

# What Constitutes a Psychiatric Emergency: Clinical and Legal Dimensions

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In true medical emergencies, informed consent is presumed or implied without application of the usual standard. In the litigation over the right to refuse treatment in psychiatry, a limited right for involuntarily committed patients to refuse treatment has been upheld, absent a finding of a psychiatric emergency. Increasingly, clinicians may find that their sole extrajudicial option in instituting treatment over the patient's objection is in invoking a psychiatric emergency. The purpose of this communication is to discuss the clinical and legal issues in defining and invoking a psychiatric emergency in treatment refusal. The substantive and procedural issues in the use of the emergency exception in treatment refusal are discussed with recommendations for their use in clinical practice.

The continuing debate on the right to refuse treatment litigation in psychiatry has raised thorny clinical and legal issues likely to stay with clinicians in the coming years.<sup>1-15</sup> In these cases, litigants have challenged the traditional medical assumption that psychiatrists may override a patient's refusal of psychotropic medication if they believe medication is in the best medical interest of the patient. This *parens patriae* notion (the duty of the state to treat those gravely in need of treatment) has come under fire from mental health law litigants as they have sought the same due process guarantees for psychiatric patients as those that prevail in the domain of criminal

justice.<sup>16</sup> This segment of the mental health bar would like any medical treatment involving restrictions of patient's rights to be subject to judicial review. Whereas for clinicians medical decision making is dictated by the clinical needs of the patients, for the mental health bar the civil rights of the patients are often preeminent.<sup>10</sup>

These challenges to medical discretion have been based on constitutional and common law arguments. The constitutional arguments, as raised in *Rogers v. Okin* in Massachusetts, hold that First, Fourth, Fifth, Eighth, and Fourteenth Amendment protection of free speech and mentation, privacy, due process, and freedom from cruel and unusual punishment are violated when psychiatric patients, even when involuntarily committed, are medicated against their

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wishes.<sup>4</sup> Litigants also argue, on a common-law basis, that forced treatment is a tort, or a technical battery of nonconsensual touching, and constitutes malpractice because of the failure to obtain valid and informed consent.<sup>8</sup> Whereas some courts appear to recognize a limited constitutional right to refuse treatment, a clearer consensus, based on common law, does appear to be emerging: a patient must give informed consent for treatment to proceed. However, treatment may be initiated without informed consent under exceptional circumstances. These include emergencies, incompetency, therapeutic privilege, and waiver of consent.<sup>17</sup> In these instances, consent is presumed or obtained by proxy. The individual liberty interests embodied in and protected by the principle of informed consent may also be overridden when important common or state interests are felt to be preeminent.<sup>17</sup>

Whereas plaintiffs and defendants disagree on most of the substantive and procedural issues in treatment refusal, all parties agree that treatment may be initiated in an emergency.<sup>15</sup> For example, in Massachusetts, after the most recent decision of the Massachusetts Supreme Judicial Court, the only situation in which medical discretion is allowed in the refusal of treatment is in a true "psychiatric emergency."<sup>18</sup> Increasingly, clinicians may find that their sole extra-judicial option in instituting treatment over the patient's objection is in invoking a psychiatric emergency. What constitutes a psychiatric emergency is then a pivotal issue in the right to refuse treatment. However, a clear and opera-

tional definition of a psychiatric emergency has not emerged.<sup>15</sup> The purpose of this communication is to discuss the clinical and legal issues in defining and invoking a psychiatric emergency in treatment refusal.

### Status of the Right to Refuse Treatment

Until recently, the courts seemed to be recognizing a limited constitutional right to refuse treatment with due process protection of the right afforded by judicial review. Due process demands threatened to become cumbersome. If, as was the case in *Rogers v. Okin*, every patient who refused treatment was entitled to a hearing as due process protection, judicial review would substantially hamper medical decision making. However, New Jersey's right to refuse case, *Rennie v. Klein*, adopted a different due process standard consisting of independent medical review.<sup>9</sup> In addition, the Supreme Court in *Youngberg v. Romeo* in 1982<sup>14-15</sup> supported medical decision making in preference to judicial review, and their opinion may be gaining influence. Three more recent right to refuse cases, *Jameson v. Farabee* (by consent),<sup>19</sup> *Stensvad v. Reivitz*, and *Savastano v. Saribeyoglu*,<sup>20</sup> have supported the notion of medical decision making.

