

Medical Incapacity Without Mental Illness: A Legal and Ethical Dilemma for Physicians

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ABSTRACT: Every state in the United States has passed legislation allowing a physician to hold a patient against his or her will for a limited period of time upon a finding of mental illness that renders the patient a danger to self or others. Given the troubled history of mental health treatment in the United States, the bar for an involuntary hold of this nature is necessarily high. However, in most states there is no statutory authority for how to manage cases involving patients who are not dealing with any form of mental illness, but who lack capacity to weigh medical information and make health care decisions due to their medical condition. This article examines the gap in legal authority on the issue of medical incapacity holds and reviews options for health care providers and hospitals trying to appropriately treat and protect such patients without a clear statutory road map to do so.

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Medical Incapacity Without Mental Illness

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INTRODUCTION

Every state in the United States has passed legislation allowing a physician to hold a patient against his or her will for a limited period of time upon a finding of mental illness that renders the patient a danger to self or others. The bar for an involuntary hold of this nature is appropriately stringent—health care providers cannot restrict patient freedom in the U.S. without a compelling basis for doing so, and without appropriate checks and balances in place. However, cases involving patients who are not dealing with any form of mental illness, but who are unable to weigh medical information and make health care decisions due to serious conditions and intense treatments that have limited the individual’s mental and physical abilities, continue to become increasingly common. Take for instance, the cancer patient who, depleted from her illness and the powerful nature of her treatment, becomes disoriented and attempts to leave the hospital with a disconnected nasogastric tube dangling from her body, indicating that she will take a taxi home and insisting that she will “be fine” without further medical interventions or even removal of the tube.

“It is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail.”¹ Therefore, physicians may be tempted to diagnose mental illness in such cases. However, it is not legally or ethically appropriate for a physician to render a clinically insupportable finding of mental illness to protect a patient who lacks medical capacity from grave danger. This article examines the gap in legal authority on the issue of medical incapacity holds and reviews options for concerned health care providers and the hospitals that support them.

In most states, there is no legal authority permitting a physician to issue temporary hold orders in the absence of mental illness; thus, physicians are left to navigate legally and ethically fraught situations with little guidance and no guardrails. Many physicians look to hospital counsel and ethics committees for assistance in these circumstances, but time is often of the essence, and without clear authority on how to proceed, patients with medical incapacity are at risk of being discharged “against medical advice” (AMA), even when the treating physician has determined that they are incapable of understanding the risks involved in refusing treatment.

1 ABRAHAM HAROLD MASLOW, *THE PSYCHOLOGY OF SCIENCE: A RECONNAISSANCE* (1966).

THE TYPICAL THREE-DAY HOLD BASED ON MENTAL ILLNESS

Every state in the U.S. has passed legislation that allows a physician to hold a patient against his or her will for a set period of time based on certain criteria. The language involved in defining the required components varies according to state. For example:

- Dangerousness to self or others—appear[s] in the law [of] nearly every state, although [it is] no longer as an exclusive criterion in most; defined in various ways [];
- Grave disability—part of the law in most states; generally defined as inability to provide for basic personal needs [];
- Need for treatment—required in nearly every state, either as an explicit criterion or as part of the definition [for] mental illness, and certainly contemplated in every state by commitment’s essential purpose, which is treatment; no longer an exclusive criterion for commitment in any state, except where defined to encompass risk of harm or some other commitment criterion;
- Deterioration—beginning to appear as a distinct criterion in some states’ laws, or as part of the definition of grave disability []; never an exclusive criterion; and
- Incompetence—part of the law in a few states; never an exclusive criterion.²

Regardless of the language utilized in defining these supplementary legal requirements, “mental illness” is required in every state:

Mental illness—required in every state; generally defined in terms suggesting serious mental illness (e.g., substantial disorder of thought or mood that grossly impairs judgment, behavior, or ability to negotiate demands of life), usually excluding substance use disorders, intellectual disabilities, and dementia[.]³

For example, in Alaska, a licensed physician “who has probable cause to believe that a person is gravely disabled or is suffering from mental illness and is likely to cause serious harm to self or others of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures . . . , may cause the person to be taken into custody by a peace officer or health officer and delivered to the . . . nearest evaluation facility, or treatment facility.”⁴ Here, “gravely disabled” is defined to mean “a condition in which a person as a result of mental illness (A) is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken; or (B) is so incapacitated that the person is incapable of surviving safely in freedom[.]”⁵

2 SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM: HISTORICAL TRENDS AND PRINCIPLES FOR LAW AND PRACTICE 1, 11–12 (2019), <https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf>.

3 *Id.*

4 ALASKA STAT. ANN. § 47.30.705(a) (2022).

5 *Id.* § 47.30.915(11).

However, again, the legal right of the physician to hold the patient against his or her will is predicated on mental illness: “A respondent who is delivered . . . for emergency examination and treatment shall be examined and evaluated as to mental and physical condition by a mental health professional and by a physician within 24 hours after arrival at the facility.” Only “[i]f the mental health professional who performs the emergency examination . . . has reason to believe that the respondent is (1) mentally ill and that condition causes the respondent to be gravely disabled or to present a likelihood of serious harm to self or others, and the respondent (2) is in need of care or treatment, the mental health professional may . . . hospitalize the respondent; or . . . arrange for hospitalization, on an emergency basis.”⁶

In Iowa, a person can be detained for up to twelve hours if the examining physician “finds that there is reason to believe that the person is seriously mentally impaired, and because of that impairment is likely to physically injure the person’s self or others if not immediately detained[.]”⁷ Here, a serious mental impairment must be involved, which the law describes as follows:

[T]he condition of a person with mental illness and because of that illness lacks sufficient judgment to make responsible decisions with respect to the person’s hospitalization or treatment, and who because of that illness meets any of the following criteria:

- a. Is likely to physically injure the person’s self or others if allowed to remain at liberty without treatment.
- b. Is likely to inflict serious emotional injury on members of the person’s family or others who lack reasonable opportunity to avoid contact with the person with mental illness if the person with mental illness is allowed to remain at liberty without treatment.
- c. Is unable to satisfy the person’s needs for nourishment, clothing, essential medical care, or shelter so that it is likely that the person will suffer physical injury, physical debilitation, or death.
- d. Has a history of lack of compliance with treatment and any of the following apply: (1) Lack of compliance has been a significant factor in the need for emergency hospitalization. (2) Lack of compliance has resulted in one or more acts causing serious physical injury to the person’s self or others or an attempt to physically injure the person’s self or others.⁸

To complicate matters further, although the distinction between mental and medical illness can at times be nuanced and difficult to clearly separate and define, some states, such as California, have interpreted the law to require the patient to have a condition listed in the

6 *Id.* § 47.30.710(a)–(b) (emphasis added).

