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Many faces of the dual-role dilemma in psychiatric ethics

Michael D. Robertson, Garry Walter

Objective: To identify the various potential manifestations of the dual-role dilemma in the psychiatric ethics literature.

Method: The terms 'dual role', 'dual agency', 'overlapping roles', and 'double agency' were searched on the electronic databases PubMed, Medline, Embase and PsychInfo. Classic papers in the field of psychiatric ethics and their references were manually searched. Papers were selected for relevance to the topic of the dual-role dilemma in relation to psychiatry.

Results: The dual-role dilemma is most explicitly addressed in the literature on forensic psychiatry and military psychiatry. Review of the ethics literature in other fields of psychiatry indicates many instances of the dilemma of psychiatrists facing conflicting obligations akin to the dual-role problem identified in the literature on forensic psychiatry. Many of these dilemmas are characterized by the presence of a powerful third party to whom the psychiatrist has some perceived obligations.

Conclusions: In psychiatric ethics, the dual-role dilemma refers to the tension between psychiatrists' obligations of beneficence towards their patients, and conflicting obligations to the community, third parties, other health-care workers, or the pursuit of knowledge in the field. These conflicting obligations transcend a conflict of interest in that the expectations of the psychiatrist, other than the patient's best interests, are so compelling. This tension illustrates how the discourse in psychiatric ethics is embedded in the social and cultural context of the situations encountered. It appears that as society changes in its approach to the value of liberal autonomy and the 'collective good', psychiatrists may also need to change.

Key words: dual-role dilemma, ethics, psychiatry.

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Ethical dilemmas in psychiatry are regularly addressed by the approach of 'quandary ethics' [1], which seeks to define and thus resolve complex cases or policy issues that are seemingly intractable

dilemmas [2]. One of the most frequent quandaries that psychiatrists face in their professional conduct is the potential for conflicting obligations towards an individual patient and another party or group. A common manifestation of this is the duty to manage the risk posed by a particular individual to the community. This may necessitate psychiatrists acting beyond their obligations to their patients in decisions as diverse as the breaching of a clinical confidence or the implementation of certain coercive treatment strategies to reduce risk, rather than alleviate suffering. The problem of the dual role, variably termed 'dual agency', 'overlapping roles',

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and ‘double agency’, is a particular quandary in psychiatry. In this paper we refer to the ‘dual role’ and define it as a quandary in which a psychiatrist faces the dilemma of conflicting expectations or responsibilities, between the therapeutic relationship on the one hand and the interests of third parties on the other. Our critical analysis of the literature in this area aimed to identify manifestations of the dual role that create quandaries for psychiatrists. In the present survey of the literature we seek to identify quandaries related to the dual role, which create a tension within the individual psychiatrist or the profession. It may be suggested that such dilemmas are all but extinguished by statutory requirements obligating psychiatrists to act for the collective good, such as a legally enforced breach of clinical confidence, where a greater good is served. But such legal imperatives merely serve to draw attention to ethical complexities in our field [3].

In preparing this overview we searched the electronic databases PubMed, Medline, Embase and PsychInfo, as well as reviewed the classic papers in the field of psychiatric ethics and their references. Papers were selected for relevance to the topic of the dual-role dilemma. The search strategies included the terms ‘dual role’, ‘dual agency’, ‘overlapping roles’, and ‘double agency’. We then manually surveyed many papers in the field of psychiatric ethics, seeking to identify those works that discussed ethical dilemmas in psychiatry and which also examined conflicting role expectations of the psychiatrist. Where necessary, we refer to general texts in ethics to further elaborate the argument.

