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Original Research Report

The Medical Incapacity Hold: A Policy on the Involuntary Medical Hospitalization of Patients Who Lack Decisional Capacity

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Background: *Medically hospitalized patients who lack decisional capacity may request, demand, or attempt to leave the hospital despite grave risk to themselves. The treating physician in this scenario must determine how to safeguard such patients, including whether to attempt to keep them in the hospital. However, in many jurisdictions, there are no laws that address this matter directly. In this absence, psychiatrists are often called upon to issue an involuntary psychiatric hold (civil commitment) to keep the patient from leaving. Yet, civil commitment statutes were not intended for, and generally do not address, the needs of the medically ill patient without psychiatric illness. Civil commitment is permitted for patients who pose a danger to themselves or others, or who are gravely disabled, specifically as the result of a mental illness, and allows the transport of such individuals to facilities for psychiatric evaluation. It does not permit detention for medical illnesses nor the involuntary administration of medical treatments. Therefore, the establishment of hospital policies and procedures may be the most appropriate means of detaining medically hospitalized patients who lack capacity to understand the risks of leaving the hospital, in addition to mitigating the potential tort risk faced by the physician for acting in a manner that protects the patient.* **Objective:** *The purpose of this article is to identify the array of clinical and medical-legal concerns in these scenarios, and to describe the development of a "medical incapacity hold" policy as a means of addressing this unresolved issue.*
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Key words: medical incapacity hold, psychiatric hold, detainment, capacity, involuntary hospitalization.

INTRODUCTION

Hospitalized adult patients who suffer serious medical illness and who request, demand, or attempt to leave the hospital prior to the conclusion of their medical care may place themselves at grave risk for harm, disability, or death. Whether the patient is permitted to leave the hospital is generally determined by an evaluation of the following 3 factors:

1. Competency, as determined by a court of law.
2. Decisional capacity, as determined by a treating physician.

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3. Eligibility for civil commitment, as determined by an authorized evaluator (typically a psychiatrist or other mental health professional) under a state's mental health law.

Competency is a legal term referring to an individual's ability to make a specific decision regarding his or her health care, finances, or estate; or preparing a will, standing trial, or entering into a legal contract. Individuals are presumed to be competent unless a judge has concluded otherwise.[1] In contrast, decisional capacity refers to a patient's ability to rationally understand the nature and consequences of a decision, to make and communicate the decision, and in the case of proposed health care, the ability to understand its significant risks, benefits, and alternatives.[2] A patient must have capacity in order to provide informed consent about a health care decision; the primary treating physician makes the determination of capacity. Hospitalized patients who lack capacity often have suffered severe cognitive impairment or delirium from a medical condition such as traumatic brain injury, stroke, seizure, brain cancer or surgery, encephalopathy or encephalitis, or metabolic abnormalities. An abundance of literature exists regarding the evaluation of health care-related decisional capacity.[1–4] Depending on the disease and care setting, up to 40% of inpatients may demonstrate compromised decisional capacity during their stay,[3,5,6] though there is no data on what proportion of such patients attempt to leave the hospital.

When a patient, who is presumed competent, insists on leaving the hospital before the conclusion of his or her treatment, the physician is confronted with 2 main problems that are dependent on the outcome of a capacity evaluation. If the patient is found to have capacity to make the decision at hand, he or she is allowed to leave the hospital against the advice of the treating physician even if it should result in harm, disability, or death (often termed a discharge "against medical advice" [AMA]). This right of self-determination is specifically protected by common law.[7–10]

On the contrary, a dilemma occurs when a patient *does not* have capacity to understand the risks of declining medical care and leaving the hospital (hereafter termed as "medically incapacitated" patients), but nonetheless demands or attempts to leave despite significant risk (Box 1). Typically, a physician faced with this situation must choose one of three options: (1) Allow the patient to be discharged AMA, (2) request that a psychiatrist place an involuntary psychiatric hold (IPH), or (3) detain the patient without regard to specific legal statutes. Each of these decisions carries a distinct legal risk for the provider and institution. Allowing the medically incapacitated patient to be discharged AMA exposes the provider to significant liability for medical negligence or, at worst, wrongful death. In our experience, the vast majority of physicians recognize this risk, but moreover they understand their ethical and moral "duty" to safeguard the patient from harm, and seek some method of preventing a discharge AMA or elopement.[11] However, which is a better medical-legal decision: requesting the placement of an IPH or "ordering" the hospital staff to detain the patient without specific legal grounds?

