Commentary: Forensic Psychiatry and Ethics—the Voyage Continues

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The fundamental ethics dilemmas inherent in the practice of forensic psychiatry were known to the founders of the American Academy of Psychiatry and the Law (AAPL). Aware of the history of ethics issues that were peculiar to the physician working at the interface of medicine and law, the original AAPL bylaws created the Committee on Ethics. In the late 1970s, the committee's first chair, Jonas Rappeport, MD, presented a set of guidelines to the AAPL membership for comments. In the early 1980s, Henry Weinstein, MD, became chair of the Committee on Ethics and, along with committee members, incorporated the comments of the AAPL membership.

During this voyage, in October 1982, Alan A. Stone, MD, gave a luncheon address at the 13th Annual Meeting of AAPL, "The Ethical Boundaries of Forensic Psychiatry: A View from the Ivory Tower."[1] Stone presented his perspective of the ethics dilemmas facing the forensic psychiatrist who functions as an expert witness. *The Journal of the American Academy of Psychiatry and the Law*, (at that time called the *Bulletin of the American Academy of Psychiatry and the Law*) published Stone's comments and a number of papers in response. Weinstein noted that AAPL Committee on Ethics was familiar with the issues raised by Stone but chose to take a different road.[2] The committee maintained that it was possible and practical to provide ethics guidelines for forensic psychiatrists.

Noting the difficulties of the role of the psychiatrist in court, in 1984 Clements and Ciccone[3] approached the issue of the psychiatric expert witness by employing an empirical analysis. We argued that (1) decisions in the legal system, in which the purpose or goal is justice, intimately involve some adequate knowledge of human motivation and behavioral constraints to achieve that goal; and (2) a psychiatric expert is an individual with an adequately described framework of scientific thinking, who can supply what Dewey called warranted assertions (probable truth). We concluded that competently done psychiatric expert witness testimony is scientific, compatible with proper understanding of "expert," and essential to the achievement of justice. Additionally, we recommended a realistic look at the social and legal role of the expert. We also outlined six reasonable expectations of the expert psychiatric witness role. Since that early paper, the ethics role and its obligations have been described for the broader activities of experts in public health and public policy.[4]

Understanding that the role of the forensic psychiatrist was broader than functioning as an expert witness, we moved on to explore the various perspectives used to dissect ethics issues in forensic psychiatry.[5] We found fault with ethics theories in the humanities that misconstrued science as mechanistic, requiring purely objective data and based on a subjective/objective dualism. This outmoded view encourages philosophers to see values as separate and distinct from the empirical world of facts. Consequently, medical ethicists have seen the task as deductively developing absolute principles that they can then use to prescribe action guidelines for physicians. This deductive method, with its acceptance of the fact/value distinction, forms the explicit basis for a significant portion of Stone's presentation of the purist "argument" that the forensic psychiatrist outside of

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the therapeutic context is meddling in alien business. We used this discussion as a springboard to present a specific method for identifying and working with ethics problems, applied clinical ethics. This approach is inductive and is based on a modern understanding of science and values that incorporates a systems theory framework. Starting with clinical cases, ethics problems were identified and ethics constructs for the analysis of issues were developed.

In October 1986, the Ethical Guidelines for the Practice of Forensic Psychiatry were approved by the AAPL executive council. The Guidelines were then submitted to the membership and published in the April 1987 issue of the *AAPL Newsletter*.[6] The Guidelines were presented to the AAPL membership for ratification at the semiannual business meeting held in May 1987. After discussion and debate, the guidelines were overwhelmingly approved. To our knowledge, this represented the first set of ethics guidelines specific to forensic psychiatry that were promulgated by a professional organization.

