

Psychiatric ‘holds’ for nonpsychiatric patients



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Series Editor

Dear Dr. Mossman:

At the general hospital where I work, doctors and nurses sometimes ask me to fill out psychiatric “hold” documents to keep seriously ill medical or surgical patients from leaving the hospital. Last week, they asked me to stop Mr. J, a man with diabetes and a gangrenous lower leg, from leaving against medical advice (AMA). If he left, he would die. But if I filled out the psychiatric “hold,” I’d be saying the man needed civil commitment for a mental illness, which wasn’t true. If this happens again, what should I do?

Submitted by “Dr. Q”

“It is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail,” wrote Abraham Maslow.¹ The situation Dr. Q describes is one that psychiatrists frequently encounter because in some situations, a psychiatric “hold” can seem like the only way to stop a physically ill patient from leaving the hospital AMA. But pounding on this problem with a civil commitment hammer is the wrong response.

What’s wrong with using psychiatric holds in these situations? Do doctors have any other equipment in their medical toolbox for stopping an improvident AMA departure? To find out, we’ll look at:

- what a psychiatric hold does
- why holds don’t apply to medical-surgical treatment
- alternative responses to patients who lack capacity to refuse care.

Psychiatric holds

All states have laws that permit involuntary psychiatric hospitalization. The wording and procedural details in these laws vary across jurisdictions, but all states allow civil (ie, noncriminal) commitment of mentally ill persons who have gross impairments of judgment, behavior, reality-testing, or everyday functioning if their recent behavior show that they pose a danger *because of their mental illness*.² **Table 1³** lists examples of the types of dangers that are potential reasons for civil commitment.

State laws also allow certain individuals (eg, police) to apprehend and transport mentally ill persons to facilities for psychiatric evaluation. Doctors may hold these persons temporarily until a court decides whether a longer involuntary hospitalization is justified. The documents used to initiate psychiatric holds have various informal names—“5150” (California), “pink slip” (Ohio), “pink paper” (Massachusetts), “Baker Act Form” (Florida)—but their function is the same: permitting lawful restraint of patients whose dangerousness results from their mental illness.

Urgent medical and surgical care

What about medical or surgical patients who refuse care despite being told they’ll die without it? Might involuntary psychiatric hospitalization procedures be a convenient way to keep them from coming to harm?

DO YOU HAVE A QUESTION ABOUT POSSIBLE LIABILITY?



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The answer: probably not, for 4 reasons:

1. Once a psychiatric hold has been executed, the person who is subject to detention must be transferred to an *appropriate facility* within a specified period (usually 24 hours) for further evaluation and care.^{4,5} In this context, “appropriate facility” means a state-approved *psychiatric* treatment setting. A hospital’s medical or surgical unit usually would not qualify.

2. The lawful use of a psychiatric hold is to declare that someone needs involuntary psychiatric examination for dangerousness arising “as a result of mental illness”—not for danger from a nonpsychiatric medical problem.⁶ Some civil commitment statutes specify that persons who have serious nonpsychiatric illness but no mental health problems that satisfy civil commitment criteria are to be offered voluntary treatment only.⁷

3. A psychiatric hold only authorizes short-term *detention*. It does not allow forcing what patients such as Mr. J need: medical or surgical *treatment*. A psychiatric hold would not solve the problem that Mr. J’s doctors are facing.

4. Doctors who execute psychiatric holds in good faith—sincerely believing a patient meets the legal criteria—enjoy statutory immunity from later accusations of malpractice or false imprisonment.⁸ Using civil commitment mechanisms when one does not actually believe those mechanisms apply might void this immunity.

