ETHICS & BEHAVIOR, *15*(2), 181
Copyright © 2005, Lawrence Erlbaum Associates, Inc.

PERSPECTIVES

Perspectives are occasional essays describing challenging dilemmas in ethics and behavior. These contributions are edited by consulting editor Daniel E. Shapiro. Potential contributors should contact Dr. Shapiro at shapiro@u.arizona.edu

ETHICS & BEHAVIOR, *15*(2), 182–190
Copyright © 2005, Lawrence Erlbaum Associates, Inc.

The Struggle to Maintain Neutrality in the Treatment of a Patient With Pedophilia

Matthew C. Lally
Department of Psychiatry
University of Arizona College of Medicine

Scott A. Freeman
Department of Psychiatry
University of Arizona College of Medicine
Southern Arizona Veterans Affairs Healthcare System

This article explores the ethical concept of neutrality through use of a psychiatric clinical vignette. In this case a psychiatry resident is faced with the treatment of a patient who was found by the FBI to be in possession of child pornography. Although not accused of any other crimes, the patient was a fugitive from the law and requesting treatment for pedophilia. Faced with the pressures of limited resources and anxiety about the patient's dangerousness to others, the resident and his supervisor tried to strike a balance between the ethical principles of neutrality and beneficence. Through this vignette, the importance of neutrality, as well as how it can be compromised by other pressures such as expediency and anxiety, is explored.

"Society, being composed of a plurality of persons, each with his own aims, interests, and conceptions of good, is best arranged when it is governed by principles that do not themselves presuppose any particular preconception of the good." (Sandel, 1982)

This statement is a definition, and a rationale, for the concept of neutrality, as written by Sandel (1982). The concept of neutrality is discussed and considered in domains ranging from bioethics, public policy, political philosophy, and medicine. However, although widely discussed, it is not universally cherished or embraced.

Correspondence should be addressed to Scott A. Freeman, Mental Health Care Line, Southern Arizona Veterans Affairs Healthcare System, 3601 S. 6th Avenue, Tucson, AZ 85723. E-mail: scott.freeman@med.va.gov

Neutrality has also been described as a "logical, ethical, and legal illusion" and "not only 'nonsense' … it is pernicious nonsense" (Beckwith & Peppin, 2000).

This case demonstrates the difficulty of maintaining neutrality in the presence of other ethical ideals such as beneficence and civic safety as well as other less idealistic pressures such as expediency, anxiety, and financial concerns. Perhaps neutrality can be seen as being an ideal for a pluralistic society as well as illusory (although hopefully not "nonsense"). In the opinion and experience of these authors, neutrality should be kept in consideration as a valuable concept, and at times, an ethical principle. Often neutrality needs to be in balance—and at times a delicate balance—with the ethical principle of beneficence.

I (the first author) was a second-year psychiatry resident rotating through an inpatient psychiatry unit. As was the case every morning, I participated in patient rounds with my attending and a second-year colleague. I started the day by sitting in the interview room to hear the nursing report on new patients who were admitted overnight. When the other resident and I heard how many new patients were admitted overnight, we would simply divide them between us depending on a number of variables, primarily how many patients we were already carrying.

On this particular morning I took, or was given, the case of Mr. J. I quickly read through the admission dictation from the resident who had admitted the patient from the emergency room in the middle of the night. After reviewing the nursing report, I walked out of the interview room and down to the common room to find the patient and bring him back for his intake interview.

> "Mr. J, I have reviewed the notes from the ER, but I would like to hear from you directly: What has been going on and what has brought you to the hospital?"

Mr. J was in 40s. He worked as a truck dispatcher in Ohio. Two days prior he radioed one of his drivers going out to the West Coast and asked him to pick him up. He met the driver on the driver's route along the interstate in the middle of the night and went with him for 2 days. In Tucson, he asked the driver to pull over and told him he planned to commit suicide by walking into the desert (not an uncommon means of suicide in Tucson, as there are no high-rises, bridges, or bodies of water). Instead, the driver brought him to the emergency room.

> "What has been going on that you decided to end your life?"

