

Forensic Ethics and the Expert Witness

A photograph of a courtroom interior, overlaid with a blue tint. In the center is a judge's bench with a leather-upholstered chair. To the left is an American flag on a stand. The back wall features a plaque with the Latin motto "Qui laborat verum sequitur".

"Qui laborat verum
sequitur"

Philip J. Candilis • Robert Weinstock • Richard Martinez

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For my first bioethics teacher, Jonathan D. Moreno, PhD, with profound gratitude and affection.

Philip J. Candilis

For my late parents, Mandel George and Ida Weinstock, for a lifetime of inspiration and support.

Robert Weinstock

For Al Martinez, my late father and friend, and the late Robert D. Miller, MD, PhD, teacher, scholar, mentor, and friend.

Richard Martinez

Foreword

Why a book about the ethics of forensic psychiatry and related disciplines? Most psychiatrists, after all, learn something in their training about the ethics of medical practice in general and of the practice of psychiatry in particular. Do the maxims that steer all physicians through the ethical complexities of clinical medicine not provide equally effective guidance to clinical and scientific expert witnesses? The answer, in short, is “No.”

When psychiatrists, for example, enter the realm of the expert witness, they tread on moral terrain with a significantly different topography than the paths to which they are accustomed in their clinical roles. Clinical psychiatrists owe primary allegiance to their patients’ interests; for them the principles of beneficence (doing good) and non-maleficence (avoiding harm) will generally take priority over all other considerations. For psychiatrists who serve as experts, however, there are no patients to whom fidelity is due. There are only persons being evaluated for the sake of providing opinions to third parties. Perhaps a defendant in a criminal case, a plaintiff in a tort action, or a claimant in an adjudication of disability benefits or workers’ compensation—but not a patient. And that makes all the difference.

Whatever its other virtues, no theory of the ethics of forensic psychiatry will serve its purpose unless it offers the psychiatric expert direction in dealing with this situation. When one no longer has the best interests of a patient as a lodestar by which to steer, what principles assume the guiding role held elsewhere by beneficence and non-maleficence? And how do those principles apply to the multifarious situations that are evoked by the adversarial context in which most forensic issues are resolved? Although the ethical theories canvassed in this volume differ in many particulars, it is the dilemma of the absent patient—replaced by an evaluee with a different moral valence—to which they all respond.

Perhaps, though, it is not obvious that the usual rules of medical ethics are inapplicable here. A simple thought experiment should suffice to make the point. Imagine the outcome if forensic experts were to feel bound by

the ethical dyad of beneficence/non-maleficence. If experts could only reveal information and conclusions that benefited and avoided harm to evaluatees, the result would be of no value at all to the process. Evaluatees already have attorneys whose role it is to argue as vigorously as possible for their interests. The expert's role is different: to bring professional—in this case psychiatric—knowledge and experience to bear on the legal issue in question. Only if experts speak from a neutral position, allowing for the possibility that their words may harm or help the person they have evaluated, can they be helpful to the ultimate legal decision maker.

Although this book is rich in descriptions of various approaches to addressing the differences between the clinical and forensic contexts, it may be worthwhile by way of example to rehearse one of those arguments here. Some years ago, I formulated a theory of forensic ethics meant to fill the gap between the ethics of clinical work and the reality of the forensic context. At the time, other commentators were asserting that forensic psychiatry lacked any moral grounding, and that perhaps it was not possible to find neutral principles on which forensic practice could rest.

In response to these challenges, I suggested that just as the principles of clinical ethics had grown from the nature of medical practice—what value, after all, does a treating physician have who is not primarily oriented toward the patient's well-being—so the ethics of forensic practice could be identified from an analysis of the functions of the psychiatric expert. Two principles seemed to arise self-evidently from this functional analysis: truth-telling and respect for persons. By truth-telling, I meant the obligation to speak honestly about one's views, regardless of whether they might benefit or harm a particular party, and also to situate those views in a broader setting of empirical data and professional opinion ("subjective" and "objective" truth-telling, respectively). And by respect for persons, I signified the duty to treat the evaluatee as a morally important person, obtaining consent, avoiding deception, and respecting confidences beyond the scope of the evaluation. Though perhaps not an exhaustive list of the principles that should frame forensic practice, these seemed to me—and still do today—to be central to the role of the expert witness.

As the following pages make clear, there is no shortage of alternative theoretical structures. Some writers would shun the "principlist" approach that I embraced for one of the other ways of thinking about ethics (virtue ethics or narrative ethics, for example). Other theorists, more comfortable with a set of principles as the basis for an ethical code, want to quarrel about the specific principles included in the list. In particular, the extent to which the standbys of beneficence and non-maleficence may still be operative in the forensic role has attracted a good deal of attention. Though the issues may seem abstract, that does not mean that they are incapable

of arousing passion, something that will be evident to the perceptive reader—especially since forensic psychiatry is involved with questions of responsibility, compensation, and punishment (above all, the death penalty), which tend to bring strong emotions to the fore.

To be sure, there are often more differences in words than in actions when varying approaches to forensic ethics are considered. I suspect that, faced with any number of challenging ethical conundra, many writers who take opposing theoretical stances would end up advising a similar course of behavior. But that is not to say that differences in theory do not often lead to differences in behavior. It is easy to cite examples such as whether experts should offer testimony on the ultimate legal issue in a case, or whether it is permissible to participate in evaluations of a death row prisoner's competence to be executed, to illustrate the very real areas of contention that remain in the ethics of the field, the outcome of which are materially determined by the ethical theories with which one begins.

So ethics do matter, often in very concrete ways. That is why a book like this has value. To be sure, it is not a guide to action. It will not tell a forensic psychiatrist what to do when faced with a particular dilemma. Rather, it is a guide to thought. These pages, carefully read, will help the psychiatrist who chooses to assist the legal and administrative processes on which so many critical determinations depend to identify a reasonable construct of ethics by which he or she may be guided. Specific answers will follow. But their value will depend greatly on the energy expended in getting the basic concepts just right.

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When we envisioned this book for our colleagues in the courts and the forensic fellowships, we knew we would have many friends to thank. Our own fellowship directors—who exposed us to the basic ethics dilemmas, the classic writings, and the methods of ethical reasoning—inspired the framework of the text. Kenneth Appelbaum, Robert Truog, and Robert Miller provided the kind of wisdom we aspire to in these pages.

We are grateful to the scholars who laid the groundwork for this discussion: the question “who bears our allegiance as courtroom experts?” We cite their work both to explore their influences and to honor them for asking the difficult questions.

Our contributions to this book would not have been possible without the intellectual and personal experience gathered over the years from three disciplines—general psychiatry, bioethics, and forensic psychiatry. In each discipline, we have been fortunate to work with mentors, teachers, and colleagues with great generosity, curiosity, and enthusiasm for their areas of study—and each with a desire to share knowledge and experience.

We are especially grateful to the former presidents of the American Academy of Psychiatry and the Law (AAPL), Drs. Richard Ciccone, Ezra Griffith, and Thomas Gutheil for their encouragement and support of the project. They are a constant reminder of the ideals of the ethical practitioner.

Paul Appelbaum played a special role for us. As mentor to the lead author, he was ever gracious, always available to rebut arguments, provoke thinking, and ultimately to provide the Foreword. If we take issue with some of his important writings on forensic ethics, it is with a keen sense of how much the field owes him in general and we owe him in particular.

Dr. Candilis also extends his thanks to mentor Charles Lidz for his warm discussions of sociologic theory, and to Jonathan Moreno—to whom this book is dedicated—for inspiring yet another career in medical ethics.

Our editor Andrew Szanton, a good friend and colleague, helped our disparate styles find one voice. His close familiarity with the tensions of professional ethics and the great writings of Western thought kept our own thinking on track even when our drafts were muddled.

We place high value on the historical narrative of our profession, a value that would be far less meaningful without the guidance of Professor Marvin Prosono. Access to his extensive historical scholarship on courtroom experts and his nuanced explanations of their history placed our work in an important context. Watching the historical struggle of science and law unfold in his work was a humbling reminder of humankind's scientific and philosophical failings.

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With Dr. Martinez, we join in thanking his friends and family, especially David Muth and the New Orleans community, for early intellectual challenges and continued support during the difficult aftermath of Hurricane Katrina.

The late Bernard L. Diamond introduced many experts to an alternative approach to forensic ethics—an approach that, in its time, received too little notice. We hope to correct that oversight in these pages.

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Our own personal narratives were important, too. We are grateful to our parents for imbuing in us a taste for the ancient philosophers and the importance of the written word. Our parents were our first teachers in this, and every, respect.

We have built on the work of many contributors, but believe we offer a new integration of thought. As we build on the people, history, and models that came before us, we invite experts, attorneys, evaluatees, and their families to anticipate our direction, to make the leaps we have made as authors, and to speculate with us on what they mean for the ethics of courtroom practice.

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Section I

Introduction and Overview

1

The Problem of the Expert's Ethics in Court

Introduction

Courtroom testimony by scientific experts is ethically challenging and complex. Expert witnesses bring the ethics of their own disciplines into the legal system, a system dominated by ethics of a different kind. This difference can be notable, especially when experts come from a helping profession such as medicine.

Psychiatry is an ideal model for discussing this problem, for at least three reasons. First, psychiatric testimony draws on many sciences; including neurology, biochemistry, pharmacology, psychology, sociology, and statistics. Second, it uses clinical and scientific reasoning that intersects politics and social policy. Finally, psychiatry describes behaviors of seminal importance to the law, ranging from sexuality and aggression to hyperactivity and obsession. The theories and science behind such behavior draw heavily from psychiatric scholarship on thoughts, perceptions, and emotions. These have important implications for the law. Psychiatry's array of hard and soft sciences, its reliance on interpretive and inferential reasoning, and its use of analytic methods common to many disciplines make it ideal for illustrating the ethical intricacies of expert testimony. It is relevant to all forensic disciplines.

Sciences like psychiatry differ from the law in how they analyze problems. Scientists develop tentative hypotheses, testing and revising them over time as new facts come to light. By contrast, the law must make definitive judgments on matters of immediate consequence and with little room for revision.

Psychiatry as a medical science differs in another important way: it is chiefly concerned with serving patients. True, it has parallel duties to society such as reporting child abuse or confining violent patients, but the patient's care is paramount.

The law has its own specific interests. As a discipline, the law is chiefly concerned with resolving disputes. Justice and truth are foundational principles. The law does have other purposes such as retribution, deterrence, and rehabilitation. In fact, it may regulate other professions. But the primary purpose remains the preservation of social order.

Forensic experts act as consultants to the legal system. Through statute and case law, the legal system expects the experts who come before it to help the law achieve its ends. At the same time, professional organizations guide experts in the practice of their own profession, with distinct codes of behavior and professionalism. This gives rise to an important ethical tension. Forensic psychiatrists and other experts work under two different—and potentially competing—ethical frameworks.

The tension between disciplines can be dramatic. It may be most evident when, in pursuit of justice or retribution, the law causes harm to an individual (e.g., by imposing fines, imprisonment, or even death). Courtroom experts in such instances contribute to goals that may differ dramatically from those of their profession.

In daily practice there are many ways in which the tension between professions and the law becomes apparent (Appelbaum, 1990; Weinstock, Leong, & Silva, 1990). Courtroom experts may feel tempted to mislead the evaluatee in order to gather information. They may feel tempted to mislead the court to gain credibility or advantage, perhaps posing as an expert instead of a fact witness. They may subordinate the facts of a case to their political or social agenda. Conversely, experts may recognize threats to a defendant so great that they feel obliged to re-define their involvement in the proceedings (Candilis, Martinez, & Dording, 2001; Weinstock, 2001). They may offer pseudo-legal counsel or therapy to an evaluatee, stepping temporarily out of role (Cicccone & Clements, 2001). Professionals who are sensitive to the special nature of forensic work often struggle to balance the court's mission, their own professional standards, and the individual's rights.

In fact, when certain distinctions between professional ethics and law are ignored, forensic experts are dismissed as “hired guns.” The term suggests that experts sell their professional expertise to the highest bidder. The perception of experts as “hired guns” was the greatest ethical problem identified in a classic survey of forensic psychiatrists (Weinstock, 1986). This group of psychiatric professionals, as we will show, has spent considerable effort analyzing ethical problems at the intersection of law and the professions.

In the adversarial atmosphere of a packed courtroom, it is a common human response for an expert or attorney to assume that an opposing expert is a “hired gun.” But this assumption is often wrong. In fact, scientific, academic, and clinical work is replete with honest differences of opinion.

This is evident in the ongoing debates over the safety of anti-depressants in children, the aggressiveness of treatment for certain cancers, and the risks and benefits of alternative or naturopathic remedies.

A courtroom battle of the experts can spring from legitimate differences of opinion. These may be based on differences in theoretical foundations, analyses of data, or inherent research biases. The vagaries of the legal system can also fuel this perception as when, for example, an expert is not aware of data that has been excluded for legal reasons.

Ethical problems in courtroom testimony, then, have multiple sources. They may arise not only from competing professional and legal influences but from both proper and improper differences of opinion. Improper differences include exaggeration, withholding of contrary data, and “spinning” data to leave false impressions or remove legitimate doubt. Proper differences may arise from one’s own perspective as a behavioral scientist or Freudian talk-therapist.

What then are the hallmarks of ethical testimony? What is the theory that grounds testifying experts in both their profession and the courtroom? How might these ethical matters influence how experts shape their arguments for the court? On a more personal level, how might being a crime victim affect the cases an expert chooses, or the testimony she gives? How might membership in a persecuted minority group affect her interaction with the legal system? This book will explore each of these questions.

Our starting point may be a modest one: merely suggesting how to stay out of trouble. By this standard, any behavior is ethical as long as it does not lead to sanctions. The letter of the law is everything; the underlying principle is only of concern if it threatens the individual with punishment.

Our hope is that forensic experts will go beyond this poor standard in gauging ethical behavior. We advocate an approach that has been called aspirational ethics (Dyer, 1988; Weinstock, 1997; Candilis & Martinez, 2006). It aspires to standards of professional and personal integrity that we will use in this book to describe a more complete view of the expert’s work. This approach crafts rules from theory, and applies them to specific courtroom arguments. It distinguishes between legitimate disagreements and unethical testimony. It integrates the professional obligations of the forensic expert into the conditions of the courtroom, and honors both professional and personal ethics. It encourages the right or best action.

First, we will explore how the study of history and of ethical reasoning on this topic can help reveal the ethics of forensic work. Our approach examines historical influences on forensic consultation and on ethics language in forensic work in general. It sets up a framework for handling difficult cases.

It is the history of thought in a profession, its rich variety of moral frameworks, and the language that recognizes inherent ethical tensions

that lead to a more robust and integrated understanding of forensic practice. Understanding the ethics of forensic consultation is especially critical because the law may not support or recognize the ethics experts bring with them. Experts must understand their own professional ethic because the law may try to constrain it.

A case in point might be a one-sided record of testifying always for the prosecution—or always for the defense. Generally ethical experts ought to be willing to testify for either prosecution or defense. In fact, federal courts require experts to provide a list of previous cases in which they have testified in the hope that the record will reveal any hidden agenda. It is one tool for recognizing unethical courtroom practice. Alone, however, this practice does not identify the “hired gun” who testifies in a balanced but unscrupulous manner. We need a more comprehensive view of ethical forensic practice. Therefore, we will also detail a number of habits or practices of ethical practitioners. Then we will develop a theory of ethical forensic practice that covers the great majority of these practices.

Some Highlights of Forensic History

The forensic expert practices an ancient profession. In ancient Babylonia, for example, midwives were used as experts in determining pregnancy, virginity, and female fertility. Similarly the Romans recognized midwives, handwriting experts, and land surveyors as legal experts (Prosono, 1990, 1994).

In most early legal codes the act mattered far more than the motivation. The Babylonian Code of Hammurabi (1792–1750 BCE), however, with its well-known call of an eye for an eye, recognized the importance of intent—a crucial distinction addressed by many modern experts. The Bible's Book of Deuteronomy also recognized the importance of intent, describing refuge cities in which those who killed someone by accident were protected from avenging relatives (Prosono, 1990, 1994).

In one instance in ancient Greece a physician testified to a “defect” in a slave when the sale was challenged (Prosono, 1994). But the ancient Greeks rarely used experts. Even when legal competence questions arose, physicians were not consulted as they are today. Conflict resolution was largely left to the parties themselves.

In Solon's time (6th century BCE Athens) criminal trials sometimes weighed psychological influences (Bordenn, 1999). But it was not until some three centuries later that Aristotle formally set the stage for modern experts by writing about how compulsion and ignorance could mitigate guilt (Aristotle, trans. 1976).

Hippocrates and his school (3rd–4th century BCE) also influenced medical thinking. Some modern commentators draw on ethics found in the writing of this ancient physician to ground their clinical and forensic work. These writers draw on Hippocratic ethics by quoting “*primum non nocere*,” or “first, do no harm.”

But this quote may not be the work of Hippocrates. Beneficence in medicine is often traced to the Hippocratic writings—often mistakenly to the Hippocratic Oath, which does not actually hold the endorsement “*Primum non nocere*.” “Above all do no harm” is found in the multi-authored *Epidemics*, the Latin re-statement coming centuries later. But even at the time, the ethics of the Oath described the values of a persecuted minority (probably the Pythagoreans) who were outside mainstream Hellenic medicine (and possibly unrelated to the Hippocratics, for that matter) (Edelstein, 1956; Jonsen, 1990; Priorieschi, 1995; University of Virginia, 2004; Weinstock et al., 1990).

The Oath, which even forbid surgery, is surprisingly outside its historical time and culture. It may well have been revived by the Christian Church because of its sympathy with certain core issues (anti-abortion, anti-suicide), but these were not values of general Hellenic culture. Hippocratic ethics may in fact have emerged in medieval Europe because they mirrored the paternalism and secrecy of the Catholic confessional. But the Oath is contrary to many writings in the Hippocratic corpus.

We should be careful, then, not to expect too much from these ancient standards. The Oath may also not serve as a proper foundation for forensic experts. The Oath does function “to establish physicians as a moral community [with] delineated obligations and responsibilities specific to the medical profession” (American Medical News, 2000). And “Do no harm” is still perceived by the public as the ethical bedrock of medicine. But whether it is an appropriate foundation for forensic experts awaits resolution of the issues we will raise in this book.

Modern forensic medicine may date from medieval Europe. Its origins have been traced by one commentator to the dawn of the sixteenth century (Gerber, 1961; cited in Prosono, 1994). In 1507, in the chief tribunal of Emperor Charles V, a penal code written by the influential Bishop of Bamberg, Germany, led to the requirement that medical testimony be used in all cases of personal injury, murder, or pretended pregnancy. Expert testimony from witch-hunters was also thought to assist the judge and those investigating criminal cases. Experts were consequently part of the legal code for many states of Charles’s Holy Roman Empire.

Another commentator (Ackernecht, 1959; cited in Prosono, 1994) finds the first modern reference to the use of a medical expert in 1511

Paris: Hapsburg monarch Philip the Handsome wrote of his “well-beloved surgeons, sworn legal experts to the courts of Paris.”

By 1664, the British were using forensic experts. The first example of a British physician as expert witness may have come in England at that time. It is recorded that physician Sir Thomas Browne testified in a witchcraft trial. Sir Thomas was called after a clever ploy revealed that the accuser experienced “witchcraft-induced” convulsions not only in the presence of the defendant, but also in the presence of a woman dressed like the defendant. This respected physician explained away the anomaly by testifying that witchcraft could be transferred. His professed expertise in witchcraft was the basis for the defendant's conviction and execution (B. L. Diamond, personal communication, 1979; Prosono, 1994.)

In the United States, matters were rather different. Rather than include physicians in legal proceedings, the United States tried to distinguish medicine from the law. By the early 19th century the United States had its own medical ethics, based in work by Thomas Percival, the English physician-philosopher and public health advocate. Around 1790, Percival had written his *Medical Ethics*, a framework for professional conduct with many features in common with the Hippocratic Oath. It followed a 1789 epidemic in Manchester, England, during which many physicians fled the scene, drawing anger and scorn from the afflicted city. Percival's work did not specifically address forensic issues but it did three very important things. First, the code formally declared that, as a matter of honor, physicians were obligated to treat the health of their patients as more important even than their own. Second, it declared that law and medicine were, and of right ought to be, separate institutions with separate codes of conduct. And third, it decreed that physicians should be free of legal oversight and legal sanction.

Though never adopted in mainstream England, Percival's Code became a model for ethical codes in the United States. It was particularly influential in 1847 when a dispute among several schools of American physicians led orthodox practitioners to found the American Medical Association (AMA). The AMA adopted a formal code of conduct based on Percival's work.

The United Kingdom, which relied more on the weight of tradition than on codified statute, impressed its physicians more with a sense of honor than a code of professional ethics. Lawyers in the United Kingdom were expected to exercise voluntary restraint in calling physicians to testify, particularly if doing so exposed confidential information. To this day Britain has no privilege laws, relying instead on a form of cultural agreement between the medical and legal professions. This difference in British and American law is an important example of how a profession may yield its autonomy to the law or retain it.

Just after 1900, U.S. professionals could not agree on how prominent a role psychiatrists should play in legal cases. In 1909 a Pennsylvania law professor, Edwin Keedy, chaired a committee to reform the insanity defense (Prosono, 1990, 1994). The committee of eminent attorneys, judges, and psychiatrists, could not reach consensus. Keedy believed the medical expert's sole task was to give the jury technical advice on a defendant's mental state. But prominent psychiatrists Adolf Meyer and William A. White, working in the 1920s, favored replacing jury determinations with psychiatric ones. They advocated integrating the concepts of medical and legal insanity into psychiatric judgments.

As time passed, the side that wanted psychiatrists to play a larger role gained strength. In the 1960s, psychiatric luminary Karl Menninger would agree with White, saying further that punishment only represented revenge and interfered with rehabilitation. Decisions in insanity trials, Menninger thought, should be left to psychiatrists (Prosono, 1990, 1994). But this did not mean that psychiatrists always excused crime. In capital cases, for example, White was willing to assist the prosecution if the prosecutor agreed not to seek the death penalty.

Around 1950 the diminished capacity defense was born. The advent and popularity of psychoanalysis led some prominent commentators, like Berkeley professor Bernard Diamond, to offer courts complex psychological explanations for criminal behavior. Psychoanalysis (Sigmund Freud's life-work) opened up many avenues for exploring the influences on people's behavior, from childhood experiences and family dynamics, to society as a whole. With Diamond's participation, the California Supreme Court developed diminished capacity as an alternative to the insanity defense. This allowed gradations of punishment that incorporated more psychological views of premeditation and malice (Weinstock, Leong, & Silva, 1996).

By the 1980s, however, the U.S. public decided that "diminished capacity" should be reformed. There was a significant public outcry when the diminished capacity defense successfully reduced the conviction of San Francisco city supervisor Dan White. White had brutally stalked and killed popular San Francisco mayor George Moscone and gay-rights advocate Harvey Milk in their offices. Readers may recall the caustic (and essentially inaccurate) label "Twinkie defense" to describe a legal defense that argued that White's mental capacity had been diminished by a diet rich in fast food. The public, media, and community leaders clearly felt the diminished capacity defense had been misused and needed to be reformed.

One result was the rise of a hybrid school called "therapeutic jurisprudence." Established in the late 1960s, this school uses the legal system to effect clinical change in patients. It arose from the tension between experts who act merely like technicians providing data to the legal system, and those who assert their own professional ethics of care in court (Stolle, Winnick, & Wexler, 2000).

The rise of managed care forced a broad reaffirmation of the primacy of patients' rights. Patients had been unhappy with restrictions placed on their choices by tighter insurance programs, and they let their politicians know. In response to managed care, the influential AMA Council on Ethical and Judicial Affairs (CEJA, the body that interprets AMA guidelines, section 8.13, *Opinions of Council of Ethical and Judicial Affairs [CEJA]*, 2002), required physicians to place the interests of their patients first in the managed care setting—over requirements of resource stewardship. By the end of the 20th century, fields like scientific research and administrative medicine were also making it clear that physicians were expected to bring their medical values with them. In scientific research researchers were expected to inform research subjects of risks and remove them from a study if they were clearly in danger. This duty to the individual existed notwithstanding the physician's duty to the research.

Today's writers continue to apply their professional perspectives to the problem: some defining their work in relation to either their profession or the law alone. Others define their forensic work as a balance or ordering of competing values. A brief look at history may consequently show that professional and non-professional values will compete no matter what the expert's role. We will argue throughout this book that societal, historical, and professional influences are strongly relevant to the expert's ethics in the courtroom.

Starting Points

Ethics discussions deserve a careful definition of terms. Depending on how and how well terms are defined, whole theoretical frameworks may succeed or fail. Even nuances or small differences in meaning can lead to different paths of discourse.

For example, University of Southern California professor Seymour Pollack (1974), a founder of the American Academy of Psychiatry and the Law and one of the leaders of modern forensic psychiatry wrote that

“Forensic psychiatry is limited to the application of psychiatry to evaluations for legal purposes. Psychiatric evaluation of the patient is directed primarily to legal issues in which he is involved, and consultation is concerned primarily with the ends of the legal system, justice, rather than the therapeutic objectives of the medical system.”

But the American Academy of Psychiatry and the Law (AAPL, 2005) defines forensic psychiatry more broadly:

“Forensic psychiatry is a subspecialty of psychiatry in which scientific and clinical expertise is applied in legal contexts embracing civil, criminal, correctional,

regulatory, or legislative matters, and in specialized consultations in areas such as risk assessment or employment.”

The evolution from Pollack to AAPL entails an important ethical shift. Pollack distinguished forensic psychiatry from the broader category of psychiatry and law that he “considered the broad, general field in which psychiatric theories, concepts, principles, and practice are applied to any and all legal matters” (Pollack, 1974). For him, this broader category of psychiatry and law included both forensic psychiatry and community psychiatry. Although often concerned with legal issues or legally involved patients, community psychiatry in his view, “lean[s] toward the traditional ends of psychiatry, that is, toward healing or otherwise helping the patient.” Forensic psychiatry by contrast does not.

But AAPL chose its definition in recognition of the many ways psychiatrists intersect the legal system. All of these are now commonly considered forensic psychiatry. For AAPL there is greater interplay of law and medicine, no absolute distinction between traditional therapeutic objectives and legal ends. Later in its guidelines, for example, AAPL endorses a balance between individual and society when psychiatrists practice in the forensic role. Indeed, until 2005 AAPL explicitly stated that the field of psychiatry should enunciate the ethics of its forensic work.

The debate is not settled by this definition however. Similar distinctions have been made between forensic psychiatry and the legal regulation of psychiatry in general (Rosner, 1985). Pollack, for example, has a strong ally in Richard Rosner of the New York University Law and Psychiatry Program. Rosner supports the distinction between forensic psychiatry and the legal regulation of psychiatry. He teaches that forensic psychiatrists function outside their role as physicians (Rosner, 1985, 1997). The expert’s function in court is ethical so long as it is clear to the judge and jury that she is not the evaluatee’s personal physician.

Rosner makes an analogy between the psychiatrist as forensic expert and the psychiatrist as consumer bargaining with a car salesman. In private life, he argues, the psychiatrist feels no compunction to consider the car salesman’s interests. In buying a car there is no pretext that the physician is using medical skills or assuming a caring role for the salesman.

But philosopher Philippa Foot disagrees. Foot responds that forensic psychiatrists in their professional role—as opposed to when they are buying a car—are clearly hired for their status as psychiatrists. Forensic psychiatrists use psychiatric and medical skills to conduct their evaluations. Therefore, Foot argues, they retain professional responsibilities (Foot, 1990). Many recent writers have taken up this argument, asserting that the use of skills developed to help patients must root forensic

psychiatry in the clinical and ethical principles of medical practice (e.g., Bloche, 1993; Pellegrino, 1993; Weinstock, 1998).

More recently Candilis et al. (Candilis et al., 2001; Candilis & Martinez, 2006; Martinez & Candilis, 2005) have endorsed this view by pointing out that society expects medical experts in the legal system to retain some medical values. The standard of societal expectation is not new to professional ethics, but it serves as an important reminder for experts who wish to leave their non-legal values behind. Diamond himself, a contemporary of Pollack, warned forensic psychiatrists not to accept legal ends blindly when assuming courtroom responsibilities; other important values are at stake.

AAPL's definition of forensic psychiatry, then, lists the multiple contexts and functions of the forensic psychiatrist. The emphasis is on the broad legal context of such psychiatric work. It does not parse out a different ethic for forensic and community psychiatry or for the legal regulation of the specialty. In practice, forensic psychiatry has come to encompass all the issues at the interface of psychiatry and law, including the legal contexts surrounding psychiatric practice: from treatment of patients in correctional settings to the legal regulation of psychiatry.

Just like the Hippocratics, Thomas Percival, and the AMA, AAPL believes that guidance for ethical conduct must come from within the profession itself. The courts decide what is legal—but they can only indirectly influence what is professionally responsible. In fact, professional ethical guidelines can and often do exceed the requirements of the law. Conversely, the psychiatric or forensic professions can consider unethical, and apply sanctions against, behavior the courts deem permissible.

Definitions, of course, can be flawed or have limited utility. Definitions can represent arbitrary distinctions or wishful thinking. They may give too little attention to respected minority views or too much.

But surveys do suggest that traditional ethics drawn from medicine are relevant to forensic psychiatrists (Weinstock, 1986, 1988, 1989; Weinstock, Leong, & Silva, 1991). Indeed, AAPL asks the American Psychiatric Association (APA), a medical specialty group, to enforce ethical conduct in its subspecialty. AAPL's ethics guidelines supplement the ethics Annotations of the American Psychiatric Association and the ethics Principles of the American Medical Association. Additionally, the recognition of forensic psychiatry as a subspecialty of the American Psychiatric Association and the American Board of Psychiatry and Neurology (the body that certifies these physicians) underscores the subspecialty's integration with the ethical traditions of medicine.

We will argue that definitions and historical narratives are important benchmarks for discussions of professional ethics in forensic practice. The current AAPL definition of forensic psychiatry, though only a starting point, has an important historical context that interacts with different visions of professional consultation. We will explore these by using the exchanges between Diamond and Pollack as a tool to tease out a more explicit ethical foundation for forensic practice. The contrasting views of these highly respected contemporaries provide an influential historical narrative for the profession.

Diamond v. Pollack: A Debate

Bernard Diamond and Seymour Pollack agreed that forensic psychiatry applies psychiatric theories and practices to legal issues for legal purposes. However, Pollack believed the end to be legal ends. He accepted the legal notion that the law seeks only justice. Indeed some of his followers thought the law alone should determine the permissible role of forensic psychiatrists; there were no distinctly psychiatric ethical questions to consider.

But Diamond felt psychiatrists should try to reform the legal system. He felt that forensic psychiatrists should retain their medical and psychiatric mission while working with the law. They should try to move the legal system toward more therapeutic and less vengeful goals. This concept, as we have seen, has a voice not only in psychiatry but also in the developing theory of therapeutic jurisprudence. In therapeutic jurisprudence the state's legal machinery can be used to achieve treatment goals, as when the legal consequences of one's actions result in the patient's behavioral change. Helping the defendant becomes a way to help society and vice versa.

Despite Pollack's embrace of the legal system, he refused, after the Sirhan Sirhan case, to testify in death penalty cases (Curran & Pollack, 1985). Pollack was concerned that his testimony had resulted in the death penalty (later commuted) for Robert Kennedy's assassin. Although he had maintained his professional ethics, Pollack concluded that no one staunchly opposed to the death penalty should testify in capital cases. He never performed that function again.

Pollack's choice is a central theme of this book. Even Pollack placed his personal repugnance for the death penalty over the needs of the legal system. The importance of personal values is a theme which we integrate into our theory of forensic ethics.

Diamond agreed with Pollack that forensic psychiatrists should refuse cases in which they opposed the legal system's goals. In fact, Diamond did not believe he should take just any side in a legal case. He, for one, was

not willing to work for the prosecution. Diamond believed that as a physician with therapeutic goals, he should support only the defendant. He also speculated that most forensic psychiatrists had prosecution biases and that courts tended to use such psychiatrists because they furthered the judge's or prosecutor's political career.

Diamond turned down most referrals either because the facts of the case did not support the defendant, or because the attorney planned a legal strategy that withheld relevant information from the court. Diamond would perform a confidential evaluation for the defense attorney so they could decide jointly whether he could collaborate with the attorney's legal strategy. His support was predicated on his own strict honesty about whether the full facts of the case supported the defense. Diamond agreed that suppressing facts was the attorney's and defendant's right, but he insisted that he had a countervailing right to decline the case, to conduct his consultations in a therapeutic spirit, and to assert his own medical values even in the midst of a legal proceeding. Diamond would not disguise the therapeutic intent of his consultations or his injection of medical values into the law.

Diamond (1956) called attention to cases where clinical and legal values clashed, such as when mentally disordered persons denied their illness against their legal interests. This simulation of sanity could be just as problematic for the forensic expert as the simulation of mental illness (malingering). Both could be missed by experts who did not recognize the conflict of legal and clinical values.

Diamond used the concept of fiduciary responsibility to define the expert's duty to the legal system. This special relationship of trust and confidence, common to both medicine and law, was an early attempt to integrate the ethical values of the two professions. In Diamond's view, much as psychiatrists must serve the patient's welfare by balancing professional judgment with patient demands, they owe the same balanced response to the law. In this regard his views shared much with the legal approach of therapeutic jurisprudence in which the goal is to make the legal system and its sentences more therapeutic.

Diamond argued that psychiatric experts must engage with the consequences of their legal testimony. In an argument we will revisit later, Diamond (1992) wrote:

"The psychiatrist is no mere technician to be used by the law as the law sees fit, nor [are] the science, art, and definitions of psychiatry and psychology to be redefined and manipulated by the law as it wishes."

In his view psychiatric experts should never content themselves with merely delivering testimony. They must always consider the legal consequences of their words.

Pollack also recognized the interplay of clinical and legal influences. He felt there was a further risk of confusing professional expertise with bias from other quarters: “In forensic psychiatry, the expert applies his material to social ends, all of which are intimately related to moral values” (Pollack, 1974). Because scientific data can be subjective, interwoven with social variables, and influenced by a variety of cultural factors, the conclusions presented as clinical data could easily include value judgments from outside the profession.

The need to distinguish expertise in medical diagnosis or scientific analysis from expertise on the interpretation of legal issues is an important part of this point. Expertise in the former does not ensure expertise in the latter. The interpretation of the legal issue in a case can be subject to varying standards and interpretations. This is starkly evident, for example, in the varying definitions of insanity or decision-making competence across jurisdictions. It is evident in the ambiguity of many legal terms. Legal opinions are also subject to a legal culture that may not be the primary expertise of the forensic expert. Although forensic experts are often trained at the intersection of science and law, they must be careful not to extend their role beyond their expertise. In fact, psychiatric experts must distinguish their scientific expertise in general psychiatry from their expertise in applying psychiatry to a legal issue, and their (even lesser) expertise in interpreting legal criteria for a legal issue. This, like Diamond’s honesty, is a habit or practice of the ethical practitioner.

But not all forensic experts are as transparent and honest as Pollack and Diamond. Some experts may cultivate false impressions and seek out work as “hired guns” (Diamond, 1990). They may not practice the habits of scrupulous professionals who explore the values of their work and decide on an ethical framework for forensic consultation. Survey data even suggests that some forensic psychiatrists believe they owe a duty only to the person who pays their fee. As long as they make their responsibilities and allegiances clear to the evaluatee, these experts feel they have exercised sufficient diligence in addressing any ethical concerns. Fortunately, among forensic psychiatrists this appears to be a minority view.

This again is the danger of the “hired gun:” “hired guns” may simply provide the opinion the attorney desires, making the best case for an argument they do not personally find compelling. Once committed to a side they may shade the data to support that side.

But it is attorneys, not experts, who may act as “hired guns”. The attorney in the adversarial system is paid to make the best case for the client consistent with the truth. Unlike the attorney, the expert swears “to tell the truth,

the whole truth, and nothing but the truth.” Although legal procedures may effectively prevent experts from telling the whole truth, experts can still resist being party to one-sided cases.

We will argue that, like Diamond and Pollack, experts must identify and balance competing professional, historical, and ethical factors. Failure to do so may result in disguising personal moral biases as expertise. It may result in testimony unsupported by standard behaviors or practices. It may result in failure to apply a consistent ethical framework. We contend that, by turning to specific practices that act as action-guides, experts can behave in a manner that honors both their fiduciary responsibilities and their legal oath.

Roles and Ethical Habits of the Forensic Expert

As we have seen, Pollack stressed the primacy of legal goals, an approach grounded in the concept of role, with the status and context of the professional determining right action. But Diamond promoted what may have become the dominant position of forensic psychiatrists in actual practice: the relevance of core medical values. This is reflected in the attitudinal surveys of the past two decades (Weinstock, 1986, 1988, 1989; Weinstock et al., 1991). Descriptive ethics (the way practitioners actually practice) provides this ethical standard for forensic psychiatry. From Weinstock's surveys it appears that many in forensic psychiatry support Diamond's position that core medical values are an important component of forensic practice.

There is further evidence for this position. In a 1988 survey of forensic psychiatrists in the American Academy of Forensic Sciences (AAFS) 91% thought that activities requiring violation of medical and psychiatric values were a serious ethical problem. Only 5% did not. In the 1986 survey cited earlier, the largest number of respondents (23 of 61) identified the problem of “hired guns” as the most important ethical challenge facing the field.

In a 1991 survey, AAPL psychiatrists (Weinstock et al., 1991) signaled clearly that they consider medical and psychiatric ethics part of forensic psychiatry (i.e., by an average score of 1.45, strongly positive, on a 5-point Likert scale). Respondents saw conflicting values as part of multiple agency duties like those found in general clinical practice, especially consultation. Moreover, most respondents responded either “definitely yes” or “probably yes” when asked if an ethics guideline should be written supporting duties to both society and the evaluatee.

Because the forensic role seems to draw on non-legal values, a problem of role-confusion arises. Outsiders often do not realize that a “hired gun” is a “hired gun.” Juries may assume that experts play a neutral or helpful

role, even when hired by the prosecution. Many medical experts suggest as much, and most conduct an assessment using clinical language. Paradoxically, even warnings about their legal purpose may serve to make them seem more trustworthy to an evaluatee (e.g., “How honest and fair this expert is. She must care about me.”).

Overlapping medical and legal roles trouble forensic ethics. AAPL’s ethics guidelines, for example, recognize the problem of casual changes in an evaluatee’s view of the expert’s role:

“There is a continuing obligation to be sensitive to the fact that although a warning has been given, the evaluatee may develop the belief that there is a treatment relationship.”

Overlapping roles can also be a problem for forensic psychologists. Forensic psychologists in their specialty guidelines raise the potential problem of dual role as well:

“Forensic psychologists recognize potential conflicts of interest in dual relationships with parties to a legal proceeding, and they seek to minimize their effects. . . . When it is necessary to provide both evaluation and treatment services to a party in a legal proceeding (as may be the case in small forensic hospitals or small communities), the forensic psychologist takes reasonable steps to minimize the potential negative effects of these circumstances on the rights of the party, confidentiality, and the process of treatment and evaluation” (Committee on Ethical Guidelines for Forensic Psychologists, 1991).

Pollack introduced further complexity by addressing the intent of courts and legislators, especially when legal criteria were ambiguous. But Pollack revealed his vision of role—and its consideration of policy issues—by carefully describing his reasoning. When using this ethical habit, experts are obliged to reveal their reasoning so that a trier of fact (the judge or jury) can understand the basis for their opinion, detect any biases and, where needed, disagree. This transparency is an important historical habit of ethical forensic practitioners. It lays open their view of how far the forensic role extends—and it seeks to mitigate role confusion.

Pollack was wary of the effects of his own bias. He did not intend to modify the legal concepts in a case, only to overcome biases, including the psychiatrist’s usual “therapeutic bias.” So he practiced even more ethical habits or skills to minimize this. He attempted to give an impartial objective opinion in his role as a consultant to the legal system (Pollack, 1974). And he would not participate in cases in which he knew his bias was strong.

Diamond agreed that forensic experts should reveal their reasoning process. He practiced similar ethical habits. Diamond felt experts should also reveal their knowledge of relevant legal statutes and court decisions.

But Diamond viewed complex legal issues in light of medical values. In this sense politics and social policy were part of his view of the forensic role as well.

Diamond believed that, for experts, medical values should trump legal ones, even in a court of law. But like Pollack, Diamond was guided by an over-riding principle: "total honesty." He promoted the interests of the defense in criminal cases, but only when an honest assessment of the facts supported it. Diamond did not support obscuring clinical data with legal technicalities. He broke with tradition in admitting to bias, but claimed all experts were biased. Impartiality was impossible, he taught. Although Diamond was solely a defense psychiatrist, honesty and truth were, to him, ultimate values.

Pollack and Diamond's differences were most evident in their interpretations of the insanity defense. Except for a brief period between 1978 and 1982, the M'Naghten definition has been the California insanity standard, and remains the current standard in a majority of U.S. states. The standard, drawn from Britain's historic M'Naghten case, includes provisions that insane defendants not "know the nature and quality of the act" and "know that it was wrong."

Pollack and Diamond played their customary roles in this discussion. Pollack's interpretation of "know" tended to favor the prosecution while Diamond's favored the defense. Pollack, as a matter of social policy and precedent, narrowly defined knowing the nature and quality of the crime. He did not feel it necessary for defendants to have a full, mature comprehension of their deeds (Pollack, 1974). Pollack's was a standard that could be met by more defendants, who could then be prosecuted and punished.

Diamond's view, by contrast, favored the defense. He interpreted "know" to mean appreciate, comprehend, or realize the act's full meaning. This was a standard that fewer defendants could meet, and could lead to more of them being found not guilty by reason of insanity. The approach could go beyond legal precedent and underscore a defendant's motivation.

Diamond preferred to focus on diminished capacity. This is a *mens rea* (or state of mind) defense that permits testimony on whether a defendant formed the intent necessary to commit a crime (especially a specific intent crime). It allows more clinical nuance and is closer to Diamond's position in favor of psychological explanations and over-arching medical values.

Diamond explained that, "Just about almost every defendant, no matter how mentally ill, no matter how far advanced his psychosis, knows the difference between right and wrong in the literal sense." He believed that if experts and courts adopted as low a standard as Pollack's, every defendant would qualify for the most severe punishment, and the psychiatrist

would become a handmaiden to the executioner (Diamond, 1961). Bare bones interpretation of M’Naghten would either encourage perjury or force the expert to “become a puppet doctor, used by the law to further the primitive and vengeful goals demanded of our society.” This would be a brutal—and tragic—error for physicians.

True to his code, Diamond rejected notions of impartiality and objectivity (Diamond, 1959), and used an ethic of total honesty to guide his interpretation of insanity. In fact, he wrote, any honest forensic expert should acknowledge the absence of both impartiality and objectivity. Diamond recognized that even total honesty may not preserve impartiality when dealing with emotionally laden topics like insanity and death. The essential subjectivity of human nature would see to that. Even if experts are impartial at first, they are too easily converted to biased adversaries by the need to defend their opinions and win the legal battle. But Diamond would ground his efforts in certain open and transparent habits and behaviors.

Psychiatrist and Yale Law School professor Jay Katz (1992) also recognized that impartiality and “true objectivity” are impossible. He recommended “disciplined subjectivity” as a more realistic goal. Like Diamond, he thought that disciplined subjectivity would allow open discussion of the flaws of human judgment and place constraints on unbridled bias.

Even if the more scientific aspects of psychiatry are fairly objective, much of clinical medicine and psychiatry involves subjective judgments. Determining an individual’s pain, disability, or diagnosis is often clouded by the patient’s and clinician’s value judgments (Sadler, 2005). In court cases themselves, applying clinical data to the legal issue and interpreting legal questions as a non-legal expert exposes testimony to subjective influences, including the training and life experience of experts themselves. Only honest, disciplined recognition of these subjective influences can separate the honest advocate from the hired gun (Diamond, 1990).

Some institutions formally replace “objectivity” with “striving for objectivity.” AAPL, in its 1991 revision of its ethical guidelines accepted that no expert could truly be impartial, requiring honesty and striving for objectivity in its place. “Striving for objectivity” is the profession’s formal attempt to resolve the struggle between objectivity and subjectivity, a solution found in other fields too (e.g., journalism, bioethics). AAFS (from its Good Forensic Practice Committee) similarly called for honesty and striving for objectivity (American Academy of Forensic Sciences [AAFS], 2000). If objectivity is unattainable, ethical experts can at least make an honest effort to reach it.

Striving for objectivity would appear to constitute self-reflection, transparent reasoning, and an effort to explore all aspects of a case. This ethical

skill means exploring even hypotheses inconsistent with either the expert's biases or the goals of the attorney. Balanced reports and testimony are also appropriate ways for a forensic expert to pursue objectivity. We might add education, consultation, and peer-review as well.

Striving for objectivity not only helps provide a fair legal outcome, but also protects experts themselves. Such efforts, habits, or skills are not only more "honest." They also defend against blind-spots and unrecognized bias. In court, this approach can protect experts from surprises on cross-examination because they will have considered other hypotheses along with the flaws of their analysis.

Transparent explanations also allow appellate courts to discount expert testimony in an informed manner. Or courts may agree in ways that allow expansion of previous judicial rulings. Unlike Pollack, who tailored his opinions to such previous rulings, Diamond openly expanded on existing interpretations when, in his view, they could lead to fairer conclusions. Indeed, the California Supreme Court often cited his testimony and agreed with him in its evolving discussions of diminished capacity.

A related skill Pollack and Diamond used to set the ethical boundaries of their role was to identify the ultimate legal question (the question for the judge or jury). Early writers in psychiatry struggled to constrain the expert's opinion in this way. In many forensic specialties there is still broad disagreement on whether experts should opine directly on the legal issue before the court.

Some prominent commentators (e.g., Katz, 1992) urge psychiatrists to avoid offering such opinions since they are "outside their expertise." But this is a minority position in forensic psychiatry. Most consider forensic experts free to apply psychiatric information to legal issues; indeed this is one of the foundations of forensic training.