Nonconsent: 2 varieties

For present purposes, let’s think of non-consenting medical-surgical patients as coming in 2 varieties:

Variety 1: patients with compromised mental status. Often, medical-surgical patients cannot express objections to treatment because they are unconscious, delirious, or incoherent. Nurses and doctors assume such patients would want proper

Table 1

Types of risks covered in civil commitment statutes

All states
Risk of harm through self-neglect, ‘grave disability,’ or failure to meet basic needs
Risk that a person might physically injure or kill himself
Risk that a person might physically harm other persons
In some jurisdictions
Risk of physical deterioration without commitment
Potential dangerousness to property
Risk of relapse or mental deterioration
Source: Adapted from reference 3

Table 2

Evaluating the quality of a patient’s decision: 4 dimensions

1. Can the patient communicate a choice and express a consistent preference?
2. Can the patient grasp relevant information about:
 - what doctors believe is wrong?
 - the proposed treatment, alternative treatments, and their risks and benefits?
 - the consequences of no treatment?
3. Does the patient appreciate the illness and its consequences? Does he recognize he is ill and acknowledge how the information applies to his situation?
4. Does the patient use the information rationally? Can he explain his decision-making and reasoning? Does he apply information to his situation in light of rational beliefs and desires?

Source: Adapted from reference 9

care and proceed with what they believe is in the patients’ best interest, often with input from family members.

Variety 2: lucid patients who refuse treatment. Patients who do not have obvious psychiatric problems may refuse necessary medical or surgical treatment for various reasons: obstinacy, distrust of doctors, fear, ignorance, incorrect but firmly held ideas

Clinical Point

All states allow civil commitment of mentally ill persons whose recent behavior poses a danger because of their mental illness



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Clinical Point

Doctors who execute psychiatric holds in good faith enjoy statutory immunity from accusations of malpractice or false imprisonment

Table 3
Detaining a patient for medical-surgical care: 7 components of documentation

1. Description of the patient's refusal or efforts to leave the hospital
2. Patient's stated reasons for refusing or wanting to leave
3. Reasonable alternatives to discharge that were offered
4. Description of how refusing medical treatment would create a clear risk of physical harm or death
5. Evidence that the patient lacks capacity to give informed consent or to refuse treatment
6. Actions taken by the treating physician (eg, obtaining psychiatric consultation, enlisting other patient services, instituting physical restraint)
7. Person who provided consent to continue treatment and that person's relationship to patient

about body functioning, cultural differences, or religious beliefs. None of these reasons is necessarily psychopathological, and none provides justification for a psychiatric hold.

Key determinant: Competence

Refusing treatment may be a bad choice and sometimes is evidence of a mental disorder, but it is not, by itself, a mental disorder. When a Variety 2 adult patient refuses care, the key question is, "Is this a competent refusal?" Assessment of a patient's capacity to make medical decisions is not a skill unique to psychiatrists. Other specialists make judgments about capacity routinely—if only implicitly—when they elicit their patients' informed consent for care. But when, as in Mr. J's case, a seriously ill medical-surgical patient refuses lifesaving treatment, our medical colleagues often get psychiatrists involved. Consulting a psychiatrist in such circumstances makes sense, for at least 4 reasons:

- Although assessment of decision-making isn't the special province of psy-

chiatry, psychiatrists often have more experience assessing the capacity of persons whose thinking seems impaired.

- Psychiatrists also have more experience in detecting subtle indications of mental disorders (eg, mild dementia, depression, psychosis) that can compromise decision-making capacity.

• A nonpsychiatrist may believe that a patient is making a competent refusal but still wants a psychiatrist's perspective to better understand the patient's reasoning or to confirm the initial belief.

- Getting an independent opinion is a prudent way to make sure one's emotions are not adversely influencing a critical judgment about a patient's treatment.

Determining whether a patient has the requisite capacity to refuse care involves a situation-specific assessment of 4 aspects of mental functioning: expressing a choice coherently, understanding relevant information, appreciating this information, and using the information rationally. *Table 2⁹* (page 35) describes these functional areas in more detail.

If capacity is lacking, what next?