Efforts to Further Develop AAPL Ethical Guidelines

From 1987 to 1995, Robert Weinstock, MD, was chair of the AAPL's Committee on Ethics. The committee continued to explore unresolved issues in forensic psychiatry and ethics and began to issue opinions. In 1997, Paul Appelbaum, MD, published "A Theory of Ethics for Forensic Psychiatry."[7] He suggested that the ethics underpinnings of forensic psychiatry be based on the particular societal functions performed by the forensic psychiatrist, that is, a social or professional role obligation. He asserted that the prime value of the work of forensic psychiatry is to advance the interest of justice, and this effort was based on two principles: truthfulness and respect for persons.

In 1998, Ezra Griffith, MD, in his article, "Ethics In Forensic Psychiatry: A Cultural Response to Stone and Appelbaum," argued for extending Appelbaum's proposal.[8] Griffith proposed viewing the issue from the standpoint of a dominant/nondominant group interaction (i.e., political or power interpretation) that reveals that ". . .too often no one has respect for the African-American who is seeking justice. From that flows a natural perversion of truth seeking." Griffith suggested using a cultural formulation (i.e., narrative to assist in focusing on the complexity of the forensic evaluation).

The Candilis Proposal

Candilis and his coauthors, in "Principles and Narrative in Forensic Psychiatry: Toward a Robust View of Professional Role,"[9] have noted that there is a tension between applying classical clinical ethics and developing new theories for forensic practice. They found Appelbaum an example of the "strict principlist approach. . . , which orders justice above traditional physicianly principles" and Griffith an example of "a narrative approach. . . , which criticizes ethical models that do not explicitly value the narrative of historically disadvantaged cultures within society."

Candilis *et al.* present an extraordinary clinical case both in its tragic landscape and the special circumstances, for example, adding a therapeutic role to a forensic role. This circumstance involves concerns about dual-agency or conflict of interest as inherent issues that must be dealt with in any ethics analysis of the function of experts. The forensic psychiatrist had not completed the competence evaluation before adding a therapeutic role.[10] It appears that the evaluation was conducted with skill and thoughtfulness; the injured individual asked the forensic psychiatrist to return and continue to assist with family and cultural problems. Here, we encounter several possibilities. Usually, the individual would be referred to another psychiatrist for treatment. Limited time made this option impractical. If the forensic task is completed, taking on a treatment role at the request of the individual evaluated, in our opinion, does not in this case pose an ethics problem. If the forensic task had not been completed, for example, testimony was going to be required, the psychiatrist could avoid dual-agency or conflict of interest by selecting one or the other role. The forensic psychiatrist could argue that because of particular background and experience, he or she had a unique understanding of the cultural issues, that the already established confidence of the patient and family members was crucial, and that there was a short time frame available. Consequently, he or she was uniquely qualified to step in. At that point, the forensic psychiatrist could abandon the forensic expert role and take up the role of treating physician. Should an ongoing or new forensic issue emerge, another psychiatrist could be asked to provide the forensic evaluation and opinions.

A comparable scenario arises when a forensic psychiatrist evaluates an individual to determine eligibil-

ity for disability and in the course of the examination, learns that the individual is suicidal. On further examination, the psychiatrist determines that the individual is an eminent risk for suicide. On the human as well as the medical level of focus, one would have an ethical obligation to take proper means to ensure the individual's safety. These actions may blur or even eliminate the forensic expert role. A forensic psychiatrist may encounter many other complex situations. In that regard, we share the fate of all physicians; we encounter ethical issues. If we (forensic psychiatrists) apply the analysis provided by applied clinical ethics, we follow our physician heritage, use a case method, and study the outcome of our derived general principles.

Applied Clinical Ethics

Ethics concerns and pitfalls abound in forensic psychiatry. There are conflicting interests of role obligations, conflicts with other participants, and internal conflicts within the person functioning as expert. The important question is what ethics theory best identifies conflicts of interest and supplies means of dealing with them. Attempts to deal with these ethics concerns have been based on traditional approaches that have been less than adequate for the task. The working model of applied clinical ethics as a method for uncovering, articulating, and studying of ethics issues and as a method for arriving at workable solutions was presented but needs further description. Applied clinical ethics retains the psychiatrist clinical approach and further develops the physician's personal ethical sensitivity with the incorporation of more sophisticated ethical theory.