Forensic psychiatry and the dual role

The dual-role dilemma has typically been associated with the practice of forensic psychiatry [4–8], where ‘obligation to serve the interests of justice’ comes into conflict with the Hippocratic principle of *primum non nocere* [9]. In this context the dual role posits that there is a prima facie conflict between the duties of the psychiatrist as ‘treater’ and ‘evaluator’. This debate was explored in two classic papers in the psychiatric ethics literature. In ‘The ethics of forensic psychiatry: a view from the ivory tower’, Stone argued that the role of ‘evaluator’ moves the forensic psychiatrist away from the role of physician and the fundamental notion of non-maleficence [10]. Taking a contrary view, Appelbaum’s ‘The parable of the forensic psychiatrist: ethics and the problem of doing harm’ averred that beneficence and non-maleficence

are not central ethical issues in forensic psychiatry [11]. Consequently, Appelbaum suggested that forensic psychiatry has a distinct set of ethics. Indeed, a distinction can arguably be made between forensic psychiatry and clinical psychiatry in the notion of the ‘forensicist’ [12]. The ethics of the forensicist is directed towards the benefit of society, not the patient, and therefore the central responsibility of the forensicist is to justice, not the patient [13].

In minor criminal or civil matters, this issue may seem comparatively benign compared to the role of psychiatrists in the administration of the death penalty, particularly in the USA. It has been argued that psychiatrists should not participate in any assessment process that ultimately may lead to execution [14]. An opposing stance is that the consequences, rendered by the State, of a psychiatric assessment cannot be the basis of consideration as to whether such assessments are ethical [15]. In other words, no distinction should be drawn between a psychiatric assessment that facilitates a financial penalty (or benefit), a custodial sentence or the death penalty.

These dilemmas seem to be more indigenous to the USA, where forensic psychiatry has a particular profile in relation to justice. In the UK context, the ‘evaluator–treater’ manifestation of the dual-role dilemma has historically been absent [16]. The ethical dilemmas faced by UK forensic psychiatrists have been more related to their advocacy role in the clinical care of mentally disordered offenders [17] and political pressures impacting upon the welfare of their patients [18]. More recently, UK forensic psychiatrists have faced dilemmas brought about by a proposed new Mental Health Act, in particular their quasi-legal participation as *de facto* prosecution counsel in mental health tribunals [19].

One potential manifestation of the dual-role dilemma in British forensic psychiatry is the prospect of pre-emptive detention facilitated by the mooted dangerous severe personality disorder legislation [18,20,21], in which a psychiatrist’s evaluation of a person as having a personality disorder with an assessed high risk of harm to others will result in their pre-emptive detention. In the Australian literature the ethical implications of mentally disordered legislation, in which persons can be detained on the basis of irrational behaviour in the absence of psychiatric disorder, has been discussed. One view is that such legislation is inconsistent with the Declarations of Hawaii and Madrid [22], whereas the alternate opinion factors in notions of the transitive nature of personhood, and psychiatrists’ obligations

to the individual patient outside of the immediate context [23]. In other words, this approach to the ethical quandary of temporary mental disorder considers the mentally disordered patient and the subsequent recovered rational individual as different people, and obliges the psychiatrist to act to protect the rational person from the dangerous acts of the mentally disordered person. In these circumstances, the dual-role dilemma manifests as the obligation of psychiatrists to the safety of society, as against the welfare of the patient.

Beyond the criminal setting, the psychiatric evaluation of prospective employees raises another potential dual-role dilemma [24]. In either identifying possible risk factors for vocationally acquired psychiatric disorder, or diagnosing established mental illness or personality disorder, the psychiatrist is utilizing his or her skills for the benefit of the prospective employer or worker's compensation insurer, rather than the patient. Moreover, such psychiatric evaluations will potentially disadvantage the individual socially or financially, thus having a potentially maleficent effect.

The dual-role dilemma is routinely faced by psychiatrists working in a military setting [25,26]. In simplest terms, psychiatrists often have conflicting loyalties between the military service in which they practise and the patient. More recently, the dual role has manifested in more alarming settings such as the psychiatric care of 'unlawful combatants' held in Guantanamo Bay or Abu-Graib prison, where loyalty to the patient and to national security come into direct conflict [27].

