Appropriate Short-Term Risk in Psychiatry and the Law

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Effective treatment decisions sometimes require substantial risk of short-term harm, which can be shown after-the-fact to have been preventable, thereby carrying some liability risk. To err on the side of short-term comfort or safety, however, may greatly increase the overall and long-term risks. For instance, to intrusively restrain a borderline patient from threatened acting out, may (1) fuel a regressive cycle that heightens future risk, (2) deprive the clinician of therapeutic leverage, and/or (3) so disrupt the treatment system that other patients unnecessarily suffer. Long-term thinking is not always convincing to judge or juror, because of less direct causal connections; hence, there is pressing need to develop rational criteria for when it should hold sway. Two competing trends of legal doctrine are relevant: risk-benefit analysis (utilitarian) and absolute values (absolutist). Presumptions of appropriate short-term risk separately weigh five relevant factors, in interaction with one another: imminent safety, long-term risk, voluntariness of other agent, therapeutic boundaries, and social values. Forensic psychiatrists are advised to take a stronger stand in support of short-term risk, when needed to enhance long-term safety and optimal standards of care.

"Appropriate short-term risk" (ASTR) attempts to answer the unresolved question of when, how, and to what degree the professional's proper course of action can be to willfully incur a significant risk of short-term preventable harm, with its associated risk of liability, because to *not* incur this risk is to incur the likelihood of some greater or otherwise unacceptable long-term harm, or to negate the long-term benefits that the professional is charged to foster. This question has profound importance to all mental health professionals, who find themselves torn between such conflicting duties as to respect patients' autonomy while at the same time protecting patients from themselves, or keeping confidentiality while warning endangered others.[1] Beyond the professional milieu, a "reasonable person" will also recognize the question as a capsule statement of the many risk-utility balancing processes that pervade all human living. Since cumulative decisions of the hypothetical "reasonable person" are the root of Common Law,[2] one might expect the law to provide rational problem-solving

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guidelines for how to approach such decision-making dilemmas. Legal doctrine, however, is quite problematic in this area.

Appropriate short-term risk is not a unitary concept, but integrates at least three discrete component issues, each one vital to regulating human affairs, beset by antinomy and paradox, and unresolved. First is the concept of "appropriate"—itself an extraordinarily complex collage of adaptive behaviors that are usually taken as a "given," but are somewhat deceptive[3] and beyond precise definition. Here, it approximates the common law implication of what a "reasonable person" in the actor's shoes would do. Second is "risk management," with rich and evolving legal doctrines dominated by unresolved tension between "utilitarian" cost-benefit reasoning and "libertarian" focus on more absolute rights, ideals, and values.[4, 5] Finally there is time, the temporal dimension so fundamental to how we humans experience ourselves, and so far from resolution in either science or the law.[6, 7]

Legal scholar Richard Epstein notes that "all human interactions, and hence all legal rules, have a temporal dimension. Offer precedes acceptance; cause precedes effect; parents are born before their children. . . . The legal treatment of temporal issues cuts across the traditional substantive categories of the law: property, contracts, torts, and restitution." [8] The primary cost of elapsed time is uncertainty, which greater certainty can reduce. Especially for risk averse individuals, this "creates pressures, both public and private, to take steps to ensure that legal rights and duties do not depend on events that are (too) remote from the present, either past or future." From this process arises a *present-centered bias* inherent within the far corners of legal doctrine.

By contrast, mental health practice is relatively farsighted. Treatment planning is often guided both by views of the remote past, and a vision of an equally remote and even more uncertain future.[6, 7] Whenever present contingencies conflict with our long-term charge for therapeutic efficacy, a practitioner is in a bind. One can focus on the here-and-now contingency, usually validated by most "reasonable persons" and thus the law; or take the presumably more therapeutic farsighted course, incurring significant risk of short-term harm for which he or she may be blamed.