At the time AAPL was beginning to grapple with the task of developing ethics guidelines for forensic psychiatrists, in 1977, George Engel, MD, proposed that the medical model be expanded and become a biopsychosocial medical model.[11] He articulated a concept, well known to psychiatrists, that to understand a patient requires a genetic and ontogenetic understanding. The life history, with its intrapsychic, interpersonal, and social components, is essential to understanding an individual. Initially, this was a systems theory model and can be found in varying descriptions in both the biological and the physical sciences (e.g., hierarchy theory,[12] chaos theory,[13] and consilience[14]). It is an epistemology and metaphysics of scales/levels of perception and organization and is not accurately conceived of as antireductionist. It is the epistemology of systems bioethics, one of the underlying components of an applied clinical ethics.

We share Stone's, Appelbaum's, Griffith's and Candilis' basic concerns about the current framework for medical ethics. The current framework is inadequate as an ethics base and, in our view, is maintained for two reasons. Its proponents and developers (e.g., Engeldhardt and Wildes[15] and Wikler[16]) assume a naturalistic, objective ethical theory and cannot be rationally based. Second, they accept the political ideology imported inconsistently into postmodernism and feel that ideological consensus can substitute for medical ethics. They are wrong on both counts.

It is not surprising that forensic psychiatrists would search for alternatives or modifications. Stone's initial suggestion was an ethical nihilism, which is not required. Appelbaum suggests there still are universalized ethics principles that we accept in a special kind of moral reasoning, but universalizing has problems with rigidity and formality, and intuitive moral reasoning produces contradictory principles that can slip into cultural relativism. Griffith wishes to push the postmodern ideology even further in forensic psychiatry, embracing the politicized ethical theory with its power, dominance, and multiple realities metaphors and strategies. His proposal is a political and racial power proposal that makes the conversion of ethics into ideology complete. Candilis believes narrative, the epistemology of postmodernism, can be combined with reason and empiricism to make medical ethics fuller and more descriptive of the human condition. He does not see the internal logical contradiction that is implied, one that would make ethics arbitrary. Still, they are all on to something. Current postmodern bioethics is not satisfactory and physicians have a sense of its inadequacy in their practice. It is not working well enough to justify its uncritical acceptance. Medicine and philosophy can do better and have done better.

Applied clinical ethics, using general systems constructs, provides a clear reason for paying attention to all levels. A commitment to truthfulness does not obviate but in fact requires that the forensic psychiatrist explain the nature of the examination, what was found, the psychiatric and legal conclusions, and the reasoning used to arrive at each. A biopsychosocial approach to the examination and a general systems theory perspective approach to the forensic reasoning meet the requirements of truthfulness and narrative.

The Candilis Case

Because ethics is complex (unless reduced to useless platitudes), we want to take a look at the Candilis case and present varying scenarios of it. Candilis describes a young, successful person who became a quadriplegic. After an attempt to adjust to this new reality, the person became determined to refuse nutrition and die. The family, with roots in a religious tradition, opposed this choice. The person's significant others expressed motivation for supporting the choice out of a desire to respect the person's wishes. The forensic psychiatrist was called in to assist in determining the person's legal competence to choose death.