Psychotherapy and the dual role

The impact of financial pressures upon the practice of psychotherapy has emerged as a dominant theme in the psychiatric ethics literature. This has placed the psychiatrist in the dual role: advocating the best treatment for the patient, versus exercising financial responsibility for the benefit of an organization, health insurer or even the public purse [28]. As Holmes asks, 'is it ethically correct to prescribe the most cost-effective (psychotherapies), thereby freeing resources for other potential beneficiaries?' [29]. The intrusion of third-party payers into the patient-therapist relationship has created new ethical dilemmas, such as breaches of patient confidentiality to financial stakeholders, or the use (or avoidance) of certain psychiatric diagnoses to attract insurance benefits on behalf of the patient.

Another, more subtle manifestation of the dual-role dilemma in psychotherapy relates to the notion of psychotherapy representing the imposition of certain values onto the patient. It has been argued that, in creating the 'talking cure', Freud had attempted to convert moral discourse to a scientific one [30]. As such, psychotherapy has been described as a masked form of moral discourse, with allusions to a quasi-religious conception of the good [31], 'veering', as Hinshelwood argues, 'between being a scientific and a moral activity' [32]. Indeed, psychotherapy has been conceptualized as the integration of a non-religious but spiritual view in the pursuit of empathic understanding [33]. Moreover, psychotherapy often works best when the value systems of both patient and therapist approximate each other, but not necessarily converge [31]. As Holmes has argued, through its advocacy for the inner world and self-reflection 'psychotherapy reflects and transmits the values of the prevailing culture' and 'makes its own unique contribution to cultural and ethical development within our pluralistic societies' [34]. By liberating patients from their suffering, psychotherapy can be considered as enabling patients to become moral agents [35] and enhancing autonomy by encouraging self-knowledge [29]. While, in the first instance, this necessitates an injunction for therapists to deliberate on how their own values affect their work [34], there is also a potential to see this area as a manifestation of the dual-role dilemma. Put simply, one view of the whole psychotherapeutic enterprise is that it represents a process of bringing the patient around to a world view consistent with his or her fellow citizens. Whether this is via dialectic behaviour therapy leading patients to experience their distress in less socially disruptive ways, or the radical reconstruction of the self into a more functional citizen, there is, perhaps, a tension between pseudosocial engineering and beneficence for the patient.

Child psychiatry and the dual role

Green and Bloch make reference to childhood as a recent social construction [36]. As such, the conceptualization of childhood within the context of psychiatric ethics relates fundamentally to the distinction between children and competent adults as autonomous, self-legislating persons. The idea of evolving or future autonomy of the child has been discussed both in terms of their cognitive development and the therapeutic setting [37]. Some of the literature in ethics and child psychiatry has considered the viability of the

construct of informed consent in childhood and how this should reflect the wishes of the child [38,39]. Ultimately, the therapeutic relationship in child psychiatry is unique in that it frequently casts the therapist in the role of de facto parent or authority figure as well as that of advocate for the child [40]. While there may be some parallels between the undeveloped autonomy of the child and the variably impaired autonomy of any psychiatric patient, there are two key differences. The first relates to the type of stakeholders, such as parents, schools and child protection agencies, who have significant influence over the child patient's situation. The second is the expectation that, with the passage of time, the normal child will gain autonomy. In some circumstances, such as enforced removal of a child from a family, the wishes of the child and their family may clash with a social institution's child protection interests. It is also clear that mentally ill children are potentially much more vulnerable than mentally ill adults. The tension is thus between a duty to a patient with variable capacity for autonomous choice and a duty to beneficence that might be against the wishes of the child or their family. Moreover, there may be situations in which the psychiatrist's position in support of parental wishes is at odds with that of the child.