Mr. J stated that on the day he radioed his colleague his home had been raided by the FBI. They were searching for child pornography on his hard drive and found it.

> "How did the FBI know you had child pornography on your computer?"

He said he believed a neighbor had called. Why he thought that, I was never able to gather. He stated that he was not arrested, but the FBI had instructed him not to leave town. He reported that he planned to walk out into the desert to kill himself because of his shame, which would be suicide by vanishing.

As psychiatrists, particularly psychiatry residents, tend to do, I asked him about his mood, sleep, appetite, medications, allergies, past medical history, family history, interpersonal relationships, social network, educational and occupational history, and childhood milestones. As is also customary, I asked the patient about his sexual history.

He said that he never acted out his pedophilic fantasies with any child or adolescent. He stated that he had one brief homosexual relationship with an adult male several years ago but was not in any current sexual relationships. He stated he had been acting as a neighborhood mentor for two adolescent boys whose mother was a colleague. He also reported that he never had sexual relations with them but recently felt an increasing desire to do so and that he was sure he would have acted out his pedophilic fantasies had the FBI not raided his house that day. He was ashamed to be known as having child pornography on his computer and stated that he knew child pornography was wrong but that it helped him control his desire and therefore, according to him, helped him from committing pedophilic acts.

As a physician and psychiatrist, my job is to listen, to try to understand, and hopefully to help. In addition, it is to maintain neutrality, but sometimes helping and being neutral are opposite actions. True neutrality implies not taking sides and, as Sandel (1982) posited, not presupposing "any preconception of the good."

Mr. J described having alcoholic parents. He was not connected in any meaningful or supportive way with his parents. He said that when he was 14, he was fondled from behind at a urinal in a public place by a stranger. He had never told anyone this before. He also described mentoring the two adolescent boys and that he taught them the basics of repairs, construction, and automotive maintenance. He said he never abused or molested them but that he was glad to be in the hospital where he could not hurt anyone. The patient was started on an antidepressant, a selective serotonin reuptake inhibitor (SSRI). He probably did not have a major depressive disorder, as his mood appeared to be troubled but not depressed prior to the FBI raid. More accurately, he had an adjustment disorder with depressed mood, which is why I elected to start an antidepressant. When starting medication, I performed a risk/benefit analysis to ensure I was actually helping the patient rather than harming him. The benefit in this case was that the medication would hopefully reduce the likelihood that Mr. J would act on his impulse to kill himself, which would be an immeasurable benefit. The risk was that the medication would cause uncomfortable or undesirable side effects. For SSRI's, side effects are not typically unsafe, but ones that are uncomfortable or unwanted by the patient. Usual side effects include nausea, restlessness, emotional blunting, decreased sexual drive, and anorgasmia.

Mr. J was informed of these side effects, just like any other patient, because, like all patients, he had the right to informed consent prior to starting a medication. He would have had the right to refuse, just like any other patient would. He accepted the medication and stated that he hoped it would decrease his sexual drive, which I hoped as well. Based on this, I offered him another treatment—an injection of leuprolide acetate. This medication acts in the body for 3 months after intramuscular injection. Leuprolide is used for women with endometriosis because it lowers estrogen levels. It also lowers testosterone levels in women and men. In men, it is used to treat aggressive prostate cancer. It is also called "chemical castration" and has been used in the treatment of pedophilia (Saleh, Niel, & Fishman, 2004). Mr. J consented and received his first injection.

