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INFORMED CONSENT VERSUS INVOLUNTARY HOSPITALIZATION IN PSYCHIATRIC PRACTICE. ETHICAL AND LEGAL APPROACHES

Daniel RăDOI[1], Mihaela RăDOI[2]

Abstract

From its beginnings as social practice, medicine has always been confronted with ethical dilemmas. Ethical issues are brought into discussion mostly when the patient lacks awareness, when he does not understand, which means that he also does not accept the disease. In order to solve these dilemmas, the physician has to combine norms, habits, customs, religious beliefs and, first of all, legal standards specific to his space of action. Psychiatric diagnosis, especially, determines multiple ethical issues, from involuntary hospitalization to therapeutic methods. As it results from the Universal Declaration of Human Rights (art. 1, 3), the fundamental rights of a person are based on the acknowledgment of his human status, that all human beings are born free. Since the autonomy and responsibility of each person – including of the one who needs healthcare – are accepted as important values, his involvement or participation to the decision-making process regarding his own body or health must be acknowledged as a universal right.

Keywords: ethics; informed consent; involuntary hospitalization.

Introduction

The term "bioethics" was coined in 1971 by the American oncologist Van Rensselaer Potter in order to define a new discipline that combined the knowledge of biology and of the cultural–human system of values. Potter (1971) pinpointed the necessity of combining moral values and science, thus underlining the dangers that menace the existence of life itself, caused by the separation between science and humanism.

[1] Daniel Radoi, psychiatrist ProLife Clinics, Iasi, 0040.0232.215903, radoidaniel@yahoo.com

[2] Mihaela Radoi, Lecturer, "Alexandru Ioan Cuza" University of Iasi, Department of Sociology and Social Work, , Iasi, blv. Carol I, nr. 11, phone: 0040.32201054, email: mihaelaciurlica @yahoo.com

Medical ethics is based on a set of fundamental principles:

- respect for the *patient's autonomy* – this principle requires the respect for self rule, independence, and freedom, by exerting a negative obligation (that of not limiting and not controlling the patient's options), as well as a positive obligation (based on the right to information, understanding, and volunteering), and by protecting the patients with limited autonomy (Gavrilovici, C., Cojocaru, D., Astărăstoae, V., 2013);
- *the non-maleficence principle* – determined from the beginnings of medical practice, which states that a physician should not do anything to harm a patient, but it also comprises a series of rules grouped into codes, oaths, statements, destined to regulate the doctor–patient relationship.
- *beneficence* – the principle stating that a doctor should do anything in his power to promote the health and welfare of his patients.
- *justice* – it assumes the non-discrimination principle (by age, gender, religion, ethnic, political, social group) for the persons who benefit from healthcare, as well as the doctor's obligation to work for the public good from two perspectives (Frunză, S., 2011). The first is utilitarian (to maximize the social good, assessed through the greatest benefit obtained by society and by the patient). The second is the egalitarian perspective, referring to the just distribution of costs and benefits (equal opportunities in the treatment of diseases and the equal right of each person to minimum medical resources).

Old moral regulations revised were grouped into ethical–medical statements, such as the Declaration of Geneva (1948), the Declaration of Helsinki (1964) on medical research, or the Declaration of Hawaii (1977) on the psychiatric activity (Prelipceanu, D., Mihailescu, M., Teodorescu, R., 2000). Several international agreements that concerned the individuals' rights for a better health and access to medical services were closed (The Universal Declaration of Human Rights – 1948, International Covenant on Civil and Political Rights – 1966, International Covenant on Economic, Social, and Cultural Rights – 1966, European Convention on Human Rights and Fundamental Freedoms – 1950, European Social Charter – 1961). This idea was put into practice towards the end of the twentieth century in the Declaration on the Promotion of Patients' Rights in Europe, which was made public during the European consultations of the World Health Organization, between 28 and 30 March 1994 in Amsterdam. This declaration comprises a set of principles for the promotion and implementation of patients' rights in the European States members of the WHO; these States took it over within their own legislations. In Romania, this declaration is applied through the Law no. 46/2003 on patient's rights.

Approaches in the psychiatric practice. Ethical and legal principles

Clinical medicine may not treat a patient without his free and informed consent. However, there are situations when a psychiatrist is required to treat a patient who is not capable of expressing his consent. On the other hand, the psychiatric treatment may also involve long-term involuntary hospitalization, and this is the doctor's call.