7 IOWA CODE ANN. § 229.22(2)(a)(4)(a) (2022).

8 *Id.* § 229.1(21).

American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM). If the patient’s issues do not specially stem from a condition listed in the DSM, the patient cannot legally be detained under California’s emergency hold process.⁹ Additionally, other states exclude the most common conditions that create the need to hold a patient who may be dangerous to themselves or others, such as intoxication and dementia. For example, under Massachusetts’ law, mental illness does not “include intellectual or developmental disabilities, autism spectrum disorder, traumatic brain injury or psychiatric or behavioral disorders or symptoms due to another medical condition . . . or . . . alcohol and substance use disorders[.]”¹⁰ While other states, such as Florida, specifically stipulate that a patient who is experiencing an emergency medical condition, but does not have mental illness, may only be offered voluntary services or placement or be released.¹¹

Therefore, when a physician is faced with a situation in which a patient is medically incapacitated due to reasons unrelated to mental illness, he or she has no protocol to follow in holding the patient to prevent the patient from further harm or from the possibility of harming others. This leads to situations in which the physician either allows the patient to leave AMA, thereby incorrectly utilizing the state’s laws for an emergency hold based on mental illness, which may require the physician to involve a psychiatrist to diagnose the patient, or determines that the patient lacks capacity and orders hospital staff and security to detain the individual.

PROVIDER OPTIONS

This section will discuss the potential options available to physicians and hospitals faced with the need to hold a nonpsychiatric patient who lacks capacity for medical decision-making.

Allow the Patient to Leave Against Medical Advice

Physicians and hospitals have a duty to protect patients with whom a patient relationship has been established. However, the limits of this duty must be examined and defined under the specific facts and circumstances involved.

As with any liability in tort, the scope of a hospital’s duty to safeguard the welfare of its patients is circumscribed by those risks which are reasonably foreseeable . . . It is [a] hospital’s duty to protect a patient from dangers that may result from the patient’s physical and mental incapacities as well as from external circumstances peculiarly within the hospital’s control.

9 See *People v. Karriker*, 57 Cal. Rptr. 3d 412, 418 n.4 (2007) (noting that in the court’s *Lanterman-Petris-Short* (“LPS”) practice, “[t]he term “mental disorder” is limited to those disorders listed by the [DSM]” (quoting *Conservatorship of Chambers*, 139 Cal. Rptr. 357, 361 n.5 (1977)); see also *Cty. of L.A. v. Superior Court*, 166 Cal. Rptr. 3d 151, 161 (2013).

10 104 MASS. CODE REGS. 27.05(1) (2023).

11 FLA. STAT. ANN. § 394.463(2)(h) (2023).

Thus, a hospital is under a duty to exercise reasonable care to protect a patient from injuring himself or herself, and from harm inflicted by third persons. Clearly, while patients are within the care of the health care providing facility, it has a duty to protect them not just from themselves but from any injuries or harm inflicted by third parties.¹²

At the same time, the duty to protect the patient “is not boundless and does not require a hospital to guarantee the patient’s security against any possible risk, regardless of how remote.”¹³ Health care providers are “bound to exercise toward a patient such reasonable care as the patient’s known condition may require, the degree of care being in proportion to the patient’s known physical and mental ailments.”¹⁴ Hence, because health care providers must also respect a patient’s voluntary decision to unilaterally terminate the physician-patient relationship and choose to discharge themselves against medical advice, physicians are often responsible for determining the extent to which a patient’s condition warrants forceable detention against his or her will due to concerns that the patient, if permitted to leave AMA, could be harmed or could harm others.

Given the complexity of weighing and balancing the competing rights and responsibilities involved in evaluating the decision to allow a patient to leave AMA, “[m]any physicians struggle with the desire to respect the patient’s wishes to leave AMA (in general, the patient’s right to self-determination or autonomy) against attempting to do what they think is best for the patient (to act with beneficence).”¹⁵ The need to perform this difficult analysis has become more common, as the number of patients who choose to leave AMA has continued to increase. “In 1992, about 0.1% of patients seen in the Emergency Department (ED) left AMA. In the years since, this number has increased significantly[,] with recent studies showing that up to 2% of ED patients leave AMA.”¹⁶ For instance, in California, the number of ER visits that ended in a patient leaving after seeing a physician but without completing their medical care increased by 57% between 2012 and 2017.¹⁷

Failing to prevent a patient from leaving AMA can create risks for all involved— not merely for the patient in question, as noted by medical experts, “AMA discharges can be ‘quite

12 Aahren Rodriguez DePalma, *Forced Detentions—A DUTY? Restraining Patients to Prevent Injuries*, 53 No. 10 DRI For Def. 52 (2011); see also Gleason v. La. Dep’t of Health & Hosps., 33 So. 3d 961, 967–68 (La. Ct. App. 2010).

13 N.X. v. Cabrini Med. Ctr., 719 N.Y.S.2d 60, 65 (N.Y. App. Div. 2001) *aff’d as modified sub nom.* N.X. v. Cabrini Med. Ctr., 765 N.E.2d 844 (N.Y. 2002).

14 St. Francis Reg’l Med. Ctr., Inc. v. Hale, 752 P.2d 129, 132 (Kan. Ct. App. 1988); see also Hofflander v. St. Catherine’s Hosp., Inc., 664 N.W.2d 545, 561–62 (Wis. 2003).

15 David J. Alfandre, *“I’m Going Home”: Discharges Against Medical Advice*, 84 MAYO CLIN PROC. 255 (2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2664598/pdf/mayoclinproc_84_3_008.pdf.

16 Matthew DeLaney, *The Proper Way to Go Against Medical Advice (AMA): 8 Elements to Address*, ACAD. LIFE EMERGENCY MED. (Jan. 13, 2014), <https://www.aliem.com/proper-way-to-go-against-medical-advice/>.