If a worst case scenario occurs, e.g. a patient commits suicide or harms an innocent third party, a clinician's potential liability is enhanced by a second bias—*hindsight*.[9, 10] Knowledge of an actual outcome leads *post hoc* evaluators to impute a far greater causal role to its antecedents, than one could possibly know in advance; this "hindsight bias" stubbornly resists instructions to "think prospectively." [11–13] Thus, we cannot expect a juror to accurately picture the inherent uncertainty of the decisional matrix facing a defendant prior to an alleged harm. Both present-centered and hindsight biases enhance liability risk for the difficult decisions that clinicians must routinely make with difficult patients. Within our litiginous climate,

both pressures mandate a need for a rational principle by which appropriate short-term risk can be prospectively assessed, and its parameters documented. This is the task to be addressed by this paper.

First, a word of caution and clarification: i.e., *guidelines for appropriate risk-taking do not obviate our charge to do all that is reasonable to avoid our ever having to apply them.* Competent and considerate therapeutic communication can often validate the many pressures impinging on our patients from within and without, so that the most extreme short- versus long-term risk dilemmas will be uncommon if not rare. And when crises do occur, many can be modulated so that short-term protective action is taken in a way that facilitates rather than undermines therapeutic goals. Nonetheless, situations do inevitably arise in which significant risk of serious harm must be accepted if we are to retain any ability to be potent catalysts for therapeutic change. Even if rare, to clarify the conditions for short-term risk-taking may go far toward clarifying such ongoing issues as who is ultimately responsible for whom and at what level, or what actually leads to therapeutic progress as opposed to regression—all toward a goal of treatment paradigms that are both effective and safe.

The Scope of Appropriate Short-Term Risk (ASTR)

Appropriate short- versus long-term risk dilemmas pervade biological, psychological, and social levels. At the first, are chemical and behavioral addictions.[14] Faced with craving, an agent knows that appropriate abstinence risks the short-term harm of mounting tension or suffering, which is clearly preventable in the short haul. Even when one gradually learns to recognize the far greater long-term costs of *not* abstaining, the causal diffusion imposed by the time lag lends far less reinforcement value than to the here and now "quick fix" of addictive indulgence. One can interdict the pattern only by employing long-term reasoning, with a near certainty of short-term discomfort and significant risk that this will be prolonged.

For an extreme social illustration, consider the dilemma of a political leader like Neville Chamberlain at the 1938 Munich peace parley, faced with escalating aggressions from a malignant violator. By hindsight, we now know that *failing* to employ the appropriate short-term risk of timely interdiction guaranteed one of history's worst catastrophes.[15] At the time, however, the worst had not yet occurred; and its likelihood was appreciated by only a few farsighted individuals and actively suppressed from public awareness. And even then, timely interdiction would have been so costly to lives and property that widespread censure would have been likely.

ASTR is equally relevant to public policy and environmental law. A popular spending program may gain wide short-term support, but displace far greater costs onto future generations.[16, 17] Short-term economic prosperity is often pitted against long-term environmental damage which, though

potentially catastrophic, remains intrinsically uncertain[18–20] and far less convincing at times when economic recession can be relieved by short-term exploitation.

At the psychological level, appropriate short-term risk pervades the very essence of our "basic humanness." Since Freud,[21] we understand growth and maturation partly as learning to delay impulse gratification in favor of seeking ever more distant goals.[22] Evolutionary biologists view consciousness itself as an "evolved organ" for long-term strategic planning.[23] Finally, management experts like Elliott Jaques find that more than any other variable, executive competence correlates with the temporal duration of one's working "vision"; i.e., whether one normally thinks ahead in terms of days, weeks, or even years.[24]

Interpersonal Boundaries and Differential Responsibility

Within forensic psychiatry, the most vexing temporal decision-making problems involve an additional dimension—often but not always present in other ASTR situations. This occurs whenever the potential harm to be risked is a voluntary act of another. When a clinician is culpable for a harm, for example, it may be not for actually committing it, but for *failing* to *prevent* another from doing it—usually a patient. When two agents are inextricably involved, this raises the question of *interpersonal boundaries:* who is responsible for what, whom, to what degree, and at what levels?[25–27]