When medical or scientific data and the legal issue are closely related, experts should address it. It is proper in this view to give opinions on such legal issues as insanity, competence to stand trial, disability, or testamentary capacity. Even in civil commitment hearings, most consider it appropriate for psychiatrists to speak on the legal issue of grave disability, which qualifies a person to be committed to a hospital.

But when the medical data and the legal issue are miles apart, experts should indeed be careful. In such cases, as in the determination of guilt or innocence, it is improper to express an opinion. A forensic pathologist should not give an opinion about who committed a murder; a forensic toxicologist should not give an opinion on whether an overdose was intentional. Generalists or fact witnesses called to testify without forensic training should also avoid giving opinions on the ultimate legal question. And forensic experts not expert in the legal criteria of a specific

case may also recognize they are beyond their expertise. The habit of questioning whether or not to testify on the ultimate legal question may provide another measure of protection against over-stepping the bounds of one's role.

Pollack and Diamond had different approaches to their role, but similar high ethical standards. Pollack tried to interpret the relevant legal issue consistent with precedent-setting interpretations. Diamond tried to expand the law by presenting clinical data to show how legal interpretations were inappropriate. Both approaches were informed by a specific view of their role in court. Both were informed by sturdy ethical principles, skills, and routines.

Attorneys seeking strict allegiance from their experts will resist this approach. But we heartily agree with Pollack and Diamond: making the best case for one side, regardless of contradictory facts, is not proper to the forensic role. Forensic experts should not become "hired guns."

In reviewing the work of Pollack and Diamond it may be clear that the ethical principles of honesty and transparency were crucial to their avoiding ethical mis-steps. Honesty requires telling the retaining attorney when the facts support the opposing side. Transparency requires explaining how. Transparency requires reports and testimony to admit uncertainty. Both behaviors allow the attorney to make an informed decision about the case or to consult other experts. Both allow juries to make better decisions. Both honor core elements of both science and law.

It is, of course, ethical to emphasize the strong parts of one's own analysis, especially where it contains new and important truths. The dangers arise when experts ignore their role limitations, ignoring the habits and skills of ethical practitioners. In daily practice, this requires acknowledging uncertainty (Katz, 1992) and resisting pressure from attorneys to do otherwise. It requires using self-reflection, balance, and education. Ethical behavior in the manner of Pollack and Diamond should not lead to distortion or denial of one's biases. Rather, it should lead to recognizing the principles and role requirements of a forensic work that uses sound ethical habits and skills.

Responsibilities or Agency of the Forensic Expert

In spite of Pollack and Diamond's contributions, however, controversy persists in defining the role of the forensic expert. To whom do forensic experts owe their primary loyalty? Whose agent are they? For clinicians, this problem arises in part because no traditional clinician-patient

relationship exists. Alan Stone (1992), a psychiatrist, Harvard law professor, and former president of the American Psychiatric Association, argues that psychiatry enters an ethical morass when it leaves the clinical setting. In his view, clinicians in forensic psychiatry operate outside medical ethics. Although he made an exception on one occasion when working "on the side of the angels," his original stance was that physicians should avoid the courtroom.

Stone (1984) challenged the Academy (AAPL) by positing that the ethical duties and boundaries of a healing profession blur once psychiatrists leave the therapeutic realm. Four key queries can be distilled from his arguments: 1) Does psychiatry have anything to offer the law? 2) Do psychiatrists try to help patients by manipulating the rules of justice and fairness? 3) Do psychiatrists deceive patients in order to serve justice and fairness; and 4) Does the adversarial legal system both seduce and abuse psychiatrists in ways that demean the profession?

When Stone questions whether psychiatry has anything at all to offer the law he is not merely being provocative. Fundamental philosophical differences in law and medicine lend legitimacy to Stone's question. Deterministic psychiatric theories, for example, may conflict with a legal system based on free will. In trying to explain behavior based in past history, childhood, brain chemistry, or environmental influence, psychiatry may run afoul of a fundamental feature of Western law: the presumption that people are rational and control their own actions.

Law professor Michael Moore (1984) contends that this is part of the mind-brain confusion in American psychiatry that dates at least to influential 19th century jurist Isaac Ray. Ray's stance was that if mental disease is physical, human agency is lost and the actor is *ipso facto* not responsible. But according to Moore (and many others), mental illness alone does not excuse people from responsibility. Someone can be excused only if they are so irrational as to be non-responsible. For Moore, this assessment may require not psychiatric expertise but simple common sense.

Stone cautioned that when physicians enter the courtroom they are tempted by several related problems. They may give factors such as justice, advancement of science, or political change greater weight than helping patients or doing no harm. Or, they may give more weight to helping the defendant than telling the whole truth. Psychiatrists in court cannot simply adjust to the adversarial system and still remain true to their calling.

Stone also warned that juries expect forensic experts to be impartial. He noted that juries do not grasp the fact that when a forensic psychiatrist testifies "he or she should be understood as having attempted to present the best case possible" for the party that has paid the professional's fee (A. A. Stone, 1990,

personal communication). Stone argued that until there is explicit recognition of this partisanship, it will not be possible to “sweep the ethical problems of psychiatry under the rug of intelligible adversarial ethics.”

Specifically, Stone objected to reliance on the cross-examination to extract the truth of a case. He argued that cross-examination does not solve the expert’s ethical quandary. A thorough cross-examination may never occur. There may be a pre-trial settlement, or the cross-examination may be uninformed or incomplete. Stone, like Pollack and Diamond, advised experts to reveal all of their findings or relevant opinions. Moreover, he proposed that, like attorneys, experts be introduced in court as partisans who do not take an oath to tell the truth.

Paul Appelbaum (1990, 1997), the former president of both AAPL and APA, is the first scholar to propose a comprehensive theory of ethics for forensic psychiatry. He agrees that forensic psychiatrists lose the primacy of beneficence and non-maleficence found in the treatment setting. But he does not suggest shunning the courtroom. Instead, truth, respect for persons, and justice must achieve primacy for forensic experts. This is a hierarchical application of principles that permits forensic testimony.

Appelbaum believes that the forensic physician should primarily assist the legal system. True, neither Appelbaum nor Stone supports playing *any* role the legal system might require. Indeed, they agree there are times when duty to the evaluatee may take precedence.

But Appelbaum (1990) argues that forensic opinions are useful only insofar as they *can* be harmful to the evaluatee. If every opinion is helpful to the evaluatee regardless of the facts, there is no value to forensic testimony. Arguably, when a treater is forced into a quasi-forensic role such as a disability evaluation for her patient, truthful advocacy may be ethically appropriate since the treatment role is primary (Weinstock, 2001). But otherwise, it is unvarnished truth that grounds the evaluation.

Appelbaum (1990), like Stone, agrees that “Psychiatrists operate outside the medical framework when they enter the forensic realm, and the ethical principles by which their behavior is justified are simply not the same.” He contends that in the forensic setting principles supporting care give way to principles supporting truth. Although he acknowledges that ethical conflicts sometimes arise, Appelbaum (1984) writes that forensic psychiatrists should present both the subjective and objective truth. Psychiatrists should gather the most relevant data that present their subjective truth. *Objective* truth requires psychiatrists to properly qualify their conclusions—with reference to the relevant psychiatric literature. This is akin to Katz’s identification of uncertainty.

Appelbaum holds physicians to high moral standards, using a classic distinction between ideals and rules. For example, physicians must relieve pain. This goal is, for the general public, only an ideal. But for physicians it is a moral rule. For Appelbaum, professional ethics—the ethics of the group of practitioners—can transform a moral ideal into a moral rule: a rule only professionals must follow.

Professions make an important bargain with society. Society gives professions privileges but expects certain duties and a degree of self-regulation in return. The profession accepts the duties society dictates or is marginalized as a profession.

In this context the ideals that should be converted into moral rules are those values which society wants the profession to promote (a use of the social expectation standard we described earlier). Thus, differences between the ethics of differing professions can depend on society's expectation of the profession (see also Robert Veatch, 1977 for bioethics' version of this argument).

But forensic psychiatrists may, in fact, be betraying evaluatees. For these professionals a significant 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” (Appelbaum, 1997). Evaluatees may think that forensic psychiatrists as physicians are there to help or at least do no harm: the subject may think it is safe to speak freely. While allowing subjects to believe it is safe can be an effective way to gain information, it is inherently deceptive and cruelly exploitive.

To some extent the deception is mutual, particularly if experts do not recognize the different influences in their work. But of course the evaluatees are far more vulnerable. They could be badly harmed.

For our historical overview, suffice it to say that Stone did not believe that allegiance to the truth solved the forensic expert's agency problem. Indeed, he believed that even clinicians who properly described their legal duties to evaluatees could not overcome the atmosphere created by use of clinical techniques.

The American Academy of Psychiatry and the Law is sensitive to the shifts that may occur even after the forensic evaluator makes clear her role. We return to AAPL's ethics guideline on this topic (2005):

“At the beginning of a forensic evaluation, care should be taken to explicitly inform the evaluatee that the psychiatrist is not the evaluatee's ‘doctor.’ Psychiatrists have a continuing obligation to be sensitive to the fact that although a warning has been given, the evaluatee may develop the belief that there is a treatment relationship.”

Appelbaum (1997) and AAPL consequently consider respect for persons a bedrock moral principle for assuring that the pursuit of truth and justice

occurs within a moral framework. The judicial system shows respect for persons by tempering its pursuit of truth with other values. For example, defendants in Western democracies may not be tortured, and in the United States the search for truth must not abridge certain constitutional and civil rights. Respect for persons is also shown when forensic psychiatrists keep information confidential except as required by their forensic function. This respect means that experts cannot ethically capitalize on a misunderstanding of their role.

In this view the betrayal of evaluatees is less likely if experts derive their ethics from the pursuit of justice rather than health. This sends a clear message distinguishing the forensic and therapeutic roles. Appelbaum does recognize that secondary medical duties may still be relevant or even determinative—as when an evaluatee collapses or expresses suicidality.

Forensic psychiatrists in this model do have duties as citizens to behave non-maleficently, but not necessarily when acting as experts. Nonetheless, basic human duties may become so important that they become determinative of ethical action (Candilis et al., 2001; Candilis & Martinez, 2006; Martinez & Candilis, 2005; Weinstock, 2001).

In modern times, there may be numerous such duties for a forensic expert. In evaluations, for example, where common protections are unavailable, rules are broken, or uncontrolled bias or racism distort the proceedings, concerns for the individual may override all others. Pre-arraignment evaluations (before an evaluatee has access to legal protections) raise this concern, as do detainee evaluations at Guantanamo Bay (conducted outside common frameworks of military and international justice). Death penalty evaluations (e.g., competence to be executed) also tempt experts to argue the primacy of non-legal values, as we shall see in Section III.

Despite the useful articulations of ethical practice by Stone and Appelbaum, forensic professionals remain uncertain about the duties incurred by their work. When, if ever, is it ethical to inject professional or personal values into the forensic evaluation? Is it even possible to avoid such influences? Is the clean separation of forensic and clinical roles the only solution to ethics dilemmas in forensics? Perhaps the professional organizations can shed some light on these persistent questions.

Ethical Guidance from the Professional Organizations

Definitions and guiding principles from professional organizations have built on the work of early scholars. Because of the special bargain between professions and society, and the importance of publicly stated values, a profession's code of self-governance is an important articulation

of ethical standards. We will therefore consider the merit of professional guidelines at length.

The American Medical Association (AMA, the parent organization of all physicians) in its Preamble to the Principles of Medical Ethics (hereafter Principles) recognizes that “a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self.” There is a sense, here, of the bargain with society and duties to multiple stakeholders.

Nonetheless, the AMA declares patient care paramount. In its 2001 revision the AMA added two principles, one of which re-emphasized its primary responsibility: “A physician shall, while caring for a patient, regard responsibility to the patient as paramount.” The clause, “while caring for the patient,” is a marker for role-specific duties which may change as physicians undertake other roles such as those in managed care administration (R. Scalettar, personal communication, March 2005; S. Taub, personal communication, March 2005). Although there are no explicit statements regarding courtroom work, respect for the law and the rights of patients are stated alongside standards upholding patient care. Indeed the Principles, like Bernard Diamond and others, recognize “a responsibility to seek changes in those [legal] requirements which are contrary to the best interests of the patient.”

AMA's judicial body reflects this claim. In a recent opinion of the AMA's Council on Ethical and Judicial Affairs (CEJA; the body that interprets AMA guidelines), the AMA reinforced the primacy of a patient's medical interest in legal reports and settings. Experts may not breach confidentiality, for example, unless authorized by the patient or compelled by the court (CEJA, 2004). Moreover, the AMA sets standards for testimony. An expert testifying against a physician must have comparable education, training, and occupational experience in the same field; and the expert must be in active medical practice or have taught the subject within five years of the incident being litigated.

Recognizing professional medical standards for legal testimony has led the AMA to join some state medical boards in making forensic physicians subject to medical board sanctions (CEJA, 2004). The AMA also considers courtroom testimony subject to peer review. Testimony is thus considered part of the practice of medicine. The AMA indicates it will assist medical organizations to discipline physicians who testify falsely against their colleagues. The AMA will also report its findings to state licensing boards. Its policy incorporates medical values into courtroom work, and makes an ethical statement with teeth.

But, in our experience forensic practitioners do not generally consider courtroom testimony to be the formal practice of medicine. After all, the

goals differ. The physician is not necessarily, in the AMA's words, "caring for the patient." The danger remains that, without a clear ethical foundation, practitioners may not know which ethic to apply.

The American Psychiatric Association bases its ethics "Annotations" on the AMA Principles. In the past, the American Psychiatric Association has provided both annotations to the AMA's Principles of Medical Ethics (American Psychiatric Association [APA], 2001a) and opinions of the APA ethics committee (APA, 2001b). Many of these are relevant to forensic practice.

For example, the Annotations and Opinions state that:

1. Exploiting patient information or practicing outside one's area of expertise is unethical (AMA Principle 2, APA Annotation 1).
2. In legal consultations, evaluatees must be informed of the nature and purpose of the evaluation as well as of the lack of confidentiality (Principle 4, Annotation 6).
3. Unless intended for treatment, psychiatric evaluations prior to access of legal counsel are prohibited (Principle 4, Annotation 13).
4. When compelled by a court, psychiatrists may ask to disclose only the information relevant to the legal issue at hand (Principle 4, Annotation 9).
5. It is unethical to submit to pressure not to give an honest opinion (specifically to government panels seeking dangerousness opinions, Opinions, Section 2-Z).
6. It is too difficult to provide competent medical service if a psychiatrist evaluates his or her own family member and testifies on that person's behalf (Opinions, Section 1-BB).
7. Testimony on aggravating or mitigating circumstances during the penalty phase of capital cases (Principle 1, Annotation 4), as well as evaluations of competence to be executed are permissible (Opinions Section, 1-N).

These professional guidelines offer important insight into the underlying ethics of professionals crossing paths with a different field. Experts cannot go back and forth without guidance, recognition of core principles, or appreciation for the context and effects of their behavior. Broad considerations of honesty, confidentiality, and justice are apparent throughout.

The APA Annotations and Opinions are not laws, but they are important standards of conduct. The APA requires psychiatrists to be familiar with their content. Local district branches investigate the ethics violations of its members, holds hearings, and recommends sanctions if needed. Sanctions include admonition, reprimand, suspension, and expulsion from the organization.

Like the AMA, the APA holds physicians accountable to the profession, society, and patients. In fact, since September 1990, the APA has reported expulsions and longer suspensions to the National Practitioners Data

Bank. Open to the public, the Data Bank contains records of medical professionals, psychotherapists, and dentists who have been sued (even if the claim was settled), whose licenses have been revoked or suspended, or who have been sanctioned by a hospital, medical group, or health plan with a peer review system. The ethics committee of the district branch can also sanction or report offending member psychiatrists to state licensing boards. If a member resigns while the case is under investigation, this can also be made public in an APA publication. There is a strong sense in these disciplinary mechanisms that the profession, society, and patients all have a claim on the practitioner's behavior.

Unfortunately professional ethics can fall victim to organizational idiosyncrasies. Most ethical issues in forensic psychiatry fall under the APA's framework. But because of the specialized nature of forensic psychiatry, it is AAPL that lays out the primary ethics guidelines for forensic psychiatrists. The irony is that the AAPL guidelines may not be subject to enforcement—the APA only sanctions behavior that violates its own framework. For those forensic psychiatrists outside the APA, state medical boards or equivalent groups in other countries provide the sole means of enforcement. For those outside AAPL, the guidelines remain relevant for court and licensing board actions.

Avoiding such mixed outcomes requires strong professional and personal ethics, and an understanding of how organizations interact with each other. There is a complex interplay of professional organizations with society's other enforcement mechanisms.

Recognizing the interplay of medical and legal values is critical to AAPL's ethics. The preamble to the organization's ethics guidelines states, for example:

“Forensic psychiatrists practice at the interface of law and psychiatry, each of which has developed its own institutions, policies, procedures, values, and vocabulary. As a consequence, the practice of forensic psychiatry entails inherent potentials for complications, conflicts, misunderstandings, and abuses.”

Certain specific principles useful for negotiating this interface include honesty, confidentiality, consent, and striving for objectivity. In the spirit of honesty and transparency, the AAPL code instructs its experts to freely admit, and even advertise, the limits of their own testimony. In a seminal section entitled “Honesty and Striving for Objectivity” the code states:

“When psychiatrists function as experts within the legal process, they should adhere to the principle of honesty and should strive for objectivity. Although they may be retained by one party to a civil or criminal matter, psychiatrists should adhere to these principles when conducting evaluations, applying clinical data to legal criteria, and expressing opinions.”

This professional guideline is consistent with the prior discussions of honesty and transparency: Pollack, Diamond, and Appelbaum all wrote in similar terms. It encourages exploring contradictory evidence, resisting one's biases, and recognizing the pressures of a retaining attorney.

In the same spirit the AAPL code addresses the conduct of the forensic evaluation itself:

“. . . if after appropriate effort, it is not feasible to conduct a personal examination, an opinion may nonetheless be rendered on the basis of other information. Under these circumstances, it is the responsibility of psychiatrists to *make earnest efforts* to ensure that their statements, opinions, and any reports or testimony based on those opinions, *clearly state* that there was no personal examination and *note any resulting limitations* to their opinions” (emphasis added, AAPL, 2005).

AAPL, like the AMA, is sensitive to the claims of its forensic practitioners:

“Expertise in the practice of forensic psychiatry should be claimed only in areas of actual knowledge, skills, training, and experience.

. . . When providing expert opinion, reports, and testimony, psychiatrists should present their qualifications accurately and precisely. As a correlate of the principle that expertise may be appropriately claimed only in areas of actual knowledge, skill, training, and experience, there are areas of special expertise, such as the evaluation of children, persons of foreign cultures, or prisoners, that may require special training or expertise.”

AAPL has developed its guidelines to match both the AMA and APA. In light of recent revisions to the AMA Principles and APA Annotations, AAPL has now revised its own ethics guidelines. Themes in AAPL's revision include the use of balancing approaches between competing ethical principles, and a clearer distinction between clinical and forensic practice. The stronger distinction is in keeping with the concerns of Stone and Appelbaum.

“Psychiatrists who take on a forensic role for patients they are treating may adversely affect the therapeutic relationship with them. Forensic evaluations usually require interviewing corroborative sources, exposing information to public scrutiny, or subjecting evaluatees and the treatment itself to potentially damaging cross-examination. The forensic evaluation and the credibility of the practitioner may also be undermined by conflicts inherent in the differing clinical and forensic roles. Treating psychiatrists should therefore generally avoid acting as an expert witness for their patients or performing evaluations of their patients for legal purposes.

Treating psychiatrists appearing as ‘fact’ witnesses should be sensitive to the unnecessary disclosure of private information or the possible misinterpretation of testimony as ‘expert’ opinion. In situations when the dual role is required or unavoidable (such as Workers’ Compensation, disability evaluations, civil commitment, or guardianship hearings), sensitivity to differences between clinical and legal obligations remains important.

When requirements of geography or related constraints dictate the conduct of a forensic evaluation by the treating psychiatrist, the dual role may be unavoidable: otherwise referral to another evaluator is preferable.”

The importance of these ethical themes is evident across professions. The American Psychological Association, for example, has also published ethical guidelines for its members (2002), and forensic psychologists themselves have developed ethical guidelines. Guidelines for forensic psychology, like those of AAPL, emphasize consent and the limits of confidentiality. Both evolve from a definition of forensic practice and espouse working within one's expertise. The forensic psychologists offer specific tools for addressing dilemmas, including consultation, independent review, and direct communication with attorneys. These recall Pollack and Diamond's habits of the ethical practitioner. Moreover, proper testimony is described as fair but forceful, stopping short of “partisan distortion or misrepresentation.” Forensic psychologists, like psychiatrists, make sure that evaluatees are represented by legal counsel.

The American Academy of Forensic Sciences (AAFS) has a similar code. This diverse group of experts from many fields (e.g., ballistics, DNA, crime scene analysis, toxicology, dentistry) promulgates a minimum standard of behavior for all forensic scientists. The code precludes professional or personal conduct adverse to the best interests and purposes of AAFS. Its main provisions forbid distortion of data and credentials (AAFS, 2002). These include misrepresenting education, training, experience, area of expertise, or any of the criteria needed for AAFS membership. It is forbidden to misrepresent the data upon which experts base their opinion.

The AAFS Committee on Good Forensic Practice has also developed aspirational guidelines for forensic scientists. These are intended to go beyond the code's minimal standards, but, unlike the code, are not binding. They have not been adopted by the organization as a whole. These aspirational guidelines are specifically intended to “differentiate the good forensic practitioner from the minimally adequate one. They are meant to serve as guidelines for forensic scientists entering the profession who aspire to become ethical practitioners, and want to learn more than the minimum requirements to avoid ethical sanctions” (AAFS, 2000).

The committee's aspirational standards echo many from other organizations:

1. Honesty and striving for objectivity require examining “all relevant obtainable data that could distinguish between plausible alternative possibilities.”
2. Experts should give opinions “only in their areas of expertise,” and keep current in their scientific discipline.

3. They should apply their assessments and skills to legal questions with great care, striving “to do high quality work.” They should be familiar with “applicable legal criteria.”
4. “They should possess an independence that would protect their objectivity.”
5. Forensic scientists should present opinions in “understandable language,” be as “accurate as possible,” and “avoid distortion.”
6. Privileged information from the attorney should be kept confidential.
7. “Unlike attorneys, forensic scientists are not adversaries. They take an oath in court to tell the whole truth. They should make every effort to uphold that oath.”

The National Association of Social Workers (NASW, 1999), whose membership provides both experts and guardians for children, adults, and families, also builds its ethical guidelines from a series of core values. These include service, social justice, respect for persons, and integrity. Rather than choosing a balancing or hierarchical ordering of values, the NASW does not “specify which values, principles, and standards are most important and ought to outweigh others,” leaving such decisions to the best judgement of their members.

Like other organizations, however, NASW espouses consent, confidentiality, competence, and trust in its interactions with clients. These principles apply in different directions: to clients, to colleagues, to the profession, and to the “broader society.” They eschew dual or multiple relationships with clients, but focus this admonition on social or business interactions. In legal proceedings, social workers protect confidentiality “to the extent permitted by law.”

The NASW’s subspecialty group, the National Organization of Forensic Social Work (NOFSW), educates the growing number of professionals involved in legal evaluations. The NOFSW divides its code of ethics into sections detailing responsibilities to the organization itself, to employers and colleagues, to clients, and to society (NOFSW, 1987). Practitioners are encouraged to treat others with respect and dignity, to report their qualifications accurately, and to respect confidentiality. They are required to avoid “potential conflicts of interest” between “personal, family, and/or professional responsibilities.”

In society and among their fellow professionals, forensic social workers try to “clarify potential conflicts among laws, rules, policies, and treatment goals when serving the client . . .”, and to influence “proposed legislation” affecting their practice.

All these organizational guidelines are similar in many ways. Obligations of honesty appear throughout, as the professions guard their credibility and community standing. These are bolstered by professional requirements of

credentialing and working within one's expertise. Confidentiality and consent are owed to those being evaluated; independence and striving for objectivity are owed to society. There are multiple responsibilities in multiple directions.

But there are ambiguities in interpreting the ethics statements of professional organizations. Like the AAFS Committee on Good Forensic Practice, Allen Dyer (1988) distinguishes ethical guidelines which function in a punitive role from those that are aspirational. Aspirational guidelines, as we have seen, are for professionals trying to behave as ethically as possible. Violation of minimal standards may lead to societal sanctions like legal penalties. But these may differ from the ethical aspirations articulated by the same organization, even within the same document. In the writings of some organizations, no cohesive ethic of practice is clear.

Guidelines may be reactive or come too late. Referring to the APA Annotations, for example, Appelbaum (1992) underscores that "they are generated on an *ad hoc* basis, as an issue rises to the surface in the APA rather than in a systematic effort to elaborate an ethical code." This is not only true of the APA. Many organizations find themselves reacting to crises rather than planning prospectively. Also, many organizational statements generally relevant to forensic work may not be relevant to all forensic settings. And, as Appelbaum observes, some rules are "so general as to create no boundaries at all."

Every group has ethics peculiar to its organization. Further subtleties consequently arise in the trajectory or evolution of each organization's guidelines. All organizations have emerging standards for which there is not yet broad agreement. They may be aspirational or not. They may be idiosyncratic or not. They are part of the profession's evolving historical narrative, and both shape and reflect its task forces or committee reports. Correctly applying these specific ethics consequently requires a deep knowledge of institutional history.

The APA, for one, is therefore strengthening its professional guidelines. As a model of the approach we will advocate, the APA is paying closer attention to the dual agency issues raised by forensic practice; the competing obligations to individuals and to society. It also includes language on the skills and habits of ethical practitioners, on recognizing ethical problems and personal blind-spots, applying formal ethics decision-making, creating safeguards, maintaining clear professional boundaries, separating roles that may pose conflicts, and seeking consultation, supervision, and further data.

But personal ethics influence the organizations as much as historical idiosyncrasies. Diamond (personal communication, April 25, 1988) reminds professionals of the interplay of organizational and personal ethics. Personal

ethics can be stricter than organizational ethics and are held by people or groups for private not professional reasons. They are standards which should not necessarily be forced on all professionals, but which can still be powerful personal guides that influence (or interfere with) organizational statements. They are most evident when organizational leaders cannot afford to offend a powerful faction or individual.

Professional guidelines are consequently only part of developing an ethical framework. No set of professional guidelines can address every ethical contingency. Dominant ethical approaches within an organization may provide no clear resolution to ethical conflicts (Rosner & Weinstock, 1990). Indeed, organizations, like ethics as a philosophical discipline, incorporate multiple analytic perspectives. Thus courtroom experts must develop specific expertise in acting ethically, in analyzing ethical dilemmas from different perspectives, and in explaining their ethical choices in suitable settings, and in suitable language.

Balancing Conflicting Duties

How do experts make sense of all these statements and approaches? As we are seeing, professionals functioning at the interface of two differing disciplines wrestle with basic ethical dilemmas. Which values hold sway? What are the bounds of interdisciplinary work? Forensic professionals seek ethical guidance from a range of sources: from definitions of practice and role, from the historical narrative of their profession and its scholars, and from professional and legal guidelines. They have developed useful tools, from identifying habits and skills of ethical practice, to choosing guiding principles, and developing procedures for sanctioning unethical practitioners.

Society has already found some partial solutions to the problem of conflicting principles and rules. The problems forensic professionals seek to resolve are not exclusive to forensic work. They pervade our society. Consequently the solutions may be present as well. When medicine and economics interact, for example, tensions arise between clinician profits and patient needs. Recall the controversy over physician ownership of the laboratories and scanners they used for their patients. Media reports and lawsuits charged that physicians were ordering more tests than were necessary and pocketing the profits. Solutions governing such conflicts of interest (e.g., laws, damage awards, institutional policies) consequently came from politicians, judges, and universities.

Similarly, when clinical and research science overlap, federal regulations address the ethical tensions arising between the needs of the individual

research subject and the needs of the research study. And, as we have seen, treaters encounter challenges to their duties to an individual patient when the law requires them to consider societal welfare, as in the reporting of child and elder abuse. Therefore, laws and federal regulations provide structure for professionals who must breach one ethic to support another.

The problem of competing responsibilities may be visible in many societal interactions: citizens have duties to themselves and others, treating clinicians have duties to patients and society, and officers of the court have duties to defendants and to the judicial system. It is not surprising that forensic experts may have multiple and conflicting duties as well.

In Section II we will suggest how forensic experts might integrate these: the allegiances to the court, to society, to the attorney who retains them, and to the evaluatee. These allegiances obtain no matter who requests the consultation. We have identified multiple sources of guidance from history, scholars, organizations, laws, and regulations. But we can identify yet two more tools for deciding among them.

Commentators in forensic medicine, as in other fields, have considered either balancing conflicting duties and values or ordering them in a hierarchical fashion (i.e., legal over professional ethics). Although a traditional doctor-patient relationship does not exist, some practitioners may still use medical principles as a counter-weight to pure legalism (e.g., Diamond, Weinstock). Others may defer to legal principles and procedures (Pollack, Appelbaum). Bench scientists may face a similar choice: their duties to the party that hires them, to the individual, and to the court are tempered by professional scientific standards of assessment and integrity.

Weinstock and others (1990) prefer a balancing approach because of its greater flexibility in addressing complex ethical dilemmas. Especially for physicians, these commentators hold that traditional medical ethics should play an equal part in the assessment of conflicting medical and legal values. They support the approach recommended by educator and ethicist Edward Hundert (1990). Hundert takes a mainstream view found in bioethics and moral philosophy. It is practiced by weighing outcomes, risks, and benefits to the parties or ideals involved. It is an approach whose rules we will describe in Section III.

Appelbaum (1997) described an alternative, hierarchical approach in which legal values are dominant. For him, truth and justice drive the ethical conduct of forensic experts. Appelbaum argues that choosing one principle *over another* (emphasis added) is often required in life but that resolving such conflicts indeed “requires balancing, among other morally relevant factors, [such as] the nature of each imperative, the benefits and harms likely to flow from its violation, and the alternative means of achieving the desired end.”

Testimony in death penalty cases offers a chance to apply these approaches. For experts taking a balancing approach, decisions must be made on how to justify their part in potentially lethal legal procedures. For some, competing values or principles are in balance up to the point of lethal injection. For others, values are not even in balance at the assessment for competence to stand trial because, in capital cases, the individual may ultimately be executed.

Alternatively, those who order their values or principles must choose which ones come first: the medical or the legal; those protecting the individual from society's ultimate punishment, or those preserving social order at a steep cost to the individual.

In a seminal article using the balancing approach, Harvard physicians Robert Truog and Troyen Brennan defined six stages of physician participation in executions, from care of death-row prisoners to certifying death (Truog & Brennan, 1993). They recognized only the care of death-row inmates as a proper medical exercise. At other stages the ugly symbolism of physician involvement outweighed the contributions of medicine to the legal process. We will take up this analysis in Sections II and III. But here are two more available tools—balance and ordering—for making choices between difficult values.

Resuming the Historical Thread

In 1998 cross-cultural psychiatrist and Yale professor Ezra Griffith re-framed the old medical vs. legal question (Griffith, 1998). He stressed the importance of dominant/non-dominant group dynamics in society, using a cultural formulation for forensic ethics. He articulated the value of the individual defendant's personal narrative as well as the influence of dominant cultural and political forces in the judicial encounter. It is an approach that seeks to address the frequent lack of respect—in court and elsewhere—shown to Americans of color.

Even if cultural sensitivity does not shape an assessment helpful to a defendant, this approach is a call for non-dominant cultural influences to be better understood. It remains important for professionals in any cultural minority to remain involved in educating the dominant system. Cultural narrative consequently becomes another tool for understanding any institution's inherent bias or unfairness.

In 2001, Candilis and Martinez (assisted by psychiatry resident Christina Dording) integrated several approaches. They proposed a view of the forensic role that unified the principled and narrative approaches. It was re-stated in 2005 in response to Griffith's powerful recounting of the personal, cultural, and

community influences on his own development as a forensic professional (Griffith, 2005; Martinez & Candilis, 2005).

In the integrated or unified view, the historical narrative of a profession, like that of a culture, anchors the profession in enduring values. Like any culture, each profession applies its own historical narrative to the development of professional identity and integrity. This is true of individual professionals as well: core values from their personal development will help resist the vagaries of social and situational forces. They will anchor and guide moral identity.

Central to this integration of principles and narrative was a professional integrity tied to community and common values. It reflected the societal expectation of a broad physician-based approach from its forensic medical experts. Candilis et al., (2001) contended that the historical narrative of forensic psychiatry was still emerging. Thus, a narrow view of forensic work, one that defined the expert's courtroom role narrowly, limited the room for this evolution. A broader view of professional integrity permitted personal and traditional physician-based values from the evolving narrative to inform forensic work. It also rejected the assumption that forensic work could be cleanly distinguished from one's personal or professional values.

Principles like truth and justice still work for these authors in theory. They create a framework for appropriate action. But alone they cannot fully address the motives and intentions of individuals. Principles cannot always navigate complex forensic situations. Rather, "Narrative can operationalize theory in a practical manner, describing the individual's unique path to the forensic encounter" (Candilis et al., 2001). As we will see, narrative ethics is an answer to the criticism of principlism in the latter half of the 20th century (Beauchamp & Childress, 2001). It effectively addresses cross-cultural issues in a multicultural society and helps balance personal, professional, and legal ethics.

But the narrative approach must guard against moral relativism. Ciccone and Clements (2001), for example, raise the fear that a narrative approach can lead ethics to become arbitrary. It is difficult to decide what is right if the only ethical standard is the individual's perspective. These scholars are not alone in recognizing an inherent moral relativism in the purely narrative approach. In Section II, we will suggest how to incorporate narrative properly into the development of an integrated ethical theory for forensic practice.

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2

Cases and Examples Using the Approaches So Far

Published opinions in response to questions for the AAPL Committee on Ethics (1995) may help clarify how one organization applies its professional ethics. It is an important element of the profession's evolving historical narrative. The responses below tie fundamental principles like truth and justice to specific professional guidelines and offer particular solutions to ethical questions. They are a window into the connection between theory and behavior. Published prior to the most recent guidelines revision (2005), the committee's responses exemplify the approach that distinguishes primary and secondary duties based on the expert's role in the proceeding (i.e., consultant or treater). They appear here with permission.

1. *Question: Is sex with a forensic evaluatee ethical?*

Answer: No. Section IV of the AAPL ethical guidelines requires honesty and striving for objectivity. Sex with an evaluatee would seriously impede objectivity and would be exploitative and coercive. It would make the APA section I requirement for delivery of competent medical service almost impossible.

2. *Question: Is it ethical for forensic psychiatrists performing an evaluation to use bullying tactics, to be rude, use name-calling, and press a plaintiff to drop the case?*

Answer: Most relevant is the APA and AMA principles of medical ethics section 1, "a physician shall be dedicated to providing competent medical service with compassion and respect for human dignity." Also relevant is AAPL section IV on honesty and striving for objectivity. The use of bullying tactics and deliberate rudeness are disrespectful of human dignity and therefore are unethical, as are pressuring a plaintiff to settle and failing to be objective. However, the special role of a forensic psychiatrist also needs to be considered. A psychiatrist retained by the defense in a civil suit is obtaining information for the

side opposing the plaintiff. What may appear to a plaintiff to constitute bullying tactics may merely be appropriate skepticism to disbelieve the plaintiff or to press for inconsistencies in order to try to determine if there is malingering. Unlike a therapeutic interview that involves helping the evaluatee as the primary purpose, a forensic evaluation may necessitate exploration of areas that a plaintiff prefers to avoid and finds upsetting. In addition, a negative evaluation by a forensic psychiatrist may motivate a desire to retaliate by filing an ethics complaint. Each case should be evaluated by exploring the forensic psychiatrist's reasons for his/her behavior. Differences in interview style do not necessarily involve ethical infractions. However, deliberate rudeness, pressure to settle, and lack of respect for human dignity are not justified.

3. *Question: I am treating an insurance company employee who for the past several years has been forging signatures on loan applications and running an illegal scheme at work. On two occasions he has been admitted to the hospital because of stress. I will be testifying at a Workers' Compensation hearing regarding the employee's ability to work. Am I obliged to reveal these illegal activities as one major source of stress?*

Answer: You are functioning in a treatment capacity and any forensic role is an adjunct to your therapeutic role and not primary. However, testifying in court might still conflict with your therapeutic role since there is no duty for a treating psychiatrist to obtain information from sources other than the patient and you will need to answer any questions the court considers relevant and admissible. You may be unable to be objective under those circumstances because of countertransference feelings toward your patient and your awareness that unfavorable statements will interfere with therapy. AAPL's guidelines require obtaining the informed consent of the subject when possible. Your patient should be informed of the possibility that if you are asked to testify you may be asked questions that would require your revealing his reported illegal activities. Since you would not wish to perjure yourself if asked direct questions in court, he should consult with his attorney and decide whether to call you to testify. In many states, the patient may automatically waive any therapist privilege if he tenders his mental state at issue. The patient should consult with an attorney about this issue in order to make an informed decision. If possible, it might be wise to separate the treatment and forensic roles since the two roles can conflict. AAPL guidelines section IV, honesty and striving for objectivity, recommend that a treating psychiatrist generally should avoid agreeing to be an expert witness or to perform an evaluation for legal purposes on a patient.

4. *Question: A forensic psychiatrist in a small town in which he is the only psychiatrist had been treating the mother who was murdered by her son, the current defendant. This same psychiatrist had been hired to perform a forensic evaluation on the son in a death penalty trial. Is it ethical for the mother's former psychiatrist to perform a forensic evaluation on the son? I am afraid the son is being railroaded.*

Answer: It is unlikely that the forensic psychiatrist under these circumstances could meet the AAPL requirements of striving to be objective. Also, regardless of privilege laws, APA's Annotated Principles clearly state that confidentiality continues after death. Could the forensic psychiatrist avoid using confidential information from the mother in the evaluation? More information is needed on the specifics of the case, but the behavior you question may in fact be unethical. Even if these issues were not problems, there would be an appearance of impropriety and a lack of objectivity. Therefore the psychiatrist should refuse to take the case even if a nonlocal psychiatrist must be found.

5. *Question: Our court clinic has been asked to provide psychiatric evaluations of defendants for dangerousness, in order to help determine bail amount prior to the defendants having access to an attorney. Is this ethical?*

Answer: Both the APA and AAPL (under Section III consent) preclude forensic evaluation prior to access to or availability of legal counsel. The only exception is an evaluation for the purpose of rendering emergency medical care and treatment.

6. *Question: An attorney has asked me to do a forensic examination on a lien, in which I would collect my fee only if the case is successful. Is this ethical?*

Answer: If your fee or its collection is dependent on the successful outcome of a trial, it is unethical as explained under the AAPL guideline section IV, honesty and striving for objectivity. It also is unethical according to the AMA opinions of the Council on Ethical and Judicial Affairs sections 6.01 and 9.07. It is ethical for attorneys to accept cases on a contingency basis since they have no ethical duty to strive for objectivity. The attorney is responsible for all expenses including your fee. A retainer presents no problems with striving for objectivity and may even facilitate it, so it presents no ethical problem. According to AMA Opinions of the Council on Ethical and Judicial Affairs, section 8.10, however, a lien may be filed as a means of assuring payment in states that have lien laws, providing the fee is fixed in amount and not contingent on the amount of the patient's settlement against the third party. Since your lien would be dependent on the outcome of the case, it would be unethical.

7. *Question: I provide psychiatric evaluations for the district attorney's office after an attorney has been appointed but before the attorney has been able to see the defendant. Under these circumstances I explain the nature and purpose of the evaluation, and that I am working for the district attorney so there is no confidentiality. If the defendant tells me incriminating evidence I see no problem since I have obtained his informed consent. Is this ethical?*

Answer: No. The APA and AAPL guidelines preclude such evaluations prior to access to or availability of an attorney. In this case, the attorney clearly has not yet been available. The attorney may not wish his client even to talk to the forensic psychiatrist. The psychiatrist cannot obtain adequate informed consent under these circumstances, as the defendant revealing incriminating evidence to you demonstrated.

8. *Question: Is it ethical for two forensic psychiatrists who work closely together to testify on opposite sides of a case?*

Answer: Yes, as long as no information is shared between the forensic psychiatrists without the approval of both opposing attorneys and both attorneys are informed about the close working relationship of the two forensic psychiatrists. The AAPL guidelines section on confidentiality and honesty are relevant.

9. *Question: On the basis of news reports, a forensic psychiatrist offered to testify for the district attorney in a death penalty case without examining the defendant. Are his actions ethical?*

Answer: AAPL guidelines Section IV, honesty and striving for objectivity, require an earnest effort to personally examine the defendant. If impossible, it is necessary to qualify the opinions and indicate in any reports and testimony that there was no personal examination and the opinion expressed is thereby limited. If such was not done, the testimony would be unethical. Moreover, the extreme interest displayed by the forensic psychiatrist casts doubt on his ability to be objective.

10. *Question: Is it ethical for a forensic psychiatrist initially retained by the defendant in the criminal case to then agree to testify for the codefendant without obtaining the approval of the attorney for the defendant?*

Answer: Commentary under the AAPL guidelines Section III, confidentiality, states the psychiatrist should clarify with a potentially retaining attorney whether an initial screening conversation prior to a formal agreement will interdict consultation with the opposing side if the psychiatrist decides not to accept the consultation. Although it could be debated whether the attorney for the codefendant is the opposing side, the frequent conflict of interest between such codefendants indicates that the essence of this AAPL guideline still applies. The failure of the forensic

psychiatrist to obtain clarification prior to the initial consultation places an affirmative obligation on the psychiatrist to obtain approval from the first attorney prior to consultation or retention by the codefendant's attorney. Alternatively, the forensic psychiatrist could inform the first attorney at the onset that he/she plans to consult with the second attorney or that a brief discussion with the first attorney will not neutralize his ability to work with the second attorney. The APA does not address this issue clearly unless Principle 2, requiring honesty with patients and colleagues, could be broadened to include attorneys and their clients. Under the conditions you mention it would be unethical to testify for the codefendant without the defendant's attorney's approval.

11. *Question: Is it ethical to testify that the psychiatrist for the opposing side is a prostitute because he is paid handsomely for his services for the side the complainant believes is frequently the wrong side?*

Answer: It is crucial to distinguish between honest differences of opinion, biases—conscious and unconscious—and “hired guns”. Ethical guidelines for the AAPL and the AMA and APA ethical frameworks no longer require proper etiquette and respect for other physicians as an ethical issue. In fact principle 2 of the AMA and APA principles indicates an ethical duty to strive to report those physicians deficient in character or competence. However, to call names would violate the APA and AMA requirements to respect human dignity. Moreover, the honesty and objectivity of the psychiatrist calling names would validly be questioned. The exposure of deficiencies of character or competence in other psychiatrists can be accomplished without name-calling.

12. *Question: A forensic psychiatrist in a death penalty case did not interview the defendant because he said such people always lie so an interview would be worse than useless. He also stated that he would express his opinion against the defendant with reasonable medical certainty. Is this ethical?*

Answer: AAPL Section IV, honesty and striving for objectivity, require an earnest effort to personally examine the defendant and if impossible, to qualify the opinion and indicate in any reports and testimony that there was no personal examination and the opinion is thereby limited. Since that was not done and there was no evidence of an attempt to do so, the testimony is unethical. Moreover, the unsubstantiated statements that such defendants always lie and that no pertinent information can come from such an interview would seem to violate to the AMA and APA section 1 requirements for competent medical service insofar as they are totally unsubstantiated opinions that are not compatible with competent service.

13. *Question: A forensic psychiatrist always testifies for the defense in death penalty trials but cannot substantiate his conclusions on the witness stand when asked for justification. He appears willing to lie in order to prevent the execution of the defendant. Is this ethical?*

Answer: AAPL does not require a witness to be expert at responding to cross examination. However, honesty and striving for objectivity are required. Although saving a life may be most consistent with traditional Hippocratic ethics, truth and honesty are the primary duties for a forensic psychiatrist. It might be argued that a secondary doctor patient relationship exists but it cannot override truth and honesty. If the true facts are not favorable, a forensic psychiatrist can refuse to become involved. To testify falsely is always contrary to the APA and AMA requirement for competent medical service and is unethical.

14. *Question: A forensic psychiatrist has testified that a defendant is competent to be executed. Is this ethical?*

Answer: The APA and the AMA forbid participation in a legally authorized execution but such participation has been narrowly defined. Although some would argue that competence to be executed evaluations are unethical because they are too close to the death penalty and the Council of the Medical Society of the State of New York and the American College of Physicians as well as the World Psychiatric Association have taken such positions, yet neither the AMA or APA currently have positions on this issue. Surveys of forensic psychiatrists show divided opinions on this issue, with a slight majority seeing no ethical problem with performing competence to be executed evaluations. It is also debatable whether evaluations showing incompetence to be executed must be unethical if evaluations showing competence to be executed are unethical. At present, there is nothing unethical about the testimony in your question.

15. *Question: A psychiatrist who is asked to evaluate a defendant found him sleeping and testified that the defendant could not be schizophrenic since schizophrenics do not sleep so soundly. Is this ethical?*

Answer: Since there is no evidence for such a statement, it would contradict AAPL's requirements for honesty and striving for objectivity and the APA requirement for competent medical service and it is therefore unethical. AAPL does not forbid testimony expressing minority points of view but there needs to be some evidence for an opinion and unusual opinions need to be honestly labeled.

16. *Question: A plaintiff's attorney has asked me to change the diagnosis in my report from a dysthymic disorder to major depression in order to strengthen the case. Is this ethical?*

Answer: Changing such a major issue would violate honesty and objectivity as well as competent medical service and therefore would be unethical. Although it may not be unethical to accept changes in phraseology or improved ways of expressing an opinion, a major change in diagnosis is unethical without new data to justify it.

17. *Question: A forensic psychiatrist clearly became very involved in a case, emotionally arguing his position in court and giving advice to the attorney about strategy. Is this ethical?*

Answer: Although many forensic psychiatrists believe advocacy is unethical, AAPL has followed the view that advocacy is permissible and advocacy for an opinion may even be desirable. Identification with a cause and even bias are not unethical in and of themselves and some emotionality and bias may be inevitable. However, bias must be openly acknowledged and not lead to distortion, dishonesty or failure to strive to reach an objective opinion.

