Family Opposition to Psychiatric Treatment: A Medicolegal Dilemma

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Psychiatric treatment is frequently undertaken at the request of the family.[1] However, when the family opposes treatment, the psychiatrist is placed in an uncomfortable role in opposition to those usually counted on to be most concerned about the patient's welfare. Furthermore, treatment in the modern era requires that the psychiatrist consider whether it is demonstratively the "least restrictive" means for accomplishing the desired result.[2] When the family demands to take responsibility for the adult patient's care, the psychiatrist is hesitant to insist otherwise. Discharge to the family, however, may shortchange the patient. Little has been written about this issue.

Case Reports

Ms. A, a 23-year-old woman, was brought to the hospital emergency room following a seizure. She was posturing, saying that God was talking to her. A diagnosis of schizophreniform psychosis (with psychomotor and grand mal epilepsy) had been previously established. Ms. A was 28-weeks pregnant. There was evidence of inadequate prenatal care, and her seizure disorder was poorly controlled.

Recently Ms. A had been something of a nomad, frequenting diners at night and staying wherever she could. She was separated from her husband, a man of limited intelligence. Because she had neglected them, Ms. A's two children had been placed under the control of Child Welfare, and her mother was caring for them.

Ms. A had a love/hate relationship with her family of origin. She had established a pattern of brief, intense involvements with various family members quickly followed by abrupt departure when her style of escalating demands and increasingly bizarre behavior ruptured the relationship.

When family troubles beset her, Ms. A sought hospitalization. Then because of her ambivalence toward caregivers she would quickly sign out, against medical advice, usually with her mother's support. For a brief time, Ms. A's mother would take an active role in her treatment, dictating her medication and dosage schedule, until she tired of the patient's many problems.

This time Ms. A was once more hospitalized at Western Psychiatric Institute and Clinic (WPIC). In the hospital her behavior ranged from childlike and clinging to demanding and litigious. Despite treatment she had

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two grand mal seizures with postictal confusion and incontinence of urine.

The hospital staff was initially unsuccessful in attempting to elicit family involvement in Ms. A's care. Finally Ms. A received the "message" that God was opposed to her further hospitalization, and she demanded to be discharged. Because we believed there was considerable danger to her fetus (Ms. A's seizure disorder remained in tenuous control) and because Ms. A's behavior remained erratic, involuntary commitment was sought and was granted by the court for a period of 90 days. Since the hospital is permitted to provide only about 25 days of acute care for committed patients, plans were made to transfer Ms. A to a state facility.

Ms. A then called her mother who, with other family members, traveled to the hospital from a neighboring state and demanded that Ms. A be discharged. There followed a series of angry meetings between the family and hospital officials. Because Ms. A's family was strongly opposed to her continued hospitalization and because the family promised to help care for her, it was decided to discharge Ms. A to their custody. A detailed letter was given to the family outlining Ms. A's treatment needs, which the family was to deliver to Ms. A's local physician.

Ms. A remained in the custody of her family for only seven days. Once away from the family, she again experienced seizures requiring hospitalization and was readmitted to WPIC with essentially the same problem as before. No court action was taken during this brief second hospital stay, and Ms. A eventually gave birth to the baby in another state. The infant, however, died two months after delivery of "crib death."

One year later Ms. A was brought to the WPIC emergency room because of bizarre behavior. She was pregnant again.

Ms. B, a 35-year-old unemployed woman, was admitted to WPIC by involuntary civil commitment after she physically assaulted her sister's children and threatened suicide. Psychiatric history was consistent with a diagnosis of paranoid schizophrenia for which she took Fluphenazine irregularly.

After hospitalization she became more cooperative and agreed to go to voluntary status, but then changed her mind again and wanted to leave. In the meantime a medical work-up had revealed the strong possibility of a pituitary mass eroding the sella turcica. Ms. B responded with indifference and inappropriate laughter. She declared that whatever happened was "up to God" and felt that she would be more comfortable at home. She said that she would pursue further medical treatment once out of the hospital. In the past, her compliance with medical care had not been good.