In general common law, even though the result may be the same, failure to act is often exonerated or punished less severely than direct agency.[28] The context of mental health erodes this protector in two ways. First, even when a patient is fully competent, the psychiatrist's "fiduciary relationship" mandates duties to warn and protect far beyond what might apply to others.[29, 30] Second, the widespread presumption of patients' impairment displaces their own accountability onto treating personnel, and "animates the law of professional negligence."[31]

This shift in responsibility is generally accepted when a patient suffers from a major mental illness like active psychosis or major depression. It is problematic, however, with that class of patients suffering from what Halleck terms "disorders of will": personality disorders, dissociative disorders like multiple personality, substance abuse and eating disorders, and many posttraumatic conditions.[32] Despite the unquestioned severity of their subjective distress and perceived dyscontrol, they retain sufficient awareness and volition at relevant levels to meet legal criteria for criminal accountability;[26] and there are dominating arguments for holding them responsible on purely therapeutic grounds.[32–34]

Accepting these arguments does not adequately relieve the clinician's dilemma, however. Suppose that a competent patient voluntarily inflicts harm on himself or another; and the treating psychiatrist was aware of the potential for this tragedy, possessed the means by which it could have been averted, and knowledgeably chose to incur the risk. Should this clinician be held liable? This

scenario hits at the heart of where a principle of appropriate short-term risk is most urgently needed within our profession. Three additional areas of inquiry are needed to adequately address the question of when the harm is voluntarily inflicted by another: the concept of moral blackmail, the regressive dependency phenomenon, and the issue of whether suicidal patients can be held solely accountable for their actions.

Moral Blackmail "Moral blackmail" occurs whenever an agent (A_1) is coerced into committing an evil (E_1), under threat that otherwise another agent (A_2) will commit a greater evil (E_2), and there is sufficient reason to take this threat at face value.[35] Terrorists' hostage-taking is a blatant social illustration. Low-level moral blackmail is routine in clinical practice; e.g., a manipulative patient threatens suicide to gain inappropriate hospital admission, or demands prescription for controlled substances under the rationale that he cannot otherwise function, and the therapist will be responsible for the resulting harm. In either case, the line between moral blackmail and reasonable request is blurred, and the most prudent course is often to assume the latter unless proven otherwise. Even when blackmail is beyond doubt, whether to yield to A_2's demands is far from clear. Most clinicians will at some times, and not at others.

Now consider a therapist, off duty and *en route* to an important event, who receives a call from a patient in an alternate personality state saying that unless therapist drops everything and comes to the rescue, patient will soon be dead. Whether or not therapist could be held liable for failing to comply, there is massive emotional coercion—the stakes being life or death. If therapist does comply, however, it may set a precedent likely to recur, with ever more desperate pleas for rescue, high-risk behavior, and escalating invasion of therapist's boundaries can make treatment untenable, at best, or even increase the risk of tragedy. This is "regressive dependency"—known to occur in treating dissociative disorders and other disorders of the will.[25, 34] While experienced clinicians readily recognize the process, remarkably little has been said or written about it.

Regressive Dependency Similar to Balint's "malignant regression,"[36] regressive dependency manifests with "a constant spiral of urgent demands ... often leading to addiction-like states ... very difficult to handle."[37] Kahn noted that regressive patients simultaneously cling to and coerce their objects,[38] even to the point of blackmail;[39] therapists, in turn, foster malignant regression in these patients by any (1) implication of therapist's omniscience or omnipotence, (2) symbolic seduction (e.g., treating patient as "special"), or (3) gratification of patient's dependency.[38] The common thread in all these regressive factors is patients' "dread of resourceless dependence,"[37, 38] or undermining of their autonomous domain.

