

A no-win situation: psychiatrists navigating competing obligations between free will, paternalism, duty of care, and position of guarantee

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Abstract

This paper examines the ethical tensions psychiatrists encounter in balancing competing obligations to patients and society, heightened in the COVID-19 era. With reference to the Italian situation, legal concepts such as duty of care or the rule of law defined “position of guarantee” engender heightened duties of care but generate discordance concerning patient autonomy. As a matter of fact, Italian psychiatrists are considered responsible for the effects of their interventions on patients and their behaviors. Consequently, managing involuntary treatment, assessing risk,

and worrying about liability strain practitioners' efforts to uphold non-maleficence. As mental healthcare needs escalate globally amidst resource constraints, the application of ethical principles is imperative. Evidence-based approaches prioritizing collaborative harm reduction over social control must be reinforced through education, oversight, and organizational policies. With balanced civil commitment criteria and realistic expectations acknowledging risk prediction limits, therapeutic alliances can be maintained. Greater investment in community-based systems can mitigate coercion and marginalization. Psychiatrists worldwide endeavor to uphold beneficence and non-maleficence within shifting accountability landscapes. This perspective advocates collective efforts to promote patient welfare through equitable, quality care. Navigating the multifaceted nexus of competing obligations demands thoughtful dialogue and judicious reforms responsive to both practitioner and patient needs. By engaging with ethical complexities with scientific rigor and compassion, psychiatry can uphold humane, ethical standards despite mounting challenges.

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Introduction

The practice of psychiatry necessitates navigating complex ethical dilemmas stemming from the vulnerabilities of patients and the duty to protect individuals and the public.¹ In recent years, societal concerns regarding patient autonomy, civil liberties, public health, and health professional accountability have amplified the ethical responsibilities of psychiatrists.² This issue is particularly salient in countries such as Italy, where the legal concept of the position of guarantee (PoG) meaningfully influences medical practice.³

Per this principle, psychiatrists possess heightened obligations of care and responsibility towards patients, given their specialized expertise. This duty ostensibly arises because psychiatrists, by virtue of their specialized knowledge and authority, are considered able to anticipate risks and adopt appropriate interventions to prevent harm. They are thus expected, as contemporary Cassandras, to ensure the protection of patients' health and third parties potentially impacted by patients' actions.⁴ However, enacting this PoG produces discordance with other ethical responsibilities, especially pertaining to patient autonomy, consent, and social control. Achieving equilibrium remains an ongoing challenge for conscientious practitioners.

The COVID-19 pandemic has further complicated this balancing act. Psychiatrists have confronted dramatic escalations in anxiety, depression, traumatic stress, substance abuse, sleep disorders, and suicidal ideation within the general population, especially during the first waves of the COVID-19 outbreak, when the prolonged quarantine and other public health restrictions seemed to

constrain care options.^{5,6} For patients with severe mental illnesses, the consequences have been particularly devastating.⁷ Disruptions in community-based services and social distancing mandates have increased relapse, hospitalization, and suicide rates.^{8,9} On the other hand, novel strategies, such as telemedicine and virtual psychological sessions, have been established to help physicians manage patients and maintain clinical and psychological support. In this unexpected scenario, psychiatrists frequently feel limited in their ability to provide efficacious assessment and intervention while adhering to PoG duties.

This paper examines emerging controversies and recent developments influencing psychiatrists' PoG, concentrating on high-risk practice areas impacted by COVID-19: civil commitment, risk assessment, and professional liability. Ethically judicious perspectives and recommendations to guide clinicians through this complex landscape are discussed.

Civil commitment in the COVID-19 era

Defensive medicine (DM) refers to all diagnostic and therapeutic procedures undertaken primarily to protect legal liability rather than patient benefit.¹⁰ DM includes both "positive", *e.g.*, prescribing unnecessary tests, referrals, or additional services, and "negative" behaviors, *e.g.*, reluctance to care for more severe patients or avoidance of risky procedures. Involuntary hospitalization and overmedication represent possible controversial manifestations of DM and risk management policies in psychiatry.¹¹ Psychiatrists must carefully weigh patient decision-making capacity, refusal of treatment, and public health when considering civil commitment.

