REGULAR ARTICLE

Principles and Narrative in Forensic Psychiatry: Toward a Robust View of Professional Role

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Recent debates in the ethics of forensic psychiatry have centered on the applicability of traditional medical ethics to forensic practice. Two prominent theories, one taking a principled approach and another taking a narrative approach, have attempted to resolve the tension between medical and legal settings. In this article we contend that the two theories are related closely and work at two different levels: principles at the level of theory and narrative at the level of application. We offer an approach to forensic ethics that reconciles competing theoretical views by relating professional role and personal integrity.

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Ethics theories of forensic psychiatry have struggled between applying classical clinical ethics and developing new theories for forensic practice.[1–4] Principles of beneficence and nonmaleficence, which attain primacy in clinical practice, may be insufficient to direct the ethics aspects of forensic work because of obligations to forces outside the traditional dyadic patient-professional relationship—namely, the judicial system.[5–9] Nowhere is the tension of clinical and forensic ethics more evident than in discussions of the incompatibility of being both therapist and forensic expert for the same individual. This is exemplified in the courtroom testimony of clinical caregivers on behalf of their patients seeking disability, damages, or defense from legal sanction. A strict principlist approach, such as that of Appelbaum,[3] which orders justice above traditional physicianly principles, consequently may differ from a narrative approach, such as that of Griffith,[4] which criticizes ethics models that do not explicitly value the narrative of historically disadvantaged cultures within society. We offer a case for analysis that underscores the conflict between clinical and forensic roles but offers a reconciliation of current principlist and narrative approaches to forensic ethics. We construct a model of forensic ethics that synthesizes both views, with a place for principled theory enriched by narrative application to specific cases. (Case material has been disguised to protect the identity of the participants.)

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The Case of Ms. George and the Forensic Expert

Ms. George was a vibrant, athletic, and strong-willed woman in her mid-40s who suffered a catastrophic brain-stem stroke that left her almost completely paralyzed. She was a college-educated entrepreneur who had managed a business and valued close contact with her relatives. Her family was deeply involved in her care, applying both the immigrant parents' southern European sensibilities and the values of American-born children to daily clinical matters. Family meetings had always been, and remained, boisterous affairs with dramatic arguments, rifts, and just as dramatic—and predictable—reconciliations.

Now, this family star and former triathlete could only raise her eyebrows to communicate her needs. As she struggled through two years of rehabilitation to maintain basic muscular tone and respiratory support, she could not penetrate the severe paralysis that had trapped an active mind in an unresponsive body. Indeed, her treaters considered it miraculous that she had even regained consciousness; she was not expected to recover further.

Ms. George ultimately was transferred to a nursing facility, having taken advantage of all that specialty rehabilitation could offer. She remained active in meeting with visitors, listening to music, watching films, and even learning advanced mathematics on videotape. She refined and memorized a communication system that used an alphabet board pasted above her bed.

Two and a half years after her stroke, Ms. George began to request help from family and health-care staff alike to end her life. Her current condition was untenable, she reported, and she preferred to be allowed to die. Indeed, she began to refuse the regular tube feedings she received. The facility's psychiatric consultant endorsed the "competence" of her decision to refuse nutrition and hydration but requested consultation by a forensic specialist because the institution lacked an ethics committee or similar body to address staff discomfort with the decision. Because her family split vehemently over her request, Ms. George asked the local probate court to appoint a legal guardian to advocate for her position. She did not wish for delays caused by the maelstrom of opinions surrounding her.

The probate court appointed a forensic psychiatrist to assess Ms. George's "current psychological/psychiatric functioning and its relevance to her decision to fast for the purpose of ending her life." The court noted that the appointment was for "the limited purpose of conducting a forensic evaluation relative to the competence of the ward."

Guided by the court's warning of family discord, the consultant's first effort was an extended family meeting, without Ms. George, to gather information, explain the forensic role, and to offer family members the opportunity to be heard. A number of concerns were vehemently and painfully expressed. One parent with conservative Eastern Orthodox views opposed her daughter's choice of "suicide" on religious grounds. One brother expressed Adventist views on his sibling's behalf, explaining that the patient had been baptized by the sect while paralyzed and that the decision to fast would be considered sinful. A second brother expressed holistic medical views, interpreting movements described as reflexive by physicians as potential evidence of a missed diagnosis or inaccurate prognosis. Another family member expressed concern that Ms. George was unduly influenced by a friend who stood to gain from the will. Although the evaluation ultimately would proceed along common clinical guidelines, a good deal of work would be required to address relevant family, religious, and financial influences.