17 Phillip Reese, *As ER Wait Times Grow, More Patients Leave Against Medical Advice*, KFF HEALTH NEWS (May 17, 2019), <https://khn.org/news/as-er-wait-times-grow-more-patients-leave-against-medical-advice/>.

a dangerous situation, both for the patient and the provider[.]”¹⁸ Studies have found that patients who leave AMA “have an increased risk of having an adverse outcome.”¹⁹ For example, “asthma patients who left AMA had an increased risk of both relapse and subsequent ICU admissions. Similarly[,] patients with chest pain who left AMA had a higher risk of myocardial infarction than other patients with similar characteristics who stayed in the ED to complete their workup.”²⁰ Moreover, “[t]he potential for malpractice litigation exists anytime an adverse event occurs after . . . [a] visit. ‘This potential increases when the encounter is not viewed by the public as ‘routine,’” according to Robert Broida, MD, FACEP. “An AMA discharge is a prime example of this.”²¹ Unsurprisingly then, patients who leave AMA are more likely to take legal action against the hospital and/or physician involved in their care. “Patients who leave against medical advice are up to 10x more likely to sue the emergency physician when compared to other ED patients. Some estimate that 1 in 300 AMA cases results in a lawsuit compared to 1 in 30,000 standard ED visits.”²²

Detain the Patient Under a Psychiatric Hold

Using a state’s psychiatric hold law to detain a patient for reasons unrelated to mental illness can create a number of issues for both physician and patient. “Twenty-two states require judicial approval for an emergency hold. In nine of these states, judicial approval is required before the admission, and whoever initiates the commitment must show probable cause before a judge or magistrate evidencing that the emergency commitment criteria have been met. In the other 13 states, judicial review and approval are required after admission.”²³ Part of this process may also involve the physician certifying or providing a detailed “description of the nature of the person’s mental illness.”²⁴ Therefore, it may be difficult to obtain judicial approval to detain the patient under a psychiatric hold in cases where mental illness is not explicitly involved and where probable cause that the criteria have been met cannot be accurately demonstrated. Further, some states require the patient to be evaluated by specialized professionals at facilities designated under the law, which may require transfer of the patient to a psychiatric hospital or treatment facility,²⁵ clearly negating the ability to hold the

18 Relias Media, *Patients Leaving AMA: Signed Forms Alone Are Not Sufficient Malpractice Defense*, ED LEGAL LETTER (Aug. 1, 2019), <https://www.reliasmedia.com/articles/144736-patients-leaving-ama-signed-forms-alone-are-not-sufficient-malpractice-defense>.

19 Matthew DeLaney, *The Proper Way to Go Against Medical Advice (AMA): 8 Elements to Address*, ACAD. LIFE EMERGENCY MED. (Jan. 13, 2014), <https://www.aliem.com/proper-way-to-go-against-medical-advice/>.

20 *Id.*

21 Relias Media, *Patients Leaving AMA: Signed Forms Alone Are Not Sufficient Malpractice Defense*, ED LEGAL LETTER (Aug. 1, 2019), <https://www.reliasmedia.com/articles/144736-patients-leaving-ama-signed-forms-alone-are-not-sufficient-malpractice-defense>.

22 Matthew DeLaney, *The Proper Way to Go Against Medical Advice (AMA): 8 Elements to Address*, ACAD. LIFE EMERGENCY MED. (Jan. 13, 2014), <https://www.aliem.com/proper-way-to-go-against-medical-advice/>.

23 Leslie C. Hedman et al., *State Laws on Emergency Holds for Mental Health Stabilization*, PSYCHIATRIC 529–535 (May 1, 2016), <https://doi.org/10.1176/appi.ps.201500205> <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201500205#F1>.

24 TEX. HEALTH & SAFETY CODE ANN. § 573.022(a)(3)(A) (2021).

25 CAL. WELF. & INST. CODE § 5150 (2023).

patient in the type of hospital facility where his or her medical, and not psychiatric, treatment needs can be met.

Additionally, most states limit the length of time a patient can be held before the patient must either be admitted for inpatient psychiatric treatment or released. For example,

Kansas requires a health care professional to evaluate the patient within 17 hours and either release the individual or initiate involuntary commitment proceedings. In Nebraska, a person who is taken into custody must be seen by a health professional within 48 hours. If the health care professional finds commitment to be medically justified, he or she will notify the county attorney, and long-term commitment procedures may begin; otherwise, the person must be released. West Virginia requires a commitment hearing within 24 hours of the person's being placed on an emergency hold.²⁶

These laws negate the usefulness of holding a patient in need of ongoing medical care and treatment to the extent that each requires prompt involuntary commitment or discharge.

Moreover, inappropriately holding a non-psychiatric patient under laws specific to mental illness could create legal liability. For instance, as discussed on page 7 regarding California law, a patient must have a mental disorder, as explicitly defined in the DSM, in order to be held under the Lanterman-Petris-Short Act (LPS Act), which is the state's law that allows patients to be detained for up to seventy-two hours for further medical and psychiatric evaluation.²⁷ Hence, holding a patient who does not have a mental disorder under the LPS Act could constitute false imprisonment.²⁸ The defining features and elements of false imprisonment vary according to state law. For both civil and criminal actions, California law defines false imprisonment as "the unlawful violation of the personal liberty of another."²⁹ In California, the "elements of a tortious claim of false imprisonment are: (1) the nonconsensual, intentional confinement of a person, (2) without lawful privilege, and (3) for an appreciable period of time, however brief."³⁰ The lawful privilege to hold a patient is only given in cases involving mental disorder; therefore, holding a patient who does not have a mental disorder would be without lawful privilege. "[C]ivil liability, whether for battery, [for] false imprisonment, or [for]

26 Leslie C. Hedman et al., *State Laws on Emergency Holds for Mental Health Stabilization*, 67 PSYCHIATRIC SERVS. 529 (May 1, 2016), <https://ps.psychiatryonline.org/doi/epdf/10.1176/appi.ps.201500205>.

27 See CAL. WELF. & INST. CODE §§ 5000-129 "This part shall be known and may be cited as the Lanterman-Petris-Short Act."

28 For example, California law specifically limits civil or criminal liability for detaining a person if . . . [t]he person cannot be safely released from the hospital because, in the opinion of the treating physician and surgeon, or a clinical psychologist . . . the person, as a result of a mental health disorder, presents a danger to themselves, or others, or is gravely disabled. For purposes of this paragraph, 'gravely disabled' means an inability to provide for the person's basic personal needs for food, clothing, or shelter. CAL. HEALTH & SAFETY CODE § 1799.111 (2023).

