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Provisional order for medical treatment

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Abstract. Safety, like risk, is an extended concept. Just like risk, safety provokes strong emotions and licenses in the exercise of power. But. While risk threatens, safety promises. And in this power to promise what it cannot offer lies a particular danger. Recognizing this danger requires special attention. The legislation of many states assigns to this term criminal legal value that distinguishes them from punishment. Apart from punishment, protective measures are referred to in many ways around the world: "corrective and protective measures", "security measures", "other criminal measures of a legal nature", "preventive measures. A summary of the analysis of the rules on protective measures around the world allows us to define them as a set of preventive measures established by criminal law and applied by the competent authorities, to the person considered dangerous due to his mental state or consumption of dangerous substances. When we act in the public space, we have a duty to respect others at least as much as we respect ourselves or to the same extent as we expect to be respected. The description of humanity as a basic element in order to put in rational terms the necessity of awareness of the aspect that the instrumentalization of the other in order to achieve one's own goals represents, mainly, the reduction of the other to the quality of object. Respect is part of our duties towards ourselves and others, what is important from the point of view of our exposure is not so much the respect we have in relation to ourselves, but respect for customers, for users, for other citizens, for the whole community. A review of legislation and psychiatric factors is called for to provide practical guidance and assistance in conducting assessments to defend against persons with mental illness. There is a participation of psychiatrists who routinely conduct assessments of competence and expertise in this complex area. The established approaches and methods will ensure the accuracy of assessing the mental state of the defendant at the time of committing the crime.

Keywords. provisional order, medical treatment, code, defendant, judge

1. General notions

1.1. Definition and purpose of the provisional obligation for medical treatment

The drafting of the provisional aspect results from certain judicial proceedings (criminal prosecution or trial) by transforming the security features – according to the Criminal Code, into procedural aspects with the help of a court decision – the security measures are properly described.

If the person who has performed a certain act, resulting from a disease, alcohol or dangerous substances, is seen as a danger to society, he can be determined to undergo medical treatment for health, to remove that danger. Medical admission can also be followed, according to the law. If the person is in prison, treatment is also carried out during the sentence period.¹

¹ Ivan Anne, *Elements of criminal procedural law*, Pro Universitaria Publishing House, Bucharest, 2015

Purpose of precautionary measures

The basic purpose of the security measures is to annihilate the danger and prevent criminal acts. Safety elements are taken towards the person who carried out the act, according to the criminal law – an unjustified act. There are also safety measures in case there is no punishment.²

Types of safety measures

- Determining the obligation to medical treatment;
- Medical admission;
- Prohibition of performing certain functions or professions;
- Special confiscation and extended confiscation

Medical treatment - mandatory provisional treatment

It is a measure with a medical aspect, described by the Criminal Code, through the court - if it is observed that through a psychiatric control the one who committed the act, due to a certain disease, is a danger to society. It is a safety measure and is based on obliging the perpetrator to undergo temporary medical treatment, until the danger situation is eliminated.³

Medical admission – mandatory temporary treatment

Over the past decade, there has been a heated debate about whether the mental health system should be used to control these people who are considered dangerous. The position of Thomas Szasz, although extreme (even in psychiatry), who argued that the criminal justice system, rather than the mental health system, should take primary responsibility for managing these people. *Szasz wrote of "the aggressive, paranoid person who threatens violence – legally, he should be treated as a person accused of a crime; Psychiatric would be desirable, of course, if she were not incarcerated in an ordinary prison, but in a hospital prison, she could receive medical and psychiatric attention"*⁴.

Thomas Szasz wants to shift responsibility for controlling dangerous people believed to be mentally ill to the criminal justice system. The issue will be explored from the perspective of psychiatric emergencies, the entry point for most violent people who are channeled into the mental health system.⁵

The specter of violence

Although for many years it has been argued that mentally ill people are more dangerous than other people, lately this position has been reassessed. As summarized by Steadman and Rabkin and a number of research studies, they have shown that the arrest rate of former mental patients is higher than that of the general population. The vast majority of mentally ill people do not behave violently towards other people, but there is a minority. The Steadman study found that after discharge from psychiatric institutions, 1.7% of patients were arrested for violent crimes over a period of twelve months.⁶

Two recent articles, one by Monahan, Caldeira and Friedlander and one by Bonovitz have shown how the police tend to bring to hospitals for evaluation and admission people who

² Ivan Anne, *Investigation of criminal prosecution bodies*, Pro Universitaria Publishing House, Bucharest, 2014

³ Art.109, Criminal Code

⁴ Art.109, Criminal Code

⁵ Art.109, Criminal Code

⁶ Jay Monahan, *The Clinical prediction of violent behavior*, Department of Health and Human Services, National Institute of Mental Health, Rockville, 2013

have committed violent acts but who, because they are believed to be ill, the police consider them more suitable for admission and provisional treatment than for detention. As Bonitz noted, "In general, police were reluctant to arrest even sick aggressive people who were resistant to treatment. Twice, officers tried to persuade relatives to seek engagement, rather than bring criminal charges",⁷.

Typology of dangerous persons

Clinicians working in hospitals face evaluation of what we'll categorize as five types of potentially dangerous people.

Obstacles to the transfer of dangerous persons to the justice system

It examines the duties of clinicians in conducting the emergency assessment and how these duties and other legal issues may impede the transfer of responsibility to the criminal justice system.⁸

- Obligation to assess, deal with or send

Clinicians have a duty to carefully and reasonably assess the treatment and hospitalization needs of everyone in emergency rooms.

- Obligation to protect third parties against dangerous persons

The duty to protect others from dangerous people could be expressed in several aspects – avoiding harm to third parties.

- Duty to protect confidential communications

In many states, emergency assessments are included in statutory provisions guaranteeing the confidentiality of information collected in the field of mental health. In the medical profession there are codes of ethics governing the disclosure of information obtained confidentially.⁹

- Other legal issues hampering transfer to the criminal justice system

Once the emergency assessment has been completed and the person meets certain criteria, the clinician's authority to detain people is still unclear.

✚ Evolution of interim safety measures

Interim safeguards are today a true preventive judicial guarantee and constitute one of the most gratifying aspects of the work to safeguard fundamental human rights internationally.

Interim measures: their transposition from domestic law to international law

First of all, some conceptual clarifications will be made taking into account the historical transposition of interim measures, from domestic legal systems to the international legal order – transposition into the international framework of human rights.