Conflicting Roles

The issue of conflicting forensic and clinical roles has only recently been addressed in the clinical literature. Paul Appelbaum notes that during his training it was commonplace for psychiatrists to act as both psychiatrist and forensic expert.[10]

Recently, however, psychiatrists and other physicians have found themselves thrust unwillingly into this role of "double agent." This particular brand of double agency confuses whether the expert acts as an agent (or advocate) of the patient or of the court. A few common scenarios include the psychiatrist who is asked to testify on damages to a patient being treated for posttraumatic stress disorder or the psychiatrist asked to render an opinion on the parental fitness of a patient in a custody dispute.

Strasburger, Gutheil, and Brodsky[11] illustrate paradigmatic differences between the two roles. Although the treating psychiatrist generally undertakes a psychodynamic approach with an emphasis on the patient's psychological perceptions and distortions, the forensic expert generally adopts a descriptive approach with an emphasis on objective diagnosis and classification. The treating psychiatrist is interested in the patient's truth, a form of "narrative" or interpretative truth that is influenced invariably by internal psychological experiences. Narrative truth in this context is a search for meaning rather than objective fact. It represents the patient's "inner personal reality, albeit colored by biases and misperceptions." This truth may be reflected on and altered as the patient gains insight and personal understanding during the course of therapy, but courts of law generally are not interested in the patient's psychic advancement. The forensic expert is concerned with factual, objective information and indeed would be worthless to a court of law otherwise.

The treating psychiatrist is obligated, in the words of Candilis and Appelbaum, "not to advance justice, but to provide good care, grounded in therapeutic process, confidentiality, and the traditional principles of beneficence and non-maleficence."[6] However, the responsibility of the *forensic* psychiatrist is more a societal one, with allegiance to the law, the courts, and society as a whole. The forensic psychiatrist serves society's interest in the delivery of expert testimony that advances the interests of justice: "the fair adjudication of disputes and the determination of innocence or guilt." One prominent theory of forensic ethics consequently places social principles of justice, truthfulness, and respect for persons above personal obligations of beneficence and nonmaleficence.[3]

Furthermore, in a therapeutic relationship confidentiality generally is maintained unless patients are a danger to themselves or others. This promise of confidentiality allows patients to reveal intimate, embarrassing, or painful details from their personal lives. When patients enter a legal setting, these same intimate revelations may become damaging public knowledge. In the forensic role, psychiatrists are not focused on protecting patients from harm. Indeed, the effect of their testimony may be more than embarrassing; it may be punitive and psychologically destructive.

In the case of Ms. George, familial strife amid a tragic situation called for more than an aseptic assessment of capacity to refuse nutrition and hydration. Ignoring the family's conflict, their lack of information, and the potential loss of emotional resolution and comfort at a critical time would be unacceptable on a human level. A compassionate professional involvement would necessarily include clinical elements of education, counseling, conflict resolution, and spiritual guidance. To do otherwise would abrogate responsibilities to an individual and family in profound distress. From an ethics perspective, a strict adherence to forensic role responsibilities would fail all parties.

As the court's expert, the forensic consultant was appointed to inform the judicial process about a fluid clinical situation requiring forensic expertise. However, once involved as an "expert," the consultant was confronted with a complex family drama. New professional responsibilities and obligations emerged, requiring a more flexible and complex approach. Although ethics principles and strict adherence to forensic role responsibilities allowed the capacity assessment to be completed, a broader conceptualization of professional role, framed within a detailed narrative of the situation, would be needed to address the larger and more ambiguous aspects of professional involvement in the case.

Beyond Roles: Professional Integrity

In forensic psychiatry, professionals are viewed as "in a role." Role morality guides professionals in their expert activity,[12] identifying both the responsibilities of the professional and the limits of professional activity. Often, however, in defining limits of activity, role morality espouses professional behavior that incorporates minimum obligations to the evaluee. Such a narrow adherence to the professional role can lead to exclusion of other important ethics considerations. In some cases, frank harm to both the evaluee and the relationship may result. A broader view of professionalism, a view that considers internal norms of the profession and professional aspirations toward moral ideals, may be useful. Although contrary to current views of forensic roles, we argue for a model of professional role that includes personal morality of the individual professional and historical elements of the medical profession. We believe this integrated approach can help clarify the moral ambiguity often found in complex situations.

