

# On Being 'Too Crazy' to Sign into a Mental Hospital: The Issue of Consent to Psychiatric Hospitalization

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**This article examines the notion of informed consent to psychiatric hospitalization. While dicta in a recent U.S. Supreme Court decision, *Zinerman v. Burch*, has stimulated considerable interest in applying informed consent to psychiatric hospitalization decisions, there are no extant cases that define the contours of the doctrine in the hospitalization context. The potential scope of disclosure and the level of decision-making capacity sufficient for valid consent are examined. A model of consent to admission recommended by the American Psychiatric Association Task Force on Consent to Voluntary Hospitalization is critiqued.**

Individuals suffering from mental illness may face difficulties in providing legally effective consent: serious psychiatric disorders impair the mental faculties necessary for understanding and rational thought. As a consequence, psychiatrists are often confronted with patients who seek care, but have diminished cognitive capacities or seriously impaired judgment; thus, whether or not adequate consent has been given for treatment is a pervasive concern. The problem is most acute at the time of hospital admission, when patients are likely to be in distress, suffering the more severe effects of mental illness, and least able to

participate in lengthy or involved consent processes.<sup>1</sup>

In spite of the problematic nature of psychiatric patients' consent at admission, provisions for voluntary hospitalization have existed since 1881.<sup>2</sup> At present, all states but one—Alabama—have statutory provisions for voluntary status.<sup>3</sup> Used sparingly in its earliest days, voluntary admission procedures have been employed with increasing frequency in recent years. Voluntary patients now account for half of all admissions to public mental hospitals; admissions to psychiatric units in general hospitals are overwhelmingly voluntary, accounting for more than 80 percent of admissions.<sup>4</sup>

The problem of obtaining adequate consent to voluntary hospitalization has

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elicited little concern over the past century. In part, this is a result of consensus on the value of the voluntary admission process. Also, voluntary admission statutes were enacted, and practices established, in an era well before the elaboration of the doctrine of informed consent, which sets more demanding consent requirements for all forms of medical treatment than had been previously required.<sup>5</sup> Even after the emergence of the informed consent doctrine, its application to the treatment of the mentally disabled was delayed.<sup>6</sup> Finally, and to date, informed consent has not been applied to hospitalization decisions in general. Anecdotal reports indicate that psychiatric patients in most jurisdictions are allowed to admit themselves voluntarily regardless of the severity of psychopathology and impaired decision-making capacity.

The voluntary admission process has become the focus of scrutiny in the wake of the U.S. Supreme Court's ruling in *Zinerman v. Burch*,<sup>7</sup> which permitted a Federal civil rights action to be filed by a Florida man who alleged that he had been incompetent to give informed consent to hospitalization as specified by that state's law. Although the issue decided by the Court concerned a technical aspect of procedural law—and the Court declined to rule on the Constitutional adequacy of Florida's statute governing psychiatric hospitalization—the majority opinion contains language that seems to call into question the practice of permitting virtually all assenting patients access to the voluntary admission process. Dicta in the Court's opinion have

brought to the fore the issue of consent to psychiatric hospitalization and the appropriate contours of legal regulation of the process.

The Court's decision in *Zinerman v. Burch* raises puzzling and controversial issues of constitutional analysis, especially the meaning of "liberty interest" in the context of non-objecting psychiatric admissions and the relationship of state law concepts of "voluntariness" and the requirements of due process. It is not the aim of this article to sort out these controversial issues. Rather, this article takes as a given the emergence of a legal requirement (*perhaps* constitutionally required under the *Zinerman* decision) of "informed consent" as a prerequisite to voluntary psychiatric admission.

Already, policy makers in some jurisdictions, eager to comply with the Court's ruling, have prescribed that voluntary admissions should be used only for patients able to give "informed consent." This approach appeals to policy makers because no change in statutory language is required: adoption can be accomplished merely by issuing directives to admitting clinicians to obtain informed consent to voluntary hospitalization.<sup>8</sup>

In the rush to respond to the Court's decision, the puzzle at its core has been passed over: what is meant by informed consent to psychiatric hospitalization? This puzzle arises in part as a result of the dual meanings attached to the term "informed consent." On the one hand, informed consent describes an ethical principle: patients should be full partic-

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ipants in medical decision making, and physicians should strive to maximize patients' autonomy in this realm. In this sense, the term "informed consent" may be used—and inserted into statutes and regulations—to connote respect for patients' rights and to signal that patients' values will be held in high regard. As with other ethical principles, informed consent in this sense is open-ended and aspirational: practitioners are to do their best to promote patients' autonomy. As such, this meaning of informed consent is not readily translated into standards and is not useful in adjudicating legal disputes regarding consent. On the other hand, informed consent also refers to a legal doctrine which specifies *minimal* obligations (rather than expansive ethical aspirations) for obtaining a valid consent. As a legal doctrine, the animating goal of enhancing patient autonomy has necessarily been shaped and limited by practical problems, the goal of providing care, and problems of proof.<sup>9</sup>

Significant legal consequences turn on the precise formulation of the informed consent doctrine. Although many patients will make better-informed medical decisions if "informed consent" is legally required, those who are unable to meet the demands of the doctrinal standard will be categorized as incompetent. As a result, they will not be respected as autonomous agents and will be denied the prerogative of making health care decisions for themselves. Thus, as informed consent standards are made more rigorous, greater protections are extended to the autonomy interests of competent patients; but a greater

number of patients will experience total loss of decision-making autonomy because they fail to meet the standards and are deemed incompetent. Among psychiatric patients seeking voluntary admission, it seems probable that minor changes in standards will result in large swings in the number found to be competent to consent.

While the literature has addressed consent to hospitalization from academic and empirical perspectives, clinicians remain concerned about the practical impact of changing current practices. Foremost among their concerns is the fear that some patients will not meet standards for competence to consent to hospitalization, but will also fail to meet commitment standards. These patients, likely to be among the most impaired, would be in a Catch-22: in need of treatment, but denied access as a consequence of their illness.

Because so much is at stake, it is generally acknowledged that the selection of a standard turns on complex moral and policy judgments.<sup>10</sup> To date, there has been some discussion of how one aspect of the informed consent doctrine—the requirement that the patient be competent—should be applied to psychiatric admission.<sup>11</sup> However, there has been no discussion of the appropriate contours of the other dimensions of the informed consent doctrine—the scope of disclosure and voluntariness—in this context.