Precaution as a legal action is directed not at subjective law, but rather at the judicial activity itself. However, all this doctrinal construction has failed to free itself from a certain legal formalism, sometimes giving the impression of a trial in itself, except as a means to achieve justice.¹⁰

Interim precautions have reached an international level (in international arbitral and judicial practice). In the Statute of the International Court of Justice – these interim measures are indicated. Despite the uncertainties in this regard, international case-law

⁷ Gheorghe Buzescu, *Police Law - University Course*, Sitech Publishing House, Craiova, 2019

⁸ Jay Monahan, *The Clinical prediction of violent behavior*, Department of Health and Human Services, National Institute of Mental Health, Rockville, 2013

⁹ Jay Monahan, *The Clinical prediction of violent behavior*, Department of Health and Human Services, National Institute of Mental Health, Rockville, 2013

¹⁰ Jose Padilla, "Provisional Measures under the American Convention on Human Rights", *Liber Amicorum Hector Fix-Zamudio*, vol. II, San Jose of Costa Rica, I.A. Court H.R./E.U., 2014

has sought to clarify the legal nature of provisional measures of a preventive nature, without prejudice to the final judgment on the merits of those cases.¹¹

Reasons and subject matter of the interim measures

The subject matter of interim measures in international disputes is widely known. Both in domestic and international processes, precautionary or interim measures have the common goal of maintaining balance between the parties¹².

This change has occurred with the more recent transposition of interim measures from the international legal order – traditional disputes between states – to International Human Rights Law.

1.2 Legal regulation of provisional obligation to medical treatment

Criminal Code

The Criminal Code may outline the legality of criminalization. The criminal law describes acts that are considered crimes. Individuals cannot be criminally punished if the act is not considered criminal.

The criminal law describes appropriate punishments and educational measures for persons who have committed crimes, but specifies security measures for persons who have violated the criminal law. Penalties and educational measures must be included in criminal law. No punishment may be determined outside the limits of the law.¹³

Code of Criminal Procedure

The rules of criminal procedure are based on the proper implementation of the action of judicial bodies, respecting the rights of the parties and actors involved in the criminal proceedings. It demands respect for the Constitution and the Treaties of the European Union in the area of criminal procedure, but also the treaties describing fundamental human rights.¹⁴

The Code of Criminal Procedure specifies that the medical unit that carried out the admission has the obligation to notify the court if it is no longer necessary. The Code of Criminal Procedure may describe the termination or replacement of the internment measure, based on the requirement of the interned person or prosecutor – but legislative parallelisms also emerge.¹⁵

Law no. 129/2012, mental health and protection of persons with mental disorders

The person with mental disorders can be described as a person who develops certain mental imbalances or is not properly developed psychologically, consumes psychoactive substances, according to the psychiatric diagnosis.

Law no. 129/2012 may describe emergency judging. Listening to the patient is appropriate if the health is good, according to the law. The presence of the prosecutor is mandatory. If the court decides, it may be ordered that medical admission be replaced by outpatient treatment with the help of a psychiatrist.¹⁶

¹¹ Jose Padilla, " *Provisional Measures under the American Convention on Human Rights*", Liber Amicorum Hector Fix-Zamudio, vol. II, San Jose of Costa Rica, I.A. Court H.R./E.U.,2014

¹² Jose Padilla, "*Provisional Measures under the American Convention on Human Rights*", Liber Amicorum Hector Fix-Zamudio, vol. II, San Jose of Costa Rica, I.A. Court H.R./E.U.,2014

¹³ Art.54, Criminal Code

¹⁴ Art.248, Code of Criminal Procedure

¹⁵ Art.248, Code of Criminal Procedure

¹⁶ Art.57 Law no.129/2012 on mental health and protection of persons with mental disorders

In emergency situations, the psychiatrist, after describing the mental health condition of the person on trial, may decide the involuntary hospitalization of the patient and inform the commission, according to the law.

 **UN Convention, 2007 on the Protection of Persons with Disabilities**

The basic objective is to protect human rights and fundamental freedoms for persons with disabilities and respect for human dignity.

1.3 Forms and stages of the provisional obligation to medical treatment

 **Application and content of the measure**

The judge of rights and freedoms, during the criminal investigation, may request the provisional obligation to medical treatment of the suspect or defendant, according to the Criminal Code. The law stipulates that the suspect must comply with the medical treatment provided by the specialized doctor, until he recovers and the state of danger disappears.¹⁷

The judge of rights and freedoms will conclude this reasoned issue.

 **Aspects of the procedure for applying and lifting the measure**

During the criminal investigation, if the legal conditions are met, the prosecutor gives the judge a reasoned proposal to determine a series of interim measures for medical treatment.

It is specified that the reasoned proposal will be based on a forensic expertise outlining the reasons for using medical treatment.

If the suspect or accused person is present, the proposal is resolved after hearing the person with the help of a lawyer.

The proposal can also be resolved without the presence of the suspect or defendant¹⁸.

The presence of the prosecutor is mandatory.

The suspect or defendant may be accompanied by a doctor, who can give a number of conclusions to the judge. The doctor can present the therapeutic plan.

If, after determining the measure, the suspect has recovered or there is a state of health improvement that eliminates the state of danger in public safety, the judge may lift the measures taken.¹⁹

If the suspect or defendant violates the measure of medical treatment in bad faith, the judge may request the suspect's provisional medical admission, according to the law.

Informed consent for medical treatment is generally essential for the provision of good quality healthcare. Compulsory treatment challenges that presumption. Mental health laws are established in many states that allow the detention and treatment without consent of people with mental health conditions or psychological disabilities in certain circumstances.²⁰

A resolution on mental health and human rights is based on the provision of mental health services to people with health conditions or psychosocial disabilities, based on free and informed consent. This statement captures an international shift away from coercive practices in mental health settings – there is only the case of the defendant forced to undergo interim medical treatment.

¹⁷ Art.109, Criminal Code

¹⁸ Ivan Anane, *Management of criminal prosecution bodies*, Pro Universitaria Publishing House, Bucharest, 2014

¹⁹ Art.58 Law no.129/2012 on mental health and protection of persons with mental disorders

²⁰ Joel Rosenberg, *The Trial of the Assassin Guiteau: Psychiatry and the Law in the Gilded Age*. Chicago: University of Chicago Press, 2012

Definition of constraint (binding)

It is important to define the constraint for an expert review. The Oxford English Dictionary defines coercion as "action or practice" to persuade someone to do something using force or threats. "Coercion" refers to "the act or state of forcing or being forced." The term "coercion" will be used in this revision to use force to provide health care. Coercion in mental health settings is usually associated with the power of a civil commitment; i.e. compulsory treatment or psychiatric detention, often required by legislation for defendants, concerning mental health. Practices may include compulsory hospitalization, treatment without consent, therapy, isolation and mechanical/physical/chemical detention²¹.

One can also draw the "shadow of coercion" that can be willing—detention, treatment, isolation, and detention, which are supreme mechanisms of clinical power. Coercion is an important feature of the psychiatric system. Coercion can occur outside hospitals, in community mental health services, residential units. Mandatory formal outpatient psychiatric interventions may also be included.²²

Finally, coercion can be understood as less visible and explicit than taking special actions against a person, imposing situations. There may be less visible forms of forced persuasion and focus on explicit actions that constitute coercion, such as isolation and detention, treatment without consent.

