

Temporal Competency in Catatonia

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A catatonic patient without known relatives or advance directives faced possible death without electroconvulsive treatment (ECT). The authors describe using medication to restore capacity to permit the patient to give critical history and consent to potentially life-saving treatment. Even had a proxy been available, the jurisdiction in which he fell ill forbade substituted judgment for ECT, permitting only recipients themselves to consent. While emergent ECT was not specifically forbidden in this jurisdiction, a full curative course presumably could not have been administered without some form of consent. Thus, the intervention prevented a treatment delay while the court was petitioned and also avoided having to insert a judge into the doctor-patient relationship. This case focuses on a specific condition, medication, and jurisdiction, but it outlines a general paradigm of pharmacologic intervention to restore temporary capacity. We encourage physicians to identify situations in which medication can create temporary "lucid intervals," thereby restoring patient autonomy and self-determination that would otherwise be lost to proxies or courts of law.

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We report a case in which medication was used to restore capacity temporarily in a catatonic patient whose identity was essentially unknown and whose legal status for definitive treatment was in limbo. At the time the events in this case unfolded, both authors were active-duty Air Force psychiatrists. Because of an administrative oversight, the patient's military records contained no information about his next of kin. Despite his steadily worsening condition (i.e., unresponsive to oral benzodiazepines during several days of inpatient hospitalization) we were legally forbidden from administering the indicated electroconvulsive therapy (ECT) to this incompetent patient until he could give written consent.

Texas, the jurisdiction within which our case unfolded, is among 20 states that require a court determination of incompetency before ECT can be administered without a patient's informed consent.¹ Only in an emergency can ECT be given, and then not a full course. Patients in all of these states may wait weeks for legal proceedings to unfold before receiving treatment they would be given immediately if they had the capacity to consent.

Although catatonia was once thought to be a manifestation of schizophrenia and thus responsive to neuroleptic therapy, contemporary investigators

consider it to be a syndrome that can be associated with psychotic illness, affective illness, or diverse medical conditions.^{2,3} Multiple reports from the past two decades describe neuroleptic drugs causing or worsening catatonia, particularly when the catatonia is a component of Neuroleptic Malignant Syndrome or Lethal Catatonia.^{4–7} The treatment of choice is thus lorazepam, oral or intravenous, followed by ECT if lorazepam fails to yield lasting improvement.^{2,3} Reports from the 1960s and 1970s describe prescribing the neuroleptics thioxanthene or phenothiazine for catatonia in schizophrenia, but current practice discourages such use because of the risk of worsening the patient's catatonic condition, particularly when its origin is uncertain.^{8,9}

In a 1998 article in *Psychosomatics*, Bostwick and Masterson¹⁰ reported several cases of restored capacity and predicted that other applications would emerge as physicians became familiar with this paradigm and applied psychopharmacological approaches to ethics dilemmas involving delirious or comatose patients. They reported the cases of four critically ill patients facing high-risk but potentially life-saving procedures whose wishes about heroic treatment were unknown. All four patients were delirious. Three patients who had undergone transplantation were given flumazenil and one patient with a heart condition haloperidol, with the goal of producing clear enough mentation for them to tell their treaters how they wished them to proceed. In all four cases, the opinions expressed while of tempo-

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rarily sound mind broke treatment impasses caused when proxies or treating physicians lacked data on the patient's wishes and could not agree on whether to perform the procedures.

A literature search at that time revealed no articles advocating the approach of restoring capacity to create ethical windows of opportunity for preserving individual autonomy. We have since discovered an example in the burn literature of taking advantage of just such windows to ascertain mortally injured patients' wishes when loss of capacity is anticipated. In a 1977 article in the *New England Journal of Medicine*, Imbus and Zawacki¹¹ described their burn center's approach to maintaining "autonomy for burned patients when survival is unprecedented." In the hours after a burn so severe that in the burn center staff's opinion a patient could not survive it, it was their center's practice to elicit aggressively the patients' wishes for care during the "lucid interval" before they slip into the inevitable coma that ensues "hours to a day after the burn." Staff seized this temporal opportunity to permit a patient about to lose capacity the opportunity to outline desired interventions. Thus, "guilt-ridden families" or "paternalistic" staff were spared from making decisions that "voiceless and vulnerable" incompetent patients might not themselves have chosen.