29 CAL. PENAL CODE § 236 (2023).

30 *Lyons v. Fire Ins. Exch.*, 74 Cal. Rptr. 3d 649, 655 (2008); *Easton v. Sutter Coast Hosp.*, 95 Cal.Rptr.2d 316 (2000).

medical malpractice is precluded insofar as the detention is “in accordance with the law.”³¹ The bottom line is that the law requires the patient to have a mental health disorder.

Holding a patient under the pretense of mental illness can also detrimentally affect the patient’s ability to receive the medical care and treatment he or she needs, resulting in his/her loss of other rights and complicating the legal conservatorship process. Patients who are detained under a psychiatric hold retain the right to refuse medical treatment. Thus, unless a court order is obtained,³² or it is an emergency situation, the physician cannot override the patient’s refusal in order to provide medical care.³³ Also, for “medically ill patients who require placement in a care facility (such as skilled nursing, residential, or rehabilitative care facilities), the presence of an involuntary psychiatric hold is often viewed as an exclusion criterion and causes complications or delays in disposition.”³⁴ Moreover, an involuntary commitment under a psychiatric hold can negatively impact the individual rights of the patient for years to come. For example, in Arkansas, having been held involuntarily for mental health treatment limits the person’s right to own a firearm.³⁵ The existence of a psychiatric hold can also cause issues and delays in the probate conservatorship process, which is often required due to the patient’s nonpsychiatric medical needs, such as in cases involving traumatic brain injury or dementia.³⁶

Make a Capacity Determination

Judge and later Justice Benjamin Cardozo ruled nearly a century ago that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body.”³⁷ In line with this foundational holding in American jurisprudence—because it is medically and ethically improper to detain a patient who is not experiencing mental illness under a psychiatric hold—physicians often resort to evaluating the patient’s decisional-capacity to leave against medical advice. Capacity, as the foundational element for informed consent, has differing definitions under various state laws. Generally speaking, “capacity refers to an individual’s ability to weigh information and make rational medical decisions. If a

31 Heater v. Southwood Psychiatric Ctr., 49 Cal. Rptr. 2d 880, 889 (1996).

32 CAL. PROB. CODE §§ 3208-8.5 (2023).

33 CAL. BUS. & PROF. CODE § 2397 (2023).

34 Erick H. Cheung et al., *The Medical Incapacity Hold: A Policy on the Involuntary Medical Hospitalization of Patients Who Lack Decisional Capacity*, 59 PSYCHOSOMATICS 169, 171 (2018), <https://reader.elsevier.com/reader/sd/pii/S0033318217301950?token=CD28C552B86257AE28119860C7ACEC0D691D4E2D4C19D20CDBAF320FE510EE55C1A7807769802DC422090A98D0FAEF79&originRegion=us-east-1&originCreation=20230508134027>.

35 ARK. CODE ANN. § 5-73-103 (2023).

36 Erick H. Cheung et al., *The Medical Incapacity Hold: A Policy on the Involuntary Medical Hospitalization of Patients Who Lack Decisional Capacity*, 59 PSYCHOSOMATICS 169, 171 (2018), <https://reader.elsevier.com/reader/sd/pii/S0033318217301950?token=CD28C552B86257AE28119860C7ACEC0D691D4E2D4C19D20CDBAF320FE510EE55C1A7807769802DC422090A98D0FAEF79&originRegion=us-east-1&originCreation=20230508134027>.

37 Schloendorff v. Soc’y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914).

person is judged to have capacity regarding a medical procedure, he or she can consent to the intervention (or refuse it); a person without capacity cannot accept or decline treatment.”³⁸ State laws often mirror this type of language. For example, in Texas, “[d]ecision-making capacity” is defined as “the ability to understand and appreciate the nature and consequences of a decision regarding medical treatment and the ability to reach an informed decision in the matter.”³⁹ Whereas “incapacitated” is defined as “lacking the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a treatment decision, including the significant benefits and harms of and reasonable alternatives to any proposed treatment decision.”⁴⁰

In practice, the process of making a capacity determination can be extraordinarily nuanced and complicated in approach.

Physicians generally do not assess a patient’s capacity in the abstract, but rather consider the individual’s capacity vis-à-vis a particular decision. In fact, many bioethics scholars endorse a ‘sliding scale’ approach that employs a higher threshold for establishing capacity as the risks of consenting to (or refusing) a particular procedure increase. Thus a confused patient in the emergency department might be found to have capacity to accept Tylenol while simultaneously lacking capacity to agree to a craniotomy. That said, the determination of capacity should not turn on whether the patient disagrees with the doctor’s recommendations. Rather, the physician must assess her ability to reason and comprehend the consequences of her decision before reaching any conclusion.⁴¹

In furtherance of this multifaceted approach, in its Code of Ethics, the American Medical Association mandates that patients who are partially impaired should still be able to participate up to the level of each patient’s unique ability to comprehend and decide in that moment. “Physicians should engage patients whose capacity is impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on his or her behalf.”⁴²

38 Charles Kersten, *The Doctor As Jailer: Medical Detention of Non-Psychiatric Patients*, 6 J.L. & BIOSCIENCES 310, 313 (2019), https://www.researchgate.net/publication/336982045_The_doctor_as_jailer_medical_detention_of_non-psychiatric_patients.

39 TEX. HEALTH & SAFETY CODE ANN. § 313.002(3) (2021).

40 *Id.* § 313.002(5).

41 Charles Kersten, *The Doctor As Jailer: Medical Detention of Non-Psychiatric Patients*, 6 J.L. & BIOSCIENCES 310, 313–14 (2019), https://www.researchgate.net/publication/336982045_The_doctor_as_jailer_medical_detention_of_non-psychiatric_patients.

42 AMA, *Code of Medical Ethics Opinion 2.1.2: Decisions for Adult Patients Who Lack Capacity* (2022), https://code-medical-ethics.ama-assn.org/sites/default/files/2022-08/2.1.2_1.pdf.

However, ultimately, determining that the patient lacks the capacity to leave against medical advice does not mean the physician can move forward in providing medical treatment, reason being just as a patient who lacks capacity cannot refuse treatment, he or she also cannot consent to receive medical treatment. Therefore, as noted by the AMA above, when a patient lacks capacity, the physician should determine whether a surrogate is available in order to facilitate holding the patient for medical treatment.