History of madness as a form of defense

For centuries, Anglo-American law has maintained its principle that a person can be found criminally irresponsible for a crime if he had mental problems at the time of the action. Justice David Bazelon succinctly summarized the moral basis of insanity; "Our collective conscience does not allow punishment where it cannot impose blame." Rules of defense against insanity have always been controversial. Attacks on the lives of kings, presidents, and government officials have often led to the revision and modification of legal standards. The most recent national review took place after the attempted assassination of President Ronald Reagan by John W. Hinckley in 1981.²³

In a commentary on the Hebrew Scriptures from the sixth century B.C., certain crimes are distinguished that occur without guilt. They were committed by children, who were considered incapable of weighing the moral implications of personal behavior, even when done intentionally, and intellectually disabled and insane people who were likened to a child.

In the twelfth century, issues of moral injustice began to develop in pre-English law that described the concept of "insanity" and culpability. The Lords of State began granting pardons to people who were convicted of a crime and obviously were insane. These graces required the accused to be admitted and treated in a mental institution instead of prison.

²¹ Bonnie Raitt: *Morality, equality, and expertise: renegotiating the relationship between psychiatry and the law.* Bull Am Acad Psychiatry Law 12:5–21, 1984; Fingarette H: *The Meaning of Criminal Insanity.* Berkeley, CA: University of California Press, 2011

²² Bonnie Raitt: *Morality, equality, and expertise: renegotiating the relationship between psychiatry and the law.* Bull Am Acad Psychiatry Law 12:5–21, 1984; Fingarette H: *The Meaning of Criminal Insanity.* Berkeley, CA: University of California Press, 2011

²³ Joel Rosenberg, *The Trial of the Assassin Guiteau: Psychiatry and the Law in the Gilded Age.* Chicago: University of Chicago Press, 2012

However, mental institutions and prisons lacked adequate facilities and treatment for the mentally ill.²⁴

The granting of pardons preserved the dignity of the legal process. In the thirteenth century, the requirement of moral illegality of Christian law merged with English law to require both the presence of a criminal act and the presence of a medical act. It was Henry Bracton, who wrote the first study of English law, and noted that children and fools were incapable of forming both the intention and the will to do evil, they lacked the ability to build an intention of guilt.

Guilt, responsibility, and punishment are used in jury and moral philosophy. Comparing law and morality, jurisdiction and moral philosophy, one sees how, on the one hand, moral attitudes and ideas are constructed into legal and legal concepts; and on the other hand, how elements of the legal structure enter morality: morality also has its accusations, judgments, judgments and sanctions. Morality is like law, a means to guide human behavior. The three concepts are mutually related.

With regard to children, another law took shape in a more complex form between the fifth century and Lord Coke's period in the seventeenth century: the doctrine outlined in the common law consists of the presumption of children under the age of seven who were incapable of committing the crime. However, between the ages of 7 and 13 (inclusive), incapacity was presumed but could be challenged. This presumption could be overcome by the prosecution presenting evidence – the child was smart enough to distinguish between right and wrong. Before the M'Naughten case, English jurists made several attempts to find the right text for madness: "*totally deprived of his understanding and memory, and knows not what he is doing, no more than a child,... a brute or a wild beast.*"²⁵

Another important element during this period was Isaac Ray's Treatise on the Medical Jurisprudence of Madness, written in 1838. Ray was concerned with tests that demonstrated only knowledge and not willpower. In 1840, Edward Oxford proposed a volitional or behavioral test that introduced the concept of irresistible impulsive defense. The test allowed a person to be acquitted as a result of a mental disorder and did not resist the urge to commit the crime. Sir James Fitzjames Stephen subsequently took this test²⁶.

Queen Victoria disagreed with Edward Oxford's test because she believed that a mentally ill person who attempted murder should be held accountable for it. A wide variety of cognitive and behavioural tests, uncertainty about the defence against insanity and the queen's dissatisfaction with the Oxford outcome, set the stage for the most publicised case in England: the M'Naughten trial of 1843.

Substance abuse and insanity as a form of defense

U.S. jurisdictions uniformly subscribe to the longstanding rule that voluntary drug intoxication cannot be used to completely exonerate a defendant. This is not to say that voluntary drug poisoning has no impact on the defendant's liability. For centuries, defendants

²⁴ Joel Rosenberg, *The Trial of the Assassin Guiteau: Psychiatry and the Law in the Gilded Age*. Chicago: University of Chicago Press, 2012

²⁵ Joel Rosenberg, *The Trial of the Assassin Guiteau: Psychiatry and the Law in the Gilded Age*. Chicago: University of Chicago Press, 2012

²⁶ Bonnie Raitt: *Morality, equality, and expertise: renegotiating the relationship between psychiatry and the law*. Bull Am Acad Psychiatry Law 12:5–21, 1984; Fingarette H: *The Meaning of Criminal Insanity*. Berkeley, CA: University of California Press, 2011

whose substance-induced illnesses or mental defects — alcohol-induced dementia — have prompted defenses of insanity²⁷.

There are two causes related to this principle. *State v. Hartfield* said the insanity defense can be invoked when voluntary drugs or alcohol caused the permanent mental state that destroyed the defendant's ability to distinguish right from wrong. In the case of *Brunner v. State*, the court held that defendant is entitled to jury instructions because long-term drug use can induce insanity.

Most jurisdictions make a clear distinction between established insanity and temporary insanity caused by voluntary intoxication and do not allow the latter to be used as a defense against criminal activity.

The California Supreme Court has established four criteria for determining insanity:

- Mental illness must be fixed and stable;
- To last a reasonable period of time;
- Extends over the ingestion or duration of the effects of the drug;
- Meet the legal definition of insanity jurisdiction.

The Kentucky courts have found it appropriate to exclude testimony about insanity induced by the defendant's voluntary drug use and that juries should be instructed to do so. *Bieber v. People* rejected that insanity occurs caused by mental illness or substance use by the defendant. A few jurisdictions, however, seem to differentiate between drug-induced psychosis and other forms of mental disability.

2. Tactical rules used to carry out provisional medical treatment

2.1. Forensic expertise in carrying out the provisional obligation to medical treatment

A. History and development of forensic medicine

Forensic medicine and forensic pathology are terms used interchangeably around the world. Forensic medicine is used to describe aspects of forensic work, rather than just forensic pathology, which is the branch of medicine that investigates death. Forensic clinic refers to that branch of medicine that involves an interaction between law enforcement, justice and police officials. Clinical forensic medicine is a term that has only become widely used in the last two decades, although the phrase has been used since at least 1951 when the Association of Police Surgeons was founded, known as the Forensic Physicians Association – a body based in the UK.²⁸

Clinical forensic practitioners have had different names over the years, but the term coroner has become broader. However, throughout the world there are doctors who are involved in both clinical and pathological aspects of forensic medicine. There are areas in clinical and pathological aspects of forensic medicine overlap, and this aspect is reflected in the history and development of the specialty as a whole, through different aspects: determining the attitude of the detainee; determining the fitness to be released; determining the suitability to hear the police or detention body; ensuring the rights of vulnerable persons or persons with mental disorder; assessment of alcohol and drug intoxication; ability of a person to drive a vehicle; body searches; documentation and interpretation of injuries; forensic sampling; assessment of injured

²⁷ Bonnie Raitt: *Morality, equality, and expertise: renegotiating the relationship between psychiatry and the law*. Bull Am Acad Psychiatry Law 12:5–21, 1984; Fingarette H: *The Meaning of Criminal Insanity*. Berkeley, CA: University of California Press, 2011

²⁸ William Guy, *Principles of forensic medicine*. Henry Renshaw, London, UK, 1844

personnel;examination of mental state;examination of claimants;examination of alleged victims;examination of victims and attackers.

