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CASE AND COMMENTARY
Psychiatrist's Role in Involuntary Hospitalization, Commentary 3
Commentary by Robert Orr, MD

Case
Psychiatrist Lisa Feinberg had been working with Suzanne Martin for 2 years. Miss Martin was referred to Dr. Feinberg by her primary care physician who suspected that Suzanne's extreme low weight was indicative of anorexia nervosa (AN). Dr. Feinberg agreed with the diagnosis of AN and began meeting with Suzanne weekly. Suzanne Martin, a 19-year-old sophomore at the state university, was an excellent student and fine musician. She managed course work, a 3-hour per day practice schedule, and a regular exercise routine with little sleep and little food. Suzanne Martin made light of what others called her "illness." She met with Dr. Feinberg mostly to keep her parents "off her back." She chatted easily with Dr. Feinberg, but the psychiatrist found it difficult to get Suzanne beyond superficial chatter, on the one hand, and deep theoretical discussions of her studies and her music, on the other hand. Suzanne avoided talking about her illness and the behaviors that must be necessary to maintain her dangerously low weight. She managed to remain just above a level of physical exhaustion and weakness that would have necessitated hospitalization.

One night Suzanne collapsed and was brought to the ER by friends over her protestations. She had received glucose and was gaining enough strength to demand to go home when her parents arrived. Her physician had been called, and he was present also. Suzanne's parents appealed to the physician to say that Suzanne was endangering her life—for all practical purposes, she was suicidal, they said—and hence should be declared incompetent to make medical decisions. Suzanne's physician had been reluctant make the declaration and had summoned to the hospital to confer about involuntary admission and artificial nutrition.

By the normally applied standards, Suzanne Martin was not incompetent to make medical decisions. She could understand the information she was given; she could analyze and measure the consequences of her refusal of treatment against an internal set of values and goals; and she could give back her decision in a coherent and consistent way. Dr. Feinberg figured that Suzanne's finely calibrated system had slipped out of control that day—a bit too much exercise or too little food. She was like a diabetic who takes too much sugar or too little insulin on a given day. One wouldn't hospitalize the diabetic against her will once physiologic balance had been restored. Dr. Feinberg feared that if Suzanne were hospitalized against her wishes and refused to eat all the food that was given her, she would be fed through

a nasogastric tube. Lisa Feinberg knew Suzanne well enough to know that Suzanne would consider this a grave and obscene violation. She thought that hospitalization and the treatment Suzanne would receive if declared incompetent would set her work with Suzanne back seriously. Suzanne might even consider Dr. Feinberg's role in the commitment so serious a betrayal of trust that she would discontinue coming for therapy.

Commentary 3

Suzanne suffers from anorexia nervosa, a chronic condition which carries some risk of life-threatening complications. However she has little insight into the condition or the dangers. An acute complication has now arisen, and her parents want her primary physician or her psychiatrist to declare her incompetent so that she may be involuntarily hospitalized and treated. Her primary physician is uncertain and requests a consultation from her psychiatrist. Dr. Feinberg, her long-standing psychiatrist, is concerned about Suzanne's safety, but she is reluctant to honor her parents' request, fearing that her participation in involuntary hospitalization might threaten her 2-year relationship with Suzanne.

Question: Is it ethically permissible, or even obligatory, to involuntarily hospitalize this patient to protect her from a potentially life-threatening condition?

Patient autonomy has gained prominence, even predominance, in contemporary medical ethics. This focus on the patient's right to self-determination has led to a consensus that it is rarely justified to impose treatment on an unwilling patient if certain conditions are met. It is almost always ethically required to allow a patient to make her own decisions if (a) she has been given adequate information to make an informed decision, and (b) professional recommendations have been made, as long as (c) she has decision-making capacity, and (d) she is not being coerced by others. It is permissible for professionals or family to try to persuade the patient, but it is not permissible to manipulate (eg, by overstating the benefits or understating the risks) or to coerce (ie, to threaten).

Are there exceptions to these criteria? It is generally accepted that a patient may sometimes be treated involuntarily if she presents a danger to herself. It is not uncommon to admit an elderly patient to a long-term care facility over her objection if it is determined that she can no longer safely care for herself. It is, however, often a difficult matter of clinical judgment to predict when a patient's current or future decisions present sufficient danger that the benefit of involuntary treatment outweighs the harm of abridged freedom. In addition, we often allow a patient to make a poor choice which presents some risk, as long as the patient understands and accepts that risk.

Primary physicians and psychiatrists not infrequently have to decide if a patient has sufficient decision-making capacity to allow autonomous decisions that carry some risk. This case narrative says "Suzanne Martin was not incompetent to make medical decisions. She could understand the information she was given; she could

analyze and measure the consequences of her refusal of treatment against an internal set of values and goals; and she could give back her decision in a coherent and consistent way." Using these criteria, some might believe that Suzanne has the capacity to refuse treatment. However, it is not entirely clear that she can "analyze and measure the consequences" because of her ongoing denial (see below). It is important to note that "capacity" is a characteristic of the patient.

It might be argued that this patient's denial has led her to make an irrational decision. Rationality (or irrationality) is not a characteristic of a person, but of a decision. An irrational decision is one that is not consistent with the patient's own goals and values. Thus a frail patient who chooses to decline nursing home admission and stay at home, placing herself at risk of a fall and fracture, is making a rational decision if she acknowledges and accepts the risk. A person of the Jehovah's Witness faith is making a rational decision if he decides to forego potentially life-saving blood transfusion based on his eternal values. However, a young man in the ED with meningitis who refuses antibiotics but says he doesn't want to die is making an irrational decision, because the choice he is making is not consistent with his goals and values. When an irrational decision has dire consequences, it is ethically justified to override that decision and treat the patient involuntarily.

Suzanne's refusal of admission cannot be considered a suicidal decision, at least not in the classical sense, since the suicidal patient wants to die. Suzanne does not want to die. She is refusing hospitalization because she believes she is not at risk. This could be interpreted as an irrational decision if her goal is to live, but her choice presents danger of death. Whether it is justified to override her autonomy and treat her involuntarily is a judgment call revolving primarily around the seriousness of the risk.

Dr. Feinberg must make a difficult decision. She must balance the physiologic benefits of involuntary admission with the harms such an action might bring to the therapeutic relationship. There comes a time when the balance tips toward the obligation to protect the patient from her own irrational decisions, but it is often difficult to determine when that time has been reached.

Recommendations:
(1) Since this is the first metabolic imbalance of Suzanne's illness and it has now been corrected, it would be acceptable for Dr. Feinberg to honor Suzanne's refusal of admission if (a) she believes continued weekly out-patient counseling will provide sufficient oversight and treatment, or (b) she has an alternative treatment plan that is acceptable to the patient. If however, she deems this collapse to be the first step down a potentially fatal course, it would be justified to involuntarily admit her for treatment.

(2) If Dr. Feinberg wants to try to maintain her relationship with Suzanne, but also feels the danger point has been reached, another option would be for her to request

a second opinion from another psychiatrist, or even to defer entirely to another psychiatrist for this critical decision.

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