Dual role and involuntary treatment

One of the most vexed ethical debates in psychiatry relates to involuntary or coercive psychiatric treatment [41–45]. Access to psychiatric treatment has been defined in terms of the right to be free from 'dehumanizing disease' [41], whereas the other justification used for such coercion in treatment is the prevention of suicide or other forms of self-inflicted harm [43]. In terms of the well recognized four-principles approach to biomedical ethics [46], this is conceptualized as a tension between respect for the patient's autonomy and the obligation to beneficence. John-Stuart Mill had argued in *On Liberty* that the State had no right to paternalistic action over an individual, unless his or her actions were harmful to others [47]. Mill specifically stated that potential or actual harm to self was not grounds for State paternalism. This so-called 'harm principle' has since been used as an argument for involuntary psychiatric treatment of suicidal patients, in that the suicidal patient is an individual who can be harmed by their own actions [48]. This is somewhat akin to Kant's argument against suicide in that it exploited the individual in order to relieve suffering [49]. In

applying Mill's philosophy to justify paternalistic involuntary psychiatric treatment, it has been argued that the preconditions to a paternalistic act are that the individual in question is not responsible for their actions, the individual's incompetence is about to cause harm, 'paternalization' will ultimately enhance the individual's competence and/or prevent further deterioration, and paternalization takes place in the least restrictive manner. As such, Mill would have supported involuntary psychiatric treatment [50]. Involuntary psychiatric treatment is justifiable from the perspective of a variety of ethical theories [44], although as Chodoff has argued in the light of human rights abuses perpetrated under the guise of psychiatric treatment, there is a need for a 'self critical and chastened' paternalism [41]. Moreover, the flip side of this process is the obligation of the community to provide adequate quality of care, not always a given. The failure of communities to coercively treat psychiatric disorder with adequate resources has been the subject of ethical and legal discourse in the USA [51]. Using a two dimensional construct, Rosenman provides a method of ethical reasoning in coercive psychiatric treatment [45]. On one dimension, psychiatric disorder is defined along a continuum of 'social definition' to 'biomedical definition'. On another sits the potential of harm to self or others. In Rosenman's model it is suggested that coercive treatment of socially defined disorders occasioning harm to self are the most problematic clinically.

In considering the issue of involuntary psychiatric treatment as a manifestation of the dual-role dilemma, the key issue revolves around the patient's autonomy. Putting aside the reasonably straightforward issue of potential harm to others, the dilemma is more complicated in regards to harm to self. On one hand, psychiatrists have an obligation to respect the autonomy of the patient. On the other, they are obliged to act beneficently. It is as if there are two parties in this dilemma: the individual whose autonomy is impaired by psychiatric disorder, and perhaps the future individual whose autonomy is restored. Given the, at times, slippery definitions of psychiatric disorder and impairment of autonomy, various reasoning algorithms like that of Rosenman help the psychiatrist deliberate.

Dual role in distributive justice

Distributive justice refers to the just allocation of limited social resources, such as money or access to services. Ethical dilemmas surrounding the

distribution of and access to limited mental health treatment resources have come into focus in the last decade, particularly given the stark contrast between systems of universal health coverage, such as in the British National Health Service, and the morphing of health care into a commodity in a market-based health-care model, such as in the USA.

The putative uniqueness of mental health resources and their allocation appears to require specific ethical consideration [52]. In the US system of managed care, third-party interference in the areas of confidentiality, consent and fidelity occur [53], highlighting another variant of the dual role between a psychiatrist's responsibility to his or her patient and to society [54]. There is accumulating evidence that managed mental health care may adversely affect clinical outcomes [55] because decisions made on apparent utilitarian grounds of cost containment seem to have the effect of reduced access to, rather than improved, clinical services [56]. The specific challenges of working in a flawed mental health system, characterized by inequalities and violation of the doctor-patient relationship have been considered [57], with the conclusion that to comply with the tenets of managed care is to abandon the fidelity of the therapeutic relationship. Psychiatrists do, arguably, have responsibility to the cost-efficient allocation of limited health resources [58], which creates further tension in this manifestation of the dual-role dilemma.