Despite apparent relaxation of the requirement of judicial review, considerable delay may still occur until an independent medical review is possible. For example, in the Jameson consent decree,<sup>19</sup> a delay of three working days is permitted until an independent medical reviewer is required to review a case. In

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addition, many of the decisions regarding the right to refuse treatment apply only to involuntarily committed patients. Thus, the discretion of the treating physician in the case of the voluntary patient, or until independent medical review is available, resides in invoking a psychiatric emergency. Hence, the substantive and procedural issues involved in invoking a psychiatric emergency remain crucial.

### Defining a Medical Emergency

In order to consider the issues involved in defining and invoking the specific case of a psychiatric emergency, the more general case of a medical emergency must be reviewed. Most investigators concur that a true medical emergency confers implied or presumed consent for medical intervention.<sup>17,21</sup> However, no clear definition of a legitimate *medical* emergency exists. Some states define medical emergencies in their statutes on informed consent. One state<sup>21</sup> defines an emergency situation as one in which "in competent medical judgment, the proposed surgical or medical treatment or procedures are reasonably necessary, . . . and any delay in treatment could reasonably be expected to jeopardize the life or health of the person affected, or could reasonably result in disfigurement or impaired facilities" (pp. 93-94). To the extent that courts have attempted to define medical emergencies in the course of litigation, they have defined them as narrowly as the threatened "loss of life or limb" and as loosely as a situation of "acute suffering."<sup>17</sup>

The threshold determination of an

emergency rests on a definition of the legitimate urgency of the patient's need for care. Urgency contains at least two elements: temporal immediacy and the expected harm in the delay of treatment. Immediacy may vary from moments to days, and harm from death to "no consequence."<sup>17</sup> Also, the duration of harm to the patient may involve a time element in itself, as well as different qualities of harm: physical, emotional, and/or economical. Despite the potential variability in defining a medical emergency, the guiding principle in foregoing informed consent is "a finding that the patient's condition was so serious that the initiation of treatment could not be delayed until consent was obtained."<sup>21,p. 15</sup> Furthermore, this principle assumes that reasonable individuals would consent to the proposed treatment if their conditions did not reduce the capacity to do so. In practice, the law also recognizes flexibility in the definition of an emergency because of the circumstances of an emergency examination. A reasonably careful physician can only be expected to examine and assess the status of a patient with the thoroughness possible under the circumstances.

Presumed or implied consent in a medical emergency rests on the assumption that the patient was unable to engage in decision making because of the emergency condition. Typically this involves the unconscious patient. Implied consent in an emergency presumes that the circumstances and not the patient's expressed wishes make consent impossible. Lack of consent cannot be equated with treatment refusal. In the former,

the clinician assumes a weak form of paternalism,<sup>22</sup> acting according to the patient's unexpressed wishes; in the latter, the clinician assumes a stronger form, "knowing more" at the moment than the patient does about the patient's "true wishes." The legal and ethical conundra in each form of paternalism are relatively distinct.

The reasoning underlying the emergency exception to informed consent is somewhat more complex in the case of overt treatment refusal. In the case of overt treatment refusal, medical intervention may be justified in one of three ways. One can argue that there is a legitimate medical emergency the true urgency of which obviates the need for informed consent—that treatment cannot be delayed in obtaining informed consent. Alternately, one can justify intervention by invoking an overriding state interest. Here one argues that the individual liberty issues embodied in informed consent may be abridged by a countervailing state interest in preserving a common good. Such a state interest might be to protect the health of other citizens, preserve the functioning of a medical setting, or protect the integrity of the medical profession. A final justification for intervention is the incompetency of the patient. Thus one would argue that the treatment refusal was a function of the patient's incompetency. Although a determination of incompetency usually calls for a substitute or proxy consent from a family member or guardian, most emergencies would make this consent impossible or impractical.

In a genuine medical emergency, most courts recognize the right and necessity for a physician to be empowered to treat in the absence of informed consent and even in the face of overt treatment refusal. As a practical matter, courts recognize that physicians are often required to make rapid judgments about emergency interventions. Thus, wrists are sutured and patients lavaged without prohibitive concerns about infringing upon the patients' liberty interests. In these cases the justifications are either that (1) informed consent need not be obtained in a truly urgent medical crisis, or (2) that health care institutions cannot function without taking into account the common good of treatment for all. In this latter justification, a calculation must be made (albeit in a hasty manner) in an attempt to balance individual liberty interests and common interests in a functioning health care setting. In this case one asks to what extent and to what harm is the liberty interest of the individual being violated and toward what benefit to the common good?

