The doctor as jailer: medical detention of non-psychiatric patients

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ABSTRACT

Most states empower doctors to detain psychiatric patients if they pose a danger to themselves or others due to a mental illness; however, they do not cover patients whose mental status is dangerously altered due to a non-psychiatric illness, for example, an electrolyte imbalance. Physicians generally handle these ‘medically incapacitated’ patients by saying they lack capacity to decide to leave against medical advice. The medical and legal literature does not address the legal basis for a doctor to effectively trap a patient in the hospital. This article analyzes the laws of California to show how and under what circumstances such a detention could be justified; in doing so, it provides guidance for a legally sound policy for holding ‘medically incapacitated’ patients.

I. INTRODUCTION

Every state gives explicit legislative authority for physicians to detain a patient against his will if he poses a danger to himself or others because of a mental illness. Yet only five states empower doctors to hold a dangerous patient when his thinking has been clouded by a non-psychiatric condition. In medical parlance, this latter patient is described as ‘medically incapacitated’ indicating that his diminished decision-making is due to a medical rather than mental illness. In the 45 states lacking such laws, the supervising doctor faces a dilemma when a medically incapacitated patient insists on leaving

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1 Leslie C. Hedman et al., State Laws on Emergency Holds for Mental Health Stabilization, PSYCHIATRY SERVS. May 2016, at 531.
2 Id.; see, eg Va. Code § 37.2-1104 (2017).
3 Erick H. Cheung et al., The Medical Incapacity Hold: A Policy on the Involuntary Medical Hospitalization of Patients who Lack Decisional Capacity, PSYCHOSOMATICS March/April 2018, at 171.
the hospital against medical advice (AMA). He/she can permit him to go—potentially to serious harm, if his mind is sufficiently addled—or he/she can confine him to the hospital despite the lack of clear statutory protections for such detention. In the medico-legal literature and in the author’s own experience, most doctors will not let a patient of unsound mind leave AMA, regardless of whether his illness is mental or medical in nature. If a patient’s reasoning is impaired due to a medical condition, doctors often say that the patient lacks capacity to decide to leave AMA and so must remain in the hospital.

Missing from the literature is consideration of what legal authority might underpin a doctor’s ability to detain a patient in this circumstance. Typically, articles on this general topic simply take for granted that a physician can confine incapacitated individuals to the hospital for their own good. Others merely remark on the absence of legal authority and then look to hospital policy to fill the vacuum. While hospital rule-making committees are helpful, they cannot trump the presumption in favor of personal autonomy rooted in the American jurisprudence. If physicians are permitted to play the role of jailer, it must be in accordance with the law. The aim of this article is to examine the legal basis supporting a doctor’s ability to detain patients against their will absent explicit statutory authority.

This inquiry into the legal justification for non-psychiatric holds is not merely an academic exercise. First, if we understand the legal basis for medical holds, we can ensure that doctors are exercising that power appropriately. For example, informed of the proper legal requirements, hospitals can draft policies that require certain conditions be met before doctors can hold a medically incapacitated patient. Second, medical holds are more likely to be enforced if they have a solid foundation in the law. Although doctors order the medical hold, the task of physically restraining the recalcitrant patient will usually fall upon nurses, security officers, and other staff. These individuals are often reluctant to enforce a hold without a clear legal basis, for fear of incurring personal liability. If these medical holds have a sound legal justification (beyond simply a physician’s say-so or a hospital’s internal policy), they are more likely to get buy-in from the personnel in charge of implementing them.

Each jurisdiction has slightly different statutes, precedents, and regulations governing patient-doctor relations; thus any discussion of these issues must make trade-offs between breadth and nuance. This paper errs on the side of latter and focuses on California law. California has been influential in this area of law because its Lanterman-Petris-Short (LPS) Act has acted as a model for civil commitment procedures.

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4 Id.; Rebecca Therkelson Raines, Evaluating the Inebriated: An Analysis of the HIPAA Privacy Rule and Its Implications for Intoxicated Patients in Hospital Emergency Departments, 40 U. DAYTON L. REV. 479, 484 (2016).

5 Nancy Byatt et al., Involuntary Hospitalization of Medical Patients Who Lack Decisional Capacity: An Unresolved Issue, PSYCHOSOMATICS Sept.-Oct. 2006, at 446 (‘If a patient is believed to lack decisional capacity and wants to leave against medical advice, the medical team must take necessary steps to keep the patient in the hospital.’).

6 Cheung, The Medical Incapacity Hold, at 173; see also Douglas Mossman, Psychiatric ‘Holds’ for Non-Psychiatric Patients, CURRENT PSYCHIATRY Mar. 2013, at 37 (‘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.’).