Confidentiality and the dual role

Confidentiality is instrumental to the therapeutic relationship in psychiatry [59,60]. Regardless of its clinical necessity, the maintenance of patient confidence has been the subject of much discussion in the light of necessary breaches of confidentiality and the potential implications for the extension of the therapeutic obligations of psychiatrists beyond the individual therapeutic relationship [61]. Indeed, as Green and Bloch have argued, 'confidentiality can never be absolute, and therein lies its ethical intricacy' [62]. The pivotal instance of confidentiality and the so-called 'duty to inform' was the famous Tarasoff case [63]. While the implementation of this Californian legal ruling has been variable across jurisdictions [64], the ethical issues raised in the case have formed the basis of much ethical reasoning in this area [7], and has presented another manifestation of the dual-role dilemma [65]. The Tarasoff precedent has no legal standing in Australasian jurisdictions and may, in fact, be vitiated by recently introduced privacy

legislation. Regardless, the notion of a duty to inform, thus breaching confidentiality, in the case of risk of harm to others is a familiar issue to most psychiatrists. In essence, there is a tension between the duty to manage the risk a patient poses to others through a breach of confidence and the role of therapeutic intervention. As with many ethical dilemmas in psychiatry, the law, or fear of the law, has eliminated the ethical quandaries related to patient confidentiality by mandating the course of action that serves the greater good. As such, it is likely that psychiatrists tend towards breaching a clinical confidence if there is a demonstrable risk to society.

Psychiatric research and publication and the dual role

Concerns about the ethics of psychiatric research emerged following the revelations of human rights abuses in the Nazi era [66], resulting in international declarations of ethical guidelines for research, such as the Declaration of Helsinki [67], and the requirements of ethical approval of studies as part of the process of scientific publishing [68]. The main theme in this area has been a tension between the duty to protect vulnerable individuals and the duty to advance scientific knowledge. Issues of informed consent and competence to participate in psychiatric research [69,70] have tended to be the focus of the literature in the area. Clinical trials involving psychotropic medications are problematic given the enforced nature of much psychiatric treatment, particularly in the chronic mentally ill [71]. The use of children as subjects in psychiatric research has been discussed in similar terms [72-74].

As a manifestation of the dual-role dilemma, the conflicting roles are between psychiatrist as advocate for the patient, whose potential for exploitation in clinical trials presents a concern, and psychiatrist as scientist, whose quest for knowledge may benefit the rest of the community

Consultation-liaison psychiatry and the dual-role dilemma

The dual-role dilemma is a frequent issue in the field of consultation-liaison (C-L) psychiatry. One of the fundamental features of the role of a C-L psychiatrist is the ambiguous nature of the relationship with the patient. C-L consults are frequently

sought by the treating team and not the patient, which creates a fundamentally social role in liaison psychiatry [75]. This social role focuses upon the relationship between primary physician or non-medical health professionals and consultant psychiatrist who works within an institutional setting. A frequent pretext of the involvement of a C-L psychiatrist is to provide an intervention at the level of system, such as where there is a problematic relationship between a difficult patient and a medical team. In such circumstances, the C-L psychiatrist is expected to be 'all things to all people' [76]. Indeed, it has been argued elsewhere that by virtue of its broad perspective, C-L psychiatry has a credible role providing ethical guidance in difficult clinical situations [77,78]. Such circumstances create a tension between the expectations of the patient and that of the referring physician or indeed the institution itself. In some instances it has been argued that some interventions of the C-L psychiatrist are directed at the staff, rather than the patient, creating a 'bipolarity of practice' [79]. Interventions such as a reframing of a patient's challenging behaviour on a medical ward serve to improve the functioning of the therapeutic relationship between the patient and other health professionals by engendering an attitudinal shift in the staff on a medical ward. This often makes use of what has been described as a 'situational diagnosis' [80], in which a diagnostic statement, integrating multiple perspectives of a situation regarding a patient, is made in order to help resolve a therapeutic impasse on a medical ward. An example is the frequent use of the diagnosis of 'adjustment disorder' in C-L settings, in which the emphasis on the overwhelming stressor of a physical health crisis removes the focus from the patient's more difficult interpersonal behaviours.

