others) that bind all citizens—although it may alter the balance among those rules when they come into conflict one with another. Nor does subscription to a professional code diminish the virtue associated with acting according to moral ideals, as long as they do not conflict with professional functions.[13, 15]

Thus, forensic psychiatrists—not as professionals, but as citizens—have the same duties as other people to behave nonmaleficently, except when acting within the legitimate scope of their professional roles, thereby advancing the pursuit of justice. Moreover, they cannot avoid the obligation of determining whether the actions they are being asked to perform in fact promote justice. Assisting in the torture or abusive interrogations of prisoners would fail that test, not as a matter of professional ethics, but by virtue of ordinary moral reasoning. To ac-

[‖] Defendants who desire to plead not guilty by reason of insanity, for example, but refuse to submit to an evaluation by the psychiatrist working for the prosecution will typically be precluded from introducing expert testimony of their own regarding their state of mind at the time of the offense.

[¶] What impact a subject's lack of competence might have on the evaluating psychiatrist's obligations is a complex question worthy of more consideration than I can offer in this article. Note the suggestion of the APA Task Force on the Role of Psychiatry in the Sentencing Process: "When it appears that the defendant is incompetent to give informed consent [*sic*], the psychiatrist should stop the examination, inform the party who requested the evaluation of the defendant's condition, and allow the legal system to arrive at a solution to the problem. It should be noted that the law is unclear as to whether a substituted consent is permissible in such circumstances, and if it is, who is authorized to provide it."[28]

cept the pursuit of justice as a basis for forensic ethics is not to say that forensic psychiatrists thereby surrender the right to determine with what actions it is appropriate to become involved, or that they avoid the opprobrium associated with participating in morally reprehensible acts.

In a similar vein, with regard to the moral ideal or aspiration of acting beneficently toward persons, such actions by forensic psychiatrists may be praiseworthy, even though they cannot be said to be part of their professional role. Conversely, although forensic psychiatrists may win acclaim for performing beneficent acts (e.g., diagnosing a melanoma in a subject they are interviewing), they should not be subject to professional sanction for failing to do so.

An Alternative Approach

What other ways might there be to think about ethics in forensic psychiatry, and how do they compare with the theory presented here? The leading alternative, embraced by several authors, although never fully elaborated or justified at the theoretical level, might be called a theory of mixed duties. According to this framework, forensic psychiatrists retain some (usually unspecified) measure of obligation to the principles of beneficence and nonmaleficence that underlie clinical ethics, in addition to whatever duties may be specific to the forensic arena.

Various commentators differ on the degree of priority these clinical principles demand. Some argue that they obligate psychiatrists only to the extent that psychiatrists can fulfill the duties of beneficence and nonmaleficence without interfering with their forensic functions.[28] Others, however, hold open the possibility that clinical duties may take center stage, maintaining that "[t]raditional medical values should be one factor in the balancing process" used by forensic psychiatrists to resolve ethical dilemmas, "given varying weight by individual practitioners in different circumstances."[30] Perhaps the most radical view is offered by a philosopher, who claims, "In spite of the other things that they are called on to do [referring specifically to forensic evaluations], psychiatrists and other doctors must surely be seen *primarily* as healers, with *primum non nocere* as their guiding light."[31]

The problems with this model of mixed duties are evident at the levels of both theory and practice. On the theoretical plane, as should be clear from the discussion above, the justification for professional ethics lies in its capacity to promote a distinct set of values that are embedded in the functions of the professionals in question. Ethical principles relevant to the forensic role, therefore, cannot legitimately be drawn from the clinical realm, because the values that underlie each function are so different: clinicians seek to promote health, while forensic evaluators seek to advance the interests of justice. As the medical philosopher Edmund Pellegrino has noted, "[t]he subject-physician relationship [i.e., in the forensic evaluation context] does not carry the implication or promise of primacy for the patient's welfare that [is] intrinsic to a true medical relationship."[18] Principles based on the pursuit of health,

therefore, have no logical nexus with forensic ethics.

What then is the appeal of a theory of mixed duties? Many forensic psychiatrists, I suspect, are reluctant to relinquish their attachment to the ethical principles imbued during their training, which motivate so many aspects of their professional lives. It is difficult for them to accept that, when they perform forensic functions, they have entered into an arena in which these principles are not dominant. Moreover, some forensic psychiatrists may share Stone's concern—that having eliminated beneficence and nonmaleficence as ethical touchstones, we are left with no principles at all to guide our actions. I hope that this discussion has eased those fears.

Other advocates of a model of mixed duties have a different agenda. They are opponents of the death penalty, looking for some way to block psychiatrists from participating in one or another aspect of the adjudication of capital cases.[10, 31] They clearly hope that principles drawn from clinical ethics will make it more difficult to justify participation by forensic psychiatrists, as the tension between the principles of justice and nonmaleficence "strains the contradictory ethical framework of forensic psychiatry to the breaking point."[10] But the tension to which this commentator was referring arises only as a result of his inappropriate introduction of principles properly confined to the clinical realm. As is often the case when teleological reasoning prevails, the attempt to shape the ethics of forensic psychiatry to impede use of the death penalty is ultimately illogical and unsatisfactory.