Thus, faced with a patient with a lacerated wrist, one might argue that such a laceration does not represent a legitimate and urgent emergency, but suturing the patient may be a necessary part of preserving the functioning of an emergency ward—that a patient bleeding without treatment disrupts the good functioning of an emergency ward. On the other hand, a self-inflicted gunshot wound to the abdomen clearly represents a legitimate and urgent medical emergency by any reckoning. Thus, the law probably remains flexible in recog-

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dition of the real contextual differences that arise in emergencies.

Another consideration in justifying interventions in treatment refusal is the intrusiveness, risk, and benefit of the envisioned treatment. In the case of the wrist to be sutured, functioning of the wrist is being restored, the risks of the procedure are trivial, and the benefits of suturing substantial. However, were the issue amputation of a limb, one would envision a different assessment and more stringent requirement that the benefits of intervention are worth abrogating the patient's wish to retain the limb.

In summary, in the general case of a *medical emergency*, interventions in the absence of consent may be justified by the emergency exception to informed consent (implied consent), by declaring the patient incompetent, or by invoking an overriding state interest in intervention. In extending this argument, however, one might also envision a very broad application of these emergency powers and, in a *de facto* sense, an abrogation of the right to die. In most patients who invoke the right to die an emergency usually supervenes in the course of their death. (In the course of exsanguination an "emergency" inevitably arises.) Couldn't a physician await or even provoke such a medical emergency to intervene against a patient's will? The cases of Jehovah's Witnesses who refuse transfusions raise this issue. However, these cases are somewhat different than *de novo* emergencies because they involve prior competent treatment refusal. In these cases, the courts *have*

sometimes recognized the right to forego transfusions if the wish to do so has been clearly articulated before the medical crisis. However, the reasoning by which some patients but not others are allowed to forego procedures or transfusions involves a complicated calculation of individual rights versus the interest of the state in preserving life or the welfare of minors. Suffice it to say that prior competent treatment refusal (analogous to a living will) represents a complex exception to the emergency powers discussed above.

### Defining a Psychiatric Emergency

Application of the emergency rule to psychiatry is more problematic. It is harder to define an emergent emotional state that permits and compels nonconsensual treatment. Whereas in a medical emergency the physical condition in question is usually objectively demonstrable, a psychiatric emergency is usually intrinsically subjective. Although readily observable dangerous behaviors (police power emergencies) may develop in a psychiatric emergency, there are inner emergent states, such as imminent psychotic decompensations (*parens patriae* emergencies), that are recognized only by subtle clinical skills. In a medical emergency, lack of consent is the usual setting for use of the emergency exception to informed consent, whereas in a psychiatric emergency treatment refusal is more common and conceptually complex. The following case illustrates some of these difficulties.

#### Case 1

Mr. A, a 22-year-old schizophrenic man, with a past history of a serious

assault, possibly while psychotic, was admitted voluntarily to an intensive treatment ward. When admitted he was psychotic and begun on neuroleptics with an initial good response and an apparent remission. After 2 weeks of neuroleptic treatment he refused further neuroleptics. The staff hoped to gradually help him see the need for medication. For several days he appeared irritable but not overtly psychotic. The staff was unsure whether his irritability was a sign of decompensation. During a Ping-Pong game on the ward, he became angry and threw his paddle, breaking a window. When approached by ward staff, he angrily denied an intent to throw the paddle and accused the staff of "watching him" to see him "crack." He refused to leave the dayroom to discuss the incident with a staff member. Several patients became tense and one became agitated enough to request seclusion. The staff was unsure about medicating Mr. A against his will.

The defendants in the Boston State Hospital case (*Rogers v. Okin*<sup>23</sup>) defined seven types of psychiatric emergencies: "1) suicidal behavior whether seriously meant or just a gesture, 2) assaultiveness, 3) property destruction, 4) extreme anxiety and panic, 5) bizarre behavior, 6) acute or chronic emotional disturbance having the potential to interfere with the patient's ability to function on a daily basis, 7) the necessity for immediate medical response in order to prevent or decrease the likelihood of severe suffering, or the rapid worsening of the patient's clinical state" (p. 313). The plaintiffs and the district court judge, Judge Tauro, rejected this view. Although they

agreed that treatment refusal could be overridden in an emergency, they argued that the defendants' definition was vague, overinclusive, and attempted to circumvent legitimate treatment refusal. Judge Tauro limited the definition of an emergency to a police power emergency in which the state might invoke its interest in preventing physical harm. He<sup>23</sup> narrowly defined a psychiatric emergency as "the substantial likelihood of physical harm" (p. 313).

