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# Controversial Ethical Issues in Forensic Psychiatry: A Survey

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**ABSTRACT:** A survey was conducted of members of the Psychiatry and Behavioral Science section of the American Academy of Forensic Sciences (AAFS) to determine their ethical concerns about controversial items. Issues were included in the survey from the American Psychiatric Association (APA) and AAFS Code of Ethics. Strong support was found for those issues. Some AAPL items from a previous version of their guidelines did not receive support. Fortunately, they have been modified in a later AAPL draft, after AAPL received this survey's results. Clarification was obtained on some ambiguous items from a previous AAFS survey. The present survey showed strong support for addressing in forensic psychiatry's ethical guidelines some issues previously considered too controversial.

**KEYWORDS:** psychiatry, ethics, privacy, doctor-patient privilege, survey, confidentiality, forensic psychiatry, criminal justice work, ethical guidelines, advocacy, hired gun, death penalty, right to refuse treatment, child abuse, Tarasoff, marijuana, bias, questionnaire

Ethical issues have become increasingly important to both forensic psychiatry and psychology. These disciplines are sometimes accused of being purely subjective, without any clear-cut scientific truth or test. The general public does not understand mental illness, and some forensic science cases that involve psychiatric issues receive much negative publicity.

Ethical conflicts can also develop because forensic psychiatry is at the interface of the differing professions of medicine and law. Sometimes it is not inherently clear which ethics to follow, and the ethics of the two professions sometimes differ. As the criminal justice system becomes more punitive, its goals and the goals of medicine become potentially more disparate, and cases in which the differences cannot be ignored grow in frequency.

During an earlier era, Seymour Pollack [*1*] formulated a definition of forensic psychiatry which concluded with a statement that the forensic psychiatrist applied psychiatry to legal issues for legal purposes and ends. It was considered not relevant to question the legal purposes or ends when functioning in the capacity of a forensic psychiatrist. When the criminal justice system included at least some serious focus on rehabilitation, efforts existed by the legal system, as well as by medicine, to help the defendant as well as society. There was, perhaps, a difference in emphasis, and retribution was always one function of the criminal

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justice system, but fundamentally the two professions were in at least some accord. Therefore, it was relatively easy for the forensic psychiatrist to adopt legal purposes and ends and find little conflict with traditional medical ethics and values.

However, as the legal system has given up on rehabilitation and focused increasingly solely upon containment and punishment, it has become at times less clear whether a beneficial purpose to anyone is being served, other than that of harsh justice being done or the satisfaction of getting even. Although these may be legitimate legal goals, there is subsequently greater potential for more frequent conflicts as the disparity increases between the requests of the legal system and the traditional goals of medicine. These differences perhaps are most clearly seen in death penalty cases. In these cases, as well as others, it has become not so easy for the forensic psychiatrist to close his eyes to the purposes toward which his expertise is utilized. Ethical issues in forensic psychiatry are also more difficult to ignore than in toxicology or pathology, since the psychiatric evaluation usually involves direct contact with the individual and not solely an application of technical expertise. Because forensic psychiatry involves the application of psychiatry, it should be within the province of psychiatry and not the law to determine the ethics of the methods the forensic psychiatrist utilizes. Until recently, little guidance existed for the confused or troubled practitioner in these difficult matters.

The American Board of Forensic Psychiatry has recognized the need for forensic psychiatrists to develop our own ethical guidelines and not relegate the profession's ethics to determinations by others. Their new definition of forensic psychiatry [*2*] concludes with a statement that "forensic psychiatry should be practiced in accordance with guidelines and ethical principles enunciated by the profession of psychiatry." The Board thereby recognized the necessity for the forensic psychiatric profession to develop ethical guidelines which are consistent with psychiatric and medical ethics and which do not, by default, leave the specific professional ethics of forensic psychiatry and psychology to the whims of the legal or any other system.