Role dilemmas in forensic psychiatry reveal much about the tension between personal and professional morality. A view of professional integrity that is helpful for this discussion of forensic roles is offered by Miller and Brody.[13] These authors construct a robust view of professional roles first by defining personal integrity and then offering a conceptualization of *professional* integrity. Personal integrity is tied to one's identity, the activity that affects trust, and the qualities of wholeness and intactness. Three elements are necessary for integrity: (1) a set of well-regarded personal principles that remain somewhat stable over time and are coherent; (2) verbal expression of those values and principles; and (3) consistency between what one says and what one does. Coherence and integration of personal and professional spheres are espoused by this model.

Although personal integrity is tied closely to individual identity, professional integrity and professional identity are more socially determined. Both professional integrity and identity are tied to the community—a community that defines expectations and places restrictions on individual expression.

Professional integrity, then, encourages a more dynamic understanding of the interplay of personal and professional morality than strict views of the forensic role allow. Currently, strict interpretation of the forensic role elevates the professional's obligations to the court over personal values and traditional professional obligations. In fact, the current view of the forensic role would appear to require a careful discrimination between professional and personal values. However, because professional integrity is tied to the community and its values, the community may legitimately expect a broader, more traditional physicianly approach from its experts.

In addition, professions possess an internal set of duties, values, and ideals that are essential for professional identity and integrity. Intrinsic values and activities of professions define the profession and operationalize the meaning of professional integrity. Just as personal integrity generates a certain consistency over time, a profession possesses tradition and a *historical narrative* of its goals, duties, values, and ideals.[13] This historical narrative anchors the profession in those values that resist the vagaries of social and situational forces, especially when these forces influence the professional to behave contrary to the historical narrative.

Strict views of the forensic role may fail to balance adequately the tension between the historical narrative of the medical profession and the need to offer objective analysis in complex cases such as that of Ms. George. Rigid adherence to an objective "expert" role in complex relationships such as this may conceivably harm individuals and their loved ones.

In forensic psychiatry, we contend that the historical narrative of the specialty, as in any professional activity, is still emerging. One approach has been to view the forensic psychiatrist through role theory and social psychology, narrowly defining professional activity as an agency of society and the court.[3,11] Others have argued for application of traditional clinical ethics to the dilemmas of forensic psychiatry.[1,2] We are closer to this latter view in proposing that broader views of professional integrity—that include the historical narrative of medical practice—permit greater flexibility in the discussion of what constitutes a true forensic interaction. This view permits personal and traditional physicianly values to inform the forensic role. Although it has been difficult to admit traditional values such as beneficence and nonmaleficence into the strict view of forensic expertise, a view that replaces professional role with the concept of professional integrity may allow exactly that. This conceptualization of professional integrity then can be applied to individual cases by describing the narrative in which the expert and the evaluee find themselves.

Finally, the choice of proper professional action must be coupled with the question of what kind of professionals we wish to be. In forensic work, for many of us, it is not possible, much less desirable, to detach forensic consultations from our traditional commitments to patients. Our profession is a large part of who we are and is deeply connected to the larger community that contains and supports us. David Luban, in his book *Lawyers and Justice, An Ethical Study*,[14] provides insight into why we must link individual and professional integrity. He writes, ". . .commitments to the duties of a profession, to a career, or to major social situations. . . . These can be, they frequently are, among the deepest loyalties and commitments in our lives; and it cannot be right to ask us to reconsider them, to trade them off, again and again."

The Narrative Context

One final element is necessary for our move toward a robust view of professional role: the use of personal narrative. The concept of narrative entered medicine through medical ethics. Initially, narrative, along with casuistry, phenomenology, the ethics of care, and virtue theory were offered as criticism of the principle-based approach that dominated medical ethics.[15] Proponents of narrative argue that the traditional principles of medical ethics—autonomy, beneficence, nonmaleficence, and justice—fail to guide us in the often complex and ambiguous aspects of moral problems in medicine.[16–19] Griffith, for example, has argued powerfully that principlism is not sufficient to address the reality of a nondominant group whose narrative is not adequately valued by society.[4] Indeed, principles alone may be limited in addressing the motives and intentions of those involved in clinical and legal relationships. Finally, as we have argued, because a strict view of professional role may be inadequate for situations such as that of Ms. George and the forensic expert, narrative may permit an alternative understanding of professional obligations and responsibilities, inform the interplay of personal and professional morality, and provide a methodology for examining the larger moral aspects involved in all human dramas.