This process can be understood as a vicious circle: on the one hand, are dependency needs that can seem insatiable; on the other, a concurrent demand

for autonomy that is inviolable.[25,40] When therapists assume responsibilities otherwise belonging to their patients, what feels supportive at the first level is experienced as a threat at the second, increasing anxiety and thus the dependency needs, leading to an escalating cycle that is opposite to what is needed for therapeutic growth and maturation,[32-34, 36-40] and can paradoxically increase the risk of destructive behavior. To yield to "moral blackmail" thus usurps patients' already fragile autonomous domain, a reciprocal boundary error that violates the dictum of *primum non nocere.*

Pilot data also confirm the therapeutic potential of holding patients solely responsible, and building on their preexisting strengths.[40] But how much is this worth if the patient is now dead, and the tragedy could have been prevented? Alternatively, how much is it worth to insist on protecting patients from themselves, if the resulting widespread use of "preventive detention" both abridges patients' autonomy on a large scale, and undermines their mental health?[41] This is the pressing dilemma that faces both clinicians and the courts that are called to judge them.

Are Suicidal Patients Competent? A third issue is whether suicidal patients can be competent to assume sole responsibility for their choices. Even if we accept Halleck's[34] and Beahrs'[26] reasoning for disorders of will, the public's massive ambivalence about suicide sets a huge barrier. Some advocate suicide as a legitimate autonomous choice,[42] and courts affirm medical patients' right to refuse life-saving treatment on even irrational grounds.[43, 44] At the same time, suicide is often viewed as an ultimate evil whose prevention is a commanding social interest.[45]

There is parallel ambivalence about voluntariness. To break the "chain of causation" that can hold another liable, one must establish a deceased's voluntariness;[46, 47] but many view "voluntary" suicide as an intrinsic self-contradiction, i.e., suicide is taken as *ex post facto* proof of nonvolition.[45] Furthermore, in psychiatric malpractice, even a clearly voluntary suicide may not exonerate a clinician who has violated some standard of care.[48, 49] Thus, practitioners of appropriate short-term risk must take exceptional care not only to document their patients' full capacity for volition, but also find a way to confront trends within the prevailing standard of care, when these have become countertherapeutic.

Legal Dimensions

Temporal Risk-Utility Balancing Versus Absolute Values Despite the ubiquity of short- versus long-term reasoning in human living and the law, no single doctrine directly addresses the issue. A review of legal paradoxes by George Fletcher[50] clarifies the most relevant dilemmas. The "Learned Hand" rule, named after the presiding judge in *United States v. Carroll Towing Co.*,[51] explicitly affirms that one can incur significant short-term risks when these are balanced by greater long-term benefits, or by avoiding greater long-term harm. This is similar to "choice of evils," in which criminal defendents may be ex-

onerated if their only alternative was to suffer or commit a greater evil; e.g., prison inmates who escaped to avoid inevitable homosexual rape.[52–54]

Such reasoning, often known as "utilitarian," is opposed by other legal doctrine. In counterpoint to Learned Hand is another decision, *Grimshaw v. Ford Motor Co.*, which vigorously punished risk-benefit reasoning as "malice" when it led to willfully marketing a suboptimal product.[55] By the second line of reasoning, some risks are simply unacceptable—the position of absolute values, or "absolutist."

Fletcher noted a fundamental interplay between utilitarian and absolutist doctrine. If a principle of appropriate risk-taking were established, it would most likely also be used to justify *in*appropriate risks, adding a new social cost that would tip the scales back toward absolutist positions, even using utilitarian logic. If the latter position were established, its effects would similarly exert pull toward the former, leading to an "antinomy of destabilization."[50] This process can be viewed in the more broad legal context of risk management.

Throughout risk management law, is a parallel and unresolved tension between "utilitarian" and "absolutist" approaches.[4, 5] The former endorse cost-benefit reasoning, and would embrace environmental protection, Learned Hand, and ASTR. The latter is the position of absolute rights, that some interests are too fundamental to allow for any compromise, even when failure to compromise incurs an admittedly greater cost. The view that suicide can never be voluntary nor acceptable is of the second type, and would make the idea of any risk-taking unacceptable.