Unlike the other specialities, where a patient may not be treated without his free and informed consent, there are two methods of hospitalization in psychiatry (Marian, G., Nica, E.A., FocȘeneanu, B.E., Cârlogea, D., Ghinea, D., 2012): with consent (voluntary) and non-voluntary. Voluntary hospitalization applies in the same manner as providing medical services for any other disease. Involuntary hospitalization is reserved to certain patients who meet the criteria for this type of admission based on the Law of mental health (Law 487/2002). In order to be efficient, the psychiatric treatment must produce long-term modifications in the patient's behaviour, and its efficiency depends largely on the way the patient approaches and accepts the diagnosis.

In most countries, two doctrines serve as criteria in determining the legal norms regarding the mandatory hospitalization of the persons suffering from a mental disease. The first criterion refers to the (potential or manifest) nuisance degree of the mentally ill, towards both his own person and the others. The second criterion refers to the notion of *parens patriae*, according to which the State has the duty to protect its ill citizens who need care and treatment.

The discussion on the legitimacy of the involuntary and mandatory hospitalizations of mentally ill persons led to the emergence of the American Association for the Abolition of Involuntary Mental Hospitalization in the 60s. The leader of the association – Thomas Szasz – gathered a circle of jurists, legists, sociologists, and psychiatrists. With their support, he tried to influence radically the system of psychiatric assistance starting from a modification brought to the meaning of "mental illness" and from supporting the idea of abolishing the psychiatric hospitals, as they were seen as unnecessary. In his view (Szasz, 1961), specialized assistance was necessary only for psychiatric emergencies, meaning in two situations: stuporous states and aggressive paranoid personalities. The first situation comprised clinical states which required emergency medical assistance provided to an unconscious patient in any specialty of medicine. The second situation referred to aggressive paranoid personalities who presented a degree of nuisance and who had to be treated according to the law, just like any other individual who threatened the safety of others and who violated the social norms. However, in their case, the suggestion was the admission to a prison–hospital, where the person would receive medical care and psychiatric assistance. The existence of a psychic condition does not automatically lead to the admission of the patient in a psychiatric ward and to the beginning of a treatment. There are

mental conditions that allow a sufficient degree of judgement, which makes the ill person behave properly. The paternalist attitude is accepted if there is a certain degree of medico–psychiatric or legal emergency (a degree of obvious social danger) or if, despite the treatment, the evolution of the illness cannot be controlled.

The norms and circumstances of involuntary hospitalization in a psychiatric facility, though mentioned in legislative codes, can lead to conceptual difficulties in defining and interpreting what one may call nuisance behaviour and risk towards one's own person. In the past, society considered the mentally ill a permanent threat for the others. These patients were forced to spend more or less time in various institutions, and, in such cases, the treatment was often limited to the prevention self-aggression and aggression towards others. The modern therapeutic concepts (by using various therapeutic means) provide a cure for mild mental conditions and stabilization for the state of patients with severe conditions. The mentally ill patients have the same rights as the other patients – including the right to a private doctor–patient relationship, while the law (Low 74/1995) stipulates the rights and obligations of the psychiatrist. However, there are some countries – including Romania – that solicit the trespassing of the private character if the patient is considered dangerous, for society especially or for another person. A common example in the specialized literature is that of the trial "Tarasoff v. Regents of University of California". In this case, the patient confessed to his psychiatrist his intentions to kill a woman who had refused his sentimental advances. The doctor did not tell that to anybody and she was murdered. The victim's family won the case against the psychiatrist, and the main charge was neglectful and wrong diagnosis and treatment. The psychiatrist's approach was paternalist, thus observing the confidentiality principle. The international law sources, which analyze the medical and legal situation of the mentally ill person, focus on a range of issues regarding the patient's consent (treatment, participation to medical experiments, disposition acts – including sterilization) and on pre and post-offense safety measures.

The general ethical principles on which the doctor-patient relationship is based are stipulated in the declaration of the World Medical Association (WMA) published within the 47th General Assembly, Bali, Indonesia, 1995. The WMA decisions constitute deontological recommendations for all the countries that belong to this medical organization. During this assembly, the WMA proposed a code made of several general principles:

- mentally ill patients are entitled to medical care without social and medical discrimination.
- a therapeutic relationship between the physician and the mentally ill patient based on trust, by providing to the patient concrete and complete information, including on the consequences of the treatment.
- the treatment without the patient's consent, as well as mandatory hospitalization are considered exceptional measures and they shall be applied only in acute stages of a disease, when the patient's state represents a danger for himself or for the society.