We believe the approach we took to our patient in a catatonic state combined features of both the Bostwick and Masterson¹⁰ and Imbus and Zawacki¹¹ reports. Lorazepam induced capacity in the catatonic patient, just as flumazenil and haloperidol did in the delirious ones. Once capacity was restored, the goal was to use this window of opportunity—just as Imbus and Zawacki did—to garner critical biographical and legal information in anticipation of an ensuing lapse into unresponsiveness. In a recent *American Journal of Psychiatry* editorial advocating working with the severely mentally ill to maximize their capacities to consent to research participation, Appelbaum opined that a "way of protecting people's rights and interests is to help them make decisions for themselves" (Ref. 12, p 1488).

In our case, with a patient no longer eating and unresponsive due to catatonia, our most pressing concern was to respond to a potentially life-threatening emergency. We needed a method to extract enough information from the patient to locate his family members and notify them of his illness. To protect his autonomy, we also had to evoke adequate

capacity for him to give consent so that we could proceed with appropriate treatment for his psychiatric condition.

Case Report

A young adult male was brought to our military hospital's emergency department by his sergeant because of inability or unwillingness to respond to his superiors.* During his initial examination, he appeared alert but bewildered. He responded to commands, but verbal replies were limited to one or two words, and it was not possible to discern his degree of orientation. He made good eye contact and denied by headshake having any history of similar problems or prior psychiatric care. He also denied any family history of psychiatric care. He acknowledged that his sleep had recently been poor and his appetite only fair. He denied suicidal or homicidal ideation but admitted later that these had been present earlier. He did not reply when asked about depressive or psychotic symptoms. He could not give the identifying data necessary to contact family members or other sources of collateral history.

Inexplicably, military records contained no information about next of kin. His medical records revealed no significant medical problems, and he was taking no medications and had no known drug allergies. Vital signs were within normal limits, and physical examination was unremarkable other than for his minimally responsive mental state. Neurologic examination was nonfocal. A screening panel of laboratory tests and complete blood count revealed no positive findings.

The examining resident assumed that the patient's brief answers were either a manifestation of anxiety or malingering to avoid a return to work. The doctor administered lorazepam (2 mg intramuscularly), after which the patient was able to give additional history. He complained of confusion and agitation, and expressed fear at his recent inability to speak normally. He also admitted to dread at having to return to his unit. Examiners failed to ask him for information about how to reach his parents.

Within two hours of the lorazepam injection, he relapsed into an essentially unresponsive state, and was admitted to the psychiatry unit. Over the next several days, his condition gradually worsened. He

* The Mayo Clinic Institutional Review Board reviewed this case study and found it to be approvable research.

ceased speaking altogether, and although he appeared to move his eyes in response to questions, he showed no other reaction. Although muscle tone and reflexes were normal, he evidenced minimal spontaneous movement. He was no longer continent and stopped feeding himself. His affect was flat, and he exhibited posturing, negativism, and waxy flexibility. Catatonia was diagnosed, and a course of ECT was recommended as first-line treatment.

At this point, the treatment team still had no means of contacting parents or other family. The patient was unable to consent to ECT. Even if next of kin had been available, they would not have been permitted under Texas law to give permission for ECT. Although the patient was hospitalized in a military facility on a federal reservation, the military lawyers had advised that Texas law applied. Texas Health and Safety Code 313.004 (Consent for Medical Treatment) specifically states that “a surrogate decision-maker may not consent to electroconvulsive treatment”, and that the only person who can consent is the patient himself.¹³

Five days after admission, the patient no longer opened his eyes either spontaneously or in response to painful stimuli. In hopes of reversing his catatonia long enough to interview him, he was moved to the Medical Intensive Care Unit and given intravenous lorazepam totaling 3 mg over a 10-minute period. His catatonic state almost immediately dissipated. He sat up, began to cry, and spoke of how he missed his parents and thought he was “going crazy.” He described awareness of his catatonic condition, and implored his examiners not to allow him to revert to that state of confusion with its perceptual distortions, persecuting hallucinations, and inability to respond to the environment about him. His interviewers decided to seize this opportunity to assess his capacity to consent to ECT.

