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RESEARCH ARTICLE
The ethics of forensic psychiatry: moving beyond principles to a relational ethics approach
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Forensic psychiatry has been described as a ‘moral minefield’. The competing obligations at the interface of the justice and healthcare systems raise questions about the very viability of an ethical framework for guiding practice. The explicit need for security and detention, and the implicit ‘untrustworthiness’ of forensic patients shape practitioners’ everyday reality. Suspicion colors client–practitioner relationship and fundamental care concepts, such as patient advocacy, take on different nuances in this milieu. Despite the complex ethical demands of this unique practice area, it has received little attention within mainstream bioethics. There is, however, a growing imperative to find a theory of ethics for the specialty. In this article, the ethics of forensic psychiatry is examined, and it is argued that relational ethics is a fitting framework for forensic practice and, further, that forensic settings are the very place to test the validity of such an ethic.

Keywords: forensic psychiatry; forensic settings; mental health ethics; relational ethics; forensic ethics; professional practice

Introduction
Ethical issues in psychiatry have been long recognized as complex and challenging. Patients can be particularly vulnerable due to the nature of mental illness (Arboleda-Flórez & Weisstub, 1997) and the stigma attached to it (Goffman, 1961, 1963; Link, Mirotznik & Cullen, 1991; Schlosberg, 1993; Wahl, 1999). Power imbalances, including the possibility of involuntary treatment, add a dimension to therapeutic relationships that is often absent in other specialty areas. In forensic psychiatry a further dimension is added, as practitioners function at the interface of two systems – justice and healthcare – and must adapt to the demands of both. Regardless of healthcare profession, practicing ethically in forensic

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psychiatric environments presents a daunting task, as practitioner–patient relationships occur within a moral climate shaped by the competing demands of ‘custody’ and ‘care’. Unlike in other healthcare settings, in forensic psychiatry, skepticism is the basic stance of both members. Patients are aware that forensic practitioners are representatives of ‘the system’ involved in the enforcement of their confinement or parole/probation. For their part, professionals learn to act with caution and skepticism, and to question patient motives and actions. Practitioners are further challenged by what has been termed the ‘dual loyalty’ dilemma (Perlin, 1991), the commitment to meeting needs of both patients and those of society simultaneously.

Despite the complex ethical demands of forensic psychiatric settings, there has been little attention paid to them from within mainstream bioethics (Adshead, 2000). ‘Forensic psychiatry still lacks a theory of ethics by which to shape its behavior’ (Appelbaum, 1997, p. 234, original italics). Fortunately, debate has begun regarding what ethical framework could and should guide forensic practice (Rappeport, 1991; Reams, 1998). In this paper, the authors examine the literature concerning the ethics of forensic psychiatry, identifying some of the common ethical issues encountered and the approaches to ethical practice that have been proposed to date. The authors then consider relational ethics as a possible framework for guiding practice in these unique settings and, furthermore, argue that forensic psychiatric settings are the very place to test the validity of such an ethic.

Forensic psychiatric settings as places of special circumstance

Forensic settings are special places where society incarcerates those who are guilty of being unlawful, untrustworthy, and suspected of being or proven to be a risk to others. With varying degrees of stringency, these are spaces of enforced estrangement from the rest of society (Bauman, 1998). Health professionals in forensic settings have among their patients those who have perpetrated serious crimes (e.g., arson, rape, child abuse, murder). Unlike health professionals in other practice areas, those in forensic settings must continuously balance the dual commitments of ‘custody’ and ‘care’, having obligations under both the justice and healthcare systems (Austin, 2001; Day, 1983; Holmes, 2005; Peternelj-Taylor, 1999). This ‘double agent’ role impacts professional–patient relationships (Shortell, 1998) and invariably affects how health professionals conceive of ethical practice. As Arboleda-Flórez (2006) observes, ‘conflicting identity claims can generate conflicting obligations that necessarily translate into ethical dilemmas’ (p. 545). For instance, one ethical issue identified by healthcare providers in prisons is the use of chemical restraints for security rather than therapeutic purposes (Conacher, 1995; Coram, 1993; Maeve & Vaughn, 2001).