Case Vignettes for Teaching and Discussion

Before offering our own integration of ethics models for forensic work, we will relate and expand existing guidelines and ethical concepts to address specific cases. These are examples that apply the dominant language and guidelines of today. They offer mainstream analyses for the forensic practitioner. As in the AAPL opinions above, these cases focus on the expert's primary and secondary duties based on their role in the evaluation.

Case 1. Changing the Expert's Report

Dr. A, a forensic psychiatrist, submits a draft report to a defense attorney. She decides that the evaluatee has bipolar disorder and meets the state's legal criteria for insanity.

The attorney suggests some changes in wording to clarify the opinion, remove some ambiguity, correct spelling errors, and improve the grammar. She corrects two minor mis-statements in the defendant's family and work history. The attorney also observes that the projective psychological tests showed some disorganization under stress, consistent with schizophrenia. To strengthen the opinion, she asks whether Dr. A can change her diagnosis to schizophrenia—or at least schizoaffective disorder. She is concerned that the prosecution psychiatrist may argue, as she has in the past, that a mood disorder does not involve enough cognitive distortion to meet insanity criteria in that state.

The defense attorney reports that she has read in the psychiatric literature that disorganization in projective testing suggests schizophrenia and that this

diagnosis would better convey the nature of the psychosis. She urges making this change, claiming that, without it, she may be unable to use the psychiatrist or her report.

The psychiatrist still believes that bipolar disorder is the proper diagnosis but acknowledges uncertainty. She also hopes to receive further referrals from the attorney. Is it ethical to make the changes?

Discussion

Rewritten prose is ethical, but diagnostic changes are not. It is certainly ethical to accept wording changes that correct factual inaccuracies and to accept rewrites that help clarify the opinion. But these changes must not change the opinion itself. A change in diagnosis is a major change, and is not considered ethical. Alterations in the nature of the opinion, even in emphasis, would be dishonest, conflicting with AAPL's requirement of honesty. They would also violate the ethical requirement of the American Academy of Forensic Sciences not to distort data.

It is important, besides, that the forensic psychiatrist recognize the difference between her role and that of the attorney. She cannot ethically "spin" the data in order to win the case. "Spin" is an expectation of attorneys, not experts. The expert remains bound by the oath to "tell the truth, the whole truth, and nothing but the truth." Though the legal system may not permit the telling of the whole truth, limiting responses by procedural rule, the expert has a duty to do as much as the legal system will allow. This is the duty to avoid distortion.

It is not enough to wait for cross-examination; good cross-examination may not occur. Reports themselves are not subject to cross-examination. Indeed, expert reports are often submitted under penalty of perjury. Resisting a change in the substance of an expert's opinion is a position most consistent with Appelbaum and others' articulation of the principle of truth-telling.

If the attorney cannot use or does not want the opinion, she has other options: she may refuse to call the expert; she may consult other experts. With enough input, she may finally choose to change the nature of her defense. Indeed, many attorneys use experts to test the strength of their case or the feasibility of certain defense strategies.

Case 2. Conducting a Forensic Examination on Your Own Patient

A patient is badly hurt in a car accident; the other driver is negligent. Dr. B is a psychologist who, for the past few years, has been treating the

patient in psychotherapy. During the accident her patient never feared that his life was at risk, but the resulting pain severely hampered his work and sleep.

The patient sues the other driver. Since the accident, the patient experiences more severe anxiety symptoms, but does not meet diagnostic criteria for post-traumatic stress disorder—a more severe anxiety disorder related to a specific life-threatening event. He takes pain medication from his orthopedist and continues psychotherapy.

The patient's attorney suggests asking the treating psychologist to conduct a forensic evaluation and prepare a report. After all, he says, his psychologist knows him best. The attorney says that since the patient placed his mental state at issue in filing the civil suit, the treatment cannot be confidential anyway, so the treating psychologist may as well do the evaluation.

The attorney is concerned that a forensic evaluator hired by the other driver's insurance company will write that the patient had pre-existing anxiety and not post-traumatic stress disorder. He may say nothing about the severe exacerbation of the anxiety after the accident. Further, since the opposing expert is retained by the insurance company, he may be biased in its favor.

The patient's orthopedist willingly writes a letter supporting the patient's post-accident disability. The patient agrees that his psychologist knows him best, and requests the forensic evaluation by his psychologist. In fact, after the accident, the treating psychologist has already written a report supporting a legitimate short-term disability claim when the patient was too anxious to work. The patient can pay the higher forensic consultation fees and knows the therapist includes forensic work in her practice. What is the ethically proper choice?

Discussion

Treating psychologists should generally not perform such forensic evaluations. The attorney should hire another clinician to perform the evaluation. The roles are generally considered incompatible and each interferes with the other.

The patient's disclosures in therapy may be affected if he tries to add clinical data relevant to the legal case. Even if he merely *considers* how his disclosures affect the civil suit, the overlapping roles will have had an effect. Also, on the witness stand the therapist may be required to present opinions that could emotionally harm the patient, harm the therapy, or otherwise interfere with the treatment relationship.

The role of expert can also interfere with the duty of therapist supportiveness. A forensic expert must approach the case from the

position of a skeptic, striving for objectivity, seeking out corroborating or contradictory evidence. She must explore the possibility of malingering. Often, others must be interviewed. This can interfere with the primacy of the therapist-patient relationship. If the treater recognizes that the dual role will compromise the relationship, the treater-turned-expert may limit the thoroughness of her forensic assessment. A treater may ordinarily attempt to emphasize positive feelings (or countertransference, in Freudian parlance) towards a patient. This is not appropriate to the forensic role.

Further, a jury may believe that the therapist is simply doing her best to help the patient, hurting her credibility on the witness stand. In their organizational statements, both the forensic psychologists and psychiatrists grasp the importance of separating treatment and forensic roles. Separating roles is also an established habit or safeguard used by ethical practitioners. Even if the therapist's treatment notes are subpoenaed and the therapist is called as a fact witness, the "fact" role is clearer to the legal system, the therapist, and the patient.

The psychologist's position is more complex in this scenario than that of the orthopedist. There is a more personal valence to the psychological assessment, and the degree of trust may be greater after intimate disclosures. Yet even for the orthopedist there is the danger that the patient will distort and exaggerate to help his case. The orthopedist, too, may wish to be helpful—rather than objective—for his patient.

It is true that in disability assessments, treaters must usually submit forms in support of a patient's disability. The therapist's involvement in such cases (and others such as guardianship, Workers' Compensation) appears unavoidable at present, but it is best to limit dual agency as much as possible.

In the unified approach we will introduce in Section II, we will speculate that the treater and forensic roles can be united when the ethical frame is clear, the therapist's motivations are transparent, the parties informed, and conflicts mitigated. An exercise for the reader at this point, would be to imagine the cases where this role unification may be permissible, and to consider what values would be needed to govern the approach.

Case 3. An Unorthodox Methodology

Ms. C is a ballistics examiner who testifies that she has matched a spent bullet to the gun of an accused murderer. The testimony proves critical to obtaining a conviction. The examiner reports that she fired the weapon over 30 times and cleaned the barrel before she could obtain the match, but does not describe this as a departure from usual practice. She is not challenged by the defense. Is there anything unethical to her testimony?

Discussion

Testing the weapon more than two or three times and altering the test conditions by cleaning the gun undermine scientific standards that require stable experimental conditions. Attempts at objectivity would appear to be obstructed.

Because expert testimony relies on credibility, fundamental principles of truth-telling and honesty require recognizing the flaws of the expert's analysis. Marginal methodologies or methods that stray from accepted norms undermine each of these principles. Minority views or methods are certainly acceptable in courts of law, but the expert must describe their status.

Case 4. Recognizing Uncertainty

Dr. D is a DNA specialist who uses accepted standards to interpret crime-scene evidence. The DNA sample she has analyzed almost certainly matches that of a criminal defendant. She has taken into account the laboratory's error rate, scored results in a blinded fashion, and considered the chances of a false-positive. She presents her methods and reasoning in a clear, but not exhaustive, fashion. She then states her conviction that the sample matches the defendant with a reasonable degree of medical certainty. Does she have further ethical obligations?

Discussion

The expert does appear to have met her full obligation to the court. The language experts use to present their evidence is critical to the court's understanding and to their own credibility. Language should reflect the inherent uncertainty of laboratory and human measurements, with phrases such as "the findings are consistent with . . ." "the evidence supports. . ." Jargon and absolutes distort scientific reporting, especially to lay audiences like juries.

The expert need not make the other side's case for them. But she can offer a balanced view of the evidence in a manner that admits recognizable sources of error. She can also take this approach in order to attenuate her own scientific biases. This is crucial in minimizing hindsight bias, which affects all experts called to testify about past events.

Case 5. Getting Paid Only if You Win

Dr. E is a neurologist hired to perform a forensic evaluation. The retaining attorney says her client has an excellent civil case against the city. Sadly, the client has little money because the case has dragged on for some time.

The attorney says she has taken the case on a contingency basis—and spent so much money that she can no longer afford to pay as she goes. She

has hired experts in other disciplines on the basis of a lien—a claim against someone’s property to secure a debt. All the experts will be able to collect their full fees once the case is settled. She wants the neurologist to take the case on a lien as well.

The neurologist says he is concerned his objectivity may suffer because his fee is contingent on a victory. The attorney responds that poor plaintiffs could never obtain the services of experts if they had to pay up front. She says that even the AMA considers liens ethical and it is clear the plaintiff will prevail. Is it ethical to take the case?

Discussion

The AMA does consider it ethical to take a case or treat a patient on a lien. The AMA’s Council on Ethical and Judicial Affairs offers an explicit statement to that effect (see AAPL response 6 above, American Medical Association [AMA], 2005).

Although the lien applies in the law regardless of the case’s outcome, in a forensic case it is essentially a contingency fee since the plaintiff has no money and can only pay if he prevails.

As we have seen, AAPL considers contingency fees unethical because they interfere with the ethical requirements to be honest and strive for objectivity. It is difficult for principles of truth and justice to be served if experts are financially invested in the outcome. Even the appearance of self-interest badly undermines the expert’s credibility.

Attorneys need make no pretense of objectivity in court, and can properly accept contingency fees. In this case, it may be best for the attorney to pay the neurologist’s fee and then recover the money when the case is won. If the case is as strong as she claims, there is little financial risk. In accepting contingency fees, attorneys receive a substantial percentage of any financial award, and pay expenses up front out of their own pockets. For the expert a fee paid in advance would solve the ethical problem and avoid the expert’s credibility issue on the witness stand.

In contrast to contingency fees, fees paid to the expert in advance are ethical. The expert is under no financial pressure to tailor his opinions to satisfy the attorney. Retainer fees that are part of standing arrangements between businesses and individual experts do undermine objectivity. The expert has an interest in maintaining a lucrative relationship over time, and may be affected by the familiarity or collegiality of the arrangement.

Although there is AMA support for taking a case on a lien, the concerns of AAPL and the importance of objective expert analysis in general are relevant for all would-be experts. Ethically speaking, it would be best to decline this case.

Case 6. Evaluation before Consultation with an Attorney

Dr. F receives a call from the District Attorney (DA). The DA asks her to perform a forensic evaluation on a person who has just been arrested for a serious crime. The DA says he wants the evaluation before the man is arraigned. He wants the prisoner evaluated as soon after the crime as possible to ensure an accurate evaluation. He knows this will confer an advantage over the defense team who would see the individual later.

Based on the police officer's report that the accused would "just get his psychiatrist to say he is crazy," he does not want to allow the accused to malingering mental illness. Moreover, after arraignment, an attorney may advise the accused not to cooperate. The DA says this procedure is legal in the jurisdiction and past psychiatrists have conducted these evaluations. Is this ethical?

Discussion

This case perfectly illustrates that what is legal may not be ethical, and that what is ethical in the law may not be ethical in another profession. In their guidelines, both AAPL and the APA forbid the forensic evaluation of a criminal defendant prior to consultation or access to legal counsel. The defendant may not be in a position to give consent prior to talking to his attorney. He may not fully grasp the situation, the dangers he faces, his rights, or the role of the clinician as an agent of the DA. Forensic assessments under such conditions run afoul of the principle of respect for persons. A forensic psychiatrist in this context would consequently subject himself to possible ethical sanctions by his professional organization.

Exceptions may occur to render care to the accused, with details of the crime left out of any documentation or discussion. Here, however, Dr. D should explain the ethical problem to the DA, and show her willingness to do the evaluation after the individual has spoken to an attorney.

There is some controversial new thinking on this topic that raises the question of whether forensic professionals working specifically for law enforcement have different obligations under these circumstances. They may not be bound by the principles or guidelines described so far. Perhaps they may assist in developing or monitoring interrogation techniques (Phillips, 2005; Schafer, 2001). In section II we propose a view of professional role theory that raises serious doubts about this activity by forensic clinicians.

Case 7. How Much Expertise Do You Need?

Mr. G is an attorney who has joined the jurisprudence section of a forensic sciences organization. This is a section largely for attorneys who meet,

discuss, make presentations with forensic scientists, and occasionally review legal matters for their organization. After attending a number of meetings and working on relevant cases, Mr. E believes he has developed enough expertise in the testing of bodily fluids for chemical substances. He describes himself to colleagues as an expert on the subject. He uses his membership in the organization as a relevant credential, is accepted by one court as an expert, used by another attorney in a case, and consequently uses the leverage to be accepted by other courts. Are there ethical problems in this professional evolution?

Discussion

There are problems here with misrepresenting one's expertise. An attorney interested in forensic science is not an expert in drug testing. The attorney may have knowledge—but he has no relevant training. Professional specialties and their professional organizations (e.g., APA, AAPL, AAFS, NASW) recognize as members those with specific credentials and education. Attending toxicology sessions at conferences or participating in a committee do not make this attorney an expert. It is an ethical breach to say otherwise and likely violates numerous organizational ethics guidelines.

Case 8. The Disability Assessment

Dr. H has a patient who applies for Social Security Disability Insurance. The agency's policy is to ask treating physicians to assess disability and (ordinarily) not to provide independent disability assessments. If the treating physician does not write a report, the patient will not receive the disability money he needs.

Though she believes the patient is clearly impaired, Dr. H knows the disability only from the patient's reports. For a truly objective assessment she would need reports from work and observations from the patient's home. But, requests for collateral information may suggest mistrust and undermine the treatment relationship. What is the ethical thing to do?

Discussion

The primary duty for the psychiatrist in this case is to the patient, not the Social Security Administration. Civic duty and scientific objectivity have their place, but they may not necessarily outweigh the primary duty. Within the constraints of honesty and truth-telling, the primary duty is to help the patient while making the best assessment of disability. Assuming a formal forensic stance is a secondary virtue.

But if there is reason to suspect that the patient is lying, it might not be in the interest of the physician, the patient, or the community to receive an uncorroborated assessment. Truth-telling remains a crucial principle for Dr. H and any community that expects professional and legal integrity. Returning to work may also speed the patient's recovery. Given the primacy of the duty to the patient, a concrete suspicion (or the presence of a certain amount of evidence) may be necessary before Dr. H asks permission to speak with collateral informants. Ultimately it may be appropriate to both the treatment relationship and to general physicianly obligations to advocate for the patient. This may include supporting a disability claim while acknowledging the limitations of the evaluation.

Better yet, Dr. H could suggest an independent evaluator. Of course, she herself could bite the bullet and tell her patient that she cannot write a helpful report. If the relationship survived, the issue would become part of re-establishing the trust and collaboration of treatment.

This case provides an example of the kind of thinking that is necessary to the dual role. Practitioners must decide between balancing or ordering principles, separating or clarifying roles, setting thresholds for requiring collateral data, and otherwise weighing duties to patient and society. It is an example of the complexities of dual roles and the difficulties of role theory in addressing common societal interactions. Our approach in Section II may be especially useful in such cases.

Case 9. Can the Expert Change Sides?

Dr. I, a forensic engineer, is asked to consult in a civil suit following the collapse of a building. The attorney discusses the case with him, describing his legal strategy and what he hopes to prove. He also discusses his conversations with the client. He wants Dr. I to be designated (reported to the court) as an expert.

After reviewing some materials in the case, Dr. I decides he is not likely to offer an opinion useful to the attorney. He informs the attorney, who decides not to use him, and sends a bill for several hours of his time.

Before his bill is paid, Dr. I hears from the opposing attorney. Dr. I is happy to get the call, is familiar with the case, and believes he can help. If he takes the case, has he done anything wrong?

Discussion

It appears that he has. Dr. I has received confidential information from the first attorney (protected by the attorney-client privilege, and by work-product

rules governing the use of experts). Had he wanted to be free to consult with the other side, he should have said so at the outset. This would assure that no specific information was revealed.

This is both a professional standard (e.g., for AAPL and the forensic psychology section) and a corollary to principles of confidentiality and respect for persons. These are in place to preserve the critical exchanges that must occur between attorneys and their clients.

AAPL's ethical guidelines also recommend that experts take precautions to ensure that confidential information does not fall into the hands of unauthorized persons. There is no need for irrelevant personal information to find its way gratuitously into forensic evaluations, or for privacy restrictions to be relaxed in an adversarial setting.

In fact, some attorneys use this scenario to preclude a well-respected expert from testifying for the opposing side. If Dr. I wishes to avoid a position in which the only ethical choice is disqualifying himself, he must warn the attorney *before confidential information is divulged* that he may be interested in working for the other side. Not having done so, he must respect confidentiality and decline the case.

Although the call from the second attorney comes before Dr. I's bill is paid, this creates no special exception to the duties of the expert and attorney or to the requirements of confidentiality. Even if the bill is never paid, the ethical analysis of the situation does not change.

Case 10. Doubts and Other Influences

On first reviewing evidence in a case, Dr. J, a forensic odontologist, believes he can assist an attorney in a civil suit. The attorney designates him as his expert and the other side is notified.

As he works, he finds evidence to suggest that the other side is right. He fears he may have misled the attorney by overstating his initial enthusiasm. He had wanted to impress him because of the attorney's friendship with the department chair. Even if he withdraws, might he be called by the opposing side? Dr. J also empathizes with the client, who could desperately use the money she is seeking. What should Dr. J do?

Discussion

This case involves many conflicting values, not all of them forensic. For personal reasons, the evaluator wants to please the attorney and would like to help the evaluatee procure some badly needed income. He is concerned on a personal level that he may have been too eager to take the case. Without meaning to, he may have promised too much or even misled the attorney. Nonetheless, honesty and truth-telling serve as

critical principles for the encounter. They are the foundation of personal and institutional integrity.

Since this is a forensic case, his primary duty may be assigned to the legal system not the plaintiff. However, he was hired by the plaintiff's attorney (rather than the court) and, as a citizen and physician, he does owe secondary duties to the client. The best course may be simply to inform the attorney. It is respectful of the attorney and plaintiff as persons and consistent with honesty and truth-telling.

A possible solution, then, is to withdraw from the case before developing an opinion for either side. Perhaps he will leave the attorney enough time to explore other strategies, consult another expert, or pursue other means of getting assistance for his client. Any other choices—withdrawing without explanation, proceeding with the case—would not seem to be ethical.

This case offers guidance on how personal and professional values may be unpacked to arrive at an ethical decision. Practitioners who recognize the interplay of these values are in a better position to navigate the multiple duties of forensic work.

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Section II

Approaches That Guide Ethical Behavior

3

Ethical Theories: Principled Models, Narrative Theory, and Professional Integrity

The Legacy of Principles

The field of bioethics is only four decades old. But many of the salient issues go back hundreds of years. In *The Birth of Bioethics*, ethicist Albert Jonsen traces historical developments in modern healthcare ethics theory to classical, religious, and enlightenment moral theories (Jonsen, 1998). In this chapter we will show the connection between these ethical traditions and those practiced by forensic experts, especially medical experts. Experts in non-biological sciences may, like Jonsen, make a similar connection between classic theories and their claims to professionalism.

As bioethics itself evolved from conversations between certain pioneers in 1970–1971, three main themes emerged. First, healthcare ethicists considered the unique qualities and moral character that ought to define professional persons and their aspirations toward ethical ideals. Specific developments in professional ethics, especially virtue ethics, tried to answer questions about the moral definition of a professional. Secondly, healthcare ethics concerned itself with the duties of professions and individual professionals. How and why are some professional activities permissible but others prohibited? What are the unique duties of professional persons and how are these duties determined and defined? Third, ethicists described the link between professions and professionals, community priorities and values. How are individual professionals and professions morally linked to the communities that contain them? This can be described as the relationship between professions and their social responsibilities. Taking these three themes together—professions and professionals defined by character, linked to communities through ethical duties while aspiring to moral excellence—ethicists described the nascent orientation of healthcare ethics.

To develop an ethical theory for forensic practice, it is useful to distinguish between minimum professional obligations and aspirational ethics—the

striving toward moral ideals. Minimum duties and professional aspirations lie on a continuum. While truth-telling must be the norm in the physician-patient relationship and exploitation must be forbidden, these acts cannot always be clearly defined. Because what is professionally required or prohibited can change over time, we argue that what may today be beyond the scope of forensic professionalism may in fact become required when analyzed through a lens of robust forensic professionalism, one rooted in medical professionalism.

Now in its fifth edition, *Principles of Biomedical Ethics* by professors Thomas Beauchamp and James Childress (2001) has become the primary textbook for teaching ethics in the American healthcare professions. Ethical decision-making, like other important human intellectual activities, requires knowledge, skills, and practice. The Beauchamp and Childress approach synthesizes these from an enormous body of knowledge: from moral philosophy, the social sciences, the medical humanities, law, public and social policy, and the biological sciences.

Their goal was to create a framework upon which to consider ethical problems in biomedicine and healthcare. While we do not consider ethical problems in forensic psychiatry a mere subset of healthcare ethics, our view of a connection between the ethics of medicine and the ethics of law must consider the ethical foundations of healthcare ethics in order to create a normative ethical theory for a subspecialty, forensic psychiatry. A review of Beauchamp and Childress's contributions is consequently in order.

Ethics and ethical decision-making are disciplines rooted in a body of knowledge. What knowledge then is crucial to create a normative theory and practice for forensic psychiatry? Beauchamp and Childress provide several powerful themes for this work. One theme is the distinction between common morality and professional morality, between normative and non-normative (or descriptive) ethical traditions, and between theories of ethics themselves. Another theme is the place of ethical rules and principles in moral dilemmas, the tension between professional codes and societal needs, and the nature of balancing between general rules and particular cases.

Beauchamp and Childress believe that four "clusters" of moral principles are the best framework for professional duties and aspirations and for providing normative guidance for professional ethics. These four clusters or grounding principles are consciously consistent with the moral norms of Western society. Given the reality of a legal and social focus on human rights, their selection is consistent with what many agree are worthy values for a liberal society (not liberal in a political sense, but in the sense that society tolerates many conceptions of the good). Their basic principles have

informed, guided, and shaped professional decisions and behaviors. They are the following:

1. Respect for autonomy, or respecting persons and their autonomous decisions.
2. Beneficence, or the duty to provide benefits over harms in professional actions and decisions.
3. Non-maleficence, or the duty to avoid harms in professional actions and decisions.
4. Justice, or the obligation of distributing benefits, harms, and costs fairly.

Respect for personal autonomy is at the root of the democratic political tradition. It is rooted in the belief that personal freedom and minimum interference from others maximize our capacity to flourish. Treating others with dignity, promoting their independence and personal responsibility, and the belief that we are separate and finite creatures—all these notions are implied in the democratic respect for the individual.

Autonomy and respect for persons are rooted in the Kantian notion that all persons have intrinsic worth; that individuals have the capacity to determine their own moral destiny. From the moral perspective, it is best if we respect others to make their own decisions, whether those are good or bad, healthy or unhealthy, right or wrong. As Mahatma Gandhi wrote, freedom to choose means little if it does not include the freedom to make wrong choices.

In professional work, autonomy ensures that patients and evaluatees are treated respectfully and encouraged to control their own lives, bodies, and minds. It defines professional obligations to respect confidences, communicate honestly, and practice informed decision-making. It applies whether the professional is a doctor with a patient or a lawyer with a client. An example of practice that reflects this principle in both health-care and forensic work (e.g., see the AAPL guidelines) is the doctrine of informed consent. Moreover, in law, constitutional protections ensure that one must be competent in order to take part in certain legal proceedings.

The next principle, beneficence, guides professionals to promote the well-being of others. Its complement, non-maleficence, instructs professionals to reduce or avoid harms in their decisions. In healthcare, some argue for a “beneficence-centered” ethos rather than an “autonomy-centered” one, since promoting well-being of patients is arguably the *raison d’être* of healthcare professionals.

A careful report by the ethics think-tank the Hastings Center entitled “The Goals of Medicine,” defined four major goals of healthcare (Hanson & Callahan, 2001). After several years of debate and discussion among

representatives of various nations, cultures, and historical traditions, this group agreed to define the essential mission of medicine by four common principles. The result was a robust beneficence-centered medicine.

The adopted goals included: a) prevention of disease and illness and promotion of health, b) relief of pain and suffering, c) cure of maladies and, in the case where cure was not possible, care of the patient, and d) avoidance of a premature death and pursuit of a peaceful death. In all four, one sees the beneficence-centered ethos of healthcare. Here beneficence and non-maleficence clearly promote well-being by making patient welfare a central duty. Flowing from this principle, the authors identified the responsibilities of competency, discernment, service, and compassion. Professionals may not subject patients to undue harms and are obliged to offer potentially beneficial interventions and treatments.

We often equate the next principle, justice, with the concept of fairness or just deserts. It supports the view that we should all be treated equally, and that we should all share in the distribution of goods and harms. The principle of formal justice promotes the concept that equals must be treated equally. It guides decisions of what is owed or due to others in a manner that is appropriate, equitable, and fair. In healthcare, it guides the professional in treating all patients fairly and equally. It helps guide choices in conditions of scarcity, promoting actions that use resources responsibly, avoid waste, and encourage professional stewardship for limited resources.

In legal and political terms, of course, to speak meaningfully of justice we must distinguish among various kinds or types of justice. We speak of distributive justice in determining what is fair and proper in taxation, property, and educational opportunity. Criminal justice considers how society inflicts punishment; and rectificatory justice considers fair compensation for breach of contracts and torts. Theories of justice abound. Utilitarian, libertarian, communitarian, and egalitarian theories can each guide us as we distribute social burdens, goods, and services, often differing in initial premises of what is owed and by whom, the criteria for distribution, and the justifications utilized.

But in ethical decision-making these principles alone cannot resolve complex ethical dilemmas. In psychiatry, we are familiar with the ethical and legal tensions that arise when dangerous patients threaten identified third parties. In these cases, duties to respect patient confidences (a duty that flows from the principle of respect for a person's autonomy) conflict with duties to protect others. In end-of-life care a patient's wish to hasten death (consistent with the patient's definition of benefit and respect for autonomy) may conflict with professional values that identify hastening death as harm. While most healthcare

institutions have resolved this conflict, other cases, as when patients refuse blood products on religious grounds, can present an irreconcilable conflict of principles. While courting death may be seen as a grotesque failure to honor the principle of beneficence, the refusal of blood transfusion may be a clear expression of individual values and autonomous choices, including the choice of death.

In cases where conflicting principles seem irreconcilable, the law instructs us to define harms and benefits according to the patient's preferences and values. What seems at first to be an irreconcilable conflict between principles may be resolved by an understanding of the patient. In fact, other ethical theories, too, are further tools for resolving conflicts between principles.

Reviewing Various Classical Ethical Theories

Imagine you are sitting in the Boston Red Sox beloved stadium, Fenway Park. You know baseball's basic rules, and you know that these rules are no different whether you are in the right field bleachers or behind home plate—or even a player in the game. Balls and strikes, home runs, stolen bases, the number of innings, the number of outs—all these are established rules of the game.

So it is with the principles described by Beauchamp and Childress. One cannot be engaged in professional healthcare practice without considering how one's conduct and decisions are guided and contained by these four principles. The trouble arises as we begin to consider applying these principles in the complex, ambiguous world of human relationships. Just as spectators at a baseball game might recognize the same rules, they may nonetheless, in seeing balls and strikes, whether a runner is safe or out, or even whether a home run is fair or foul, be influenced by perception. Their judgment can depend a great deal on where they are sitting. They can also be affected by their allegiance.

Point of view is the great equalizer, and the distorter. It is an influence which is elusive and can be morally corrupting. It is that thing that demands we keep a wary eye on the very perceptions we depend upon to make decisions. In order to minimize the distortions, we must constantly remind ourselves that there is no such thing as a view from nowhere (Nagel, 1986). Judgment is a moving target, powerfully determined by perception and point of view.

In professional ethics, we can be guided by different viewpoints as well as the four principles. These are the different theories of morality. In baseball, there is a "best" place for the umpire to call balls and

strikes—right behind the catcher. Another umpire is placed next to first base so he can best judge whether a throw beats the runner. Yet another is at third base to determine whether the base-runner, on a sacrifice fly, leaves for home an instant too soon. These are the places with the least distortion in perspective. As spectators, we are more likely to see what the umpire sees if we are seated behind the catcher. We will see like a right fielder if we are seated in the right field stands. And the closer we sit to the chalk foul line, the more confident we are that we can call fair and foul balls.

Ethical theories operate the same way. These theories can be seen as strategies to adjust one's point of view in complex and ambiguous human interactions. They work in a world where external behavior and speech must be considered as well as human intention and motives. The more one develops facility with changing points of view, the more likely one is to move toward a decision that has moral as well as practical validity.

So, as principles can provide a basic framework or setting for ethical decision making, ethical theories provide the chance to vary our perspective. As philosopher Thomas Nagel reminds us in *The View from Nowhere* (1986), objective reality is a moving target. We can approach, approximate, or imagine objectivity—but we may never achieve it. Nagel writes:

“If we try to understand experience from an objective viewpoint that is distinct from that of the subject of the experience, then even if we continue to credit its perspectival nature, we will not be able to grasp its most specific qualities unless we can imagine them subjectively. We will not know exactly how scrambled eggs taste to a cockroach even if we develop a detailed objective phenomenology of the cockroach sense of taste. When it comes to values, goals, and forms of life, the gulf may be even more profound” (p. 25).

In the realm of moral and ethical considerations, this capacity to change perspective is highly valuable. Since we are engaging morality in complex human interactions, our best effort to change perspectives is required. Returning to the baseball analogy, using many umpiring and spectating positions allows for a better mapping of the game itself—and of the myriad mini-dramas within it.

Before a brief review of various theories that offer different perspectives, we must review the dynamics of ethical dilemmas. Each ethical dilemma can be understood (or “deconstructed”) as involving a moral agent, an action or choice, a consequence or outcome, and a context that contains it. In healthcare, we usually consider ethical dilemmas where the moral agent is a healthcare professional, the action or choice involves a clinical decision, and anticipated and unanticipated clinical outcomes are embedded in a moral or value perspective.

Because we write as physicians, the context for us involves the entire world of healthcare where the roles of professionals and patients are familiar, rules for interpersonal behavior are expected (e.g., informed consent), and the experiences of illness and suffering are central to the situation. Particular institutions with their own entrenched values further define the context. Lastly, larger social, political, legal, and cultural considerations that help define the institution enrich the context. Thus, healthcare behaviors are cultural practices, whose context involves multiple moral perspectives, ambiguity, and uncertainty.

Ethical theories, then, serve as flexible multi-layered frameworks, changing perspectives, which participants can use to make better, more ethical decisions. It is important for our position and discussed in greater detail later, that the “process of changing perspectives” be as important in working toward an ethical decision as the theories which provide perspective. We underscore that the greater our capacity to shift perspectives, the more likely we are to move toward an action that is morally justifiable.

The likelihood of understanding the complex legal and ethical question of physician-assisted suicide, for example, increases if we examine multiple perspectives or theories. As Timothy Quill has so aptly demonstrated in his writings on assisted suicide (Quill, 1993, 1994, 2005), the credo that “doctors should not kill,” while satisfying in its simplicity, fails to capture the moral complexity of this agonizing private—and public—issue.

To review, we will present some of the important ethical theories that later find a place in our integrated approach to forensic practice and professionalism. Each theory tends to highlight a different aspect of an ethical drama. Some theories focus on the character of the moral agent. Other theories consider the act or decision. Still others focus on evaluating the outcome of decisions. Lastly, we offer a view of narrative ethics as essential to understanding the context and duties of the forensic practitioner.

Virtue Theory

Virtue ethics focus our attention on the moral agent. This theory is most valuable when it sets up normative (“ought” or “should”) expectations for professionals. It supports both professional duties and professional aspirations. This theory of ethics has its origins in the writings of Aristotle and has seen an important re-emergence in healthcare ethics in the work of Pellegrino, Thomasma, and Sulmasy (e.g., Pellegrino & Thomasma, 1993). Virtue theorists focus principally on what a person must be like, and what qualities of character she must possess to make good decisions and live a good life.

Aristotle defined virtue as “the excellence of a thing.” The virtue of a physician is to heal. The virtue of a lawyer is to strive toward justice. The good life for people depends on their exercising virtue. Virtues consequently pave the way to *eudemonia*, meaning fulfillment or happiness. This is the concept of “being all one can be.” By cultivating the virtuous life, we find balance between excesses and deficits, and can attain *eudemonia*. For the ancient Greeks, the very practice of the virtuous life was the path toward purpose and happiness.

The goal of virtue theory is to train and cultivate qualities of character that lead to appropriate ethical decision-making. It assumes that people want to do what is right and good, but that they require cultivation of character to do so. Virtue theorists recognize that while virtuous people desire good, good intentions alone cannot guarantee good decisions. Knowledge and practice must be joined in order to create habits of virtuous action.

Aristotle defined “dispositions of character” that support actions, feelings, and judgments necessary for good decisions. The ancient Greeks believed that these dispositions were innate to human beings, but required training and exercise, practice and commitment. Just as no one becomes a great violinist without practice, one cannot cultivate virtuous dispositions without practice and commitment. To virtue theorists, good actions without virtuous dispositions suggest moral failure. Actions coupled to a virtuous agent are the moral ideal for human relationships.

Qualities of the virtuous person, and thus the virtuous professional, include fortitude, temperance, a concern for justice, and a cultivation of wisdom. These qualities must regulate and guide temperament, desire, and passions. Moderation is the goal of the virtuous person. Prudence in decisions increases the chance that one will live the “good life,” achieve the character of the “good person,” and reach moral and creative potentials. All three are needed to find meaning in life. Our proposal for a robust professional integrity, authenticity, and ethical habits as a framework for forensic psychiatry owes much to the virtue theorists.

What are the shortcomings of this theory? Mainly, virtuous people make bad decisions. The Nancy Cruzan case provides a good example of well-intentioned people making bad decisions—decisions at odds with the wishes of Nancy Cruzan, her values, and her family’s values.

Case: Nancy Cruzan

In 1983, in a tragic automobile accident, twenty-four-year-old Nancy Cruzan was thrown from her car and left in a persistent vegetative state (PVS). After many years, Ms. Cruzan’s parents went to court to earn the legal right to disconnect their daughter’s feeding tube. Only after a

landmark Supreme Court decision in 1990 returned the case to a lower court in Missouri, was Nancy Cruzan disconnected from her feeding tube and allowed to die.

While the case involves complex issues surrounding surrogate decision-makers and standards of evidence in life-support cases, several moral principles were supported by the majority court opinion. Most important, the Court supported a “liberty interest” to be free of unwanted medical treatment (Pence, 1995).

Only after a thorough social, legal, and political analysis did commentators, politicians, and ethicists recognize the moral wrong in forcing medical treatments, including food and hydration, on unwilling subjects. However, those who wished to keep Nancy Cruzan alive were not necessarily lacking in virtue. In fact, a detailed examination of the case supports the view that virtuous people worked on both sides of the case. In hindsight, it seems clear that virtue alone may not lead to right decisions.

Deontology

Rather than focus on the character of the moral agent, deontological or duty-based theories focus on decisions or acts themselves. In these theories, there is an assumption that intrinsic properties or aspects of actions make them right or wrong.

Immanuel Kant (1724–1804) is the earliest and most quoted deontologist. He was a brilliant Prussian philosopher who wrote on astronomy, philosophy, politics, and ethics. Writing on duty-based ethics, Kant invoked the golden rule, “Treat others as you would wish to be treated yourself.” Another Kantian version of this is “Act as if your behavior is generalized to all situations.” Telling the truth, for example, is a correct action because it has inherent universal properties of the good, and we ourselves dislike being lied to.

Sadly, duty-based theories cannot handle all real-life ethical dramas. Other things being equal, telling the truth is always the right thing. But what happens when telling the truth causes harm?

In physician-assisted suicide, for example, the central moral dilemma is how we define harm and benefit. The actions themselves are context-defined. Although we might find the rule “Physicians should not kill” is generally convincing, to abandon patients at the time of their greatest suffering, as Quill and others have argued, forces a reconsideration of what we mean by killing. When might killing then become mercy? Deontological theories offer quite simplistic answers to such torturous questions.

Consequentialism

This brings us to consequentialist theories, the best known of which is utilitarianism. For our present purposes, it is enough to know that consequentialist theories focus on the ends or consequences of actions. These theories ask questions about outcomes. What is it we wish to achieve through certain actions, and which actions will accomplish the ends we value most?

Utilitarian logic, common to public policy discussions, assumes that all people have equal moral worth. The theory then guides us to actions that will produce the greatest net good for the greatest number, whether we are distributing a limited resource or forming a government policy.

Central to the utilitarian theory is the notion that pleasure (not in the hedonistic sense, but in the higher sense of social good) is an intrinsic good and pain an intrinsic evil. We must try to make decisions that increase pleasure and decrease pain. For many utilitarian theorists, maximizing utility or pleasure leads to obvious answers about what is right.

But as with any theory, consequentialism has its critics. In cost-benefit analyses, for example, some individuals are harmed while others benefit. What if we believe it is inherently wrong to harm the most vulnerable members of a group? How do we *know* the desired consequences for the greatest number? Are some consequences desirable for some, but undesirable for others?

We interpret consequences by our own values and by the values of the groups affected by our decisions, not by an abstract ethical calculus. Consequences cannot always be measured on the same scale by different people. This is the problem of incommensurability.

Utilitarian theory implies a homogenous community where cultural, racial, ethnic, religious, and gender differences are minimal. The method of analysis usually involves cost-benefit-like calculations. Values are reduced to a monetary value. In this view the cost of an educational program or even the cost of a human life can be calculated. Readers may recall that the Ford Motor Company's production of the Pinto involved such reasoning. The Pinto's tendency to explode when rear-ended was well-known to Ford executives; they weighed the cost of fixing the gas tank against the cost of litigation and of lost human life (Birsch & Fielder, 1994).

Social Contract Theory

Social contract theory is also relevant because the discussion of forensic ethics draws, as we have seen, on the expectations of society. Societies have certain expectations of their intellectual and social leadership—expectations linked to

strong views of how its scientists, physicians, or attorneys should behave (recall Bloche, 1993; Candilis et al., 2001; Pellegrino & Thomasma, 1993; Veatch, 1977). This is a view that may be traced to specific writers on social contract theory.

Social contract theorists (like Thomas Hobbes, John Locke, and Jean-Jacques Rousseau) developed models for how people consent to live peacefully together. Thomas Hobbes (1588–1679), living in the midst of a violent, plague-ridden century, described a kind of general agreement that people must establish to escape the “nasty, brutish, and short” life found in the unregulated “state of nature.” Rousseau (1712–1778) wrote of the importance of the people’s “general will” in guiding societal leadership. In this view, political authority over humankind comes only through the development of their rational agreements (Friend, 2005; Rachels, 1993).

This school of thought has major implications for interactions between the professions and the law—especially because many modern writers use it to describe the reciprocal influences of institutions and their constituents.

But even for an enlightened citizenry, rationally synthesized agreements rarely suffice to describe all of their interactions. There are no specific rules for all instances, nor for all persons caught in similar circumstances. Moreover, leaders may assume they know the will of the people better than the people do. This is a classic criticism of Rousseau, for example, as well as of politicians who claim to speak for a “silent majority.” Nonetheless, it is an important theory in the search for multiple perspectives.

Post-Modern Ethical Theories: Social Responsibilities

As we have seen, none of the previous four approaches (and there are more), properly address the individual’s relationship to the community. While the ethical theories of virtue, deontology, consequentialism, and social contract have been influential in healthcare ethics and offer important perspectives on ethical questions, other theories have emerged to address their shortcomings.

Communitarian ethics, for example, weigh the context of ethical dilemmas by incorporating the moral connection between individual and community. Questions of professional social responsibility are crucial to the connection. Communitarian theories ask about the origins of duties and obligations, responding that duties and obligations arise from the nature of specific human relationships. The duty owed patients, for example, is different from the duty owed a spouse. What we owe to our colleague is different from what we owe to our brother. In the words of Wayne Booth, we define ourselves and our duties by the company we keep (Booth, 1988).

Several ethical and political movements can be described as communitarian ethics. Environmentalism and feminism are two of the better known. We include these as prominent intellectual movements which have tried to connect individuals to their context and their community.

In the late 20th century, feminist thought made major contributions. Feminism became one of several 20th century intellectual movements that challenged the precepts of the 18th century Enlightenment. Characterized as “post-modern” thought, this approach expanded discussion of the concepts, methods, and underlying values of ethical deliberation.

Carol Gilligan, a Harvard University psychologist and feminist, first brought attention to the differences between male and female ethical problem-solving in her landmark work, *In A Different Voice* (Gilligan, 1982). Critiquing the work of psychologist Lawrence Kohlberg, Gilligan made the important point that girls’ moral thinking is not inferior to that of boys, simply different. Gilligan observed that boys tended to solve problems by focusing on fairness or justice, often applying abstract rules or principles. Boys seemed to want and need universal rules, impartially applied. Their approach stressed individual rights.

Girls’ reasoning styles appeared to focus on relationships and context. In problem-solving and assessing blame, girls paid special attention to particular human relationships and the virtue of care or compassion. Gilligan and other feminists in her wake tended to make the “feminine” approach synonymous with the insight that personal relationships lie at the center of any moral solution, and that avoiding harm and expressing care in those relationships must be central to ethical analysis.

Often, in healthcare ethics, the feminist perspective is represented in the approach known as the ethics of care. The ethics of care are grounded in the assumption that human beings are interdependent. Identity requires interconnection and interdependence, not simply autonomous individuals contracted to leave each other alone. In the ethics of care, moral decisions cannot be made fairly and wisely with universal rules, impartially applied. Instead, an involved emotional stance is not only inevitable, but desirable.

Feminist ethics have helped promote an ethics of care, have supplied a useful critique of the historical theories of moral philosophy, and have cast a bright light on a little understood aspect of power dynamics within organizations and institutions. Feminist ethics have helped expose the second-class treatment of women in the workplace, in education, and in leadership. In philosophical thought they increased awareness of the importance of context, and facilitated the introduction of relational, affiliative solutions (Holmes & Purdy, 1992).

Between 1975–2005 as a complement to feminist theory, two further ethical approaches emerged. Both brought increased attention to the

importance of context in ethical problem-solving. Casuistry is the first. Practiced in many religious traditions, it is a method of reasoning by analogy. Situations or cases are compared to “paradigm cases” which illustrate the correct course of action. By comparing differences and similarities to the paradigm case, moral actors determine the correct course of action, or at least increase their confidence about certain decisions.

Court cases are paradigmatic of the casuist approach. The Nancy Cruzan case is now a paradigmatic case which has shaped discussions of many cases involving surrogate decision-making and end-of-life decisions. Both religious theorists and law courts utilize the process of analogy and precedent in a similar manner. Of course, many professional dilemmas are less dramatic than the cases that find their way through the courts. Still, casuist theorists remind us that attention to the details of a situation combines with experience, good judgment, and appreciation of context to resolve ethical dilemmas. This leads us to the most recent theory in bioethics, narrative ethics.

Narrative Ethics

One way to understand the conflicts of human relationships is to draw on the tradition of storytelling and the epistemology (the thinking and methods) that evolved from the analysis of stories. In healthcare, medical knowledge is often determined and embedded in the telling of the patient’s history. The patient’s illness is the act of telling a story, often in the language of medicine. Ideally, professionals join this story with empathy, compassion, and scientific expertise. The result is a joined telling and re-telling known as the doctor-patient relationship.

In narrative ethics, we assume this conversation is part of a moral process, where behaviors of both the patient and professional, the choices made, and the outcome are parts of the narrative. Listening and participating show us the particulars of a single human relationship situated in time, place, and circumstance. Narrative ethics challenge us to consider how poorly we deliberate about moral choices if we fail to understand the nuance intrinsic to human dilemmas. The narrative method counters the tendency in other theories to obfuscate by imposing simple, absolute standards: “One always does one’s duty” or “We must promote the greatest good for the greatest number.”

Narrative ethics are a tool that offers deep insight into the human moral drama, whether that drama involves the world of the hospital or the world of the courtroom. Values, beliefs, and cultural practices of individuals are

supported and enhanced by contextual understanding and illumination of experiences. Narrative comes in “low” forms such as news briefs, anecdote, and gossip. It comes in “high” forms such as a documentary film, costume drama, and literary fiction. Both forms offer vital cultural messages, and reveal hidden meanings and intention. The narrative practice provides an interpretative stethoscope to enhance perception and listening. Arthur Frank in *The Wounded Storyteller* (Frank, 1995) called this approach “an ethics of listening.”

But Frank and other narrative theorists recognize that the telling and listening *with stories* is more than an attempt to confirm our abstract theories of ethics. He argues that the stories we tell and listen to become our lived experience:

“The stories we tell about our lives are not necessarily those lives as they were lived, but these stories become our experience of those lives. A published narrative of an illness is not the illness itself, but it can become the experience of the illness. The social scientific notion of reliability—getting the same answer to the same question at different times—does not fit here. Life moves on, stories change with that movement, and experience changes. Stories are true to the flux of experience, and the story affects the direction of that flux” (p. 22).