The Court of Appeals criticized the District Court in this case for imposing an overly restrictive definition of a psychiatric emergency and held that a physician must have substantial discretion in deciding when an impending emergency requires medication. They held that the District Court had required an unrealistic calculation of the "quantitative" likelihood of harm.<sup>24</sup> The Supreme Court, reluctant to rule on the constitutional issues, vacated and remanded the case to the state courts in Massachusetts to be reconsidered in the light of the Massachusetts Supreme Judicial Court's opinion in *Richard Roe III*.<sup>25</sup> The Massachusetts Supreme Judicial Court then broadened the emergency definition, ruling in the Boston State case that an emergency could be defined by police powers or *parens patriae*. A police power emergency was defined as the "occurrence or serious threat of extreme violence, personal injury, or attempted suicide."<sup>26</sup> In addition, the court defined a *parens patriae* emergency as the necessity of preventing immediate, substantial, and irreversible deterioration of a serious mental illness . . . in which even the smallest of delays would be intoler-

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able”<sup>18</sup>, pp. 511-12 Although this ruling went to some length to spell out the harmful situations to be prevented in an emergency, it did not specify the psychiatric disorders for which emergent intervention might be indicated. This issue remains problematic because it potentially adopts a criminal threshold for intervention. For example, not all emergencies among psychiatric patients are a function of their psychiatric conditions. Psychiatric intervention ought to be mandated by the state for treatment of behavior *consequent* to a psychiatric condition. Thus, an adequate legal definition of a psychiatric emergency must define the psychiatric conditions and the types of potential harms to be prevented.

The Massachusetts court’s final definition of an emergency sets the threshold for *parens patriae* emergency intervention unrealistically high. One is hard pressed to predict a situation of “irreversible deterioration of a serious mental illness . . . in which even the smallest of delays would be intolerable.” Thus, in a *de facto* sense the court’s definition restricts psychiatric emergencies to police power emergencies. By not defining mental illness in its emergency definition, Massachusetts draws no line between mental health and criminal justice emergencies, effectively restricts psychiatric discretion to police powers, and invokes no state interest in preserving the functioning of an institution. Therefore, there is little recognition that physicians occasionally need to forcibly treat patients to preserve the functioning of a disrupted treatment setting.

In evaluating or proposing a more appropriate definition of a psychiatric

emergency, the principle underlying the emergency exception to informed consent will be recalled: “That the patient’s condition was so serious that the initiation of treatment could not be delayed until consent was obtained.”<sup>21</sup>, p. 15 To define the analogous situation in psychiatry, we must define the *emergency condition*, its *seriousness*, *treatment*, and, implicitly, the harm expected to result from delay in treatment. A second case further illustrates the problems in defining an emergency.

### Case 2

Mr. B, a 36-year-old man with a known history of alcohol and substance abuse and an uncertain diagnosis of a borderline personality disorder, presented himself to the emergency room seeking admission for “depression.” He stated that if admitted he did not want to be treated with any “chemicals.” In the initial interview, the patient was pleasant but evasive. The initial physical and mental status examinations were normal with the exception of mild suspiciousness and mild difficulty with concentration. The examiner offered admission but explained that he could make no promises about the nature of the patient’s treatment program on the ward. When the patient became more demanding about the need for a “chemical-free” treatment program, the examiner terminated the interview somewhat abruptly, saying that he needed either to make admitting arrangements for the patient or see the next patient waiting to be seen. The patient suddenly became angry, lunged from his chair, and punched the examiner.

Stromberg and Stone<sup>26</sup> in their American Psychiatric Association (APA)-endorsed model state statute on civil commitment, offer a statutory definition of an emergency situation in severe mental disorders in which emergencies might arise. They state that an "emergency situation means a situation in which the patient exhibits substantial behavior that is self-destructive or assaultive, threatens significant damage to the property of others, or indicates that the patient is suffering from extreme anxiety amounting to panic or sudden exacerbation of a severe mental disease" (p. 294). They also state that a severe mental disorder is "an illness, organic brain disorder, or other condition that 1) substantially impairs the person's thoughts, perception of reality, emotional process or judgment; 2) substantially impairs behavior as manifest by recent disturbed behavior" (p. 312). Their definition roughly describes a psychotic disorder. Together, these definitions set a rather high threshold for mental illness, in effect, psychoses, while relaxing constraints on intervention from pure police power in the direction of *parens patriae* intervention.