The American Academy of Psychiatry and the Law (AAPL), under Jonas Rappeport and later under Henry Weinstein, has done some valuable preliminary work on ethics in forensic psychiatry [*3*]. John Monahan in 1980 conducted a survey of psychologists regarding which ethical issues generated concerns among psychologists [*4*]. In 1984 the Committee on Ethics of the Psychiatry Section of the American Academy of Forensic Sciences (AAFS) conducted a survey of the membership regarding their ethical concerns [*5*]. Of the 63.0% of the members who responded, only 6.2% stated they had never encountered an ethical problem in their work. The members, in a write-in section, listed the problem of the "hired gun" as the issue of greatest ethical concern to them, followed in order by: becoming an advocate and not giving an honest evaluation, confidentiality, patient versus societal obligations, testifying in court without adequate knowledge, and the differences between medical ethics and legal ethics. Of the issues directly addressed in the questionnaire, those of greatest concern, in decreasing order, were: breach of confidentiality, right to refuse treatment, pretrial evaluation before consultation with attorney, conflicting loyalties to a patient and to the people who pay one's salary, and the differing ethics of the medical and legal professions. There was little agreement on the issues of: a psychiatrist contributing in *any* way to a death penalty verdict, a right to rehabilitation, a positive effect of therapy, or the prediction of dangerousness. Some of the results were ambiguous, and the disagreements on the death penalty issue when stated in absolute terms, as above, that is, contributing in *any* way to a death penalty verdict, may have obscured aspects about which actual agreement did exist.

The American Psychiatric Association (APA) has developed *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* [*6*], which are based upon the American Medical Association's (AMA) *Principles of Medical Ethics,* as well as *Opinions of the Ethics Committee on the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* [*7*]. Although many forensic psychiatrists, in my experience, are not

familiar with these, some important issues in forensic psychiatry are confronted in these works by the APA.

The AAFS also addressed some issues relevant to forensic psychiatry in its Code of Ethics and Conduct [*8*]. However, its emphasis is on all the forensic sciences, and therefore the Code does not address many ethical issues of special concern to the Psychiatry and Behavioral Science section. The Code, however, does include some relevant provisions.

The AAPL has recently developed proposed ethical guidelines which primarily address noncontroversial issues [*9*]. Many issues, however, were not included, partly because they were believed to be too controversial. The guidelines serve a very useful purpose in specifically formulating some important and basic ethical issues. This contribution is very significant since it would be impossible to hold forensic psychiatrists accountable if there were no ethical guidelines, a point originally noted by Alan Stone [*10*]. Moreover, the guidelines do supply guidance on some important matters. AAPL, however, did not formally survey its members on any issues. Although preliminary drafts were made available to all members via the organization newsletter, the majority never did comment on it. Therefore, it remains unclear how the general membership felt about some specific issues, especially those which were not included.

Because of a lack of clarity in some of the items in the previous AAFS questionnaire, the Committee on Ethics of the Psychiatry and Behavioral Science Section of AAFS decided to conduct another survey of the membership in 1986, in which an attempt would be made to clarify further some controversial items from the 1984 questionnaire. In addition, it was decided to address some of the more problematic items in AAPL's October 1986 draft of its Ethical Guidelines. For comparison purposes, ethical issues already addressed by the APA and AAFS were also included in the survey. An attempt was made especially to consider and evaluate those controversial ethical issues not yet covered by ethical guidelines, as well as to clarify those issues which were not addressed clearly in our previous questionnaire.

## Method

A total of 104 questionnaires were mailed to psychiatrists and psychologists who were members of the Psychiatry and Behavioral Sciences Section of AAFS and were either listed in the Directory or already had been approved for provisional membership. Effectively 102 questionnaires were distributed because 2 members were deceased. The questionnaires were mailed in October 1986. Responses were tabulated until 1 Feb. 1987. All members were apprised that they should answer the questionnaire promptly if they wished their views to be included. Each question asked whether the psychiatrist or psychologist saw an ethical *problem* in a series of situations. Each answer on the questionnaire had 5 points of response, with the central point being neutral, the extremes representing "definitely yes" and "definitely no," and the intermediate points, "qualified yes" and "qualified no." There also was a question, "Do you believe our ethical guidelines should contain a provision which treats death penalty matters as different because of their special seriousness?"