As a method in ethical decision-making, narrative approaches teach people to hear and see in heightened ways; to improve perception of the storyteller’s values and perspective. Narrative helps us to understand the subjective and existential values of the patient or client through improved listening. At the same time, the obvious problem is that in its extreme form, a form of moral relativism can leave participants uncertain of the relative values of the stories being recounted. We will have more to say on narrative in the development of a professional ethics for forensic psychiatry in particular.

To conclude, it is clear that principles and theory alone do not solve the problem discussed by Thomas Nagel—the view from nowhere. Position is critical in ethics. Lacking full neutrality and objectivity the best we can do may be to appreciate the value of multiple perspectives, flexibility, comprehensiveness, and deep humility. This includes the knowledge that we can only *approach* truth and goodness in our relationships with others, including in our consultations to the law. Because there are limits to each of the approaches discussed, we recommend that forensic specialists try to integrate them all into their analyses.

Now to the harder tasks: to review how some have argued for a theory of professional ethics in forensic work. We will then propose an integrated and robust professional ethics that incorporate these concepts of professional integrity, permit the inclusion of personal morality in the

professional context, and consider the proper use of narrative in the forensic setting.

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4

Theories and Perspectives from Other Quarters

We will ultimately argue for an integration of major schools of thought on forensic ethics, as well as consideration of societal, personal, and professional influences. Because familiarity with multiple perspectives is a crucial element of our approach, and enriches the practitioner's repertoire in analyzing complex cases, we look at some of the developments in professional ethics that will affect our theory.

Jennifer Radden and the Nesting of Obligations

One theory of forensic duty takes a topographical approach that underscores the interplay of context and individual. It is somewhat different from the hierarchical ordering of principles we described in Paul Appelbaum's work in Chapter 1. Where Appelbaum supports a hierarchical ordering of principles, moral philosopher and Chair of Philosophy at the University of Massachusetts, Boston, Jennifer Radden, suggests a nesting of one set of obligations within another.

In Radden's view professional duties for psychotherapists and psychiatrists derive from at least three different standards: 1) Standards of professional ethics in general (standards any profession might agree upon to avoid exploitation of the client or patient), 2) The standards or values guiding general medical practice (valuing health and common biomedical principles such as beneficence and non-maleficence), and 3) Role-related standards specific to the particular specialty (Radden, 2001).

The nested architecture of this approach appears to recognize the social interplay between the individual and professional. The notion of embedding one set of values within the other strengthens the influence of values from outside the specific profession. It offers context in a way that forensic specialists can use to enrich their profession's moral narrative.

Radden's approach is still based in discussions of role morality (recall AAPL, Halleck, Rosner, Appelbaum)—that is, applying a different kind of ethic depending on one's role. But it recognizes a flexible form of role that is less absolute than the one requiring the complete separation of forensic and clinical values. She takes a mainstream approach in describing the inadequacy of a more absolute role morality. In this view, strong role morality must give way to broad-based or common morality.

“The role morality sometimes attributed to doctors, lawyers, and government servants in the practice of their professional duties introduces a kind of moral double standard, in that it prescribes different conduct for professionals than for other people. One version of this system is known as strong role morality. Strong role morality asserts that what is morally permissible or even morally required by a professional role is not necessarily required and is sometimes not even permitted according to that common or broad-based morality applicable to the rest of the community. Even when some action conflicts with the values and ends of broad-based morality, such as the patient's usefulness to society, (role) morality for the doctor or healer is dictated by the goal of maintaining the patient's health.

Not all role morality is so strong, however. A profession's role morality may also require more, not less, stringent obligations than those dictated by broad-based morality. Weak role morality, which is widely accepted as characteristic of the professions, is often used as a marker of professional status. *Weak role morality never overrides the dictates of broad-based morality, however; it just adds to them* [emphasis added]. Strong role morality has often been challenged. Some refuse to accept that any professional roles should contravene the dictates of broad-based morality, and certainly the dangers surrounding the ‘just doing my (professional) duty’ defense have been amply exposed. But weak role morality is not vulnerable to the same criticisms” (p. 322).

It is no accident that this approach arises from the discussion of improper sexual contact between therapists and their patients. Nor is this an ethical violation in the mental health professions alone. Any attempt to exploit the vulnerability of the sick role or even the power differential between attorney and client raises similar questions. But in the predominant context of male therapists violating female patients, Radden and others point out the greater social meaning.

Because medicine and law have often been guilty of patriarchal practices, inappropriate sexual behavior that victimizes a woman carries broad social import. The individual exploitation of a female client or patient consequently has greater meaning for the societal narrative because it is nested in the inequities of the past. It is an example that draws on historical context and underscores the importance of social commentary on professional values.

The model recalls Griffith's concerns for the non-dominant cultures within society and the value of their history. Indeed, we speculate that a

further nesting of professional obligations can occur in the deeper context of humanity itself: professional obligations nested in community obligations nested in obligations among persons.

Ciccone and Clements: The Systems Approach

Another theoretical model for reconciling the conflicting values of forensic experts in the courtroom has been offered by physician and medical educator Richard Ciccone and ethicist Colleen Clements (Ciccone & Clements, 1984, 2001). Dissatisfied with classic ethical theories which require “pure objective data” and an artificial separation of facts and values, they honor the relationship between facts and values by offering an interdisciplinary view of forensic work. They *relate* the medical value system to the legal one instead of differentiating it.

Rather than accept historical models of utilitarian or principlist thought which result in classic conflicts between the individual and society, Ciccone and Clements offer a general systems approach. This approach is not the antiseptic development of principles that gives rise to rigid action-guides for courtroom experts. It recognizes the significance of general human values and relates the ethical analysis directly to the case. One example of how this model might work in psychiatry is as follows:

“When the psychiatric disorder is major and the legal charges minor, therapeutic values determine the outcome. Where the criminal charges are dominant and psychiatry has little to offer, the individual remains within the legal system. Where the individual has a significant treatable psychiatric disorder and there are major criminal charges, both systems have a socially determined obligation to remain involved, with all the brokering and negotiation between the systems that this state of affairs implies” (pp. 266–267).

Recognizing a cooperative ethic of science and law gives practitioners more freedom to draw models of right action from both systems. It recognizes that the “professional skills and accountability” of the clinician as well as the “legal guarantees and codified safeguards” of the law work to protect the individual while also addressing community safety. It recognizes the importance of different perspectives.

In other cases, this model may use family and cultural values to inform its ethical analysis. It may address multiple levels of meaning, from the cellular to the societal.

This approach recognizes, as do others in ethics and medicine (e.g., Childress, 1997; Hundert, 1990), that, at times, dual agency dilemmas cannot be resolved in a structurally satisfactory manner. It may be prudent to

avoid the conflict wherever possible, but this may not always be ideal or even ethical. Rather, the systems approach calls for a balanced tension between individual and social values. It suggests a richer understanding of the expert's role by integrating multiple perspectives and value systems.

"If justice is more than social control, it must be connected with issues of intent, appropriate punishment, and the social effects of unnecessarily sacrificing individual interests. These are the issues an excusing function addresses. One can argue such a function is both in conflict with and essential to the goals of justice. The expertise of the [medical expert] is a requisite for justice to operate in the real world: following the spirit as well as the letter of the law" (p. 273).

John Arras and a Typology of Narrative Ethics

One strategy for determining the impact of different theories on professional practice is the development of a typology. This classification or analysis of "types" affords scholars the chance to distinguish models of thought by rule or kind. It separates approaches to ethical problem-solving by descriptive or analytic methods recognizable to the field—whether it is law, medicine, or philosophy. In our discussion it is a tool for recognizing the interaction between competing schools of ethical thought: whether principlist, narrative, or something else.

John Arras, Chair of Bioethics at the University of Virginia, has described a typology of narrative ethics that is directly relevant to forensic work. As forensic ethics strive to find a balance between their principle-driven, theory-based roots and the narrative context of individual cases, it is this kind of qualitative analysis that clarifies the interplay between case and theory (Arras, 1997).

As we have argued, the search for universal laws, objectivity, and rationalism may ignore crucial issues of social context, personal relationship, and subjective values. We must recognize the individual's narrative in reaching a moral decision. This typology reinstates the legitimacy of narrative within moral theory.

Arras recognizes three distinct uses of narrative ethics: one as an enrichment to principle-driven theories, the second as a distinct model of ethical justification based in historical roles, and a third as a substitute "for the entire enterprise of moral justification."

Arras recognizes at the start that narrative has been a consistent element of even the strictest principlist theories. Principles are invariably exemplified in individual stories, while meaning and context—in the narrative—frame the moral problem. Dr. Rita Charon of Columbia University is an expert on how human stories are constructed. Drawing on Dr. Charon's work discerning the

meaning of illness among patients, Arras points out narrative's capacity "to apply principles with greater sensitivity and precision." The war stories told by attorneys and medical experts about their worst dilemmas exemplify the widespread use of this model.

This typology also joins principle and narrative in the theory of John Rawls. Rawls, who died in 2002, is considered by many the greatest political philosopher of the 20th century, at least in the Western world. Philosophers, political scientists, legal theorists, economists—even sociologists and theologians—have been shaped by the work of John Rawls. His concept of "reflective equilibrium" is one of the most powerful philosophical ideas of the 20th century (Rawls, 1971). The reflective equilibrium recognizes an interplay of cases and theory ignored by theorists who simply derive cases directly from principles. In this view, the stories we use in making moral judgments shape our thought just as much as the principles themselves. Rawls creates a reciprocity between the theory behind the rules and the application of the rules to specific cases: "principles and cases thus coexist in creative tension or 'reflective equilibrium.'"

As Arras frames it,

"Principles and theories do not emerge full-blown from some empyrean realm of moral truth; rather they always bear the marks of their history, of their coming-to-be through the crucible of stories and cases" (pp. 71–72).

This approach recognizes that narrative enriches theory-driven, principled approaches to ethical dilemmas. It adds meaning to ethical theory and clarifies the levels at which ethics must work: at the levels of theory *and* practice.

There is another version of narrative ethics that Arras sees as a stronger response to pure principlism. This approach honors the way that rules and principles are rooted in a culture. The writers from this school contend that the claims of morality from "objective" thinkers are still based more in each culture's traditions than in any single theory of moral reasoning. The objective, rational stance is no more a product of scientific thinking than the subjective influences which it has tried to supplant.

This type of narrative ethics bases its reasoning on the "foundational stories" of each culture, whether they are "the tradition of Greek or Norse epic poetry, the Bible and traditions of biblical commentary (such as the Talmud and Mishnah), or Confucianism." The regression-stopper, or final boundary to an argument, is found within the traditions and narratives of a people, their journey, and their ultimate destination.

Proponents of this school use social roles liberally, drawing on the narratives of their group to fashion moral codes. Arras gives this model well-known action-guides: "We are doctors; we don't kill," or "We

help the needy, just as Christ bade us to do in the story of the Good Samaritan.” These narratives, or roles, function as final moral authority. They do not suffer the distance or artificial objectivity of Enlightenment thinking.

The trouble with this approach is clear to Arras. At some point, one story will not be sufficient to overcome the struggles with opposing stories from neighboring cultures. Someone’s narrative must ultimately hold sway. Otherwise there exists an uncertainty that accepts each moral narrative as equally valid.

Arras is among the writers who recognize the need for some kind of criteria for assessing the force of each story—the action-guides that gauge which version is more compelling. They might be criteria, he says, that minimize distortions, eschew violence, or avoid destructive alternatives (Burrell & Hauerwas, 1977). They might be criteria from W.D. Ross’s model of *prima facie* duties, wherein duties are balanced by rule where they conflict (Ross, 1930). Otherwise, “. . . narrative ethics would have to remain silent on the fundamental question of which story might be better than another, thereby settling for a disquieting relativism.” Narrative strengthened by rules might then be an appropriate model for the discussion of forensic ethics. We need not depend exclusively on a single theory.

The final element of this typology describes the most ambitious form of narrative: a form that uses an individual’s story to completely justify ethical action. This model uses narrative not to judge right and wrong by universal rules but to legitimize the individual’s perspective. This approach has been vital to empowering crime victims within the judicial system, patients within the parentalistic medical system, and non-dominant cultures in American democracy generally. The individual’s narrative is seen as creating “moral space” for a more balanced conversation with those in power.

The dangers Arras sees in this approach is the loss of more general standards for justifying right action. Ethics cannot simply be about “personal self-development.”

“Narrative provides us with a rich tapestry of fact, situation, and character on which our moral judgments operate. Without this rich depiction of people, their situations, their motives, and so on, the moral critic cannot adequately understand the moral issue she confronts, and any moral judgment she brings to bear on a situation will consequently lack credibility. To paraphrase Kant, ethics without narrative is empty. But if all we do is strive to comprehend, if we are exclusively concerned with discerning coherence within a person’s narrative, then we have no moral space left over for moral judgment” (pp. 82–83).

But there is more to this criticism. In stressing the individual story, narrative alone may miss history's "deep structures," its "laws of social development," and the "recurring patterns" that identify changing moral sensibilities. Using feminism in a manner that exemplifies any non-dominant culture, Arras points out that justifications for patriarchal dominance are found in all cultures. Empowering non-dominant groups thus requires some integration of principles and narrative to produce a more robust social ethic.

Gutheil and Colleagues' Decision Analysis

Harvard professor Thomas Gutheil and his colleagues at the Law and Psychiatry Program of the Massachusetts Mental Health Center recognize a similar interplay between society and individual (Gutheil, Burstajn, Brodsky, & Alexander, 1991). Their work on malpractice and related court cases is shaped by the developmental stage theory of developmental psychologist Lawrence Kohlberg, whose important work, as we have seen, was critiqued by Carol Gilligan. The approach of Gutheil and his colleagues builds a decision-making model for forensic experts that centers on the complexity of interactions between individuals, their institutions, and society at large.

In constructing their model of decision-making, Gutheil's group begins by distinguishing mechanistic (some might say deterministic) from probabilistic thinking. This distinction is familiar to many students in law and medical school ethics classes as well as to general ethics and philosophy scholars. Mechanistic (or deterministic) thinking generally identifies specific answers for scientific questions, and requires a high level of certainty and objectivity.

But probabilistic thought recognizes uncertainty in the observation, measurement, and analysis of scientific phenomena. Science is seen as a more subjective enterprise, where observers affect the observation and dynamic relationships govern complex roles and actions. This approach is reflected in the work of philosophers as diverse as Thomas Hobbes and Edmund Husserl, and characterizes the post-modern movement. Even in modern business thinking, the "Hawthorne effect" describes the phenomenon of behavior changing merely by virtue of being observed.

Gutheil recognizes that probabilities and values become incorporated into scientific interpretations. There is a clear tension in this model between values, between professionals, and between objective and subjective factors. How should we balance the safety of society and the autonomy of a patient being committed to the hospital (a tension of values), the

behavior of judges who try to think like testifying experts and experts who try to anticipate judges (a tension between professions), and actuarial risk factors and whether an individual “looks” dangerous (a tension between objective and subjective factors)?

Complex social interactions have an “atmosphere” in this view that provides institutional or contextual influences. The ethical atmosphere is made up of a network where the moral claims of individual, clinician, and society are addressed all at once. At the highest levels of ethical reasoning this model ultimately requires that “. . . doctors rely not on their professional roles, but on their values and principles as people. . . .” (p. 248).

Related Movements in Allied Fields

Sociology

Sociology as a field offers a classic backdrop for the interplay of context and individual. Berger and Luckman, in their seminal text on the sociology of knowledge, develop the idea that “no human thought is immune to the ideologizing influences of its social context” (Berger & Luckman, 1967, p. 9). Drawing on developments in nineteenth century German philosophy, especially the work of philosophers Karl Mannheim, Friedrich Nietzsche, and Karl Marx, they build on the principle that knowledge is always knowledge “from a certain position” (p. 10). In this vein, society may indeed establish a series of starting-points for discussions of ethics—perhaps some “objective” facts agreed upon by attorneys, experts, and lay-people. Yet the analysis of right or wrong will involve subjective meanings based on the experiences of each actor, a kind of interplay of objective and subjective.

This interplay becomes clear in the discussion of roles. Roles arise from the forces that mold a particular society, from the community’s common needs and its “stock of knowledge” (p. 74). In this mainstream view, the role of judge, for example, “stands in relationship to other roles, the totality of which comprises the institution of law” (p. 75). Using the language of narrative like modern-day ethicists, Berger and Luckman write:

“The institution, with its assemblage of programmed actions, is like the unwritten libretto of a drama. The realization of the drama depends on the reiterated performance of its prescribed roles by living actors. The actors embody the roles and actualize the drama by representing it on the given stage. Neither drama nor institution exist empirically apart from this recurrent realization. To say, then, that roles represent institutions is to say that roles make it possible for institutions to exist, ever again, as a real presence in the experience of living individuals” (p.75).

This model goes on to describe the importance of certain roles in the integration of elements of society, especially in political and religious spheres. Such roles are critical to integrating values within society. They represent a kind of total institutional order that is derived from society at large. The judge in this schema draws on a broader knowledge of human behavior than is relevant to her professional role alone.

Burkart Holzner echoes this sentiment in his own classic treatise, *Reality Construction in Society* (Holzner, 1968).

“Role constructs are, thus, symbolic stabilizations of inherently changing and sometimes fleeting interactions. They are anchored in networks of symbolically defined relationships with other roles. They identify and at the same time define the perspectives, or orientations, which the role occupant is likely to have toward his partners, and the orientations which his partners are likely to have towards him. In their cognitive significance, roles can be seen as the prime stabilizers of the orientational structure of society. They must be related to the encompassing conceptions of collective identities and must be compatible with the specific conceptions of personal identities held by their occupants” (p. 64).

The importance of across-role integration is underscored in the creation of a community’s language and collective history (e.g., at p. 103). The ranking of events and roles in language and story-telling establish order in a way familiar to many lay observers: from the identification of others as “barbarians” (as in ancient Greek culture), as “outcasts” (as in the culture of India), or even “sub-human” (as in far too many cultures in human history). The total symbolic community is established by multiple social influences.

Of course there are elements of personal knowledge that may not be the result of socialization. People do see themselves as individuals as well as part of a collective (e.g., a family, a town, a nation). The point of these influential theories is that there is a delicate balance (and numerous interchanges) between individual and social worlds (p. 134). It is a balance we will adopt in addressing the ethics of courtroom experts.

Medical Anthropology

Cross-cultural studies have also addressed the interplay of individuals and society. When the values of different societies clash over trade agreements, boundary disputes, or scientific exchanges, we face a complex set of cross-cultural exchanges. From the manner in which to show respect to one another, to manage time, or to balance collective against individual rights, each participant in cross-cultural exchange faces an array of unfamiliar values.

Nowhere is this clearer than in healthcare settings where the meanings of illness, abnormality, and deviance are colored by cultural differences. This is the thesis of the classic work of medical anthropologist Arthur Kleinman, who developed an interdisciplinary approach to the study of medicine. His model treats disease and illness as distinctly separate ideas: disease as malfunction of biologic or psychologic process, and illness as the personal and cultural reactions to disease.

Medical illness, for example, can be anything from a biologic disruption to a spiritual possession to an imbalance of hot and cold humors. The manner in which differing cultures assign meaning to these models affects the patient's experience. The model takes context into account, welcomes personal and community narrative, and expands the strictly mechanistic views of clinical science (Kleinman, 1988; Lopez & Guarnaccia, 2000).

Physicians in the United States often note these differences in the process of informed consent. Different cultures have different expectations in the exchange of information with their physicians. Some favor complete family involvement, others patriarchal or matriarchal leadership, and still others tend to exclude the patient from discussions altogether. All differ from the strongly individualistic stance of American medicine.

Rather than running rough-shod over these cultural differences, physicians are taught to respect them. The hope is that by honoring their meaning and value, communication and understanding will improve.

Far from being a static descriptive model, Kleinman's culture is clearly dynamic and fluid. It is influenced by individual and group experiences and the manner in which they interact within the community. His view is one of exchange between individual and community values, a kind of reflective equilibrium to which we aspire in our integration of professional and courtroom ethics.

Language Interpretation

A striking example of cultural differences arises in the use of interpreters to translate foreign languages. Those who speak a different language from the courtroom expert often draw on a unique literature, history, and idiomatic repertoire. The manner in which the language is translated requires more than the rote substitution of one group of words for the other (Dean & Pollard, 2001; Glickman & Gulati, 2003).

Interpreters do more than merely translate words. They draw on their knowledge of one culture to communicate with the other. They bridge idioms of one language with explanations from the other. They even make judgments of an evaluatee's understanding in order to match the

complexity of their word choice. They assess fluency, speed of communication, and prosody to match to their interpreting. They make inferences about emphasis and tone.

For example, interpreters of sign language also take into account sight-lines, seating arrangements, power dynamics, and communication control. There is an important emphasis on turn-taking, since Deaf persons cannot easily follow statements that overlap or interrupt. Moreover, the abstractions of one language can be difficult to translate into the conceptualizations of another. Familiarity with the developing linguistic constructions within different Deaf communities is critical in such situations. Here too there is a dynamic relationship between the technique of interpreting and the context of the communication.

The model of sign-language interpreting is especially useful to those who use role theory to limit professionals' obligations in a complex human interaction. There are, for example, mainstream commentators who insist that interpreters remain in role, transmitting "everything that is said in exactly the same way it was intended" (Registry of Interpreters for the Deaf, 1994). Interpreters' only function, in this view, is to "facilitate" communication. Assessment of what constitutes intention or facilitation, however, is not an easily identifiable task.

Recently, however, some innovative thinking about role has allowed interpreters new tools for facilitating communication. After the model of Dean and Pollard (2001) we offer an example from our experience where strict role theory would impede rather than facilitate communication:

Case: The Sign-Language Interpreter

An interpreter in a general hospital is asked to interpret for the admission of a Deaf patient, known to her from prior experience. The patient's signing is affected by both sign language and spoken language deprivation as a child (a common finding in the Deaf community). The communication is also influenced by pain, and the multiple challenges of technical, rapid-fire, and untranslated communications from the hearing staff.

Rather than simply interpret the patient's imperfect signs, the interpreter briefly explains the requirements of Deaf communication, offers her past experience with the patient's capacities, and offers editorial comments as the patient signs (e.g., "The patient signed New York but means New Haven").

Without this sense of the patient's baseline, her symptoms or narrative, the clinicians would be without critical tools for making diagnostic and treatment decisions. The communication would be chaotic and perhaps

incoherent. Healthcare staff might be led to make large inferential leaps about the patient's physical complaint. The interpreter's work here serves as an example of extending personal, professional, and community values beyond the role itself.

Medical Ethics

Ethicists themselves struggle with the operant ethics of appearing in court. They worry that the information they are provided in an adversarial process is biased, that their testimony may distress colleagues or their home institution, and that payment for courtroom work may create conflicts of interest (Morreim, 1997).

Naturally, ethicists tend to focus on their own expertise: ethics, a broad, multi-disciplinary field that often takes a descriptive, not a normative stance. That is, ethicists often approach their work by describing mainstream approaches to a problem and leaving the solution to others. They do not simply tell people what to do. The commentary of ethicists about their courtroom work consequently addresses the broad interplay of moral and legal values.

Kenneth Kipnis, for example, offers a narrative of his own provision of courtroom testimony to suggest how it is "honorable" to perform this kind of work (Kipnis, 1997). His self-reflective story, following the best traditions of narrative ethics and habits of the ethical practitioner, describes who he is as a person, his training, and his philosophical approach to cases. He concludes that there are certain areas where his ethics expertise can assist a legal proceeding.

Distinguishing consensus issues from cutting-edge issues, for example, is part of his view of appropriate courtroom testimony. Describing the moral consensus and offering arguments that are substantiated and sound are the crux of his approach. He describes the "variations in which scholars reach" similar conclusions without advocacy of any particular outcome. In essence he gives a lecture and answers questions in court. The authority and advocacy for his opinion derive from the power of his justifications, a critical element of any good testimony.

Advocating for an opinion, rather than a client, is a distinction often made among forensic experts. Yet attorneys frequently expect outright cheerleading from their expert. Kipnis's view, like ours, is that the limits of testimony and the integrity of the expert are closely allied. It is the process of arriving at a conclusion (what Kipnis calls substantiation, soundness, and justification) that is more important than the outcome. If the perspective and outcome of the ethicist's forensic reasoning do not favor the client, the attorney can seek an opinion elsewhere.

Kipnis brings specific ethics expertise to problems all experts face in the courtroom. He recognizes the tension between the “obligation of disinterestedness that should characterize all professional judgment and the financial incentive to color judgment to order” (p. 338). Indeed, as we have seen, the problem of the “hired gun” pervades expert testimony. Some attorneys boast: “I can find an expert to say anything.”

“One should avoid rallies and victory parties,” Kipnis writes, tongue in cheek. Humor aside, he offers strategies for overcoming the financial pressure experts experience. First, he is clearly self-reflective, analyzing his own conduct and motivation—a skill and virtue of any ethical expert. Moreover, his first look at a case sets a range for possible testimony, protecting against over-reaching later on. After the initial review he seeks a “bilateral acknowledgement of the precise services being offered: what I will and will not say.” He points out that, as a tenured professor, his livelihood does not depend on courtroom work, allowing him to refuse cases or recognize when he is not needed. Non-medical ethicists teach this as well: there should be a certain balance between the number of cases accepted and the number refused.

The strategy of setting up rules of behavior before an ethical dilemma arises is a sound practice for ethicists and courtroom experts alike, whether one testifies on ethics or technology. It sets parameters for deciding the virtues or failures of one’s behavior even before a problem is apparent. Some call this preventive ethics.

Kipnis succeeds in bringing the expertise of his field to play in the legal arena, requiring the courtroom to accept a series of well-thought-out parameters for his expertise. It is an approach echoed by Morreim, for example, who aspires to addressing the underlying moral values of the legal system. They are values she can analyze, that are important, that must be considered, and that provide more interplay between her expertise and the legal world.

The intersection of moral and legal values is crucial to courtroom testimony because the ultimate legal question (the one answered by judge or jury) is influenced by values from many sources. Experts offer values from their professional perspective; jurors from their perspective as citizens with a particular history and culture; judges from their perspective as referees and interpreters of law; attorneys from their perspective of defense or prosecution. The pluralism of society inevitably affects the decision being made in the court. Values from many perspectives will be in play.

To some, this sounds a cautionary note. Important thinkers like Wildes, Pellegrino and others worry that because too many moralities and methodologies abound, a conservative approach to testimony is best. They exhort ethics experts to limit themselves to a teaching function,

leaving broader advocacy to the legislative forum. Separating facts from values is not possible in this view. “Critical analysis is imperiled,” they say, by remuneration, by the adversarial structure of law, and the temptations of advocacy (e.g., Sharpe & Pellegrino, 1997).

But as courtroom experts gain experience, they may find a variety of approaches to testimony available. Not only is there Kipnis’s approach that limits the effects of pressure on the testimony. Experts can fashion professional rules for accepting cases and fees, standards for contracts and consultation, and scripted responses to over-broad questions (e.g., “Based on the information available to me . . . ; In the literature I have reviewed. . .”). These are ethical habits or skills. They are all reasonable strategies for overcoming bias, defining professional standards, and allowing experts to cross into the legal frame.

We return to Kipnis in advocating “a critical understanding of all the main philosophical accounts: a mastery of their intrinsic intellectual strategies and an appreciation of their limitations and contraindications” (p. 340). He is among those who recognize that different approaches apply to different aspects of complex problems and that selecting *from* theories rather than *among* them is the richest approach (ibid). “Bentham,” he reminds us, “. . . looks at legislation for the general welfare; Kant examines inner judgment, Locke tells us about building institutions.” Principles and narrative give the courtroom expert a good start, although even they may not be enough.

We, like Kipnis, suggest experts embrace many perspectives or approaches to the same problem. Knowing how different theoretical and professional perspectives frame a particular case is as important as knowing how diagnostic approaches or assessments of harm or disability may differ. This is all part of the armamentarium of the ethical expert.

Special Topics Underscoring the Interplay of Scientific and Social Values

Definitions of Disease

How might Kipnis’s integration of various ethical approaches assist courtroom experts? We will spend Section III on specific forms of argument that can be useful in court. In advance, however, we explore two areas where integrating professional and societal values yield a richer understanding of professional ethics: diagnosis and scientific uncertainty.

Diagnosis is one of the most common areas addressed by clinical experts. It is testimony that often affects whether judges and juries will accept the presence of an injury or whether they will excuse a certain behavior.

Diagnosis may be a simple matter in diseases caused by a known problem; for example pneumococcal pneumonia. An individual may have an identified lung infection caused by the pneumococcal organism. Testing reveals the specific cause. In such cases diagnosis is not complex. The illness is etiologic; it has an identifiable cause. But among illnesses that are less identifiable, diagnosis is less certain.

There are many collections of symptoms that are not yet clear as single diagnostic entities. They may have uncertain causes, imperfect tests, and a heavy reliance on the individual's self-report. They may be diagnoses of exclusion, that is, other clearly identifiable causes must be excluded before one even considers them. They may rely on the experience of the scientist or clinician who has observed similar cases in the past.

An example is chronic fatigue syndrome. We do not know what causes this problem. We have no way of testing for it. We only know that it shows up in more and more disability claims. It would seem to be a catch-all diagnosis for a wide range of problems, from the physical to the emotional.

Clinicians take various medical, neurological, and psychological approaches to assessment and treatment, none of them linked to a single unifying hypothesis. Advances in the understanding of immune function and neurologically mediated blood-pressure changes are generating new ideas about this elusive syndrome but are still considered experimental.

So what does it take for a collection of symptoms like those in chronic fatigue syndrome to gain the status of a true disease? We consult the medical historians on this question, those thinkers who identify the social, cultural, and historical values that influence scientific classification. As the sociologists and medical anthropologists made clear earlier, both history and politics influence the community's sense of what it means to be ill. Similarly, there are spiritual and metaphysical elements to the meaning of wholeness or normality.

Case: The Morality of Tuberculosis

David Barnes's treatise on how social influences shaped early approaches to tuberculosis is an exemplary study of how cultural, literary, and moral precepts frame an illness (Barnes, 1995). In his analysis of French society, Barnes traces how, in the 1820s, the French viewed tuberculosis as a random force possibly linked to heredity but not to contagion. The French tended to see illness as part of a person's constitution, unmasked by "sorrowful passions" or sexual "excesses."

The artistic community mirrored this view, introducing the romantic ideal of the exquisitely sensitive consumptive beauty, exemplified in

heroines from Victor Hugo's *Les Miserables* to Alexandre Dumas's *La Dame aux Camellias* and Giuseppe Verdi's *La Traviata*. The redemptive power of suffering was a related religious theme, linking the "decay of the body" with the "blossoming of the spirit." It was a theme that recalled ascetic prophets of the past, and would portend the anorexia of pious Victorian women.

As scientists and public health officials argued over the possibility of contagion, a view of social class shaped public debate. Connections between alcoholism, syphilis, and tuberculosis combined to describe a kind of moral etiology of the disease. French commentators and politicians worried publicly of the social "degeneration" that resulted from the threat of the "dangerous classes" (see p. 141). This brand of thinking polarized a society with strong socialist loyalties.

These views seem quaint today when the tuberculosis bacillus is identified and poor working and living conditions are established contributors to poor public health. Yet it is a classic example of scientific thought during times of meager information.

So how does society define disease? Can it be a simple statistical deviation from the norm? Under this approach, often taken in the interpretation of laboratory values, the more one deviates from population data as a whole, the more sick or abnormal one is. Of course clinicians add their own interpretation to such values, ascribing less danger, for example, to a low potassium value in a bulimic patient whose usual reading is low than to a cardiac patient who needs every ounce of potassium to fuel her heart.

Perhaps to define disease is, in fact, to assign values. Those who differ in ways we value by say, higher IQ scores or height, may be deviant but not diseased. Medical historian Lester King makes this point in his classic writings on clinical thinking (e.g., King, 1982). His view is that social values strongly influence the distinctions between disease and discomfort, between normality and deviance. All that may be necessary for some individuals to accept medical classification may be their report of discomfort or "dis-ease." Whether this is enough for the rest of society is another matter.

So who will assign the classification of disease? Is it up to the priestly class, as in primitive societies? Is it up to the ruler or ruling class as in more recent cultures? Or is it the medical class that will determine the conceptualization of disease? Perhaps there is a unique place for the forensic expert in this decision, as the one who must bridge the medical and legal frames, defining disease for the legislature or the court. Any one

of these choices is a moral decision that sets one group of values above another.

For the courtroom expert, these writings emphasize once again that there is an interplay of social and scientific values, a kind of reflective equilibrium. In the same way that forensic and clinical (or professional) values relate and interact, non-scientific influences will affect each decision of inclusion and exclusion—whether in a research project or a clinical assessment. Values will be recognizable in each numerical or clinical cut-off, each threshold set for the expert's testimony. It will not matter whether the thresholds are set by the expert herself, the professional organization, the legal system, or the culture as a whole. The multiple influences will be there.

*Scientific Uncertainty**

The complexity of influences governing diagnosis is nothing compared to the uncertainty surrounding clinical practice itself. The lack of surety in the clinical sciences only begins at the conceptualization of disease. It then passes through the development and testing of research questions, and lands squarely in the vagaries of assessing individual patients. How does the courtroom expert establish ethical frameworks for harnessing these uncertainties? There is certainly inherent optimism in the publication of diagnostic algorithms, practice guidelines, and best practices standards.

Probably the single best articulated model of scientific uncertainty derives from the empirically based typology of Eric Beresford (1991). His combination of literature review and practitioner surveys out of the Centre for Bioethics at McGill University describes the origin of numerous scientific and non-scientific values that shape clinical medicine. This model is directly relevant to courtroom testimony.

Chief among the sources of scientific uncertainty is what Beresford and his physician-respondents describe as technical uncertainty, or the lack of sufficient data to predict the outcome of treatment (*ibid*). More specific to testimony about individual evaluatees is the lack of data (and hence certainty) on how a specific illness will progress. Related to this is the rapidly evolving quantity of new information practitioners must absorb. Especially early in the

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description of new syndromes it is difficult for experts to assimilate. As Beresford articulates it:

“... each piece of information, as part of a complex and multifaceted web of data, becomes itself a source of more questions that must be answered if we are to predict its significance for any particular situation or course of action.”

Ironically, technical uncertainty is heightened at first by the usual conduct of research. The very care shown in conducting investigations in carefully selected groups (before application to broader populations) underscores the uncertainty of developing scholarship. It is that much harder to generalize research findings from early data. To apply new knowledge ethically requires a conservative touch. Conservatism—and its cousin, parsimony—become ethical virtues in this context, as well as matters of safety for those considering new treatments. Guidance in applying these virtues will come only with answers to the questions posed so far: what are the sources of uncertainty in making a diagnosis and what values influence the process?

Beresford's typology goes further by describing an area of uncertainty which is conceptual, not technical. Practitioners describing this kind of uncertainty focus on the problems of incommensurability and applying abstract criteria to specific cases. Respondents to the McGill surveys generally applied incommensurability concerns to prioritizing patients with similar needs, but this clearly applies to courtroom work also.

In the early stages of knowledge about controversial diagnoses (e.g., chronic fatigue syndrome, fibromyalgia, dissociative identity/multiple personality disorder) it will be difficult to prioritize the individuals and circumstances that qualify for the diagnosis, for treatment, or for disability. Which symptom patterns and risk factors will be most reliable in identifying sick individuals? Which patients or evaluatees will receive greatest priority in utilization of already scarce medical or personal resources? It is foreseeable that new ethical problems will arise as incommensurable differences present themselves with each new evaluation.

Applying abstract criteria to specific situations underscores the presence of conceptual uncertainty (*ibid*). For there is an ethical problem in applying general guidelines to specific cases. Nor is it merely the problem of assimilating and applying new knowledge. Individual cases differ enough in their presentation to cause uncertainty even when diagnoses are well understood and etiologic. But when diagnoses are newly emerging, descriptive, and influenced by unflattering social perceptions, ethical concerns increase manyfold. Under these circumstances conservatism and parsimony again become the operative ethical virtues.

The final element of this typology is personal uncertainty—or the uncertainty that arises from the patient-physician relationship. Beresford's community sample of practitioners responded with great concern to the lack of knowledge of patient values when treating incompetent patients. But for the purposes of courtroom ethics, the failure to express values need not be absolute. The literature has been quite clear that clinicians are not always certain about what drives patient decisions, even when patients *are* capable of expressing their wishes.

Physicians do not predict correctly, for example, how their patients will respond to specific clinical scenarios. In fact, patients often make decisions prior to discussion with the physician (see for example, Layson et al., 1994; Ritchie, Sklar, & Steiner, 1998). Given this lack of certainty regarding general patient values, experts will certainly struggle in gauging the motivation or values of forensic evaluatees.

At a minimum, ethical courtroom practice calls for robust discussions with evaluatees: on why they seek a legal forum, the importance and prospect of primary and secondary gain, and their history of interaction with the legal system. This is not simply good forensic assessment; it is an ethical habit that recognizes the multiple values and uncertainties influencing the evaluation.

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5

Robust Professionalism: Beyond Roles

In previous articles in the *Journal of the American Academy of Psychiatry and the Law* (Candilis & Martinez, 2006; Candilis et al., 2001; Martinez & Candilis, 2005), we presented an ethical theory for forensic psychiatry that bridged the current divide between the “principlist” and “culture-sensitive” approaches discussed in Chapter 1. In this chapter, we expand on our approach.

We recognize the difference between the ethical guidance involved in the traditional patient-professional relationship and the ethical foundations for forensic work. But we reject approaches that splinter the ethical foundations into two or more camps. Instead, we offer an integrated approach where both traditional professional duties/aspirations and forensic obligations/aspirations are contained within a robust concept of professionalism.

Previous attempts to provide an ethical theory of practice for forensic professionals involved separation of dual roles and avoidance of conflicts of interest. But we present a view of professionalism that, for physicians, requires integration of ethical traditions from healthcare practice and obligations that have evolved in the forensic arena. While we understand and acknowledge role conflicts as central to understanding conflicts of interest—such as the problem of being both a therapist and a forensic expert for the same individual—we hold the view that to divide professional roles and responsibilities along absolute and clean divisions ignores the complexity of the human dramas found in this work. Moreover, clean and absolute divisions obscure the hidden dangers of assuming any “pure” forensic role, and undermine the evolution of professional identity in the field. We will present some cases to illustrate this. First though, a reminder about concepts in professional ethics that are necessary to frame the discussion.

In a 1999 article in the *New England Journal of Medicine*, Matthew Wynia and his colleagues clarify medical professionalism as something more than

a list of characteristics (Wynia, Latham, Kao, Berg, & Emanuel, 1999). For example, to define professionalism as “self-regulatory” without addressing the moral basis for self-regulation, does little to further the acceptance and legitimacy of professional autonomy. In fact, defining professionalism in terms of specific characteristics may raise criticism and skepticism. Such an approach allows the public to dismiss professional claims of self-regulation as self-protection or self-interest.

Wynia and his colleagues define professionalism “as an activity that involves both the distribution of a commodity and the fair allocation of a social good but that is uniquely defined according to moral relationships. Professionalism is a structurally stabilizing, morally protective force in society.” These authors argue for a professionalism that “protect(s) not only vulnerable persons but also vulnerable social values” (p. 1612).

We agree that for professionalism to have any meaning, it must have a clear foundation in moral relationships. It is this foundation in moral relationships that anchors the profession as a profession.

One of the best literary examples of moral relationships is found in Kazuo Ishiguro’s novel, *The Remains of the Day* (Ishiguro, 1989). In this novel, the professional butler, Mr. Stevens, acts with the emotional and personal neutrality (he calls it “dignity”) that is the core moral guide of a superb English butler in 1940. Mr. Stevens describes his theory of professionalism:

“. . . ‘dignity’ has to do crucially with a butler’s ability not to abandon the professional being he inhabits. Lesser butlers will abandon their professional being for the private one at the least provocation. For such persons, being a butler is like playing some pantomime role; a small push, a slight stumble, and the façade will drop off to reveal the actor beneath. The great butlers are great by virtue of their ability to inhabit their professional role and inhabit it to the utmost; they will not be shaken out by external events, however surprising, alarming, or vexing. They wear their professionalism as a decent gentleman will wear his suit: he will not let ruffians or circumstance tear it off him in the public gaze; he will discard it when, and only when, he wills to do so, and this will invariably be when he is entirely alone” (pp. 42–43).

In the novel, Mr. Stevens is challenged to merge his theory of professionalism with practice when his own father falls ill during an important affair at his employer’s home. While his father lies dying in an upstairs attic, Stevens tends to his employer’s needs, neglecting his dying father. Ishiguro explores, with great skill and understatement, the personal, psychological, and spiritual consequences of his butler’s view of professionalism. The reader readily sees what Mr. Stevens cannot—that by “inhabiting his role to the utmost” he has abandoned his father in the time of greatest need.

While an abundant literature struggles with the justification for rigid social roles even when they result in harm, the case of Mr. Stevens provides an opening for the difficult questions of role in forensic work. Currently, forensic ethical standards and the dominant theories of ethics applied to forensic work err on the side of supporting a narrow, restricted professional role which reduces conflicts of interest and serves the legal obligation rather than the client. While some dissenting theorists have rightfully nuanced this view by presenting culture as a factor in forensic work, few have examined the moral significance of the narrow view of professional role in forensic practice.

We believe forensic practitioners must consider not just their duty to the legal elements of the work, but to the ethical obligations of the profession from which forensic activity springs in the first place. After all, before we begin to specialize in forensic work, all of us are doctors, lawyers, or other professionals. The activity of forensic work rests on a general moral foundation.

In the same vein, a professional role in forensic work should also consider personal morality as well as professional morality. Views on such matters as the death penalty, on retribution and fairness, and compassion and human dignity cannot be made invisible. We must not seek to hide them behind the false claim that forensic specialists simply need to remain objective, neutral, and exclusively allied to the legal system.

In contrast to Mr. Stevens in Ishiguro's novel, we argue that professional forensic work should consider personal morality and cultural values. We integrate the professional ethics of the expert into forensic work. This need not ignore conflicts of interest, but it does demand a subtler grasp of those conflicts. We believe this greater complexity is more truthful to the human experience of conflicted loyalties. For clinicians to say forensic work is obligated to justice and minimizes clinical obligations does not make it so. The experiences of most professionals in this work are rarely so simple that such a theory of ethics can be an adequate guide.

But before developing our case one more consideration is in order. In defining relationships (rather than activities or principles) as central to forensic professionalism, a professional ethic emerges that allows our discipline to explore obligations or duties as well as evolving moral ideals or aspirations.

We believe that our profession, and any profession interested in its moral basis, must recognize that although duties may seem constant, willingness to define and re-define its moral aspirations encourages the profession to reflect and remain self-critical. This willingness to re-define increases the chance to respond to society's needs while embracing the professions obligation to "protect . . . social values." We must keep our

eye on both the duties and the moral ideals of a profession that define its ethical behavior.

To accept one's primary duty to the flawed judicial system as it exists now is to negate much of forensic professionalism. We think that activities that help re-shape the system—while respecting fundamental duties—are an essential part of professionalism in forensic practice. The following disguised cases illustrate these ideas.

Case: Ms. Rodriguez

Ms. Rodriguez is a single, 32-year-old Mexican-American with four brothers and a sister, all young adults. Her parents came to the United States when her two older brothers were infants. Ms. Rodriguez and her younger siblings were born in the United States. Three of her siblings completed college and are working as professionals.

After suffering a kidney stone as a college junior, Ms. Rodriguez began to abuse painkillers. Although she went on to complete a degree in business and open her own small clothing store, her drug abuse continued. Over the next several years, Ms. Rodriguez became drug-addicted, and was arrested twice for forging prescriptions. Both times she was ordered into drug rehabilitation programs.

Although Ms. Rodriguez completed both drug rehab programs, in recent years her drug problems extended to cocaine and heroin. For three years, she used intravenous drugs until she was arrested for possession of controlled substances, reckless driving and endangerment, and several other felony charges. Ms. Rodriguez had crashed into another car, and slightly injured the other driver. Because of her past arrests, Ms. Rodriguez faced a possible 8–10 years in prison.

Because Ms. Rodriguez reported hallucinations, paranoia, and amnesia at the time of her arrest, the court asked a forensic psychiatrist for both a competency assessment and an assessment of mental state at the time of the alleged crimes. Ms. Rodriguez had been knocked unconscious and sustained a facial fracture during the car accident. Since voluntary intoxication disqualified an insanity claim, she and her attorney introduced her mental state to challenge elements of the *mens rea* (mental state) required to commit the alleged offenses. The charges against her were “specific intent” crimes, where her mental state at the time of the alleged offenses was crucial to a successful conviction.

In reviewing records, the forensic evaluator uncovered an intriguing history. Several days before her arrest, Ms. Rodriguez had entered an experimental (and controversial) treatment program known as rapid opiate detoxification. Proponents of this five-hour procedure, in which the patient is placed under

anesthesia and rapidly detoxified, report that it helps patients avoid the pain of protracted withdrawals and avoids long-term methadone maintenance (an accepted treatment that dispenses controlled amounts of the opiate methadone). Critics of the procedure argue, however, that the problem with opiate dependency is not simply the physiologic withdrawal from the opiate, but the long-term psychological and physiologic aspects of addiction after withdrawal. Since the procedure is relatively new and uncertain, some critics argue further that providing adequate informed consent is problematic.

Ms. Rodriguez and her parents went to a clinic that offered the procedure and expressed her desire to “kick my habits once and for all.” After several weeks of deliberation, Ms. Rodriguez’s parents charged \$5000 to their credit card to pay for the procedure.

After the procedure, Ms. Rodriguez went home with her parents with instructions for using certain medications in the post-procedure period. But complications developed: Ms. Rodriguez developed severe opiate withdrawal symptoms including severe dysphoria, depression, agitation, and suicidal thoughts. Numerous calls to the clinic by both Ms. Rodriguez and her parents failed to elicit what they believed to be an adequate response. They believed that the professionals at the clinic were rude and dismissive and that they failed to address the seriousness of their daughter’s suicidal intentions.

On the third day after the procedure, Ms. Rodriguez became increasingly agitated and left her parents’ home with a friend. Within twenty-four hours, she had used both cocaine and heroin, wrecked her car, and been arrested. Witness and police statements supported her claim that she was suicidal, paranoid, and hearing voices.