For all these examinations, a coroner must accurately document himself, present the information orally in a court.

Police officer, forensic officer and coroner are examples of names used to describe those practicing in clinical forensics, but such designations refer more to the role than to the work done. Some clinical forensic practitioners may only fulfill some of these roles, while others may play a larger, expanded role, depending on geographic location (country), local status, and judicial systems. Forensic doctors must have a thorough knowledge of medical jurisprudence, which can be defined as the application of medical science to the law of their own jurisdiction.²⁹

Historical references

The origins of forensic medicine date back many centuries, although Smith rightly commented that "forensic medicine [cannot be considered] as an entity.... until we reach a stage of civilization where we have.... a recognized legal system.... and an integrated body of medical knowledge and opinions",³⁰

Specific terms in forensic medicine and medical jurisprudence (forensic medicine) date back to the early nineteenth century. In 1940, Thomas Stuart Traill, referring to the link between medicine and legislation, stated that: "It is known in Germany, the country where it developed, under the name of State Medicine, in Italy and France it is called Forensic Medicine, and in our country in the United Kingdom it is usually called Medical Jurisprudence or Forensic Medicine". However, there are many previous references to the use of the notion of medical experts to assist with legal process in many other jurisdictions; These doctors would be involved in civil crimes or cases, as well as public health, frequently and somewhat confusingly referred to in the nineteenth century as medical police.³¹

In 1975, Chinese archaeologists discovered numerous bamboo pieces dating back to about 220 î.Hr. (Qin dynasty), with rules and regulations for examining the residencies inscribed on them. Other historical examples with links between medicine and law can be found throughout the world. Amundsen and Ferngren concluded that forensic medicine had been used by Athenian courts and other public bodies, and that doctors' testimony in medical matters was given particular allegiance, although this use of physicians as expert witnesses was "lax and indefinite" in Roman courts.³²

In Rome, the Lex Duodecim Tabularum (laws written on 12 tablets in 449 î.Hr.) referred to forensic matters, including the duration of gestation (to determine legitimacy), deceased persons, punishments according to the degree of injury caused by an attacker, and poisoning. Various papyri related to Egypt from the Roman period to the fourth century d.Hr, contain information about forensic examinations or investigations.

The interaction between medicine and law is the quality of forensic medicine, as presented in historical documents. A specific role of the medical expert as provider of impartial opinion, since the judicial system was clearly identified by the Justinian Laws between 529 and 564 d.Hr. Traill stated that: "Medical jurisprudence as a science cannot date back more than the sixteenth century." George, Bishop of Bamberg proclaimed it with penal code in 1507. The

²⁹ William Guy, *Principles of forensic medicine*. Henry Renshaw, London, UK, 1844

³⁰ Sydney Smith, *The history and development of forensic medicine*, British Medical Journal, London, 1951

³¹ Sydney Smith, *The history and development of forensic medicine*, British Medical Journal, London, 1951

³² Sydney Smith, *The history and development of forensic medicine*, British Medical Journal, London, 1951

Constitutio Criminalis Carolina, the code of law published and proclaimed in 1553 in Germany by Emperor Charles V, is considered to be an original element in forensic medicine: medical testimony became an important element of expertise.³³

Since the end of the eighteenth century, several books and treatises have been published in English relating to forensic medicine and jurisprudence. In 1783, William Hunter published an essay entitled "On the Uncertainty of the Signs of Murder in the Case of Bastard Children"; this may be the first true forensic publication in England. The first major work was published in 1788 by Samuel Farr. John Gordon Smith wrote in 1821 in the preface to his own book: "The earliest production in this country, which purported to treat Medical Jurisprudence, was a summary from a foreign work, contained in a very small space. It's called Dr. Farr's Elements" and first appeared thirty years ago"³⁴.

John Gordon Smith stated in *The Principles of Forensic Medicine* that "Forensic medicine—forensic, judicial, or legal medicine—and medical jurisprudence are synonymous terms. Alfred Taylor in his *Handbook of Medical Jurisdiction* defined medical jurisprudence as: "*That science which defines every branch of medicine for the purposes of law*,"³⁵.

The following working definition has been suggested: "Clinical medicine includes all medical areas that may be related to the judicial and police system." Even though medicine and law interact more frequently in living persons, forensic pathology has been established as the academic basis for forensic medicine. Over the past two decades, research and academic interest in forensic medicine has become a more focused area of research. Recent awareness of human rights abuses and civil liberties has shifted attention to the application of justice in the eyes of both victim and suspect.³⁶

The Committee for the Prevention of Torture and Inhuman and Degrading Treatment in the early 1990s drew attention to the lack of independence of some police doctors. In England and Wales, the Human Rights Act 1998 reinforces the need for doctors to be aware of those human rights issues. It is worth noting that the law was adopted almost 50 years after the publication of the European Convention on Human Rights and Fundamental Freedoms.

The coroner has several roles: the role of forensic expert for law enforcement; the role of treating physician; the treatment of persons who have been mistreated by the police.

Forensic medicine works in a variety of countries and jurisdictions, addresses key questions. The following comments have been made about forensic medicine: forensic practice cannot be repeated; emphasis can be placed on the alleged victim than on the alleged suspect; standard of medical care for detainees in police custody is variable – recognition of human rights issues; there are no international standards of practice or training – there are several standards at national level; there are obvious gaps in the investigation of police complaints in some states; statistics on investigation of deaths in custody.

There appears to be wider recognition of the interrelationships between coroner's roles and forensic pathology in many jurisdictions, both in the clinical and pathological aspects of forensic medicine. The use of GPs in clinical forensics is common in England, Wales, Northern Ireland, Scotland, Australia and the Netherlands – all of which remain heavily dependent on such professionals. In the United Kingdom, much effort has been put into trying to establish a range of research into forensic medicine. The Diplomas of Medical Jurisprudence and the

³³ William Guy, *Principles of forensic medicine*. Henry Renshaw, London, UK, 1844

³⁴ Sydney Smith, *The history and development of forensic medicine*, British Medical Journal, London, 1951

³⁵ Sydney Smith, *The history and development of forensic medicine*, British Medical Journal, London, 1951

³⁶ Payne-James, *Clinical forensic medicine*. J. Clin. Forensic Med, 2012

Diploma of Forensic Medicine, are internationally recognized qualifications with centers developed around the world. Mastership in Medical Jurisprudence is the highest qualification in the field in the UK.³⁷

Many forensic doctors undergo higher training in law or medical ethics in addition to their basic medical qualifications. In addition to medical professionals, other healthcare professionals may have a direct involvement in clinical forensic matters, in particular when the number of medical professionals with a specific interest is limited. Undoubtedly, the multiprofessional approach can have, as in all areas of medicine, some benefits.