In the Stromberg and Stone definition, the "psychiatric condition" requiring intervention is essentially a psychosis, and its "seriousness" is a behavioral disturbance resulting in dangerousness or extreme anxiety amounting to panic. The "harm" expected to result in delay of treatment is self-injury or assault, significant property destruction, or extreme emotional suffering. Elsewhere they stipulate that the psychiatric condition itself must be treatable—the rationale being that abridging individual

rights for the good of emergency treatment makes treatment a *quid pro quo* for the loss of individual liberties. Similarly, one cannot invoke an emergency—in which one argues that treatment cannot be delayed—if there is no treatment to delay. In this context, treatment must be defined broadly to include the multiple elements of a treatment plan. Restraining a patient to prevent further deterioration might well be considered an element of a treatment plan as long as a treatment plan was being initiated.

According to Stromberg and Stone, a legitimate psychiatric emergency also demands that the condition involved be truly acute and thus a departure from a chronic condition. The condition is not a diagnosis, *per se*, but a substantially impaired mental state and resultant grossly disordered behavior. A schizophrenic condition thus might *not* meet this criterion without ongoing evidence of impaired cognition and a severe behavioral disturbance. However, other primarily nonpsychotic conditions, such as personality disorders, might meet these criteria in the case of a coexisting condition or severe exacerbation of the disorder, such as severe agitation or a psychotic regression in a borderline patient.

A psychotically depressed patient who stops eating and slowly deteriorates represents a "semi-emergency." The law would probably remain flexible about the management of these patients unless the physician was seen to provoke an emergency as a justification for intervention.

An alternate way to view a psychiatric

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emergency is to subsume the emergency under the incompetency exception to informed consent. By this reasoning, the effect of the emergency is that it relaxes the standards for determining incompetency and/or obtaining substituted consent. A psychiatric emergency would then be defined as an emergent form of incompetency accompanied by dangerousness or severe affective arousal. This would broaden the Stone and Stromberg<sup>26</sup> definition of an emergency situation wherein dangerousness or severe affective arousal must be seen as a function of a "*sudden exacerbation of a severe mental disease*" (p. 294) to dangerousness or severe affective arousal subsequent to a *mental disorder wherein the patient lacks the capacity to make an informed decision concerning treatment*. Competency in the emergency context would be defined as an apparent inability on the part of the patient to understand or weigh the risks and benefits of a proposed treatment despite reasonable attempts on the part of the clinician to assist the patient in understanding and reasoning. The Stone and Stromberg sudden exacerbation standard would cross this threshold of incompetency but would also allow other nonpsychotic mental disorders to be treated. An example would be the rageful, but not manifestly psychotic, patient in example 2, whose rage may make decision making impossible. On the other hand, a chronically dangerous antisocial person ordinarily would not meet this incompetency test.

Returning to the cases presented above, courses of action can be considered. In the case of the schizophrenic

male who threw a Ping-Pong paddle, a critical determination with regard to the emergency definition would be whether there is (1) reasonable evidence of an impaired mental state or temporary incompetency, and (2) reasonable medical certainty that the psychiatric condition resulted in dangerousness or extreme anxiety in the patient. If so, working within this definition and the emergency exception to the principle of informed consent, one might intervene.

Recall that one might also justify intervention and override the requirement of informed consent in the circumstance of an overriding state interest. In the case of a ward hopelessly disrupted by such a patient, the need to preserve the common good of treatment might justify intervention even if the situation itself might not truly be deemed an emergency. In the spirit of the Supreme Court's ruling in *Youngberg v. Romeo*,<sup>15,27,28</sup> such an intervention would be presumed to be valid as long as the treatment afforded adhered to reasonable psychiatric practice.

This reasoning might also be applied to the personality-disordered substance abuser in the emergency room discussed above. By the definition in the APA model statute, one would need to show that the patient's assaultiveness resulted from a substantially impaired mental state. In the alternate proposal above, the test would be whether the mental state impaired the patient's capacity to make treatment decisions. Thus, in a situation such as the second case of the assaultive, personality-disordered substance abuser, emergency intervention ought not to be justifiable without rea-

sonable evidence of an exacerbating condition, such as a psychosis, or substantially impaired capacity to give consent. Applying the principle of a countervailing state interest in treating this patient over his will makes little sense unless the patient's behavior is felt to be a product of a treatable psychiatric condition. If not, the *control* of the disordered behavior of the second patient is more reasonably the province of the criminal justice system. *Control* of "criminal" emergencies cannot be justified under the guise of emergency psychiatric *treatment*.