The moral climate of forensic psychiatric settings encompasses the ethical challenges of both psychiatric and forensic spaces, with patients
doubly stigmatized as 'mad' and 'bad' (Martin, 2001). Furthermore, it is largely acknowledged that the scope of practice of someone working in forensic psychiatry is beyond that of a 'regular practitioner' (Arboleda-Flórez, 2006; Wettstein, 2002). In the course of their practice, forensic mental health practitioners evaluate the mental health status of patients/clients (e.g., determining if an individual qualifies as Not Criminally Responsible for his or her crime) and may provide therapeutic intervention, requiring them to reconcile their roles as helpers and healers with their roles as investigators. Beside the rights of patients, duties toward their profession, demands of an institutionalized healthcare system, and social expectations, forensic psychiatric practitioners must consider the legal implications of their practice. While it can be argued that the complexity of the forensic psychiatric setting is no greater than any other specialty practice area, in no other environment is the provision of healthcare so closely intertwined with the needs and demands of the justice system. How practitioners reconcile their different, and at times opposing roles, invariably affects the professional–patient relationship.

Professional–patient relationships are of great importance in all healthcare settings, but are seen as particularly crucial in forensic psychiatry. These relationships are foundational to the day-to-day provision of treatment and care. Within such relationships, patients are supported in developing their capacity for respect (of both self and others), empathy and trustworthiness, and to make positive cognitive and behavioral changes (Doyle, 1999; Kent-Wilinson, 1993; Koller & Hantikainen, 2002; Mercer, Mason, & Richman, 1999; Peternelj-Taylor, 1995, 1999). These relationships, however, are shaped by complex issues particular to the forensic psychiatric context, such as security concerns and patient assessment for fitness to stand trial or risk of recidivism, to name but a few. These can pose unique difficulties for mental health professionals’ practice, most obviously that of manifesting the core elements of a therapeutic relationship (trust, respect, and advocacy) in a forensic milieu.

The core elements of therapeutic relationships, often unquestioned in other practice areas, are not absent in forensic psychiatry, but rather become greatly nuanced in this environment. Practitioners may be challenged to engage authentically with patients who constitute a risk to their personal safety and/or who have committed acts that the practitioner finds morally disturbing (Mercer et al., 1999). Further, the development and enactment of trust between practitioner and client/patient can be overtly constrained by concerns for present and future security. Løgstrup (1971) writes, ‘it is a characteristic of human life that we normally encounter one another with trust’ (p. 8). It is only under special circumstances that we distrust a stranger in advance, and forensic psychiatric settings are one such circumstance. Suspicion colors every interaction between professional and patient, as practitioners are ever-vigilant, recognizing an implicit ‘untrustworthiness’ of
forensic patients. Conversely, patients recognize practitioners’ competing obligations, that they must create court reports and ensure institutional and public safety, and therefore may not always hold their patient’s interests as their first priority. In their study of mental health practitioners’ moral distress, Austin, Kagan, Rankel, and Bergum (2008) illustrate the moral angst that such decisions can evoke in psychiatrists.

The enactment and establishment of trust between patient and practitioner can also be constrained by the restrictions on confidentiality between practitioners and their clients, particularly concerning reports. According to Ackerman (2006), the American Psychiatric Association recognizes a violation of a client’s privacy every time a report is written, even where a waiver is given. This violation, combined with the central role of assessment reports within the forensic psychiatric system, has led some like Taborda, Abdalla-Filho, and Garrafa (2007) to claim ‘forensic psychiatry is not bound to the same commitment of confidentiality expected in ordinary clinical practice’ (p. 510).

