

The Ivory Tower v. the Marketplace

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In his American Psychiatric Association address, Alan A. Stone, MD provided a stimulating and controversial argument. I appreciate the candor and clarity with which he stated his position and his acknowledgement of its limitations. The purist in the ivory tower has a significant contribution to make concerning ethical problems in our profession but so has the practitioner in the marketplace. I shall proceed on the assumption that the purist's position is as assailable as any other, including my own.

Dr. Stone seems to assume that a proper perspective of ethical dilemmas and possible solutions proceeds only (or mostly) from the ivory tower. Also, he limits the forensic psychiatrist to only one role, that within the traditional doctor-patient dyad. I hope I have not misstated his premises and intentions. My perception of them may have been colored by my contradictory position.

Joseph Fletcher confronted the religious-philosophical ivory tower with his concept of situational ethics.¹

Until modern times the most common form of *a priori* ethics was religious morality. It usually held in advance of any concrete or actual problem of conscience that certain kinds of acts, such as lying and stealing and fornication, are always wrong intrinsically.... Their inherent wrongness was believed by faith and by metaphysical opinion to be matter of "natural" moral law or of divine revelation. They were always negatives, never affirmatives — prohibitions, not obligations.... Right and wrong were determined by a religious or metaphysical or nonempirical kind of cognition. There is still a widespread disposition to take an ethical posture of this kind, even though it is unconscious. It is metarational ethics.

Pragmatic Morality

Fletcher believes that the current commonly held ethical approach is a pragmatic morality. For situational or clinical consequentialists, results are what count. This ethic is implicit in biomedical research as well as clinical care. Reasoning is based on the data of each actual case or problem, and a course is chosen that promises optimum desirable consequences. Consequentialists are prompted to make decisions empirically. The question then becomes "When would it be right, and when would it be wrong?"² The point to be made is that a useful system of ethics, applicable to daily human conduct, must have content as well as principles; must be seen in context, not just in the abstract.

The entire April 1983 issue of *Psychiatric Annals* is devoted to Clinical Ethics in Psychiatry. The lead article by Colleen Clements argues persuasively for practical, pragmatic, clinical ethics. A priori ethics rest on universal generalizations, not on situational choices. The ethicist attempts to fit the situation to the rule. In

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clinical practice, however, the psychiatrist is involved with a patient or client who, with his/her biological and psychological variations, is imbedded in a particular family, social order, and culture at one point in history. Clements opines that "is" (practice) can influence "ought" (ethics) as well as vice versa.

A corollary point is that our social context is in a constant state of evolutionary change, and situational or contextual ethicists live in a predictable condition of flux. So does everybody else, whether they realize it or not. This is nothing new. The eminent medical historian, Henry Sigerst, has shown that the medical ideal "was a different one in different periods of history, determined by the structure of the society of the time and by its general conception of the world."³ The physician's position in society, and his/her service to it, is not solely determined by the physician but largely by the society he/she serves. Fifty years ago Sigerst wrote, "Never before has society presented the physician with so wide a field of activity and with so much influential power. If never before, certainly today the doctor may become the *asklepios politicos* visualized by Plato." The exigencies of the time affect our manner of participating in our social order. How can it be otherwise?

Stone notes with disapproval the most recent version of the Code of Ethics developed by organized medicine. He particularly decries the loss of "do no harm" and absence of any comment about easing the suffering of our patients. I can share his concern if I yield to his constricted role for the forensic psychiatrist, but another view is possible.

In his *Theory of Medical Ethics*, Robert Veatch convincingly argues against the relevance and applicability of the traditional Hippocratic ethic to the professional scene of the 1980s.⁴ He shows that it addresses the patient (and doctor) in isolation and ignores social context; that its extreme paternalism denies the patient both judgment and autonomy; that it emphasizes only benefit or outcome narrowly conceived, ignoring other principles such as duties and rights. Veatch applauds the current Principles of Medical Ethics of the American Medical Association⁵ because they differ from the Hippocratic position and recognize patients' rights and doctors' social responsibilities. His solution to the modern medical ethical dilemma is a triple contract, a three-level covenant. He suggests that the practicing physician see himself/herself as participant in a basic social contract; a contract between society and the profession; a contract between professionals and patients.