As other authors have noted, psychiatrists are frequently called upon to evaluate and place an IPH in these scenarios.[12] Yet, psychiatric consultants are rightfully wary of using state mental health laws for

BOX 1–Case Vignette.

A 50-year-old male patient with no psychiatric history has been hospitalized for 20 days in the medical intensive care unit (ICU) for rapidly worsening, nonalcoholic liver cirrhosis, awaiting liver transplant. On day 21, he tells his nurse "I need to go, I am late for my meeting downtown, they've been calling me all day." Indeed, he owns a home and works as a corporate attorney. However, he is clearly suffering from hepatic encephalopathy, profoundly confused, and he has no insight regarding his medical condition. Nurses try to convince him to stay, but he leaves his room and exits the ICU. A hospital emergency "code" for an agitated patient is called, and staff stop him at the elevator. Confusion ensues about whether he can be lawfully detained in the hospital; the team calls a consult to psychiatry to assess for placement of a psychiatric hold.

The psychiatrist determines that the patient does not have a "mental illness" as defined by the state's involuntary commitment law and therefore does not meet criteria for an involuntary psychiatric hold (IPH). Instead, the patient clearly lacks decisional capacity to understand the risks of leaving the hospital and declining care as the result of his medical condition. There is consensus that the patient must be prevented from leaving the hospital as the ethically "right thing to do," but ultimately the team does not know whether it is lawful to involuntarily hospitalize such a patient, and they are unsure of the best means of accomplishing this.

involuntary medical hospitalization, as the patient in such circumstances generally does not meet the legal criteria, and the psychiatrist faces liability in falsely imprisoning a patient through the misuse of civil commitment statutes.[12] The specific criteria for placement of an IPH varies from state to state, but a review of involuntary commitment statutes across all 50 states and the District of Columbia revealed that the common criterion justifying an involuntary hold is "mental illness that results in danger to self or others." None of the statutes specifically address the involuntary hospitalization of medically incapacitated patients in the absence of a mental disorder.[13] Rather, states' mental health laws generally make a distinction between "mental" (or "psychiatric") and "medical" illness and allow the use of IPHs only for the former.

Ultimately, physicians who desire to adhere to the current interpretation of mental health statutes find that the last remaining option is to attempt to order hospital staff to detain the patient involuntarily despite the absence of laws that explicitly permit this.[12,14] We have observed that physicians, nurses, aides, and security staff have all been significantly uncomfortable with enacting such an order, again bearing the potential tort risk of false imprisonment. There is currently no identified standard of practice regarding the involuntary hospitalization of medically incapacitated patients.[12,14] To provide our physicians and staff with practical guidance in this complex medical-legal situation, we developed an institutional policy known as a "Medical Incapacity Hold" (MIH). This article aims to demonstrate the process of creating and implementing the MIH policy and model algorithm at a single academic medical center, and to define the ethical and risk management areas of concern.

METHODS

The development of our institutional MIH policy followed a quality improvement process over a span of 1 year. A broad committee of stakeholders was formed and included representatives from psychiatry, internal medicine, neurology, ethics, nursing, security, patients' rights, and administrative leadership. In the strategic planning phase, the committee thoroughly analyzed and debated the issues in Table 1 and conducted a review of both national and state law as well as existing hospital policy pertaining to mental health holds, assessment of decisional capacity, emergency medical treatment, treatment without consent, and treatment authorized by surrogate decision makers. There were no identified legal statutes or institutional policies that specifically addressed

TABLE 1. Rationale Against the Use of Psychiatric Holds for Patients Lacking Decisional Capacity Due to Medical Illnesses*