To date, the literature addressing the issue of confidentiality predominantly concerns general advice to guide the practice of those called upon to create reports. This includes a wide variety of suggestions, from ensuring the limits of confidentiality are known by the examinee (Ackerman, 2006) and that the report is balanced (Taborda et al., 2007) to limiting the inclusion of sensitive information in cases where the report is not compromised (Anfang & Wall, 2006), avoiding wording that can lead to labeling (Michaels, 2006), and ensuring the report is written addressing the purpose for which it is required and no more (Anfang & Wall, 2006). This literature, however, does little to grapple with the complex reality of attempting to establish trust in an environment where confidentiality is limited, especially when working with vulnerable populations such as adolescents. It similarly avoids addressing the possibility of long-term harm to clients from unexpected adverse events associated with the disclosure of information contained in reports. For example, in a Canadian case, a judge ruled that, due to the importance of transparency of process, the media could access an assessment report of a person being tried for a serious crime. The patient had been explicit in his discussion with his assessor, who included the information in the report with no expectation that it would be seen by anyone outside the legal and mental healthcare systems. When the information became public, it was a violation of both the patient’s trust in the practitioner and the practitioner’s trust in the judicial system. Thereafter, the practitioner warned all of his patients that anything disclosed to him could become public.

Complex and yet inadequately addressed in the literature surrounding confidentiality, trust between practitioner and patient in forensic psychiatric settings remains paramount. In his study of psychiatric nursing within correctional facilities, Holmes (2005) found that ‘trust proves to be of prime
necessity on both disciplinary and therapeutic levels . . . When the [nurse’s] relationship with inmates is strong, compliance follows’ (p. 8). However, tension between security and therapy, and the management of violence remain major ethical issues that forensic psychiatric staff constantly faces (Holmes, 2005; Mason, 2002).

Like trust, another fundamental care concept, patient advocacy, takes on additional dimensions when approached from within a forensic psychiatric context. Riley and Fry (2003) found that the most frequent ethical issues encountered by nurses in forensic psychiatric settings involved patient advocacy. When contemplating the ethical aspects of specific cases, the difficulties of advocating for patients in forensic settings has lead Welchman and Grienier (2005) to postulate that advocacy at the individual level is impossible, but should instead be assumed as the responsibility of professional organizations. Nurse philosopher, Gadow (2003) suggests that professionals working at the intersection of corrections and healthcare are confronting ethically incompatible and oppositional systems: ‘In no other setting do health professionals legitimately, deliberately, and necessarily work against the values of the system in which they practice’ (p. 162). Thus, ethical conflict seems intrinsic to the practitioner’s role.

Is ethical practice possible? Frameworks for ethical practice in forensic psychiatric settings

Others agree with Gadow’s assessment. In 1984, Stone called forensic psychiatry a moral minefield, and it appears that the ethical challenges confronting forensic medicine are only increasing in complexity with technological advances such as DNA evidence, telemedicine, and neuroimaging (Arboleda-Flórez, 2006; Taborda & Arboleda-Flórez, 1999). Indeed, the field has become so complex that some ethicists – led by Stone – have argued that ethical conduct is simply impossible in forensic psychiatry due to the competing obligations that health professionals hold. Stone is particularly concerned about the practitioner’s role as ‘double agent’. Others support his concern that there are fundamental incompatibilities in assuming this dual role, but argue that, in spite of duties such as forensic evaluation, it must be given that all physicians are primarily healers with ‘do no harm’ as a foundational principle (Strasburger, Gutheil, & Brodsky, 1997). This view seems to be supported by front-line practitioners. A 1989 survey of randomly selected members of the America Academy of Psychiatry and the Law (AAPL) found that most forensic psychiatrists believe the ethics of forensic psychiatry are grounded in medical and psychiatric ethics (Weinstock, Leong, & Silva, 1991). Acknowledging that conflicting values and duties will be inevitably encountered was supported, including the development of ethical guidelines stating such. Yet, while this is currently the dominant view, Weinstock (2001), following a review of the
historical development of the forensic role, warns that the idea that medical values should be ignored in forensic contexts is gaining dominance: ‘Perhaps because it is simpler and therefore requires less thought in any specific forensic case’ (p. 181).