Each question was scored, with "Definitely yes" receiving a score of 2, and "Qualified yes" a score of 1. "Definitely no" received a score of $-2$, and "Qualified no" a score of $-1$. "No opinion" received a score of 0, and no answer on any questionnaire item was not counted. An average score was then obtained by subtracting negative scores from positive scores, and dividing by the number of responses. The maximum possible score was thus 2.0 if all respondents believed the issues to be a definite ethical problem. A score of $-2$ would result if all respondents definitely saw no ethical problem. A score of 0 would result if those who saw an ethical problem were equally balanced by those who did not. "No opinion," therefore, contributed to a zero score. No answer to the question was not scored. Percentages of "yes" and "no" responders were also tabulated.

## Results

There was a good response to the questionnaire with a response rate of 60.7%. Only two members returned the questionnaire with personal objections to the survey and no responses to any question. Their questionnaires were tabulated as "no response" to each item. One other respondent gave detailed answers which were translated by the author into the categories in the questionnaire as closely as possible. The overwhelming number of respondents were psychiatrists, reflecting the present membership of the psychiatry and behavioral science section.

The issues on the questionnaire which most saw as reflecting ethical problems are listed in Table 1, in descending order of importance.

The problem areas which most did not see as reflecting ethical problems or regarding which there was significant disagreement are listed in Table 2.

Table 3 gives responses to the 1984 questionnaire [5] for comparison purposes, and scores are tabulated in a manner identical to the items in Table 1.

## Discussion

Responses on the questionnaire show that significant numbers of forensic psychiatrists perceive many of the issues in the questionnaire to represent ethical problems, which should be addressed in guidelines in some manner. APA and AAFS items, which were included in the questionnaire from existing codes and annotations, *all* received significant support as representing ethical problems. Many controversial AAPL items, from their October 1986 draft, which were included in our questionnaire. were not supported by most members, except for the item of continually clarifying one's role to a defendant who misunderstands it, which was included in earlier versions but initially was deleted from the October 1986 draft. It was later returned in a modified manner in the February 1987 draft. Fortunately, since receiving the results of our AAFS questionnaire, AAPL has modified the February 1987 draft to take into consideration some of the results of this survey and to delete or modify the items which the present survey showed to be objectionable.

In our 1984 survey, forensic psychiatrists perceived the most significant ethical issues to be the problems of the "hired gun" and of becoming an advocate and thereby not giving an honest opinion. Consistent with these views, there was also substantial support in the new (1986) questionnaire for not becoming committed to a position before examining the person, the records, or the facts.

The new questionnaire also showed concern about withholding a portion of the truth on the witness stand. Becoming an advocate for an opinion by voluntarily revealing only those facts which help one's side, and by coaching the attorney about what questions *not* to ask even though the original opinion was reached in an impartial objective manner, was seen as an ethical problem by a slight majority. This result was found in spite of AAPL encouraging advocacy for an opinion in its October 1986 guidelines draft. This remains an issue of concern to AAFS Psychiatry and Behavioral Science members, and AAPL in its February 1987 draft fortunately has modified its support for becoming an advocate for an opinion. AAFS members generally also opposed telling only that portion of the truth which helps one's side on the witness stand. Perhaps a distinction here needs to be made between what an expert witness reveals voluntarily on the witness stand, and what is revealed under cross-examination—a distinction made by some respondents.

Some selective bias in favor of one's side is probably unavoidable and is almost expected by all participants in the legal system, at least after an unbiased opinion is reached. Perhaps, our guidelines need nonetheless to encourage less bias and advocacy, as well as a willingness not to mislead. If one is asked, the whole truth should be revealed to the best of one's ability.