7 Cheung, The Medical Incapacity Hold, at 171.

8 See Steven P. Segal et al., Factors in the Use of Coercive Retention in Civil Commitment Evaluations in Psychiatric Emergency Services, PSYCHIATRIC SERVS. Apr. 2001, at S14.
said, the general principles discussed in this article should have universal applicability, even if the details vary from state to state.

II. THE STATUTORY FRAMEWORK FOR HOLDING PSYCHIATRIC PATIENTS DOES NOT EXTEND TO MEDICALLY INCAPACITATED PATIENTS

Before exploring the legal justification for physicians’ power to hold medically incapacitated patients, it is worth considering why the etiology of the patient’s illness is so important. Under Section 5150 of the California Welfare and Institutions Code, certain medical professionals (and other civil officers) can hold an individual for up to 72 hours if two conditions are met. First, that individual must be a danger to himself or others, or gravely disabled (ie unable to provide for his own food, clothing, or shelter).9 Second, this danger or grave disability must be the result of a mental illness.10

Although many physicians may regard the distinction between psychiatric disorders and medical illnesses as somewhat arbitrary or even antiquated, California law has yet to adopt such an enlightened attitude toward mental health. California courts have consistently stated that a 5150 hold is appropriate only for a person suffering from a condition listed in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM).11 If the patient’s mental disturbance is due to a medical condition not listed in the DSM—such as hepatic encephalopathy, carbon monoxide poisoning, an electrolyte imbalance, or a brain tumor—the doctor cannot legally use a 5150 hold.12

If the physician were to invoke Section 5150 in such circumstances, she would expose herself to liability for the tort of false imprisonment. To prevail in such a claim, a plaintiff must show that the defendant confined the plaintiff against his will and lacked a lawful privilege which would excuse her actions.13 Section 5150 would count as a ‘lawful privilege’ only if the doctor meets its conditions, ie he/she had a reasonable belief that the source of the patient’s dangerousness or grave disability was a mental illness. If the physician believed the patient’s illness were medical in nature, she would no longer enjoy the protections of Section 5150.14 Under those circumstances, that doctor would be treated like any other tortfeasor.15

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9 Cal. Welfare & Insts. Code § 5150(a) (2017); see also Cal. Welfare & Insts. Code § 5008(h)(1) (2017).
10 Cal. Welfare & Insts. Code § 5150(a) (permitting custodial detention ‘[w]hen a person, as a result of a mental health disorder, is a danger to others, or to himself or herself, or gravely disabled’) (emphasis added).
11 People v. Karriker, 57 Cal. Rptr. 3d 412, 418 n.4 (Cal. App. 4th 2007), as modified (Apr. 20, 2007) (noting that in the court’s 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 (Cal. App. 1st 1977)); Cty. of L.A. v. Superior Court, 166 Cal. Rptr. 3d 151, 161 (Cal. App. 4th 2013).
12 Some states have followed California’s narrow definition of mental illness. See, eg, La. Rev. Stat. Ann. § 28:2(24) (defining it as ‘a psychiatric disorder which has substantial adverse effects on his ability to function and … requires care and treatment’ (emphasis added)). Others have adopted a broader perspective on the matter. See, eg, Alaska Stat. § 47.30.915(14) (defining it as ‘an organic, mental, or emotional impairment that has substantial adverse effects on an individual’s ability to exercise conscious control of the individual’s actions or ability to perceive reality or to reason or understand’ (emphasis added)). This more expansive definition of mental illness may blur into medical illnesses in some instances.
13 Lyons v. Fire Ins. Exch., 74 Cal. Rptr. 3d 649, 655 (Cal. App. 4th 2008)
14 See Heather v. Southwood Psychiatric Center, 49 Cal. Rptr. 2d 880, 889-90 (Cal. App. 4th 1996).
15 See Maben v. Rankin, 358 P.2d 681, 683 (Cal. Sup. Ct. 1961).
If the prospect of a lawsuit were not enough, other commentators have noted numerous other problems with using a 5150 hold for medical patients, such as its negative impact on discharge planning and the law’s requirement that the patient be transferred to a special facility for psychiatric evaluation. Moreover, a 5150 hold can have other legal implications, such as triggering a five-year prohibition against gun ownership.

Given the illegality of using a 5150 hold on a medical patient and the additional hindrances imposed by the law, one might question whether doctors are actually using it for medically incapacitated patients. Yet one study that reviewed the records of two hospitals’ 5150 holds concluded that 20 per cent of them were prompted by non-psychiatric conditions. This accords with the author’s own limited experience; at one hospital, the staff had coined the term ‘courtesy 5150’ to refer to a psychiatric hold requested by the internists when a medically incapacitated patient was demanding to leave AMA.