A surrogate's assent should serve as an adequate legal justification for detaining a patient. From a legal perspective, the patient is not truly being held against his will in this scenario. Since the patient lacks capacity, he can neither consent to the hold nor refuse it. The surrogate's decision is taken as the best representation of what the patient would have chosen had he been in his right mind. Consequently, the law accords the surrogate's decision the same weight as if the patient himself had made it. If the hospital holds the patient after obtaining consent from the surrogate, it is merely carrying out the patient's (imputed) wishes to the best of its knowledge.⁴³

In the common event that a surrogate cannot be located or simply does not exist, the physician is left with the option of either holding the patient with the hope that the patient will attain capacity within a matter of a few hours to a few days or resorting to the often lengthy and expensive judicial process of having a guardian appointed for the patient.

Surrogate Decision Making

In the event a physician has certified that a patient lacks capacity and is therefore no longer able to make his or her own medical decisions, there are essentially two avenues through which a surrogate decision maker may be appointed. If the patient has executed an advance directive, which come in many forms, including, but not limited to, living wills, durable powers of attorney for health care decisions, and medical powers of attorney, the advance directive will list the person whom the patient has chosen to make his or her health care decisions during the time period in which the patient is unable to do so.

The requirements of a legally binding advance directive vary based on state law. If the patient is outside of his or her home state, then the health care provider in the state where the patient is located will need to verify their state's law. Most states have reciprocity laws allowing an advance directive executed in one state to be accepted by another state. However, although this sounds simple, reciprocity laws do not always ensure that the out-of-state

43 Charles Kersten, *The Doctor As Jailer: Medical Detention of Non-Psychiatric Patients*, 6 J.L. & BIOSCIENCES 310, 314–15 (2019), https://www.researchgate.net/publication/336982045_The_doctor_as_jailer_medical_detention_of_non-psychiatric_patients.

directive will be followed “because of varying mandatory language, restrictions, and differences in how state statutes are interpreted.”⁴⁴

For example, Texas’s reciprocity law states that “[a]n advance directive or similar instrument validly executed in another state or jurisdiction shall be given the same effect as an advance directive validly executed under the law of this state[,]” but goes on to articulate that “[t]his section does not authorize the administration, withholding, or withdrawal of health care otherwise prohibited by the laws of this state.” Therefore, if the decisions outlined in the advance directive do not align with certain provisions of Texas law, then those decisions will not be enforced in accordance with the directive. Hence, a physician who is treating a patient whose advance directive is from another state will certainly want to seek help from the facility’s legal counsel or the physician’s personal counsel to ensure the enforceability of the document.

In cases where the patient has not executed an advance directive, most states have promulgated laws outlining who can step in as a surrogate decision maker. In Texas, if an adult hospital patient “is comatose, incapacitated, or otherwise mentally or physically incapable of communication, an adult surrogate[,]” in order of priority, will be chosen from the following:

1. the patient’s spouse;
2. an adult child of the patient who has the waiver and consent of all other qualified adult children of the patient to act as the sole decision-maker;
3. a majority of the patient’s reasonably available adult children;
4. the patient’s parents; or
5. the individual clearly identified to act for the patient by the patient before the patient became incapacitated, the patient’s nearest living relative, or a member of the clergy.⁴⁵

However, if the decision being made involves withholding or withdrawing life-sustaining treatment, the attending physician and one person, if available, from a similar list to that outlined above would make the decision together.⁴⁶

WHAT STATE-IMPLEMENTED MEDICAL HOLDS ACCOMPLISH

A few states have passed laws that specifically apply in situations where the use of an emergency hold based on mental illness is not legally or ethically appropriate. Often termed a “medical hold,” these laws allow patients who lack capacity for non-mental health reasons to be held against their will for a set period of time so as to prevent further injury to the patient or others. For example, in Virginia, “with the advice of a licensed physician who has attempted to obtain informed consent of an adult person to treatment of a mental or physical

44 Lesley S. Castillo et al., *Lost in Translation: The Unintended Consequences of Advance Directive Law on Clinical Care*, 154 ANNALS INTERNAL MED. 121 (2011), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3124843/pdf/nihms299001.pdf>.

45 TEX. HEALTH & SAFETY CODE ANN. § 313.004(a).

46 *Id.* § 166.039.

condition,”⁴⁷ a court or magistrate⁴⁸ may “issue an order authorizing temporary detention of the adult person in a hospital emergency department or other appropriate facility for testing, observation, or treatment upon a finding that (i) probable cause exists to believe the person is incapable of making or communicating an informed decision regarding treatment of a physical or mental condition due to a mental or physical condition and (ii) the medical standard of care calls for observation, testing, or treatment within the next 24 hours to prevent injury, disability, death, or other harm to the person resulting from such mental or physical condition.”⁴⁹

However, unless authorized by a court, the temporary detention cannot exceed 24 hours, and notably, if “before completion of authorized testing, observation, or treatment, the physician determines that a person subject to an order under this subsection has become capable of making and communicating an informed decision, the physician shall rely on the person’s decision on whether to consent to further testing, observation, or treatment.” Moreover,

[i]f, before issuance of an order under this subsection or during its period of effectiveness, the physician learns of an objection by a member of the person’s immediate family to the testing, observation, or treatment, he shall so notify the court or magistrate, who shall consider the objection in determining whether to issue, modify, or terminate the order.⁵⁰

This type of medical hold applies in the case of mental as well as physical conditions and allows the physician to legally detain the individual if the person lacks capacity to consent to or refuse treatment and to provide treatment to the patient in order to prevent the person from potential harm. It limits the provider’s ability to 24 hours or until the patient regains capacity or a surrogate decision maker becomes available. Additionally, the physician is given immunity from legal liability, as the licensed health professional or licensed hospital that administered treatment, provided testing, or detained a patient pursuant to the court’s or magistrate’s authorization “shall have no liability arising out of a claim to the extent the claim is based on lack of consent to the treatment, testing or detention.”⁵¹

47 VA. CODE ANN. § 37.2-1104(A) (2023) defines “mental or physical condition” to include intoxication.

48 See *id.* § 37.2-1103(A) (stating that “[b]ased upon the opinion of a licensed physician that an adult person is incapable of making an informed decision as a result of a physical injury or illness and that the medical standard of care indicates that testing, observation, and treatment are necessary to prevent imminent and irreversible harm, a magistrate may issue, for good cause shown, an emergency custody order for the adult person to be taken into custody and transported to a hospital emergency room for testing, observation, or treatment”).