McConnell's Principle The tension between "cost-benefit" and "absolute values" can also be clarified by the problem of moral blackmail discussed earlier: pressure on A_1 to commit evil E_1, or else A_2 will commit a far greater evil, E_2. Using several examples, McConnell argues that few reasonable people would exclusively support either position.[35] First, A_1 must either lie to someone, or A_2 will kill an innocent third party. If one can *never* commit a wrong to prevent a worse wrong, the agent will avoid lying even at sacrifice to an innocent's life. That few would take this course, limits the absolutist approach. Second, A_1 must kill some innocent, or else A_2 will kill three different innocents. By undiluted cost-benefit reasoning, A_1 should commit murder. That few would, similarly limits the utilitarian approach. After discussing a few more ambiguous moral blackmail dilemmas, he proposes a general principle that he believes will encompass most reasonable decision-making:

> An agent in a situation of moral blackmail is morally required to do something evil in order to prevent the blackmailer from doing a greater evil (to nonconsenting persons) just in case either (1) the agent's action does not irreparably violate the rights of some nonconsenting, innocent person, and if an innocent person's rights are violated he is to be compensated, or (2) if a nonconsenting, innocent person's rights are irreparably violated by the agent's action, then the same (or equally strong) rights of the same person would have been violated even if the agent did not comply with the blackmailer's demand.

Using suicide risk in a regressive patient as illustration, we can consider how this algorithm might apply to determining appropriate short-term risk in the psychiatric setting. The evil that A_1 is being demanded to do is to undermine A_2's prospects for therapeutic recovery, possibly increasing the long-term risk of harm. Most would consider these a lesser evil than A_2's imminent death. To avoid risking the greater evil cannot be accomplished without violating the rights of an innocent at two levels, however; the therapist's right to exercise autonomous therapeutic judgment, and the patient's right to receive optimal treatment, at the deeper levels at which he or she remains innocent. These violations will not occur if A_1 refuses to comply. Thus, by McConnell's principle, the therapist should refuse the blackmail in favor of optimal treatment, affirming ASTR.

McConnell has a fatal flaw, however: failure to consider the uncertainties. Rarely do we know if either violation was "irreparable," nor can we reliably predict the probability of a completed suicide—both essential components of the decisional matrix. Also confusing the picture is uncertainty over whether or to what degree the dilemma could have been avoided in the first place, by using reasonable clinical skill.

Luhmann[56] also proposes that utilitarian and absolutist principles be considered in tension with one another. In essence, he advocates a shift from dichotomous "either-or" to more inclusive "both-and" reasoning. Because the latter is so relevant to the complexities within mental health, it is especially useful for psychiatric decision making.[25] The overspecificity of McConnell can be avoiding by not attempting a rigorous operationalizing. Instead, relevant factors can be listed as *presumptions* to guide decision making, similar to "innocent until proven guilty" in criminal law,[25] whose weighting will necessarily vary with the overall context, and its many complexities. By avoiding the precision of an operationalized formula, they remain maximally relevant.

Presumptions of Appropriate Short-Term Risk (ASTR)

Presumption 1: Imminent Safety All else equal, a clinician must err on the side of short-term safety. This is usually most therapeutic as well as prudent, both to avoid irrevocable tragedy and to foster a clear sense of priorities. Burden is thus on the agent to seek risk-reducing alternatives.

—Corollary: Risk Within Acceptable Limits Relevant factors include:

(a) probability of harm (prior behavior, other risk factors)
(b) severity of potential damage (e.g., lethality)
(c) irreversibility of damage
(d) innocence of victim (e.g., homicide vs. voluntary suicide).

This presumption acknowledges that there is a point beyond which absolute values prevail over utilitarian reasoning. Where this occurs, however, will be profoundly influenced by the other presumptions that follow.

Presumption 2: Minimizing Long-Term Risk If short-term risk is not unacceptably severe, it becomes more pru-

dent the more that *failing* to take the risk increases the very same or related risk factors over extended time. Regressive potential and the undermining of therapeutic goals contribute to this assessment, as well as to presumptions 4 and 5.