III. THE DETENTION OF MEDICALLY INCAPACITATED PATIENTS CAN BE JUSTIFIED USING STATE LAW ON CAPACITY AND CONSENT

Since Section 5150 is unavailable for non-psychiatric patients, a law-abiding doctor in California must take a different tack for these individuals. Because there is no formal statutory authorization for detaining such patients, there are much fewer procedural requirements than a psychiatric hold. In practice, the physician might merely conduct an assessment of the patient’s decision-making capacity. Assuming she concludes the patient lacks capacity, the doctor could then put a note in the patient’s file stating that he should not be permitted to exit the hospital because he cannot rationally decide to leave AMA.

In analyzing this framework, the starting point must be capacity. In simple terms, capacity refers to an individual’s ability to weigh information and make rational medical decisions. If a 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. For purposes of health care decisions, California law defines capacity as ‘a person’s ability to understand the nature and consequences of a decision and to make and communicate a decision, and … to understand its significant benefits, risks, and alternatives.’ This legal definition tracks closely with the accepted understanding of the term as used by medical practitioners.

Although the definition of capacity is relatively straightforward, its application can be more complex. 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.\textsuperscript{22} 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.\textsuperscript{23} Rather, the physician must assess her ability to reason and comprehend the consequences of her decision before reaching any conclusion.

Here, the health care decision before the patient is whether to stay in the hospital or leave AMA. In essence, this question is whether to accept a treatment. Admittedly, the treatment under issue is not a conventional one, such as going under the knife or taking a pill. Yet it is a course of action, proposed by the patient’s physician, that is designed to improve (or at a minimum maintain) his health. In its purest form this treatment may simply be keeping the patient in the hospital for observation. If the medical problem is self-limited, the chief aim may be to prevent the patient from harming himself until the illness runs its course. In other instances, detaining the patient may be the \textit{sine qua non} for other treatment that can be safely provided only in the hospital.

A patient’s incapacity is a necessary condition for a medical hold, but it is not a sufficient one. Indeed, the lack of capacity is a double-edged sword: the incapacitated patient cannot refuse treatment, but neither can he consent to it.\textsuperscript{24} Thus, determining that a patient lacks capacity to leave AMA does not automatically mean that hospital can implement a medical hold. That would be tantamount to saying that, since the patient cannot refuse treatment, he must accept it. Thus a doctor cannot support her decision to implement a medical hold on the bare fact that the patient lacks capacity.

In California, if a patient lacks capacity to consent to treatment, the decision-making authority vests in a surrogate. The rules for determining who can act as a surrogate can be complex\textsuperscript{25} and are beyond the scope of this piece. Suffice to say, whoever that surrogate decision-maker is must choose whether to accept the proposed treatment—here, confinement to the hospital. So if a patient lacks capacity to leave AMA, the hospital’s first response should not be to implement a medical hold but rather to seek consent from the surrogate.

A surrogate’s assent should serve as an adequate legal justification for detaining a patient.\textsuperscript{26} 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

\textsuperscript{22} Paul J. Moberg and Jacqueline H. Rick, Decision-Making Capacity and Competency in the Elderly: A Clinical and Neuropsychological Perspective, 23 NeuroRehabilitation 403, 404 (2008).

\textsuperscript{23} Linda Ganzini et al., Ten Myths About Decision-Making Capacity, 6 J. AM. MED. DIRECTORS ASSOC. S100, S101 (2005).

\textsuperscript{24} Leo, Competency and the Capacity to Make Treatment Decisions, at 132.

\textsuperscript{25} See Miriam Piven Cotler, Stories from the Grey Zone: Implications of Change in Advocating for Frail, Elderly and Dependent Clients, 4 Nat’l Acad. Elder L. Attys. J. 153, 158 (2008).

\textsuperscript{26} Cal. Probate Code § 4740(a) (2017); Edward W. v. Lamkins, 122 Cal. Rptr. 2d 1, 14 (Cal. App. 4th 2002) (‘[I]f the patient is a minor or incompetent, the authority to consent is transferred to the patient’s legal guardian or closest available relative.’ (quoting Cobbs v. Grant, 502 P.2d 1, 10 (Cal. Supreme Ct. 1972))).
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.