The psychiatrist found himself in an uncomfortable position. The actual forensic assessment was easy to make. Following current postmodern bioethics in medicine and law, the person's competent choice is the only determining factor in allowing the patient to die, and that competence is a narrow legal definition. This individual easily met that standard. However, the psychiatrist, despite his own competence in doing the evaluation and despite fulfilling his forensic role obligation, had the vague sense that what he was doing did not meet his own sense of ethics or a historical sense of ethics. Current bioethics initially based its principle of autonomy on two philosophers, Kant and Mill.[17] However, in terms of conceptual systems neither Kant nor Mill would support the current autonomy to choose to die and the emphasis on the legal or civil right to die. Both of these philosophers stood in a tradition of rationalism and natural law and reflected that tradition. Both assumed there were irrational or bad choices possible, and both made provisions for denying individuals such choices. The basis for their denial was the value of reason and the value implied in respecting oneself and others. For them, ethics theory could be objective and either universalizable or generalizable. Current bioethics has redefined autonomy or free choice to mean a legal competence to choose whatever the single individual wishes to choose, a conception that has run counter to ethics theory since the famous debate between Thrasymachus and Socrates, and has only gained acceptance in our postmodern culture, which rejects reason and ethics.[18]

It is no wonder that Candilis and his forensic psychiatrist were uneasy about the routine accomplishment of evaluation and the medical ethics of the right to choose to die. This ethic narrows the human condition and the human being to a legal definition of competence and nothing more. It eliminates the social interactions at multiple levels of the human environmental and cultural system, giving the family and loved ones no say in the medical choice. It removes the professional role obligation to achieve an objective good outcome based on consequences throughout the system and leaves only the obligation to evaluate competence within the legal standard. The ethics choice of this patient is of no concern to any other person within the system, within the human condition. Postmodern bioethics in this regard is profoundly dehumanizing.[18] Forensic psychiatrists have good reason to be uneasy.

Narrative, the epistemology of postmodernism, will not alleviate its problem but rather exacerbate it by making more arbitrary and irrational the ethics analysis and interaction. Candilis shows this well in the denouement of his case. Feeling somehow that he has failed the patient and family, the forensic psychiatrist agrees to the quadriplegic individual's request to provide assistance with allowing the family to accept the person's decision. The family is counseled to accept the member's wishes, the narrow definition of ethical competence being legal competence is allowed to stand over all, and the patient does cause his death by refusing nutrition. We can quibble about the term "suicide," but the question whether the person was respecting of self in choosing death remains unasked and unanswered, along with its corollary, whether the forensic psychiatrist should be involved in such a process. This question cannot be asked and answered in postmodern ethics or in the narratives that form the multiple realities of postmodernism.

Candilis focuses on one ethics issue: whether the forensic psychiatrist has isolated his ethics role by now engaging in a treatment role with the family. The reasons for treatment are given. The psychiatrist is of the same religious tradition as the family and in a unique position to help them accept the member's choice. There is little time to help the family establish rapport with another therapist. The forensic evaluation has been done already. Therefore, in bringing narrative and treatment into the case, the psychiatrist has not violated the ethics of forensic psychiatry. However, focusing on these issues obscures the larger problem. The psychiatrist has collaborated completely in defining this human being only in terms of a legal person, not a human person, for the purposes

of a bureaucratic postmodern ethics that supports the routine choice of self-death. The only things we know about this individual are that the person was very active physically, economically highly successful, and legally competent to claim the civil right to be allowed to die.

Conflict of interest on the part of the psychiatrist can be dismissed with the completion of the evaluation and the option to have another forensic psychiatrist re-evaluate if that became necessary. Other questions, not asked by current medical ethics, are not so easy to dismiss. Why is there no further meaning possible for this human being? Is the person aware of the rippling effects throughout the personal and social system that such a choice for dying will entail and which needs should be sacrificed, the person's or the systems? What are the person's religious beliefs and why do they differ from the family's? Even if the religious tradition agrees this is not suicide, is this correct? Can we determine the ethics of suicide? What is the basis for his ethical conclusion that he should help the family stop resisting the choice? What are the actual motives of the person's companion and do burnout and guilt play a role in support for the decision? In compassion, should experts or ordinary human beings allow a tragic ethics mistake out of respect for the struggles of the person against the human condition? Ethics once proposed all these questions, and systems bioethics still is capable of raising them. Postmodern medical ethics is not, which explains perhaps to a large extent Candilis' unease with it. We suspect that his human nature still asks such questions but no longer has social or professional support for asking them, as a result of the changes in medical ethics since the 1970s. Narrative is too arbitrary and idiosyncratic to support such ethics questions. Only an applied clinical ethic can begin to address them.