During the two-month period spent evaluating Ms. Rodriguez, the forensic psychiatrist met with Ms. Rodriguez’s parents and two siblings to understand her mental state in the days and hours prior to her arrest. During these meetings, Mr. and Mrs. Rodriguez told the story of their immigration to the country, described the cultural divide between Mexico and the United States, and their sorrow over the troubled life of their daughter.

During the outpatient evaluation period, Ms. Rodriguez was bonded to her parents’ custody. She used cocaine on one occasion, failed a urine test, and was expelled from the treatment program. She returned to jail for violating the conditions of her bond.

Ms. Rodriguez’s father called the forensic psychiatrist and asked for help in placing his daughter in a residential drug treatment program; he knew that otherwise his daughter must remain in jail until her trial. The court would agree to release her to a structured inpatient program, he said. The forensic psychiatrist called several addictions experts, and helped identify a program for Ms. Rodriguez. Within two weeks she was

released from jail and entered the residential program. The psychiatrist completed the evaluation for her court appearance.

In his report, the psychiatrist offered forensic opinions that supported her competency to proceed. But at the same time, the psychiatrist argued against her capacity to form the culpable state of mind necessary for the charges against her. Ultimately, Ms. Rodriguez entered a plea agreement that resulted in a 10-month jail sentence followed by a long probation period with closely monitored substance abuse treatment.

After the plea agreement, Ms. Rodriguez's parents called the psychiatrist to thank him. Ten months later, they called again to let the psychiatrist know that Ms. Rodriguez was released from prison and doing well. In the next year, she was working and participating in her outpatient treatment program.

*Case: Ms. George**

Ms. George was a vibrant, athletic, and strong-willed woman in her mid-40s when she suffered a catastrophic brain-stem stroke. The stroke left her almost completely paralyzed. She had completed college and owned a business; she was close to her family and her boyfriend. Her family was deeply involved in her care, applying both the immigrant parents' southern European sensibilities and the values of American-born children.

Family meetings were, at times, boisterous affairs with dramatic arguments and just as dramatic reconciliations. In this family, no one was shy about expressing an opinion. Sadly, the "golden girl" of the family could now communicate only by raising her eyebrows. As she struggled through two years of rehabilitation to maintain muscle tone and respiratory support, she remained paralyzed—an active mind trapped in an unresponsive body. Her treaters thought it a miracle that she had regained consciousness, and she was not expected to recover further.

After she completed all that rehabilitation could offer, Ms. George was transferred to a nursing facility. She continued to meet with visitors, watch films, and listen to music. She learned to communicate by using an alphabet board pasted above her bed.

About two and a half years after her stroke, Ms. George began to ask family members and nursing staff for help in ending her life. She wanted to die, she said, because she believed her situation was untenable. She began to refuse some of her tube feedings.

*Case and portions of its analysis reprinted with permission from Candilis et al., 2001, *Journal of the American Academy of Psychiatry and the Law*, 29(2), 167–174.

A split developed between the staff and family members about her request, so a psychiatric consultant was asked to evaluate her. While the consultant determined her to be “competent” in her decision to refuse food and water, there was no ethics committee within the facility to mediate. The psychiatrist asked an outside specialist to consult as well. Her family too was split in its opinions about Ms. George’s request to die. Ms. George herself asked the local probate court to appoint a legal guardian to advocate for her position. She resented the delays caused by the difference of opinions surrounding her.

The probate court appointed a forensic psychiatrist to gauge 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.”

After the court warned her of the family discord, the consultant called a family meeting. At this meeting, the consultant forensic expert explained her role and asked each member of the family to speak. One parent with conservative Eastern Orthodox views vehemently opposed her daughter’s choice of “suicide” on religious grounds. One brother expressed Adventist views on his sibling’s behalf. He explained that Ms. George had been baptized by the sect while paralyzed, and that Adventists would consider any starvation fast to be sinful. A second brother worried that the medical team had missed the diagnosis and were too pessimistic about his sister’s prognosis. He believed that certain reflexive movements were evidence of a potential recovery. Another family member expressed concern that Ms. George was unduly influenced by her boyfriend who stood to gain from the will.

Although the evaluation would proceed along common clinical guidelines, a good deal of work would be required to address the relevant family, religious, and financial considerations. The consultant recognized that the simple determination of Ms. George’s “competence” was only a part of the work ahead. While the law required an answer to this simple question, morality and the consultant’s own sense of obligation required more from her.

Ultimately, the consultant included elements of counseling, education, and family conflict resolution. She referred members of the family to spiritual and religious experts. She explored the motives behind Ms. George’s request and the influence of family dynamics; she determined the absence of mental illness, and assessed her decision-making capacity.

Based on the psychiatrist’s report, Ms. George was determined to be competent to refuse nutrition and hydration. Although some members of the family continued to resist her choice, the court supported her and Ms. George was allowed to die some ten days into her fast.

Conflicts in Role: Personal and Professional Obligations

As the two cases of Ms. Rodriguez and Ms. George illustrate, forensic specialists often find themselves in cases which require a more robust notion of professionalism to meet professional and personal moral obligations. This is also true of cases that require clinicians to be both treader and expert, as in guardianship, Workers' Compensation, or certain disability hearings. Interaction with Ms. Rodriguez's family, for example, required sensitivity to the cultural barriers to access to care, including racism within the system. It required sensitivity to family and community standards of shame, as might arise in their cold-calling other professionals for help. Any narrow view of professionalism was inadequate to the task.

As we saw in Chapter 1, the issue of conflicting forensic and clinical roles has been debated since the early development of forensic specialists. The very nature of the work often places the forensic expert in the role of "double agent." While some scholars like Bernard Diamond have argued for a forensic role that advocates for the client (a position with particular poignancy in death penalty cases), over time, an ethical consensus evolved that encourages experts to see themselves as objective consultants in pursuit of justice. Experts were encouraged to avoid conflicts where clinical and forensic roles clash.

A few common examples include those we described earlier, such as the psychiatrist who is asked to testify on damages to his PTSD patient or the psychiatrist asked to render an opinion on the parental fitness of her patient in a custody dispute. While these examples illustrate the problem when a clinician is asked to participate in legal matters involving patients, guidance for forensic professionals who find themselves engaged in clinical issues during their forensic work is less clear. The cases of Ms. Rodriguez and Ms. George illustrate this latter problem.

Historically, there are indeed paradigmatic differences between the two roles. The treating psychiatrist generally undertakes a patient-centered approach with emphasis on the patient's psychological perceptions, thoughts, and feelings. By contrast, the forensic expert generally adopts a descriptive approach with an emphasis on more "objective" diagnosis and classification. The treating clinician is interested in the client's truth, a form of interpretative truth that is based on the client's subjectivity. Often, this sort of "narrative" truth or interpretative truth represents the patient's "inner personal reality, albeit colored by biases and misperceptions" (Strasburger, Gutheil, & Brodsky, 1997). While this truth may be reflected upon and altered as the patient gains insight and personal understanding, courts of law generally are not interested in the client's psychological reality and advancement. The forensic expert, while in the service of the

court, is concerned with more factual and corroborative information. Without these priorities, as we have said, the forensic expert would be worthless to the legal process.

If we agree that the treating professional is obliged to provide good care without regard to other social relationships, we ground the relationship exclusively in clinical knowledge, confidentiality, and principles of beneficence, non-maleficence, and respect for autonomy. In contrast, the forensic expert must assume greater responsibilities to society, with even stronger allegiances to the law, the courts, and society as a whole. The forensic expert 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" (Strasburger et al., 1997). Current theories of forensic ethics, as we have seen, generally place social principles of justice, truthfulness, and respect for persons above professional clinical obligations of beneficence and non-maleficence.

Consider confidentiality specifically. In a therapeutic relationship, confidentiality is maintained unless patients are a danger to themselves or others, or in situations where patients request disclosure of information for their own purposes. It is not always a simple moral choice, but it is made with an initial presumption in favor of the patient. The U.S. Supreme Court in *Jaffee v. Redmond* recognized the importance of confidentiality in psychotherapeutic work, holding that psychiatrists and other psychotherapists cannot be compelled to give testimony in federal court when doing so would involve violating client confidences without client permission (*Jaffee v. Redmond*, 1996). The ethical practice of confidentiality encourages clients to reveal intimate, sometimes embarrassing, and painful details from their personal lives.

When clients enter a legal setting, these same intimate details can be damaging. In the traditional forensic role, professionals do not focus on protecting clients from harm. Indeed, the effect of expert testimony may be embarrassing; it may result in punishment and may be physically and psychologically destructive.

So, what should forensic specialists do when faced with situations similar to those of Ms. Rodriguez or Ms. George? Should they define the minimum duty as fulfilling the court-appointed task? Is further activity by psychiatrists prohibited, voluntary, merely permissible, or supererogatory (beyond the call of duty)? Are there activities outside the court-ordered task that should be required—activities defined as part of the forensic expert's duties as a professional person?

In the case of Ms. George, familial strife amid a tragic situation called for more than an aseptic assessment of decision-making capacity to

refuse nutrition and hydration. Ignoring the family's conflict, their lack of information and understanding of Ms. George's wishes, and the potential loss of emotional resolution and comfort at a critical time would be unacceptable on a human and moral level. A compassionate professional involvement included clinical elements of education, counseling, conflict resolution, and spiritual guidance. To avoid these elements would have been to abrogate responsibilities to a person and her family in profound distress.

Personal morality of the professional and the ethics of healthcare clinicians are necessary to navigate such morally confusing circumstances. A strict adherence to the duties of the forensic role would fail Ms. George, her family, the court, and the consultant. The forensic consultant was appointed in order to inform the judicial process about a straightforward technical assessment. But a fluid, time-pressured, and complex clinical situation was part and parcel of the central question regarding Ms. George's competency. Once involved, the forensic expert was confronted with a complex family drama. Professional responsibilities and obligations emerged, requiring a flexible and adaptive approach. While ethical principles and strict adherence to role responsibilities allowed the capacity assessment to be completed, a broader conceptualization of professional role was needed to address the larger and more ambiguous aspects of professional involvement.

Similarly, in the case of Ms. Rodriguez the expert assigned by the court found himself recruited into what can best be defined as activities of treatment and consultation. They were outside the specific court-ordered activity. Within a narrow forensic professional role, mainly responsible to justice, many of the activities in which the psychiatrist participated could be seen as aspirational and beyond the purview of the professional expert. One can argue that these activities are prohibited by role considerations. Or they may be entirely voluntary, left to the discretion of the individual professional.

However, once the relationship with Ms. Rodriguez and her family began, the mere disclaimer that the psychiatrist is not a treater but an evaluator for the court does not make it so. At least, not if we consider the elements of moral relationships as presented by Wynia: we have a duty to vulnerable people and values. While the psychiatrist may be protected from legal liability if he declines to act clinically, the ethical question remains. Does this psychiatrist have duties and obligations beyond his forensic role? If there are no obligations, can he turn to professional and personal aspirations or ideals, crafting these into clinical service? Does our profession have an obligation to better define these various "roles?"

How do we understand—in a moral sense—the clinical activities of the psychiatrists in both of these cases? How do we judge their willingness to serve clients and their families in a clinical manner when their role is limited by the needs of justice and the courts? If these extra responsibilities exist, do they exist because common morality (everyday decency or morality that precedes professional obligations) requires them to respond in this human way?

Or do ethical obligations of the clinician—foundations of clinical professionalism—require the psychiatrist to aid these clients and their families through education, referrals, and other therapeutic help? Does the principle of beneficence apply? If so, does this principle have form through current notions of professional forensic roles, or must we re-define a professional role that integrates the clinical obligations of professionals with their forensic role obligations? Lastly, if such an integrated model is desirable, is it obligatory or simply aspirational? In the next section, we will address these questions.

Professional Roles: Conflicts with Institutional Values

F.H. Bradley, the nineteenth century British philosopher, argued that self-realization occurs when duty and happiness are joined: “Yes, we have found ourselves, when we have found our station and its duties, our function as an organ in the social organism” (Bradley, 1988, p. 163). Bradley was reacting to the moral absolutes of Immanuel Kant, locating moral understanding in the cultural and historical particulars—the class distinctions and social-hierarchical constraints—of his day.

Bradley is often cited as the source of current role morality theory, where moral behavior is located in the role obligations defined by our place in the social order. It is distinguished from the common morality that delineates duties and obligations in daily human relationships.

But Jennifer Radden’s definition of role morality and its dynamics may be more useful for analyzing the forms that role morality takes in our modern world (Radden, 2001). Recall that Radden distinguishes role morality and “broad-based” or “common” moral duties from professional ones. She espouses a weak rather than strong role morality to integrate professional and common values.

Using Radden’s model, forensic practice can involve elements of both strong and weak role morality. Forensic work sometimes requires an expert assessment that will lead to harm for the person being evaluated. This is permitted under the concept of strong role morality: professionals may deviate from common moral expectations. That is, the forensic expert

is allowed to use his expertise to serve justice and not the individual. This causes harm that would not normally be acceptable outside the courtroom context. In role morality theory, we consider these situations “dirty hands” dilemmas: certain professional roles and situations require that something “dirty” occur for the greater good. We appreciate Radden’s effort to clarify concepts of role morality in the area of boundary theory, but also believe it has important implications for forensic practice.

To illustrate this point, we might draw on the metaphor of theater. As with players in a theatrical production, individuals in a role are wearing costumes, even masks, to conceal their true selves. Just as the stage, the script, the traditions of theater, and the director define the limits and extensions of theatrical activities, the professions are limited by internal and historical values and the context of professional activity.

Of course, theater performers do not extinguish their own interpretation and creativity. Performers’ interpretations of the playwright’s product, the way they move across the stage, hold themselves, gesture or speak—all reflect the uniqueness of the person behind the character. So it is with professional roles; moral actors are constrained by professional obligations and responsibilities yet open to the natural and unique expression of the individual.

Clearly, there are limits to the personal qualities that find expression in the role one is performing. There are limits beyond which most professionals are, and ought to be, justifiably reluctant to go. The American Psychiatric Association and many other professional organizations, for example, have defined any sexual relationship between therapist and client as a serious case of professional misconduct. Like prohibiting participation in executions or torture, adherence to a strict rule for professional behavior is often useful and morally justified.

In situations where professional role and the societal structures that contain them are united in moral priorities, the strong or narrow conceptualization of professional role may be able to define personal responsibility. However, what happens when institutions and professionals are not united in common moral priorities? How does the concept of professional role serve the institution, the individual professional, and the profession? When we define professional role in a strong or narrow sense, as primarily a social role, the moral framework may be inadequate for resolving conflicts between institutionally driven requirements and individual professional desires.

In fact, modern Western society already shows a widening gap between individual professional values and institutionally or societally driven priorities. In the managed care environment of recent decades, for

example, many U.S. healthcare institutions discouraged professionals from expressing views or taking actions that might disrupt the priorities of those institutions. “Gag clauses” in contracts between physicians and managed care organizations stand as a stark example of this reality in recent times.

In an insightful book, *Ethics of an Artificial Person: Lost Responsibility in Professions and Organizations* (1992), Elizabeth Wolgast examines this very problem of individual responsibility in the face of institutional values. Wolgast believes that many of our modern professions and organizations diffuse and discourage individual responsibility by encouraging professionals to speak and act in the name of institutions. She is concerned that large, impersonal institutions silence critics, enforce conformity, and, in the absence of healthy, transparent discourse, harm individuals and the institutions themselves.

Drawing from the philosophy of Thomas Hobbes, Wolgast uses the concept of “artificial,” “feigned,” or “fictional” persons to describe the moral vacuum of individuals speaking and acting on behalf of their institutions. These artificial people do not represent their own moral values. Hobbes introduced such concepts to explain the relationship between citizens and representative government. Using examples such as servants acting for their employers and parents making decisions for their children, Hobbes coined this concept of “artificial persons.”

Concerned about the diffusion of personal responsibility, Wolgast feels that modern institutions must choose a set of values and pledge to fulfill them. She cautions: “The motive for tackling these gargantuan projects of reform is that the alternative is a further thinning in the meaning of responsibility on one side while nurturing institutions that defeat it on the other. A decision to change is acutely a moral decision, and moral courage is needed to make it” (Wolgast, 1992, p. 157).

The strict, strong, or narrow professional role may well be the concept that allows for this “further thinning of individual responsibility.” The greater the distance that people see between their own morals and the morals of their work, the less their incentive to take moral stands. We will have to look carefully at the connection between professional role and institutional or societal needs if we are to develop the “moral courage” to seek reform—by improving the judicial system and improving the lot of non-dominant groups.

Forensic work is one of the professions subject to these concerns. While the cases of Ms. Rodriguez and Ms. George are not the dramatic stories invoked by death penalty cases, we believe they are important. For, surely, the integrity of individual practitioners and of forensic psychiatry as a specialty requires us to examine how conflict between

institutional priorities and individual professional obligations shapes our practice. To do this we turn to the more specific moral considerations involved when individual and institutional values collide.

Professional Harms: The Case of the Executioner of Paris

In *Ethics for Adversaries: The Morality of Roles in Public and Private Life*, author Arthur I. Applbaum (1999), presents the fascinating story of the executioner of Paris, Charles-Henri Sanson:

“Sanson’s grandfather’s father was appointed Louis XIV’s headsman in 1688. The professional calling, with its art and science of torture, dismemberment, and death, was handed down through apprenticeship and regal appointment to Charles-Henri. He began doing his father’s work in 1751 and was formally appointed in 1778 by Louis XVI (who would come to observe his appointee’s handiwork up close). Sanson formally passed the commission on to his son in 1795 . . . All six of Sanson’s brothers, along with uncles and cousins, were also executioners . . . The Paris post stayed in the family until 1847. For decades, Sanson and his assistants conscientiously attended to the punitive needs of the *ancien regime* . . .

Sanson seamlessly adapted to both the Revolution and its new technology, the humane and ennobling machine proposed by the good Doctor Guillotin. He ministered with professional detachment to, in turn, common criminals under the constitutional monarchy, royalist ‘plotters’ at the direction of the Paris Commune, the king upon conviction by the National Convention, the moderate Girondins when purged by the Jacobins, the extremist Hebertistes at the instigation of Danton, the indulgent Dantonistes after their denunciation by Robespierre, and Robespierre himself when finally outmaneuvered by the Thermidorians” (pp. 16–17).

The story of Charles-Henri Sanson examines troubling questions about the nature and justification of public professional roles that involve controversial behaviors. The professional ethics literature calls this the problem of “hired hands:” “How can a professional have an obligation to do (or fail to do) on a client’s behalf what would be wrong if done on the professional’s own behalf” (p. 8)? In forensic work, it is routine to perform a professional activity for the court that may harm the client. But it is forbidden for common citizens to do this.

The practical answer is that neutrality and objectivity cannot be guaranteed in the institutional processes of justice without granting moral exceptions within professional roles. The lawyer who is not allowed moral exceptions to keep the confidences of guilty clients would be of little use in an adversarial judicial system. Society and the law consequently provide these exceptions. For a greater societal good, the law permits professional experts to commit a type of harm.

The case of Sanson allows us to explore the justifications for these harms and their limits within the professional role. By examining an admittedly extreme example, we illustrate the need for an integration of the ethics of the professional expert with the ethics of the clinician (or scientist) and the person. After all, there may be certain foundational values upon which the forensic expert's professional role is based.

In Applbaum's book, Sanson is asked to justify his life and work in a clever fictional dialogue between Sanson and one of his critics, Louis-Sebastien Mercier. Mercier was a writer and politician who survived the many violent transformations of the French Revolution. Through this fictional device, Applbaum treats several major themes. We invite readers to apply the reasoning to the activities of modern-day professionals monitoring or engaged in interrogations or even torture.

First, Mercier asks Sanson how he continues to move about Parisian society without guilt or shame after cutting off so many heads. Sanson responds:

"I take it that you are wondering how I can detach people's heads for a living? I will tell you. It is my profession. The role of Paris executioner has been handed down, father to son, from my grandfather's father to me, and will be passed on to my grandson. It is not, strictly speaking, a hereditary position, but one in which each successive generation has been initiated and that each has adopted as its vocation. There are families with a tradition of doctoring, families with a tradition of soldiering, families that have handed down cheese-making and wine-making and all manners of art and trade. We are a family of professional executioners: that is what we do, and each generation seeks to do it better. It is our calling" (p. 28).

Once Sanson claims that his is a profession, like other professions, with an apprenticeship and history, Mercier challenges him. He tells Sanson that he is confusing "professional" with any activity done for pay, such as "professional gambling" or "professional begging." Mercier argues that a professional cannot simply describe a tradition of apprenticeship, but must also make a moral claim. Professions are defined by their aspiration—the pursuit of a moral ideal that serves both individual and society.

Sanson answers the challenge:

"I agree that if a claim of professionalism is to have any moral force it has to refer to ideals and commitments, and that a claim of tradition must involve more than mere habit. But the role of executioner meets both requirements. We take great pride in our craft and hold ourselves to the highest ethical and technical standards . . . We have learned from our predecessors and teach our apprentices to value excellence in the practice, which reflectively adapts to both new technologies and new political sensibilities . . . you cannot always appreciate our commitments, so we must appear rather ghoulish . . .

I have come to expect such reactions: you know, one of the marks of a true profession is that excellent practice can only be judged by fellow practitioners. You are

not an expert judge of a court or of a surgical procedure; why do you think that you can appreciate the niceties of the executioner's craft? For example, you may have thought from his scream that it was cruel to rip Robespierre's bandage from his shattered jaw, but I assure you it was a mercy—the consequences of an obstructed blade are far worse than the moment of pain he suffered. To carry out the judgments of law with dependable precision, the executioner worries about dozens of similar details that are designed to treat the condemned, the spectators, and the law with precisely the respect that each is owed" (pp. 28–29) . . .

Sanson argues that professionalism requires standards of practice and that these standards aspire to excellence. In addition, he introduces the notion of the guild—replaced in today's world by the professional organization and peer review—as the only legitimate way that the profession can judge this excellence.

Once again, Mercier is not satisfied, for these are merely claims for self-regulation. They do not address the more difficult moral questions which trouble him. Mercier wants Sanson to get to the question of "hired hands"—the justification for the horrific activities of his profession. Sanson responds, "to allow personal views about the sentences I execute to interfere with my duty is to substitute arbitrariness for the rule of law" (p. 31).

Further, Sanson dismisses the argument that he has a duty to resist taking part in an unjust legal system. It is not a moral problem for him to change allegiances so readily, one day executing the previous day's leaders: "By putting the criminal to death, the executioner simply obeys a good law. How can that make him bad? The penal code that established death by decapitation was enacted by a democratically elected legislature, and so has the force of law" (p. 31).

Sanson does turn here to the argument that a good professional is simply "obeying orders," a view that looked much different in 18th century Europe than in the post-Holocaust world of today. However, when confronted by Mercier on the point that there may be laws that a good person must reject, Sanson reveals what he believes defines a professional: his concept of professional role.

"In exercising my professional duties I must set aside personal considerations. I naturally have views, held at varying degrees of certainty, about the guilt or innocence of my victims. I may personally admire or loathe those who come before me. I have my own views about the politics of the day. These are the views of Charles-Henri, man and citizen. But the executioner must set aside the reasons of Charles-Henri, for it is not Charles-Henri acting on the scaffold, but the Executioner of Criminal Sentences of Paris. I do not mean simply that the executioner *may* not take personal considerations into account, but that the executioner *cannot*, and still be the executioner. Charles-Henri can commit murder, can massacre, as you put it. But only the executioner can perform an *execution*. The act of

execution that the executioner performs on the scaffold does not exist apart from his professional role—it is constituted by it” (p. 39).

Sanson does not deny that there are bad laws and even bad practices, but he claims that professionals must take part in such activities as part of their role. It is the role itself that provides moral excuses when personal morality is in conflict with professional behavior. He hints that to abandon this formula would make certain societal practices impossible: isolation of personal values is central to the legitimacy of the professional role.

Mercier is not satisfied—nor are we. Mercier does not accept that professions can insulate themselves from broad moral concerns. He challenges Sanson again to explain why he executed so many citizens under so many regimes—regimes which history looks upon as perverse and immoral. Sanson responds:

“On the job, I am neither an instrument nor a man . . . I am not a mere instrument, if by that you mean one who takes no responsibility for what his superiors demand of him. Indeed, I roundly reject any simple appeal to authority to justify my career, if such an appeal takes the form of ‘One must follow orders; I was ordered to kill; therefore, I must kill.’ I am not an instrument devoid of mind or conscience, but a *professional*. . . . Professions are the guardian of a political value that is of utmost moral importance. Although the good sought by my profession is valuable for all of society and capable of being recognized as valuable by all subjects and citizens, this good cannot be pursued except from within my professional role or roles like it. To this good I have dedicated my life, and my practice as executioner has aimed at it through all the changing regimes to which you accuse me of whoring. My devotion is not to any one regime or political ideology, but to the good of *social order* and the stability and security it brings. By stability, I do not mean the stability of any regime or form of government, but of civilized life itself; and by security, I mean security from the random horror of murderous mobs. To realize the good of social order, my profession is committed to a simple principle: the state must maintain its monopoly over violence” (p. 36–37).

Sanson now argues that if personal views conflict with one’s role, one must remain in the role or the entire system will fall apart. Furthermore, it is a higher calling and greater organizing principle that guides his profession. The value of social stability allows him to survive the ever-shifting political winds of his time. His “dirty hands” are better than the alternative: chaos and mob violence. As Sanson sees it, his practices are not blind obedience, but central to social order. And since he places great store by social order, he is willing—almost eager—to grant those who safeguard order broad exceptions from common morality.

But how does this inform the professional dilemmas affecting Ms. Rodriguez and Ms. George? It may be true that a certain detachment and

neutrality are required to be a useful forensic expert. But is it necessary to distinguish so sharply the professional role of expert and the professional role of clinician? Even in the case of Charles-Henri Sanson, the executioner argues that he is not unaware of his personal feelings. He is not a monster. Sanson performs a socially sanctioned professional role—horrific as it is—with humane consideration of his charges. Nothing prohibits him from conducting his executions with respect for those being executed. In fact, Sanson argues that carrying out his professional role in the most professional manner possible requires that he treat his victims in a manner that maintains their dignity.

In a newspaper notice, Sanson even defends himself from claims that he participated or sanctioned any indecency following the 1793 execution of Louis XVI. With professional detachment he defends his profession from the claims that he participated in the distribution of souvenirs after the execution.

“I have this moment learnt that there is a rumour abroad to the effect that I am selling Louis Capet’s hair, or causing it to be sold. If any of it has been sold, the infamous trade can only have been carried on by knaves: the truth is that I did not allow anyone connected with me to take away or appropriate the smallest vestige of it” (p. 24).

Sanson argues further that the adversarial nature of some professional activities requires that we judge the role rather than the actor playing the role. If we disagree with the role, we must change it. But we cannot punish the person performing the role for the failings of the society-sanctioned behavior.

Society justifies these moral exceptions within a role by re-defining the actor’s moral culpability while in the role. In addition, society also re-defines the moral descriptions of the actions within the role. With Sanson, both rationales are present. Since he (as individual) is in the professional role of executioner, he cannot be culpable of harms. And if the executioner’s role is justified “for the greater good of society,” then the actions of the executioner must be morally acceptable. Such conclusions from the Executioner of Paris should leave us uneasy.

In the cases of Ms. Rodriguez and Ms. George, too, is the primary duty to justice a morally adequate standard for the expert? If so, the “clinical-like” activities are unnecessary. They would be considered aspirational (or forbidden). However, we believe that a richer theoretical approach that rejects strong role morality and integrates non-professional values provides a more robust theoretical justification.

In our own discussions with experts who describe cases similar to those of Ms. Rodriguez and Ms. George, we find a split between what many

intuit as the right thing to do and their actual practice. The current claims of what professionalism requires of us cannot fully address this split. We may need a better theory to incorporate the reality of current practitioners, and to support them in their view that core obligations do not vanish because they enter a different professional role. We turn to this now.

Beyond Roles: Professional Integrity

We support Wynia's view that professionalism is "a structurally stabilizing, morally protective force in society" that embraces the elements of "devotion to service, profession of values, and negotiation within society" (Wynia et al., 1999). But to get there forensic clinicians will need an integrated ethical approach that embraces both the traditional professional ethics of healthcare and the commitments to justice.

The model we offer is a robust professionalism where professional integrity guides us beyond the role theory offered by Sanson. Within this model "cultural formulations," as discussed by Griffith (1998), are incorporated through narrative theory and narrative considerations. We agree with Griffith when he writes: "The forensic psychiatrist must seek the psychological and sociocultural truth about the subject and his behavior. This search must be fueled by a profound respect for the subject as person. The important question is how to implement this practically" (p. 181).

A broader view of professionalism, then, considers internal norms of the profession and professional aspirations toward moral ideals. What are the "moral relationships" of our work? Although contrary to current views of forensic roles, we argue for a model of professional role that includes personal or "common morality" of the individual professional and historical or traditional ethics of the core profession. We believe this integrated approach can help clarify complex and morally ambiguous forensic situations. We also think that a better understanding of "narrative perspectives" may allow for a more penetrating look at the meaning of moral relationships in forensic work.

Role dilemmas in forensic psychiatry reveal much about the tension between personal and professional morality. A useful view of professional integrity is offered by Franklin G. Miller and Howard Brody (1995). These ethicists construct a robust view of professional roles by defining personal integrity and then offering a concept 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 this 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 supported within this model.

While personal integrity is tied closely to individual identity, professional integrity and professional identity are more socially determined—shaped by norms and restrictions expressed in society. Both professional integrity and identity are tied to the community—a community that defines expectations and places restrictions on individual expression. Professional integrity, then, grows from the dynamic interplay of personal and professional morality.

But strict views of the forensic role ignore or dispute this. Currently, strict interpretation of the forensic role (strong role morality) elevates the professional's duty to the court over personal values and traditional professional obligations. In fact, the current view of the forensic role would seem to require a careful discrimination between professional and personal values. However, because professional integrity is tied to the community and its values, the community has the right to expect a broader, more traditional physicianly approach from its medical experts.

We believe that the cases of Ms. Rodriguez and Ms. George illustrate a model of forensic work more closely aligned to societal expectations and consistent with a professionalism that incorporates physicianly duties with forensic ones.

Professions also possess an internal set of duties, values, and ideals essential for professional identity and integrity. A profession's intrinsic values and activities 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, and ideals. This historical narrative anchors the profession and helps it resist the vagaries of social and situational forces, especially when these forces influence the professional to behave in ways contrary to the historical values of the profession. In forensic psychiatry, we define this historical narrative to include the duties, values, and ideals which have evolved from both the forensic specialty *and* the medical profession from which the specialty emerged.

Strict views of the forensic role may fail to properly balance the tension between the historical narrative of the profession and the need to offer objective analysis in complex cases such as those of Ms. Rodriguez and Ms. George. Rigid adherence to an objective "expert role" in complex relationships may harm individuals and their loved ones. In adopting a broader, less restrictive view of professional integrity, we could consider

“clinical-like” activities as duties, not simply as failure to reach for moral ideals. Striving to reduce harm and neglect would be integrated into the forensic role when possible.

We see no conflict of interest in situations where duties to both the court and to the client and client’s families can be accomplished. Professional integrity—which integrates both the historical values of the profession and personal values of individual practitioners—would actually require a more strenuous normative standard for forensic work.

In forensic work, we also remind readers that the historical narrative of the specialty, as in any professional activity, is evolving. Differing views of ethics are healthy. Robust debate on ethical questions is good for our profession. As we have discussed, one approach has been to view the forensic practitioner through role theory and social psychology, defining professional activity narrowly as an instrument of society and the court. Evolving views like ours have argued for applying traditional clinical ethics to the dilemmas of forensic work. A broader view of professional role leaves room for ongoing debate.

Less rigid role theory permits greater flexibility in deciding what constitutes a true forensic interaction. We believe that both personal and traditional medical values such as beneficence and non-maleficence should inform the forensic role. It has been difficult to admit such values into the narrow view of forensic expertise, but a view that replaces professional role theory with the concept of professional integrity may allow exactly that. We can then apply this concept of professional integrity to individual cases.

In keeping with our use of aspirational values, we pair the choice of proper professional action with the question of what kind of professionals we wish to become. In forensic work, for many of us, it is not even possible, much less desirable, to detach forensic consultations from our traditional commitments to patients—the traditional ethics of healthcare practice that lend weight to our forensic activity. Our profession helps define us and is deeply connected to the larger community that contains and supports us.

David Luban, in his book *Lawyers and Justice, an Ethical Study*, provides insight into why we must link individual and professional integrity (Luban, 1988). 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” (p. 142).

For healthcare experts, therefore, we advocate a forensic professionalism that never forgets its roots in the professional values and responsibilities of the healthcare tradition.

The Narrative Context

One last element is needed to support our robust view of professionalism: the narrative context. Recall that the concept of narrative entered medicine as biomedical ethics evolved. At first, narrative—along with casuistry, the ethics of care, and virtue theory—was offered as a method and critique of the principle-based approach that dominated healthcare ethics. Proponents of narrative theory argue that the traditional principles of healthcare ethics—respect for autonomy, beneficence, non-maleficence, and justice—fail to steer us through the complex and ambiguous aspects of moral problems in healthcare (Beauchamp & Childress, 1994; MacIntyre, 1984; Nelson, 1997; Pellegrino & Thomasma, 1993; Zaner, 1993). This movement makes more credible our concerns about which specific principles should guide forensic practice.

As we noted in our theoretical review, narrative theory reveals some of the general weaknesses of principlism. Some of these same criticisms apply in forensic work. So it may be necessary to have an ethical theory of practice that is not determined by principles alone. Indeed, as Arras pointed out, ethics was never about principles without narrative. Griffith too has argued that principlism is not sufficient to address the cultural reality of the power differences between dominant and non-dominant groups. As a theory closely allied to the new movements in professional ethics, narrative provides a theory and practice that helps expand the world of principles.

It was Enlightenment scientists who established and pioneered the scientific traditions leading to general medicine, psychiatry, and related scientific fields. These scientists believed in reason and analytic thinking. The scientific method they bequeathed us establishes the “truth” by reducing the objective and knowable world to its building blocks. It supports current claims that forensic professionalism involves the pursuit of objectivity.

However, those who work in forensic practice will recognize the value of the written and verbal work-product and its rhetorical construction. For example, once we have concluded that an individual facing a First Degree murder charge is competent to proceed, we construct a narrative that is persuasive toward our conclusion. Some would argue that this product must be rooted in objectivity and scientific knowledge; but there is a strong and equally legitimate claim that our point of view is shaped by subjective experience—including understanding our own subjective meaning-making activity. This experience also determines what we say or do not say. When forensic experts agree to “tell the truth, the whole truth, and nothing but the truth,” it may be clear that the court is asking that the expert present a “relative truth or

probabilistic truth, assuming a margin of uncertainty” (Gutheil, Hauser, White, Spruiell, & Strasburger, 2003, p. 426).

Narrative theory provides a method of moral reflection that serves the subjective world that is both the subject and object of our assessments. With narrative theory and tools, we can discover and savor complexities and ambiguities that cannot be uncovered through the objective empirical model. Also, principles alone as a moral check on our professionalism fail to provide perspectives that guide us in our subjective experiences. Principles are limited in helping us grasp the subjective world of motives, intentions, emotions, and beliefs. Joining a principled model to narrative theory in a model of professional integrity allows us to see professional duty in myriad new ways. This integration informs the interplay of personal and professional morality, and provides a methodology for examining the larger moral aspects involved in all human dramas, especially forensic ones.

With the waning of psychoanalytic and psychodynamic approaches in forensic assessments, narrative brings concepts and language that can expand our understanding of individual experiences. It can increase our respect for the people we evaluate. A narrative perspective encourages a deeper kind of relationship with our subjects, and a better understanding of those relationships. As Michael White states in *Narrative Means to Therapeutic Ends*, “Persons find meaning in their lives and relationships by storying their experience . . . In interacting with others in the performance of these stories they are active in the shaping of their lives and relationships” (White & Epston, 1990, p. 13).

The individual’s predicament is best described by a humanistic narrative which draws on empathy and compassion. Unlike principles alone, narrative attends to the particulars of cases. It fortifies our moral deliberations by heightening our appreciation of the nuance and subtlety involved in human dilemmas. What is left out of the text can be as important as what is put in.

As ethicist Tod Chambers describes in his book, *The Fiction of Bioethics: Cases as Literary Texts* (Chambers, 1999), narrative is an approach that brings greater intellectual and moral honesty to what we construct and claim as truth. Chambers reminds us that all discourse is “constructed,” a form of rhetoric to support a viewpoint. Objectivity is not possible, it can only be approached. In forensic work, we need to bring our discipline into line with other areas of scholarship that have used narrative methods to reflect on claims of the truth. Chambers writes:

“I hope to provide a model for a self-reflexive [self-reflective] bioethics. A similar self-reflexive posture has been developed in other disciplines. What many of these disciplines have in common is that their data is a literary construction. Consequently, anthropologists, historians, economists and philosophers of science

have argued that attention to the historical, social, and rhetorical constructions of disciplines is a necessary move in academic honesty. Recognizing that the data of one's discipline is a fiction, made up, should not result in abandonment of the discipline but rather a desire for as much rigor as possible in the analysis of that data. Because of that desire, I have turned to the tools of narrative theory; I believe the best way to read the data of bioethics is through the tools of what they are: that is, narrative" (p. 19).

Chambers and other narrative theorists in bioethics show us that in moral deliberation there is far more than principles alone. The descriptions of cases (or the assessments of forensic specialists) are fictions in a sense. We consequently have an important obligation to listen and speak in ways that bring legitimacy to our descriptions. We are duty-bound to remain skeptical of other's stories while at the same time valuing these stories as the data upon which we draw conclusions. In medicine, as in other professions, moral dilemmas arise from the human drama. The narrative approach shows us those elements of language and storytelling that showcase the intricacies of morality. Soon we have a methodology for describing moral-laden situations. We cannot provide guidance for moral and legal dilemmas until we identify and describe the problems we hope to solve.

This is not to say that narrative works alone in describing the ethical landscape. It is the "text" of our descriptions. Justification of right action requires use of principles to represent the ideals of objectivity and generalizability in reaching reasoned ends. Principles still work at the theoretical level to create a framework for right action, to move toward normative standards. Narrative works to loosen our grasp on certainty, keeping us honest in our work.

In the cases of Ms. Rodriguez and Ms. George, the two experts could not answer the question of right action by simply turning to current ethical guidance in forensic work. Only by recognizing that they had been drawn into a complex moral narrative, could the two psychiatrists fully grasp their situation. They could recognize further duties. They could hear the language of human suffering expressed by the clients and their families. Savoring the moral ambiguity in the intentions and motives of the people involved, they struggled with the tension between therapeutic engagement and expert detachment. They embraced the human responsibility to witness, affirm, and validate the insights and life-history of all involved.

Psychiatrist Bradley Lewis specifically discusses the problem of a psychiatry that continues to behave as a modernist project with the goals and beliefs of the Enlightenment (Lewis, 2000). Lewis argues that psychiatrists and patients would be better served if the theories, knowledge, and

values of the *post*-modern perspective were embraced. He envisions a post-modern psychiatry which transforms our current quest for objective truth. Professionals join their patients struggle in the search for what is most beneficial. Finding meaning is elevated to a status equal to that of problem-solving and diagnosing. Faith in categories and methods is challenged by post-modern skepticism toward grand truths. Humility and tolerance of uncertainty are accepted in the patient-professional relationship. The goal-directed activities of progress and improvement are modified by the values of struggle and compromise. Personal responsibility is encouraged.

We do not suggest that the forensic specialties compromise their duty to justice and the legal system. But we do believe that they must remain mindful of their foundations in the core professions. To remain credible in the courts, experts must embrace new knowledge and understanding in ethical disciplines, including narrative understanding and emerging theories in professional ethics. They must appreciate that the world is not always certain about grand truths and proclamations.

Most of us in medicine know that our diagnostic certainty is an approximation, a partial description of the complex human person under our scrutiny. As Bernard Diamond wrote over forty years ago in “The Fallacy of the Impartial Expert,” the adversarial nature of legal proceedings almost always results in the expert becoming an advocate. “His testimony does in fact support one side of the legal battle . . . if he is at all human, (he) must necessarily identify himself with his own opinion, and subjectively desire that ‘his side’ win” (Diamond, 1959).

We raise the expectations for our specialty by defining professional duties as not only serving the ends of justice, but also obliging us to join with our evaluatees and their families. This allows sensitivity to the problems of the judicial system itself, and to the subjective influences that affect experts in the conduct of their difficult work. Humbly accepting the setbacks of subjective experience through dialogue with our evaluatees and a willingness to consider reasonable acts of service may bring together our forensic and professional duties, forging a more dynamic, effective, and compassionate specialty.

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Section III

Applying Theory to Practice

6

Ethical Reasoning for the Courtroom Expert

Next we consider how to integrate principled and narrative approaches into the courtroom itself. The specific process of ethical reasoning is not taught widely in university science courses or law schools, leaving experts and attorneys at a loss when analyzing testimony. Getting to what is “right,” or to what one “ought” to testify, is the principal question we address here. It is not enough to know the historical or theoretical landscape. We must also apply it in a coherent manner.

In the sections that follow we place the names or terms related to specific arguments in boldface type.

Justification

We have already hinted at the chief elements of ethical reasoning. In our treatment of Kipnis, for example, we noted the importance of justification in making proper arguments. Indeed, this is the starting point of any robust argument. Justification is the grounding of reasons in theories or thought frameworks which have been recognized and tested. It is the process that makes an argument legitimate.

Theories used to ground an argument cannot be flimsy in their philosophical or scientific foundation. Thus in explaining criminal behavior, we advocate for testable hypotheses backed by empirical testing rather than unique phenomena. In court we might have to say, “The evaluatee responded in a manner consistent with the behavior of those who suffer from a thought disorder. He is not possessed by the ghost of his grandmother.” Experts can justify an explanation based on psychotic behavior from an extensive peer-reviewed literature that tests specific theories of illness and diagnosis. They cannot do the same for paranormal phenomena.

Specification

But basing an argument in accepted theory or principles is just a starting point. Applying the theory in a manner acceptable to science and the law requires consistency and coherence. We need some recognized pattern of application to bridge the gap from theory to cases, and indeed we have one. It is called specification.

Specification takes the theory and makes it *specific* to the case at hand. If experts base an argument on the principles of physics that describe patterns of blood spatter, they must then apply those principles to the case being discussed. In the case being analyzed, physics principles apply in a specific way, supported by specific evidence from the case.

Balancing

Before experts can apply our theoretical view to specific arguments, they will need one more guide. Enriching principles with narrative at the case level will require some rules for specification. We have been using a balancing approach in the manner of philosophers John Rawls and James Childress (Childress, 1997; Rawls, 1971). It is an approach we draw from our discussion of Rawls's reflective equilibrium and the *Principles of Biomedical Ethics*.

The simplest form of balancing weighs the harms and benefits arising from one approach (e.g., pure principlism) against those from another (e.g., pure narrative). Pure narrative, for example, might allow one's personal life-story to justify any behavior rooted in an established cultural, familial, or religious framework (recall Arras's criticism of this approach). Pure principlism might permit few behaviors outside the accepted rules of the dominant group within a society.

James Childress selects balancing, as we do, from a broad choice of models. Invoking Henry S. Richardson's (1990) classic connections between principle-based thinking and cases—what he calls application, balancing, and specification—Childress is among many who favor balancing (e.g., like Hundert, 1990). In order to avoid a simple appeal to intuition in deciding *how* to balance conflicting values, Childress uses a number of rules that can help anyone using this approach.

1. Infringing one principle or rule requires a realistic prospect of realizing the moral objective;
2. The infringement must be necessary to the resolution;

3. The infringement should be the least possible; and
4. The actor must minimize the negative effects of the infringement.

We can justify infringements on principles of autonomy, for example, by arguments for social welfare, leading to the accepted government regulation of public safety and commerce. Societal infringements on personal freedoms may be limited in order to assure communal peace. Advantages of wealth and power may be limited by taxation or oversight. These are all examples of balancing.

But the overall process of justifying, specifying, and balancing should not be rigid. The process requires testing and revision (Beauchamp & Childress, 2001; McCarthy, 2003). The traffic between theory and cases (Rawls's reflective equilibrium) is dynamic. Its purpose is to minimize violence to cherished principles and to achieve the most complete and coherent argument consistent with the case.

The Arguments Themselves

We turn next to specific arguments that arise in the legal setting, critiquing arguments that appear in a well-known and heated exchange in the literature. It is an argument over clinical assessments for competence to be executed, one of the elements of American law.

American (and English) law forbids us to execute anyone who is unaware or unable to understand the punishment. The debate draws on some of the finest intellects in medicine and law, pitting them against each other on a topic closely related to society's broader argument over capital punishment.

We will point out both strong and weak arguments wherever we can. We will underscore models of robust reasoning. We emphasize where narrative can enhance principlist theory, and point out where Childress's rules can help us weigh ethical options. We intend not only to put our theoretical arguments in play, but also to help others recognize commonly used arguments. As we have suggested, it is justifying and specifying one's arguments that carries the day in court.

It is always provocative to analyze death penalty debates; so we note in advance that we oppose capital punishment. Though we disagree with elements of the discussion below, we honor those who write in opposition to the death penalty. We offer our analysis as a thought exercise that must also transcend the emotion that attends the debate on capital punishment. This is an added challenge for the reader as well.

*Forum—Psychiatrists and the Death Penalty:
Some Ethical Dilemmas*

A Crisis in the Ethical and Moral Behavior of Psychiatrists

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A critical controversy is occurring in the United States in regard to physician participation in legal execution that has worldwide implications for ethics and morality in medicine [1]. It is disconcerting that efforts are being made in the USA to permit psychiatrists to participate in legal executions. This is surprising as many national and international organizations have passed resolutions prohibiting such participation. In particular, it should be noted that at the World Psychiatric Association Congress in Madrid, in August 1996, the General Assembly unanimously passed the Declaration of Madrid that included the statement: ‘Under no circumstances should psychiatrists participate in legally authorized executions nor participate in assessments of competence to be executed’.