During the next two hours, three psychiatrists separately interviewed him. He was able to paraphrase explanations of the risks and benefits of ECT and alternative treatments. He reasonably answered questions such as, “what is ECT for?” and “why would we want to give you this treatment?” He repeatedly said he wanted ECT. He also provided the correct names, address, and phone number of his parents in a distant state. All examiners agreed that he demonstrated, at least temporarily, the necessary understanding and judgment to consent to ECT. Within hours he had returned to a catatonic state.

Once contacted, his parents concurred with his decision to have ECT. Over the next three days, he received daily bilateral treatments resulting in near complete resolution of his catatonic symptoms. What emerged, however, was a mixed manic picture, with paranoid ideation, ideas of reference, inappropriate jocularity, and hypersexuality. Treatment with risperidone (1 mg, once a day) and fluoxetine (20 mg, once a day) was begun and continued with every-other-day ECT treatments. After 15 treatments over four weeks, the patient was able to be discharged to his parents’ care with normal kinetics and speech, and resolution of his affective and psychotic symptoms. His discharge diagnosis was bipolar disorder, manic (provisional).

A follow-up phone call three months later found him living with his parents and employed full time. He remained euthymic, without psychotic or catatonic symptoms, and his only medication was risperidone (1 mg, at bedtime).

Discussion

An existing model for recording treatment wishes in advance of a capacity-robbing medical condition is the advance directive (AD) or living will. “The use of advance directives is recommended so that people can determine the medical care they will receive when they are no longer competent,” write Danis *et al.* (Ref. 14, p 882). With this tool, patients who presently possess capacity record their wishes for how they wish to be treated should they become incompetent. Mentally intact at the time the AD is executed, they create a record resembling a will to be referred to in the future. When used appropriately, however, the AD is “limited to situations in which patients are considered hopelessly and terminally ill, not when aggressive treatment could return them to useful existence” (Ref. 15, p 2265). To pen ADs, patients must be able to anticipate disease processes that will kill them after first robbing them of their mental faculties.

Obviously, this tool is not of use in those who have not foreseen or cannot anticipate their incompetent state. It rarely applies to those who have had accidents or illnesses rendering them temporarily incompetent—patients who are frequently young and not expecting to be at risk for death. Nor does it fit particularly well conditions such as organ failure or certain mental disorders that were uniformly fatal in an

era before heroic measures such as transplantation or emergency treatments such as ECT were available.

Our patient epitomizes the context in which ADs are largely irrelevant. The patient was young. His catatonia could not be anticipated. With treatment, his condition would not likely be terminal and his unresponsive state not permanent. His case is analogous to those in the series reported by Bostwick and Masterson,¹⁰ in which it is assumed that the patient will regain capacity after treatment is provided. These cases emphatically do not represent the end-of-life decision-making for which ADs are tailor made.

In a situation in which there is no AD and a patient is incompetent, Lo *et al.* advocate that “clinicians follow wishes that the patient had previously expressed when competent” (Ref. 16, p 1613). The patient must have stated his or her wishes for this scenario to work, and those to whom he stated them must be known. Add to this the legal proscriptions in some jurisdictions for proxies to give permission for certain treatments, and the need for a new approach becomes even more apparent.

In the paradigm we propose, therefore, capacity becomes an entity that should be actively retrieved. Not only must examiners assess the degree of capacity, but they should also consider whether patients assessed to lack adequate capacity could regain it, at least for a while. Although we believe it is always best to do what can be done to maximize the patient’s participation in treatment planning and decision-making, the added urgency in certain cases comes from having to restore capacity long enough for legal or ethics hurdles to definitive treatment to be overcome. One of the advantages of restoring capacity stems from its preservation of the doctor-patient relationship without having to insert a judge into that relationship. In the specific case of administering ECT to an incompetent patient, restoring capacity also avoids a legal quagmire “so cumbersome it discourages any practical application” (Ref. 17, p 661).