Rationale	Description
The legal criteria for a psychiatric hold are not met	The patient does not meet the criteria of dangerousness to self or other, or grave disability, *due to a mental illness*.[15*] Dangerousness due to a nonpsychiatric medical problem or lack of capacity are not valid legal criteria for a psychiatric hold.
The patient does not need a psychiatric hospitalization	Subjects detained under a psychiatric hold must be transferred to a "designated" facility (i.e., psychiatric hospital) for evaluation and treatment.[15] The medically incapacitated patient does not need psychiatric hospitalization, and such action could be detrimental.
Psychiatric holds are time-limited and involve judicial proceedings	Psychiatric holds are time-limited, and require the expenditure of administrative, physician, and mental health court time and resources for legal hearings and proceedings, which are not necessarily appropriate for medically ill patients (e.g., traveling to mental health court hearings).
Psychiatric holds do not authorize medical treatment without consent	Patients on a psychiatric hold retain the right to refuse treatment, except in the cases of court-ordered treatment[16] or emergency treatment.[17] Laws that address treatment without consent do not explicitly authorize the detainment of a patient.
Discharge planning options can be negatively impacted by the presence of a psychiatric hold	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.
Medical conservatorship applications may be complicated by the presence of a psychiatric hold	The medical team may be considering or pursuing probate (nonpsychiatric) conservatorship[18] (common for traumatic brain injury and dementia patients), which is a legal process that is distinct and separate from mental health conservatorship.[19] The presence of a psychiatric hold can create complications and delays in the legal process.

*The rationale against the use of psychiatric holds cited in this table refer to laws and procedures in the State of California, and may not necessarily apply to institutions in other states.

the involuntary detainment of a medically incapacitated patient. Several peer hospitals across the county and state were queried on this subject, and though they acknowledged the significant clinical dilemma presented in such cases, they reported an absence of any relevant policy or "standard of care" to manage them.

The committee performed retrospective case reviews of medically hospitalized patients who were placed on involuntary psychiatric holds to determine the potential frequency of meeting criteria for a MIH. Additionally, the committee reviewed data on attempted and actual patient elopements that might have been prevented by the use of a MIH. Finally, the committee performed multidisciplinary case simulations and drafted a MIH policy to define the clinical criteria and procedures by which a medically incapacitated patient should be involuntary hospitalized.

RESULTS

Institutional data from the 2 hospitals within the Health System (770 medical and surgical adult beds) prior to the development of the MIH policy demonstrated that an average of 15 involuntary psychiatric holds were placed on medically hospitalized patients each month. Three physicians independently performed a retrospective chart review of all IPHs placed over a 3-month contiguous time period. It was estimated that 1 in 5 patients would have likely qualified for a MIH as opposed to an IPH.

The institution created a MIH policy that permits an adult patient to be kept from leaving the medical center if he or she meets all of the following criteria:

1. He/she is making efforts to leave that place him/her at grave risk for serious harm, disability, or death.
2. He/she does not have the capacity to understand the risks of leaving and declining care.
3. He/she does not meet legal criteria for an IPH.

If the patient meets all of these criteria, then the patient shall be kept from leaving the medical center by order of the treating physician for a "medical incapacity hold." If the patient has a surrogate decision maker, efforts should be made to obtain his/her consent for the MIH order. If the surrogate does not consent to the involuntary medical hospitalization of the patient, and wishes to remove the patient from the hospital, the patient should be allowed to be discharged AMA with the surrogate (provided that the surrogate is of sound mind and has capacity to make this decision for the patient).

To assist providers in understanding the policy, a decision support flowchart was generated (Figure 1). The procedures of the policy addressed the following critical issues:

Urgency

In cases where the patient attempts or threatens to leave the hospital and decline care despite staffs' concern of grave risk of serious harm, disability, or death, staff should not permit the patient to leave until the treating physician (or his/her designee) has tried to clarify the reasons for leaving and has made a determination about the patient's capacity to leave the medical center and decline care.

The Role of Psychiatric Consultation and Civil Commitment Orders

If the patient has a known or suspected psychiatric illness, a psychiatric consultation should be requested to evaluate whether the patient meets the criteria for an IPH in accordance with relevant statutes.