Many of the arguments of those who propose to make it ethically permissible for psychiatrists to participate in legal executions are troublesome if not fallacious. For example, they confuse the propriety of a physician’s testimony regarding a defendant’s competence to stand trial, that is a defendant who has not yet been found guilty, let alone sentenced, with the ethically impermissible testimony regarding the competence of a condemned prisoner to be executed. The question of competence to be executed arises only after a court sentences a person to death and not infrequently after the final decision to execute has been made. It is at this point that the forensic psychiatrist is invited to engage in the ethically prohibited participation in a legally authorized execution. The proximity of this participation and the act of killing casts doctors, metaphorically, as hangmen’s accomplices [2].

Even more troublesome is a proposal for ‘forensic psychiatry exceptionalism’ that should dismay psychiatrists internationally. This notion asserts that a forensic psychiatrist is not a psychiatrist when performing evaluations for a court and thus not bound by the ethical principles formulated by various psychiatric societies. To obfuscate the departure from psychiatric ethics, the forensic psychiatrist is referred to as an ‘advocate of justice’ or an assistant in ‘the administration of justice’, or

simply as 'an agent of the state'. A leading proponent of this belief stated, 'forensic psychiatrists, however, work in a different ethical framework, one built around the legitimate needs of the justice system' [3] and has suggested calling a forensic psychiatrist a 'forensicist'. This is a dangerous notion that opens the door to any sort of behavior by a physician participating in executions, torture or managed care administration by declaring in this role 'I am not committed to traditional medical ethics'. This notion has had its application in the state of Illinois, USA, where legislation permits physicians to participate in executions, including injection of lethal substances, without losing their license, because in that role they are not acting as physicians and are not subject to the ethical constraints of physicians.

Equally perturbing is the issue of psychiatric treatment that restores competence to be executed. The prohibition against this sort of treatment has been weakened by permitting interventions in the case of 'extreme suffering' without adequately defining suffering; thus relief of suffering could be facilely invoked by psychiatrists or prison physicians to effectuate the restoration of competence and facilitate execution. In 1992 the Royal College of Psychiatrists published guidelines for the situation where the necessity of intervention and treatment are compelling in which it was stated 'on no account should the psychiatrist agree to state, after treatment that the person is fit for execution'. In the state of Maryland, USA, the sentence of a seriously mentally ill death-row inmate who requires treatment is commuted to life imprisonment without parole. This is a wise procedure that should be made universal.

Psychiatrists today are indeed torn between traditional ethical principles and strong pressures from society, particularly certain segments of the legal profession, to make compromises and become collaborators in the demands of the law. Rather than look for compromises, one must adhere to traditional concepts. Psychiatrists and other physicians must join in the struggle to uphold ethical and moral principles or they will in time reap a whirlwind of public condemnation. When confronted with major changes in the ethical guidelines promulgated by the American Medical Association, the American Psychiatric Association Board of Trustees in July 1995 deferred action in order to have the components of the American Psychiatric Association enter into discussion and hold a debate on the subject in San Diego in May 1997. So far, the issue remains unresolved. We are gratified that further American Psychiatric Association review is under way, and the Council on Ethical and Judicial Affairs of the American Medical Association has been requested by its House of Delegates to reconsider its position in regard to the issue of psychiatrists' participation in legally authorized executions.

While some may wish to redefine themselves as ‘agents of the state’, such rationalizations constitute complicity in immoral and unethical behavior.

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Commentary: Logical and Ethical Distance

Authors Freedman and Halpern begin this section by defining the problem—a critical first step in any argument. Good debaters, like courtroom experts, define their terms in a manner that is most conducive to their line of argumentation. In essence they begin to build their narrative. Here the authors invoke world opinion as expressed by international organizations to state their premise: psychiatrists should play no part in legally authorized executions or in assessments of competence to be executed.

The stage is set. Pressure from a world body brings to bear the weight of international opinion, as well as that of an important professional organization. It is an **argument from authority**: a respected, august group has an opinion that carries weight simply by virtue of who they are. The argument from authority is also the justification for having experts in the courtroom. Authorities in their field testify about their opinions. It is not a sufficient argument, of course, because the methodology or reasoning is not always robust or transparent, hence the interest in more formal standards for testimony (from the Federal Rules of Evidence to precedent-setting case law like *Daubert v. Merrell Dow*—see below). But it is a solid starting point for building an argument.

Subtly, a professional ethic (that of the World Psychiatric Association) is set above societal concerns. This is relevant because some in this forum will argue *for* clinical opinion to inform the administration of physical punishment. Moreover, participation in an execution itself and participation in an execution competence assessment have been conflated so that there is no **logical and ethical distance** between them. They are described as part of the same problem.

In the struggle between society's ethic and that of a profession, the former often trumps the latter. After all, professions cannot prosper without a stable society. To avoid forcing readers to choose where their duty lies, to profession or to society, the authors subtly elevate professional ethics at the outset. There is a diminished sense of interplay between the two.

The narrative of the medical profession could have been useful here. Medicine has historically held a special place in society, from the exalted status of ancient religious healers and shamans to the current socioeconomic standing of physicians. It is generally an elite privilege to treat a patient—especially to perform an invasive procedure like an injection. It is a privilege grounded in treatment and social context.

Given this social contract, could society justify a small number of physicians injecting for a purpose like execution? This may well require a shift in the professional narrative and affect the status of the profession as a result.

The argument next coins the phrase, “forensic exceptionalism,” to introduce and encapsulate the argument that follows. To summarize an opposing argument so sharply is to undermine it, to reduce it to a catch-phrase or sound-bite. In this instance “exceptionalism” refers to the clinician acting out of role (i.e., as an exception to clinical work) when serving the judicial system. It is a view offered by various prominent figures in our discussion. The danger of “exceptionalism” is that working in a non-clinical ethics framework “opens the door to any sort of behavior . . .” by abandoning traditional medical ethics. It is an argument that rejects strong role distinctions.

This argument can be classified as a **slippery slope argument**. This is a criticism of positions that lead one to slip unavoidably down a permissive slope toward unacceptable outcomes like torture and execution. The role separation itself portends an inexorable moral descent.

The importance in recognizing this form of reasoning lies in recognizing its weakness. As many teachers in ethics and philosophy have noted, the slippery slope argument asks us to avoid certain choices uphill only because it is hard to make moral choices further down the slope. It asks us to suspend moral judgment as if we will soon lose the capacity to make moral distinctions in the future. The slippery slope argument is speculative, disdainful of future moral analysis, and dismissive of moral shading. Certain slope arguments supported by historical data demonstrating a rising frequency of unjust outcomes carry more force, but it is more often a weak form of reasoning.

The slippery slope approach is echoed in the argument against treating prisoners to restore competence to be executed. The permissibility of treating “extreme suffering” on death row may devolve into a facile intervention meant only to restore enough competence to make the prisoner

eligible for execution. Here a balancing approach might consider arguments introducing life-long prison psychosis into the moral equation. Allowing extreme suffering in the form of life-long psychosis may well offend traditional medical ethics. Perhaps it is of comparable horror to execution.

Intent also makes a difference here, much as in classic **double-effect arguments**. Double-effect arguments are often used when a clinician's effort to alleviate suffering may cause death as a result (e.g., at the end of life large doses of narcotics alleviate pain but depress breathing). In simple terms, an action has two effects, only one of which is intended or fully acknowledged. Readers must judge here whether this comparison is specific to the execution argument. If the second consequence is the inevitable result of the first, it may still be wrong to claim that the first is the only intended action. Here, is the intent to treat pain (to the point of death) as justifiable as the intent to alleviate psychotic suffering (to the point of permitting execution)?

We also find intent in exploring narrative thinking. As the principle of double effect comes into play, narrative can enrich the discourse by exploring the intent of the moral actors. Are the expert's motives disinterested and well-informed—or biased and pre-ordained? Have the inmate's wishes been carefully assessed and honorably represented? Is there a place for consideration of the crime victim's narrative?

If legitimate judicial process results in execution, readers must also judge whether or not an individual professional can ethically seek to impede the result, particularly if one subscribes to strict role theory. Is it *this* individual's role to impede execution—or to treat suffering? One may not be the same as the other, even though the two may lie in close proximity. Readers may look here for arguments about the logical and ethical distance between the two actions, gauging their intent, process, value, and historical narrative. This analysis is about more than simply outcome.

Logical and ethical distance is critical in courtroom reasoning. Inference, and hence distance, between cause and effect plays a crucial role because experts are rarely eyewitnesses; they must reconstruct events after the fact.

Case: The British Nanny; Logical and Ethical Distance in Court

In the explosive case of British nanny Louise Woodward, attorneys on both sides used experts with a broad range of expertise in head trauma, neurology, and child abuse. It was critical for defense experts to show that the traumatic injuries incurred by the child Matthew Eappen could have occurred well before the day of his death. Such a finding could exculpate Louise Woodward, who had handled Matthew both during a bath and again in a reported attempt to arouse him (courttv.com, 2001).

One expert in head trauma had written that the discovery of retinal hemorrhages, often found in babies shaken violently, left little doubt about “malicious intent.” The expert coolly inferred a non-accidental injury from the pathologic findings. She had identified physical findings and then taken the additional step of ascribing malicious intent to their origins.

But in later testimony she opined that the hemorrhages were caused by increased intracranial pressure rather than shaking. The expert withdrew her prior assessment, conceding under cross-examination that she should not have implied that someone had *purposely* caused the damage. Her inferences had taken her too far afield. She had gone from objective physical findings (i.e., retinal hemorrhages) to a likely cause (i.e., shaking to harm vs. shaking to arouse) to the state of mind of the perpetrator (i.e., malicious intent). The logical and ethical distance between the objective findings and the presumed intent had been too great.

If there were any doubt about the weakness of this analysis, it was put to rest by the testimony of an expert who made the distinctions ignored by his colleague. The second expert testified, accurately in our view, that the physical findings of “shaken baby syndrome” are “consistent with” but not necessarily “diagnostic of” child abuse. This is because the causes can be either intentional or accidental. His analysis recognized the distance between physical evidence, potential causes, and the intent of the agent causing the injury.

For courtroom experts this discussion intersects the related principle of **parsimony**. Also known loosely as **Occam’s razor**, after the 14th-century English logician William of Occam (also spelled “Ockham” or “Ockhem”), this eponym reminds analysts not to ascribe more causes to an event than absolutely necessary. Specifically, given two equally predictive theories, choose the simpler one. Diagnosis in both clinical and forensic medicine, for example, requires the simplest, most conservative reasoning. Rather than diagnose a patient with every possible diagnosis that could cause observed symptoms, experts choose the fewest diagnoses most likely to explain them all. This is parsimony at its best.

The authors in the Forum debate have made an overt appeal to traditional professional ethics. At a time of strong societal pressure to change medicine, the authors resist any reform of traditional concepts of patient care. And yet they have a difficult task, for society has already accepted compromise in the use of clinicians in the correctional system, in the military, in the workplace, and in the insurance industry (i.e., for disability assessments). Clinicians in all of these dual roles owe allegiance to two

or more institutions. They work within weak role theory. Therefore a different balance, a compromise, of ethical principles already exists.

James Childress's rules can be useful here—each moral agent decides which ethic takes precedence, which incursion does least violence to another principle, and which strategy minimizes negative effects. Although we disagree with elements of the argument here, our view accepts that the moral analysis must weigh in the balance medicine's historical narrative, weak role theory, and the narrative of the actors in the drama (the evaluatee and the expert).

The authors conclude by accusing those who define themselves as agents of the state of outright complicity with immoral behavior. This **characterization** is a rhetorical device which, however unjustified it may be, carries great force. Out-and-out characterization packs an emotional punch when it comes at the end of a logical build-up.

Nonetheless, many readers will disagree, as we do, that dual agents are by definition engaging in immoral behavior.

Forum (cont.)

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In 1975 a working group from the Regional Office for Europe of the WHO met in Siena, Italy. The subject for discussion was forensic psychiatry. The discussion inevitably embraced ethical matters. One of the important conclusions from the meeting was that “general medical ethics applied to forensic psychiatry in exactly the same way as they apply to other parts of the medical profession, and, in particular, a forensic psychiatrist should see his first duty as to his patient, and should not operate as a part of the state control systems”.

Contemporaneously there were persistent allegations that political dissidents in the Soviet Union were locked up as mentally abnormal and were “treated” with psychotropic drugs in order to change their opinions [1, 2].

The Soviet Union was forced to resign from the World Psychiatric Association for a few years because of this pressure. Eventually the Soviet government allowed western observers to inspect their hospitals. The United States sent an official delegation in 1989. A further visit was conducted in 1991 on behalf of the World Psychiatric Association. This team was chaired by James Birley from the UK and included Loren Roth, the medical leader of the previous US delegation.

Different concerns have led to pressure on the Japanese government [3,4]. From 1968, reports of violence to patients, including patient deaths,

began to emerge. In 1984 the director of a Japanese hospital was sent to prison for putting profits before patient care. Totsuka and his group campaigned via the United Nations Commission on Human Rights and in 1988 a new Mental Health Act became law in Japan.

In such ethical matters, many of us look to the United States for support and for leadership. The United States has a remarkable written constitution (the oldest in the world) based on liberal principles and is genuinely democratic. In this context it is difficult for European people, who have (with the notable exception of some countries of the old USSR) effectively given up the death penalty, to understand why a civilized nation indulges in the ritualized cold-blooded killing of individuals it has cast out from its midst. It is harder still for European doctors to understand a contemporary debate about the involvement of the medical profession in such a process. It is widely assumed that, should the worst happen and capital punishment were reintroduced into western European countries, the medical profession would set its face against such a political catastrophe and not partake in it. Surely, the public would expect nothing less from the medical profession. The public knows that doctors are bound by the ethics of their profession to comfort, to try to preserve life, and to never harm anyone. The privileges, the responsibilities, the status of medical practice, come from a clear understanding that this is what doctors are like, and that if individuals lapse from these high standards they will be, in one way or another, disciplined within their own profession or may be ejected from it.

From the eastern shore of the Atlantic Ocean, therefore, the debate which has been going on for some time in the United States and which is so well encapsulated in the Freedman and Halpern article, seems almost incomprehensible. It is difficult to get all the nuances of this debate from afar, and even visits to the United States do not completely clarify the matter as this is essentially an internal American grief. To some extent, non-Americans feel like helpless bystanders hoping that Uncle Sam, or at least Uncle Sam's doctor, will soon come to his senses so that he can join, once again, with the rest of the medical profession in the world to try to defeat the distortions of medicine which can so easily occur when it is hijacked for nefarious purposes.

News is emerging that suggests doctors in China are active as executioners [5]. It has been reported that one doctor is experimenting with various cocktails, such as a veterinarian would use to put down a pet dog, to find alternatives to the firing squad provided, of course, they do not interfere with the sale of the offender's organs to Hong Kong for transplantation!

The world medical fraternity needs to stand shoulder to shoulder to speak out against such misuse of medical science and the misuse of

medical practitioners. Yet, any kind of world protest against China would probably be ineffective and useless without the weight and influence of the medical profession from the United States. US doctors cannot wholeheartedly and properly join in with such a campaign while they are themselves giving approval to their own members who collude with executions and whilst they try to find ways to redefine the medical practitioner as a non-medical practitioner or “forensicist” (an agent of the criminal justice system) when he or she is involved with legal processes.

It is time to restate the 1975 Siena principles [6] and to have these endorsed worldwide. Not just in the interests of patients (although that is paramount), but also in the interests of the medical profession. A profession which strays from the high ideals expected of it will, ultimately, not be tolerated by its paymaster, the public.

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Commentary: Absolutism

This next section recalls a number of rhetorical strategies of the first section. The pressure of world opinion (in the form of the World Health Organization) begins the piece, and restates the absolutist position that forensic psychiatrists should never operate as part of state control systems. The dangers of such participation are stark and have been widely seen in abuse cases from the Soviet Union, China, and Japan.

There is real risk in taking absolute positions. Arguments that do not allow nuance cannot adapt to specific cases. Cases at the margins are important because, as we have seen, the entire school of **casuistry** functions by presenting case-examples. Recall that casuistry tends to argue

the merits of specific cases as conditions drift toward the unacceptable. But as we have seen, many cases require clinicians to act as agents of social control.

The author hopes in this section that stark examples of institutionalized abuse will underscore the danger of even starting down the path. It is, indeed, he implies, a slippery slope.

The next appeal is to principle. The United States, despite its noble constitutional and democratic roots, is described as an outlier among civilized nations; one whose use of capital punishment Europeans cannot fathom because it violates liberal democratic principles. Although the author presumes to speak for an entire continent, the approach is understandable in this context. Although substantial minorities may still support it, no other liberal democracy uses capital punishment. Readers will not be looking for chapter and verse in an established debate of this kind. They may change their minds, however, if such generalities persist.

But medicine's role in capital punishment is less settled, given the medical nature of executions, of death pronouncements, and of the importance of medical judgments of pain and suffering.

It may help the reader to review a range of arguments within the topic. If, for example, medicine were to abandon the field to those without clinical sensibilities, it might result in a starker outcome. This argument cannot be easily dismissed (see, for example, Boehnlein, 1990; Foot, Parker, Arnold, Bosk, & Sparr, 1995). Moreover, Griffith has emphasized that one cannot do forensic work without recognizing the values one brings from personal, family, and cultural sources (Griffith, 2005). Barring medical experts from competence assessments robs the system of those most likely to be informed by ethical clinical values. Again, this is where the absolutist position is at its weakest.

We must also recognize how professional and community values interact. Even if capital punishment were re-introduced in Europe, the author argues, the medical profession and the public would not cooperate. The public expects doctors to comfort, care, protect, and avoid harm. This important societal expectation recognizes the interplay of social and professional values. It may not be realistic here, however, since the public can have a capricious or uninformed change-of-heart (i.e., by favoring execution after a high-profile case). Moreover, the author offers no culture-specific reason that physicians in a death-penalty Europe would behave differently than they have in the United States.

What is missing is an acknowledgment of the common requirements of forensic examination: experts must describe their function when they step into the forensic evaluation. They are not the evaluatee's doctors. As the guidelines of the professional organizations underscore, experts must

describe their purpose clearly to evaluatees and their representatives to avoid abusing their role. Organizational ethics, codes, and sanctions all protect against abuse by forensic professionals. The public's understanding of this need not be under-estimated.

The tenor remains perfectly rigid: the community cannot condemn abuses without being rid of forensic roles entirely. There is no gray area: in China, we hear physicians are active as executioners; therefore, the world must stand against abuse of medical science.

Clearly, the focus of the argument has changed. The writer's stand against misuse has become a stand against *any* role of medicine in social control. But participating in an abuse of medicine is not the same as taking on a forensic role, and the shift implicitly recognizes this.

Forum (cont.)

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I agree fully with Freedman and Halpern and the World Psychiatric Association 1996 Declaration of Madrid that stated "under no circumstances should psychiatrists participate in legally authorized executions nor participate in assessments of competence to be executed." This position has been argued well, and in far greater detail, by Bloche [1].

The central issue, I think, is that of participation in execution. To participate too directly in execution creates legitimate exceptions to some medical procedures that are otherwise ethical. To treat psychosis, for instance, is generally ethical, but to treat a prisoner's psychosis so that he or she can be executed is unethical; so is final evaluation of competence to be executed unethical. In countries that allow capital punishment, such as the United States, such evaluation nearly always occurs after much other psychiatric and legal work has been done, and after a prisoner has been sentenced; thus it is, in time and effect, too directly a part of execution to be ethical for a profession that should protect its therapeutic and compassionate aims and its over-riding value of helping and not harming individuals.

Some see the debate on banning final psychiatric evaluation of competence to be executed as a covert debate on capital punishment. Not so. Opposing capital punishment is relevant, but one can be against physician participation in executions whether one favors capital punishment or not. Some see banning such evaluation as likely to embody or lead to less psychiatric care. Again, not so. I think it would probably lead to better, clearer, and more care.

I find the issue of forensic psychiatrist exceptionalism both troublesome and interesting. Appelbaum and others claim that "the forensic psychiatrist

in truth does not act as a physician.” Appelbaum more or less creates a more or less ethic of “truth” and “the legitimate needs of the justice system.” Such roles and values clash with ordinary medical ethics, and do and will harm medicine.

I have suggested that if any psychiatrist does carry out evaluations of competence to be executed, he or she should be required to wear a police uniform while doing so to make his or her dominant role clear, not just to the psychiatrist but even to a multiply stressed and often less than clear-headed late-stage prisoner.

When the American Psychiatric Association Board of Trustees yielded to its forensic psychiatrists in 1994 and, after too little debate, changed its position and allowed participation in evaluation of competence to be executed, the Board was not adequately aware that in forensic psychiatry (as in other subspecialty groups such as managed-care-company-executive psychiatrists) the expert subgroup will often have vested interests and values and wishes at odds with the values of the larger whole of psychiatry or medicine.

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Commentary: Arguments of Distance, Assertion, and Incompleteness

The previous section focuses on the concept of logical and ethical distance. The author asserts that treating psychosis in too close proximity to execution is not only unethical but tantamount to assisting the execution.

One might begin a critique of this argument by recognizing **argument by assertion**. Asserting a moral conclusion is a far cry from justifying it, and no underlying argument (a related sequence of statements leading to a proposition) is available here. Whether or not treatment on death row is “too directly” part of execution itself awaits resolution of the intent and moral nature questions we discussed earlier. Is the intent to treat suffering the same as the intent to execute, and is there a moral difference between treating someone on death row and preparing a prisoner for execution? Readers may wish to know why the two are the same for this author. Are there ever legitimate reasons to treat such inmates? What is the meaning of “too direct”? Does it countenance committing the prisoner to a life-term

without treatment? The narrative of the prisoner and the evaluator may be useful here in attaching meaning and perspective to these questions.

The author next critiques the Appelbaum theory that elevates the needs of the judicial system above medical ethics. There is a rich point to be made here: for example, can government elevate certain notions of justice above others? Are certain minority views acceptable? May a government adhere to a single view of justice—one that supports the death penalty—or must it recognize alternatives? How much respect is owed to other community narratives of justice? It is a point underscored in the United States by allowing states to decide whether or not to put prisoners to death.

But this point is never fully developed. In fact, American justice *has* elevated certain principles above others. Often described as imperfect procedural justice, it is a system that values above all else the process and rules of evidence. Conceding the difficulty of achieving absolute truth, our legal system relies on strict rule-making instead. We resolve different views of truth by adversarial procedure. Moreover, if the system is as just as may be expected, perhaps citizens have a primary duty to maintain the system (Rawls, 1971; esp. at pp. 85–86). Ethicist Mark Yarborough has argued provocatively in support of the belief that “the entire legal proceeding, once completed, will provide enough good evidence to allow . . . a good decision” (Yarborough, 1997).

Our sense is not that Appelbaum creates an abstract ethics of truth (by favoring legal values), but one that values the social fabric above the values of the professions. We ourselves criticized this approach in Sections I and II. Nonetheless, although there *is* potential harm to the public’s view of the helping professions it may be legitimately balanced against the profession’s capacity to ably assist the judicial system.

Childress’s rules can generate some helpful questions here: is competence assessment on death row an acceptable incursion into medical principles or does the contribution to judicial process come at too great a cost? From the narrative perspective, is competence assessment an acceptable part of the medical profession’s narrative or does it do violence to its origins? A balancing approach may yield a better developed, more complete answer.

Readers may say that the author’s argument leaves crucial questions unanswered. It is incomplete. If physicians do not conduct competence assessments before execution, will a special breed of non-clinical assessor step in? Will those who remain be the clinicians who favor the death penalty? The proffered argument leaves an important hole in its development: what will happen to assessments after physicians withdraw? Will there still be protection of vulnerable social values? The importance of finding some inmates incompetent to be executed is not considered.

The elephant in the room remains the immorality of capital punishment, as is made clear in the objections of the author. He doth protest too much, as Hamlet might say, insisting that barring competence-to-be-executed assessments is not a judgment on the death penalty. It is relevant, he says, but not determinative. He does not explain why, again leaving the analysis incomplete.

What is missing is the observation that competence is required before the American system will allow an inmate to be executed. This ethical standard, however low, forbids society from executing criminals who do not understand what is happening to them. The intervention of competence assessment is required to prevent a greater wrong: execution of an uncomprehending prisoner. But for this author the connection is now “too direct.”

One can argue against the death penalty, but for a death penalty opponent to oppose one of the safeguards against execution is counter-intuitive. The author is trying to make capital punishment even less just in order to undermine it.

The author has used a form of **begging the question** (i.e., restating the question as if it is answered): he re-states or re-formulates the close proximity of the two events (a requirement of law) as proof that they are unethical. The manipulation here suggests once again that this argument is truly aimed at the death penalty.

His is an argument that can only come from a singular view of medical ethics, one that does not see beyond the duties of physician and patient to each other. Without context or recognition of the sharply different perspectives of community, professionals, and other affected individuals, this view of the profession denudes it of real moral content.

There *is* a compelling mind-picture in this section, one that resonates with all of us who see a place for medical ethics in forensic assessment: the author's requirement that those conducting competence-to-be-executed assessments wear police uniforms. Courtroom experts may search long and hard before arriving at a scenario as compelling as this.

Case: Scott Peterson; Defense Arguments by Assertion

Arguments by assertion frequently find their way into court. In the notorious case of Scott Peterson, the California man convicted of killing his pregnant wife, defense attorneys made several promises in early arguments. They promised to prove that his wife, Laci, had been alive on the day of her disappearance, that she had been abducted by transients, that her child had been born alive (a refutation of prosecution claims), and that both mother and child had been killed by their transient abductors.

Given the circumstantial nature of the case, the defense needed only to raise doubt in the jurors' minds: there was no murder weapon, no witness to the killing, and—at first—no bodies. Mr. Peterson was, however, having an extramarital affair, and had left home in disguise with his brother's identification and carrying thousands of dollars.

Defense assertions were quite specific. The defense said it would implicate neighborhood transients in Laci's kidnapping. Defense attorneys would connect the death to a nearby burglary, and prove that someone other than Mr. Peterson had pawned a piece of Laci Peterson's jewelry.

But the pawnbroker was not called to substantiate the claim. A police officer called for the defense described the local burglars as unlikely murderers. There was no proof that the baby had been born alive, and no one could testify they had seen Laci alive the day of her disappearance.

Overall, journalists and other commentators panned the lack of defense-team follow-through (e.g., Finz & Walsh, 2004; KABC-TV News, 2004). No witnesses had been called as promised, no alternate theory of the crime developed, and early assertions were never substantiated. The defense argument resulted in nothing more than a string of unsupported arguments by assertion. Scott Peterson was convicted and sentenced to death.

Forum (cont.)

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Freedman and Halpern are thoroughly right in their unequivocal criticism of Appelbaum's twin assertions that (1) psychiatrists judging competency for execution are not practicing psychiatry; and that (2) the ethics of medicine as applied to forensic psychiatry should be suited to the needs of the Court. Both assertions are patently illogical, socially deleterious, and utterly corrosive to the integrity of medical ethics.

Psychiatry is not defined by the purposes to which we put it. Competency determinations depend on knowledge and methods developed by, and specific to, psychiatry. The Courts do not have this knowledge. That is why they need psychiatric expertise in the first place. Appelbaum's clumsy euphemism, making the psychiatrist a "forensicist," is a bizarre and transparent distortion of reality to give benediction to an ethically illicit act.

Similarly, the ethics of medicine (and psychiatry as a branch of medicine) is not defined by convenience, the needs of the state or the purposes to which we wish to put medical knowledge. Medical ethics derives from

the universal predicament of human illness, from the vulnerability, dependence and exploitability of those the physician attends. The ends of medicine are healing, helping, comforting and caring: every physician pledges to serve those ends when she or he enters the profession. Being an accomplice in the death of a human being is totally inconsistent with the ends of medicine. No act of law or fiat can change that fact.

Appelbaum's elastic logic invites the usurpation of medical power in the name of politics and ideology, and not primarily in the interest of the patient. Totalitarian states do so with gross abandon; democracies with more discretion. The result, in either case, is to imperil the most vulnerable members of our society.

Physicians must remain the guardians of the moral integrity of the profession and its ethics. Psychiatrists must heed the ethical proscription against assisting in legal executions enunciated by the World Psychiatric Association. In these times, their witness to the integrity of medical ethics is an assurance that some things are not at the disposal of whim, fancy, or political power.

Recommended Reading

1. Pellegrino ED. Guarding the integrity of medical ethics: some lessons from Soviet Russia. *JAMA* 1995; **273**:1622–1623.
2. Pellegrino ED. The Nazi doctors and Nuremberg: some moral lessons revisited. *Ann Intern Med* 1997; **127**:307–308.

Commentary: Is a Profession One Thing or Many?

In the brief, pointed previous section, one of the nation's great scholars takes aim at two elements of "exceptionalism" and fires both barrels. He begins with outright characterization but backs it up with solid argument.

First he takes issue with defining psychiatry by the purposes it is used for. Indeed, clinical science of any kind is never merely the work of a technician. Professions are built of persons with unique expertise grounded in ethical ideals and trust.

Clinical science is also informed, as we have pointed out, by a powerful historical narrative. Psychiatry is not a discipline *of* the courts. It brings its own values to bear. This is a strong argument by any measure.

And yet it is weakened by what follows. In choosing to characterize forensic exceptionalism as a "clumsy euphemism," and calling it a "bizarre and transparent distortion," the author loses the moral high ground. It is an unfortunate resort to a personal attack, sometimes called an *ad hominem*

argument, one aimed “to (or at) the man.” Moreover, the attack attributes a sinister motive to the opposing intellectual construct.

Narrative would be helpful to this writer. With a more judicious view of how the opposing theorist reached his opinion, Pellegrino could legitimately criticize his motivation. Absent this, we are dubious of this approach. It is a classic **argument from motivation**, that is, one that questions the motivation or mind-set of an opponent. Arguments from motivation are not only untestable, but fundamentally flawed, for no one can know fully what someone else is thinking. Attribution of motive becomes particularly ironic in discussions with mental health professionals, who know well the difficulty of determining motivation—even under the scrutiny of intense psychotherapy. Glibly ascribing motivation in others is worse than poor argumentation, it is essentially an intellectual cheap-shot. In this sense, it is akin to the *ad hominem* argument.

Case: An ad hominem Attack on the Expert

In a New Jersey daycare center a young employee was accused of multiple counts of sexual and physical abuse. Direct interview of the children resulted in a bizarre panoply of complaints. The teacher had played piano in the nude; the teacher had cut off little boys’ penises; the teacher had turned one child into a mouse. Expert testimony was used to address the credibility of the children’s testimony, the physical impossibility of many of the accusations, and the improper conduct of the children’s interviews.

Among the appeals was a complaint against the prosecution’s characterization of a defense expert (State of NJ v Michaels, 1993). Defense attorneys called the State’s summation a form of prosecutorial misconduct because “there was an *ad hominem* attack upon the character” of the defense expert. In the exchange below the prosecutor describes the expert as a “witch doctor.”

Q: “Doctor, are you saying that you used subjective experience [to judge] how long it takes someone to get undressed?”

A: “Sure.”

Q: “And, Doctor, the scientist who relies on subjective experience to make an opinion, has regressed to the level of a witch doctor, isn’t it so?”

A: “That’s a totally different thing.”

Q: “Doctor, isn’t that what you wrote in your book, the opinion, “A doctor who bases his opinion on unchecked subjective experience has regressed to the level of a witch doctor?”

A: "That's *unchecked*."

Q: "Yes."

A: "This is not unchecked."

The appellate court rejected the *ad hominem* point of the appeal, finding that the prosecution had indeed shown the defense expert to fit his own definition of a witch doctor.

Dr. Pellegrino's criticism also raises the idea of the **testable hypothesis**. This is an historically important standard for science in general and courtroom testimony in particular. Traceable to the falsification methodology of Karl Popper (trans. 2002), testability offers a standard to assess many of the answers provided by experts and the police: from how someone died to what motivated them. Hypotheses which can be tested have more scientific merit than those which cannot. In forensic work, Popper's standard can also be found in Pollack and Diamond's explorations of contradictory evidence (to test the expert's conclusions), and their transparency in explaining the data which support their views.

In this view, if the explanation is not part of a hypothesis that can be refuted, the theory behind it is not scientific. The manner in which a body decomposes or in which a projectile moves through the air is part of a model that has been observed, tested, and reproduced. Its testability supports widespread reliance.

Psychological arguments are problematic here because courtroom explanations that try to describe motivation are not easily supported by testable data. Indeed, this is an observation found in Popper's classic criticism of Sigmund Freud. All federal courts and many state courts now use the Daubert standard (*Daubert v. Merrell Dow*, 1993) to assess an expert's testimony for its scientific nature, its testing of its own claims, its error rates, its professional acceptability and the like.

Case: The Gypsy Defense; An Untestable Hypothesis for Crime

A New England man raised as a Gypsy was accused of a driveway paving scam. He offered elderly customers a low estimate for a patching job, performed a complete re-paving, and then demanded a higher price than he had originally offered. A psychiatric expert called for the defense testified that the defendant had been reared by gypsies and taught "different rules." Lying and deception had been a cultural "survival strategy,"—therefore the defendant could not reason about consequences in the manner of "average" people (Pfeiffer, 1999; www.praxagora.com, 2004).

This argument is well-known to legal and clinical ethics. In another version of it, ethicist Carl Elliott has openly questioned whether anti-social individuals, those with fixed character traits that render them unable to “understand moral concerns,” are morally blameless for their actions (Elliott, 1996). They *cannot*, rather than will not, comport themselves with the rules of society.

But for such an argument to succeed in our framework it must be based in a proper clinical narrative from the evaluatee *and* a specific scientifically based literature. Never mind that criminals cannot be legitimately defined as a culture. Arguments cannot simply be drawn from common knowledge about motivation or psychological thinking. If there is robust data for such an argument—robust in the way we have defined our unified theory—then it is ethically permissible. But if testimony is built merely on the unique experience of the expert and the narrative of the evaluatee, the argument is weak on its face. The jury in this case was almost certainly correct to reject it.

Pellegrino’s argument continues in more mainstream fashion by describing the ends of medicine as healing and helping. But he later describes forensic work as complicity in the death of a human being. Of course, if the ends of medicine are not always pure healing—as in administrative, correctional, military, or disability assessment—a more nuanced description of role may be needed.

The next point is an intriguing one, because it describes a purely forensic role (distinct from the clinical) as being used for political purposes rather than for the patient’s best interest. A standard political gambit is to ask an opponent to stop playing politics with an important issue. The refrain suggests that the opposing view is selfish and disingenuous. Such an argument cannot be used without support from the opponent’s narrative; otherwise it is again simply speculation about motivation.

Yet if Aristotle is any guide, the business of the city, or *polis*, is all politics. Aristotle’s ancient *polis* was full of such debates. He deemed them necessary for a city-state working toward the happiness of its citizens. Indeed, politics was the *primary* science in the Aristotelian view. In our own day too, values broader than those of the profession must be applied where institutional justice, crime, punishment, and morality are at stake.

The separation of roles is then harshly described as a characteristic of totalitarian states that abuse or even murder their most vulnerable members. The specters of Nazism and Soviet medicine cast a long shadow here. Yet even democratic states struggle, as we do, with the nuances of dual agency. The extreme statement does not appear workable here.

The final appeal is to medicine’s moral integrity, which is threatened in this view by the separation of forensic and clinical roles. And yet the meaning of integrity is richer than the one being offered. We believe we

can integrate pluralistic values into a society's moral fabric. If so, it may be possible—despite their differences—to meld clinical influences into judicial ones. This is the integrity—the integration of values—we strive for in our theory of forensic ethics.

Forum (cont.)

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Freedman and Halpern should be commended for their dogged efforts to focus professional attention on the ethical ambiguity of forensic psychiatry and, more specifically, on the unique ethical dilemmas raised by medical participation in capital cases. Although I do not agree with their position on evaluations of competence of condemned prisoners, I share many of their concerns.

I want to begin by emphasizing that I wholeheartedly agree with Freedman and Halpern about the need for vigilance in maintaining the profession's ethical integrity in the face of political and economic pressures that can undermine public trust in the healing role of the profession. The Nazi experience and the abuses of Soviet psychiatry provide compelling evidence of the dangers to the profession, and to human rights, that arise when the tools of medicine are appropriated to serve the goals of the state. That is why I have joined hands with psychiatrists in the former Soviet Union and other formerly communist nations of central and eastern Europe to help them build the institutional foundations for professional independence, including an autonomous system for promulgating and enforcing ethical norms [1].

I also agree that medical participation in an execution (as by injecting a fatal dose of barbiturates, selecting injection sites, giving technical advice, or monitoring an injection given by someone else) must be unequivocally prohibited. The American Medical Association and the American Psychiatric Association have condemned such conduct and, as far as I know, nobody within the professional community has argued that it is ethically permissible.

It is helpful to identify the ethical principle that underlies the prohibition against medical participation in executions. Clearly, the objection does not simply lie in the fact that the doctor is serving a non-therapeutic role for the legal system: some non-therapeutic roles are ethically acceptable, for example an assessment of disability for the worker's compensation system or an assessment of competence to stand trial for the criminal justice system. (As these observations suggest, the debate about psychiatric

involvement in executions is being carried out in the shadow of a broader controversy concerning the ethical foundations of forensic psychiatry. I will return to this problem below.)

Why, then, is medical participation in executions almost uniformly regarded as unethical? The answer lies not in the logic of therapeutic ethics, but rather in the fundamental idea that serving as an agent of the state's punitive apparatus is not an acceptable social role for a doctor.

Doctors should never use their skills or knowledge for the purpose of facilitating punishment. This principle covers all forms of punishment. For example, some painful punishments, such as isolation in dark cells and whipping, are not categorically prohibited under prevailing international standards of human rights and persist in many parts of the world. Medical assessment of a prisoner's fitness for these punishments and medical monitoring of their administration might be characterized as being beneficial to prisoners because it can prevent injury and suffering more extreme than intended or legally authorized. However, medical assistance in the administration of punishments is nonetheless objectionable because doctors must not align themselves with the punitive aims of the state, either in deciding whether a particular punishment should be carried out or in administering it or directing how it should be administered. So, too, participation in an execution must be categorically forbidden.

Unfortunately, the issue of competence assessment is not so easy to resolve: In some situations, such an assessment would seem to be ethically unacceptable on the same theory I have just outlined. Suppose, for example, that a psychiatrist is assessing the mental status of a condemned prisoner for the sole purpose of telling the warden or director of the prison whether the prisoner is 'fit' to be executed. Such an assessment should be forbidden because it aligns the psychiatrist with the execution, implicating him in the process as if he or she had given the 'ok' for the execution to go ahead. This is similar to the prohibition against a doctor observing a prisoner being whipped and saying whether he is 'fit' to receive any additional lashes.

But consider a different context. Suppose a lawyer representing the condemned prisoner asks a psychiatrist to assess his client's mental state for the purpose of ascertaining whether the mentally disturbed prisoner has the capacity to understand the nature, purpose, and consequences of the impending execution. Suppose further that, if the psychiatrist concludes that the prisoner's competence-related abilities are impaired, a hearing on the issue will be held in court, and that the decision whether to stay the execution will be made by a judge. First, the examination is being requested on behalf of the condemned prisoner to ascertain whether there is a clinical basis for raising a legal barrier to an execution

that would otherwise occur. Second, the psychiatrist is serving as an expert, not a decision maker.

I recognize that it can still be argued, as Freedman and Halpern do, that the psychiatrist's assessment of the condemned prisoner's competence is so intimately connected with the execution itself that it should be forbidden. However, it can also be argued (as I have done elsewhere [2]) that the psychiatric assessment of competence in this situation does not differ in principle from pretrial forensic assessment of a capital defendant's competence to stand trial and that testifying on the prisoner's competence does not differ in principle from testifying in a capital sentence hearing. In all these settings, testimony by the psychiatrist can be used to establish a legally necessary predicate for a capital conviction and a death sentence. If forensic participation in the earlier stages of a capital case is ethical (and, in the United States, psychiatrists routinely participate in capital cases), a properly structured assessment of competence for execution would also seem to be ethically acceptable, as long as the process is invoked on the prisoner's behalf and as long as the ultimate decision maker is a judge. This approach to the issue may not be indisputable, but it has been embraced by the American Psychiatric Association after years of consideration and debate. I fear that Freedman and Halpern have misinterpreted the Association's careful deliberation over a genuinely difficult issue as an unprincipled abdication of the profession's prerogatives to the legal profession.

Specialists in psychiatric ethics also disagree about the conditions, if any, under which it is ethically permissible to treat a condemned prisoner whose deteriorated mental condition may preclude the execution. Some say that a condemned prisoner should never be treated if a possible effect of the treatment is to restore competence and thereby remove a legal barrier to an execution. Others (including myself [3]) argue that such a categorical prohibition is too sweeping. Of course it is unethical to treat a prisoner for the sole purpose of facilitating an execution but, under some circumstances, treatment may be necessary to alleviate a prisoner's torment and suffering. The ethical permissibility of treatment under such circumstances can be demonstrated by imagining (as an heuristic device) that a condemned prisoner, while competent, has executed an advance directive requesting restorative treatment from his own doctor even if one possible consequence of such treatment would be to increase the likelihood of execution. Would it be unethical to treat the prisoner under these circumstances? By asking this question, I do not mean to encourage prisons to seek advance treatment directives from condemned prisoners. I mean only to show that therapeutic ethics may sometimes permit, or even require, treatment of the condemned prisoner. Freedman and Halpern seem to concede the ethical permissibility, in principle, of treatment to alleviate extreme suffering, but they rest their

objection on the possibility that devious prison psychiatrists could invoke this 'vague' exception to justify unethical efforts to facilitate executions. I suppose there is a risk of such abuses, but I think it would be preferable to scrutinize such situations if they arise in practice rather than adopt an admittedly over inclusive ethical prohibition.

Having highlighted an area of continuing disagreement, I want to emphasize two points on which I completely agree with Freedman and Halpern. The issue of treating condemned prisoners puts doctors in an ethical bind. The only sensible way out of the dilemma is for the law to require commutation of the death sentences of prisoners who have been found by a court to be incompetent for execution. Also, even if the possibility of execution remains, the psychiatrist responsible for treatment should play no role whatsoever in the process of competence evaluations; as in other contexts, therapeutic and evaluative roles should be completely separated.

I want to close by emphasizing, once again, that I applaud Freedman and Halpern for their vigorous efforts to generate ethical discussion of these issues. At the same time, however, I must also note my suspicion that many physicians who condemn execution competence evaluations are either morally opposed to the death penalty, or have deep ethical qualms about forensic psychiatry. For the record, I will note my own opposition to capital punishment. In my experience, lawyers, judges, doctors, and anyone else who participates in the administration of the death penalty inevitably become mired in ethical quicksand. Unfortunately, professional efforts to evade the quicksand tend to erode the rights and interests of defendants and condemned prisoners. The death penalty should be abolished, but as long as it remains in force neither psychiatric assessment of condemned prisoners nor treatment of incompetent ones should be categorically forbidden.

As for forensic psychiatry, I think Freedman and Halpern have mischaracterized the terms of the debate about the ethics of forensic psychiatry. Nobody argues that psychiatrists serving forensic roles are not bound by psychiatric ethics. What Appelbaum and others have argued; correctly in my view, is that the ethical principles governing forensic psychiatry cannot be derived from the therapeutic ethic that governs that physician-patient relationship. The challenge is to formulate principles that are designed to govern this particular social role (and so, too, with other social roles) while being rooted in the professional aspirations of medicine, and while forbidding the sorts of abuses that arise when doctors surrender their professional identity and allow themselves to become agents of the state. Freedman and Halpern would serve the profession better by helping to frame the ethic of forensic psychiatry rather than by denying the need to undertake the task.

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Commentary: How to Build an Argument I

This is one of our favorite pieces of reasoning in the forensic literature. Law professor Richard Bonnie builds his analysis on first principles, carefully parses out the ethical issues, and avoids the mistakes of the preceding writers.

Bonnie leads with an important piece of civility: praise for authors Halpern and Freedman in their efforts to address the ethical issues of capital cases. His concern for a profession's integrity in the face of political and social pressure draws on Nazi and Soviet evils in a way that will resonate with readers. Because the frequent rhetorical use of the Nazi experience can cheapen the historical event, we do not generally favor the Nazi comparison. However, its use here is measured and appropriate. The short-hand is suitable because of the well-known history of the Nazi doctors; it serves the purpose of describing the unchecked role of physicians. Moreover, Bonnie is known for describing a model of professional independence for psychiatry in a related totalitarian regime, the Soviet Union. He holds a special place in this debate.

Professor Bonnie continues by agreeing with the overwhelming majority of clinicians, that direct participation in executions is flatly wrong. Moreover, he defines “direct participation” so that he has a concrete starting point. Bonnie defines “participation” as giving an injection or otherwise supervising the act of execution. This is not simply argument by assertion or appeal to authority; it sets the parameters of his argument. The key concept of logical and ethical distance is addressed at the outset. One may disagree with the definition, but there is no danger of drift or ambiguity once the central term is defined.

But rather than simply moving on from this point, he appeals to the principles underlying the debate. Building an **argument from first principles** is an established strategy for clearing the air of posturing and raw emotion. He points out that the guiding principles of forensic work cannot arise simply from the therapeutic background of the evaluators.

Their non-therapeutic work is already accepted, he points out, in society's assessment of disability, Workers' Compensation, and competence to stand trial. The guiding principles must arise from the expert's agency as *part* of a punitive apparatus.

We should note that role theory has trouble satisfying dual agency conditions. Without a richer sense of what it means to be a clinician, the primary problem of dual agency will persist—relying heavily on what others expect of the role. Bonnie recognizes this by using role theory to weave elements of beneficence into the clinical assessments on death-row, both close to and distant from execution.

He draws on **casuistry** (case-based reasoning) to make his case, moving from an impermissible example to one that he believes to be permissible. It cannot be clearer where he stands. He goes further than his predecessors by offering criteria for determining permissibility: the request for assessment is by the prisoner, and the judge serves as decision-maker. Here are specific rules for deciding what is right.

To appreciate the power of this approach recall that the question “who decides” is fundamental in ethical systems. Finding the ultimate decision-making authority (e.g., the patient, the physician, the judge, the legislature) is a useful touchstone in resolving a broad range of ethical dilemmas (Berger & Luckman, 1967; Veatch, 1977).