This article examines the implications of an informed consent model in the context of voluntary psychiatric admissions. In the first section of this paper, advantages and disadvantages of the vol-

untary admission process are described. In the second section, a strong version of informed consent to psychiatric admission is described; this section examines the scope of disclosure, the degree of decision-making capacity necessary to consent, and protections against coercive intrusions on voluntariness. In the third section, a weaker form of informed consent is described and found to be better suited to fulfill the values underlying the principle of informed consent. In the final section, the framework constructed in this article is used to critique a recent proposal for reform.

### **Voluntary Admission: Benefits and Critiques**

***The Advantages of Voluntary Admissions*** The voluntary admission process is valued because it is believed to promote therapeutic goals: 1) informal admission practices encourage patients to seek help quickly, when illnesses are less advanced and more likely to be treatable<sup>12</sup>; 2) patients who voluntarily seek treatment are more committed psychologically to its outcome, with corresponding improvements in compliance with treatment and efficaciousness of hospitalization<sup>13</sup>; and 3) voluntary admissions avoid legal proceedings that may damage patients' trust in their doctors and impair the development of a working relationship.<sup>14</sup> In addition to therapeutic goals, to the extent that prospective patients are capable of making meaningful choices regarding hospitalization, autonomy is maximized by accepting their decisions to enter the hospital. According this respect to patients'

decisions also serves dignitary interests: patients are treated on par with other medical patients and are spared publicity about private affairs associated with a judicial hearing. Voluntary admission processes are also economical; delays and costs attendant to court proceedings are eliminated.

***The Disadvantages of the Voluntary Admission Process*** Criticisms of voluntary admission policies can be categorized as follows.

***Autonomy.*** Voluntary hospitalization has included some individuals who cannot be said to have made a meaningful choice to seek psychiatric care. Mr. Burch, the litigant in *Zinerman* is an example; the available evidence indicates he believed that he was entering heaven when he consented to hospitalization.<sup>15</sup> This level of understanding does not vindicate notions of personal autonomy; choices flowing from such gross misconceptions need not be respected.

In addition, research indicates that some patients are pressured into signing into the hospital as an alternative to facing criminal charges or involuntary commitment; they are not truly making a voluntary and autonomous decision.<sup>16</sup> It has been reported that some institutions employ voluntary admission to avoid the cost and inconvenience of commitment hearings, bringing pressure to bear on patients to become nominally voluntary patients.<sup>17</sup>

Finally, statutory release procedures may transform voluntary admissions into involuntary ones. Most states have statutory provisions which require pa-

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tients to give notice (typically three days) before they must be released. Many patients agree to enter the hospital uninformed about these procedures.<sup>18</sup> Because discharge delays entail sacrifice of a significant measure of personal liberty, patients should be fully informed about release procedures before consenting to hospitalization. Patients considering hospitalization may alter decisions on the basis of this potential loss of freedom. Even if decisions would not be altered, failure to inform individuals offends their dignity.

*Quality of Care.* Capable patient involvement in the informed consent process serves as a check on physicians' decision-making and enhances the quality of care. To the extent that psychiatrists inappropriately admit patients—as a result of incentives to overutilize hospitalization or of poor clinical assessments—patients are called on to understand the basis of the decision, to correct any factual misunderstandings, and to exercise independent judgment as a check against unnecessary hospitalization.<sup>19</sup> Patients' ability to perform this checking function may be seriously impaired at the time of admission to a psychiatric hospital.

Following admission, inappropriate treatment may be administered in order to preserve institutional order or as a result of substandard clinical practices. Patients deficient in ability to understand the basis of treatment and to assess independently its quality are at risk of receiving improper treatment. One empirical study suggests that among chronic, voluntary patients, inappro-

priate treatment may be prevalent and more frequently associated with patients who have serious impairments in abilities related to decisional competence.<sup>20</sup>

*The Informed Consent Model: The Strong View* Informed consent doctrine can be broken down into three components: information, competence, and voluntariness.

*Standards of Disclosure* The physician's obligation to disclose information is framed as a legal standard. For example, language from one leading decision mandates that all information "material" to the reasonable patient's decision be conveyed.<sup>21</sup> Courts have interpreted such broad (and potentially all-encompassing) language more narrowly; physicians are bound to disclose the risks and benefits of the proposed treatment, treatment alternatives, and their risks and benefits.<sup>22</sup> There are no cases that define the relevant information to be disclosed regarding medical or psychiatric hospitalization itself (as distinct from the treatment to be administered in hospital).

Courts in some jurisdictions look to professionals to define the standard of disclosure. Although there are no empirical studies in this area, there is general acknowledgement that the prevailing practices of admitting physicians—across the spectrum of specialties—do not conform to an informed consent model. For example, physicians do not routinely describe the adverse consequences of hospitalization: falls, mistaken administration of medications, altercations with other patients, acquired infections, etc. Therefore, there is no

standard that can be adapted to the specific context of psychiatric hospitalization. A recent APA task force that addressed consent to psychiatric hospitalization noted that patients' decision-making capacity should be assessed after admitting psychiatrists have "disclosed sufficient information to maximize the patient's opportunity to understand the decision"; however, the task force did not elaborate further what information was entailed in the disclosure.<sup>23</sup> Thus, adoption of an informed consent approach to hospitalization would require courts or legislatures to take the lead in identifying areas of disclosure and relevant risks and alternatives.

A wide range of information has been identified in the literature as relevant to an informed decision regarding psychiatric admission.

***Waiver of Rights*** Patients are entitled to know that they are giving up the right to contest hospitalization and are thereby waiving a variety of legal protections associated with commitment, including the right to a hearing by an impartial decision maker, the right to representation, and a hospitalization decision based on commitment criteria.<sup>24</sup> This conceptualization is modeled after the criminal justice system, which requires defendants to explicitly waive specified rights when exercising choices implicating liberty interests. For example, a defendant pleading guilty must understand he is waiving his right to a jury trial.

***Restricted Right to Be Discharged*** Patients who voluntarily enter the hospital unknowingly accept some risk

of future loss of liberty. Because personal liberty may be at stake, according to a strong view of informed consent, patients should be told about discharge procedures, including the possibility that discharge may be sought by the patient before the physician recommends it; the right to request a discharge under these circumstances; the ensuing procedures and waiting periods; and the risk that involuntary commitment would result. Furthermore, if the admission is transformed into an involuntary one, other legal disabilities may result; patients should understand this at the time they voluntarily enter the hospital. For example, the patient should be told that he may come to disagree with treatment recommendations, the ensuing procedures in that jurisdiction for adjudicating treatment refusal, and the risk that involuntary treatment may result.