Narrative offers an approach by which medical knowledge is seen as storytelling knowledge. The individual's predicament is the telling of a story, with empathy and compassion elevated using humanistic language. In addition, narrative ethics is a methodology that increases sensitivity to the particulars of cases. It fortifies our moral deliberations by heightening our appreciation of the nuance and subtlety intrinsic to human dilemmas. Narrative includes such forms of communication as news, gossip, anecdote, history, drama, and fiction. Broader views accept all forms of human expression as narrative. Visual arts, film, dance, and music become texts that can be deconstructed to reveal hidden meanings and intentions. What is left out of the "text" becomes as important as what is included.

In medicine, as in other professions, moral dilemmas arise from the details of human drama. The narrative approach allows attention to those elements of language and storytelling that actively permit reflection on the intricacies of morality. In this sense, the narrative approach becomes a methodology for describing the situations that raise moral questions. How are we to provide guidance for moral dilemmas if we cannot adequately describe the problems we hope to solve?

However, this is not to say that narrative works alone in describing the ethics landscape. Justification of right action still requires use of principles to represent the ideals of objectivity and generalizability in reaching reasoned ends. Principles work at the theoretical level to create a framework for right action.[15] Then, narrative can operationalize theory in a practical manner, describing the individual's unique path toward the forensic encounter.

In the case of Ms. George and the forensic expert, then, can we incorporate the language of suffering; appreciate moral ambiguity in the intentions and motives of the people involved; struggle with the tension between therapeutic engagement and expert detachment; and consider the place of witnessing, affirming, and validating?

Narrative and the Case of Ms. George

At first glance, the case of Ms. George and the forensic expert involves a competence determination. The methodology of competence assessment (more accurately, decision-making capacity) has become routine practice when patients make requests that are in conflict with the values or wishes of caregivers and families. However, the case of Ms. George requires more from the forensic expert than the mere report to the court on the state of her decision-making. From the perspective of professional integrity and narrative ethics argued for this case, several themes become apparent.

First, although principles and forensic role responsibilities generally are adequate to direct capacity assessments, the doctrine of informed consent that undergirds these assessments is poorly served by the narrow approach. Decision-making capacity and its determination are processes by which we ensure that the doctrine of informed consent has integrity. For the purposes of informed consent to be realized, certain conditions must be present. One of these conditions is that individuals should be involved in medical decisions from a position of increased power; that is, they should be informed and supported in their capacity to evaluate, communicate, and understand choices. The risk here is that a strict view of the forensic role will meet only minimum standards of informed consent, failing to support its larger purposes.

The importance of informed consent lies in its ability to create, facilitate, encourage, and if necessary, require a kind of conversation between the individual and the professional—a conversation that serves to reduce the power differential between vulnerable individual and powerful professional. This conversation diminishes parentalism and increases the likelihood that the decisions reached are truly the voluntary informed decisions of an autonomous person. What is intended by informed consent doctrine is the creation of a process that embraces its full spirit.[20,21] For the forensic expert in this case to ignore this larger view would be to undermine the moral integrity of informed consent.

Second, limiting professional obligations to the strict forensic role fails to address larger professional obligations. Although it is clear under the principle of autonomy that Ms. George has a right to her competent decision, other morally ambiguous aspects of her case remain unclarified. What is the obligation of the professional toward the family and toward the individual after her decision-making capacity becomes clear? The dynamics of moral agency, of so-called "expert testimony" in the midst of human tragedy, must be expanded if we are to appreciate fully the place of experts in such situations.

A third related theme is the tension between principles of autonomy and beneficence. In the language of law, one might argue that individual rights and the duties created by such rights are to be practiced stringently. This practice is supported within our political-philosophical tradition. Individuals and courts respect autonomy and self-determination—as they should—and the presumption is that the dignity of Ms. George is supported. However, respect for autonomy may be operationalized inappropriately as a form of "pseudoempathic" medical practice, in which the professional acts as if the only obligation is to assess the individual and then leave her alone. In such cases, the doctrine of informed consent is implemented as a kind of "Miranda" warning.[20,21] The forensic consultant is particularly vulnerable to such an approach.