Alternative Scenarios

Let us change to a second scenario. This case occurs in a rural area where only one forensic psychiatrist serves such functions as evaluating for competence. The evaluation has been done, the family is in distress, and the psychiatrist has to determine whether he or she will be asked to perform the role of forensic evaluator or whether he oe she can avoid conflict of interest while treating the family and the patient. If the psychiatrist is in a unique role because he or she is a member of the same religious tradition or if he or she has already established a close, perhaps too close, rapport with the family, he or she will feel again as Candilis does that his or her professional obligations have not been met completely. He or she will want to help the family. The psychiatrist does need to ask why he or she has such a strong wish to help. Does he bring an internal conflict of interest within him- or herself? Such a conflict of interest is just as important in ethics as the conflict of different levels and can generate unexamined biases that could interfere with competent functioning. What is the probability that another forensic examination will have to be done? If high, then the sole forensic psychiatrist would need to have a compelling reason to shift roles to treatment while maintaining the role of evaluation. Is there no one else to help the family? Is the family in considerable human distress? Having identified the conflict of interest for him- or herself and all others involved, the psychiatrist often may be capable of performing two roles without raising serious ethics questions. Not all conflicts of interest can or should be avoided. They are a reality of existence and can be dealt with, particularly if properly identified and made known.[4] Steps can be taken then to correct for biases that might intrude, at least if everyone is intellectually and professionally honest.

If there is a third scenario, in which there are other forensic psychiatrists who could be called on to re-evaluate or serve other forensic functions, the conflict of interest issue is muted. There still will remain the internal conflict question, why is the psychiatrist so certain he is the only one who could adequately help the family and individual, and is his identification with the culture of the family a mixed blessing, carrying with it the potential for bias? This is the same internal conflict question that should be asked of other ethnic, racial, or gender situations. Feeling familiar with, comfortable with, a segment of the culture (ethnic, religious, racial, sexual, and sex object orientation) can introduce its own biases. Those biases can result in intellectual dishonesty/rationalization, unfair preference, overly affirmative analysis, political agendas—in other words, conflict of interest within the self can be a major ethics problem. Both Griffith and Candilis need to develop an ethics theory that could deal with such internal conflicts of interest, and narrative or postmodern ethics are precisely the theories that cannot deal with this. Only a

probabilistic inductive theory of ethics and a systems epistemology can adequately handle such typical realities, in other words, an applied clinical ethic based on a content ethics and a scientific epistemology rather than a special moral reasoning.

Conclusions

Current bioethics will not allow professionals, society, or family to ask the ultimate ethics questions of altruism and self-need or the respect and worth of human life. By focusing only on the process of choice and not on the content of self-death current bioethics eliminates the most basic of ethics questions. It does this deliberately, believing they cannot be answered and that process and political consensus are the only options we have in ethics. That is a false belief. Applied clinical ethics, based on systems theory epistemology and metaphysics, on the science of human nature, on the inductive reduction, and then on synthesis of science and ethics that Wilson outlines is more than logically possible. It is a good rational argument in which conclusion follows from reasonable premises. It is probable. It is opposed by nothing more than political ideology, as Thrasymachus represented in that ancient argument with Socrates. For over 50 years, in medical ethics, we returned to Thrasymachus' position, although through history his was the weaker of the two positions. It can be maintained only through political power and bad law, and its consequences for patients and physicians justly give Candilis, Griffith, Appelbaum, and Stone pause for concern.[18]

However, as the scenarios show, we cannot regain humanism by expanding postmodernism. It is a poor player on the stage of life, with no content to its narrative, no true meaning to its story.

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