In the era of managed care, figuring out what the disposition plan ("dispo plan") is for a patient begins as soon as he or she is admitted. The dispo plan details where the patient is going to go as soon as he or she is healthy enough or safe enough to live outside the hospital. Options for disposition include a nursing home, the patient's own home, a skilled nursing facility, a substance abuse program, a group home, or a homeless shelter. Our unit needed, but lacked, a social worker to help with this and other social services, as did a lot of other departments. It therefore fell to the residents to piece together the dispo plan and any other posthospital services. Mr. J was no exception. Prior to starting this particular rotation, my plan would have been self-evident: dispo to law enforcement. But our attending supervisor, Dr. G had taught us better, stating, "We are doctors; our duty is to the patient." He taught us this very clearly several weeks earlier when we had a patient who had made a rushed attempt to cut his throat with a jackknife after he was pulled over by police. He attempted suicide because, as he told us later when he was admitted to our unit, he preferred to die rather than go back to jail. When the officer saw the patient bleeding, he called for an ambulance. The patient, still attempting to escape imprisonment, ran from the car in a desperate and bloody dash for freedom. He was wrestled to the ground in the desert, brought to the ER, and then to our unit. Initially there was no record that he had actually been arrested during the melee. The hospital security guards, who are the heroes of the psychiatric unit because they are often called to protect us, left a message with the nursing staff that the police department would appreciate a call when the patient was being discharged. The understanding was that the police would be waiting outside the doors of the psychiatric unit, ready to apprehend the patient on discharge. To the nurses' awe and contempt, Dr. G would have no part of this "understanding."

"We are health care professionals; our duty is to the patient alone," he asserted to my colleague and me, "not to the security officers, or to the police, or even to society, unless we know of specific individuals that the patient has indicated he or she will harm." Eventually, during that patient's stay, paperwork did come from the police documenting that the patient had in fact been arrested at the scene and was still in custody. With these new data, because the patient was

under a police hold, the police were informed of the time of his discharge. He was not discharged any sooner or later than any other patient. When he was told that he would be leaving the hospital that morning and that the police were waiting in the nurses' station, he frantically grabbed his chin with one hand and the back of his head with the other. He feverishly tried to wrench his own neck before our eyes. It was incredibly pathetic and, at the same time, incredibly shocking and scary. In the end, he was escorted off the unit by police with no serious harm done. Through this experience I learned that all patients are to be treated equally and that our duty is to the patient first, despite all pressures and circumstances. It was a first-hand lesson in neutrality.

As several days passed by during his admission, Mr. J seemed to be improving. His appearance and grooming changed significantly. He no longer looked haggard, like a man on the brink of suicide. The nursing report noted that he was having no problems on the unit. During the daily interviews he also changed. When he first entered the unit, his defenses were down due to stress, and he openly disclosed things about himself, his past, and his inner life. After several days in the hospital, however, with some of his ego strength regained, he presented less as a man at the end of his rope and more as what he was: a successful national trucking dispatcher who was articulate, could get along with people, and was motivated for treatment of his sexual disorder. His mood was improved and, as we speculated, he appeared not to have major depressive disorder. On a daily basis I asked him how he was tolerating the medications. He said he had mild to moderate nausea and that his sexual drive was declining. Other patients were being admitted on a daily basis, as much in crisis as Mr. J had been on his admission, and it was time to come up with his dispo plan.

A social work student from Germany had been interning on our unit several weeks prior. My fellow resident and I remembered with a smile her first week on the unit when she decided she would coordinate by herself a dispo plan for a local homeless man with chronic alcoholism. The next morning she stated, in her concerned tone and careful English, that she had found on the Internet a private residential treatment center for alcoholism in suburban Minneapolis, called Devonshire Springs or something of the sort. My colleague and I could not help but enjoy that one. Dr. G, in an equally concerned tone, responded respectfully that the hospital did not have funds to send the patient there or to pay for his stay. He thanked her for her initiative and suggested she call the local public mental health agency that might set the patient up in a short-term facility. What my colleague and I knew was that even if this did happen, it would only prolong for a few days his ultimate dispo: back to the street. By discharging patients from the hospital to the public mental health short-term (often meaning one-night) facilities, we could absolve ourselves, as physicians, from discharging people to the street. That way we could retain our own superficial sense of beneficence. On the other hand, there did not seem to be any other choice.