Presumption 3: Effects of Another's Volition Where risk arises from a second agent's behavior, its appropriateness increases with the latter's

(a) *voluntariness* (e.g., least with psychosis or external coercion; most with "disorders of will")[3,26,32]

(b) *willful deception*, depriving the clinician of the information necessary for meaningful treatment decisions[26]

(c) *moral blackmail*, in which clinician is coerced by threat of voluntary harm, into inappropriate treatment decisions.[35,39]

Presumption 4: Effects of Therapeutic Relationship Therapist should foster that delicate blend of rapport, shared understanding and protective limits that will in most cases prevent extreme ASTR dilemmas from occurring.

—Corollary 1: Minimizing Regressive Dependency Patient risk factors for regressive dependency include a simultaneous plea for support and behavior oppositional to this plea, both pulls fueled by high affective intensity; demands to be treated as "special," or seductive treatment of therapist as special; history of regressive dependency in prior treatment.[25,40] These factors call for extra burden on therapist to avoid fostering regression.

—Corollary 2: Therapist Responsibility for Short-Term Harm From Patient's Behavior is Increased by

(a) explicit contracting that therapist is indispensible:
  i—primary protector and/or crisis resource
  ii—primary agent of change

(b) less explicit fostering of regressive dependency, which carries covert contractual implications.[27]

Iatrogenic regression variably undermines and may even neutralize the protection otherwise provided by presumption 3. This occurs via the context-dependency of psychological structures; how one defines the reality *actually changes it*, especially when transactionally validated.[25,27]

Presumption 5: Support To Prevailing Social Roles, Values

(a) specific therapeutic goals

(b) prevailing standards of care

(c) overall societal values.

This fifth presumption acknowledges that treatment does not occur in a vacuum, but is constrained by competing pressures that impinge on both care providers and their patients from the greater societal milieu. These unavoidably influence prevailing beliefs about health and illness, what treatment goals are appropriate, how these should be implemented, and even how psychosocial realities are defined and assessed.[57] The "reasonable person" standard of common law makes prevailing societal values a formal determinant of what is or is not ultimately deemed "appropriate."[2,3]

Case Illustrations

Case 1: Turning Point After an initial hospitalization following a suicide attempt, a young woman entered intensive treatment for affective symptoms with features of posttraumatic dissociation. Addressing relevant psychodynamics led not to the hoped-for treatment alliance, but to a regressive dependency on care providers, with escalating demands and expectations frequently in conflict with one another. Self-destructive acts were made in violation of clear contracts for safety, with patient disclaiming voluntary control over the process. After considerable time lapse with little change in the pattern, her therapist told her that he would no longer accept the charge of protecting her from herself; even when alarm signals were high, he would have to trust in her own inner resources and hope for the best—clarifying the resources that were always available for emergency. This proved to be a turning point: treatment sessions rapidly became more productive, acting out abated, and treatment progressed to a satisfactory outcome.

Was it appropriate to renounce the role of primary protector? By the first presumption alone, imminent safety, few therapists would want to take that risk—especially so, with an increasingly risk-averse social climate. She had demonstrated her suicide potential on many occasions, suggesting a significant probability of a lethal and irreversible outcome. Other presumptions work in a different direction, however. By the second, reasonable protective measures had been taken, which failed to lessen the overall risk but appeared to *increase* it. Third, her thinking was cogent and her actions voluntary enough for accountability in criminal law,[26] complicated by willful deception, and coercion of caregivers away from their therapeutic charge. Fourth, regressive potential was now established beyond dispute, mandating all reasonable measures to establish rigorous therapeutic boundaries.[40] The fifth presumption was less relevant, with strong societal pressures in both directions. In the composite, the presumptions of appropriate short-term risk were met, supporting the action in question.

Case 2: Psychotic Vengeance A middle-aged man was in treatment for long-term persecutory delusions accompanied by helpless rage, and belief that he might some day seek revenge against his tormenters. Diagnosis was chronic paranoid schizophrenia, with symptoms responsive to neuroleptic medication but worsened by episodic substance abuse. Delusions had recently focused on personnel at a specific business institution. He was not floridly psychotic, and strongly denied any assaultive or homicidal ideation, but did admit to enjoying an "occasional beer."