- mandatory treatment or hospitalization shall be imposed only on a fixed-term basis.
- not all mentally ill patients are automatically considered irresponsible for their deeds.
- individualized psychiatric therapy, in concordance with the state and the diagnosis.
- confidentiality and undisclosure of medical secret shall be observed, and significant data may be disclosed only in case of danger and by the authorized bodies.
- the psychiatrist shall be loyal to the patient and, if a conflict should arise (in the patient's role as defender of the social values, appointed by society), the doctor must inform the patient on the nature of his conflict.
- the physician shall not take advantage of his position to abuse his patients physically, sexually, or mentally.
- the physician shall not allow any person or group to influence the treatment or his medical decisions.

In 1977, the Parliamentary Assembly of the Council of Europe adopted the Recommendation 818/1977 on the situation of the mentally ill. This recommendation mentioned the need for a better legal protection of the mentally ill. In 1983, the Committee of Ministers of the Council of Europe adopted the Recommendation R(83)2 concerning the legal protection of persons suffering from mental disorders. In 1994, the Parliamentary Assembly of the Council of Europe adopted in unanimity the Recommendation 1235 (1994) on psychiatry and human rights. In general, all of these legal recommendations are based on the document entitled "European Convention for the Protection of Human Rights and Fundamental Freedoms" (art 3, 5, 6, and 8). The main provisions of these recommendations are as follows:

- The mental illness diagnosis is a strictly medical issue; it is set by a physician in conformity with the medical science; a person's difficulties to adjust to certain morale, social, or political values cannot be included in the category of mental illness.
- A representative of the law, following the recommendation of a specialist physician, can decide mandatory (pre-offense) hospitalization; this decision may be taken only if the person represents a danger for himself or for others. In case of a psychiatric emergency, the patient may be hospitalized on a short-term basis, in conformity with a competent medical letter and in within a fixed-term protocol. In this situation, the patient must be informed and he is allowed to contest the decision legally.
- The patient must be represented by a legal representative, named *ex officio* if the patient cannot represent himself.
- The psychiatric treatment must follow the same rules as any medical treatment. If the treatment is not homologated, the patient's consent is

essential. If the patient lacks judgment, the legal representative of the patient will give his consent. Other experimental treatments on the mentally ill inpatients for safety measures are forbidden.

- The restrictions of the freedoms of the mentally ill may be taken only to protect the person and the society. In any case, the patient has the right to communicate freely with a lawyer or with a magistrate and to send sealed letters.
- Mandatory hospitalization is only possible on a short-term basis or it will be re-assessed periodically.
- Mandatory hospitalization can be annulled by a physician or by a competent body without interrupting the mandatory treatment.
- Mandatory hospitalization does not involve the application of restrictive measures regarding the material interests of the patient..
- In all situations, the patient's dignity shall be respected.

If there is a conclusive diagnosis of lack of mental capability of a patient, the latter will be represented legally in all the situations by the institutions he belongs to (including by the relatives). This legal provision is based on art. 124 of the Law 3/1978. In conformity with the same article, the lack of consent for treatment in emergencies, in the case of patients without legal capacity, requires a paternalist interventional attitude from the physician's part.

The International Union of Criminal Law chose the notion of "safety measures", in order to make the distinction between the pre- or post-offense sanctions and the punishments. In Romania, they have been adopted since 1936; they are considered criminal sanctions and they are different from the punishments. The safety measures are meant to eliminate the state of danger that a person may determine and to replace it with a state of safety. Medical safety measures are seen as criminal sanctions and they are usually taken by a competent legal court. Criminal prosecution bodies may also take some measures, but they have a strictly provisional character. Safety measures fall, depending on the purpose, into the following categories: curative measures (mandatory treatment or mandatory hospitalization) and educative measures (including professional reorientation). These measures can include deprivation of liberty, restriction of liberty, and deprivation of patrimonial rights (confiscations). Depending on the duration of application, these measures can be non-determined safety measures (as long as the danger persists), fixed-term safety measures (without medical application), and permanent safety measures (without medical application).