Codes of Ethics and professional guidelines
Despite this concerning trend, currently most forensic psychiatric professionals (like their colleagues in other settings) appear to be relying on their professional Codes of Ethics to direct their practice. These documents, however, are standardized and largely nonspecific in order to ensure broad applicability. This is problematic when the scope of one’s practice and the ethical challenges one faces daily are inadequately (or simply not) addressed by one’s Code of Ethics. This appears to leave forensic psychiatrists and other practitioners ‘without any clear guidelines as to what is proper and ethical’ (Stone, 1984, p. 58).

Various associations have attempted to deal with the ethical complexities of forensic practice through the creation of guidelines and opinion papers. In the United States, the AAPL adopted its Ethics Guidelines for the Practice of Forensic Psychiatry in May 1985, which were subsequently revised in 1987, 1995, and 2005. While the American Psychiatric Association’s Principles of Medical Ethics (2008) does not explicitly address forensic psychiatric practice, the Association does provide advice on specific questions related to the discipline in its Opinions of the Ethics Committee on the Principles of Medical Ethics (American Psychiatric Association, 2001).

To date, only one profession in North America has attempted to address the complexity of forensic practice by revising their Code of Ethics. In 1992, American psychologists opted to include explicitly forensic activities in the American Psychology Association’s Ethics Code (Perrin & Sales, 1994). Although this drew attention to the concerns common to forensic practice, the Association later decided that the ethics of specialty practice could not be appropriately addressed in a Code that needed standards as generic as possible. The forensic section was abolished in the Code’s 2002 revisions (Knapp & VandeCreek, 2003).

Principle approach
Despite these various efforts, practitioners and ethicists continue to question the adequacy of relying on professional Codes and supporting documents as the sole guide for ethical forensic psychiatric practice. Lolsa (2006) points out that the mere existence of codes of ethics does not assure ethical behavior. Though some continue to argue the necessity of developing codes specific for the practice area (Sen, Gordon, Adshead & Irons, 2006), others
argue for a separate overarching theoretically based ethical framework to guide practice. Most frequently cited and consistent with the tradition of medical ethics is the principle approach of Beauchamp and Childress (1994), with discussion centering on which principle should take precedence in ethical decision-making. This practice underscores the belief that forensic psychiatry falls within the ethics of psychiatry and, more broadly, of medicine. Of those who adopt this approach, two dominant ethical paradigms have evolved: one underscored by beneficence/welfare, the other by justice (Adshead & Sarkar, 2005; Arboleda-Flórez, 2006).

Others, believing a direct application of the four principles is inadequate or overly difficult in guiding this specialty area, call for the development of guiding principles specific to forensic psychiatry. The most well-known and broadly adopted approach is that offered by Appelbaum (1997) who, responding to Stone’s (1984) challenge that forensic psychiatry has no ethical basis, proposed forensic psychiatric practitioners use a set of principles based on the ethical underpinnings of forensic work that can be operationalized and used to resolve conflicts. He suggests two principles: truth-telling and respect for persons (i.e., being clear about one’s non-healer role with forensic patients). He theorizes that, so long as practitioners follow these two principles along with the values of truth, justice, and respect toward patients, they will be ethical in their everyday practice. According to Appelbaum, there is no place for self-questioning or self-doubt as the role of forensic psychiatrist is clear: assess the clients within the medico-legal system. Therefore, argue Arboleda-Flórez (2006) and Taborda et al. (2007), Appelbaum’s conception of forensic ethics does not rigorously bind practitioners to medical ethics but meets the needs of what they are asked to do. While this approach appears to suit practitioners who interpret forensic psychiatry as solely the application of a collection of evaluative tools applied within a legal framework for the purposes of obtaining information for a third party (Perlin, 1991), it remains problematic for those who approach their practice as also encompassing the therapeutic branch of medicine. A forensic ethic needs to encompass more than the forensic–legal relationship; it needs to inform and support the forensic–therapeutic relationship, as well. If it can apply only to the former, such a distinction or limitation must be clearly delineated.