AAFS members appear to be concerned about a forensic psychiatrist becoming an advo-

TABLE 1—*Problem areas with most agreement.*

| | Issues | Score | % Yes | % No | % No Opinion |
|---|---|---|---|---|---|
| 1. | Lawyers give proportion of fee (APA)[a] | 1.78 | 96.6 | 3.3 | 0.0 |
| 2. | Does not describe lack of confidentiality (APA) | 1.78 | 96.6 | 3.3 | 0.0 |
| 3. | Misrepresents a portion of the data (AAFS)[b] | 1.68 | 93.3 | 1.7 | 5.0 |
| 4. | Raises no objection when asked to violate psychiatric ethics (APA) | 1.67 | 95.0 | 5.0 | 0.0 |
| 5. | Claims expertise where no experience (AAFS) | 1.62 | 91.6 | 5.0 | 3.3 |
| 6. | Commits to position before examining person, record, or facts | 1.61 | 90.6 | 5.1 | 3.4 |
| 7. | Does not apprise patient of consequences of waiving privacy (APA) | 1.58 | 93.2 | 5.1 | 1.7 |
| 8. | Reports prison marijuana usage despite promise not to | 1.57 | 93.3 | 6.6 | 0.0 |
| 9. | Pretrial evaluation before attorney consult, not solely for treatment (APA) | 1.52 | 93.3 | 5.0 | 1.7 |
| 10. | Permits certification for involuntary treatment without exam (APA) | 1.48 | 88.4 | 8.3 | 3.3 |
| 11. | Does not personally examine in death penalty cases, yet gives opinion | 1.39 | 81.4 | 10.2 | 8.5 |
| 12. | Does not continually clarify role to defendant who misunderstands (AAPL)[c] | 1.34 | 86.4 | 8.5 | 5.1 |
| 13. | Writes seclusion order solely to support discipline | 1.26 | 79.6 | 10.2 | 10.2 |
| 14. | Does not respect competent prisoner's right to refuse psychiatric treatment if not committable | 1.26 | 82.7 | 6.9 | 10.3 |
| 15. | Ordered to reveal patient confidences yet makes no effort to preserve confidentiality (APA) | 1.22 | 86.5 | 6.8 | 6.8 |
| 16. | Specifically recommends death penalty verdict | 1.08 | 71.7 | 13.3 | 15.0 |
| 17. | Expresses opinion on legal issue without attempting to ascertain legal criteria | 1.08 | 80.0 | 18.4 | 1.7 |
| 18. | Sees no duty to protect *both* defendant and society, regardless of who pays | 1.03 | 70.7 | 15.5 | 13.8 |
| 19. | Performs forensic evaluation without attempting to obtain significant material | 1.02 | 78.3 | 16.6 | 5.0 |
| 20. | Reveals irrelevant material which can be used to press settlement | 0.98 | 73.2 | 19.7 | 7.1 |
| 21. | Tells only a portion of the truth on witness stand despite oath | 0.96 | 75.0 | 20.0 | 5.0 |
| 22. | Reports past child abuse when no current abuse is suspected | 0.95 | 67.8 | 10.2 | 22.0 |
| 23. | Is a participant in a legally authorized execution (APA) | 0.90 | 65.0 | 20.0 | 15.0 |
| 24. | Sees a need to treat death penalty differently because of special seriousness (opinion) | 0.78 | 63.7 | 20.7 | 15.5 |
| 25. | Expresses opinion on legal criteria amounting to death penalty recommendation | 0.71 | 56.9 | 19.0 | 24.1 |
| 26. | Reports threat not considered imminently serious, merely for maximum self-protection | 0.63 | 66.1 | 28.7 | 5.0 |

[a]This issue is included in the American Psychiatric Association's *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* or the *Opinions of the Ethics Committee on the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry.*

[b]This issue is included in the American Academy of Forensic Sciences' *Code of Ethics and Conduct.*

[c]This issue was included in the October 1986 Draft of the Proposed Ethical Guidelines of the American Academy of Psychiatry and the Law.