After Mr. J tolerated the SSRI and leuprolide and reported improved mood, it occurred to me that I had better start putting together a dispo plan for him. Having no idea how to proceed, I decided to follow the approach that I had snickered at a few weeks previously. However, once online I did not know where to look. A place in New England appeared to be for pedophilic priests, but I could not imagine Mr. J would be eligible. I also found a handful of "Devonshire Springs"-type places that offered posh residential treatment for a variety of addictions and disorders at a cost of $30,000 to $40,000 for 30 days. Mr. J confirmed that he did not have money for that. The conundrum of what to do with a person seeking treatment for pedophilia who said he was not under arrest, not a religious professional, and not wealthy was beginning to set in. What added to the pressure was that Mr. J stated that he *wanted* to be in treatment. He said he did not want to hurt anyone and that he feared he could be a risk to others if he did not receive treatment in a secure setting.

Amid this backdrop of circumstances, Mr. J told the team that he had been talking with a staff member and, given that no other options appeared available (which we had intimated the previous week), he had been considering calling the FBI. He said he had not been arrested but had also been asked not to leave the state, which he had clearly done. He thought that he should stop running and start getting his legal troubles straightened out. However, he also made it clear that he was not completely sure that this was a good idea. Dr. G and I concluded that session by saying that if he wanted to call the FBI, the staff could assist him with the call, but we added that it was his choice. Afterward, as we discussed the case, this option began to seem like music to our ears, and I think here we made one step away from neutrality and toward expedience.

In medical ethics, neutrality is often framed across from its antagonists: beneficence and paternalism. In the case of Mr. J, however, I think expedience—or to put it more bluntly, convenience—was the counterpoint to neutrality. With no other realistic options evident, having the FBI come in and "help," especially because it would be at the patient's own request, seemed like the perfect deus ex machina dispo plan. It also seemed like a good solution because, although the patient was not technically arrested by law enforcement, he had clearly breached its dictate. Also, this course of action could be rationalized as therapeutically valid. The patient was, after all, demonstrating mature ego strength by facing his responsibilities and being accountable rather than avoidant. Last, and perhaps most insidious, I was still uncomfortable with my own anxiety that the patient represented a risk to innocent children, and if he called the FBI, I would not have to tolerate my anxiety that he could hurt someone. This dispo plan would be my own disposition—from anxiety and potential guilt. Neutrality lost out to what I wanted to call beneficence.

The next morning, Mr. J stated that he was feeling better but had not yet called the FBI.

> "Well, we want you to know that it is ultimately your decision. However, to be frank, I haven't been able to find any other treatment alternatives. If you do want to call the FBI, the staff would be happy to coordinate it with you. I certainly would tell them that you have voluntarily sought and cooperated with treatment here."

Dr. G met with FBI agents the next day on the unit. They stated that because Mr. J had not been charged or accused of harming anyone and because he had voluntarily sought treatment and contacted the FBI, things would "go well" for him. They assured us they had a residential treatment center that could provide Mr. J with treatment. They stated that there would, however, be some bureaucratic processing prior to his treatment and that they would be flying Mr. J back to Ohio.

This sounded good to Mr. J. The next morning, which was his last day, he thanked us for the treatment he received, not just as a patient, but as a person. The agents escorted him from the unit while I was interviewing new patients admitted overnight. I was on to treating new patients.

Several months later while on a new rotation I received a letter in my department mailbox, with my name spelled incorrectly, from the Ohio State Prison. It was from Mr. J, although I did not remember who that was until I was at least halfway done reading it. Things had not gone as planned. In the letter he wrote that he was immediately turned over from the FBI to federal marshals. He was sent to a maximum-security state prison. He was given no medications or psychiatric treatment. He told fellow inmates he was imprisoned for computer fraud. This worked, he wrote, until the inmates were watching the Ohio State football game. He wrote that it was a miracle he decided not to watch the game. During halftime, the local news aired the story of the arrest of a Mr. J. He wrote in the letter that someone told him that a group of inmates were coming after him. He wrote that he was able to tell the guards and get locked in his cell just prior to being assaulted—or killed. He wrote in the letter that he was facing a sentence of 17 years in a maximum-security prison. He asked if there was anything I could do to help and again thanked me for his treatment. There seemed to be no sarcasm in his last comment. He wrote that *we* had been duped.