**Beyond principles: cultural awareness and the use of narratives**

Although Appelbaum’s approach is the most renowned in forensic psychiatric ethics, some theorists find his top-down framework troublesome, in particular the neglect of factors such as cultural difference and the effect of class and race on judicial rulings (Griffith, 1998). ‘For the ethical behavior of forensic psychiatrists to be convincingly good a theoretical discourse is not enough, nor even the existence of a code containing these guidelines’ (Taborda et al.,
Rather, some suggest that the best way to move toward a forensic ethic is through adapting ethical practice to fit the realities of the role as it occurs in practice. The most notable of these is Griffith (1998), who argues for the need to give voice to the socio-political aspects of practice. For him, forensic psychiatrists must address the context of the patient’s illness and perspective in order to enhance understanding of the person and situation. Kirmayer, Rousseau, and Lashley (2007) similarly stress that patients’ cultural background should be taken into account when evaluating or treating forensic patients, as both the presentation of mental illness and the formation of criminal intent may be culturally dependent. We can give as example: Aboriginal people represent 19% of persons incarcerated in Canada, but make up only 3% of the Canadian adult population (Office of the Correctional Investigator, 2007). The complex interaction of cultural oppression, marginalization, victimization, poverty, and substance abuse is attributed to creating this disparity (Correctional Services of Canada, 2005; Kirmayer, Brass, & Tait, 2000; Latimer & Foss, 2004). Kirmayer and colleagues conclude that forensic mental health practitioners need to include a cultural component in their legal and moral reasoning, particularly when working in multicultural societies such as Canada. Duncan (1990) takes this position further, arguing that practitioners must not only attend to their client’s cultural perspective, they must also be aware of the influence of their own. The privileged perspective of a white, middle-class, well-educated physician or psychologist must be first recognized before he or she can move beyond it. Such understanding, Layde (2004) believes, should be emphasized in the professional training of forensic psychiatric practitioners.

Building upon Griffith’s (1998) work, Norko (2005) interprets the need to include patient’s stories and socio-political contexts as evidence of the importance of compassion in forensic psychiatry. Through the concept of compassion, Norko argues that Griffith’s position is not incongruent with that of Appelbaum’s. ‘Griffith’s concern for the professional’s authenticity and representativeness is a legitimate extension of respect for persons, as is truth-telling’ (p. 389).

In a more direct attempt to merge the divergent approaches, Candilis, Martinez, and Dording (2001) seek to reconcile Appelbaum’s approach with narrative ethics. They take the position that personal and traditional values need to inform forensic practice; otherwise broader human and professional obligations are not addressed. A model that arbitrarily divides functions [the forensic psychiatrist is ‘an expert in one place, a clinician in another, a complete person at home’ (p. 173)] is not consistent with the way life is experienced. Rather, they contend that under their model the principles work at the level of theory while the narrative approach works at the level of application.

This separation of theory from practice, while appearing to bridge divergent approaches and blend the various functions a forensic mental
health professional serves, is seriously problematic when considered in the light of everyday practice. How one is to practice ethically cannot be understood using one particular framework, while enacted using another. Although an ethical foundation for addressing the obligations and constraints of a forensic psychiatric environment must be found, the answer can hardly lie in a disconnection between theory and practice. Rather, it must be found in an approach inclusive of principles and Codes of Ethics, one that enables cultural awareness and provides a place for individual and group narratives, while recognizing and not minimizing the unique ethical challenges practitioners face every day in their practice.

Relational ethics: an alternative approach

Relational ethics, a relatively new approach to health ethics, situates ethical practice in relationship, with particular emphasis on concepts of interdependency, authentic dialogue, persons in relation, and relational environment (Bergum & Dossetor, 2005; Austin, Bergum, & Dossetor, 2003). Developed by an interdisciplinary team at the University of Alberta, relational ethics is a meta-ethic theoretically grounded in the work of such scholars as Bauman (1993), Dillon (1992), Gadow (1999), Jeffko (1999), Lévinas (1979), Løgstrup (1971), Macmurray (1961), Neibuhr (1963), and Olthuis (1997). The core elements (or themes) of this approach have been identified as engaged interaction, mutual respect, embodied knowledge, uncertainty and vulnerability, and interdependent environment (Austin et al., 2003; Bergum, 2004, 2002; Bergum & Dossetor, 2005). Proponents of this action-oriented ethic argue that ethical healthcare practice is more than applying principled decisions to resolve moral dilemmas or making good crisis decisions. It includes the everyday expression of commitment to those in one’s care and the ways one interacts with others. A relational ethics approach to healthcare practice focuses on being with, as well as being for, patients, families, and other professionals.