During the pandemic, compulsory admission rates increased in many areas as community resources declined.¹²⁻¹⁵ The discomfort of living all together with the family in confined spaces with an increased risk of attacks and violence against other family members, the reduced availability of substances of abuse, and the disruptions of contacts with mental health services have been invoked as possible explanations, among others, of the increased use of mandatory psychiatric treatments, especially during the second wave of the COVID-19 pandemic. Not only the most severely or chronically ill, but even young people experiencing the pandemic's first acute crisis were subject to mandatory hospitalization.¹⁶ This exacerbated concerns in the field that such instances of involuntary hospitalization could potentially be motivated by non-clinical factors exceeding the necessity standard for compulsory treatment. The proportionality between compulsory admission and therapeutic requirements during a time of strained community support remains an ongoing issue of debate within the literature on psychiatric ethics and policymaking amidst public health crises.¹²⁻¹⁸

However, the dangers of underutilizing civil commitment are also grave. The principles of beneficence and non-maleficence require psychiatrists to protect patients at acute risk of self-harm or aggression. Studies consistently show impaired rational decision-making, impulse control, and cognitive functioning in individuals experiencing psychotic, manic, or suicidal states. One study found that children with psychotic symptoms had deficits in inferring and representing others' mental states and a lower IQ.¹⁹ Another study focused on bipolar disorder and found that self- and other-referential processing was impaired in bipolar patients with psychotic symptoms.²⁰ Growing evidence supports cognitive deficits as possible neurocognitive markers with predictive utility in identifying those at risk of suicide. The opportunity to develop targeted interventions may rely on further characterizing these deficits. Indeed, a study on late-life suicide linked executive dysfunction to emerging suicidal

thoughts, with patients showing deficits in sustained attention, response inhibition, set-shifting, and verbal fluency.²¹ Failure to intervene can lead to fatal consequences, professional censure, and negligence charges, encouraging defensive commitments.

Compulsory admissions may violate autonomy to an extreme degree in cases where a patient has the capacity to make informed treatment refusals and poses no immediate health risk. In such scenarios, the principle of beneficence would not ethically justify the profound loss of liberty.

Moving forward, policy and legislative reforms should aim to properly balance patient liberty and duty to protect during public health emergencies. Expanding community-based outpatient services and crisis programs can also limit unnecessary hospitalizations. Psychiatrists can promote ethical practices through strict commitment criteria adherence, exhaustive alternative exploration, diligent consent efforts, and meticulous documentation.

Weighing risks in assessment and management

Risk assessment is a central yet complex component of psychiatric practice and treatment decision-making. Psychiatrists are tasked with accurately evaluating the potential risks of suicide, violence, self-neglect, and other harmful behaviors while also taking reasonable precautions. However, predicting human behavior inherently contains elements of uncertainty and could not be demanded of physicians more than reasonably.⁴ No standardized measurement or rating scale can ensure perfectly prescient judgments, a challenge amplified when evaluating patients with active, severe mental illness who may lack insight or reliable recall of historic details.

Nevertheless, failing to reasonably foresee probable risks can constitute negligence. Consequently, defensive psychiatric practice relying on risk-averse decisions is prevalent, despite undermining the therapeutic alliance and patient autonomy.²² For instance, psychiatrists may hospitalize or intensely pharmacologically treat patients deemed dangerous based on questionable grounds or be reluctant to expeditiously discharge stabilized patients with histories of aggression due to lingering liability fears.

A fairer balance could be achieved by establishing realistic standards and acknowledging the fallibility of risk prediction. Promoting structured, empirically validated evidence-based tools demonstrated to confer predictive validity may help avoid overly subjective judgments of dangerousness as well. Fundamentally, the primary aim should be individualized harm reduction rather than avoiding each unlikely adverse scenario. This requires comprehensive assessments incorporating personal strengths and protective factors while empowering patients to collaboratively self-manage risks. Risk assessment approaches that emphasize collaborative decision-making and empower patients to manage their own risks help respect autonomy, whereas paternalistic approaches that impose external restraints without patient input err towards pure beneficence.