49 *Id.* § 37.2-1104(B).

50 *Id.* § 37.2-1104(C).

51 *Id.* § 37.2-1106.

CONCLUSION AND RECOMMENDED POLICY IMPLEMENTATION

In the absence of legislative action to address this significant gap in the law in most states, hospitals and physicians are left to navigate the issue on an ad hoc basis, informally sharing best practices at conferences and through networking and mentorship in the field. It is the recommendation of the authors that each hospital develop a specific policy to address medical incapacity holds where practicable, incorporating the concepts, timeframes, and standards outlined in state law on the issue of involuntary holds of any nature, and detailing the hospital's required procedure for addressing the issue, with capacity to be evaluated by the treating physician before any discharge can be processed against medical advice.

Following the evaluation of capacity, the policy will specify that in the event the patient is found to have capacity to make his or her own medical decisions, the patient should be counseled regarding the risks of his or her refusal of treatment, and ultimately discharged "against medical advice" in accordance with the hospital's AMA policy. If, however, the patient is found to lack capacity to appreciate the risks associated with their proposed decision-making, then the treating physician, the hospital's ethics committee, and the family (if any) will enter uncharted territory regarding the appropriateness of detaining a patient who is free of mental illness and seeks to cease treatment and leave the hospital.

The language of the patient's advance directive (if any) should be evaluated in order to ascertain if it is enforceable and to determine when the surrogate's authority to make decisions begins to override the patient's ability to make his or her own decisions. Without clear authority to defer to a surrogate decision-maker, and with no statutorily permitted involuntary detention, the clinical team will be left to navigate waters fraught with potentially catastrophic consequences to the patient. Rather than leaving clinicians to navigate situations of this nature on their own, or in an ad-hoc manner during the pendency of a patient-care crisis, hospitals would be better served to map out an acceptable policy in advance to assist clinicians in traversing such murky terrain.

Policy development should include a committee comprised of at least hospital risk management, physician ethics committee leadership, hospital's legal counsel, and an interdisciplinary team of clinicians. Together, the team will need to craft a policy that carefully balances patient rights and the right to human autonomy against the health care provider's duty to provide reasonably prudent care for the patient and, of course, some consideration should be given to the potential for legal liability exposure for all concerned as next steps are taken. While claims of false imprisonment or violations of patient rights are an obvious risk to involuntary detention, there can be little doubt that a counterbalancing risk exists with respect to liability for the discharge of a patient who was documented to lack capacity for medical decision-making yet was allowed to walk out of the hospital despite foreseeable risk of death, extreme pain, suffering, and loss of function as a result of the discharge.

Ultimately, the facts and circumstances of each situation, including the likelihood and gravity of the risk(s) associated with the patient's proposed course of action, may dictate the lengths to which the hospital and the attending physician are willing to go to overrule the patient's decision-making authority. Because each unique case must inherently include an analysis of the distinctive facts and special circumstances involved, it would be beneficial for the applicable hospital policy on this matter to include a requirement that the hospital's ethics committee participate in each case.⁵²

Further, it would be beneficial for the policy to require decision-making by not only the treating clinician but a sign-off from a second clinician as well, particularly if the medical ethics committee has not been assembled due to emergency action being required.

For example, consider the case of a motorcycle accident in which the patient arrives with a head injury. The clinicians order a CT scan, but before the results are back, the patient becomes agitated and demonstrates an intent to leave without waiting for the result. In such a case, the treating clinicians may not be able to ascertain whether the patient has a brain injury that is influencing his/her decision-making capacity. Quick action would be needed in this scenario to decide whether to hold the patient involuntarily or process their departure as a competent patient's decision to leave against medical advice. A medical incapacity hold would likely be indicated in this situation in order to retain the patient a brief time, at least until the CT results come back, at which point the health care provider will be able to confidently discharge the patient if the CT reflects no capacity-limiting brain injury or, alternatively, extend the involuntary hold if the CT shows brain injury suggestive of incapacity and the patient's departure would create grave risk to the patient. In such situations, if the timing is such that the physician must decide immediately and without input from the hospital's ethics committee, it is the authors' recommendation that a second physician sign-off on such decision contemporaneous with the issuance of the involuntary hold (or as soon as practicable thereafter).

In the event involuntary detention is to be undertaken, each hospital's policy should strictly limit the duration of any such involuntary hold to closely track the statutory limitations on involuntary holds for mental health reasons because those statutes will be most analogous with respect to that state's tolerance for involuntary holds of any nature. During the hold, the patient should be treated only to the extent necessary to preserve life and function; the patient should not be forced to undergo objectionable curative or long-term treatments

52 While oftentimes emergency situations will make a full assembly of the medical ethics committee challenging, ideally, each hospital will have emergency processes in place to address this situation and obtain input from such committee or one or more of its designated on-call members before any involuntary medical hold decision is made. In lieu of that input, and when faced with time-sensitive urgent decision-making, the authors recommend that, at a minimum, a second physician be required to sign-off on any involuntary hold that is not clearly authorized by state law. In such instances, the situation may have resolved itself before the medical ethics committee can be convened. If such is the case, the authors recommend that the medical ethics committee still perform a review of the circumstances for the purposes of process and quality improvement.

until emergency judicial intervention that confirms or denies the hospital's detention of the patient has been obtained; and request for appointment of a guardian of the patient for medical decision-making purposes has been obtained. Involvement of hospital counsel in policy drafting will be necessary to ensure that state law and local court rules provide an avenue for judicial consideration of such matters on an urgent basis, and so that counsel is prepared to file necessary briefings with the court before such situations arise.

Ideally, and with appropriate HIPAA authorizations in place, family members and/or other surrogate decision-makers will be involved every step of the way as these individuals are often the first line of defense for the patient. They can de-escalate a situation by persuading the patient not to leave AMA or decline treatment, and they can participate in and attend any necessary judicial proceedings. At a minimum, the attending physician, the family members included in the patient's care, a representative from case management, and a clinician representative of the hospital's medical ethics committee should be involved, with the full ethics committee and legal counsel available for team consultations throughout the process.

With permission, this article provides a sample policy and sample decision-making flowchart, starting on page 20. The sample materials reflect the recent work of how one U.S. hospital is addressing this issue and the gaps in their state law. The hospital in question voluntarily offered to share their materials with readers of this article. The hospital is not affiliated with the authors of this article. The authors note that some components of the attached policy, such as evaluation of capacity by an advance practice provider, may not be permissible in every state.