There are key areas that need to be addressed in clinical forensics:

- must be recognized globally as a distinct subspecialty;
- Forensic doctors and other forensic health professionals should ensure independence, impartiality and upholding of basic human principles.

B. Forensic expertise and provisional medical treatment

Incarceration causes behavioral, cultural, mental or physical changes, it is a overwhelming event with negative connotations. The prison environment is closely monitored in terms of human rights, healthcare and psychology. It is important to analyze the psychiatric-medical-legal profile for the purpose and motivation of the criminal act – a study elaborated by Delcea.³⁸

On the other hand, as Kopak points out, relapse is associated with drug use and certain mental disorders. The assessment of people with mental disorders should be based on knowledge of the patient's medical history, current assessment and knowledge of criminal circumstances. Recent studies have investigated associations between psychopathological personality and cognitive schemas in relation to the type of crime.³⁹

Even though provisional medical care is important, there are warnings about the importance of knowing and using prisoners' health data. Many pathologies remain undiagnosed even if the system works properly.

An objective method of assessing the condition of persons deprived of liberty is the forensic report. This is an interdisciplinary assessment aimed at establishing the physical and mental state, the existence of traumatic injuries or their consequences. The execution of a sentence on medical grounds may be interrupted for interim medical treatment. On this occasion, the patient's status, the possibility of a vital risk arising from the existing pathology or the need for emergency intervention, to improve health or therapeutic recovery are analyzed – all can be quantified.

Expert reports are the only route for provisional medical treatment. It is important to mention that Romania is one of the few states where there are certain facilities. Iftenie and Dermengiu showed the conditions under which such expertise is carried out: at the request of the judicial authority to determine whether pathology can be treated in certain hospitals and whether it poses any danger to society. The patient's entire medical record is analyzed. In general, pathological conditions themselves do not require interruption of punishment, but complications can cause significant changes in prognosis. Therefore, a strong medical system

³⁷ William Guy, *Principles of forensic medicine*. Henry Renshaw, London, UK, 1844

³⁸ Payne-James, *Clinical forensic medicine*. J. Clin. Forensic Med, 2012

³⁹ Sydney Smith, *The history and development of forensic medicine*, British Medical Journal, London, 1951

is needed, with adequate resources for costs related to infrastructure and security requirements and a prompt and adequate response when needed⁴⁰.

On the other hand, it is known that some people abuse the possibility of requesting expert reports to interrupt the sentence on medical grounds. The role of medical expertise for interruption of punishment and provisional treatment is essential in assessing and maintaining the health of people and it is necessary to optimize the time for preparing the expertise to provide the best conditions for patients and forensic doctors.

C. Unique claims in forensic medicine and provisional medical treatment

The concept of uniqueness is based on inductive reasoning, where thinking goes from the particular to the general. Modern scientific forensics and philosophy both favor the hypothetical-deductive model. Deductive thinking is basic: if something is true for a class of things in general, then it is true for all members of that class as well. This type of reasoning begins with the presentation of the general statement, a hypothesis or theory⁴¹.

There is another side to the coin. Today, more than ever, forensic medicine and medical expertise in provisional medical treatment are under review and scrutiny due to multiple errors – innocent individuals convicted. How can it be possible, when technology is at the cutting edge, with tools that give accurate results, providing highly qualified expertise. These technological errors are human cognitive; And if they are human errors, is it due to misuse, incompetence, bias, lack of understanding of the principles of epistemology? These disciplines should be approached through the prism of their uniqueness⁴².

In academic circles, the so-called "proof" of individuality is an unproven claim. One can argue the uniqueness of their theory. The argument is that no two objects were found identical to each other. The induction model would sound like this: there are a number of samples, and there are none identical. No sample may be identical.

It follows that uniqueness seems to be more a matter of faith than a scientific rule. People want to believe in the concept of uniqueness even though there is no scientific evidence for this. Andre Moenssens argues that this well-established concept is based on the term "snowflake syndrome", no snowflake looks the same.

It is believed that in the practice of forensic medicine the concept of uniqueness is not favorable for three reasons::

- Computers and imaging devices use models;
- The uniqueness of fingerprints is based on several experiments;
- For the legal system, uniqueness is irrelevant.

"Uniqueness" should not be used in forensic science, since it is in the area of pure philosophy. The induction model, which is based on uniqueness, does not favor forensic individualization. It's certainly not a scientific conclusion, it's just pure guesswork. The coroner's job is to gather the facts supported by evidence and not to claim uniqueness that can lead to prejudice.

⁴⁰ Ian Coyle, *Pattern recognition and forensic identification: The presumption of scientific accuracy and other falsehoods*. Crim LJ. 2012

⁴¹ Ian Coyle, *Pattern recognition and forensic identification: The presumption of scientific accuracy and other falsehoods*. Crim LJ. 2012

⁴² Ian Coyle, *Pattern recognition and forensic identification: The presumption of scientific accuracy and other falsehoods*. Crim LJ. 2012

D. Personality traits of coroners

It is an important research topic, because occupational stress has an impact both on professional activity and the relationship with partners in the institution, but also on the doctor-patient relationship. The main stressors can be: working hours, stressful tasks, time pressure, difficult relationship with superiors, colleagues or patients, lack of appreciation.⁴³

The coroner, who is often a member of the multidisciplinary assessment team, must show intelligence, intuition, openness and empathy to capture both the causes and context of the diagnosis. Professional tasks are often exhausting and can leave traces in behavior, attitude, judgment, and vision of life or death.

The literature in the field shows that there is no research in the field of burnout in forensic doctors in Romania, although this medical specialty is often involved in different categories of patients – children, adults, prisoners, etc. Therefore, the diversified casuistry and professionalism of forensic doctors is parallel to the emotional charge specific to this job.

E. The institutionalization of forensic psychiatry in Bucharest – a historical sketch

Beginning in 1820, Moldavia and Wallachia experienced profound political, social and economic upheavals. The union of the principalities and independence from the Ottoman Empire, the Balkan Wars, and the aftermath of World War I caused a number of effects. The history of Romanian medicine has mirrored these historical changes, given the significant involvement in the nation-building process⁴⁴.

In Romania, as in other parts of Eastern Europe⁴⁵, the "health of the nation" was based on the creation of a modern health system. Together with other medical professionals, psychiatrists and forensic scientists – doctors contributed to the creation of a network of hospitals, asylums, research institutes, universities, sharing the hope of providing cures for social ills. The process of institutionalization of psychiatry as a scientific discipline played a fundamental role, emerging a new medical language.

Most Romanian doctors studied in France and were influenced by French medical practices and ideas. In 1838 the first mental health law was passed. In November 1838, the first modern insane asylum was built – Marcutza Asylum, near Bucharest. It was built in the headquarters of Marcutza monastery, and specially designed for this area.