Forensic psychiatric settings, because of the competing forces of therapy and justice that shape the relationships in them, provide a particularly significant environment in which to consider the possibilities of a relational ethics framework. Within a forensic psychiatric setting, such a framework holds promise for enabling the answering of questions that arise from both ‘justice’ and ‘care’ perspectives (Beauchamp & Childress, 1994). This approach argues that it is a fitting response to ethical situations that should be sought (Neibuhr, 1963) rather than a universal ‘correct’ answer. In order to determine the fitting action, attentiveness, conscientiousness, dialogue, and interaction with patients and colleagues are valued as important considerations in answering the question, ‘How should we act?’ To be fitting, an action is suitable. We would argue that to be suitable, the ethical
action is congruent with the core elements of relational ethics. For instance, it is not merely a question of when a client is informed about the contents of a court report; relational ethics also demands that we consider the ethics of how the information is conveyed. The particulars of the situation need to be recognized in determining a fitting response, as well as its more general or universal aspects.

Within an environment shaped by ever-shifting, competing demands of providing therapy and ensuring security, a relational ethics framework recognizes and supports practitioners, in dialogue with those around them, to assess the best course of action for individual cases. What is the best thing for this person, at this particular time, under these circumstances, given this information? Such an approach is not relative – it does not consider all decisions or positions equally valid – rather, it enables a recognition that the ethical decision in one situation does not necessarily mean it will be the same in another, and it calls upon practitioners to consider all relevant factors, obligations, and interests (e.g., principles, Codes of Ethics, social responsibilities, individual opinions).

While relational ethics enables the complexity and uniqueness of individual cases to be considered, such an approach to ethical practice also opens up the possibility of uncertainty regarding our decisions and actions, and our own vulnerability as moral agents. It acknowledges that practitioners in forensic psychiatry may not always be certain of the right thing to do, or may face a situation where the best course of action involves doing the least worst thing. For instance, it may be the ‘best’ to initiate an apparently random drug test for a parolee when his battered wife reveals that he is abusing cocaine again, or the ‘best’ to hospitalize someone who begins to threaten his neighbors even though such an act may reinforce his delusional belief that people wish to harm him. Such an approach to the lived ethics of practice also opens up a possibility of recognizing that being ethical is not restricted to our moral decision-making; rather it encompasses all aspects of how we are in relation to those around us. How we are with the offender before us is an ethical act. And while a relational ethics approach does not resolve the innate problems of being a ‘double agent’, neither does it minimize nor ignore the difficulties such a role engenders. Relational ethics does acknowledge, however, as Holmes (2005) contends, that ‘sanctioning, prohibiting, and punishing do not exclude treating, transforming, rehabilitating, and reforming’ (p. 8) and, further, recognizes that, despite difficulties they may face, every day practitioners attempt to meet the multiple obligations they have.

Similarly, a relational ethics framework recognizes that we are embodied beings – we may feel repugnance toward a client. In fact, it has been said that forensic practice can ‘require a strong stomach’ (Coram, 1993, p. 28). One’s forensic client may have committed horrendous acts, such as serial murder, the sexual abuse of children, or torture and rape. Such acts and the
perpetrators of them can bring to mind the notion of the human potential for ‘evil’. Yet, forensic practitioners accept the responsibility to meet the healthcare needs of the human being before them, despite his or her crimes. Forensic clients, in turn, may be without the option to accept or reject the services of the professional. Mandated to assessment and/or treatment, they may suspect, even despise, the efforts of the forensic practitioner. Even though this relationship has serious challenges and constraints upon it, it is still a relationship. Relational ethics allows for the complexities related to the encounter between professional and client, intrinsic to forensic settings, to be explicitly acknowledged. In this way, professional–client relations, including the dark and dangerous components, can be more honestly addressed.