### **Approaching a Psychiatric Emergency**

Clinicians who treat seriously ill psychiatric patients are increasingly called upon to translate medical reasoning into the legal arena. To be equipped to handle these diverse medicolegal patient care problems, clinicians must be familiar with evolving legal doctrines with regard to treatment refusal, incompetency, emergency treatment provisions, involuntary civil commitment, and, especially, informed consent, as well as procedures to follow when problems arise. One has to develop a sound conceptual framework into which to incorporate these evolving substantive and procedural legal doctrines. Unfortunately, many clinicians adopt an *ad hoc* approach, learning specifics without principles and leaving themselves unable to reason through novel situations.

The clinician needs to incorporate into this conceptual framework more specific state laws derived from local statutes and litigation. Specifically, he needs to be conversant with any state

law regarding informed consent. For what types of treatment must informed consent be expressed and written? What, if stated, is the state definition of incompetency or a psychiatric emergency? What are the necessary provisions to satisfy due process in invoking incompetency or overriding treatment refusal, in obtaining substituted consent, or in invoking a psychiatric emergency? Has there been local litigation or legislation regarding treatment refusal? Is there pertinent law hierarchizing the intrusiveness of different treatment options? For example, in a psychiatric emergency, on occasion, one has the alternatives of medication, seclusion, restraints, and/or electroconvulsive therapy (ECT). Intrusiveness or the least restrictive treatment option ought not to be the standard for clinical judgment, but in some states that standard is mandated. For example, in certain states, ECT is set aside as an "extraordinary" treatment that cannot be given, even in an emergency, without court approval.<sup>29</sup>

Faced with a psychiatric emergency, the clinician must be guided by reasonable practice. The conscientious clinician will examine the patient as carefully as is appropriate to the situation with attention directed toward the mental status examination, potential for harm, signs of imminent decompensation, and capacity to make treatment decisions. If it is appropriate to the situation, consultation with a colleague and substituted consent from a relative may be obtained.

Documentation is critical and should include the clinician's definition of the psychiatric emergency and the choice and rationale for treatment. The defini-

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tion of the emergency is best expressed in the language of local statutory definitions of mental illness. Police power and/or *parens patriae* conditions for treatment are found in the local state statutes on civil commitment. Invoking an emergency on the basis of police powers (dangerousness) is more clear-cut than is *parens patriae* (need for treatment).<sup>30</sup> Most states define dangerousness in their statutes on involuntary civil commitment, but the clinician needs to be alerted to local vagaries in the determinations of dangerousness.<sup>31</sup> How recent and overt must the evidence of dangerousness have been? Must the future harm be physical, or can it involve emotional harm or property damage? How imminent and dangerous must the future harm be? State laws vary widely in their interpretation of the elements of dangerousness.<sup>31</sup>

Defining and invoking a *parens patriae* emergency is more complex. Local statutes again should be consulted for provisions allowing involuntary civil commitment for those gravely in need of treatment. Latitude in defining such *parens patriae* justifications for treatment also varies widely. In the absence of a specific local *parens patriae* definition, Stromberg and Stone's<sup>26</sup> definition of a *parens patriae* emergency, a state of "extreme anxiety amounting to panic or sudden exacerbation of a severe mental illness" (p. 294), is a reasonable definition to keep in mind. A good example of a *parens patriae* justification for emergency intervention is uncontrollable excitement with the risk of exhaustion.

The trend to abandon *parens patriae* justification for intervention in the favor

of dangerousness will eventually hamper needed medical discretion. Clinicians who resort to vague use of dangerousness to justify their actions embark on a slippery slope in that the definition of dangerousness may not be defensible. Such vagueness accedes to social pressures to restrict medical discretion to police powers and invites disuse in an area of important and humane medical discretion.

Selection of treatment modality requires attention. As noted above, in some states certain treatments cannot be given, even in an emergency, without legal adjudication of incompetency, guardianship proceedings, and substituted consent. In addition, a given state may have hierarchized the relative intrusiveness of various treatments, feeling that clinicians should use seclusion first, before forced medication, or vice versa. The clinician has to be aware of these guidelines, even if he or she disagrees with them, to be able to justify selection of the most appropriate treatment. Legal consultation should be sought if continued treatment refusal is anticipated.

Although none of these practical guidelines is fully satisfactory, the clinician must be guided by an understanding of the evolving legal principles and hope that the law will become more aware of clinical problems and realities.

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