In Romania, the involuntary hospitalization of a mentally ill patient must observe the law on mental health and the protection of the mentally ill. The involuntary hospitalization takes place according to Low 487/2002 and 129/2012. This low mentions that, because of the mental condition, there is an imminent harm risk for himself or for other persons. In the case of a person who suffers from a severe mental illness and whose judgment is affected, the refuse of hospitalization could lead to a serious setback in his condition or it could prevent the patient from receiving the proper treatment. The violent or antisocial behaviour

may be determined through various specific instruments; a potentially violent, self-aggressive, or aggressive behaviour is not enough to justify the paternalist attitude of psychiatrists, meant to hospitalize the patient against his will. The involuntary hospitalization does not involve an "annulment" or a definitive and irrevocable denial to the right to self-determination. During the hospitalization or treatment, the patient may regain autonomy, he may get to understand his disease and its consequences, its nature and the therapeutic option provided to him.

When the ill person (because of a mental illness or following substance intoxication) can no longer represent correctly the consequences of his deeds, which means that he is a danger to society, then a treatment has to be imposed on him. The safety measure of imposing a medical treatment is on a non-determined basis, with the mention "until the patient is cured". The safety measures mentioned in article 113 of the Criminal Code are provisional and they may also be taken during criminal prosecution or trial. When the measure accompanies a period of imprisonment, the treatment will continue in the prison, too. Article 113 of the Criminal Code states that a treatment has to be imposed on a person who suffers from an illness or from chronic intoxication with alcohol, narcotics, or other substances, who represent a social danger; however, the article does not define the conditions or all the substances that may lead to a chronic intoxication of the wrongdoer. Regardless of whether we are faced with mental disorders or chronic intoxication, one should always consider the possibility of treating them as outpatients. The safety measure of imposing a medical may be taken regardless of the existence of a criminal punishment. The existence of the disease or of the chronic intoxication must be determined by the specialized healthcare bodies, by the psychiatric medico-legal commissions of expertise, as they are the only ones able to determine which cases requires the imposition of a medical treatment.

The order of execution that refers to the imposition of a medical treatment consists of a notice sent by a legal court to the said person, to the corresponding bodies, which are obligated to apply the order o (art. 429 par. 1 Code of Criminal Procedure) or to the administration of the prison, when the medical treatment accompanies an imprisonment or if the person is under arrest (art. 429 par. 3 Code of Criminal Procedure). The healthcare unit where the person was required to follow the treatment is obligated to communicate to the court that emitted the order the behaviour of the patient, the effectiveness of the treatment, whether the treatment can be continued under the same circumstances etc. If the person who was required to follow a medical treatment does not follow it regularly, then an involuntary hospitalization may be considered. Article 114 of the Criminal Code states that, when the wrongdoer is mentally ill or a drug addict and he is a danger to society, he may be confined in a specialized medical facility until he is cured. This measure is justified by the state of danger resulting from the alteration of the individual's mental capacities, reason for which he could commit criminal offences because of the disease. Unlike the provisions in article 113 of the Criminal Code, this measure is applied when the person's mental state is severely altered, reason for which the individual can no longer account for his actions. Another reason for the hospitalization is the fear that, if he is not confined in a facility, we will commit other antisocial deeds, of a very serious nature; hence, the conclusion

is that this measure is the only solution to eliminate the state of danger. According to the law provisions, the decision of involuntary hospitalization falls into the charge of the court who judges the person for a criminal accusation – following a psychiatric evaluation that had determined the mental disease or a substance addiction etc – and that proposed the safety measures stated in article 114 of the Criminal Code. After determining that such is the case, the person is confined to a specialized medical facility, where he has to follow the prescribed treatment. The issue here, too, is that the person or the person's tutor has to sign a free and informed consent.

Discussions

In the context of involuntary hospitalization, ethical analysis is all the more necessary as involuntary hospitalization is often seen as a deprivation of liberty and as a violation of the individual freedoms. Many psychiatrists, too, believe that the imposition of a treatment under such circumstances is for the patient's benefit, as it prevents a potential social impact though an involvement in aggressive acts. On the other hand, involuntary hospitalization without a proper treatment can be compared with imprisonment, just like in the case of a criminal with no mental disorder. The issue here is to foresee future actions, meaning to determine whether there is a possibility of committing a crime. In this sense, the followers of libertarianism, such as Thomas Szasz (Szasz, 1961), pinpoint that involuntary hospitalizations are a violation of individual freedom. This is why they believe that the right thing to do is to wait; if the person commits a crime, then he belongs to a prison, not to a psychiatric ward.