Was short term protective action needed in that situation?, the reciprocal inverse of ASTR. Here, the presumptions work in the other direction. By the first, danger was not imminent, but might escalate. By the second, protective action would not worsen the patient's condition, but *improve* it by setting clear limits and consequences. Third, patient

was not in voluntary control of the delusional process, and was electing to do something known to worsen it. Fourth, regressive dependency was neither present nor expected. Finally, courts have clearly imposed duties to warn and protect endangered third parties. Since patient was not imminently committable, decision was made to warn the institution at potential risk. This case is significant for the degree to which ASTR presumptions mitigate *against* short-term risk, and instead support imminent protection.

Case 3: Suicide Risk A young adult man was in treatment for atypical depressive disorder superimposed on mixed personality disorder, the former being responsive to a specific thymoleptic. When depressed, he was a high suicide risk; when euthymic, not. Compliance with treatment was marginal; patient frequently attempted to make caregivers responsible for what only he could do, and then to act out against any perceived intrusion into his autonomous domain. Severe regressive potential was repeatedly documented.

Acute ASTR dilemmas occurred at two points in treatment. First, he simply failed to report to a scheduled appointment. *Should caregivers have attempted outreach, making maximal effort to return him to treatment?*—again, the inverse of ASTR. This was not standard clinic policy, and treatment had explicitly contracted for patient's responsibility. Suicide potential was well known, but regressive dependency would be enhanced by active outreach, further reinforcing patient's failure of responsibility, with resulting long-term harm. Further, patient's behavior was voluntary and accompanied by moral blackmail. The decision was against outreach, to await contact or close the case after appropriate time lapse.

After some time passed, he ended up in intensive care. He acknowledged having been voluntarily planning a suicide for months, hoarding medication during this time while willfully lying about both his affective status and his compliance with treatment. After consultation with both peers and administrators, decision was made to unilaterally terminate treatment. Alternative resources were available, but at sufficient hardship that follow-up was unlikely, and recurrent depression more probable.

Was unilateral termination an appropriate short-term risk? Despite the obvious severity of the risk, presumptions 2 through 4 all mandated against further treatment. The deciding factor became the patient's willful deception, violating the duty to provide the accurate and complete information without which treatment cannot proceed.[26] Even when a patient's untreated condition is life threatening and alternative resources inadequate, courts affirm caregivers' right to unilaterally terminate patients who are rendered untreatable by the extremity of their own disruptive behavior.[58, 59] It was also evident that therapist had made extensive efforts to engage the patient and pursue treatment alternatives, satisfying the fourth presumption.

Case 4: Assaultive Alcoholic A young man was hospitalized for suicidal and assaultive impulses after breakup of

a highly enmeshed and abusive relationship, with diagnoses of personality disorder and alcoholism. After a few days of mild alcohol withdrawal, his mood became euthymic. By the next week, he consistently expressed a commitment to "let go" of his former relationship and "get on" with life, citing numerous plans and resources congruent with this vow. As discharge approached, he was given a pass after having made a witnessed and clearly stated agreement that he would abstain from both alcohol and contact with the former intimate.

With these assurances, two questions are posed for ASTR: (1) *was it appropriate to grant a pass?*, and if so, (2) *should treaters have notified the former intimate that patient was at large?*—again inverse to ASTR. In comparison with the other cases, presumption 5 carries disproportionate weighting here. The first choice is easy: in an era of patients' rights and cost containment, few would support extended hospitalization in this situation. The second question is less clear. On the one hand, the patient's statement plus congruent behavior indicated that no danger even existed; hence, to "warn" is an unwarranted breach of confidentiality, and would risk reactivating a regressive relationship and creating new dangers. On the other, when the risk is assault, the innocence of a potential victim gives greater weight to the first presumption, and clinical skill should suffice to find a way to provide warning without stirring up trouble.