***Risks*** Some commentators have identified stigmatization as a dimension of informed consent to psychiatric hospitalization.<sup>25</sup> Under a strong view of informed consent, clinicians might be required to tell patients about the likelihood of stigmatization and its probable consequences, e.g., loss of job.

***Competence*** It is recognized that decision-making abilities vary along a continuum. A Presidential commission, charged with studying legal and ethical dimensions of informed consent, suggested that the level of decision-making ability necessary to make a medical decision entailing minimal risk should not be set as high as that required for high-risk decisions.<sup>26</sup> The President's Commission indicated that policy goals are

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best served by this model of consent: the autonomy of patients and health-related goals are maximized. When patients choose a given treatment, individual autonomy is promoted; and health goals are furthered by honoring the decision, even when decision-making capacity is impaired. When the stakes are high—particularly when the patient seeks to ignore the recommendations of the treating doctor—then a higher level of decision-making capacity should be required.<sup>27</sup>

One commentator has suggested that the sliding-scale framework may be deployed to understand the *Zinerman* dicta as calling for a high level of decision-making capacity. According to this analysis, because hospitalization entails serious risks to patients (stigmatization, loss of liberty), the U.S. Supreme Court implicitly recognized capacity to provide informed consent as a constitutional prerequisite for voluntary admission in the *Zinerman* case.<sup>28</sup>

**Voluntariness** Voluntariness of consent is difficult to operationalize or ascertain. One approach is competence-related: patients who can understand the nature and consequences of their decisions can check coercive influences.<sup>29</sup> But concerns about the voluntariness of consent to psychiatric hospitalization cannot be so easily addressed. The threat of involuntary commitment may lead patients to become nominally voluntary patients. Empirical evidence indicates that some facilities will bring pressure to avoid the cost and inconvenience of commitment hearings.<sup>30</sup> Since most patients are aware of civil commitment, no

decision they make can be uninfluenced by fear of commitment. This argument, carried to its logical conclusion, would lead to elimination of the voluntary admission process.

**The Informed Consent Model: The Weak View** In this section, the strong version of informed consent is scrutinized closely. The expansive disclosure required by a strong version of informed consent is found to be incompatible with established law. Reliance on a high degree of decision-making capacity is analyzed and found to be inconsistent with established norms of competence to consent. Voluntariness problems prove to be complex and unlikely to be resolved by reliance on informed consent. A strong version of informed consent for psychiatric admissions is rejected as incompatible with the values underlying informed consent: maximization of the well-being and autonomy of patients. A weaker version of informed consent is described that more fully satisfies these goals.<sup>31</sup>

### Clinical Limitations on the Scope of Disclosure

Considerable attention has been paid to the clinical process of obtaining informed consent and maximizing patients' understanding. The President's Commission Report called for clinicians to adopt a flexible approach, in which disclosure of information is tailored to the capacities and circumstances of the individual. In order to effect maximum understanding, informed consent should be viewed as a process requiring multiple interchanges between doctor and patient

over time. Relevant areas of information should be introduced when appropriate to the clinical circumstances, with greater elaboration of detail over time, in keeping with the patient's understanding of more basic information and consonant with their ability to assimilate new data.<sup>32</sup>

Any reasonable modification of the current voluntary admission process must take into consideration the clinical context in which hospitalization decisions are made. Patients seeking admission have acute psychiatric symptoms and often urgently need and desire treatment. Prior discussion of hospitalization is often not possible: the admitting psychiatrist may be encountering the patient for the first time. In addition, acute psychiatric hospitalization predictably involves individuals with significant cognitive impairment whose capacities are further diminished by distress. In these circumstances, an elaborate informed consent process is likely to be ineffective. Patients are not motivated (and may have impaired ability) to attend to extensive disclosure of information unrelated to the immediate problem of alleviating distress. In the absence of a prior doctor-patient relationship, discussion of treatment should necessarily be tentative: psychiatrists will not be sufficiently familiar with patients' concerns and prior knowledge to convey other than essential information about hospitalization.<sup>33</sup> It would be unwise to require psychiatrists to provide unfamiliar patients with extensive, standardized disclosures about hospitalization, not informed by or shaped within the context of an on-

going doctor-patient relationship. Patients may be distressed by artless efforts to provide information, and therapeutic interventions may be dangerously delayed.

### **Policy Limitations on the Scope of Disclosure**

What information, other than the fact of hospitalization itself, should be transmitted at the time of admission in order to achieve sufficiently informed consent? The doctrine of informed consent has evolved from paradigmatic cases involving discrete interventions, such as treatments and diagnostic procedures. The disclosure requirements that have emerged have an implicit logical structure: they promote the efficient transfer of professional expertise from doctor to patient.<sup>34</sup> Consider disclosure requirements for typical, discrete medical interventions. These procedures and treatments have risks, alternatives, and outcomes, described formally and, in many instances, empirically in the clinical and research literature. Relevant information can be readily identified in the literature by clinicians, who can then summarize and disclose it to patients. This information is medical in nature, arising directly from clinical conditions or treatments. Indeed, mastery of this technical data forms the foundation of physicians' professional expertise. If questions about decision-making capacity arise, clinicians can test their patients' understanding of this information. If disputes arise, the clinical literature serves to guide courts in deciding whether standards of disclosure were met.<sup>35</sup>

Thus, anchoring disclosure to medical information serves the primary purpose of informed consent: to facilitate the sharing of specialized medical information with patients. This also serves as an inducement to clinicians to stay abreast of the field.

Disclosure of non-medical information has not traditionally been a requirement under the doctrine of informed consent. That is, physicians are not required to "disclose" psychosocial consequences of treatments. Consider, for example, a patient who must have a leg amputation. The surgeon is responsible for disclosing the inherent risks of amputation, such as infection and hemorrhage. But we would not expect the physician to tell the patient that his employer may fire him—perhaps unlawfully—or that he may encounter people who will make fun of his condition.