A major factor in solidifying resistance to further treatment was the appearance of a brother-in-law who wanted Ms. B to leave the hospital so she could stay at his house and babysit when he and his wife (Ms. B's sister) went out. Unfortunately, the children requiring babysitting were the ones she had assaulted. Despite this, the brother-in-law began to call the ward staff daily to demand release of the patient. He reiterated that she was needed at home to care for the children. He was not receptive to appeals for

his support for continued hospitalization.

By this time the acute phase of Ms. B's illness had subsided, and she had demonstrated a superficial understanding of her medical situation. Furthermore, she remained opposed to continued requests to stay, so that the staff, which had decided to forego additional legal efforts, was obligated to discharge Ms. B against medical advice.

As a final measure, a letter was prepared summarizing her medical status including recommendations for follow-up care. A copy of the letter was sent to her home by registered mail. It was returned one week later with a notation that Ms. B had moved and left no forwarding address.

Ms. C, a 78-year-old retired librarian, became quite confused and disoriented at home and was brought to the hospital by a friend. During the initial interview she stared straight ahead and was non-verbal. When questioned, she spoke with a quavering voice about being a little girl who did bad things and about being a sinner who was "punished in hell." Much of her talk was irrelevant and tangential. She had many somatic delusions and made a host of comments about hearing various noises. She did surprisingly well on some of the mental status questions; for example, she knew the year, the president, and the president's home state. She identified the place as Western Psychiatric Institute and Penitentiary.

Medical investigation, which included an EEG and CT Scan, was negative. She was taking an anti-cholinergic medication but there was no clinical improvement when it was discontinued.

Later it was discovered that Ms. C had had a course of ECT thirty years previously. She had one relative, a physician-brother, who lived in a distant state. Ms. C and her brother were the survivors of a very large family where there was a history of premature death before age sixty.

In the hospital the patient's clinical condition had not improved. She remained delusional and fearful. During an interview with a consulting psychiatrist and attorney, she quite spontaneously declared "I am afraid of shock." This was followed by some extensive semi-delusional material concerning ECT. At the same time the treatment team had been considering ECT, but all subsequent attempts to discuss the issue with her proved futile. Every time the question was directly raised, she voiced irrelevant thoughts or became agitated saying that "the box was put on your head to blow out your brains." She admitted to hearing voices crying "die, die."

Because of the difficulty obtaining informed consent, an attempt was made to discuss the matter with the patient's brother. He stated that Ms. C had said that she never wanted to have ECT again, and he adamantly refused to give any form of approval for the procedure. Furthermore, the clinical team was completely unsuccessful at engaging her in additional discussion of the risks and benefits of such treatment.

The attending physician felt that it was senseless to go any further (for example, court-appointed guardian) without family approval, therefore, the issue of ECT was dropped. Subsequently Ms. C was transferred to a state hospital.

Discussion

These cases illustrate several medicolegal dilemmas. The right of the child to be well born has been discussed previously.[3,4] Legal guardianship and the right to refuse treatment has also been analyzed extensively.[5,6] Little has been written, however, about the rights of the family during psychiatric treatment of a member, yet family concerns are often paramount in such matters.[7,8] Families often bring patients in crisis to the attention of psychiatrists. If the psychiatrist disagrees with the family's request for treatment, they may consider him or her irresponsible and make unreasonable demands that he or she must resist. If the psychiatrist agrees with the family, they will consider him or her an expert.[9]

The present cases, however, illustrate the other side of the coin; that is, what can happen when the psychiatrist overvalues family requests—requests that may not be in the best interests of the patient or of others.