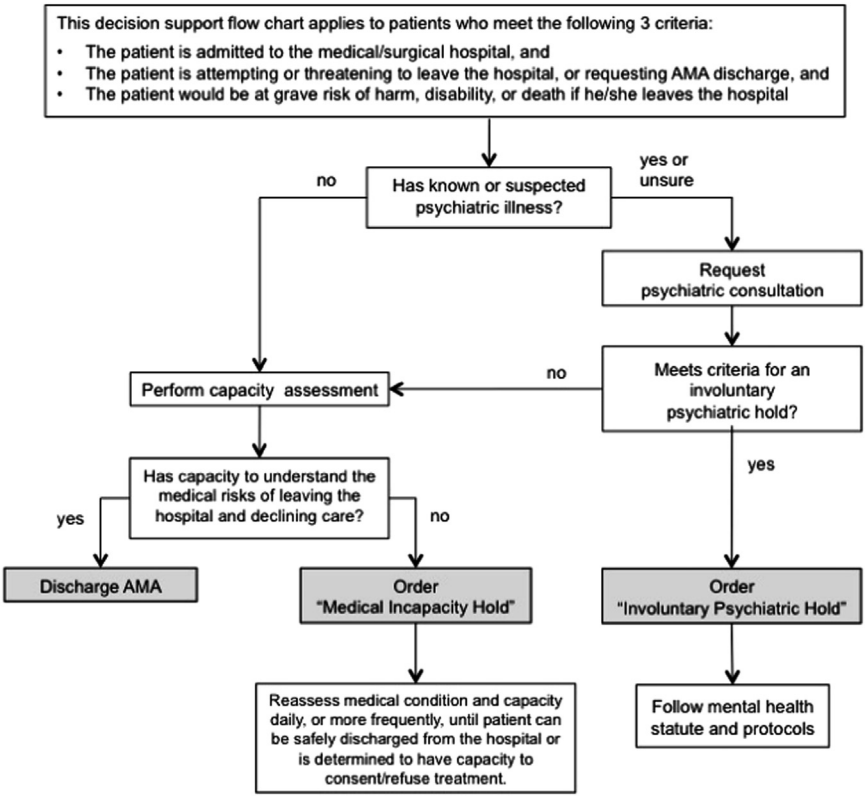
The Process of Evaluating Capacity

The primary team physician determines if the patient has capacity to leave the medical center and decline care (in accordance with the hospital's informed consent policy). A court may also determine whether a patient lacks competency to make health care decisions. Consultation by another physician for a "second opinion," may be requested to assist with capacity evaluation. The evaluation of the patient's capacity should be performed immediately, or as soon as possible, to minimize the duration of detaining a patient who might ultimately be found to have capacity to refuse treatment and leave the hospital.

Criteria for Permitting Discharge AMA

If the patient is determined to have capacity regarding the decision to leave the medical center

FIGURE 1. Evaluation Flowchart of Patients Attempting or Threatening to Leave the Hospital Despite Grave Risk.



and decline care, even if he or she may be gravely ill, the patient shall be discharged in accordance with the hospital's AMA discharge policy. Documentation should clearly articulate the patient's capacity and the rationale for this decision.

Patients' Rights

The MIH order permits hospital security and staff to detain the patient if he/she attempts to leave. The MIH policy does not authorize treatment. Acknowledging that the vast majority of patients will require ongoing medical treatment, providers are referred to the specific relevant statutes and hospital policy regarding such issues. The MIH policy does not limit any other patient rights, such as the right to have visitors or make phone calls. The patient is informed of the right to contact the patient's rights office (which has authority to request peer review) to file a grievance, or to file a complaint with the department of public health or the Joint Commission.

Duration of Order

The institution established a maximum time frame for an MIH order of 24 hours, whereupon the patient must be reassessed to determine whether he/she continues to meet criteria. Additionally, the policy requires a second physician review for appropriateness and adherence to policy in cases that are requiring an MIH for greater than 72 hours.

Documentation

The policy describes the documentation standards that should accompany an order for an MIH (Box 2):

Discontinuation

The criteria for discontinuation of the MIH are clearly articulated and include any of the following: the patient regains capacity, the patient is deemed clinically safe for discharge, or the patient has a

BOX 2–Physician Documentation Template for a Medical Incapacity Hold.

