The concept of Primum non nocere (“First, do no harm”) is a cornerstone of medical education. This Latin phrase reminds physicians that medical treatments can potentially have both good and bad effects. Sometimes, the ultimate net benefit of an intervention is clear to both the physician and the patient, and treatment proceeds unimpeded by doubt. When the net benefit of a treatment is less certain, in most branches of medicine patient choice and self-determination play a major role in determining which "gray zone" treatments are appropriate. For the most part, this is also true in psychiatry.

However, it is the inherent nature of psychiatric illnesses to sometimes cloud a patient’s judgment or limit his or her ability to participate in treatment decision making. Furthermore, the cyclic nature of any mental illness means that a patient's capacity to make decisions changes over time. Behavioral interventions often are necessary to prevent imminent harm to the patient or others. Because of these aspects of the illnesses they treat, psychiatrists--more than other medical professionals--are empowered to make treatment decisions on behalf of a patient even if he refuses treatment.

Over the past several decades, as instances of abuse of this power have come to light, psychiatric authority has been tempered. Most states have a wide array of judicial remedies available to patients to limit the possibility of "psychiatric abuse." Nonetheless, especially in urgent situations, psychiatrists are often called on to evaluate patient competency and to authorize involuntary treatment with little time and using sketchy information. In this issue of Psychiatric Issues in Emergency Care Settings, Darin D. Signorelli, MD, and Stephen Mohaupt, MD, review the most common legal issues that psychiatrists and other mental health practitioners face: informed consent, involuntary treatment/forced medication, physical restraints/seclusion, and civil commitment. They follow up their review with a series of 3 cases designed to highlight these points in clinical practice, including one in which a patient's right to refuse care is examined.

H. Richard Lamb, MD, a leading expert in forensic psychiatry, then examines the national phenomenon of the "criminalization" of the mentally ill and potential strategies to alleviate this trend.

Together, these articles should be of interest and practical value to emergency physicians and psychiatrists charged with making rapid decisions involving involuntary care.

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