We encounter a formidable obstacle when we turn to disclosure of information relevant to psychiatric hospitalization: there are no known medical or psychiatric sequelae of acute hospitalization. Indeed, a review of proposed categories of disclosure detailed in the discussion of the strong view of informed consent reveals that the information is social or legal in nature, not medical. Therefore, the primary purpose of informed consent, to promote sharing of professional expertise, is not really at stake in the context of psychiatric hospitalization.<sup>36</sup>

The non-medical nature of this information stymies the clear, flexible, and efficient implementation of disclosure requirements. Clinicians would have to

expend resources to identify and acquire information not within the professional domain: diagnosing and treating mental illness. And, because there are no professional norms, it is probable that there would be little agreement among psychiatrists regarding the content of disclosure. Courts, which rely on physicians or the scientific literature to inform them regarding the risks of treatment, would face related problems in determining whether adequate information had been conveyed. Also, it is not apparent when or how standards would evolve.

As an example, consider social problems such as stigmatization. Unlike medical facts that have a defined and accepted relationship to interventions, social problems vary considerably and are contingent on factors external to the treatment relationship. Attitudes about mental illness vary greatly across cultures. Even within a culture, reactions to mental illness range widely. What someone's father, boss, or neighbors think of hospitalization will differ from patient to patient. Societal and individual attitudes toward mental illness may change; there is evidence that stigmatization has become less prevalent over time.<sup>37</sup> It seems reasonable to expect psychiatrists' understanding of stigmatization to vary in a similar fashion; thus, there would be considerable differences in the content of their disclosures.

The example of stigmatization also demonstrates the inefficiency of requiring non-medical information to be conveyed by physicians. Typically, physicians inform patients about matters

within their expertise. But in the instance of stigmatization, the consequences are a matter of conjecture for the admitting psychiatrist. Under any circumstances, the psychiatrist would not be conveying superior knowledge or special expertise. Such attitudes are likely to be better known to the patient, even in a compromised mental state, than to the doctor. Physicians' disclosures, therefore, at best would be inefficient; at worst, these disclosures would be inaccurate.

Furthermore, disclosure of this information may be detrimental to patients. Mandating physician discussion of negative attitudes about psychiatric treatment will likely solidify, perpetuate, and promulgate these views. Obligating psychiatrists to "disclose" to patients this "risk" will lend legal recognition to stigmatization. From the perspective of the patient, the psychiatric profession may be seen to be accepting stigmatization as a fixed reality. Finally, focusing discussion on legal disabilities associated with hospitalization may create confusion, paranoia, and legitimate fear in acutely disturbed individuals who have sought care. At the very least, it seems likely that these individuals will enter the hospital at greater cost to their self-esteem. Indeed, patients are likely to sort into two groups: experienced patients who will know more about the social and legal consequences of hospitalization than will the psychiatrist, and new patients who will still be struggling with the meaning of mental illness. Patients in this latter group whose experiences are formative will have the greatest like-

lihood of suffering damage from disclosures about stigmatization and legal disabilities.<sup>38</sup>

Similar arguments apply to the disclosure of legal information. Physicians are not experts in the law. Nor would it be desirable or efficient to implement a system which requires psychiatrists to acquire and maintain this expertise. In an era of burgeoning research and an expanding mental health literature, it is difficult for psychiatrists to maintain currency in their own field. It would be a waste of resources to divert psychiatrists from improving their therapeutic effectiveness to improving their understanding of statutory and case law. Without such expertise, psychiatrists would not fully understand the meaning of legal protections, could not answer patients' questions about them, and would be likely to convey inaccurate information.<sup>39</sup>

There are other reasons to object to imposing an obligation on psychiatrists to convey legal information. No other field of medicine bears such a burden, even though involuntary treatment occurs in general hospital settings, and general medical-surgical patients may face barriers to leaving the hospital.<sup>40</sup> It makes far more sense to relate information about involuntary treatment only in the unfortunate event of doctor-patient disagreement and impending legal process. Empirical research indicates that involuntary psychiatric treatment will only occur in a small percentage of cases.<sup>41</sup> Overall, it seems likely that the net social harm to all mentally ill individuals in terms of increased stig-

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matization of mental health care will outweigh any speculated gains in the autonomy of the few patients who might—legitimately—be given involuntary treatment at a later time.

Requirements to disclose non-medical information could raise significant ethical problems. It seems likely that many psychiatrists would view disclosure of this information to be contrary to their own understanding (for example, some psychiatrists may not view mental illness as stigmatizing in general, or may feel that a particular patient will not be stigmatized). Thus, the physician may perceive a conflict between telling the truth and conforming to the prescribed informed consent disclosure. It is also likely that some psychiatrists will view disclosure of stigmatization or legalities as harmful to patients and, therefore, contrary to their fiduciary responsibilities.

The damage to the field of psychiatry—beyond the aforementioned problems—cannot be estimated. However, it seems likely that to have such onerous, non-medical obligations forced on the field of psychiatry, in contrast to other branches of medicine, would advance and fortify the vision of psychiatrists as agents of social control, rather than as medical specialists. This vision, if left unchallenged, will affect how psychiatrists, patients, and the public regard the profession of psychiatry.

In sum, there is no information, other than the fact of hospitalization itself, to be transmitted to patients facing hospitalization decisions that is analogous to the medical information provided to patients facing discrete procedures. Man-

dating that other information of a social or legal nature be disclosed carries high costs to patients, to doctors, and to the integrity of the profession.

## **Clinical Factors and the Competence Standard**

Several features of the admission process protect patients against inappropriate hospitalizations or diminish the probability that patients' autonomy will be compromised. These features, therefore, weigh against adoption of a strong version of informed consent.

Structural features of hospitalization, private and public, increase the likelihood that patients are admitted for appropriate reasons. Private hospitalization is regulated by third-party payors, including government insurers. As one component of cost containment measures, these third-party payors subject clinicians' admission decisions to increasingly stringent review, prospective and concurrent. State governments are similarly motivated to minimize expensive use of hospitalization and to reduce lengths of stay for the indigent in public facilities. Hospitalization in a public facility often occurs only after outpatient clinicians become convinced that admission is absolutely necessary. Generally, inpatient psychiatrists must approve admissions; and additional layers of oversight, sometimes considered burdensome by those initiating admission, are often interposed. Approval may be required from case managers, nursing supervisors, and administrators. In both public and private systems, recent years have seen the growth of oversight mech-

anisms focused on bottom-line economic considerations that discourage overuse or misuse of hospitalization.<sup>42</sup>

As a result of these review mechanisms, it is likely that patients are admitted when it is known, based on patients' treatment history, that hospitalization will be beneficial, or, if patients are not known to the system, when diagnoses or other clinical markers indicate that hospitalization is likely to be effective.