SAMPLE HOSPITAL POLICY ON MEDICAL INCAPACITY HOLDS

Policy [#] — Medical Incapacity Hold Policy

Effective Date:

Revision Dates:

Purpose:

To establish the [Insert Hospital Entity] (“Hospital”) Policy for detention of a patient against the patient’s wishes, to be utilized in the event that a patient is incapacitated due to a medical condition that is NOT a psychiatric condition.

Every effort shall be made to obtain willing consent from the patient, from the patient’s guardian, or from the surrogate decision maker appointed by the patient on his or her advance directive.

Policy Statement:

This Policy is to provide the procedure for detaining patients who are threatening to leave against medical advice, where the patient is believed to lack decisional capacity due to a non-psychiatric medical condition and who, by leaving the Hospital, could place themselves or others at serious or substantial risk of harm.

Definition of Terms:

Medical Incapacity Hold: Detaining a patient against the patient’s will because the patient lacks decisional capacity due to a medical condition and leaving the Hospital could place the patient or others at serious risk.

Resources:

Risk Management Department
[Insert Hospital Name] Campus Security¹ Department

Policy Authority:

Chief Medical Officer

Related (Supporting) Policies:

#[Insert Policy #] — Restraint & Seclusion
#[Insert Policy #] — Discharge Against Medical Advice
#[Insert Policy #] — At Risk Patient
#[Insert Policy #] — Security Holds & Law Enforcement with Patients

¹ Some hospitals have police departments, which differs from hospital security personnel. If your hospital has a police department, you may need to reference other policies.

SAMPLE HOSPITAL POLICY ON MEDICAL INCAPACITY HOLDS (CONTINUED)

potentially place the patient and/or others at risk of harm, appropriate medical personnel will assess whether the patient lacks decision-making capacity due to: (1) a non-psychiatric illness or injury or (2) mental illness.

1. **Patient Lacks Decisional Capacity Due to Illness or Injury Other Than a Mental Illness:**

If the patient's judgment is believed to be impaired because of a non-psychiatric medical condition, this Policy should be followed.

2. **Patient Lacks Decisional Capacity Due to a Mental Illness:**

Policy [Insert Hospital Policy #], "[Insert Title of Hospital Policy]," should be followed.

B. Determination of Issuing Medical Incapacity Hold

1. A physician member of the Medical Staff authorized to write orders in the Hospital (each a "Provider"), will determine the patient's decisional capacity.
2. The patient has decisional capacity if the patient is capable of understanding the risks and benefits of the proposed treatment and the risks and benefits of refusing the proposed treatment.
 - a. Every person has decisional capacity unless it can clearly be determined otherwise.
 - b. A patient has decisional capacity if the patient is able to understand the information provided regarding a treatment decision and has the ability to appreciate the risks of leaving against medical advice.
 - c. In the case of a patient presenting a risk to others, the patient lacks decisional capacity if the patient exhibits substantial disregard for identified risk to others (for instance, a patient at risk for a seizure who intends to drive away from the Hospital).
3. Common conditions which might impact a person's decisional capacity: Traumatic brain injury or other head injuries; stroke; seizure; significant infection; shock (including extreme grief); cognitive deficiencies (including age-related and developmental disabilities); and being under the influence of drugs or alcohol.²
4. If the Provider determines that the patient lacks decisional capacity, the Provider must clearly document the Provider's rationale in support of such decision.
5. The signatures of two physicians³ should be obtained prior to (or in the case of an emergency situation, within 24 hours following) a decision to hold a patient based upon medical incapacity in accordance with this Policy.

² Incapacity due to being under the influence of drugs or alcohol is specifically addressed in involuntary hold procedures in some states. Check state law.

³ Check state law and hospital credentialing if evaluating whether any non-physician providers are qualified to independently assess capacity.

SAMPLE HOSPITAL POLICY ON MEDICAL INCAPACITY HOLDS (CONTINUED)

and the patient should be reevaluated within that period. The reevaluation period should be based on the specific circumstances (for example, if a patient is being held until test results are completed, the reevaluation should take place once the test results are completed and explained to the patient).

- 2. In no case shall the patient fail to be reevaluated at least every twenty-four hours. The Medical Incapacity Hold must be reevaluated daily to justify continuation, and the ongoing rationale for any decision to continue the Medical Incapacity Hold must be clearly documented.

D. Restraint of Patients Who Attempt to Leave While Under a Medical Incapacity Hold

- 1. If a patient attempts to leave after a Medical Incapacity Hold has been issued, the patient may be restrained according to Policy [Insert Hospital Policy #], “[Insert Title of Hospital Policy]” which requires, in each case, careful consideration of the patient’s safety and autonomy, and the use of minimal restraints required to address each situation.
- 2. Absent Hospital capacity issues preventing alternative safe options, in no event shall a person be held in excess of 24 hours in the Hospital’s Emergency Department on a Medical incapacity Hold.

Attachments:

Attachment A –Decision Algorithm

Applicability (select all that apply):

WHO: Employees Physicians Volunteers Other:

SITES: All Sites If not All Sites, check applicable sites below:

[Insert Hospital/Entity Name]

