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REVIEW ARTICLE

# Review article: Detaining patients against their will: Can duty of care be used to justify detention and restraint in emergency departments?

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## Abstract

Every day in EDs, clinicians are faced with situations where they need to decide whether to detain a patient for assessment and treatment. For patients who meet the relevant criteria, provisions of mental health legislation can be used. For other patients, clinicians often rely on so-called 'duty of care'. This article briefly explores this complex area of law, including the relevant legislation, common law principles and grey areas. It also proposes an approach to decision-making in this area.

**Key words:** *consent, duty of care, restraint.*

## Introduction

Every day in EDs, clinicians are faced with situations where they need to decide whether to detain and/or restrain a person for assessment and treatment. Some examples are shown in Box 1. For patients who meet the relevant criteria, provisions of mental health legislation can be applied. These are however very narrow and, except in uncommon circumstances, only apply to assessment and treatment of mental illness, not physical illness or injuries. For other patients, clinicians often rely on so-called 'duty of care'. This is however a complex area of law where unlawful restriction of liberty or treatment without consent could result in civil claim or criminal prosecution. This brief review will summarise the relevant common law principles and legislation, propose an approach to decision-making regarding detention without consent and apply these principles to some common scenarios (Box 1).

## What is the relevant legislation?

The relevant legislation is shown in Table 1.

In addition, power of attorney acts (or equivalents) may have provision for the appointment of a medical treatment decision-maker. These appointments are made while the person has capacity but can only be used in circumstances when the person lacks capacity at a later time.

Although criminal codes have been included for completeness, it is highly unlikely that a doctor acting

### Key findings

- People with healthcare decision-making capacity, even if mentally ill, have the right to make decisions that may have adverse consequences for their health, including the risk of death.
- Healthcare decision-making capacity is time and decision specific. It must be assessed separately at each decision-making event.
- The fact that a person is, or was, under the influence of an intoxicant is not sufficient to assess them as lacking healthcare decision-making capacity.
- Mental health act provisions cannot be used to detain, assess and treat patients unless there is a reasonable belief (supported by evidence) that they have a mental illness that is impairing their healthcare decision-making capacity. The presence of a mental illness does not necessarily mean a person lacks capacity.
- Mental health act provisions may allow detention to treat mental illness, not physical injuries.

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**BOX 1.** *Scenarios*

Case 1: A 50-year-old man is brought to hospital by ambulance. He was found 'asleep' in a park with a partially empty bottle of whisky beside him and bystanders could not rouse him. There are no signs of a physical injury and vital signs are normal. After a few hours, he wakes up and wants to go outside for a 'smoke'. When staff will not let him (on the grounds that he requires further assessment for medical clearance), he becomes agitated and verbally aggressive.

Case 2: A 25-year-old woman arrives by ambulance after friends observed her to become unconscious and blue after injecting recreational drugs. Paramedics have administered naloxone with rapid improvement. On arrival at the ED – even before triage – the patient says she does not want to be at the ED and is leaving.

Case 3: A 20-year-old man is brought to hospital by friends. He was punched in the head outside a nightclub and has been behaving erratically. Clinically he is confused and uncoordinated.

Case 4: An 85-year-old woman who has mild dementia has fallen at home hitting her head. She lives alone. She is mildly confused (probably in her normal state) and has a bump on her head but is otherwise uninjured. This is her third trip to the ED after a fall in the last month. After the assessment and a normal CT scan, she wants to go home. Clinicians have significant concerns about her safety at home.

Case 5: A 55-year-old man came to the ED with chest pain. An ECG shows that he has had an ST-elevation myocardial infarction. He is homeless, unkempt and known to have chronic schizophrenia managed in the community. After having been told the diagnosis and treatment plan, he declines treatment and indicates that he will self-discharge.

honestly or without criminal intent or reckless interference would face criminal charges.

## What are the relevant legal principles?

### *Consent to treatment*

The ethical principle of autonomy is reflected in law as the common law principle of consent. Autonomy describes the right of a person to independent thought, will and action, subject to legal boundaries.[1] In the healthcare context, autonomy describes the right of a person to make healthcare decisions for themselves – including the right to consent to, or decline, treatment. Patients have the right to refuse medical treatment or leave the ED, even if that decision appears unwise or risky to the clinician – even at the risk of death – provided that the patient has the capacity for decision-making. In law, consent is paramount.[2,3] A patient can refuse treatment for any reason, or no reason at all. It is not up to the medical profession, or the legal profession, to judge the patient's reasons.[4]

Liberty requires that people must not be subject to arrest and detention, except as provided for by law.[1] To detain a person without a lawful justification can open clinicians to civil claims of assault and false imprisonment (and in rare cases, prosecution).