Threats to autonomy are not great at the time of admission. Concerns about autonomy will center on the risk that the expressed wishes of acutely ill, assenting patients are not the choices they would make when cognitively less impaired. Two features of acute admission reduce this risk. First, family members are often involved in decision-making. Family members often serve as surrogate decision makers—formally or informally—because they are intimately familiar with the values of incompetent patients and the nature of their prior competent decisions. Thus, family members can validate the hospitalization decision as an autonomous patient choice. Second, the risk that patients do not truly want to be in the hospital is a short-term one. With treatment, decision-making capacity will improve; initial treatment decisions, including the one to enter the hospital, can be easily modified in light of capable patient involvement.

These features of the admission process support a policy of accepting patients' desire to enter the hospital even in the face of significant cognitive im-

pairment. By setting the threshold for adequate consent to hospitalization at the level that minimally vindicates notions of autonomous choice, the decisions of the greatest number of patients are respected, and care may be provided to those in need. In contrast, rigorous standards of decision-making capacity would place the burden of intrusive mechanisms of assessment and adjudication on many patients at significant cost to their freedom of choice and with no anticipated benefit: treatment is the desired outcome.

### **Voluntariness**

Gilboy and Schmidt identified a significant problem with "voluntary" hospitalization: institutions have incentives for patients to be voluntarily admitted, and coercion may be used to ensure that patients enter the voluntary admission process rather than the civil commitment system. Hospitals may wish to avoid the costs attendant to civil commitment. Alternatively, psychiatric facilities may accommodate other public agencies (for example, the police force) by admitting problem cases "voluntarily." Finally, many back ward "voluntary" patients would be better served by placement in supervised homes that are expensive for states to develop and maintain.

Coercive practices do implicate informed consent: an individual's consent is not valid unless it is voluntary.<sup>43</sup> The problem is that coercion and free will are elusive concepts that do not readily submit to definition or operationalization. Thus, while coercion in treatment

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settings is discussed in ethics treatises, no case law exists that explicates coercion in the consent process in a meaningful way.<sup>44</sup>

Alan Wertheimer, a political philosopher, has supplied the richest discussion of coercion, which he finds to be a fundamentally moralized concept.<sup>45</sup> That is, whether acts are coercive will depend on the moral nature of the influences. Take as an example the findings of Gilboy and Schmidt. They reported that many potential patients were brought to the hospital by police; in at least some cases, the individual was told that jail was the alternative, in other instances that civil commitment was the alternative; in yet other instances, these alternatives were not voiced. The authors concluded that some patients voluntarily entered the hospital, in part, in order to avoid these less desirable alternatives. Their consent to hospitalization, it was argued, was coerced and, therefore, not truly voluntary.

But if we apply Wertheimer's concepts of coercion, this conclusion may not be justified. We would first want to know how and why these individuals came to be in police custody. Was it legitimate for the police to claim that jail was an alternative to hospitalization? Or, in the case of the admitting officer, was civil commitment truly the alternative to a voluntary admission? If the answer to these questions is no, then the patients were deceived, and we would look upon the process with moral disdain; we may safely reach the conclusion that the patients were coerced. But if the information conveyed was accurate, then the

police and admitting officer were supplying information relevant to decision-making; the actual alternatives were presented to patients. The patients' prospects for autonomous action were enhanced by this increased range of options. We would not want to say that these patients were coerced because they chose what they perceived to be the best alternative. They faced a hard choice, but were not coerced.

The doctrine of informed consent does not appear to be well-suited to correct the problem of coercive practices. Informed consent is firmly situated in the doctor-patient relationship; identifying coercion in a particular case requires a judgment by a third party with an independent moral perspective. Enforcement of informed consent is based on after-the-fact patient complaints; coercion, if effective, will mute patient complaints.

## Policy Considerations

The practical consequences of adopting a strong version of informed consent to hospitalization must be considered. Two distinct outcomes are likely, and neither is desirable. It is possible that psychiatrists would adhere to the legal rule. Many patients currently hospitalized via voluntary procedures would be shifted into the involuntary commitment process. These patients will be deprived of their prerogative to make decisions about hospitalization, will suffer intrusions into their privacy, will be denied the therapeutic benefits that would have accrued under voluntary admission procedures, and will be deprived of the

respect accorded nonpsychiatric patients seeking treatment. In short, the degree of coercion in the mental hospitalization process will be increased. Mental health treatment and, therefore, mental illness will be stigmatized as a result. Of even greater concern is the possibility that the most seriously impaired individuals who cannot meet a rigorous consent standard, but who do not meet commitment criteria, will be denied access to needed care. The harm that will befall them, in human terms, grossly outweighs any harm likely to result from respecting their wishes to be hospitalized.

The disenfranchisement of the most impaired is so offensive to society's collective moral intuitions that it is unlikely to be the most common outcome. It seems more likely that humane psychiatrists, attorneys, and judges would express their concern for these patients by disobeying the law. The grave disability standard for commitment would likely be stretched to include many patients who are not now thought to be within its scope. Alternatively, judges are likely to be willing to find patients with severe impairments in decision-making capacity to be competent nonetheless, in order to allow voluntary admission.

Note that these outcomes do not address the real issues raised by voluntary admission of patients with diminished competence: prolonged confinement and substandard treatment. Patients will either be committed or adjudicated competent despite impairments. In the case of committed patients, the judge will merely determine whether the standard for commitment has been met,

not whether treatment is administered appropriately. Patients admitted as competent are no better off than under the current system.

### **The APA Proposal: A Critique**

While a minority of states have procedures already in place to admit incapacitated psychiatric patients through mechanisms other than the involuntary commitment system, most do not. In the wake of *Zinerman*, significant modifications of laws, regulations, and clinical practices are to be expected.

A recent APA Task Force Report on Voluntary Hospitalization is likely to be influential in the reform movement and, therefore, warrants special consideration. The Task Force report contains a set of suggested procedures for voluntary psychiatric admissions; key provisions of the APA model are reviewed below.<sup>46</sup>

First, the APA model adopts what has been termed in this article a weak version of informed consent. A person must understand "that he/she is being admitted to a psychiatric hospital for treatment" in order to enter the hospital as a routine voluntary patient.<sup>47</sup> In the author's view, this standard clearly respects patients' autonomy interests and sets a clear and reasonable standard for admitting psychiatrists.