Stringent adherence to the autonomy principle without considering the rich context surrounding Ms. George may marginalize the professional and family voices intimately connected to the case. A narrow focus on principles can foster a compartmentalization of professionalism, in which the voice of the expert is confined to the purposes of the court but fails the larger moral commitment to the individual and the family. In the case of refusal of treatment, Sullivan and Youngner point out the dangers of this approach: "Reluctance to explore the reasons for refusal can be particularly dangerous when combined with a superficial adherence to the ideal of patient autonomy and respect for the 'right' to refuse treatment."[22] These authors agree that a more complicated involvement of the expert is necessary.

This use of professional integrity and narrative to contextualize a specific case has its pitfalls no doubt. But in the view argued here, the neglect of evaluee and family that might result from a rigid adherence to principlism and a narrow view of professional role is of greater harm than the inclusion of all voices involved in the drama. In our view, the activity of the forensic consultant that includes clinical therapeutic involvement is not disrespectful of the patient's right to decide but honors the complexities and ambiguities of the case.

Professional Integrity, Narrative, and Moral Agency

The narrative approach, then, considers the humanistic elements in such cases. The uncertainties of suffering—the impact of the patient's decision on her family, on the doctors and nurses involved in her care, and on the expert witness and the court itself—are enhanced when a robust view of the forensic role drives the interaction. The tradition of disengaged and objective involvement would be troubling here. Objectivity and distance, like other values of the enlightenment, are intended to serve the goals of both evaluees and professionals. However, in the case of Ms. George emphasizing objectivity and distance may undermine the involvement necessary if professionals are to consider their obligations humanely. In the postmodern age, when we know to be skeptical of the "objective" and "disengaged" position, we must create a language for those dramas that is larger than the language of law and the courts alone. The inevitability of shared suffering requires the expert consultant to engage the sorrow and grief of the participants. Moral process in forensic psychiatry, unlike legal process alone, requires a professional integrity that is robust, humane, and resistant to forces that would overly restrict professional behavior.

This approach broadens moral agency in forensic work. As physicians called to these tasks, is it justifiable to be merely agents of the court carrying out a technical procedure? The tension between different professional roles, the blurring of the proper uses of medical knowledge (i.e., therapeutic versus forensic), and the tension between the professional's personal morality and professional role are evident here. However, without the humanistic language of narrative to clarify moral ambiguity, the language of the courts alone trumps our attempt to improve participation in the larger moral context.

In the narrative tradition, in which all medical and legal dramas are viewed from the perspective of characters in a play, the process itself is moral agency. The participants cocreate a moral tale, and in their shared decisions, in their dialogue and actions, develop a moral outcome. Ms. George's decision and its effects involve difficulties from which legal and medical language cannot protect the participants. The particulars of human struggle and suffering should be the origin of the ethics analysis of this case. How did the forensic expert struggle with his engagement at the bedside and in the court? How did his personal values and private feelings come into play? How did personal and professional ideals inform the conduct of the forensic evaluation? Clearly, the consultant is

pulled toward a "therapeutic relationship" while performing an "expert role." But the arbitrary division of functions—an expert in one place, a clinician in another, a complete person at home—although desirable in a theoretical sense, is not consistent with the particulars of human drama and the manner in which most of us experience our lives. Such an approach fails to capture the richness of our experience.

Conclusion

In the case of Ms. George, the complete consultation ultimately did include elements of counseling, education, conflict resolution, and referral for spiritual guidance. Although it is plausible that a forensic-therapeutic split could be conducted humanely, the consultant did not include another outsider in the emotionally charged and time-pressured setting. The consultant's own Eastern Orthodox upbringing served to penetrate and resolve cultural tensions between immigrant parents and their American-born daughter. Ms. George's narrative was explored to clarify the motivations to refuse treatment and her family's resistance to her choice. With her family's reluctant support and the court's acquiescence, Ms. George died quietly and comfortably some 10 days into her fast.

The case of Ms. George illustrates the need for a richer method to examine the ethics dilemmas that naturally arise in complicated forensic cases. A view of professional integrity that includes personal and traditional physicianly values and that is contextualized by narrative argues for a new approach toward cases such as this. Not only are new professional obligations and responsibilities elucidated, but also aspirations toward professional ideals are supported and encouraged.

Although the strict view of the forensic role attempts to prevent harm to evaluees and patients, role dilemmas also can be intimate moments when the professional's moral and clinical capacities are joined. The movement toward creative thought, discernment, and judgment shapes this moment. Consequently, for the practitioner who aspires to professional ideals, the robust view of role responsibility is an opportunity to balance the needs of the individual and society and derive greater meaning from the work.

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