The physician ordering a medical incapacity hold should document the following:

- Evidence that the patient lacks capacity regarding the decision.
- A description of the patient's efforts or the patient's stated reasons for wanting to leave the hospital and decline care.
- A description of the clinical circumstances and anticipated outcomes, including a description of how leaving the medical center and declining care would create a clear and grave risk of harm, death, or disability.
- Reasonable alternatives to discharge that were offered.
- Actions taken by the treating physician/designee, if any (e.g., obtaining psychiatric or ethics consultation, enlisting other ancillary patient services, contacting family, instituting restraints, etc.)
- Surrogate decision maker or legal authority who provided consent to detain the patient in the hospital under the Medical Incapacity Hold order, if any.

surrogate decision maker who chooses to remove the patient from the medical center.

DISCUSSION

Physicians, including consulting psychiatrists, struggle to determine the best means of protecting the safety of the medically incapacitated patient who threatens or attempts to leave AMA and yet does not meet criteria for an IPH. The absence of decisional capacity is not a criterion for involuntary psychiatric detention and hospitalization under current state and federal laws, and the use of mental health civil commitment statutes in such cases is therefore a questionable practice, if not entirely improper.

The medical ethics principles of nonmaleficence and beneficence require that physicians take all reasonable precautions to prevent harm from coming to their patients. When patients demonstrate decisional capacity, the principle of respect for autonomy supersedes physicians' paternalism, effectively allowing the patient to make a "bad" decision such as leaving a hospital AMA. In the case vignette (Box 1), the patient does not have capacity, and therefore nonmaleficence and beneficence appropriately override autonomy. Physicians have a professional and moral duty to safeguard patients who lack capacity to understand the risks of their actions, which is a duty that cannot be simply shirked by the lack of applicable laws. Institutional guidance is necessary to delineate the policy and procedures of involuntarily detaining medically incapacitated patients, and therefore the establishment of an MIH policy fills this significant gap in clinical care.

Certain areas of controversy remain, such as the variability in how states define a "mental" illness vs a "medical" illness. For example, some states specifically include or exclude substance use disorders or major neurocognitive disorders as a "mental" illness. Other states offer no specific definition of what constitutes a "mental illness" in their statutes, leaving the distinction to be interpreted by the courts. In our experience, courts have generally upheld a narrow definition of mental disorders, finding that illnesses such as hepatic encephalopathy (cited in the case vignette (Box 1)) are "medical" illnesses to which civil commitment statutes do not apply. However, it is possible that different states, and even different jurisdictions within the same state, would apply idiosyncratic definitions and rulings. Furthermore, ethicists and medical professionals assert that the distinction between "mental" and "medical" illness is neither scientifically nor societally valid and contributes to the continuing stigma of patients suffering from these disorders.[20,21] Nevertheless, the law as currently interpreted in many states continues to use this distinction, necessitating physicians and institutions to act within these parameters.

Additionally, the distinction between "mental" and "medical" causes of incapacity represents 1 aspect of the clash between the legal paradigm and the clinical ethics paradigm. In the legal paradigm, the diminution of one's civil rights to have "freedom of movement" and to be free from "unlawful restraint" is seen as a great harm, and exceptions to this rule are specifically and narrowly crafted in order to minimize infringement (e.g., civil commitment laws are specifically limited to "mental illness"). However, in the paradigm of clinical ethics, the cause of a patient's incapacity is much less important, almost immaterial. When the overriding priority is the safety of the patient, the corresponding actions by physicians become ethically justifiable, even obligatory, especially when a patient's autonomous decision making is effaced by incapacity of any cause. The MIH serves as an element of reconciliation between these clashing paradigms,

defining physicians' and institutions' ability to act legally (avoiding improper use of IPH) and ethically (in the best interest of the safety of the patient) to the fullest extent possible.

There are potentially several ways to craft policy to aid in these situations. In our view, policies that establish the clinical grounds for an MIH should address several key factors, including delineating the process for determining if a patient is best served by psychiatric evaluation and civil commitment, by being allowed to leave AMA, or by being placed on an MIH; establishing clear criteria for the placement of an MIH; and embedding procedures that uphold and protect patients' rights. We emphasize that the MIH policy as developed by our institution is intended only to articulate the procedures to be followed for the involuntary detention of medically incapacitated patients, and the policy makes no provisions for treatment without consent (involuntary treatment), as these are separate legal and therapeutic issues for which relevant statutes and hospital policies already exist. Further study is required to understand the outcomes of implementation of an institutional MIH policy.

AUTHORS' NOTE

Authors have no conflicts of interest to report.

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