TABLE 2—*Problem areas opposed or with little agreement.*

| | Item | Score | % Yes | % No | % No Opinion |
|---|---|---|---|---|---|
| 1. | Performs forensic evaluation on former patient in major case (AAPL) | −0.88 | 15.3 | 74.6 | 10.2 |
| 2. | Testifies for patient on basis of information from therapy | −0.47 | 26.7 | 58.4 | 15.0 |
| 3. | Evaluates competency to be executed | −0.39 | 25.4 | 57.6 | 16.9 |
| 4. | Testifies about child custody suitability without examining parent if states limitations (AAPL) | −0.29 | 33.8 | 59.3 | 6.8 |
| 5. | Treats someone to restore competency to be executed | −0.12 | 38.4 | 45.0 | 16.7 |
| 6. | Becomes an advocate for an opinion (AAPL) | 0.14 | 49.1 | 44.1 | 6.8 |

TABLE 3—*1984 ethics questionnaire (AAFS).*

| | Item | Score |
|---|---|---|
| 1. | Breach of confidentiality | 1.02 |
| 2. | Right to refuse treatment | 0.98 |
| 3. | Pretrial evaluation before attorney | 0.93 |
| 4. | Conflicting loyalties | 0.53 |
| 5. | Differing ethics of medical and legal professions | 0.47 |

cate, both in the 1984 survey and the present one. This concern probably is an outgrowth of the concern about the "hired gun" problem—the issue of greatest concern in the 1984 survey. Advocacy remains of concern as a problem, despite the points made by Bernard Diamond [*11*] in 1959 regarding the impossibility of a totally impartial expert.

The second item of highest concern in 1984 was the problem of confidentiality and patient versus societal obligations. This issue was supported in the present study. It was manifested by concerns about the problem of reporting prison marijuana use despite a promise of confidentiality and the problem of not revealing irrelevant material to one's employer which can be used to pressure a settlement (for example, blackmail). Four items were included in the present study which involve confidentiality and which a large consensus saw as ethical problems: not describing the lack of confidentiality to a defendant in a competency exam; not apprising a patient of the possible consequences of waiving the privilege of privacy; doing a pretrial evaluation of a defendant before he has had access to an attorney and the purpose is *not* solely treatment; and being ordered to reveal patient confidences, yet making no effort to preserve confidentiality. These four items were all adopted from the APA annotations.

Testifying in court without adequate knowledge was another major concern in 1984. It was supported in the present study in the items of not expressing an opinion on a legal issue without attempting to ascertain relevant legal criteria, or performing a forensic science evaluation without attempting to obtain significant materials. The AAFS Code of Ethics item of not claiming expertise in an area without experience also received significant support as an item of ethical concern to members.

The right to refuse treatment was supported in the questionnaire item that saw an ethical problem in writing seclusion orders solely to support prison discipline, as well as in the problem of not respecting a competent prisoner's right to refuse psychiatric treatment if he does not meet the state's criteria for civil commitment. AAPL in the February 1987 draft of its

guidelines still takes a much more limited position on this issue, making the need to respect a prisoner's right to refuse treatment contingent on the rules in the jurisdiction. AAPL states, "the psychiatrist providing treatment in these settings should be familiar with the jurisdiction's rules in regard to the patient's right to refuse treatment."

The issue of not evaluating a defendant pretrial before an attorney is involved was clarified by including "not evaluating him solely for treatment." Such clarification raised the score from 0.93 in 1984 to 1.52 in 1986, indicating much greater agreement and strong support for this APA issue.