In the practice of C-L psychiatry the dual-role dilemma is unavoidable in that the C-L psychiatrist is often a third party in a therapeutic relationship and faces the challenge of managing multiple relationships within a general hospital setting. In such circumstances the C-L psychiatrist is compelled to reflect upon whose interests are being served by their intervention.

Aspects of the dual role not addressed in the literature

In our review of the literature several possible manifestations of the dual-role dilemma in contemporary psychiatric practice were not readily evident. There is little or no literature addressing the dual-role

dilemma faced by psychiatrists running private psychiatric practices, in particular the duty to run a small business effectively and the duty to best care. Aspects of private practice and the dual role are indirectly addressed in other areas of the literature. The potential dual role faced by psychiatrists employed in the corporate sector, such as working for pharmaceutical companies, has been little addressed. Moreover, psychiatrists and their dual role of accurately informing public debate while avoiding adding to stigmatization of their patients has not been directly tackled. In Australia, a particularly contentious issue has been the activism of some psychiatrists around the issue of the treatment of asylum seekers by the Commonwealth Government [81]. Such a debate could be framed as a dual-role dilemma between the perceived moral obligations of the psychiatrist as private citizen and as member of a pluralistic professional group characterised by diverging views of such issues.

Discussion

Throughout this paper we have considered the dual-role theme in psychiatric ethics. In each domain where the dual-role dilemma occurs, the psychiatrist finds him or herself the servant of two masters: the patient and a third party. This third party, whether it be the courts, the family, employers or society itself, is usually in a position of power over the patient. With the exception of some aspects of the literature in forensic psychiatry, the dual-role predicament produces tension within the individual psychiatrist, or the psychiatric profession.

Despite controversy about the current relevance of the Hippocratic tradition in medical ethics there is still a fundamental obligation to the best interests of one's patient. As our survey of the literature has indicated, the dual-role dilemma is protean in nature and represents a set of implied obligations outside the therapeutic relationship. It is clear that society endows the profession of psychiatry with powers beyond most other professional groups. Powers such as detention in secure hospitals, enforced treatment with psychotropic medication and professional opinions that are highly influential in the justice system appear to come at the cost of serving society's interests over the patient's. As such, the dual-role dilemma extends beyond a conflict-of-interest problem in that there are compelling arguments from both sides of the dilemma. While this notion segues into narratives of psychiatry as an agency of social

control, the fact remains that the dual-role dilemma appears to arise out of the powers endowed to psychiatry. As discussed elsewhere, professional ethics in relation to psychiatry refer to the application of skills and knowledge for the collective good [3]. In the light of the present review, this frequently puts the patient's interests or preferences at odds with those of the rest of society.

In this context the dual-role dilemma can be seen as reflecting the social constitution of the psychiatrist as moral agent. In other words, the ethical quandaries of psychiatry, and the values psychiatrists bring to these, integrate social and cultural issues as much as clinical ones. The contextualizing of dilemmas of medical ethics in terms of community interests versus patient interests is captured in the communitarian approach to biomedical ethics [82,83]. The substance of such an approach is that any ethical quandary has to take into account the interests of the individual patient and the interests of the community. As the communitarian bioethicist Daniel Callahan argues metaphorically, if we were introducing a new fish to an aquarium, the liberal ethicist would be concerned with the effect of this on the individual fish, while the communitarian would be concerned about the effect of this measure on the rest of the aquarium's ecosystem [82].

Implicit here is the view that there is a moral equivalence between psychiatrists serving collective good and serving the good of the patient. While this view may be uncontested in liberal democracies, this has been only a recent state of affairs. History is sadly replete with psychiatrists exerting their socially apportioned powers for malevolent ends in societies whose values were clearly in violation of any notion of human rights. The dual-role dilemma in Hitler's Germany or the Soviet Union is, ostensibly, a different proposition from the present day liberal West. Given the ubiquity of the dual-role dilemma, the creeping influence of communitarianism, and the drift of societies away from civil rights in the post 9/11 geopolitical setting, this assumption requires regular reflection.

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