Second, the APA model suggests that "assenting" patients with impaired capacity—that is, who are unable to meet the specified standard of understanding—should be admitted as voluntary patients, but should also be provided clinical oversight greater than that received by patients admitted routinely.

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Under the APA proposal, this would take the form of periodic reviews of patients' hospitalization, conducted by an independent psychiatrist. These independent reviews would focus on the capacity of patients to consent to hospitalization and the appropriateness of inpatient treatment. The reviewer, while independent of the treatment team, would report to the facility's medical director, who would have ultimate decision-making authority. The Task Force recommends that in cases in which impaired capacity is prolonged (defined as greater than 30 days), a formal procedure for surrogate decision-making should be invoked.

The primary policy question, as previously discussed, is whether this new category of voluntary admission would be sufficiently inclusive so that patients would not be needlessly committed or, worse, would be unable to be admitted as voluntary or involuntary patients. This is ultimately an empirical question. However, one aspect of the APA proposal is ambiguous and, therefore, merits discussion. The Task Force defines "assent" operationally as "verbal, written, or behavioral actions, [that] express agreement with the admission decision." The report elaborates by specifying that a "patient who can express no opinion whatsoever is not an appropriate candidate for voluntary admission."<sup>48</sup> Under one interpretation of the proposal definitions, it is not clear who would fall into the APA's "impaired voluntary" (but assenting) group; it is difficult to imagine that a patient would have the capacity to "express agreement with the

admission decision" and be able to express an opinion about hospitalization, yet fail to understand he is being admitted to a psychiatric hospital. A second interpretation, and perhaps the intended one, is that admitting psychiatrists should be able to accept any verbal or physical signal from patients that can be construed as manifesting willingness to enter the hospital, as assent, even in the absence of any indication that patients actually understand they are being admitted to a psychiatric hospital.

The idea contained in the APA model—to create a third admission category of impaired, but voluntary patients who receive heightened review—has much to commend it. The criteria for inclusion in this new category should be set, in the author's view, so that a large proportion of impaired patients could be admitted on a voluntary basis. The author favors a slightly more inclusive category of patients than even that which would be permitted by the second interpretation of the APA definitions. In sum, a pragmatic admission scheme would reserve the involuntary process for patients who protest hospitalization; use the routine voluntary procedure for the patients who meet the APA criteria (under the first interpretation); and apply the new, third category of admission for all non-protesting patients who are unable to enter on a voluntary basis. Patients in this last category would not have to "assent" as defined by the APA Task Force, but patients who protest could not be included.<sup>49</sup>

Finally, we must consider the ways in which the APA plan would protect the quality of care administered to voluntary patients. The APA Task Force report acknowledges the importance of assuring quality care and incorporates two oversight mechanisms in addition to regular clinical review. At the time of admission (and at subsequent intervals), an independent psychiatrist will review the appropriateness of hospitalization of those thought to offer impaired assent. When patients' capacity is impaired for greater than 30 days, the report notes, "some formal procedure for surrogate decision-making should be utilized."<sup>50</sup>

In the author's view, additional protections for voluntary patients who have impaired decision-making capacity are warranted. At the time of admission, a simple and easily-implemented procedure is suggested: admitting psychiatrists would identify impaired patients for a required early, independent review. This should occur as soon as possible, but no more than several days should pass after admission. The review would serve as an independent check on the judgment that admission is appropriate; this need not be an expert judgment; the review is meant to provide the check a competent lay patient would have provided regarding the need for hospitalization. The review would also be a safeguard against coercion (the reviewer would make an open-textured assessment and would examine each case, regardless of whether the patient complained). Finally, the review would stand as an independent means of assuring propriety, should the patient come to question the process of

admission. Like Mr. Burch, some patients emerge from the acute effects of their illnesses and have little recollection of what took place; worse, they may be suspicious. The availability of a third party to relate events and provide a measure of assurance regarding the propriety of the admission would serve therapeutic and dignitary ends. For these latter two functions, lay reviewers would be superior to psychiatric reviewers; they would be able to formulate judgments free of professional mores and, in assuring suspicious patients, would be more likely to be seen as truly independent of the psychiatric establishment. As in the APA model, the reviewers must have independence from the hospital and the mental health system so that their judgment would not be affected by internalization of institutional needs. In some systems, human rights officers or ombudsmen would be able to fill this role.

In some (probably rare) instances, lay reviewers will disagree with clinical judgments about the appropriateness of hospitalization; a mechanism for making a final determination about hospitalization will be necessary for the impaired patients concerned. In the author's view, it is important that these determinations **not** be made by clinicians; the advantages of lay judgment described above should be preserved. Decision-making by guardians, family members, judicial decision-makers, or other independent parties would be acceptable options.

In order to address the problems raised by the long-term hospitalization of voluntary patients, judicial review of all voluntary patients at the end of a

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reasonable period of treatment (no more than several weeks) should be required. At this juncture, in most instances, the effects of treatment—antipsychotic medications for the majority of the seriously ill—will have been manifested for many patients. Judicial review offers distinct advantages over clinical or administrative oversight at this point in hospitalization. First, after several weeks of treatment, the most serious risk facing patients is that acute hospitalization, with all of the attendant factors weighing in favor of treatment, will become a chronic, custodial placement. The presumption that hospitalization is in patients' best interests may no longer be warranted. Unfortunately, prolonged hospitalization in state facilities often is a substitute for appropriate placement in nursing homes and supervised settings.

Quality reviews by hospital committees and administrative oversight are not adequate in these circumstances. Ultimately, clinicians and hospital administrators must accept the realities of placement limitations; they have no authority beyond the hospital itself. Thus, acceptance of the status quo (typically, inadequate placement options) is inevitable; it is unreasonable to expect otherwise. By accepting final authority for chronic placement decisions, the mental health system risks bearing sole responsibility for untenable policy decisions. Nor are surrogate decision-makers, such as family members, likely to be effective in curtailing unnecessarily prolonged hospitalizations in state facilities. Too often, family members have an interest in

maintaining custodial arrangements in state facilities and, therefore, are unlikely to question the quality of treatment administered or the appropriateness of hospitalization.