Engagement within a correctional facility is fundamentally complex because of the essential estrangement that occurs when persons are incarcerated for breaking social norms. Incarceration means more than spatial separation from the general community. It creates a profound disconnection in which communication is suspended and unfamiliarity is cultivated between offenders and the rest of society (Bauman, 1998). Although colloquially it is said that someone is ‘put inside’, they are in a very real sense ‘put outside’. Those who work in corrections must work to traverse this estrangement in addition to the other barriers to engagement. Yet engaging with clients in forensic psychiatric settings is more than bridging this estrangement, it involves a constant movement of engagement and disengagement.

Practitioners constantly struggle to be authentic in their relationships with patients: to neither minimize their client’s crimes, nor lose sense of their patient’s humanity. Within such a relationship, concepts like trust and respect require a deeper, less simplistic understanding, which relational ethics can begin to offer. For instance, a forensic practitioner will comprehend relational issues of trust differently with a patient who has an anti-social personality disorder than with a patient who is ill with a psychotic disorder. The idea of ‘trustworthiness’ will be tempered with professional understanding of the worldview of the patient as it is shaped by his or her disorder. A relational ethics approach to forensic psychiatric practice similarly calls for increased attention to the issues of power and control, diversity and difference, and vulnerability and suffering that shape the moral climate of practice. For example, nurses in forensic psychiatry are both subjects of power, in their use of ‘brutal and subtle technologies of “government”’ . . . to control mentally ill criminals’ and objects of power, in that their practice is constrained within the forensic milieu (Holmes, 2005, p. 3). This points to the possibility of relational ethics offering a basis for examining systemic, as well as individual, moral issues, opening a space to consider the immediacy and complexity of moral responsibility associated with the provision of healthcare (Bergum, 2004).
From theory to practice

There is significant synergy between the need for an ethic to guide practice in forensic psychiatric settings and the need to examine further the viability of a relational approach to healthcare ethics. The challenges are great, and as much as relational ethics offers a rich but realistic action ethic for this speciality area, forensic settings offer a crucible for relational ethics. As Gadow (1999) has put it, relational engagement in correctional settings ‘offers an extreme test of relational narrative’ (p. 166). This article, however, is but a theoretical consideration of relational ethics applied to forensic psychiatry practice. Empirical research is needed to fully assess its validity to theoretically ground ethical practice in forensic psychiatric settings. To this end, an interdisciplinary research project in health ethics, funded by the Social Sciences and Humanities Research Council of Canada, is currently examining this very possibility.

Conclusion

Previous research and experience supports the need for healthcare professionals to reflect on their practice in order to cultivate ethical sensitivity, to be attentive and thoughtful to the relational context of the environment of care, and to embrace the potential vulnerability of their patients and themselves. It could be said that ‘all relationships as experienced are moral, for in each relationship one is enacting the question of what is the “right thing to do” both with oneself and with others’ (Bergum, 2004, p. 485). In no area is this issue more pressing than in forensic psychiatry. For Gadow (2003), practice within a forensic setting is akin to a prism ‘that refracts ethics into sharply different colours’ (p. 167). Therefore, as health professionals and ethicists, we must not ignore the unique configuration of ethics within this specialty area, nor in our attempt to understand it simplify the complexity of forensic psychiatric practice. Rather, we must work toward finding an ethic that acknowledges the complexity and possibilities of this area: relational ethics offers one possibility for doing so.

Notes

1. For the purposes of this article, the term forensic psychiatric environments or settings is used to encompass outpatient programs, as well as traditional correctional institutions and forensic units within psychiatric hospital.
2. In Canada, a person who commits an offence but is unable to under the nature of the act due to a mental disorder may be deemed Not Criminally Responsible under Section 16(1) of the Criminal Code of Canada. Assessments made by forensic psychiatric professionals provide essential information for judges to determine the degree to which a person’s mental disorder has incapacitated their ability to understand their actions.
3. No citation has been provided to avoid further harm to the practitioner or his client. Please contact the first author should information about the case be requested.

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