Were the patient to have then gone directly to a bar, *en route* to creating a corporal threat, it is likely that things would subsequently be held in a different light. Any hint of unreliability in the patient's character might then be magnified to support a charge that the therapist should have erred on the side of short-term safety—the hindsight bias. Most probably, this situation lies within a domain of professional discretion in which courts will affirm either choice as long as it is "reasonable," with relevant risk-benefit analyses documented well in advance of any alleged harm. As in the prior case, patient's willful provision of inaccurate information should focus the culpability solely upon himself.[26]

Incorporating ASTR into Legal Doctrine

Most troublesome is the question of how to take appropriate therapeutic risks in the face of risk-averse standards of care, which can arise from present-centered, hindsight, and absolutist biases. Whenever a dominating ethic becomes countertherapeutic, the "reasonable person" test of common law likewise becomes problematic. There are several ways in which appropriate short-term risk might become incorporated into legal doctrine, better supporting clinicians' prerogative for making difficult decisions in difficult circumstances. They fall into legal and clinician-implemented strategies, discussed in turn.

Legal Strategies When problematic trends in common law are recognized, the most obvious strategy is to change them by statute; malpractice reform falls under this rubric. An allied strategy would be to permit the use of ASTR as an affirmative defense for malpractice

litigation. This is close to "choice of evils."[52–54] used primarily in criminal law but also relevant to civil proceedings. In either case, its effect is to shift the burden of proof to the plaintiff, to show that the defense doesn't apply.

Within common law, Fletcher challenges the prevailing "reasonable person" standard, arguing for a limited return to an earlier standard, "reciprocity."[60] By the first, even contractual proceedings between two individuals are ultimately decided by an external standard. In reciprocity, the competing interests and risk-takings of a litigant are assessed only in relation to those of the other. The litigants thus become a composite unit, to be assessed by its inherent merits independently of the interests of society. This is similar to a defendent's relative autonomy within the "attributive" (just desserts) model of criminal justice.[3] This is especially unlikely to occur in health care, however, where standards are increasingly bound to the external pressures of quality management[61] and internal pressures to operationalize diagnosis[62] and treatment.[63]

Clinician Strategies Other strategies attempt to influence the prevailing standard of care, and can be implemented by clinicians without the direct intervention of law. In a large treatment institution, for example, one can build the guiding presumptions directly into its policy manual. If reviewed and supported by relevant peer review and ethics committees, this would help to establish ASTR at least as the *local* standard of care—significantly assisting practitioners' defense. Another is to advance scientific knowledge of the regressive risks often inherent in taking the short-sighted course, and the relative efficacy and safety of treatment alternatives.[40] Much more data are needed in this area.

Another viable option is to carry the "reasonable person" doctrine beyond its usual application toward more appropriate conclusions. As noted by *Morrison v. MacNamara*, it is physicians' "special knowledge" that leads to high liability risk; they are judged by what a "reasonable person" *with that special knowledge* would do.[31] If one has *additional* knowledge about flaws in standard practice, for a particular case, the same reasoning will mandate the agent to act according to this additional knowledge. Otherwise, one could paradoxically incur liability for actually following the standard of care—against one's better judgment. Even if the additional knowledge subsequently proves to be problematic, it is still "reasonable" to follow if it (1) adequately considers the accepted fund of knowledge, (2) is rationally based, and (3) is carefully documented. Perhaps this is one way that doctrines of appropriate care can and actually do change.

Finally, forensic psychiatrists can take a strong stand in support of appropriate short-term risk, when called to testify against another professional whose otherwise appropriate risk-taking has led to a bad result. There are unfortunately powerful covert pressures to do otherwise. Whether viewed as equilibration,[3] reciprocity,[23] hypnotic-like transactions,[27] or complementary communica-

tion,[64] there are pulls both to adapt to the expectations of others (e.g., prevailing social and legal climate), and even bring one's own beliefs into line. This can lead to scapegoating others who violate the tacit rules, thus preserving system homeostasis and reinforcing even those rules with which one is rightly troubled.[64] An antithesis is to recognize this pull, and when contrary to autonomous clinical judgment and reasonable risk-benefit analyses, support the latter. By reasserting its own influential role, forensic psychiatry can help to redefine prevailing standards of care in a way that better permits making those tough decisions often needed in difficult situations, helping to best fulfill practitioners' therapeutic charge for patient care that is safe, efficient, and effective.

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