The appropriate place for the custodial care of chronic patients is a matter of public policy, and is not a medical determination. The burden of placement decisions should be borne directly by societal decision-makers. "Voluntary" admission status should not shield the results of policy decisions from scrutiny. Thus, the author would require the presiding judge either to certify that hospitalization is appropriate because continued inpatient treatment is necessary or, alternatively, to certify patients for temporary custodial care because appropriate placement is not available.

## Conclusions

The fate of Mr. Burch in the *Zinermon* case illustrates the problems that may arise under prevailing statutory provisions for voluntary psychiatric admissions. While reform is necessary, adherence to a strong version of informed consent would undermine the opportunity of many mentally ill individuals to obtain needed psychiatric treatment. Furthermore, implementation of a strong version of informed consent would seriously distort professional values and impose unique and corrosive obligations on psychiatrists.

A weak version of informed consent, one which sets more modest (and attainable) demands for physician disclosure and patients' understanding, would enable disordered individuals to continue

to voluntarily enter hospitals for needed treatment. The adverse consequences of voluntary admission are better addressed through greater oversight.

#### Acknowledgments

The author would like to thank Paul Appelbaum, Richard Bonnie, John Monahan, and Walter Wadlington for suggestions and comments made on earlier drafts of this article.

#### References

1. Any single characterization fails to capture the diverse range of patients who seek admission. Private hospitals may serve individuals with little cognitive impairment. Access to public facilities may be restricted in many jurisdictions to the severely mentally ill.
2. Massachusetts General Laws, Chapter 272, § 3 (1881)
3. Brakel SJ: Chapter 3, Voluntary Admission, in *The Mentally Disabled and the Law*, (ed 3). Edited by Brakel SJ et al. Chicago: American Bar Foundation, 1985
4. There are many reasons posited for this increase in voluntary admissions. Mental health professionals have placed greater emphasis on gaining the cooperation of patients. The voluntary admission process has become more important as commitment laws have become more restrictive, and increased coverage of psychiatric inpatient treatment by third-party payors has led to expansion of private sector psychiatric facilities that attract voluntary patients. See Brakel, *ibid*, for a summary of statistics concerning public and private admissions
5. See generally, Appelbaum PS, Lidz CW, Meisel A: *Informed Consent: Legal Theory and Clinical Practice* New York: Oxford University Press, 1987. Before the doctrine of informed consent, the law required "simple consent." Simple consent required an understanding of the essential nature of the procedure. For example, a person with a broken leg must understand that the doctor intends to reset the leg. Under the doctrine of informed consent, the patient must understand the risks and benefits of the procedure as well as the alternatives to resetting the leg—including the option of no treatment—and their risks and benefits
6. Weiner BA, Chapter 6, Treatment Rights, in *The Mentally Disabled and the Law*, (ed 3). Edited by Brakel SJ et al. Chicago: American Bar Foundation, 1985
7. *Zinerman v. Burch*, 110 S. Ct. 975, 1990
8. For example, see Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services memorandum to private hospitals licensed by DMHMSAS, dated 9/17/90, instructing facilities to obtain competent, informed consent to voluntary admissions
9. Appelbaum PS, Lidz CW, Meisel A: *Informed Consent: Legal Theory and Clinical Practice*, *supra* note 5
10. *Ibid*
11. Winick BJ: Competency to consent to voluntary hospitalization: a therapeutic jurisprudence analysis of *Zinerman v. Burch*, *Int J Law Psychiatry* 14: 169–214, 1991
12. Early statutes were enacted to enable public facilities to admit patients who did not meet involuntary commitment standards. Prior to this time, only committed patients had access to these facilities. See Overholser W, The voluntary admission law: certain legal and psychiatric aspects, *Am J Psychiatry*, Jan 1924
13. *Ibid*. Also see Klatte EW, Lipscomb WR, Rozytko VV, Pugh LA: Changing the legal status of mental hospital patients. *Hosp Community Psychiatry*, July, 1969, 199–202
14. Overholser W: *supra* note 13. Also see Note, District of Columbia Hospitalization of the Mentally Ill Act, *Colum.L.Rev.* 65:1062–74, (1965), commitment "an experience which itself often increases mental instability". It should be noted that the therapeutic benefits enumerated in the text are plausible; however, they have never been empirically proven
15. See *Zinerman v. Burch*, 110 S.Ct. at 979
16. See Gilboy JA, Schmidt JR: "Voluntary" hospitalization of the mentally ill, 66 *Nw. U. L. Review* 66:429–53, 1971; Lurigio A, Lewis D: Worlds that fail: a longitudinal study of urban mental patients. *J Social Issues* 45:79–90, 1989; Lewis D, Goetz E, Schoenfeld M, Gordon A, Griffin E: The negotiation of involuntary civil commitment, *Law Soc Rev* 18:629–49, 1984; Reed S and Lewis D, The negotiation of voluntary admission in Chicago's state mental hospitals. *J Psychiatry Law*, Spring/Summer 137–63, 1990
17. *Ibid*
18. Appelbaum PS, Mirkin SA, Bateman AL: Empirical assessment of competency to consent to psychiatric hospitalization, *Am J Psychiatry* 138:1170–6, 1981; Olin GB, Olin HS: Informed consent in voluntary mental hos-