Yet all too often a surrogate is not readily available when an incapacitated patient is attempting to leave AMA. Some loners may be truly ‘unbefriended’—without any family or friends to serve that role. Or if the patient is found in an altered mental state, it may be impossible to discern who his next-of-kin or companions are. In other instances, the patient may have a clearly identified surrogate, but the doctor may not be able to contact that individual before the patient leaves the hospital premises. Normally, when no surrogate can be found, a petition must be filed to designate a guardian to make medical decisions on the patient’s behalf. In theory, this ‘medical probate’ process can be accomplished within days; in practice, many physicians find that the overburdened public guardian system can take significantly longer to appoint someone to act as the patient’s guardian. Even if one assumes an ideal timeline, a guardianship will still typically arrive too late to prevent a recently admitted patient from leaving AMA.

Apart from a handful of narrow exceptions (including 5150 holds), California law permits doctors to act without obtaining consent from the patient or a surrogate only in cases of emergency. Its definition of medical ‘emergency’ is broad. One early case describes it simply as ‘an unforeseen combination of circumstances which calls for immediate action.’ Another law defines it as circumstances in which treatment ‘is immediately necessary for the preservation of life or the prevention of serious bodily harm to the patient or others.’ Perhaps most relevant is the definition provided in California’s probate code, which describes it as a situation in which action ‘is required for the alleviation of severe pain or … the patient has a medical condition that, if not immediately diagnosed and treated, will lead to serious disability or death.’

The notion of what does or does not constitute an emergency is reasonably clear on the extremes. One has little trouble recognizing an emergency in a patient with a severe electrolyte disturbance who will likely die from cardiac arrhythmia if he does not stay at the hospital to receive intravenous fluids to correct that imbalance. Conversely, a patient who is simply befuddled because of a benign brain mass probably does not qualify as an emergency. Yet these distinctions can get blurrier the closer one examines the case. For instance, would a 1 per cent risk of a fatal arrhythmia be sufficient to warrant the designation of an emergency? And what if the patient’s benign brain tumor would not kill him, but the doctor doubts whether the patient could safely navigate home if he left AMA? The sparse language in statutes and judicial opinions leaves much to interpretation. Hammering out the precise boundaries of an emergency would require substantial case law in an area that is rarely litigated. In the absence of clarification from

27 Cal. Probate Code § 4733(b) (2017).
28 Cal. Probate Code § 3201(b) (2017); see also Cal. Probate Code § 1820 (2017).
29 Denise Connor et al., The Unbefriended Patient: An Exercise in Ethical Clinical Reasoning, J. GEN. INTERN. MED. 2016 Jan;31(1):128-32.
30 Piedra v. Dugan, 21 Cal. Rptr. 3d 36, 44 (Cal. App. 4th 2004) (‘[I]n emergency situations, physicians need not obtain consent before treating a patient.’).
31 Wheeler v. Barker, 208 P.2d 68, 73 (Cal. App. 2nd 1949).
32 Cal. Welfare & Inst. Code § 5008 (2017).
33 Cal. Probate Code § 3201(b) (2017); see also Cal. Bus. & Profs. Code § 2397(c)(3) (2017).
the legislature and courts, hospital rules committees can provide valuable guidance to their physicians.

IV. CONCLUSION
From these laws, one can glean the contours of a legally compliant policy governing medical holds. Such a policy would have four explicit requirements. First, the patient must lack capacity to decide to leave AMA. Second, that incapacity must be due to a non-psychiatric reason. If the patient’s incapacity stems from a mental illness, the doctor needs to abide by the more demanding procedures of Section 5150; she cannot sidestep them by invoking a medical hold. Third, the physician must have made a good-faith attempt to contact a surrogate decision-maker for the patient. If a surrogate is available, that person—not the doctor—must determine whether the patient be confined to the hospital. If no surrogate can be reached, then the fourth requirement kicks in: the patient’s circumstances must rise to the level of a medical emergency. Only in such dire situations does the law permit a doctor to force treatment upon a non-consenting patient.

In the author’s experience, doctors are generally already following these guidelines when ordering a medical hold. The requirement most often lacking has been a clear finding of emergency. As discussed above, the law’s definition of ‘emergency’ is slippery and subject to conflicting interpretation. Some physicians, driven by either altruism or a fear of liability, act as though the mere possibility of any injury befalling the patient is enough to support a medical hold. This approach effectively eliminates the law’s requirement of an emergency for nonconsensual treatment, because virtually every incapacitated person will be at some level of risk (however slight) if permitted to leave AMA. A hospital policy unambiguously requiring an emergency situation for a medical hold (and supported by clarifying language about what the hospital deems an emergency) would encourage doctors to treat this requirement more assiduously. I leave it to future jurists and doctors to tease out the limits of these emergencies.