Typically, the delirium that is a manifestation of an underlying medical process will remit as that derangement responds to treatment. Incapacity is commonly a component of the course of delirium, and its reversal is a marker of successful treatment. When treating the underlying condition is not in question,

vanquishing the delirium, even temporarily, is not a prerequisite to treatment. With a patient such as ours, however, in whom the treatment is considered heroic or is legally restricted, it cannot be administered without his competent participation. Catatonia is a condition for which ECT is the treatment of choice,^{18–20} and yet we were unable to administer it to him because of the neuropsychiatric effects of the very condition for which he needed it.

By any criteria, our patient’s situation was emergent. Citing case law and statutes, Parry²¹ states that two conditions must be present to constitute an emergency: (1) a patient too incapacitated to participate in decision-making; and (2) a life-threatening condition demanding immediate treatment. Yet not all jurisdictions permit ECT to be deployed in an emergency. Forty-three states have some sort of ECT regulation, but there is no national legislative standard.¹ In at least 6 of the 11 large states in one survey, ECT could not be administered emergently because there were no legal “allowances for obtaining timely consent in clinical emergencies” (Ref. 22, p 1353). Twenty states require a court determination before ECT can be given without the patient’s consent.¹

For almost any other medical or surgical condition, treatment delivered by physicians acting in good faith in emergencies is protected—even expected. Not so with ECT. Writing specifically about ECT, Culver and colleagues²³ declare that a next-of-kin proxy is the next best thing when mental incapacity prevents a patient from speaking for him- or herself. Yet, since a series of 1970s court opinions, numerous jurisdictions have specifically forbidden use of proxy in ECT, lumping it with lobotomy, aversive conditioning, “or other unusual or hazardous treatment procedures” (Ref. 24, p 294). Physicians using it without specific consent from the patient can be charged with battery,^{1,25,26} even when they have been able to persuade hospital administrators and legal advisors to share potential liability for permitting its deployment in their facility.

Although Texas is not one of the jurisdictions that explicitly forbids emergent ECT, it explicitly forbids surrogate decision-makers from consenting to ECT on behalf of incompetent patients. In the absence of a means to restore capacity even if ECT is begun emergently, it thus becomes mandatory in certain situations to petition the court for permission to ad-

minister a full course of ECT if the patient does not quickly regain capacity. As numerous observers have pointed out, there is no relief for inevitable treatment delays, because legal time is not medical time.^{21,27} Roy-Byrne and Gerner²⁷ reported a series of four cases in California that illustrate this distinction. Although California law requires a competency hearing within three days of petitioning the court, a petition cannot be filed until a temporary conservatorship is established, a process that usually takes weeks.¹ In their series, securing permission took 22 days and 24 days and when a special effort was made by the physician and family to obtain a rapid hearing, only 14 days. The fourth patient died after “repeated procedural difficulties” over several months failed to garner legal permission to proceed with ECT for her medication-refractory mania.²⁷

The dilemma is between the conflicting professional and philosophical perspectives and goals in law versus medicine. The law values personal autonomy and emphasizes application of abstract ideals in a deliberative process meant to maintain “procedural perfection no matter how long it takes to reach a decision,”²⁷ while medicine champions the expedient administration of medical care and the alleviation of suffering, even when paternalistic liberties may be taken with patients.²² One way out of the physician’s dilemmas is to do whatever it takes to maximize capacity in patients, thus reducing the need to involve the law in the medical arena. Neither legal nor medical authorities question the right of competent patients to decide their care. Restoring capacity thus becomes even more critical for medical providers to consider when cumbersome and time-consuming judicial procedures expose patients to the potential for suffering unnecessarily and expensively—even dying—before permission is granted for the treatment of choice.^{27–29}

Conclusion

This example of the use of lorazepam in a catatonic patient expands the literature on using psychopharmacologic treatment to restore mental capacity. We advocate that physicians consider, in other potentially reversible states of mental incapacity, creative deployment of the pharmacologic armamentarium, with the goal of inducing a “lucid interval.” The resultant opportunity to elicit critically ill patients’ opinions about their treatments will preserve their

autonomy and right to self-determination when they would otherwise be at the mercy of proxies or courts of law, with the associated inevitable delays in receiving medical treatment.

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