The word "mad" was used, a term derived from Latin "ex mente" (outside the mind). Official documents of the time pointed out that Marcutza Monastery had no connection with the asylum. To show respect, officials used the name "Hospital or Institute of the Insane from Marcuta".

The medical expenses for this institutionalization were paid by a central provider of medical assistance "Central House", under the Organic Regulation. The first director of Marcutza Asylum, Nicolae Gănescu (1799-1875) was trained at the Faculty of Medicine of the Imperial University of Moscow. He was director of the Marcutza Asylum from 1840 until the Wallachian Revolution of 1848. Gănescu managed to improve the standards of personal

⁴³ Diaconescu Nicolae, *Centenary of the first regulation of psychiatric assistance in the United Principalities*, Neurology, Psychiatry, Neurosurgery, 1964

⁴⁴ Protici Petre, *Medical report with tables of movement of patients from the Marcuta Institute*, Medical Monitor, 1863

⁴⁵ Gheorghie Buzescu, *Internal and international police cooperation*, Sitech Publishing House, Craiova, 2020

hygiene, nutrition and clothing of hospitalized patients and improve constraints for agitated mental patients⁴⁶.

The Macutza asylum was run in short periods of time by⁴⁷: I. Bren (1849-1851); Gheorghe Polizu (1851-1852) – who later became professor and dean of the Faculty of Medicine in Bucharest; Constantin Miniș (1852-1854) – graduate of the Leipzig Faculty of Medicine; Petre Protici (1822-1881) – with medical studies in Paris.

Protici introduced methods of drug treatment for psychiatric conditions and improved methods of occupational therapy by organizing special workstations for hospitalized patients. He presented an occupational therapy for the mentally ill, which was a revolutionary method at that time. The Marcutza asylum gradually developed into a well-organized hospital with medical admission procedures, proper living conditions and treatment, proper hygiene and different therapies⁴⁸.

Other elements of modernity in psychiatry were brought by Alexandru Sutz (1837-1919). Sutz began his medical career in 1856 in Athens and defended his dissertation, entitled 'Considérations sur la dyspepsie essentielle' at the Faculty of Medicine in Paris on 16 May 1865. Thus, Sutz took Morel's theories to Romania and became directly involved in the so-called "medicine aliéniste", from 1866. Morel's theory flourished in the 1860s in Romania, showing the influence of the environment for certain diseases and giving new tools of interpretation in the relationship between social and biological. Mental illness is often a biological reaction to special environmental conditions.

He was eventually appointed Mina Minovich (1858–1933), as head of the Department of Forensic Medicine. Sutz also served as an expert-witness in forensics, psychiatric and forensic investigations. He founded modern forensic psychiatry (1877) and the first Romanian Scientific Society of Psychiatry and Neurology.

According to Sutz, by the end of the nineteenth century, the new wave of modern psychopathology, inspired by Kraepelinian psychiatry, was brought to Bucharest Alexandru Obregia (1860-1937). Obregia obtained her medical degree from the Faculty of Medicine in Bucharest, with a thesis on experimental studies of cerebral-cortical visual centers. Obregia spent four years (1888-1892) in prestigious neurological and psychiatric clinics and laboratories in Germany and France (at Rudolf Virchow, Siegmund Munk, Carl Friedrich Otto Westphal in Berlin, Germany and Jean-Martin Charcot, Valentin Magnan, Gilbert Ballet and Benjamin Ball in Paris, France).⁴⁹

Obregia was one of the first European clinicians to define schizophrenia as a clinical entity and introduced methods of psychiatric diagnosis and treatment. In 1908, eager to experiment with new biological products and new methods of exploration in neurology and psychiatry, Obregia began using suboccipital puncture as a diagnostic and therapeutic procedure.

Through professional organizations and specialized magazines, Romanian psychiatrists advocated for the improvement and sanitation of the nation. In the late nineteenth

⁴⁶ Diaconescu Nicolae, *The Centenary of the First Regulation of Psychiatric Assistance in the United Principalities*, Neurology, Psychiatry, Neurosurgery, 1964

⁴⁷ Sutz Alexandru, *The beginnings of scientific psychiatry in nineteenth-century Romania*, Do-minor Publishing House, Bucharest, 2017

⁴⁸ Sutz Alexandru, *The beginnings of scientific psychiatry in nineteenth-century Romania*, Do-minor Publishing House, Bucharest, 2017

⁴⁹ Protici Petre, *Medical report with tables of movement of patients from Marcuta Institute*, Medical Monitor, 1863

century, medical professionals argued that only the strong state could infuse medical careers with new morality and assign doctors a socially responsible role.⁵⁰

F. Forensic science: ethical principles in provisionally compelling medical treatment

▪ **Ethical practice and forensic expert**

Forensic experts must have experience in their field, provide authority in their work, become an expert, must have extensive and in-depth knowledge, being competent to prepare a final report.

Magistrates trust forensic experts in the area of provisional obligation to medical treatment. Tribunals accept reports without challenge, mainly due to the difficulty of the information provided. Thus, expert evidence must be reliable and free from bias – because medical treatment is important. Concerns about the admissibility of evidence and expert testimony have been widely expressed regarding validation in methods used in investigations.

According to Hiss, Freund and Kahana are forensic experts called upon to provide expert opinion on their professional field – for example: provisionally ordering medical treatment. In this context, two ethical requirements are suggested: the use of reliable data and a restricted report in the area of expertise, honestly written according to qualification or experience.

Experts must behave ethically correctly when testifying on a particular topic; Emphasis is placed on qualifications and experience.

This type of professional faces murder, violence, death on a daily basis. Given the urgency and complexity of the work carried out in this area, Walterscheid believes that political issues, stress and personal bias can cause uncertainty in providing appropriate treatment.

Forensic experts, as scientists must have appropriate skills, education and training. In such cases, ethics has standards of conduct underpinned by justice and consistency. They should be objective, showing how they reach the conclusions presented in their reports. Ethical professionals achieve clear and explicit results without any bias, do not extend beyond their own skills, competencies or knowledge, recognizing the importance of conducting a thorough investigation before drawing a conclusion.

▪ **Professional and ethical conduct in provisionally ordering medical treatment**

Forensic experts must meet the highest ethical norms and professional standards. Several entities in the field establish codes of conduct in the area of medical treatment, which must be evaluated and updated periodically. The principles of the structure of codes of professional ethics help make decisions and solve problems in shaping medical treatment.

Forensic sciences include professionals with diverse backgrounds of training, such as doctors, scientists, dentists, psychologists, engineers, chemists, pharmacists, etc. In each category there can be a code of ethics, emphasizing the principles for each specialty.

2.2. Provisional order for medical treatment

A. Gaps and future research; Directions

There are several gaps and limitations in the literature reviewed. Most research in this area is conducted by academic psychiatrists, usually in the form of quantitative research based

⁵⁰ Diaconescu Nicolae, *Centenary of the first regulation of psychiatric assistance in the United Principalities*, Neurology, Psychiatry, Neurosurgery, 1964

on service data. Governments and research institutions could take steps to ensure that people with mental health conditions or psychosocial disabilities can be limited to crime.