The law only sanctions infringement of autonomy and liberty if authorised by legislation, where consent is given by an adult with capacity to do so or by a court/tribunal appointed substituted decision-maker or by an attorney under an enduring power of attorney or under the legislative statutory health attorney regimes. The critical question is 'Does the patient have capacity?'

### *Capacity*

In law, a person has capacity to make a decision in relation to a matter if the person is able to:

- Understand the information relevant to the decision and the effect of the decision; and
- Retain that information to the extent necessary to make the decision; and
- Use or weigh that information as part of the process of making the decision; and
- Communicate the decision, including by speech, gesture or other means.[5]

A person is presumed to have decision-making capacity unless there is reasonable evidence to the contrary. A person may have decision-making capacity in relation to some matters and not others. Additionally, lack of decision-making capacity may be temporary. This means that assessment of capacity is time and decision specific. It follows that capacity needs to be re-assessed for each decision. The fact that the decision may seem ill-advised, risky or irrational is not, on its own, sufficient to overturn the presumption of capacity.[6]

If a person lacks capacity, it is important to establish whether the person has made a valid advance care directive. An advance care directive may identify treatment that the person consents to or refuses. It may include a statement of values to be considered when identifying what treatment is in the patient's best interests. It may indicate who the person trusts to make decisions or their behalf. An advance care directive is legally binding and must be honoured.[7]

Where there is no advance care directive, medical treatment decisions can be made by a person's medical treatment decision-maker, if one is available. There is a hierarchy for determining a person's medical treatment decision-maker. Although the legislation varies slightly from state to state, it is usually:

1. A formally appointed medical treatment decision-maker (a legal process resulting in a signed document); or if none;
2. A guardian appointed by a court or tribunal, or if no formally appointed guardian;
3. A close relative (the patient's primary carer, spouse, child, parent or sibling) or

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**TABLE 1.** *Relevant legislation*

| Type of legislation | State | Relevant act |
|---|---|---|
| Civil liability acts | Australian Capital Territory | *Civil Law (Wrongs) Act 2002* (ACT) |
| | New South Wales | *Civil Liability Act 2002* (NSW) |
| | Northern Territory | *Personal Injuries (Liabilities and Damages) Act 2003* (NT) |
| | Queensland | *Civil Liability Act 2003* (Qld) |
| | South Australia | *Civil Liability Act 1936* (SA) |
| | Tasmania | *Civil Liability Act 2002* (Tas) |
| | Victoria | *Wrongs Act 1958* (Vic) |
| | Western Australia | *Civil Liability Act 2002* (WA) |
| Mental health acts | Australian Capital Territory | *Mental Health Act 2015* (ACT) |
| | New South Wales | *Mental Health Act 2007* (NSW) |
| | Northern Territory | *Mental Health and Related Services Act 1988* (NT) |
| | Queensland | *Mental Health Act 2016* (Qld) |
| | South Australia | *Mental Health Act 2009* (SA) |
| | Tasmania | *Mental Health Act 2013* (Tas) |
| | Victoria | *Mental Health Act 2014* (Vic) |
| | Western Australia | *Mental Health Act 2014* (WA) |
| Guardianship and consent to medical treatment acts | Australian Capital Territory | *Guardianship and Management of Property Act 1991* (ACT) |
| | New South Wales | *Guardianship Act 1987* (NSW) |
| | Northern Territory | *Guardianship of Adults Act 2016* (NT) |
| | Queensland | *Guardianship and Administration Act 2000* (Qld) |
| | South Australia | *Guardianship and Administration Act 1993* (SA); *Consent to Medical Treatment and Palliative Care Act 1995* (SA) |
| | Tasmania | *Guardianship and Administration Act 1995* (Tas) |
| | Victoria | *Medical Treatment Planning and Decisions Act 2016* (Vic), *Guardianship and Administration Act 2019* (Vic) |
| | Western Australia | *Guardianship and Administration Act 1990* (WA) |
| Criminal codes | Australian Capital Territory | *Crimes Act 1900* (ACT); Criminal Code 2002 (ACT) |
| | New South Wales | *Crimes Act 1900* (NSW) |
| | Northern Territory | Criminal Code 1983 (NT) |
| | Queensland | *Criminal Code 1899* (Qld) |
| | South Australia | *Criminal Law Consolidation Act 1935* (SA) |
| | Tasmania | *Criminal Code 1924* (Tas) |
| | Victoria | *Crimes Act 1958* (Vic) |
| | Western Australia | *The Criminal Code Compilation Act 1913* (WA) |