Situational Ethics

Forensic psychiatrists must be keenly aware of the social context in which they practice and of how it molds their thinking and role performance. Some months ago I participated in a People-to-People tour of five European countries with a group of colleagues interested in mental health law. There were numerous seminars with psychiatrists, legalists, government officials, and mental health society officers. Several striking differences between European and American forensic practice were clearly attributable to differences in social conditions, cul-

tural values, and political structure. Thus there are several different dimensions of ethical practice, horizontally across space as well as vertically through time.

We must ever consider the inevitability of change — Toffler's "rapid change" — that insidiously alters beliefs, values, behaviors, and ethical precepts.⁶ What is ethical today may be anathema tomorrow. For example, if unchecked overpopulation further inundates this small, finite planet, is it not likely that in the foreseeable future unplanned pregnancy successively will be judged irresponsible, then ruled illegal, and finally deemed immoral?

As a point in my argument for situational, marketplace ethics, I wish to quote the theologian, Seward Hiltner, who in discussing a paper of mine wrote

Now let me put in a good word for understanding morals and ethics in context — what Joseph Fletcher calls "situation ethics." It is true, as Modlin says, that this approach means reasoning from the concrete data in any situation toward an optimum of desirable consequences. What he does not say is that the reasoning must be done from committed foundational principles; and that putting the hard diagnosis of the actual situation against the basic principles requires far more of the person or group than does a law ethic in which the person simply conforms or rebels. Contextual ethics, as I prefer to call it, is much more difficult, precisely because it values development and character and responsibility beyond the abstract rightness or wrongness of particular acts. Its focus is characterological rather than behavioristic.⁶

It is just this point Stone seems to ignore. He is concerned with those in the forensic setting whom he characterizes as flirting with risk and courting danger. He does set up straw men, perhaps inadvertently, who lack sufficient knowledge, experience, perspicacity, and integrity to understand and manage the hazards.

These thoughts on the social context of professional practice lead to my next point, the role(s) of the forensic psychiatrist in the mental-legal arena. The double-agent bugaboo needs to be demythologized. For a century or more medicine has coped with this misapprehension with reasonable success through the performances of the military surgeon, the occupational physician, the public health officer, and the psychiatric hospital administrator.

In psychiatry, the most relevant and recent development was in the community mental health movement of the 1960s, wherein the specific role model of the physician was usually labeled mental health consultant. In that role psychiatrists functioned as consultants to schools, industrial plants, welfare departments, public health departments, police departments, jails, law firms, and courts. A clear definition of the client being served and for what purpose was usually accomplished once a frame of reference for understanding "consultant" was established.

The American Psychological Association has struggled with some of the ethical issues that concern medical professionals. A task force report concludes that the psychologist working in the criminal justice system may perform different roles with different clients.⁷ He/she may function as a therapist for an inmate or an employee of the agency. He/she may also work as a consultant to the agency that becomes the primary client. The important ethical consideration is that the

professional be clear about his/her role, the client, and his/her responsibilities, and communicates his/her conclusions to others involved.

In my court appearances I carry my consultant's role to a social system different from mine but about which I have acquired sufficient knowledge and experience to be at ease there.⁸ The First Commandment for the mental health consultant is "Know your agency." This knowledge distinguishes the forensic from the general psychiatrist and eventuates his/her understanding that in the legal arena the client is not a patient but a plaintiff or defendant seeking resolution of a legal, not a medical, problem. The psychiatrist is there to help the trier of fact achieve a legal disposition of the case.

Another difference between traditional and forensic practice is that many we examine because of their civil or criminal legal problems are not patients in a strict sense. Usually they appear because their attorney told them to come. They do not seek us out; they may express no symptoms; they do not view themselves as ill; and they do not anticipate treatment. A doctor's automatically casting such persons into the role of sick patients is an act of egocentric paternalism.

I shall forego responding to many of Dr. Stone's specific arguments on the assumption that other articles in this issue will address them. It is a particular temptation to rebut his charge that forensic psychiatrists are "meddling in alien business" and his skepticism about the clinical inference process. I do not agree with his conclusion that in the ethical practice of forensic psychiatry none of us has any answers. I have tried to explicate the thesis that there is a viable frame of reference that allows some of us to have some answers some of the time. This is probably all we can offer at present.

We humans, in our tireless search for certainty, are doomed to frustration, but we can gradually learn to cope more ably with the realities of our existence. I believe that in what law and psychiatry through alliance can achieve, there is some promise of social gain.

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