National research funds may require the involvement of service users, and ethical research guidelines on mental health research could better promote the importance of research conducted. Thomas and Cahill argued for the link between coercion (provisional compulsion for medical treatment) and psychiatry. There are several mixed research methods that incorporate both.

While there are clear benefits to quantitative research, especially in conducting large-scale research such as national surveys, it is also important to achieve the phenomenological benefits of research, considering prevention practices, ending with the reduction of coercive practices, which are complex social interventions. The complexity of these interventions may have an impact on the effectiveness of quantitative methods, including control studies. The results of such studies depend on multiple contextual factors related to the intervention itself – the provisional obligation to medical treatment, but also on how it is researched and by whom. Certain advance planning, support, and family responsiveness are complex social interventions. Each emerges in a complex web of formal and informal relationships.⁵¹

The "organizational culture" for addressing the use of coercion and temporary compulsion to medical treatment has been identified in several studies – the strategy for reducing coercive practices in clinical mental health. It is research that focuses on organizational culture and human behavior – sociology, anthropology and behavioral psychology.

As for psychiatric research, Kleinman called for a "rebalancing of academic psychiatry," arguing that academic psychiatrists should pursue social, clinical, and community studies in a humanistic setting. He argues that links between psychiatry, public health and the social sciences need to be strengthened in research aimed at preventing, ending and reducing coercion in mental health services.⁵²

B. Mai multe cercetări privind schimbarea culturii organizaționale în obligarea provizorie la tratament medical

Organizational cultural change has been an important component in compelling preventive medical treatment. There is literature assessing organizational social context and organizational factors and work attitudes in mental health services, but there is little research on effective ways to change organizational culture and management culture⁵³.

Social psychological theories of group processes and intergroup behavior could shed light on how to change organizational culture. Organizational climate refers to attitudes and perceptions of the work environment.

C. Temporary obligation to medical treatment in low-income settings (increased crime in these areas)

It seems reasonable to infer that there is coercion in low-income areas against mentally ill people who commit certain crimes. According to Davar, low-income regions tend to be more concerned with inclusive development than mental health support. Davar gives India as an example: "*Indians seek mental institutions as ideal for the elderly, parents, sisters or brothers, and dependents. This represents 7% of the Indian population. For the remaining 93% of the*

⁵¹ Salomon, Carmela: Hamilton, Bridget and Elsom, Stephen, 'Experiencing Antipsychotic Discontinuation: Results from a Survey of Australian Consumers', Journal of Psychiatric and Mental Health Nursing, 2014

⁵² Salomon, Carmela: Hamilton, Bridget and Elsom, Stephen, 'Experiencing Antipsychotic Discontinuation: Results from a Survey of Australian Consumers', Journal of Psychiatric and Mental Health Nursing, 2014

⁵³ Gheorghe Buzescu, *Particularities of contravention law*, Sitech Publishing House, Craiova, 2017

population in rural areas, slums, mountainous terrain and other remote regions, where there is no doctor or asylum, this has no relevance⁵⁴."

D. Establishing a framework for collecting empirical evidence

Any examination of how existing laws work – can contribute to available empirical evidence. Regardless of the ideological issues of provisional medical treatment and coercion, evidence is crucial in assessing the effectiveness of steps to modernise certain practices. Some conceptual clarity may also be required to generate valid and reliable data.⁵⁵

The term "coercion" is not necessarily used appropriately. Some studies use "coercion," "leverage," "treatment pressures," "conflict," and "isolation." The field could benefit from establishing an agreed vocabulary or a global research agenda. Sz mukler argued that *"substantial work is still needed to develop a vocabulary for provisionally compelling medical treatment."*

While acknowledging time and language limitations, this review identified clear themes and concepts relating to coercion and preventive compulsion to medical treatment – in mental health settings.

More importantly, the findings are generally positive. Efforts to reduce, prevent, and coerce preventive medical treatment appear effective in most studies, despite certain limitations.

"Crisis resolution" can be solved in specialized hospitals for preventive compulsion to medical treatment.

Empirical research studies suggest that the following interventions are likely to address the constraint in preventive compulsion to medical treatment: national prevention policies through the use of appropriate treatment; organizational culture change through emphasis on recovery, care, support; independence for decision-makers and service providers.

Clinical risk management for mental health care in temporary medical treatment

Generally, health practitioners are required to exercise skills that should be reasonable. A healthcare provider will not be held liable for "errors of judgment" as long as clinical judgment is diligently determined, taking into account the patient's assessment by the healthcare provider and all available information from other sources.⁵⁶

A hospital that can also treat defendants for interim medical treatment is required to meet appropriate standards, competent staff and adequate facilities and equipment, as well as the competence of doctors to provide interim medical treatment.

Based on case law, the size of the hospital, its location and the community it serves will be relevant factors in assessing standards. Documentation serves both a clinical and legal purpose. Clear, effective and complete documentation is a communication tool for the health team. The courts have recognised that they highlight information relevant to the patient –

⁵⁴ Schneeberger Andres Ricardo, Kowalinski Eva, Frohlich Daniela, Schroder Katrin, von Felten Stefanie, Zinkler Martin, Beine Karl, Heinz Andreas, Borgwardt Stefan, Lang Undine, Bux Donald and Huber Christian G, 'Aggression and Violence in Psychiatric Hospitals with and without Open Door Policies: A 15-Year Naturalistic Observational Study', Journal of Psychiatric Research, 2017

⁵⁵ Schneeberger Andres Ricardo, Kowalinski Eva, Frohlich Daniela, Schroder Katrin, von Felten Stefanie, Zinkler Martin, Beine Karl, Heinz Andreas, Borgwardt Stefan, Lang Undine, Bux Donald and Huber Christian G, 'Aggression and Violence in Psychiatric Hospitals with and without Open Door Policies: A 15-Year Naturalistic Observational Study', Journal of Psychiatric Research, 2017

⁵⁶ Schneeberger Andres Ricardo, Kowalinski Eva, Frohlich Daniela, Schroder Katrin, von Felten Stefanie, Zinkler Martin, Beine Karl, Heinz Andreas, Borgwardt Stefan, Lang Undine, Bux Donald and Huber Christian G, 'Aggression and Violence in Psychiatric Hospitals with and without Open Door Policies: A 15-Year Naturalistic Observational Study', Journal of Psychiatric Research, 2017

presentation and treatment is an important component of intra-team communication and the graphic is evidence of compliance with requirements for the content, retention and disclosure of medical records. The documentation must meet statutory, institutional and professional requirements for defendants provisionally obliged to treatment. The documentation must be legible, objective, include relevant information, use specific terminology.

Some care homes use a certain type of chart – providing temporary medical treatment. The philosophy underlying the diagram contains significant elements. Routine care and normal interventions are documented in abbreviated methods. The documentation system shall be based on the assumption that care was provided in accordance with written standards of care, unless otherwise specified. The courts upheld this practice as long as the diagram included a check or assessment of the defendant.