I was in shock. My first impulse was to throw the letter away. After all, it is a known principle that after treatment, doctors—particularly psychiatrists—should have no outside contact with their patients. That would be a breach of neutrality. Yes, I would throw the letter away. How dare a patient be so entitled as to think they could contact me and ask for help after dispo. Still in shock in the department hallway, I saw a senior resident walk by.

> "Hey, S. What do you think about this? Do you believe the nerve of this guy!"

"What are you going do with it?"

"I'm going throw it away. I've already discharged this guy. … What do you think I should do with it? "

"Show it to the attending."

Later, possibly several weeks later, I put it in Dr. G's mailbox with a draft of a response letter I had written to Mr. J. The letter essentially said nothing. I was trying to send the message: "Good luck … sounds like a tough break … thanks for saying 'thanks' … yeah, we did get duped.… I had nothing to do with it. … I hope you have the opportunity to get a good lawyer." Wishing that he had a good lawyer was the extent of my "help."

Dr. G wrote back suggesting that I change my letter (I had not sent it yet). He encouraged me to be more empathic and tell the patient that we would be willing to help in any way we could. He was recommending a letter of beneficence, not neutrality. He also said he was contacting the agents with whom he had met. With trepidation, I changed my letter in accordance with his suggestions and sent it.

After a couple of exchanged letters, Mr. J's lawyer contacted me asking if I could document that Mr. J had voluntarily sought treatment and complied with treatment recommendations. He also confirmed that Mr. J had been charged only with owning child pornography, not accused of any other crime. The mother of the two boys Mr. J mentored had become his strongest supporter during his imprisonment.

In the end, Dr G, who has specialty training in forensic psychiatry, composed a psychiatric summary, which led to a change in Mr. J's sentencing. Mr. J was sentenced to 3 years at a minimum-security facility that specializes in psychiatric treatment of sex offenders. In his last letter, Mr. J thanked us for the psychiatric summary and for our willingness to provide additional help.

In this vignette, the ideals of beneficence and neutrality were at times in balance and at times in conflict. Mr. J was offered medication to reduce his libido for what was felt to be for his own good, but it was ultimately his decision. Beneficence was present in the offering of treatment, but neutrality in the requirement for true informed consent from the patient before starting medication. However, in Mr. J's disposition, the balance and contrast of ethical ideals was more complex. A factor of beneficence existed toward the patient (and perhaps society) in assisting with disposition to the FBI. However, in encouraging and assisting with this action, neutrality was clouded and compromised by the pressures of expediency, anxiety, and questions of guilt and responsibility. For instance, rather than encouraging and facilitating custody to the FBI, the treatment team could have treated the patient in the hospital and let him know what his choices were after discharge. The relevance and importance of the theoretical principle of neutrality was made very clear after reading Mr. J's first letter. A consequence of compromising neutrality for pressures such as expediency and anxiety (perhaps cloaked as beneficence) could have

led to the patient being assaulted, killed, or enduring a prison sentence that he would not have independently chosen.

Our opinion is that neutrality is a vital component of ethical patient care. It is a component that can be attended to alongside other ethical ideals such as beneficence and patient autonomy. However, as the outcome of decision making can never be known, there are times, as in this vignette, when the balance between neutrality and beneficence may be in conflict or competition. This case also exemplifies how nonethical pressures can also compete with neutrality in an insidious way. Last, this vignette serves to illustrate that one very good approach to understanding and working through these factors is open communication and dialogue with supervisors and colleagues.

REFERENCES

Beckwith, F. J., & Peppin, J. F. (2000). Physician value neutrality: A critique. *Journal of Law and Medical Ethics, 28,* 67–77.

Saleh, F. M., Niel, T., & Fishman, M. J. (2004). Treatment of paraphilia in young adults with leuprolide acetate: A preliminary case report series. *Journal of Forensic Science, 49,* 1343–1348.

Sandel, M. J. (1982). *Liberalism and the limits of justice*. Cambridge, England: Cambridge University Press.

Copyright of Ethics & Behavior is the property of Lawrence Erlbaum Associates. The copyright in an individual article may be maintained by the author in certain cases. Content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.