Case: Reginald Clemons; Casuistry in Court

In April 1991 Reginald Clemons and three acquaintances committed a horrific crime. They attacked two women and their male companion on a Missouri bridge. They raped the women then pushed them off the bridge to their deaths. They forced the male companion to jump as well, but he survived to testify against his attackers.

During the guilt phase of the trial, one of the prosecutors compared Clemons to Charles Manson, using casuistry's approach of a paradigm case to begin his argument (Missouri v Clemons, 1997). But, the judge ruled this inflammatory, saying:

“The prosecutor can't use any analogy involving Charles Manson, or raising any type of a horrible and well-known scenario and get the jurors thinking about it. I'm not saying you're going to compare it, but just get the jurors thinking about it.”

Remarkably, the prosecutor repeated the comparison during the penalty phase of the trial:

“[The fact that Clemons] has no significant history of prior criminal activity, you know, the same can be said of John Wayne Gacy, Charles Manson, the fellow that killed the seven . . .”

After the defense objected, the judge not only sustained the objection, but struck the comment from the record, interrupted the proceedings for a contempt hearing, and fined the prosecutor \$500.

The comparison to Manson and Gacy was significant enough to appear in appeals both to the state supreme court and to the region's federal appeals court. But Clemons's appeals were denied, and he was sentenced to death.

Bonnie does characterize Halpern and Freedman's argument as a misreading of the professional organization's debate, but does so in a fashion that does not resort to *ad hominem* attack and is likely palatable to most readers.

He goes on to use the role theory behind clinical care to gain permission for treating a condemned prisoner. Bonnie uses the example of a prisoner who has written an advance directive specifically requesting such treatment, despite its leading to execution. Here narrative ethics might be useful in embellishing the prisoner's story. Even without it, the case-example makes short shrift of absolutism, underscoring our own criticism above. It does so by creating a clearly acceptable exception to the opposing argument and driving a wedge through the resulting opening. Ultimately, Bonnie uses therapeutic ethics to justify forensic work, a position that seemed untenable to this point.

Bonnie also shows that his argument admits a degree of nuance. He accepts that treating condemned prisoners places clinicians in an ethical bind, offering a solution: commutation of death sentences for those found incompetent to be executed. This is a clear example of the Childress rule for minimizing the negative effects of competing values. The incursion of clinical values into the high-stakes forensic situation is minimized by commuting the evaluatee's sentence. Bonnie also exercises strict role theory here by advising separation of therapeutic and evaluative roles in competence-to-be-executed evaluations. This is an appropriate mainstream solution recognizable from other correctional work.

He ventures into motivational arguments by voicing his suspicion that the argument against competence evaluation is motivated by anti-death penalty animus. But he couches this in terms of his own personal "suspicion." Perhaps he knows the narrative of his colleagues on this topic. Readers already recognize the anti-death penalty motive from prior argumentation. If readers need more to support keeping clinical sensibilities in the arena, it is found in this writer's vast experience of the ethical quagmire of death penalty cases.

Bonnie concludes that the first principles of courtroom work must be different from those of therapeutic work, though he still looks to define

a unique social role. He does move toward the position of this book by advocating principles governing the forensic role that are rooted in medicine's professional aspirations: a challenge we have undertaken throughout.

Forum (cont.)

Dr M Gregg Bloche

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More than any other specialty, psychiatry is enmeshed in conflict between the expectations of patients and society. The role of US psychiatry in the determination and restoration of competence for execution presents this conflict in particularly stark form.

The acrimony that characterizes the international debate over this role reflects the larger failure of medical ethics discourse to address, in realistic fashion, the tension between physicians' obligations to their patients and their societies. To be sure, some criticism of this role stems from opposition to the death penalty. But the animating ideas behind most such criticism are the Hippocratic ethic of undivided loyalty to patients and the classic injunction, *primum non nocere*.

In practice, we routinely depart from these ideals, and traditional medical ethics offers us no guidance when we do so [1]. Society maintains contradictory private and public expectations of medicine [2]. As patients, we expect doctors to keep faith with us in moments of medical need, and we take offense when they fail to do so. Yet as citizens, we condition myriad rights, duties, and opportunities upon people's physical and mental health status, and we thereby ask of medicine that it serve multiple gatekeeping functions. Employment opportunities, eligibility for disability benefits [3], military service obligations [4], criminal responsibility, child custody, access to abortion [5], and ability to make contracts are among the matters that often hinge on medical evaluation and treatment.

Forensic psychiatrists earn their living by trying to meet these latter, public expectations, even when doing so results in harm to the people they attend. Their clinical work on death row, when competence for execution is at stake, poses this contradiction with singular poignancy. But this contradiction suffuses all of forensic practice—and all other exercises of clinical judgment for purposes other than patient care. Thus, the controversy over psychiatric involvement in capital punishment resonates far

beyond death row. In this sense, Freedman and Halpern are on to something important in identifying a “crisis” in the ethics of psychiatry.

Should we, then, condemn as unethical all clinical work that serves the state or society or some other third party at the expense of the well being of individual patients or clinical subjects? In rejecting “compromises” that make physicians into “collaborators in the demands of the law,” Freedman and Halpern suggest this. But to do so would be to demand that the medical profession dismiss society’s expressions of need in this regard. The pervasive import of health status in legitimate decision-making about rights, duties and opportunities renders this absolutist position unrealistic.

What, then, of the claim advanced by some forensic psychiatrists, most recently in connection with capital punishment, that the physician who serves the state and/or the legal system “in truth does not act as a physician” [6] and thus need not worry about the Hippocratic duty to keep faith with patients and avoid doing them harm? The recurring appeal of this claim—and its greatest danger—lies in the escape it offers from discomfort occasioned by tension between state expectations and the Hippocratic tradition. To their credit, European forensic psychiatrists have rejected this claim; preferring instead to acknowledge the moral turbulence this tension creates. US forensic practitioners have also generally eschewed this easy answer in favor of the search for balance between their commitments to the justice system and to patient well-being [7].

By acknowledging both of these commitments, and the tension between them, forensic psychiatrists accept a healthy measure of restraint on their service to the state. A lack of such restraint opens the way for such abuses as the use of psychiatry to suppress dissent in the former USSR and the attendance of physicians at executions by lethal injection in the United States. The proposition that physicians who serve the state do not act as physicians is also at odds with the state’s reasons for calling upon them. Legal systems look to forensic psychiatry when rights or duties turn on mental health status. Clinical evaluations that bear upon rights and duties make use of medical concepts and categories.

To the extent that these exercises of medical judgment result in harm to clinical subjects, they risk undermining society’s expectations about the benevolent use of medical skill. They also violate the expectations of forensic examinees. Even if the psychiatrist clearly says, in advance, that an evaluation will be put to legal use, other, non-cognitive cues confound the examinee’s understanding. His or her belief in medical benevolence is unlikely to disappear after such disclosure; on the contrary, the dynamic of transference in the clinical setting may well encourage it. Indeed, that most crucial of clinical skills—empathic connection with the evaluatee—invites trusting feelings that do not reflect the examiner’s forensic purposes.

Ethically sensitive forensic practitioners are uncomfortably aware of these difficulties. Neither rigid insistence on the wrongfulness of clinical work that causes harm nor categorical refusal to admit the ethical relevance of such harm moves us toward their resolution. The controversy over clinical ethics on death row presents an opportunity for more productive exploration of this larger problem. In this regard, reports that some US forensic psychiatrists, including Appelbaum, tried behind-the-scenes to reverse US organized medicine's opposition to physician assessment of competence for execution [8] are troubling. Their effort briefly prevailed within the American Psychiatric Association. However, objections by many leading US psychiatrists and ethicists, including Freedman, Halpern, and Hartmann, prompted the Association to revisit the question.

The larger challenge before us is to accommodate psychiatrists' conflicting obligations to their patients and their societies in a manner that respects both the social significance of health status and the fragility of physicians' therapeutic credibility. I have argued elsewhere, in some detail, that such an accommodation requires that we bar clinical work on the state's behalf when it too provocatively and dramatically breaks with society's faith in doctors' benevolence [9]. I believe the case against psychiatric involvement in the determination and restoration of competence for execution can best be stated in these terms [10].

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Commentary: When the Argument Takes a Wrong Turn

Next, readers find another careful piece of argumentation. Gregg Bloche defines the problem, as we do, as a direct tension between the expectations of patients and society. Again, readers will notice the power of stating the ethical dilemma at the outset. Bloche calls this a larger failure of medical ethics, acknowledges the acrimony of the debate, and softens the tenor of his own argument.

He, too, invokes role language by focusing on the role of psychiatry in determining and restoring competence for execution. He also draws on first principles by calling on the Hippocratic ethic of **First, do no harm**. We, too, endorse the use of first principles, particularly in this debate but, as we have said earlier, hesitate to use Hippocratic ethics to do so.

Still, it is difficult to argue with modern medicine’s adoption of the principle of non-maleficence, “First, do no harm.” We contend simply that in complex ethical debates, the absolutist Hippocratic version may be too simplistic and flawed in its origins to assist us. The principle of undivided loyalty to patients stands on its own merits, as many modern writers on non-maleficence have made clear. We object only to the justification arising from a partial understanding of Hippocrates’s place in history.

We also have a subtle criticism of **tradition serving as moral warrant**. Whatever the force of history, it is not necessarily determinative of modern ethical dilemmas. We endorse the importance of medicine’s historical narrative in our own theory but imbue it with no ultimate ethical authority. Our balancing approach weighs as many approaches as possible, including the reflective equilibrium, and principles enriched by narrative.

Bloche sees instantly that pure beneficence, no matter what its origins, does not take us far in this debate. Medicine, in his words, serves “multiple gate-keeping functions,” from assessing disability and criminal responsibility to determining child custody. Even reporting requirements in clinical medicine (e.g., abuse, violence) can cause harm. Forensic professionals too must meet these public expectations even when harm may result. This is the core of the “dirty hands” problem; it “suffuses all of forensic work.”

Should readers condemn all forensic work then? Clearly not. He recognizes this as an absolutist—and thus unrealistic—position. He identifies a

critical need for medical assessment in bolstering society's decision-making about basic rights and duties. As such, he agrees that clinical thinking cannot simply abandon the field.

Bloche's disagreement lies with that aspect of forensic theory that suggests the forensic clinician does not act as a clinician. He dislikes an approach to forensic work that abandons beneficence theory completely. He describes the pure forensic role as an escape from an identifiable ethical tension, a powerful point with roots in the intuitionism and self-reflection of clinical ethics. Bloche favors the approach that balances duties to the judicial system and the patient, describing it as accepted in the medical literature. It is an observation supported by Childress's balancing rule and Rawls's reflective equilibrium.

But Bloche goes further in a careful, step-wise progression. He declares that the very tension of his position is a restraint against unfettered allegiance to state goals. He says that it is the lack of restraint from this tension that has undermined psychiatry in totalitarian regimes. He points out, as Pellegrino did, that the legal system routinely calls on the courtroom expert to make use of clinical concepts and categories.

But what of the evaluatee's expectations? In the context of unequal power (i.e., the clinician holds more information, the examination is often in a controlled setting) the evaluatee's expectation of benevolent handling is difficult to overcome. The trust in medical benevolence is primary in society—an observation we found in Alan Stone's arguments earlier in this text. The use of clinical skill and compassionate interview technique resists the forensic warnings at the outset of court evaluations. Being alert to "slippage" in the evaluatee's view of the examiner is a bulwark of the forensic ethic, as the American Academy of Psychiatry and the Law's ethical guidelines make very clear.

Bloche's argument sets a certain threshold for clinical service to the state. It sets a default position in favor of the individual being evaluated, and guides readers through the discussion with care. Bloche does prohibit forensic activities that undermine society's expectations of medicine, but what such activities might be he does not make clear.

He does make this standard clearer in the next section. Indeed, it is surprising at this juncture to find an objection to competence-to-be executed evaluations. After emphasizing the distinction between the evaluation and the execution itself, and identifying the ethical problem as one of general forensic ethics, the argument retreats.

Paradoxically, there is still room for the competence evaluation in his re-statement of the problem: the challenge is one of balancing duties to patients and to society. Bloche's balance respects the importance of health status in social disputes (and hence the need for physician-experts) as well as the therapeutic credibility of the profession. Clearly, the balancing

model still holds, as does the tension between clinical and forensic ethics. But a line has been drawn without sufficient justification.

After some incisive argumentation, this writer has chosen to draw the ethical line at a more abstract point: where forensic work breaks with society's faith in medical benevolence. But after the discussion of balance and tension between roles, a societal expectation standard alone cannot be enough in this debate. Though endorsed by Pellegrino (1993) and by others in their time, it is too vague for a moral choice of this magnitude. Why must the line be drawn at competence evaluations? Having set on a particular path, this argument seems to have taken a wrong turn.

Forum (cont.)

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Is there a crisis in the ethics of US psychiatry? As managed care challenges physicians' traditional fidelity to patients' interests by encouraging them to place their own economic interests first, there may well be. But the notion of Freedman and Halpern that the crisis has been provoked by psychiatrists' evaluations of death row prisoners whose competence has been questioned would surely surprise most psychiatrists in the United States. Some background on the issue will reveal why.

Thirty-eight of the United States' 50 states allow the death penalty to be imposed, generally for homicides committed under aggravated circumstances. Under US constitutional law, however, prisoners cannot be executed if they are legally incompetent [1]. Generally that requirement has been interpreted to mean that prisoners who fail to understand the nature of the punishment and the reason for its imposition must be spared from execution. In one state (Maryland), such prisoners have their sentences commuted to life in prison and in another (Louisiana), if the state elects to treat the prisoner's incapacity, it can never carry out the death sentence. Although no centralized statistics are kept, evaluations of prisoners' competence to be executed appear to be quite uncommon.

What is it that troubles Freedman and Halpern? They believe that psychiatrists should not participate in evaluations of the competence of death row prisoners. Why they take that stance is not made terribly clear in their piece, other than the assertion that such evaluations constitute physician participation in execution—something that no one believes is ethically permissible. It is worth noting that their view is not supported by the official bodies charged with developing ethical standards for US medicine in general, and psychiatry in particular. The Council on Ethical and Judicial Affairs of the American

Medical Association, after studying the issue for years, concluded that conducting such evaluations was not equivalent to participating in an execution. Indeed, “. . . without physician participation, [incompetent] individuals might be punished unjustifiably” [2]. This conclusion was supported by the American Medical Association’s House of Delegates and Board. Similarly, the American Psychiatric Association’s Committee on Ethics ruled that it was permissible for psychiatrists to engage in competence evaluations [3].

These conclusions are consonant with a reasoned view of the psychiatrist’s role in competence evaluations. After assessing the prisoner’s capacities, the psychiatrist testifies at a competence hearing regarding his or her conclusions. Other evidence is heard, as well, typically from prison guards and others who have been in contact with the prisoner. The determination regarding the prisoner’s competence is left to the official decision maker, usually a judge. Taking part in this process is simply incommensurate with participation in execution.

Not only are such evaluations ethically permissible, but it is the very ban that Freedman and Halpern propose that would create impossible ethical dilemmas for psychiatrists. Envision a psychiatrist treating a prisoner on death row. The psychiatrist believes that the prisoner is psychotic or demented to the point where competence may be in question. As the prisoner is withdrawn and not overtly disruptive, no one else seems to notice. Under the rule proposed by Freedman and Halpern, the psychiatrist would have to stand by silently (because formally evaluating or testifying about a prisoner’s competence would be forbidden) and watch the incompetent prisoner go to his death. How anybody could believe that such behavior is ethically justifiable is incomprehensible.

What, then, lies behind efforts to elevate an infrequently performed evaluation, agreed to be ethical by the professional groups that have studied it most closely, to the level of a “crisis” in medical ethics? The death penalty evokes strong feelings among both its supporters and its opponents. Understandably, many opponents will seek any argument available to attempt to delegitimize the process. But it is manifestly unfair to psychiatrists and to death row prisoners themselves to use them as pawns in a game of political posturing over the use of the death penalty.

Although it is not clear from Freedman’s and Halpern’s piece, it should be noted that no one involved in this debate—not the American Medical Association, the American Psychiatric Association, nor me—argues that psychiatrists should treat persons found incompetent to be executed so that the sentence can be carried out. That is not at issue here. As for my views on the ethics of forensic psychiatry as a whole, which are misstated by Freedman and Halpern, I have addressed this issue at length elsewhere and refer the interested reader to that discussion [4].

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Commentary: How to Build an Argument II

Paul Appelbaum now has the chance to address the ethical problem. He takes a more **descriptive** rather than **normative** approach. Rather than prescribing outright how psychiatrists should behave—a normative approach—he describes the moral landscape. This is a richer exercise than simply quoting one professional organization or another. It surveys the entire scene of death penalty evaluations and usefully defines the limited scope of the dilemma.

His argument, not surprisingly, takes issue with the overly close logical and ethical distance between competence assessment and execution described by others. He quotes chapter and verse from prominent professional organizations to clarify the preceding sections. Although this may look like a mere appeal to organizational authority, it makes the point that the professional organizations have not been as prohibitive of psychiatric involvement as some authors had suggested. The characterizations of professional viewpoints to this point had been getting a bit facile. This reality-check is welcome.

Moreover, Appelbaum reminds readers that Maryland and Louisiana commute sentences in order to minimize the harm that can arise from competence-to-be-executed evaluations. It is a recognizable use of the rule to minimize the harm of incursion into cherished ethical principles.

Appelbaum echoes Bonnie's model by using the decision-maker as a criterion for ethical permissibility. Physicians do not make the final judgment. They are part of a process that offers clinical data and, we would add, values. It is the judicial board or judge who answers "the ultimate question," the matter of law. This honors the broad societal forum of the courts, and allows values beyond medicine to take their place. As one organization puts it, "without physician participation, [incompetent] individuals might be punished unfairly."

Next, an example illustrating a ban on competence evaluations adds flesh to the descriptive argument. The hypothetical construct illustrates

the void that would result if competence evaluations were prohibited. With this, the argument has carefully evolved toward the normative—what the ethical standard should be. We see an example of opinion moving from a general description of the problem to an incisive statement of where the ethical dilemma arises, and then to a clear example. It is a model for all persuasive arguments.

There is some iron in the tone as the prose decries use of psychiatrists as pawns in the anti-death penalty movement. Here, Appelbaum too worries that his critics are motivated by anti-death-penalty animus, but the easy manner the author uses to refer readers to his complete opinion on forensic ethics takes the high road in sharp contrast to the incivility of some prior sections.

We note that narrative ethics allows for these differences of opinion, particularly when they are well justified and drawn from a range of ethical thinking. Narrative's appreciation for the wisdom gained from multiple perspectives aspires to a more civil discourse and a richer sense of the ethical issues involved.

Forum (cont.)

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Medical involvement in the death penalty has, until recently, been an issue that has not received sufficient recognition. Within Amnesty International, a Medical Group against the Death Penalty has been established, with the main objective of fighting against the death penalty by increasing the public's—and in particular physicians'—awareness of the issue. This group, located in Denmark, publishes a regular newsletter and has published a number of papers over the years [1–3] on different aspects of the role of doctors, including psychiatrists [4], in the death penalty.

Among psychiatrists, Appelbaum [5] has highlighted areas of concern to psychiatrists in relation to the death penalty for more than 10 years but has been standing relatively alone in the US debate. Therefore, the recent article by Freedman and Halpern [6] and the present forum are very welcome. Freedman and Halpern mention the clear stand of the World Psychiatric Association in the Declaration of Madrid and the guidelines for specific situations, including the participation of psychiatrists in the death penalty. However, the World Psychiatric Association had previously issued a statement in 1989 in which it is considered a violation of professional ethics for psychiatrists to participate in any action connected to executions. Thus, there is no doubt about the position of the World Psychiatric Association when it comes to the participation of psychiatrists in capital punishment.

Freedman and Halpern focus in particular on the question of competence to be executed, and testimony regarding both competence to be executed and treatment to restore competence. Other aspects also deserve mention, including the role and capacity of psychiatrists in assessing future dangerousness. Here, psychiatric evidence may be influential and indeed play a key role in the jury's decision to vote for the death penalty. Finally, the whole issue of psychiatric problems on death row deserves further attention. This must include the problems present in prisoners on death row as well as the problems that are caused by the conditions on death row.

The death penalty is an issue of concern for the psychiatric community and, as such, further recognition is justified.

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Commentary: Misusing the Slippery Slope

A short section now follows that adds the weight of Amnesty International and an allied group to the debate. Professor Kastrup offers these as support for the arguments to follow as well as for the ones that preceded it. It is familiar short-hand for those unwilling to begin at first principles and construct an entire framework for their argument. It is again the argument from authority. Readers will recall from prior sections, however, that organizations have moved in various directions on the topic: more *and* less restrictive. The force of this argumentation is uncertain.

This approach is a form of the historical narrative and invokes the force of tradition. Reviewing the stance of one international organization as reflected in 1989 shows the proximity of more absolutist views of psychiatric involvement in capital punishment. The example demonstrates that, until recently, one prominent view was even more restrictive of forensic practice. It appears

to strengthen the author's position by setting a kind of precedent. She endorses **tradition as moral warrant**, as well as the august nature of the organization. There remains the flavor of argument by assertion and argument from authority.

What follows demonstrates the way in which opposing one event can be used to oppose related acts as well. Here, competence evaluations in proximity to execution are used to object to other psychiatric interventions. This is the slippery slope in reverse. Rather than sliding toward closer involvement in executions, clinicians are asked to retreat from numerous functions of forensic practice.

The primary example is the assessment of future dangerousness. Experts are frequently asked by courts, employers, and attorneys to evaluate future risks of violence. In capital cases, however, this author argues that such testimony may be "influential" and "affect the jury's decision" (certainly the point of expert testimony in the first place). The author is careful to say only that questions are raised by this practice, opening speculation into what circumstances, if any, might allow the use of experts. Is it to be left to the general knowledge of the jury; to the presentation of the prosecutor?

The door is open to the next step of generalization: "Finally, the whole issue of psychiatric problems on death row deserves further attention." But what is the "whole issue" she describes? Given the context, and a nihilistic flavor, it would seem that we are again seeing a form of absolutism that abides no flexibility.

Our sense is that this violates **generalizability** practices in ethical reasoning. To generalize arguments of proximity (distance) into complete disavowal of dangerousness assessments and psychiatric involvement on death row takes classic arguments to unprecedented heights. Recognizable from the Golden Rule ("Do unto others") and Kant's **categorical imperative** (e.g., "Act as if your behavior were a universal law"), the test of generalizability has a storied past. If a behavior does not generalize to all settings, it may be ethically suspect. Of course some justification is necessary to the use of generalization. Here, however, no reasoned justification is clear—except perhaps a ghost of the slippery slope.

Readers may also recognize that the historical narrative (represented by the author as the WPA and Amnesty International) cuts both ways. Appelbaum has already pointed out that professional organizations have been willing to consider competence evaluations. Indeed, in ancient times, Aristotle recognized that external influences affected behavior, identifying compulsion and ignorance as foundations for diminished personal responsibility (esp. Aristotle *Ethics* Book V). He did not condemn those who had acted involuntarily. In the modern era, Aristotle's

ethic avails itself of clinical expertise on matters of compulsion and ignorance. Readers familiar with Aristotle's analysis may recognize that the historical narrative underscores the *need* for psychiatric testimony not the reverse.

Forum (cont.)

Ahmed Okasha

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Issues in the relationship between law and psychiatry were present in ancient Greece and Rome over 2000 years ago. The evolution of this relationship cannot be seen as a process of accumulating medical knowledge being made available to the legal system. Nor can it be understood in terms of new legal concepts progressively influencing medicine and, later, psychiatry. Rather, law and psychiatry were subject to mutual adjustments and a continuous exchange of knowledge, techniques, and objectives. Over the centuries, the two disciplines seem to have followed general shifts between the care of the individual and the protection of society. Their encounter always brings us back to the duality that exists between our conflicting conceptions of the value of health on the one hand, and our conception of liberty, integrity, and autonomy on the other.

The main objective of any physician, the psychiatrist being no exception, is to alleviate suffering and improve the quality of life of patients to allow a better existence. To alleviate suffering and to cure the patient to be competent for execution is against medical ethics. I am privileged to chair the Ethics Committee of the World Psychiatric Association and, with its members, have produced the Declaration of Madrid and the special guidelines for specific situations. The paragraph on the death penalty states that "Under no circumstances should psychiatrists participate in legally authorized execution, nor participate in assessments of competence to be executed." The declaration was unanimously endorsed by the World Psychiatric Association General Assembly in 1996. The proposal to exclude forensic psychiatrists from this commitment, on the basis that they are advocates of justice or an assistant in the administration of justice, i.e. simply an agent of the state, is ethically unacceptable.

Freedman and Halpern state that "equally perturbing is the issue of psychiatric treatment that restores competence to be executed," allowing intervention in the case of extreme suffering. Here I beg to differ that we should intervene in case of severe suffering from psychotic symptoms or self destructive behavior, considering that the time between sentencing and actual execution could extend for years, and that court sentences can and are

usually proceeded. However, I do agree with the guidelines of the Royal College of Psychiatrists (1992): “On no account should the psychiatrist agree to state, after treatment, that the person is fit for execution.”

This commitment constitutes a component of the codes of ethics of several national and international medical organizations: the World Medical Association, World Psychiatric Association, American College of Physicians, British Medical Association, Royal College of Psychiatrists and the American Psychiatric Association.

Commentary: Balancing Medical and Legal Values

The next commentator, the distinguished former chair of the WPA ethics committee, begins by describing how law and medicine have shaped each other through history. This is another exercise in descriptive ethics (as in Appelbaum’s section). He rejects the simplistic understanding of the interrelationship as either a transfer of medical knowledge into law or of legal precepts into medicine. The two disciplines have, at various times, forged alliances to both the individual and society. This appears to describe the permissive interplay of weak role theory, and the balancing model that we endorse.

But there is a faint flavor of **the straw man**. Setting up a straw man—an easily refuted argument—in order to knock it down is a familiar debating trick. We see it here in the inference that those who favor evaluations for competence to be executed must be ignoring the duality of forensic duties and the primary therapeutic purpose of the medical profession. Debating trick or not, it is a form of reasoning which courtroom experts should expect.

Having begun with a leisurely description of the historical relation between law and medicine, the writer turns abruptly to an assertion: “The main objective of any physician is to alleviate suffering . . .” This, of course, obviates any flexibility in the role of physicians, or to a more complex understanding of dual agency. The author refers to the explicit prohibition of the World Psychiatric Association against competence-to-be-executed evaluations, and as chair of the ethics committee, interprets the ban to cover forensic practitioners. Forensic practitioners may not be excluded from the ban on competence evaluations.

This is an expert interpretation of the organization’s regulations, and no one can dispute the standing of the author to make this pronouncement. But it does emphasize the distinction between the ethics of professional organizations and the ethics of communities or of individuals. In this discourse, readers are likely looking for an analysis that goes beyond an

opinion of the organization's ethics committee. In the overall discussion so far, the most successful approaches have identified important principles and used cases, or narrative, to amplify them.

The writer later expands his view. He politely disagrees with the chief authors (Freedman and Halpern) on treating cases of extreme suffering. He justifies such treatment with solid reasons (i.e., the length of time inmates have until execution, and the likelihood of court review). But he would never state whether or not the prisoner, once successfully treated, is fit for execution.

This approach admirably parses out what is permissible and what is not. The argument could easily have gone the route of some previous ones, with overbroad generalizations and unjustified assertions. But by rigorously using relevant justification, the historical narrative, and his own professional status, the writer has pushed the ethical limit in a different direction than his colleagues. It is a well-crafted approach and a strong model.

Case: Did the Anti-Depressant Cause Suicide? The Straw Man in Court

Matthew Miller was a thirteen-year-old boy diagnosed with depression. Seven days after being prescribed the anti-depressant Zoloft, he hanged himself at his home. The Miller family sued Pfizer, Inc., the maker of Zoloft, for wrongful death.

In the course of the suit, the Millers presented a medical expert (Professor Silverman) who testified to the link between Zoloft and akathisia—the inability to sit still. The expert opined that Matthew may have experienced this side-effect, leading him to commit suicide.

Later, Pfizer moved to exclude the expert's testimony. Citing the expert's own statements on the uncertainty of predicting suicide, the defendants sought to disallow his entire testimony. Using Daubert arguments, Pfizer argued that the expert had not tested his methodology for assessing suicide risk, that his error rate was too high, and that there was no factual basis for his opinion on suicide (Miller v Pfizer, 2000). The court disagreed, noting this was no prediction but a retrospective diagnostic evaluation. Moreover, the court identified a straw man argument in Pfizer's appeal.

“Dr. Silverman does not state that Zoloft probably caused Matthew Miller to commit suicide and at his deposition, Dr. Silverman admitted that he could not state *to a reasonable degree of medical certainty* that Matthew Miller had a drug-induced akathisia or that SSRI drugs like Zoloft (by producing akathisia) were “likely to trigger suicidal behavior.” Defendant argues that these opinions . . . are inadmissible because Dr. Silverman cannot state *to a reasonable degree of medical certainty* that Zoloft causes suicide or that Matthew Miller [had] akathisia.

This prospect appears to raise a straw man argument, however, for nowhere in the record before the Court does Dr. Silverman purport to advance such an opinion. Indeed, he appears to stop gingerly short of any such claim. Therefore the Court need not exclude Dr. Silverman's testimony on that ground. Dr. Silverman merely opines that Zoloft *can* cause akathisia and that Matthew Miller *may* have had akathisia."

The Court's sense was that Pfizer was over-stating Dr. Silverman's testimony. The defendants were setting up arguments that the Court could reasonably strike down. But they were not precisely the expert's arguments; they were only a straw man. Courtroom experts of every kind will find their arguments thus distorted by opposing attorneys. They would do well to recognize it.

Forum (cont.)

Professor Juan J López-Ibor

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There are two peculiarities in the US legal system which may wrongly lead readers to think that the issue raised by Freedman and Halpern may not be of significant interest worldwide.

The first aspect is that the death penalty exists in some states in the United States and the problems are different where it does not. When a psychiatric patient commits an offence and is condemned to death, the insanity defense becomes a life saving issue. Where the death penalty does not exist it can be argued that long term sentences in jail or in a mental institution are equivalent; especially now that psychological rehabilitation is provided in many prisons whereas mental hospitals have deteriorated in many countries. It may even be better to have a limited prison sentence than to be an inmate of a mental institution without time limitation. Nevertheless, the institutional setting is essential for the job of professionals and an adequate doctor-patient relationship and treatment and rehabilitation procedures are difficult to carry out in prison.

The second peculiarity of the US legal system and of Anglo-Saxon countries in general, is that the emphasis is placed on procedural law rather than normative law. The latter is standard in other countries, especially those where Roman law prevails (France, Italy, Spain, and Latin American countries). In normative law, the involvement of psychiatrists and other professionals as court experts seems to be easier and is carried out from a certain distance and with little involvement. The expert has two roles: the first is clinical diagnosis of the patient, the second is to evaluate the effects of the derangement of the patient's mind on the offence being judged.

Two recent cases in Spain help to clarify these points. In both there was an absence of mental disorders but psychiatrists were called to study the accused. In the first, one of a group of adolescents playing a game called “role” brutally killed a sweeper in the early hours of the morning. The game involves the adoption of the role of different people during a normal day and this group adopted the role of “vigilantes” or “racial cleaners” liberating society from weak, old and foreign people. After a few failed attempts the group found the sweeper, aged, fat, and perhaps ugly looking, at night. During the trial there was a struggle between the psychologists and psychiatrists. The latter were unable to bring forward their argument as none of those involved in the crime, particularly the leader, fulfilled criteria for any psychiatric diagnosis. The psychologists, without the burden of having to provide a psychiatric diagnosis, were much more able to make a description of the personality of the accused and to suggest that they should be considered fully responsible. The psychiatrists, who were appointed by relatives of the accused, supported the notion that the accused were not responsible for their actions based on weak diagnostic formulations. In fact, they were trying an insanity defense without insanity being present. Here the pressures came not from the judicial system itself, but from one of the parties involved.

The other case, in which I participated along with another professor of psychiatry, involved a former head of the police forces in Spain who was accused of corruption and other similar offences. The image of this man in the press and the descriptions by his colleagues in the government as well as his own political party described him as being full of evil and as a psychopath or mentally abnormal person. The study of this person revealed no psychiatric disease and produced a detailed description of his personality and circumstances. The trial is ongoing, but the expert report was able to change the public perception of the accused. Removal of the stigma of mental illness also releases mental patients from the stigma of other social factors.

The lesson from Freedman’s and Halpern’s paper is that a psychiatrist should in any circumstance, behave as a psychiatrist and only as a psychiatrist. A thorough reading of the Declaration of Madrid makes the task of psychiatrists more demanding even in circumstances not as extreme as those described by Freedman and Halpern.

Commentary: Do Different Legal Systems Yield Different Ethics?

This final section begins by stressing the universality of the ethical question being discussed. The distinguished former president of the WPA, Juan López-Ibor, assures readers that the matter is of international

importance despite the absence of capital punishment in some U.S. states: insanity defenses, he says, are just as important in shaping long prison sentences. He worries that long-term commitment of acquirers to hospitals may be even more punitive than psychological rehabilitation in prisons. In the context of the death penalty, the two outcomes may be similarly egregious.

The validity of this statement aside, it again raises the question of what kind of clinical expertise is permissible in the legal system. Until now competence assessments have been challenged for being the handmaiden of executions. Now even long prison sentences and commitments may be objectionable. Clinical expertise is not simply being pulled back from the moral precipice of aiding in executions, but from even commenting on crimes with far lesser punishments.

This point feeds into the distinguishing features of American law. The U.S. emphasis on procedural law—imperfect procedural justice—is distinguished from that of nations using what the author calls “normative” law. “Normative” here describes systems that codify behavior, or norms, in legislation or written law, rather than case-law.

Law in nations like France and Italy is described as easier on courtroom experts because of a “certain distance” and “little involvement.” The author states that the expert in such systems fulfills two simple roles: diagnosis and determination of the effects of the “derangement” on the offense. This is a direct appeal to strict role theory and may not recognize the richness of interplay between society and its scientific experts. It also seems to describe the role of U.S. courtroom experts just as much as that in Europe.

Two following examples seek to clarify the distinction between systems. One example describes defense psychiatrists trying to deflect criminal responsibility with “weak diagnostic formulations.” The other describes the use of courtroom expertise in dispelling stigma and public misperception of the accused. Neither makes use of the distinction between American and European legal systems. The author concludes that clinicians—here, psychiatrists—should behave as clinicians and only clinicians. He skirts the question of how one defines “clinician.” The examples do little more than to advise experts to resist pressure from those paying their fee, and to resist spinning the media.

Still, there is an important point to be found here. Common law systems, such as the English and American, do differ from systems that use code (civil/Roman or Napoleonic code) approaches. Precedent and consistency are primary in the former, rationally synthesized rules (e.g., equal standing before the law, primacy of property ownership, integrity of the family etc.) in the latter.

What is less clear is how the thought behind these systems influences this debate. It is just as easy to find deterministic as free-will philosophies in the two systems; some argue that crime is a product of one's genes, others that crime is a result of one's exercise of free will. No matter how society uses the excusing function of courtroom experts, the values conflict remains. We still need multiple theoretical perspectives to address complex cases.

Readers may reasonably have expected arguments on how agency conflicts of the adversarial American system differ from those of the inquisitorial European system. In an inquisitorial system, for example, the judge is involved in case preparations, questions witnesses, and can ease the disputes between parties or at least smooth out the process. Investigation and wide-ranging information-gathering by judicial police, including psychological and characterologic information about the accused, are prominent in this system. Perhaps this is what the author means by "a certain distance" between experts and the court proceedings. The inquisitorial system may insulate the expert from the dual agency conflict. But, just as likely, the investigator-expert may be a more obvious agent of the state.

The narrative of experts who have worked in both systems would be very helpful in clarifying how differences in the two systems play out. But there is no such description or reasoning in this section: the pressures on experts described here are universally known to all professionals of the courtroom.

Forum—Psychiatrists and the Death Penalty: Some Ethical Dilemmas

Response

Alfred M. Freedman and Abraham L. Halpern^a

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We wish to thank all our colleagues who have taken the time to respond with comments to our article "A crisis in the ethical and moral behavior of psychiatrists." The issues raised in both the article and the commentaries have broad implications and ramifications beyond psychiatry and medicine extending to ethical and moral issues of contemporary society. Thus, discussion can only bring enlightenment in this critical area. We are confident that this aim is well served by the extremely insightful and pertinent observations of the commentators.

Unfortunately, in his comment, Appelbaum does not directly respond to our quoting of his statement delivered at the Annual Meeting of the American Academy of Psychiatry and the Law in 1996, namely that “forensic psychiatrists, however, work in a different ethical framework, one built around the legitimate needs of the justice system.” This notion of forensic exceptionalism is the cornerstone of Appelbaum’s arguments and the justification of the sharp departure from psychiatric ethics. This concept that he has put forward in numerous articles, including the one he refers to in his commentary, implies that in the court-related situation the psychiatrist is no longer a psychiatrist but an “advocate of justice,” an assistant in “the administration of justice,” or a “forensicist” no longer bound by the ethical principles to which psychiatrists are committed. We strongly agree with the statement in Pellegrino’s comment that Appelbaum’s idea is “patently illogical, socially deleterious and utterly corrosive to the integrity of medical ethics.”

In a recent article, by Stone of the Harvard Medical and Law Schools [1], the departure of some forensic psychiatrists from a strong commitment to preserve confidentiality to acquiescence of a break of confidentiality in court is deplored. Stone attributes this to a need to conform to the needs of the court. We agree, but believe it is an outcome of the above idea that the forensic psychiatrist is no longer a psychiatrist but an agent of the court. Adherence to the ethics of confidentiality is no longer necessary. Forensic psychiatry will suffer immeasurably for this surrender.

Appelbaum cites the report of the Ethics Committee of the American Psychiatric Association (APA) on 17 February 1996, but fails to mention the clearest statement included in this otherwise ambiguous report, namely that “. . . psychiatrists are physicians and physicians are physicians at all times.”

It must be mentioned further that at the June 1997 meeting of the American Medical Association (AMA), the New York State delegation introduced modifications of the 1995 report of the AMA Council on Ethical and Judicial Affairs (which was referred to by Appelbaum). The modifications were sent to the Council for reconsideration. Therefore, this whole issue is still in a state of flux and neither the APA nor the AMA has an unquestioned position at this time.

Both Bonnie and Appelbaum imply that our objection to physician participation in executions is a covert maneuver to discredit and eliminate capital punishment. There is no such effort as the issue of capital punishment is, as indicated by Hartmann, unrelated to physician participation. It is noteworthy that when we were collecting signatures at an APA meeting to oppose approval of psychiatrists’ participation, a number of those who signed stated that although they were in favor of capital punishment they were strongly opposed to physician participation.

In the matter of treatment of a condemned prisoner's "extreme suffering," we are gratified that Bonnie agrees with us that the law should require commutation of the death sentence in such cases. Beyond that, however, in the interests of a truly sensible and rational way out of the dilemma, we have made no secret of our strong support for the abolition of capital punishment. We applaud the American Bar Association's call, in February 1997, for a moratorium on capital punishment in the United States. (The reasons given include racially discriminatory application of the death penalty, the grossly inadequate legal representation of the defendants and the restriction on appeals to the federal courts even in cases where new evidence is presented that points to the innocence of the condemned prisoner.) We have also repeatedly endorsed the 1969 resolution of the Board of Trustees of the APA calling for the abolition of the death penalty and declaring that "the best available scientific and expert opinion holds it to be anachronistic, brutalizing, ineffective and contrary to progress in penology and forensic psychiatry." We must say, again, that we are quite distressed that both Bonnie and Appelbaum imply that we condemn execution competency evaluations solely because we are morally opposed to the death penalty. It has been our purpose to give indisputably realistic meaning to the ethical canon that prohibits participation by physicians in legally authorized executions and we are gratified that the World Psychiatric Association has clearly proclaimed that psychiatric assessments of competency to be executed fall within the ambit of ethically unacceptable conduct. There is reason to believe that our view in this regard is shared even by physicians who hold that capital punishment has a place in civilized society.

We note that 21 death row prisoners in the United States were exonerated by the courts between 1993 and 1997. These findings of innocence were arrived at over a period of 7 years in almost all of the cases. With the defunding of many federal post-conviction defender organizations last year, the limitations on appeal petitions and the broadening of the federal death penalty, we can expect an acceleration in the number of executions, including the executions of innocent persons. Obviously, there is a distinct risk that psychiatrists will examine innocent prisoners and declare them competent for execution. Unlike Appelbaum, we see this as a crisis.

Bonnie declares that the assessment of a condemned prisoner's competence to be executed, "for the sole purpose of telling the warden or director of the prison whether or nor the person is 'fit' to be executed," is ethically unacceptable. He nevertheless accepts as ethically sound for a psychiatrist to assess, at the request of a lawyer representing the condemned prisoner, whether the mentally disturbed prisoner "has the capacity to understand the nature, purpose and consequences of the impending execution." What Bonnie fails to understand is that this ostensibly altruistic participation "on

behalf of the condemned prisoner” at once opens the door for the “decision-maker” to invite psychiatrists to evaluate the prisoner’s competence and arrive at an assessment contrary to what the prisoner’s lawyer desires, with the result that the decision-maker is then free to declare that the execution should take place. This is not merely a theoretical possibility. The recent execution of Pedro L Medina in Florida is a case in point. Here, according to his attorney to whom we spoke, three psychiatrists had been appointed by the Governor to examine Mr. Medina to determine his competency to be executed. They all agreed he was competent and was malingering. An appeal was filed with the Circuit Court judge who appointed three experts—they all found the inmate to be severely psychotic and not malingering. The judge then appointed two psychiatrists who said that Mr Medina, although “eating his feces and talking crazy,” was faking. The lawyer appealed to the judge to send Medina to the state hospital for treatment and/or reassessment. The judge refused and the execution was carried out. (As an additional macabre point of interest, we were told by the lawyer, who witnessed the execution, that two doctors examined the prisoner after the mask over his face caught fire and the current was turned off; the attorney left with the other witnesses when a Department of Corrections representative announced “sentence carried out—you may leave now.”)

The fact that doctors serve in a non-therapeutic role for the legal system (for example, in assessments of disability for the workers’ compensation or social security systems, or of competency to stand trial for the criminal justice system) in areas that no ethical code prohibits in no way justifies, contrary to Bonnie’s and Appelbaum’s insistence, the participation by psychiatrists in legally authorized executions which is ethically prohibited. We thus take strong exception to Bonnie’s assertion that the psychiatric assessment of a death row inmate’s competence to be executed “does not differ, in principle, from pretrial forensic assessment of a capital defendant’s competence to stand trial” or “from testifying in a capital sentence hearing.”

We would remind Appelbaum of his comments as a member of the affirmative team debating, at the 1987 Annual Meeting of the APA in Chicago, the resolution “It is unethical for psychiatrists to diagnose or treat condemned persons in order to determine their competency to be executed.” Appelbaum pointed out that psychiatric ethics require the psychiatrist to function as a healer and that this role was not compatible with determining that someone was competent to be executed. The role of consultant to the criminal justice system, he said, is secondary and it has to be subordinated to the role of healer, and in rendering an opinion in favor of execution, the physician allows his secondary role to dominate his primary role. Appelbaum stated at that time that an

evaluating psychiatrist is “as directly involved as one could imagine, short of flipping the switch, when he serves in this role [2].”

As Appelbaum and Bonnie were the only people to make oppositional comments, we found it necessary to refute their statements. The remainder of the comments were essentially supportive of our position and we are grateful for the endorsement of our colleagues. Thus, we will make only brief response as their papers speak for themselves.

Gunn makes us aware that the Siena meeting promulgated the declaration that forensic psychiatrists should abjure operating “as part of the state control systems.” He gives proof of the danger of forensic psychiatrists characterizing themselves as “advocates of justice” or “agents of the state” by citing the sad story of psychiatry in the former USSR.

As has been pointed out above, Hartmann vigorously dismisses the contention that opposition to physician participation in executions is a covert way to undermine and do away with capital punishment.

It is to Okasha that we owe credit for his vigorous and wise leadership of the Ethics Committee of the World Psychiatric Association from which the Declaration of Madrid (which we quote above) emerged. We also agree that the 1992 statement of the Royal College of Psychiatry gives us a guideline in regard to intervention in “extreme suffering.”

López-Ibor, as President-Elect of the World Psychiatric Association, was also a critical supporter of the Declaration of Madrid. We are cognizant of the temptations to interpose an insanity plea in capital cases in a humanitarian effort to avoid a death sentence. However, misuse of psychiatry in the presentation of expert witness testimony frequently occurs, resulting in widespread ridicule and criticism of our profession. It should be noted that execution of severely mentally ill inmates is prohibited in the United States. The unwarranted (manufactured?) plea of insanity in capital cases can be nullified by abolition of the death penalty.

Kastrup raises an interesting bit of history in regard to Appelbaum’s position on physician participation in legal executions. In Appelbaum’s 1986 paper cited by Kastrup and in the debate in 1987 referred to by us above, Appelbaum was intransigent in his opposition to physician participation. Regrettably, by 1990 Appelbaum had reversed his position and has continued to this day to favor lifting prohibitions to physician participation as can be seen in his comment.

Pellegrino is one of the outstanding medical ethicists in the United States and his comments demonstrate his rare ability to sum a most commendable position with his strong but spare prose. We have cited above his condemnation of some of the flimflam justifying physicians serving the court or state and thus participating in legal executions. His comment reinforces this position.

Bloche has campaigned for years against physician participation in legal executions and his comment demonstrates his continuing indefatigable commitment.

Thus, a wide-ranging discussion is completed, not just of psychiatrist participation in legal executions but of the very basis of morality and ethics in medicine that is being seriously eroded. It is our hope that this discussion will raise the consciousness of physicians and psychiatrists to the fragility of our ethical and moral standards that are now subject to attack. In the words of Pellegrino, “physicians must remain the guardians of the moral integrity of the profession and its ethics. . . . In these times, their witness to the integrity of medical ethics is an assurance that some things are not at the disposal of whim, fancy or political power.”