As Judge Benjamin Cardozo ruled nearly a century ago, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."¹⁰ In a case such as Mr. J's, where a patient wants to leave the hospital or refuses medical treatment despite grave risk to himself, staff members should not let him leave until his treating doctors have tried to clarify his reasons for leaving and determined whether he has the capacity to give informed consent and refuse treatment. Psychiatrists may be consulted in this process, although the final judgment about capacity rests with the responsible physician. If an assessment shows that the patient has the capacity to make medical decisions, his treatment refusal is binding, even when it creates a clear risk of death.

What should happen if an assessment shows that a gravely ill patient lacks capacity to refuse treatment? Clinicians should consult with the hospital attorney about their facility's policies and how to implement them properly.

Thinking about the possible legal implications of their actions, treating clinicians might worry that if they detain an unwilling patient without authorization from a court or guardian, they would risk being sued later for false imprisonment. But attorneys are likely to advise clinicians that they have more to fear liability-wise from letting incompetent patients leave the hospital than from detaining them for their own safety. As an Ohio court commented about a police officer who stopped a patient from leaving the hospital:

What in the name of all that is reasonable should the officer have done? The court finds that the officer acted properly under the circumstances known to him at the time—and the reasonableness of an officer's actions must be judged at the exigent split second on the street...¹¹

Rather than allowing an incompetent patient to come to harm, attorneys may advise physicians to write an order to keep the patient in the hospital. Then, physicians can obtain consent for treatment from family members, making them aware of any physical or chemical restraint that might be needed to continue the patient's treatment. Depending on the situation and the reasons for the lack of capacity, hospital staff members may later need to help a family member obtain a court's authorization

Related Resources

- Appelbaum PS. Clinical practice. Assessment of patients' competence to consent to treatment. *N Engl J Med.* 2007; 357(18):1834-1840.
- Disability Rights California. Involuntary psychiatric treatment: California's 72-hour hold and 14-day certification. www.disabilityrightsca.org/pubs/502401.pdf.
- Treatment Advocacy Center. Know the laws in your state. www.treatmentadvocacycenter.org/get-help/know-the-laws-in-your-state.

Disclosure

Dr. Mossman reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

Acknowledgment

Dr. Mossman thanks David Schwallie, Esq, for his helpful insights about the topics discussed in this article.

for emergency guardianship to allow non-urgent care to continue.

Treating physicians also should document the thinking and findings that support their actions. **Table 3** provides an outline for this documentation.

References

1. Maslow AH. *The psychology of science: a reconnaissance.* New York, NY: Harper & Row; 1966.
2. Mossman D, Schwartz AH, Elam ER. Risky business versus overt acts: what relevance do "actuarial," probabilistic risk assessments have for judicial decisions on involuntary psychiatric hospitalization? *Houston Journal of Health Law & Policy.* 2011;11:365-453.
3. Pinals DA, Mossman D. *Evaluation for civil commitment.* New York, NY: Oxford University Press; 2012.
4. Ohio Revised Code § 5122.10.
5. Oregon Revised Statutes § 426.060.
6. California Welfare and Institutions Code § 5150.
7. Florida statutes § 394.463.
8. *Cruze v National Psychiatric Services, Inc.*, 105 Cal. App. 4th 48 (2003).
9. Appelbaum PS, Grisso T. Assessing patients' capacities to consent to treatment. *N Engl J Med.* 1988;319(25):1635-1638.
10. *Schloendorff v Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92 (1914).
11. *State v Clay*, 43 Ohio Misc. 2d 5, 539 N.E.2d 1168 (1988).

Clinical Point

If a patient has the capacity to make medical decisions, his decision is binding, even when it creates a clear risk of death

Bottom Line

A psychiatric 'hold' is not the way to stop a seriously ill medical-surgical patient from leaving the hospital. If evaluation shows that a patient lacks capacity to refuse treatment, psychiatrists can encourage treating physicians to get legal help with initiating appropriate procedures for detaining the patient and furthering necessary care.