-
-
-
-
-
-
-

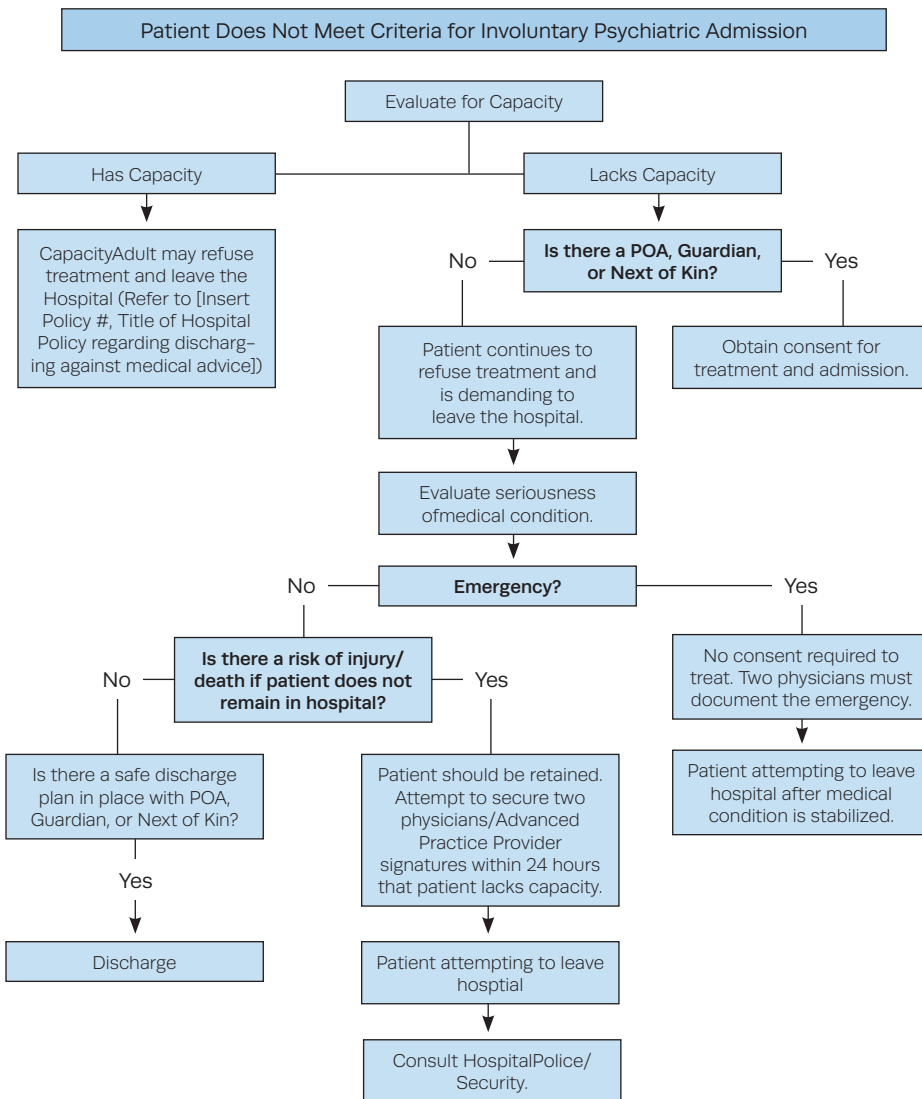
Other:

APPROVED:

President and CEO

Date

SAMPLE DECISION-MAKING FLOWCHART



HELPFUL RESOURCES

- Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice⁵³
- The Medical Incapacity Hold, University of California, Los Angeles, San Gabriel Valley Fiduciary Roundtable⁵⁴
- Capacity Decisions in the General Hospital: When Can You Refuse to Follow a Person's Wishes?⁵⁵
- Involuntary Hospitalization of Medical Patients Who Lack Decisional Capacity: An Unresolved Issue⁵⁶
- Psychiatric 'holds' for nonpsychiatric patients⁵⁷
- State Laws on Emergency Holds for Mental Health Stabilization⁵⁸
- Grading the States An Analysis of U.S. Psychiatric Treatment Laws⁵⁹
- The Medical Incapacity Hold: A Policy on the Involuntary Medical Hospitalization of Patients Who Lack Decisional Capacity⁶⁰
- Medical-legal Issues in the Agitated Patient: Cases and Caveats⁶¹

53 SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM: HISTORICAL TRENDS AND PRINCIPLES FOR LAW AND PRACTICE 1, 11–12 (2019), <https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf>.

54 Erick H. Cheung et al., *The Medical Incapacity Hold: A Policy on the Involuntary Medical Hospitalization of Patients Who Lack Decisional Capacity*, 59 PSYCHOSOMATICS 169, 171 (2018), <https://reader.elsevier.com/reader/sd/pii/S0033318217301950?token=CD28C552B86257AE28119860C7ACEC0D691D4E2D4C19D20CDBAF320FE510EE55C1A7807769802DC422090A98D0FAEF79&originRegion=us-east-1&originCreation=20230508134027>.

55 Jeff C. Huffman & Theodore A. Stern, *Capacity Decisions in the General Hospital: When Can You Refuse to Follow a Person's Wishes?*, 5 PRIMARY CARE COMPANION TO J. CLINICAL PSYCHIATRY 177 (2003), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC419388/pdf/i1523-5998-5-4-177.pdf>.

56 Nancy Byatt et al., *Involuntary Hospitalization of Medical Patients Who Lack Decisional Capacity: An Unresolved Issue*, V FOCUS 438 (2007), <https://focus.psychiatryonline.org/doi/10.1176/foc.5.4.foc438>.

57 Douglas Mossman, *Psychiatric 'Holds' for Nonpsychiatric Patients*, 12 CURRENT PSYCHIATRY 35 (2013), https://cdn.mdedge.com/files/s3fs-public/Document/September-2017/1203CP_Malpractice.pdf.

58 Leslie C. Hedman et al., *State Laws on Emergency Holds for Mental Health Stabilization*, PSYCHIATRIC 529–535 (May 1, 2016), <https://doi.org/10.1176/appi.ps.201500205> <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201500205#F1>.

59 TREATMENT ADVOC. CTR., GRADING THE STATES: AN ANALYSIS OF U.S. PSYCHIATRIC TREATMENT LAWS, <https://www.treatmentadvocacycenter.org/storage/documents/grading-the-states.pdf>.

60 Erick H. Cheung et al., *The Medical Incapacity Hold: A Policy on the Involuntary Medical Hospitalization of Patients Who Lack Decisional Capacity*, 59 PSYCHOSOMATICS 169, 171 (2018), <https://reader.elsevier.com/reader/sd/pii/S0033318217301950?token=CD28C552B86257AE28119860C7ACEC0D691D4E2D4C19D20CDBAF320FE510EE55C1A7807769802DC422090A98D0FAEF79&originRegion=us-east-1&originCreation=20230508134027>.

61 Jessica Thomas & Gregory Moore, *Medical-legal Issues in the Agitated Patient: Cases and Caveats*, 14 W.J. EMERGENCY MED. 559, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3789925/pdf/wjem-14-559.pdf>.

STATE SURVEYShort-Term Emergency Commitment Laws⁶²

62 THE POL'Y SURVEILLANCE PROGRAM, *Short-Term Emergency Commitment Laws*, <https://lawatlas.org/query?dataset=short-term-civil-commitment> (last updated Feb. 1, 2016).

Author Profiles



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