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Final Comments

We have already addressed many of the arguments that appear in this rebuttal, but let us pause to summarize our efforts below. First, we note that, as of this writing, the American Medical Association, American Psychiatric Association, and the American Academy of Psychiatry and the Law are all inclined to permit execution competence evaluations. Meanwhile, a number of conscientious practitioners continue to articulate their objections.

We can point out the use of one author’s past comments against him. Appelbaum’s thinking on competence evaluation has certainly evolved. But the evolution has been both disciplined and principled. Indeed, mindful and intelligent evolution is in the best tradition of academic scholarship. It is a method for fine-tuning arguments, receiving feedback, and contributing to the evolution of professional discourse. Courtroom experts need not fear criticism of this kind of evolution.

Our focus remains on the characteristics of sound reasoning: on the importance of justification, specification, and balancing; on the need to maintain perspective on logical and ethical distance, to avoid absolutism and the “straw man.” We reject arguments from authority, motivation, or assertion; and deplore *ad hominem* attacks.

As we move from theory to practice in courtroom ethics, we offer Rawls and Childress to help balance principles—using the reflective equilibrium between theory and cases, and the rules for minimizing damage to core beliefs when they conflict.

To assure robust professional practice, we apply habits and skills of the ethical practitioner by advocating education, peer review, consultation, and familiarity with ethical frameworks. We suggest transparency in testimony, open and honest analysis of the strengths and weaknesses of one's own view, avoidance of the ultimate question, and separation of legal and scientific questions.

For forensic work, we propose using an individual's narrative to enrich the way that principles are applied to specific cases. We draw on differing perspectives and theories to enrich our analysis. We do not want to miss the vivid currents of history or culture that underlie our work. Nor can we condone persistent mistreatment of non-dominant groups.

How will the individual stories in the moral drama change our reasoning? The reasoning we advocate is truly a dynamic process which will change our own participation in the courtroom setting. Incorporating narrative may be the step that allows a more complex, or robust, vision of our professional role.

Our hope is that this robust sense of role gives a proper place to personal morality and personal values alongside the dominant professional ethic. It allows us to aspire to professional ideals rather than minimalist rules. The resulting space for moral disagreement allows room for more collegial discussion and less recourse to absolutism.

In fact, this dynamic reasoning about role can lead to a rich variety of ethical positions, ones that require experts to go beyond the pronouncements of their lawyers or organizations. This is a reasoning that offers no simple solutions to the complexities of forensic work, yet enhances its appeal.

Attaining this unified ethics of courtroom experts is a complex task that draws on the thinking of many individuals from many fields. Judges and juries, physicists and chemists, lawyers and legal theorists, ethicists and law enforcement personnel, patients and their loved ones all have a story to tell—and a crucial perspective on the expert's work in the courtroom.

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Appendix of Ethics Codes

American Academy of Forensic Sciences

Code of Ethics and Conduct (reprinted with permission)

SECTION 1 – THE CODE: As a means to promote the highest quality of professional and personal conduct of its members and affiliates, the following constitutes the Code of Ethics and Conduct which is endorsed and adhered to by all members and affiliates of the American Academy of Forensic Sciences:

- a. Every member and affiliate of the American Academy of Forensic Sciences shall refrain from exercising professional or personal conduct adverse to the best interests and purposes of the Academy.
- b. Every member and affiliate of the AAFS shall refrain from providing any material misrepresentation of education, training, experience or area of expertise. Misrepresentation of one or more criteria for membership or affiliation with the AAFS shall constitute a violation of this section of the code.
- c. Every member and affiliate of the AAFS shall refrain from providing any material misrepresentation of data upon which an expert opinion or conclusion is based.
- d. Every member and affiliate of the AAFS shall refrain from issuing public statements that appear to represent the position of the Academy without specific authority first obtained from the Board of Directors.

SECTION 2 – MEMBER AND AFFILIATE LIABILITY: Any member or affiliate of the American Academy of Forensic Sciences who has violated any of the provisions of the Code of Ethics (Article II, Section 1) may be liable to censure, suspension or expulsion by action of the Board of Directors, as provided in Section 5h. below.

SECTION 3 – INVESTIGATIVE BODY: There shall be constituted a standing Ethics Committee (see Article V for composition), the primary function of which shall be:

- a. To order or conduct investigations and, as necessary, to serve as a hearing body concerning conduct of individual members or affiliates which may constitute a violation of the provisions of Article II, Section 2.
- b. To act as an advisory body, rendering opinions on the ramifications of contemplated actions by individual members or affiliates in terms of the provisions of Article II.

SECTION 4 – INVESTIGATION INITIATING ACTION: The following are the principal forms by which the Ethics Committee may initiate investigative proceedings:

- a. A member or affiliate of the Academy may submit a formal written complaint or allegation of violation(s) concerning a member or affiliate to the Secretary of the Academy (see section 5, Rules and Procedures, below) or to the Chair of the Ethics Committee.
- b. The Ethics Committee may institute an inquiry based on any evidence brought to its attention which in its opinion indicates the need for further query or action under the provisions of these Bylaws. Appropriate to this form of action, Section Officers, upon receipt of a complaint or allegation concerning the professional or personal conduct of a member or affiliate of their sections, may refer the complaint or allegation to the Ethics Committee in writing, accompanied by a recommendation, if any, concerning the need for further investigation. However, such recommendations shall not be binding on the Ethics Committee.

SECTION 5 – RULES AND PROCEDURES: The following procedures shall apply to any written complaint(s) or allegation(s) of unethical or wrongful conduct against a member or affiliate of the Academy whether initiated by a member or affiliate, or resulting from an inquiry originated by the Ethics Committee:

- a. Written complaints or allegations against a member or affiliate if delivered to the Academy Secretary, shall promptly be transmitted to the Chair of the Ethics Committee.
- b. The Ethics Committee shall determine whether the complaint(s) or allegation(s) fall(s) within its jurisdiction and whether there is probable cause to believe that the complaint(s) or allegation(s) may be well founded.
- c. If the Ethics Committee, in its preliminary determination, finds that it does not have jurisdiction or that there is a lack of probable cause to

- believe that the complaint(s) or allegation(s) may be well founded, it shall dismiss the complaint(s) or allegation(s). It shall issue a report of such determination to the Board of Directors, setting forth the basic facts but omitting the names of the parties, and stating the reasons for its decision to dismiss. Notice of the filing of the complaint or allegation shall also be given to the accused.
- d. If the Ethics Committee finds that it has jurisdiction and that there is probable cause to believe that the complaint(s) or allegation(s) may be well founded, it shall give notice of the filing of a complaint(s) or allegation(s) to the accused, and, in accordance with Rules and Regulations formulated by the Ethics Committee and approved by the Board of Directors, shall assemble such written data from both the accused and the accuser(s) which shall permit the Ethics Committee to determine whether the complaint(s) or allegation(s) requires further investigation.
 - e. The Ethics Committee may appoint an Academy Fellow or Fellows to investigate the complaint(s) or allegation(s) and, if necessary, to present the charge(s) on behalf of the Academy to the Committee.
 - f. If, as a result of an investigation, the Ethics Committee decides to dismiss the charge(s) without a formal hearing, it may do so. It shall notify the accused and the accuser(s) of its decision and shall issue a report to the Board of Directors setting forth the basic facts but omitting the names of the parties and stating the reason(s) for its decision.
 - g. If the Ethics Committee decides to formally hear the charge(s), it shall give both the accused and the accuser(s) a reasonable opportunity to be heard and to confront each other. It shall then make a decision and notify both parties of its decision. The Ethics Committee shall then make a report to the Board of Directors on its decision including reasons and any recommendation for further action.
 - h. Following receipt of a report of the Ethics Committee and upon a vote of three-fourths (3/4) of the members of the Board of Directors present and voting, the party accused of unethical or wrongful conduct may be censured, suspended or expelled. No member of the Board of Directors who is the subject of a pending accusation under the provisions of this Article shall sit in deliberation on any matter concerning ethics. Suspension of the accused shall be qualified by the permissible method of reinstatement.
 - i. The accused has the right to appeal from the action of the Board of Directors to the membership of the Academy. In effecting an appeal, the appellant must file a brief written notice of the appeal, together with any written statement he or she may wish to submit in his or her behalf, with the Academy Secretary not less than one hundred twenty (120)

- days prior to the next Annual Meeting of the Academy. The Secretary shall immediately advise each member of the Board of Directors of the appeal and shall forward to each a copy of the supporting papers submitted by the appellant.
- j. The Board of Directors shall then prepare a written statement of the reasons for its actions and file the same with the Academy Secretary not less than forty (40) days prior to the next Annual Meeting.
 - k. Within twenty (20) days thereafter, the Academy Secretary shall mail to each voting member of the Academy a copy of the appellant's notice of appeal and supporting statement, if any, and a copy of the Board of Directors' statement.
 - l. A vote of three-fourths (3/4) of the members present and voting at the Academy's annual business meeting shall be required to overrule the action of the Board of Directors in regard to censure, suspension or expulsion of a member or affiliate.
 - m. The Ethics Committee shall formulate internal Rules and Procedures designed to facilitate the expeditious, fair, discreet, and impartial handling of all complaints or matters brought before it. The Rules and Procedures, and any subsequent deletions, additions or amendments thereto, shall be subject to the approval of the Board of Directors.

SECTION 6 – SUSPENSION OF MEMBERS AND AFFILIATES: Members or affiliates who have been suspended may apply for reinstatement once the period of suspension is completed. A suspended member or affiliate shall not be required to pay dues during the period of suspension. If reinstated, the required dues payment shall be the annual dues less the pro-rated amount for the period of suspension.

American Academy of Psychiatry and the Law

Ethics Guidelines for the Practice of Forensic Psychiatry Adopted May 2005 (reprinted with permission)

I. Preamble

The American Academy of Psychiatry and the Law (AAPL) is dedicated to the highest standards of practice in forensic psychiatry. Recognizing the unique aspects of this practice, which is at the interface of the professions of psychiatry and the law, the Academy presents these guidelines for the ethical practice of forensic psychiatry.

Commentary

Forensic Psychiatry is a subspecialty of psychiatry in which scientific and clinical expertise is applied in legal contexts involving civil, criminal, correctional, regulatory or legislative matters, and in specialized clinical consultations in areas such as risk assessment or employment. These guidelines apply to psychiatrists practicing in a forensic role.

These guidelines supplement the Annotations Especially Applicable to Psychiatry of the American Psychiatric Association to the Principles of Medical Ethics of the American Medical Association.

Forensic psychiatrists practice at the interface of law and psychiatry, each of which has developed its own institutions, policies, procedures, values, and vocabulary. As a consequence, the practice of forensic psychiatry entails inherent potentials for complications, conflicts, misunderstandings and abuses.

Psychiatrists in a forensic role are called upon to practice in a manner that balances competing duties to the individual and to society. In doing so, they should be bound by underlying ethical principles of respect for persons, honesty, justice, and social responsibility. However, when a

treatment relationship exists, such as in correctional settings, the usual physician-patient duties apply.

II. Confidentiality

Respect for the individual's right of privacy and the maintenance of confidentiality should be major concerns when performing forensic evaluations. Psychiatrists should maintain confidentiality to the extent possible, given the legal context. Special attention should be paid to the evaluatee's understanding of medical confidentiality. A forensic evaluation requires notice to the evaluatee and to collateral sources of reasonably anticipated limitations on confidentiality. Information or reports derived from a forensic evaluation are subject to the rules of confidentiality that apply to the particular evaluation, and any disclosure should be restricted accordingly.

Commentary

The practice of forensic psychiatry often presents significant problems regarding confidentiality. Psychiatrists should be aware of and alert to those issues of privacy and confidentiality presented by the particular forensic situation. Notice of reasonably anticipated limitations to confidentiality should be given to evaluatees, third parties, and other appropriate individuals. Psychiatrists should indicate for whom they are conducting the examination and what they will do with the information obtained. At the beginning of a forensic evaluation, care should be taken to explicitly inform the evaluatee that the psychiatrist is not the evaluatee's "doctor." Psychiatrists have a continuing obligation to be sensitive to the fact that although a warning has been given, the evaluatee may develop the belief that there is a treatment relationship. Psychiatrists should take precautions to ensure that they do not release confidential information to unauthorized persons.

When a patient is involved in parole, probation, conditional release, or in other custodial or mandatory settings, psychiatrists should be clear about limitations on confidentiality in the treatment relationship and ensure that these limitations are communicated to the patient. Psychiatrists should be familiar with the institutional policies regarding confidentiality. When no policy exists, psychiatrists should attempt to clarify these matters with the institutional authorities and develop working guidelines.

III. Consent

At the outset of a face-to-face evaluation, notice should be given to the evaluatee of the nature and purpose of the evaluation and the limits of its confidentiality. The informed consent of the person undergoing the

forensic evaluation should be obtained when necessary and feasible. If the evaluatee is not competent to give consent, the evaluator should follow the appropriate laws of the jurisdiction.

Commentary

Informed consent is one of the core values of the ethical practice of medicine and psychiatry. It reflects respect for the person, a fundamental principle in the practices of psychiatry and forensic psychiatry.

It is important to appreciate that in particular situations, such as court-ordered evaluations for competency to stand trial or involuntary commitment, neither assent nor informed consent is required. In such cases, psychiatrists should inform the evaluatee that if the evaluatee refuses to participate in the evaluation, this fact may be included in any report or testimony. If the evaluatee does not appear capable of understanding the information provided regarding the evaluation, this impression should also be included in any report and, when feasible, in testimony.

Absent a court order, psychiatrists should not perform forensic evaluations for the prosecution or the government on persons who have not consulted with legal counsel when such persons are: known to be charged with criminal acts; under investigation for criminal or quasi-criminal conduct; held in government custody or detention; or being interrogated for criminal or quasi-criminal conduct, hostile acts against a government, or immigration violations. Examinations related to rendering medical care or treatment, such as evaluations for civil commitment or risk assessments for management or discharge planning, are not precluded by these restrictions. As is true for any physician, psychiatrists practicing in a forensic role should not participate in torture.

Consent to treatment in a jail or prison or in other criminal justice settings is different from consent for a forensic evaluation. Psychiatrists providing treatment in such settings should be familiar with the jurisdiction's regulations governing patients' rights regarding treatment.

IV. Honesty and Striving for Objectivity

When psychiatrists function as experts within the legal process, they should adhere to the principle of honesty and should strive for objectivity. Although they may be retained by one party to a civil or criminal matter, psychiatrists should adhere to these principles when conducting evaluations, applying clinical data to legal criteria, and expressing opinions.

Commentary

The adversarial nature of most legal processes presents special hazards for the practice of forensic psychiatry. Being retained by one side in a civil or

criminal matter exposes psychiatrists to the potential for unintended bias and the danger of distortion of their opinion. It is the responsibility of psychiatrists to minimize such hazards by acting in an honest manner and striving to reach an objective opinion.

Psychiatrists practicing in a forensic role enhance the honesty and objectivity of their work by basing their forensic opinions, forensic reports and forensic testimony on all available data. They communicate the honesty of their work, efforts to attain objectivity, and the soundness of their clinical opinion, by distinguishing, to the extent possible, between verified and unverified information as well as among clinical “facts,” “inferences,” and “impressions.”

Psychiatrists should not distort their opinion in the service of the retaining party. Honesty, objectivity and the adequacy of the clinical evaluation may be called into question when an expert opinion is offered without a personal examination. For certain evaluations (such as record reviews for malpractice cases), a personal examination is not required. In all other forensic evaluations, if, after appropriate effort, it is not feasible to conduct a personal examination, an opinion may nonetheless be rendered on the basis of other information. Under these circumstances, it is the responsibility of psychiatrists to make earnest efforts to ensure that their statements, opinions and any reports or testimony based on those opinions, clearly state that there was no personal examination and note any resulting limitations to their opinions.

In custody cases, honesty and objectivity require that all parties be interviewed, if possible, before an opinion is rendered. When this is not possible, or is not done for any reason, this should be clearly indicated in the forensic psychiatrist’s report and testimony. If one parent has not been interviewed, even after deliberate effort, it may be inappropriate to comment on that parent’s fitness as a parent. Any comments on the fitness of a parent who has not been interviewed should be qualified and the data for the opinion clearly indicated.

Contingency fees undermine honesty and efforts to attain objectivity and should not be accepted. Retainer fees, however, do not create the same problems in regard to honesty and efforts to attain objectivity and, therefore, may be accepted.

Psychiatrists who take on a forensic role for patients they are treating may adversely affect the therapeutic relationship with them. Forensic evaluations usually require interviewing corroborative sources, exposing information to public scrutiny, or subjecting evaluatees and the treatment itself to potentially damaging cross-examination. The forensic evaluation and the credibility of the practitioner may also be undermined by conflicts inherent in the differing clinical and forensic roles. Treating psychiatrists

should therefore generally avoid acting as an expert witness for their patients or performing evaluations of their patients for legal purposes.

Treating psychiatrists appearing as “fact” witnesses should be sensitive to the unnecessary disclosure of private information or the possible misinterpretation of testimony as “expert” opinion. In situations when the dual role is required or unavoidable (such as Workers’ Compensation, disability evaluations, civil commitment, or guardianship hearings), sensitivity to differences between clinical and legal obligations remains important.

When requirements of geography or related constraints dictate the conduct of a forensic evaluation by the treating psychiatrist, the dual role may also be unavoidable; otherwise, referral to another evaluator is preferable.

V. Qualifications

Expertise in the practice of forensic psychiatry should be claimed only in areas of actual knowledge, skills, training, and experience.

Commentary

When providing expert opinion, reports, and testimony, psychiatrists should present their qualifications accurately and precisely. As a correlate of the principle that expertise may be appropriately claimed only in areas of actual knowledge, skill, training and experience, there are areas of special expertise, such as the evaluation of children, persons of foreign cultures, or prisoners, that may require special training or expertise.

VI. Procedures for Handling Complaints of Unethical Conduct

The American Academy of Psychiatry and the Law does not adjudicate complaints that allege unethical conduct by its members or nonmembers. If received, such complaints will be returned to the complainant for referral to the local district branch of the American Psychiatric Association (APA), the state licensing board, and/or the appropriate national psychiatric organization of foreign members. If the APA or the psychiatric association of another country expels or suspends a member, AAPL will also expel or suspend that member upon notification of such action. AAPL will not necessarily follow the APA or other organizations in other sanctions.

Commentary

General questions regarding ethical practice in forensic psychiatry are welcomed by the Academy and should be submitted to the Ethics Committee.

The Committee may issue opinions on general or hypothetical questions but will not issue opinions on the ethical conduct of specific forensic psychiatrists or about actual cases.

The Academy, through its Ethics Committee, or in any other way suitable, is available to the local or national committees on ethics of the American Psychiatric Association, to state licensing boards or to ethics committees of psychiatric organizations in other countries to aid them in their adjudication of complaints of unethical conduct or the development of guidelines of ethical conduct as they relate to forensic psychiatric issues.

Specialty Guidelines for Forensic Psychologists^{*1}

Law and Human Behavior, Vol. 15, No. 6, 655-665, 1991

Committee on Ethical Guidelines for Forensic Psychologists²

The Specialty Guidelines for Forensic Psychologists, while informed by the *Ethical Principles of Psychologists* (APA, 1990) and meant to be consistent with them, are designed to provide more specific guidance to forensic psychologists in monitoring their professional conduct when acting in assistance to courts, parties to legal proceedings, correctional and forensic mental health facilities, and legislative agencies. The primary goal of the Guidelines is to improve the quality of forensic psychological services offered to individual clients and the legal system and thereby to enhance forensic psychology as a discipline and profession. The *Specialty Guidelines for Forensic Psychologists* represent a joint statement of the American Psychology-Law

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¹ The *Specialty Guidelines for Forensic Psychologists* were adopted by majority vote of the members of Division 41 and the American Psychology-Law Society. They have also been endorsed by majority vote by the American Academy of Forensic Psychology. The Executive Committee of Division 41 and the American Psychology Law Society formally approved these *Guidelines on March 9, 1991*. The Executive Committee also voted to continue the Committee on Ethical Guidelines in order to disseminate the *Guidelines* and to monitor their implementation and suggestions for revision. Individuals wishing to reprint these *Guidelines* or who have queries about them should contact either Stephen L. Golding, Ph.D., Department of Psychology, University of Utah, Salt Lake City, UT 84112 801-581-8028 (voice) or 801-581-5841 (FAX) or other members of the Committee listed below. Reprint requests should be sent to Cathy Oslzly, Department of Psychology, University of Nebraska-Lincoln, Lincoln, NE 68588-0308.

² These Guidelines were prepared and principally authored by a joint Committee on Ethical Guidelines of Division 41 and the American Academy of Forensic-Psychology (Stephen L. Golding, [Chair], Thomas Grisso, David Shapiro, and Herbert Weissman [Co-chairs]). Other members of the Committee included Robert Fein, Kirk Heilbrun, Judith McKenna, Norman Poythress, and Daniel Schuman. Their hard work and willingness to tackle difficult conceptual and pragmatic issues is gratefully acknowledged. The Committee would also like to acknowledge specifically the assistance and guidance provided by Dort Bigg, Larry Cowan, Eric Harris, Arthur Lemer, Michael Miller, Russell Newman, Melvin Rudov, and Ray Fowler. Many other individuals also contributed by their thoughtful critique and suggestions for improvement of earlier drafts which were widely circulated.

Society and Division 41 of the American Psychological Association and are endorsed by the American Academy of Forensic Psychology.

The **Guidelines** do not represent an official statement of the American Psychological Association.

The Guidelines provide an aspirational model of desirable professional practice by psychologists, within any subdiscipline of psychology (e.g., clinical, developmental, social, experimental), when they are engaged regularly as experts and represent themselves as such, in an activity primarily intended to provide professional psychological expertise to the judicial system. This would include, for example, clinical forensic examiners; psychologists employed by correctional or forensic mental health systems; researchers who offer direct testimony about the relevance of scientific data to a psycholegal issue; trial behavior consultants; psychologists engaged in preparation of *amicus* briefs; or psychologists, appearing as forensic experts, who consult with, or testify before, judicial, legislative, or administrative agencies acting in an adjudicative capacity. Individuals who provide only occasional service to the legal system and who do so without representing themselves as *forensic experts* may find these **Guidelines** helpful, particularly in conjunction with consultation with colleagues who are forensic experts.

While the **Guidelines** are concerned with a model of desirable professional practice, to the extent that they may be construed as being applicable to the advertisement of services or the solicitation of clients, they are intended to prevent false or deceptive advertisement or solicitation, and should be construed in a manner consistent with that intent.

I. Purpose and Scope

A. Purpose

1. While the professional standards for the ethical practice of psychology, as a general discipline, are addressed in the American Psychological Association's **Ethical Principles of Psychologists**, these ethical principles do not relate, in sufficient detail, to current aspirations of desirable professional conduct for forensic psychologists. By design, none of the **Guidelines** contradicts any of the **Ethical Principles of Psychologists**; rather, they amplify those **Principles** in the context of the practice of forensic psychology, as herein defined.
2. The **Guidelines** have been designed to be national in scope and are intended to conform with state and Federal law. In situations where the forensic psychologist believes that the requirements of law are in conflict with the **Guidelines**, attempts to resolve the conflict should be

made in accordance with the procedures set forth in these *Guidelines* [IV(G)] and in the *Ethical Principles of Psychologists*.

B. Scope

1. The *Guidelines* specify the nature of desirable professional practice by forensic psychologists, within any subdiscipline of psychology (e.g., clinical, developmental, social, experimental), **when engaged regularly** as forensic psychologists.
 - a. “Psychologist” means any individual whose professional activities are defined by the American Psychological Association or by regulation of title by state registration or licensure, as the practice of psychology.
 - b. “Forensic psychology” means all forms of professional psychological conduct when acting, with definable foreknowledge, as a psychological expert on explicitly psycholegal issues, **in direct** assistance to courts, parties to legal proceedings, correctional and forensic mental health facilities, and administrative, judicial, and legislative agencies acting in an adjudicative capacity.
 - c. “Forensic psychologist” means psychologists who regularly engage in the practice of forensic psychology as defined in I(B)(1)(b).
2. The *Guidelines* do not apply to a psychologist who is asked to provide professional psychological services when the psychologist was not informed at the time of delivery of the services that they were to be used as forensic psychological services as defined above. The *Guidelines* may be helpful, however, in preparing the psychologist for the experience of communicating psychological data in a forensic context.
3. Psychologists who are not forensic psychologists as defined in I(B)(1)(c), but occasionally provide limited forensic psychological services, may find the Guidelines useful in the preparation and presentation of their professional services.

C. Related Standards

1. Forensic psychologists also conduct their professional activities in accord with the *Ethical Principles of Psychologists* and the various other statements of the American Psychological Association that may apply to particular subdisciplines or areas of practice that are relevant to their professional activities.
2. The standards of practice and ethical guidelines of other relevant “expert professional organizations” contain useful guidance and should be consulted even though the present *Guidelines* take precedence for forensic psychologists.

II. Responsibility

- A. Forensic psychologists have an obligation to provide services in a manner consistent with the highest standards of their profession. They are responsible for their own conduct and the conduct of those individuals under their direct supervision.
- B. Forensic psychologists make a reasonable effort to ensure that their services and the products of their services are used in a forthright and responsible manner.

III. Competence

- A. Forensic psychologists provide services only in areas of psychology in which they have specialized knowledge, skill, experience, and education.
- B. Forensic psychologists have an obligation to present to the court, regarding the specific matters to which they will testify, the boundaries of their competence, the factual bases (knowledge, skill, experience, training, and education) for their qualification as an expert, and the relevance of those factual bases to their qualification as an expert on the specific matters at issue.
- C. Forensic psychologists are responsible for a fundamental and reasonable level of knowledge and understanding of the legal and professional standards that govern their participation as experts in legal proceedings.
- D. Forensic psychologists have an obligation to understand the civil rights of parties in legal proceedings in which they participate, and manage their professional conduct in a manner that does not diminish or threaten those rights.
- E. Forensic psychologists recognize that their own personal values, moral beliefs, or personal and professional relationships with parties to a legal proceeding may interfere with their ability to practice competently. Under such circumstances, forensic psychologists are obligated to decline participation or to limit their assistance in a manner consistent with professional obligations.

IV. Relationships

- A. During initial consultation with the legal representative of the party seeking services, forensic psychologists have an obligation to inform the party of factors that might reasonably affect the decision to contract with the forensic psychologist. These factors include, but are not limited to

1. the fee structure for anticipated professional services;
 2. prior and current personal or professional activities, obligations, and relationships that might produce a conflict of interests;
 3. their areas of competence and the limits of their competence; and
 4. the known scientific bases and limitations of the methods and procedures that they employ and their qualifications to employ such methods and procedures.
- B. Forensic psychologists do not provide professional services to parties to a legal proceeding on the basis of “contingent fees,” when those services involve the offering of expert testimony to a court or administrative body, or when they call upon the psychologist to make affirmations or representations intended to be relied upon by third parties.
- C. Forensic psychologists who derive a substantial portion of their income from fee-for-service arrangements should offer some portion of their professional services on a pro bono or reduced fee basis where the public interest or the welfare of clients may be inhibited by insufficient financial resources.
- D. Forensic psychologists recognize potential conflicts of interest in dual relationships with parties to a legal proceeding, and they seek to minimize their effects.
1. Forensic psychologists avoid providing professional services to parties in a legal proceeding with whom they have personal or professional relationships that are inconsistent with the anticipated relationship.
 2. When it is necessary to provide both evaluation and treatment services to a party in a legal proceeding (as may be the case in small forensic hospital settings or small communities), the forensic psychologist takes reasonable steps to minimize the potential negative effects of these circumstances on the rights of the party, confidentiality, and the process of treatment and evaluation.
- E. Forensic psychologists have an obligation to ensure that prospective clients are informed of their legal rights with respect to the anticipated forensic service, of the purposes of any evaluation, of the nature of procedures to be employed, of the intended uses of any product of their services, and of the party who has employed the forensic psychologist.
1. Unless court ordered, forensic psychologists obtain the informed consent of the client or party, or their legal representative, before proceeding with such evaluations and procedures. If the client appears unwilling to proceed after receiving a thorough notification of the purposes, methods, and intended uses of the forensic evaluation, the evaluation should be postponed and the psychologist should take steps to place the client in contact with his/her attorney for the purpose of legal advice on the issue of participation.

2. In situations where the client or party may not have the capacity to provide informed consent to services or the evaluation is pursuant to court order, the forensic psychologist provides reasonable notice to the client's legal representative of the nature of the anticipated forensic service before proceeding. If the client's legal representative objects to the evaluation, the forensic psychologist notifies the court issuing the order and responds as directed.
 3. After a psychologist has advised the subject of a clinical forensic evaluation of the intended uses of the evaluation and its work product, the psychologist may not use the evaluation work product for other purposes without explicit waiver to do so by the client or the client's legal representative.
- F. When forensic psychologists engage in research or scholarly activities that are compensated financially by a client or party to a legal proceeding, or when the psychologist provides those services on a pro bono basis, the psychologist clarifies any anticipated further use of such research or scholarly product, discloses the psychologist's role in the resulting research or scholarly products, and obtains whatever consent or agreement is required by law or professional standards.
- G. When conflicts arise between the forensic psychologist's professional standards and the requirements of legal standards, a particular court, or a directive by an officer of the court or legal authorities, the forensic psychologist has an obligation to make those legal authorities aware of the source of the conflict and to take reasonable steps to resolve it. Such steps may include, but are not limited to, obtaining the consultation of fellow forensic professionals, obtaining the advice of independent counsel, and conferring directly with the legal representatives involved.

V. Confidentiality and Privilege

- A. Forensic psychologists have an obligation to be aware of the legal standards that may affect or limit the confidentiality or privilege that may attach to their services or their products, and they conduct their professional activities in a manner that respects those known rights and privileges.
1. Forensic psychologists establish and maintain a system of record keeping and professional communication that safeguards a client's privilege.
 2. Forensic psychologists maintain active control over records and information. They only release information pursuant to statutory requirements, court order, or the consent of the client.

- B. Forensic psychologists inform their clients of the limitations to the confidentiality of their services and their products (see also Guideline IV E) by providing them with an understandable statement of their rights, privileges, and the limitations of confidentiality.
- C. In situations where the right of the client or party to confidentiality is limited, the forensic psychologist makes every effort to maintain confidentiality with regard to any information that does not bear directly upon the legal purpose of the evaluation.
- D. Forensic psychologists provide clients or their authorized legal representatives with access to the information in their records and a meaningful explanation of that information, consistent with existing Federal and state statutes, the *Ethical Principles of Psychologists*, the *Standards for Educational and Psychological Testing*, and institutional rules and regulations.

VI. Methods and Procedures

- A. Because of their special status as persons qualified as experts to the court, forensic psychologists have an obligation to maintain current knowledge of scientific, professional and legal developments within their area of claimed competence. They are obligated also to use that knowledge, consistent with accepted clinical and scientific standards, in selecting data collection methods and procedures for an evaluation, treatment, consultation or scholarly/empirical investigation.
- B. Forensic psychologists have an obligation to document and be prepared to make available, subject to court order or the rules of evidence, all data that form the basis for their evidence or services. The standard to be applied to such documentation or recording *anticipates* that the detail and quality of such documentation will be subject to reasonable judicial scrutiny; this standard is higher than the normative standard for general clinical practice. When forensic psychologists conduct an examination or engage in the treatment of a party to a legal proceeding, with foreknowledge that their professional services will be used in an adjudicative forum, they incur a special responsibility to provide the best documentation possible under the circumstances.
 - 1. Documentation of the data upon which one's evidence is based is subject to the normal rules of discovery, disclosure, confidentiality, and privilege that operate in the jurisdiction in which the data were obtained. Forensic psychologists have an obligation to be aware of those rules and to regulate their conduct in accordance with them.

2. The duties and obligations of forensic psychologists with respect to documentation of data that form the basis for their evidence apply from the moment they know or have a reasonable basis for knowing that their data and evidence derived from it are likely to enter into legally relevant decisions.
- C. In providing forensic psychological services, forensic psychologists take special care to avoid undue influence upon their methods, procedures, and products, such as might emanate from the party to a legal proceeding by financial compensation or other gains. As an expert conducting an evaluation, treatment, consultation, or scholarly/empirical investigation, the forensic psychologist maintains professional integrity by examining the issue at hand from all reasonable perspectives, actively seeking information that will differentially test plausible rival hypotheses.
- D. Forensic psychologists do not provide professional forensic services to a defendant or to any party in, or in contemplation of, a legal proceeding prior to that individual's representation by counsel, except for persons judicially determined, where appropriate, to be handling their representation pro se. When the forensic services are pursuant to court order and the client is not represented by counsel, the forensic psychologist makes reasonable efforts to inform the court prior to providing the services.
1. A forensic psychologist may provide emergency mental health services to a pretrial defendant prior to court order or the appointment of counsel where there are reasonable grounds to believe that such emergency services are needed for the protection and improvement of the defendant's mental health and where failure to provide such mental health services would constitute a substantial risk of imminent harm to the defendant or to others. In providing such services the forensic psychologist nevertheless seeks to inform the defendant's counsel in a manner consistent with the requirements of the emergency situation.
 2. Forensic psychologists who provide such emergency mental health services should attempt to avoid providing further professional forensic services to that defendant unless that relationship is reasonably unavoidable [see N(D)(2)].
- E. When forensic psychologists seek data from third parties, prior records, or other sources, they do so only with the prior approval of the relevant legal party or as a consequence of an order of a court to conduct the forensic evaluation.
- F. Forensic psychologists are aware that hearsay exceptions and other rules governing expert testimony place a special ethical burden upon them. When hearsay or otherwise inadmissible evidence forms the basis of their opinion, evidence, or professional product, they seek to minimize sole reliance upon such evidence. Where circumstances reasonably permit,

forensic psychologists seek to obtain independent and personal verification of data relied upon as part of their professional services to the court or to a party to a legal proceeding.

1. While many forms of data used by forensic psychologists are hearsay, forensic psychologists attempt to corroborate critical data that form the basis for their professional product. When using hearsay data that have not been corroborated, but are nevertheless utilized, forensic psychologists have an affirmative responsibility to acknowledge the uncorroborated status of those data and the reasons for relying upon such data.
 2. With respect to evidence of any type, forensic psychologists avoid offering information from their investigations or evaluations that does not bear directly upon the legal purpose of their professional services and that is not critical as support for their product, evidence or testimony, **except where such disclosure is required by law.**
 3. When a forensic psychologist relies upon data or information gathered by others, the origins of those data are clarified in any professional product. In addition, the forensic psychologist bears a special responsibility to ensure that such data, if relied upon, were gathered in a manner standard for the profession.
- G. Unless otherwise stipulated by the parties, forensic psychologists are aware that no statements made by a defendant, in the course of any (forensic) examination, no testimony by the expert based upon such statements, nor any other fruits of the statements can be admitted into evidence against the defendant in any criminal proceeding, except on an issue respecting mental condition on which the defendant has introduced testimony. Forensic psychologists have an affirmative duty to ensure that their written products and oral testimony conform to this Federal Rule of Procedure (12.2[c]), or its state equivalent.
1. Because forensic psychologists are often not in a position to know what evidence, documentation, or element of a written product may be or may lend to a “fruit of the statement,” they exercise extreme caution in preparing reports or offering testimony prior to the defendant’s assertion of a mental state claim or the defendant’s introduction of testimony regarding a mental condition. Consistent with the reporting requirements of state or federal law, forensic psychologists avoid including statements from the defendant relating to the time period of the alleged offense.
 2. Once a defendant has proceeded to the trial stage, and all pretrial mental health issues such as competency have been resolved, forensic psychologists may include in their reports or testimony any statements made by the defendant that are directly relevant to supporting their

expert evidence, providing that the defendant has “introduced” mental state evidence or testimony within the meaning of Federal Rule of Procedure 12.2(c), or its state equivalent.

- H. Forensic psychologists avoid giving written or oral evidence about the psychological characteristics of particular individuals when they have not had an opportunity to conduct an examination of the individual adequate to the scope of the statements, opinions, or conclusions to be issued. Forensic psychologists make every reasonable effort to conduct such examinations. When it is not possible or feasible to do so, they make clear the impact of such limitations on the reliability and validity of their professional products, evidence, or testimony.

VII. Public and Professional Communications

- A. Forensic psychologists make reasonable efforts to ensure that the products of their services, as well as their own public statements and professional testimony, are communicated in ways that will promote understanding and avoid deception, given the particular characteristics, roles, and abilities of various recipients of the communications.
1. Forensic psychologists take reasonable steps to correct misuse or misrepresentation of their professional products, evidence, and testimony.
 2. Forensic psychologists provide information about professional work to clients in a manner consistent with professional and legal standards for the disclosure of test results, interpretations of data, and the factual bases for conclusions. A full explanation of the results of tests and the bases for conclusions should be given in language that the client can understand.
 - a. When disclosing information about a client to third parties who are not qualified to interpret test results and data, the forensic psychologist complies with Principle 16 of the *Standards for Educational and Psychological Testing*. When required to disclose results to a nonpsychologist, every attempt is made to ensure that test security is maintained and access to information is restricted to individuals with a legitimate and professional interest in the data. Other qualified mental health professionals who make a request for information pursuant to a lawful order are, by definition, “individuals with a legitimate and professional interest.”
 - b. In providing records and raw data, the forensic psychologist takes reasonable steps to ensure that the receiving party is informed that raw scores must be interpreted by a qualified professional in order to provide reliable and valid information.

- B. Forensic psychologists realize that their public role as “expert to the court” or as “expert representing the profession” confers upon them a special responsibility for fairness and accuracy in their public statements. When evaluating or commenting upon the professional work product or qualifications of another expert or party to a legal proceeding, forensic psychologists represent their professional disagreements with reference to a fair and accurate evaluation of the data, theories, standards, and opinions of the other expert or party.
- C. Ordinarily, forensic psychologists avoid making detailed public (out-of-court) statements about particular legal proceedings in which they have been involved. When there is a strong justification to do so, such public statements are designed to assure accurate representation of their role or their evidence, not to advocate the positions of parties in the legal proceeding. Forensic psychologists address particular legal proceedings in publications or communications only to the extent that the information relied upon is part of a public record, or consent for that use has been properly obtained from the party holding any privilege.
- D. When testifying, forensic psychologists have an obligation to all parties to a legal proceeding to present their findings, conclusions, evidence, or other professional products in a fair manner. This principle does not preclude forceful representation of the data and reasoning upon which a conclusion or professional product is based. It does, however, preclude an attempt, whether active or passive, to engage in partisan distortion or misrepresentation. Forensic psychologists do not, by either commission or omission, participate in a misrepresentation of their evidence, nor do they participate in partisan attempts to avoid, deny, or subvert the presentation of evidence contrary to their own position.
- E. Forensic psychologists, by virtue of their competence and rules of discovery, actively disclose all sources of information obtained in the course of their professional services; they actively disclose which information from which source was used in formulating a particular written product or oral testimony.
- F. Forensic psychologists are aware that their essential role as expert to the court is to assist the trier of fact to understand the evidence or to determine a fact in issue. In offering expert evidence, they are aware that their own professional observations, inferences, and conclusions must be distinguished from legal facts, opinions, and conclusions. Forensic psychologists are prepared to explain the relationship between their expert testimony and the legal issues and facts of an instant case.

National Organization of Forensic Social Work

Code of Ethics (reprinted with permission)

Preamble

In accepting membership in the National Organization of Forensic Social Work, each Forensic Social Work Practitioner solemnly pledges to adhere to the Code of Ethics. The Forensic Social Work Practitioner agrees, in accordance with this Code of Ethics, to fulfill the following obligations to society, fellow colleagues and their organizations, individual members of the National Organization of Forensic Social Work and the National Organization of Forensic Social Work. Each Forensic Social Work Practitioner shall promote well being, minimize potential harm, and encourage the equal availability of quality Forensic Social Work services to all.

Section I

Ethical Responsibility to the National Organization of Forensic Social Work

Canon 1. Each member of the National Organization of Forensic Social Work shall possess the required qualifications of education, background and experience to perform the duties of a Forensic Social Work Practitioner.

Canon 2. Members of the National Organization of Forensic Social Work shall not misrepresent a member's qualifications, education, background or experience either orally or in writing for any purpose, including purposes of obtaining membership, licensing and/or certification.

Canon 3. Each Forensic Social Work Practitioner shall keep abreast of changing laws effecting practice, participate in inservice training

programs, attend professional conferences, expand their practice skills through professional publications, consult on forensic matters with professional colleagues, and present educational material to colleagues and other professionals when so requested.

Canon 4. Each member shall be responsible for informing other professionals and the public about the work and standards of the National Organization of Forensic Social Work.

Canon 5. The Forensic Social Work Practitioner shall clearly distinguish between his/her statements made on behalf of the National Organization of Forensic Social Work and those made as a private citizen.

Canon 6. The Forensic Social Work Practitioner shall attempt to clearly identify potential conflicts among laws, rules, policies and treatment goals when serving the client, in consultation with other agencies or with members of society.

Canon 7. Each Forensic Social Work Practitioner who pursues scholarly inquiry through research and publication shall insure confidentiality and minimize physical and/or psychological harm to all clients.

Canon 8. Members of the National Organization of Forensic Social Work shall only participate in research with subjects who have voluntarily given his/her informed written consent. Care shall be taken to protect the privacy and dignity of research subjects. There shall be no penalty to the client for refusal to participate in any research project.

Canon 9. Appropriate credit should be given in publications according to standards set by publishers. Major contributors shall be listed. The primary author should be listed first.

Section II

Ethical Responsibilities to Employers and Colleagues

Canon 10. The Forensic Social Work Practitioner shall adhere to commitments voluntarily entered into between the Forensic Social Work Practitioner and the employing agency.

Canon 11. The Forensic Social Work Practitioner shall report unethical conduct of employers or colleagues to appropriate agencies and/or professional organizations.

Canon 12. The Forensic Social Work Practitioner shall refuse to participate in any unethical conduct or procedure against any client, colleague or agency.

Canon 13. The Forensic Social Work Practitioner shall treat clients, colleagues, supervisees, students and trainees with respect and dignity.

Canon 14. The Forensic Social Work Practitioner shall conduct evaluations of supervisees, students or trainees in a fair and equitable manner according to agency norms or personnel practices. Such evaluations shall be shared with the subject of said evaluation.

Canon 15. The Forensic Social Work Practitioner shall consult with colleagues upon request.

Canon 16. The Forensic Social Work Practitioner shall not solicit clients from the member's agency for private practice unless such is in accordance with the agency's policies.

Section III

Ethical Responsibilities to Clients

Canon 17. The Forensic Social Work Practitioner shall not discriminate on the basis of race, nationality, religion, color, age, sex, sexual orientation, mental or physical disability, political belief, marital, or legal status in providing Forensic Social Work services.

Canon 18. The Forensic Social Work Practitioner shall clearly identify the source of referral, inform individuals being evaluated or treated of the nature and purpose of the evaluation, and use applicable standards of confidentiality with whom the information will be shared.

Canon 19. The Forensic Social Work Practitioner shall not provide treatment that could endanger the physical, emotional or psychiatric health of the client.

Canon 20. The Forensic Social Work Practitioner shall seek consultation when appropriate.

Canon 21. The Forensic Social Work Practitioner shall make referrals to other professionals and agencies when it is deemed to be in the best interest of the client. The client shall be informed of such referral.

Canon 22. The Forensic Social Work Practitioner shall avoid potential conflicts of interest by refusing to accept clients when there is a possible conflict between personal, family and/or professional responsibilities.

Canon 23. When terminating treatment against the client's wishes, care shall be taken to adequately explain the basis for the Forensic Social Work Practitioner's decision and to insure the opportunity for continuity of services by appropriate referral to other professionals or agencies.

Canon 24. The Forensic Social Work Practitioner shall protect the confidentiality of all records and documents subject to law. Disclosures of information shall be made only with the client's informed, written consent.

Canon 25. The Forensic Social Work Practitioner shall set reasonable and customary fees which are in accordance with rates for services performed of a similar nature by other professionals.

Canon 26. The Forensic Social Work Practitioner shall make services available to selected indigent clients.

Canon 27. The Forensic Social Work Practitioner shall receive remuneration for services performed.

Canon 28. The Forensic Social Work Practitioner shall not engage in any illegal activities, fraud or deceit.

Canon 29. The Forensic Social Work Practitioner shall not accept, demand, give or receive anything of value for making or receiving a referral from a colleague.

Canon 30. The Forensic Social Work Practitioner shall not allow his/her personal problems, mental illness, or drug or alcohol dependency to interfere in the delivery of services to clients. The Forensic Social Work Practitioner has the responsibility to seek appropriate treatment.

Canon 31. The Forensic Social Work Practitioner shall not engage in any sexual contact with clients, students, or any person under the authority of the Forensic Social Work Practitioner.

Canon 32. The Forensic Social Work Practitioner shall report any documented or suspected child abuse or neglect, abuse of patients or any other dependent persons to appropriate local or federal agencies in accordance with relevant local and national laws.

Canon 33. The Forensic Social Work Practitioner shall notify both the appropriate legal authorities and identified potential victim(s) when serious threats to do imminent bodily harm are made by clients.

Canon 34. The Forensic Social Work Practitioner shall obtain written consent of clients when video taping or recording interviews for professional or educational purposes.

Canon 35. The Forensic Social Work Practitioner shall be mindful of special duties to clients under legal age and shall insure that only the necessary information to maximize the client's progress in treatment be given to parents, guardians or appropriate agencies.

Section IV

Ethical Responsibility to Society

Canon 36. The Forensic Social Work Practitioner has an obligation to impact proposed legislation affecting the practice of Forensic Social Work.

Canon 37. The Forensic Social Work Practitioner shall promote quality services and high standards for Forensic Social Work care equally to all people.

Canon 38. The Forensic Social Work Practitioner shall not perjure him/herself.

Canon 39. The Forensic Social Work Practitioner shall not delegate duties or responsibilities to any person not qualified to perform those duties or to accept those responsibilities.

Canon 40. The Forensic Social Work Practitioner shall not use professional knowledge and skills in any enterprise detrimental to the public well being.

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