The death penalty questions produced significantly differing results, depending upon the specific matters in question. The members clearly discriminated between the various facets. There was very strong support for including not giving an opinion in a death penalty case without personally examining the defendant (despite the U.S. Supreme Court *Barefoot* decision) [*12*]. There also was strong support for including a requirement not to recommend specifically a death penalty verdict. There was more support for these two issues than for including the APA guideline on this subject, which requires that a psychiatrist not be a participant in a legally authorized execution [*6*]. That latter item, nevertheless, still did get significant support also. There was also substantial but lesser support for including "not expressing an opinion on a state's legal criteria for the death penalty," virtually amounting to a death penalty recommendation. Support additionally was shown for considering as an ethical problem—treating death penalty cases differently because of their special seriousness. Opposition was found to including consideration of evaluation of competency to be executed, as being contrary to professional ethics. There was very slight opposition, approaching a true equal mixture of opinion, to considering treating a person to restore his competence to be executed to be an ethical problem. The 1984 questionnaire had shown mixed opinions regarding the issue of testifying in such a way as to contribute in any way to a death penalty verdict. Clarifying and separating the issues in the present survey did lead to differing opinions on different aspects.

It appears that the members clearly oppose a forensic psychiatrist expressing an opinion in a death penalty case without a personal examination—an impossible task. It generally was believed that such a serious situation necessitates personal examination before expressing an opinion, regardless of the fact that the U.S. Supreme Court decided to permit such testimony in the Barefoot case [*12*]. This is an example of the differing ethics of the legal and psychiatric professions and the impossibility of the legal system determining what is ethical or even technically adequate for a psychiatrist. The survey results suggest that our profession wishes to hold its members to a more stringent ethical standard than did the Supreme Court in the Barefoot decision. The psychiatric profession wishes to determine its own ethical guidelines in this regard as expressed in the definition of forensic psychiatry by the American Board of Forensic Psychiatry. Only the psychiatric profession legitimately can determine the ethical guidelines of the forensic psychiatric profession.

Most members also believe it to be an ethical problem to recommend a death penalty verdict specifically or to do so indirectly by giving an opinion about a state's legal criteria for the death penalty, virtually amounting to a recommendation for death. Such a recommendation apparently was believed to be almost a direct recommendation and to be a role not consistent with usual psychiatric practice. It also was considered unethical to participate directly in a legally authorized execution, consistent with the APA's Annotations to the AMA's Principles of Medical Ethics. Most members apparently believed that it was ethical to perform our usual roles, such as evaluating a prisoner's competency to be executed or also in treating him to restore his competence to be executed, even if performing these roles indirectly led to an execution. These differentiations clarify the item from the 1984 questionnaire on the death penalty issues and demonstrate the value of including the various facets in the current questionnaire. A few members in their questionnaire responses had objected to the

number of death penalty questions in the current survey, but discriminating among the various aspects did lead to agreement about certain facets of the problem. Moreover, the death penalty is increasingly a very real issue in many states.

Some controversial issues from the October 1986 version of the AAPL guidelines also were included for consideration in the AAFS 1986 questionnaire. The results of this AAFS survey fortunately were instrumental in AAPL's making changes in those items, after they were informed about the results of the survey. There was strong support for the original AAPL guideline (now changed) which required the continual clarification of one's role to a defendant who apparently misunderstands it. This survey still has not resulted in restoration of the original form, however, the questionnaire showed clear opposition to other matters and these items have been modified. Strong opposition existed to the preliminary AAPL guideline item which forbids forensic evaluation on former patients in major cases. Opposition also appeared to the preliminary AAPL guideline forbidding testimony about a parent's child custody suitability, without an examination, if the limitations of the opinion are stated. However, the last two controversial issues fortunately were modified by AAPL in the February 1987 versions of their ethical guidelines and now reflect better the views of our membership. These changes strengthen the possibility of a successful implementation of ethical guidelines and encourage consistency between the two organizations.