A final group of supporters of the role of "traditional medical ethics" in forensic work fails to distinguish forensic from therapeutic functions. One example comes from the writings of the philosopher Phillipa Foot, who was cited above to the effect that *primum non nocere*, the principle of nonmaleficence, must be physicians' ethical "guiding light."[31] She suggests that the principle might help psychiatrists to determine at what stages of capital proceedings they ought not to participate. But the only example she offers is that psychiatrists should decline to treat a defendant (presumably she means a prisoner) on death row to restore his competence to be executed; this is a treatment function outside of the forensic realm, which legitimately should be governed by ordinary medical ethics.

A similar example comes from a report of surveys of forensic psychiatrists that is said to show support for the relevance of the principles of clinical ethics in forensic psychiatry.[30] The examples cited, however, such as psychiatrists' rejection of a request to write a seclusion order solely to support prison discipline, almost all relate to treatment rather than forensic examination. Those few items that pertain to the forensic context—for example, respondents' agreement with the statement that they should not reveal embarrassing information acquired in an evaluation that could be used to press the evaluee for a settlement—are consistent with principles such as respect for persons that inhere in forensic ethics *per se*. The survey results offer no persuasive evidence that

forensic psychiatrists support the blurring of the boundaries between clinical and forensic ethics.

When we turn from the theoretical to the practical level, an additional good reason appears to shun the model of mixed duties. Many writers have worried about the "double agent problem" in forensic work. Stone, for one, has come to see "the intermingling of the roles of expert and therapist" as one of the major issues in forensic ethics.[7] He is concerned that the forensic psychiatrist might take advantage of the subject's tendency to view the evaluator as a treater (i.e., to develop a therapeutic transference), in order to extract information that will later be revealed in court to the subject's detriment. His proposal is that "forensic psychiatrists should as a first principle eschew any overlap between their clinical and evaluative functions." Indeed, if the evaluation begins to take on therapeutic overtones, Stone would demand that the forensic psychiatrist withdraw from testifying on the basis of the information obtained.[#]

The extent of the double agent problem, that is, the frequency with which subjects in forensic evaluations develop therapeutic transferences, is an open empirical question. Nonetheless, as I noted above, I consider failure to address this issue as constituting a deception of the subject, which violates the principle of respect for persons. Stone's key insight, I think, is that double agency is a matter of countertransference as well as transference. That is, when the forensic psychiatrist approaches the subject as a treater would, the subject responds accordingly. The first task in combatting the problem is to persuade both parties that the situation in which they find themselves bears no relationship to the therapeutic setting. The psychiatrist is not present to help the subject: his or her job is to ascertain the truth relevant to the legal issue at hand.

The most deleterious effect of the insistence on holding on to therapeutic principles of ethics in forensic work, therefore, may be its consequences for psychiatrists' and subjects' perceptions of the evaluators' role. If forensic psychiatrists persuade themselves that they maintain a residual duty—of a professional nature—to benefit and not to harm evaluees, they are likely to communicate that to their subjects.[**] The psychiatrist, for example, who believes he has a duty to evaluate the efficacy of a subject's current treatment, when that is irrelevant to the legal issue in dispute, will ask the kind of questions that treating psychiatrists ask, and should not be surprised to receive the same kind of answers. Both

[#] Unfortunately, Stone never specifies how one might determine when an evaluation "has turned into a therapeutic encounter," clearly the key question on which the implementation of his proposal depends.

[**] A similar phenomenon, which I have called the "therapeutic misconception," occurs for much the same reason between clinical researchers and their subjects. Potential research subjects enter discussions over participating in research with the expectation that physician-investigators will manifest that same loyalty to their personal care that they have experienced in ordinary clinical settings. Researchers, often uncomfortable with the different ethical framework under which they are operating, may encourage these beliefs through the words they use and the attitudes they convey. When subjects and family members, however, discover that subjects' interests have not been given primacy by the researchers, they feel angry and betrayed.[32] Clarifying prospectively the actual scope of researchers' ethical duties is the only way to prevent this unfortunate outcome.

parties may be misled into thinking that this is a quasi-therapeutic encounter. In this process of mutual deception, it is the subject who will be betrayed and potentially hurt.[††]

If we are serious about ridding ourselves of the problem of double agency, we must begin with the code of ethics to which we adhere. When we allow therapeutic principles to creep in to our thinking, we open the door to profound confusion over the psychiatrist's role. A clear advantage of deriving the professional ethics of forensic psychiatry from the pursuit of justice, rather than of health, is the message that it sends regarding the distinction between the forensic and therapeutic roles.

Conclusion

The success of any moral theory depends on how well it satisfies its audience, accounting for their ethical intuitions and providing useful guidance in resolving ethical dilemmas. The extent to which this theory meets those *desiderata* will only be known over time. It is my hope, however, that this effort to describe and justify a theory of ethics in forensic psychiatry will provide a stimulus for a thorough examination of the ethical foundations of our behavior.

[††] Shuman focuses on a different aspect of the examiner-subject interaction, the deliberate use of empathic techniques by the forensic psychiatrist, especially "reflective empathy," defined as "the communication of a 'quality of felt awareness' of the experiences of another person;"[33] (e.g., "Oh, that must have been a horrible experience for you. I can imagine how frightened you felt.") To the extent that these techniques are employed, they reinforce the false image in the mind of the subject that the current interaction is akin to those that he or she may have had previously in therapeutic settings. Allowing practitioners to believe that they have residual beneficent duties toward subjects increases the risk that they will use empathic techniques.

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