Managing professional liability

Fears regarding malpractice litigation and criminal charges further reinforce defensive postures among psychiatrists tasked with duties of care.²² A recent survey revealed that apprehension regarding potential legal liability constitutes a predominant motivator for risk-averse clinical judgments among about 60% of Italian psychiatrists.²² However, this percentage only encompasses respondents who consciously acknowledge such influences, likely

substantially underestimating actual rates. This mentality has grown steadily in recent decades alongside rising patient expectations, sensationalized media coverage of rare violent events, and increasingly punitive laws. Early-career psychiatrists, especially, report feeling burdened.²²

However, analysis of actual legal outcomes paints a less dire picture. In Italy, very few malpractice complaints against psychiatrists reach trial, even fewer result in guilty verdicts, and the damages awarded are low compared to other specialties.²² Nonetheless, some recent positions taken by the Italian Court of Cassation have broadened psychiatrists' PoG to the point of including forms of liability for violent acts committed by their patients, not only self-harming but also harming others.³ The return of a legal perspective considered culturally outdated is worrying, almost a concealed restitution of social defense demands to psychiatry, imposed by the evolution-involution of case law rather than legislative changes. Nevertheless, the closure of the forensic psychiatric hospitals, leading to the inclusion in community-based care of psychiatric patients involved in criminal acts, and the mental health consequences of the pandemic explain, at least in part, the increased apprehensions experienced by psychiatrists in the last few years. According to legal precedent, psychiatrists' PoG, differently from other specialties' PoG, moved from an obligation of means to an obligation of results that is not reasonable from a scientific point of view. To improve this situation, efforts to educate psychiatrists on managing liability through proper documentation, transparency with patients, and continuous quality improvement are needed. Establishing channels for alternative dispute resolution outside of lengthy court battles should also be explored. Although the PoG represents an important ethical foundation, it may benefit from modifications that better accommodate modern expectations and treatment options. For example, key criteria defining psychiatrist liability for patient actions could be updated to reflect current science on risk assessment limitations and evidence-based practice. Realistic legal responsibilities would be restored through such measured reforms. This discourse on revising the PoG exists within a broader debate, including the decriminalization of medical errors, a standard still present only in Italy, Poland, and Mexico. Updating antiquated liability concepts would cohere with burgeoning appeals internationally to address medical errors under a framework of institutional accountability and continuous quality improvement rather than individual culpability and punishment. Situating proposed PoG reforms within this wider movement towards systems-based patient safety paradigms could render judicious revisions more explicable and feasible within the medicolegal field.

With thoughtful reforms and continuing dialogue, psychiatrists can maintain high ethical standards despite PoG pressures and limitations. The risk otherwise is increased marginalization of the most vulnerable. And sometimes it happens that the most isolated are not only the patients but also the psychiatrists themselves, who, at times, find themselves in a desert of dialogue and horizons. They warn society of a danger and scream in fear of the threats and assaults that have become more and more frequent, feeling rejected by the harshness of the walls they encounter and demoralized and debased by the icy words of "impracticability" used to describe their proposals. As it happened to the Italian psychiatrist Dr. Barbara Capovani, whose murder at the hands of a man she had assisted during a hospitalization some years prior brought the difficult role of the psychiatrist, who is often isolated in the practice of his/her profession, under media attention.²³ On the one hand, they are called to a precise deontological, clinical, and legislative responsibility towards their patients, while on the other hand, they suffer constant institutional and social pressures aimed at shifting the delicate balance of the obligation to protect and control towards

the latter, despite the demedicalization of social dangerousness carried out within the framework of Italian Law 180 of 1978.²⁴

Conclusions

PoG shapes psychiatrist ethics in profound ways that have far-reaching impacts on patient lives and public health. The difficulties of fulfilling associated obligations are magnified by the recent challenges posed by the pandemic and other constraints on mental healthcare delivery. Finding the right equilibrium between beneficence, non-maleficence, and respect for patient rights is an everyday struggle for conscientious practitioners. Tensions between competing psychiatric duties are ubiquitous across diverse cultural and medicolegal systems worldwide. The issues explored regarding civil commitment criteria, risk assessment, and liability have meaningful resonance for mental health practices globally. Psychiatrists internationally can promote ethically sound practices by adopting evidence-based risk assessment approaches focused on collaborative harm reduction with patients. Healthcare organizations must provide better education, oversight, and organizational policies to support this aim. Critically, increased public investment is needed to expand community-based microsystems of welfare as alternatives to social marginalization and coercion. With thoughtful reforms and continuing dialogue, psychiatrists globally can maintain high ethical standards despite multifaceted pressures.

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