There also was clear support in the questionnaire for seeing a duty to *both* the defendant and society, regardless of who pays the fee. This finding may represent partially a concern about the differing ethics of the medical and legal professions, as well as being another facet of the strong concern about the "hired-gun" problem that had been expressed in the 1984 questionnaire. It also indicates that the majority believe that a forensic psychiatrist should not ignore the traditional values of the medical profession, and that as a member of the medical profession, the forensic psychiatrist has a duty to both the defendant and society, regardless of who pays the fee. There also was support for considering it an ethical problem to make reports which violate confidentiality, merely for the purpose of maximal legal self-protection, when it is not clearly necessary to do so. There was concern about reporting a threat of serious violence toward an identifiable victim when the therapist evaluates the threat to be a mere expression of anger with no imminent danger to a victim. Some Tarasoff-type laws, such as those adopted in California [*13*], and supported by major professional organizations, present such ethical problems. A recent questionable interpretation of the Child Abuse Laws by some California agencies suggested that all *past* abuse should be reported even when there is no reason to suspect a child currently to be at risk and regardless of whether the child is now an adult. This interpretation created additional serious ethical dilemmas for treating therapists. Such laws and interpretations create ethical problems by encouraging or demanding behavior which most forensic psychiatrists and probably psychologists would consider unethical.

The results of the present questionnaire show that many issues previously thought too controversial to appear in guidelines receive strong support from a significant majority of the membership of the AAFS Psychiatry and Behavioral Science Section. These items are supported to a degree equal to that of many ethical issues already addressed by many major professional organizations in the area of forensic psychiatry which had been included for comparison purposes. It is quite likely that most forensic psychiatrists and possibly psychologists share the same views on these matters. There is no reason to suspect any unusual bias in the AAFS membership. Therefore, the results most likely reflect the views of most forensic psychiatric and possibly psychological practitioners and should be addressed in ethical guidelines. Those issues which received only qualified support for inclusion should be included in our guidelines in a qualified manner so as to allow for some of the exceptions which were of concern to many members. It is crucial that ethical guidelines do not result in a majority forcing its views on a substantial and significant legitimate minority. The present

survey provides a means to acknowledge, address, and assess the concerns of the membership about various ethical issues. All members were encouraged to respond if they wished their views to be included in the final results. A majority did so, and therefore the results should be considered as reflective of the views and concerns of the membership as a whole and not merely the views of our Committee on Ethics or of our section officers. Nonresponders were given every opportunity to have their opinions considered, and there is no valid reason to expect any systematic bias in the nonresponders. Therefore, it is reasonable to interpret the results as representative of the views of the Psychiatry and Behavioral Science section membership.

In the absence of any absolute ethical standards, a survey of the members appears to be a reasonable way to assess the prevailing sense in the profession regarding ethical matters. Potentially, it should lead to the development of ethical guidelines which go beyond an individual's personal moral beliefs and should represent the views of a general consensus in the profession, thereby becoming part of its professional ethics. A general consensus should be required for inclusion but not necessarily total agreement, which probably is impossible and is not even present for existing APA and AAFS "guidelines." The primary goal of ethical guidelines is to guide the practitioner. A secondary goal should be to provide a basis for disciplinary action. Some guidelines might legitimately provide guidance, yet be sufficiently broad to preclude successful disciplinary action. Such a result would still not negate the value of the guideline. The Ethics Committees of the American Psychiatric Association and American Psychological Association, as well as that of the American Academy of Forensic Sciences, would be available for investigation of ethical violations or disciplinary action since the Committee on Ethics of the Psychiatric and Behavioral Sciences Section does not have such capabilities. Both the Ethics Committees of the American Psychiatric Association and the American Academy of Forensic Sciences already have expressed an interest in the results of our survey and in cooperating with us when ethical guidelines are developed.