Caring for the mentally ill can sometimes involve assessing and managing the risk of serious harm to both the patient and others. The terms most often referred to are "harassment" and "violence" – keywords. Violence is real physical harm. The mental care facility may be at risk resulting from the patient's behaviors that may fall under the definition of harassment or violence.

The Occupational Health and Safety Act requires staff carrying out provisional medical treatment to receive information about the risk of violence at work from the violent defendant and whether there is a risk of physical violence that may subject the nurse to physical harm.

While legislation specifies that there is a disclosure of information – disclosure of "personal information"⁵⁷ if necessary to identify/disclose risk, but legislation does not determine the type and amount of information that should be disclosed. If an individual has a history of violence, information regarding this history may be included in clinical notes and records.

„People with a history of violence" can only be included in mental health hospitals. Any history of violence, including domestic violence, shall be taken into account. In the case of staff members, the policies of the organization (hospital) will also need to address the balance between staff confidentiality and how any information can be managed. There are important HR issues that arise in situations of history of violence.

Health organizations have a number of obligations in the area of reducing incidents of violence at work, through:existence of workplace violence policies – from defendants provisionally obliged to medical treatment;conducting workplace violence risk assessments within the facility;developing violence programmes to develop evaluation policies;measures for seeking immediate assistance;violence reporting measures; investigations into workplace incidents; provision of information and training to staff; display of policies within the organisation.

While the obligations of health care organizations focus on their own employees, there are legal and ethical obligations to patients and visitors to consider.

Interactions with the police

When patients are brought to hospital by police, a number of challenges arise when leaving the patient in hospital. It is important to have communication between officers and the medical team to ensure that everyone involved can exercise their professional responsibilities in this situation.

⁵⁷ Ivan Anane, *Elements of computerized evidence of the person*, Pro Universitaria Publishing House, Bucharest, 2015

In the case of a patient in a secure psychiatric unit, special attention will need to be paid to whether police presence is required and the impact this may have on other patients.

Depending on the defendant's clinical presentation, it may be appropriate for the police to leave the hospital with the patient in the care of the clinical team, based on the judgement of the treating doctor. If it is determined that the patient requires transfer to another facility, the police may be asked to facilitate this transfer.

A clinical decision of a doctor is required for admission of a patient to the hospital. Once the decision is made to admit the patient, the facility is the legal authority to retain that patient if necessary.

It is important for all health care organizations to develop lines of communication and understanding with police and correctional officers⁵⁸.

2.3. Determination of the rights of the defendant provisionally ordered to treatment

Tragically, prisons have been becoming "psychiatric hospitals" since the 1990s. There are studies stating that 8% of prisoners suffer from severe mental illnesses such as schizophrenia or bipolar disorder. These statistics are a direct reflection of the failure of public mental health to provide adequate treatment.

Key personnel in these systems—such as police officers, prosecutors—may have limited knowledge of mental health. Moreover, the procedures, terminology and practices that characterise the justice system can be quite uncertain.

Right to appropriate medical treatment

Every defendant has the right to appropriate medical treatment, adequate medical care, including people with serious mental illness. All persons in prison are entitled to provisional treatment. Mental illness needs to be treated first and then incarcerated if necessary.

3. Role and importance of the decision of the executing court

Enforcement is the last stage of any civil dispute. It is positioned in three stages:

- Contentious institution;
- Adjudication of disputes;
- Implementation of disputes.

The implementation of disputes as enforcement can also be presented. The enforcement order may describe the functioning or conclusiveness of the judgment. The enforcement order may be determined by the court that issued the decision. In exceptional circumstances, the judgment will be enforced by another court that has jurisdiction. Enforcement may allow the holder to recover the fruits of the judgment.

The term "execution" has not been defined in the code. The expression 'execution' simply means the process of enforcement or effect on a court decision. The principles governing enforcement may also be dealt with in the Code of Civil Procedure.

Enforcement is the enforcement of an enforceable title through a judicial process that allows the title holder to reconfigure the fruits of the title and the court's decision in its favour. Enforcement is the enforcement of a judgment through a judicial process enabling the holder to realize the fruits of the decree issued by the competent court in his favour. All enforcement proceedings begin with the submission of a request for enforcement.

Request for enforcement

⁵⁸ Gheorghe Buzescu, *Place and role of the civil servant in the state apparatus*, Sitech Publishing House, Craiova, 2017

All proceedings begin with the submission of a request for enforcement. The persons who may apply for enforcement are: the holder, the legal representative of the holder, the representative of a person, the transferee of the holder of the enforcement title.

The role of the executing court's decision can be shaped by arrest and detention for the provisional execution of medical treatment.

Principles relating to the enforcement of enforcement orders

The enforcement order may be drawn up by the court that issued the decision or by another court that is competent to enforce the decision of another court, as follows: the court that issued the enforcement order may send it for enforcement to another court either at the request of the plaintiff or by the court itself; or the court may order the enforcement of an enforcement order on the application of the holder's decision – arrest and detention for provisional medical treatment; at the request of the holder of the enforcement title; all questions arising between the parties to the proceedings are determined by the executing court; where an enforceable title is adopted against a party as the 'legal representative' of a deceased person; where there may be a dispute; how the enforcement order was implemented.

It may be specified that the executing court is represented by the district court in the area of the enforcement body, domicile or seat of the debtor.

Enforcement orders are enforced using the enforcement formula – this shows the importance of the enforcement court's decision.

From our point of view, *de lege ferenda*, it would be useful to adopt legal provisions with a clearer definition of the concept of "severity of the disease", since the law does not expressly describe the nature or severity of the disease for which the perpetrator may be a danger to society. *De lege ferenda*, we also consider it appropriate to define the "concept of provisional" – its expediency or rationale. It defines what triggered the provisional issues.

A provisional condition derives from the severity of the disease.

The concept of provisional can have two components: a legal framework consisting of constitutional elements and legal bases for the provisional situation – until sentencing; an operational framework involving the organisation of the structure and strategic plans to deal with the provisional situation.

These documents must be compatible – the legal framework must take into account operational requirements and legal aspects. There must be the rule of law and respect for human rights.

De lege ferenda, I consider that a detailed desecration of the definition of 'lifting of the safety measure', with reference to the meaning of the concept of 'measure'. The positive and negative consequences of improved health can be determined.

Also, *de lege ferenda*, we consider it appropriate to create and define more clearly the concept of "safety measure". It is already outlined in the Code of Criminal Procedure – a deeper analysis of forensic expertise is required.

Also, *de lege ferenda*, we consider it opportune to modernize the expression - "medical treatment during the execution of the sentence". The duties of the Code of Criminal Procedure and compliance with international treaties can be further outlined.

We note as *de lege ferenda*, the adoption of legal provisions with a clearer definition of the concept of "state of danger" and the improvement of the elements of medical expertise for the purpose of presentation to the forensic commission.

Also, *de lege ferenda*, I consider it appropriate to outline the expression "safety measure of the obligation to undergo medical treatment" in order to outline the prosecutor's conclusions.

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