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- pital admissions, *Am J Psychiatry*, 132:938–941, 1975
19. Enhancing the quality of care and improving patients' well-being is characterized variously as a value underlying informed consent or as a consequence of informed consent. See Chapter 2, *The Values Underlying Informed Consent*, in President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship*. Volume One: Report, pp 41–44, Washington, D.C.: U.S. Government Printing Office, 1982; Appelbaum PS, Lidz CW, Meisel A: op. cit. note 5, at 26–28; and Katz J, Capron AM: *Catastrophic Diseases: Who Decides What?* New York, Russell Sage Foundation, 1975. Richard Bonnie originally used the term "checking function" to capture this dimension of consent (personal communication, Richard Bonnie)
20. Hoge SK, Feucht-Haviar T: *Chronic, assenting psychiatric patients: decisional capacity and the quality of care*, unpublished
21. *Canterbury v. Spence*, 464 F. 2d 772 (D.C.Cir. 1972)
22. See Rozovsky FA, *Consent to Treatment: A Practical Guide* (ed 2). Boston: Little, Brown, 1990, pp 42–55
23. American Psychiatric Association Task Force Report 34: *Consent to voluntary hospitalization*. Washington, D.C., American Psychiatric Association, 1992
24. Appelbaum PS, Mirkin SA, Bateman AL: op. cit. note 19; P.S. Appelbaum and A.L. Bateman, *Voluntary psychiatric hospitalization: a theoretical approach*, *Bull. Am. Acad. Psychiatry and Law* 7:390–399, 1979; Norko MA, Billick SB, McCarrick RG, Schwartz MA: *A clinical study of competency to consent to voluntary psychiatric hospitalization*, *Am J Forensic Psychiatry* 11:3–15, 1990; Winick BJ op. cit. note 12
25. *Ibid*
26. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research: *Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship*. Volume One: Report, pp 60–62, Washington, D.C.: U.S. Government Printing Office, 1982
27. See President's Commission, *id.* Also see, Drane JF: *The many faces of competency*, *Hastings Center Report* 15(2):17–21, 1985
28. See Winick BJ, *Competency to consent to treatment: the distinction between assent and objection*, *Houst L Rev* 28:15–61, at 56–57
29. See Brakel, op. cit. note 3
30. Lurigio A, Lewis D, op. cit. note 17
31. Again, I am not addressing the (at present, unfathomable) issue of whether the due process clause would preclude a weak version of informed consent
32. President's Commission, op. cit. note 26 at pp 69–78
33. The author has proposed in order to be admitted via routine voluntary procedures, patients must understand they are entering a psychiatric facility for evaluation or treatment of mental or emotional problems; "Consent to Hospitalization after *Zinerman*," presented at the Twenty-Second Annual Meeting of the American Academy of Psychiatry and the Law, Orlando, Florida, October 17, 1991
34. See Rosovsky, op. cit. note 23
35. Of course, in actual practice, physicians often convey to their patients not only objective medical information but also their own views and personal preferences regarding options
36. The author does not mean to suggest that physicians should not discuss non-medical concerns with their patients, only that these discussions are outside the domain of the informed consent doctrine. Physicians, in fulfillment of their professional fiduciary responsibilities, should be helpful to their patients whenever possible
37. For a review of cultural, social, and other variables that influence attitudes toward illness, see Eisenthal S, *The sociocultural approach*, in Lazare A, (ed.), *Outpatient Psychiatry: Diagnosis and Treatment*, (ed 2). Edited by Lazare A. Baltimore: Williams and Wilkins, 1989
38. As previously noted, the author does not suggest that individual physicians should not discuss these—or any other—matters when they feel it is appropriate and in the patient's best interests. In some cases, discussion of stigmatization may be therapeutic, may strengthen doctor-patient relationships, and may assist patients in their struggle with discrimination. However, the danger of situating these topics in the doctrine of informed consent results from the presumption that they must be part of a standard discussion with every patient. It is this standardization that is objectionable
39. See *Clark v. Grigson* 579 S.W. 2d 263 (Tex Civ App 1979), disclosure of "legal conse-

- quences" of psychiatric evaluation not required for informed consent
40. Appelbaum PS, Roth LH: Treatment Refusal, in President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship. Volume Two: Appendices, Empirical Studies of Informed Consent, pp 411-77 Washington, D.C.: U.S. Government Printing Office, 1982
  41. See Appelbaum PS, Hoge SK: The right to refuse treatment: what the research reveals, *Behav Sci Law* 3: 279-92, 1986. The rate of refusal of antipsychotic medication among committed patients ranged from 1-15 percent; it is likely that voluntary patients' refusal rate would be substantially lower
  42. See Hoge SK, Appelbaum PS, Geller JL: Involuntary Treatment, in *American Psychiatric Press Review of Psychiatry*, Volume 8, (Tasman A, Hales RE, and Frances AJ, eds.), pp 432-50, Washington: American Psychiatric Press, 1989 and Hoge SK, The Legal Regulation of Psychiatry, in *Psychiatry*, edited by Michels R. Philadelphia: Lippincott, 1992
  43. See Appelbaum PS, Lidz CW, and Meisel A, op. cit. note 5
  44. See Beauchamp TL, and Childress JF, *The Principles of Biomedical Ethics, Third Edition*, pp. 107-113, New York: Oxford University Press, 1989. See also *Kaimowitz v. Department of Mental Health for the State of Michigan*, Cir.Ct. for Wayne Co., 1973, Civil Action No. 73-19434-AW
  45. Wertheimer A. *Coercion* Princeton: University Press, 1987
  46. Task Force Report, op. cit. note 23
  47. Presumably, the Task Force guidelines are intended to convey that simple consent is sufficient. Thus, patients may be admitted voluntarily for assessment or observation, rather than treatment, if they understand the essential nature of the admission. The author endorses this approach. The APA model also requires that patients understand any restrictions on discharge. In my view, it would be preferable to do away with these restrictions rather than to require patients to understand them. The voluntary nature of psychiatric hospitalization should not be compromised by routine requirements of notice and delay in discharge. Elimination of 3-day notices would bring the treatment of psychiatric patients in line with the way in which other medical patients are treated, thereby reducing stigmatization. There are two justifications for notice periods. They provide a "cooling-off" interval for negotiation between patients and treatment staff. Also, the treatment staff is afforded time to determine whether or not to initiate involuntary commitment procedures. In an earlier era of underfunded, understaffed public psychiatric facilities, delay in decision-making may have been necessary to permit psychiatric evaluation. Currently, psychiatric facilities should have sufficient information to be able to make rapid decisions to seek commitment or release patients. General medical hospitals must make these decisions when patients seek to leave against medical advice. Similarly, psychiatrists in emergency room settings routinely make release decisions with less information and familiarity with patients' circumstances than would be the case for psychiatrists called on to make judgments regarding discharge from the hospital
  48. Task Force Report, page 8
  49. The creation of this third category of admission would eliminate *pro forma* commitment hearings of mute or catatonic patients. While it is likely that the vast majority of severely impaired patients can be involuntarily committed under criteria of "gravely disabled" or "inability to care for self," these commitments may be associated with complications, such as stigmatization. Also, some jurisdictions interpret the "grave disability" criterion narrowly and will not involuntarily commit even the most severely-disabled person who can be cared for by others. This has led some families to abandon their disturbed relative so that they might get care. See Hoge, Appelbaum, and Geller, op. cit. note 42
  50. Task Force Report, supra note 23, at page 13