The most striking and reassuring finding in our survey was the strong concern in the profession about ethical issues. It is, of course, still necessary to distinguish between personal politics and morality, and professional ethical guidelines. For example, it is possible to be personally *for* the death penalty as a citizen, yet *against* recommending it specifically in the professional capacity of a forensic psychiatrist.

Members in general were not totally against the death penalty, but the survey showed discrimination among specific aspects. Generally, the members did not consider it unethical to perform acts traditionally within the psychiatrist's role, even if they indirectly result in a death penalty verdict. They did not consider it unethical to perform evaluations for competency to be executed or to treat a defendant incompetent to be executed to restore his competence. They did consider it unethical to testify on an issue as important as the death penalty without a personal examination. They also did consider it unethical to recommend a death penalty directly, but generally did not require forensic psychiatrists to look too deeply into the ends to which their performance of traditional psychiatric roles would be utilized. Members, nevertheless, did consider it also unethical to express an opinion on a state's legal criteria for the death penalty, apparently since that would virtually amount to a death penalty recommendation.

Issues with strong support in the 1986 and 1984 questionnaires should be addressed in the ethical guidelines of forensic psychiatry and in particular those of the Psychiatry and Behavioral Science Section. Most likely this could best be accomplished by addenda to AAPL's ethical guidelines which provide a good basic foundation in their latest February 1987 draft. Many items of concern in the AAFS questionnaire still have not been addressed in the AAPL guidelines, and such an absence represents an important remaining problem.

Many AAFS survey items represent issues which have generated strong concerns both within and outside the profession. The questionnaire results mirror the needs of our profes-

sion for guidance in these areas. AAPL, the APA, and the AAFS already have set the precedent by developing ethical guidelines, principles, or codes of ethics. There was overwhelming support for the existing "guidelines" relevant to forensic psychiatry already included in the American Psychiatric Association's *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*. It would seem useful to restate these issues in our organizations' guidelines, to give them additional emphasis, and to broaden dissemination. This suggestion is especially apropos since informal discussions with forensic and nonforensic psychiatrists indicate that a majority are not familiar with or even aware of the existence of this work by the APA which is very relevant and pertinent to forensic psychiatry. Items adopted from the AAFS Code of Ethics also received strong support as reflecting ethical problems.

## Concluding Remarks

Our survey results lend support to addressing and including in ethical guidelines many issues which were considered previously as too controversial. It also highlights the need of forensic psychiatrists for guidance through professional guidelines which address their concerns, and recognize the complexities and ramifications of ethical issues. The best way I can interpret the survey results is that most forensic psychiatrists do not wish to perform blindly the bidding of the legal profession. They wish their endeavors to be consistent with traditional medical and psychiatric ethics and values, which they do not wish to sacrifice in their role as a forensic psychiatrist. They believe the forensic psychiatrist is still a physician and psychiatrist and not merely a technician. However, they do not believe it reasonable to require a forensic psychiatrist to look into potential distant ends to which his/her expertise can eventually be directed. They nevertheless believe that the forensic psychiatrist's ethics are different from that of the legal profession.

The survey indicates that the majority of forensic psychiatrists are troubled by the complex ethical issues which sometimes arise, and they have opinions regarding the ethics of certain behaviors. They have thought about these matters and wish these issues to be addressed in ethical guidelines in some manner. The substantial response to our lengthy questionnaire strongly indicates that the members of the profession want many of these "controversial" issues included. We should listen and respond.

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[*10*] Stone, A., "The Ethics of Forensic Psychiatry; A View from the Ivory Tower" in *Law, Psychiatry, and Morality*, American Psychiatric Press, Washington, DC, 1984, pp. 57-75.
[*11*] Diamond, B., "The Fallacy of the Impartial Expert," *Archives of Criminal Psychodynamics*, Vol. 3, 1959, pp. 221-229.
[*12*] *Barefoot v. Estelle*, 51 U.S.L.W. 5189, U.S. Supreme Court, 6 July 1983.
[*13*] California Civil Code Section 43.92.

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