Family support and cooperation is important for providing continuity of care of psychiatric patients. Under the protective wing of the family, some patients who might otherwise require hospitalization may instead be treated as outpatients. In the well known Supreme Court case, *O'Connor v. Donaldson,* psychiatrists were criticized for failing to discharge a patient to friends who were willing to provide a home for the patient.[10] The preferences of family and friends must, for both therapeutic and legal reasons, therefore be carefully considered if hospitalization is contemplated. Unfortunately, however, for a variety of pragmatic and psychological reasons, some families cannot meet (and may even undermine) the treatment needs of their members. However paternalistic the idea, the psychiatrist is at times unavoidably the "guardian of last resort" for the patient.[11] This is an uncomfortable position for the psychiatrist; psychiatric paternalism expressed simultaneously both toward adult patients and their families requires fortitude. Such paternalistic behavior, however laudatory, may subject the psychiatrist to psychological assault by others (for example, being reported to a higher authority, verbal abuse, threats to professional identity). Yet, just as the psychiatrist should withstand inappropriate requests of family members to hospitalize patients, psychiatrists should also oppose requests of families that hospitalized patients be discharged when it is clear that the family is acting contrary to the patient's best interests. In either case, if the psychiatrist fails to resist, he or she may unintentionally collude in the covert task of helping the family ignore the reality of the situation.

In retrospect, Ms. A and Ms. B probably should not have been discharged. The case of Ms. C involves more complex issues. A recent APA task force report on ECT recommends obtaining informed consent from relatives when the patient is incompetent.[12] However, when that is impossible the situation becomes problematic, particularly in light of the latest court trends toward greater patient autonomy in treatment matters.[13,14]

These cases demonstrate the wisdom of involving the court when there are disagreements among the psychiatrist, the patient, and members of the

patient's family concerning the propriety of treatment or continuing treatment. Just as courts now decide whether a family's request for hospitalization of a member is compatible with medical necessity, perhaps they (or other more neutral persons out of the clinical chain of command) also should review whether family recommendations against continued treatment are compatible with the adult patient's best interests. The least restrictive environment, even within the bosom of the family, is not always the most beneficial environment either for the patient or for others.[15,16]

References

1. McGarry AL, et al: Civil Commitment and Social Policy: An Evaluation of the Massachusetts Mental Health Reform Act of 1970. Rockville, MD. NIMH Center for Studies of Crime and Delinquency, DHHS Publication No. (ADM) 81-1011, 1981
2. Pa. Stat. Ann. Tit. 50 §7102 (Purdon Supp. 1982-83)
3. Ament M: The right to be well born. J Leg Med 2:18-23, November/December 1974
4. Soloff P, Jewell S and Roth LH: Civil commitment and the rights of the unborn. Am J Psychiatry 136:114-115, 1979
5. Isenberg EF and Gutheil TG: Family process and legal guardianship for the psychiatric patient: A clinical study. Bull Am Acad Psychiatry Law 9(2):128-139, 1981
6. Mills MJ and Gutheil TG: Guardianship and the right to refuse treatment: A critique of the Roe case. Bull Am Acad Psychiatry Law 9(4):239-246, 1981
7. Hibler M: The problems as seen by the patient's family. Hosp Community Psychiatry 29:32-33, 1978
8. Vogel W and Peterson LE: Comment on Massachusetts law governing management of the mentally ill. Massachusetts Physician Sept. 23-25, 1976
9. Scott RD: Cultural frontiers in the mental health service. Schizophrenia Bull 10:58-73, 1974
10. O'Connor v. Donaldson, 422 US 563 (1975)
11. Roth LH, in McDonald MC: Patients rights—a psychiatrists' view. Psychiatric News 15:29-30, Nov 7, 1980
12. Task Force Report 14: Electroconvulsive Therapy. Washington, DC. American Psychiatric Association, 1978
13. Brooks AD: The constitutional right to refuse antipsychotic medications. Bull Am Acad Psychiatry Law 8(2):179-221, 1980
14. Appelbaum PS: Limitations on guardianship of the mentally disabled. Hosp Community Psychiatry 33:183-184, 1982
15. Perr IN: President's message: the most beneficial alternative: a counterpoint to the least restrictive alternative. Bull Am Acad Psychiatry Law 6(4): iv-vii, 1978
16. Appelbaum PS: Least restrictive environment: some comments, amplification. Hosp Community Psychiatry 31:420, 1980

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