The issue of competence, of the capacity to take decisions of behalf of the said person is less assessed in the case of involuntary hospitalization (when the person is a danger to others). Hence, the patient has nothing to say on being committed, but only on the treatment. Ethical controversies arise regarding the informed consent because of the variability in the patient's competence, depending on the case. The most serious ethical dilemmas arise in the case of patients with major mental disorders, such as psychoses, dementias, and oligophrenias. The fact that a person has a dangerous behaviour does not mean that he suffers from a mental illness, just as a person diagnosed with a mental disorder is not necessarily aggressive towards himself or the others. Under these circumstances, the permanent commitment of a person with mental disorders with potential aggressive behaviour should be considered with caution. In psychiatry, the patients' competence is important when respecting their decisions, but also when protecting them from excessive exploitation (Kitamura, 2000; Kitamura & Kitamura, 2000). When medical emergencies appear, the patient must be informed on his health state and his autonomy must be observed. The correct and complete information provided to the patient increases the confidence in the physician, which is an important step in obtaining the patient's compliance and in the road to recovery (Irimia, 2006).

Autonomy supposes a free access of the patient to information on his situation and to his participation to the decision-making process. Starting from the etymology of the word, autonomy supposes someone's capability of being his own legislator. Autonomy means choosing a certain course of actions, based on judgment, on knowledge of interests and of one's own good. Autonomy is closely connected to the notion of individual freedom. Autonomous persons have the right to take decisions concerning their lives, in conformity with their own values. It is mandatory to respect another person's right to self-determination, and paternalism is only acceptable in certain situations and only if it is in the person's best interest (Astărăstoae, Loue, & Ioan, 2009). The paternalist approach can undermine the principle of autonomy when the patient is not aware of his disease, reason for which he cannot adhere to a proper treatment.

The respect for autonomy has been a priority in the past few years, and the patient has become ever more active in the decision-making process concerning his health. From an ethical perspective, autonomy is the principle that embodies the respect for another person, with fundamental rights and privileges in our society (Roberts, 2002). In agreement with this principle, the informed consent is no longer just a bureaucratic act, but it is part of the recovery process and it constitutes the legal grounds of the medical act (Vulpoi, Ungureanu, & Stoica, 2007). The beneficence principle and the responsibility towards society replace the patient's autonomy sometimes, mostly when the mentally ill are a danger to themselves and to others

Conclusions

Paternalism supposes the limited access of the patient to information on his situation and regarding the decision-making process. In the context of psychiatric medical practice, paternalism supports the physician to take decisions in the best interest of the patient, mostly concerning involuntary hospitalizations. When paternalist interventions interfere with a person's freedom, the measures taken are justified through acts meant to ensure the well-being, welfare, interests, or values of the person on behalf of whom the measures are taken (Vicol, 2010). Within this conflict (Ivic, 2010) of autonomy versus benefit, the questions to ask are whether the persons committed without their consent would be able to take the best decision for their health, in conformity with their own values and whether those who take the measures on his behalf are able to analyze objectively the multitude of factors making up the notion of another person's "well-being". In other words, can they let aside their own system of norms and values in order to make an objective decision in the patient's interest?

The position of the civil freedoms states that the patient's autonomy is above the therapeutic benefits and it labels the decisions of psychiatrists as paternalist (Levenson, 1986); psychiatrists should act in agreement with the principle of beneficence and non-maleficence. The ethical aspects related to involuntary hospitalization (Buda, 2008) should take into account the patient's autonomy, his

knowledge on various medical conditions, as well as risks versus benefits. The implementation of mental health policies, laws, and services that promote the rights of the mentally ill provide possibilities for the patients to make choices regarding their own lives, as well as legal protection. The application of the legislation on mental health involves issues related to medical ethics and deontology, which require a very cautious approach. Mandatory commitment and treatment are objective events that each patient, family, and physician experiences subjectively, and the therapeutic relationship becomes very important within this process (Crăciun, Vicol, Turliuc, & Astărăstoae, 2012). The argument that mandatory measures may lead to beneficial results does not prevent additional investigations of the ethical aspects within this field.

The paternalist intervention – especially concerning the involuntary hospitalization – is considered necessary sometimes to prevent a self-destructive behaviour (Cohen, 2000) but the issues related to the psychiatric medico-legal expertise are multifold and – at times – highly difficult.

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