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4. An adult person with a close and continuing relationship with the person.[8]

### *Defence of necessity: where no consent is provided*

Where a patient is not competent and a substitute decision-maker is not available in an appropriate time frame (such as in an emergency), medical care can be given based on what is referred to as the doctrine of necessity. It presents a defence to both criminal and civil allegations based on common law principles. It requires that actions taken are in the best interests of the assisted person.[9] Necessity cannot be relied upon when a more appropriate decision-making process is available or when action is contrary to the known wishes of the assisted person.[9]

Legislation (guardianship and consent acts) also authorise practitioners to administer urgent treatment where a patient cannot give or refuse consent and it is impracticable to seek alternative consent.[10] These provisions do not authorise treatment contrary to an advance care directive or where the patient retains competence. Treatment is urgent when it is necessary to save life or prevent long-term harm. Mere convenience, either for the patient or medical staff, is not sufficient.[11]

In practical terms in ED, necessity and/or guardianship and consent acts are most likely to be applicable when the patient has an acute illness or injury and urgent investigation and/or treatment is in their best interests in order to prevent serious harm (including severe pain and distress) or death. In more chronic or less emergent situations, substitute decision-making processes are likely to be more appropriate.

Necessity justifies treatment that can include both physical and chemical restraint where that is necessary to treat a physical condition. For example, it would include placing a patient in an induced coma in order to treat their head injury or maintain their airway. Necessity can also justify detention of a person who is behaving uncontrollably and disruptively and posing an immediate danger to themselves or others.[12] Simply acting erratically is unlikely to meet the threshold for justifying necessity.[13] Note, both the behaviour and immediate danger are required, not just the possibility of future danger. Restraining someone who is an immediate danger to others may also be justified by the law of self-defence, but that would not authorise the administration of any treatment.

Necessity will not justify treatment that a competent patient has refused. As described above, a person is presumed to be competent unless and until a medical practitioner has confirmed that they are not. In other words, a practitioner must satisfy themself that a patient is not competent before relying on necessity.

Where there is some doubt about the patient's competence, but the patient is compliant or cooperative there is no issue. Treatment will be justified by the patient's consent or, if it is determined that they were not competent to give consent, then by the doctrine of necessity. There is a grey area where the patient's competence is in doubt and the patient refuses treatment or seeks to leave the ED before an assessment of capacity can be undertaken. It has been argued that necessity could justify brief detention in order to complete an examination and determine a person's competence or mental health.[14] It could probably only be justified where there were strong grounds to think the person was not competent and was a danger to themselves to the extent that there was imminent danger of inevitable and irreparable harm.[14,15] Necessity could not justify detention because a doctor has not 'cleared' the patient or on the basis that if they leave 'something' might happen.

## Criminal codes

### *Trespass to the person*

Trespass to the person can result in both criminal and civil proceedings. It ranges from mere touching through to the application of violent force. In general terms, it can occur when, unlawfully:

1. There is any intentional and unwanted physical force used against a person;
2. There is any intentional and unwanted direct or indirect contact with another person (even slight contact) if the person committing the assault knew that the victim might reasonably object to the contact;
3. There is a threat to apply force and the victim reasonably believes that the person can carry out the threat or there is a real possibility that they will; or
4. A person approaches and confronts another person aggressively (accosts) or blocks the way of (impedes) another in a threatening manner.[16–18]

### *False imprisonment*

False imprisonment (in some states referred to as deprivation of liberty) can result in both criminal and civil proceedings. It is the intentional and unlawful restraint of the liberty (inability to move from one place to another) of another person against that person's will.[19] The restraint must be total, with no reasonable means of escape. The use of physical force or a physical barrier is not required; the threat of force is sufficient.

The actions of clinicians and security officers in an ED to detain or restrain a person may constitute assault or deprivation of liberty unless there is a lawful reason to do so. Compensation for civil claims of for unlawful touching and false impressment are likely to be nominal unless injury had occurred.

## Duty of care and civil liability acts

The concept of 'duty of care' was developed in common law as the principle that a person should take reasonable care to avoid acts or omissions which could be reasonably foreseen to be likely to injure a person affected by them.[20] It follows that healthcare professionals owe a duty of care to their patients to

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exercise reasonable care and skill in their provision of medical care. The duty is a single comprehensive duty covering all the ways in which a doctor is called upon to exercise his [or their] skill and judgement. It extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case.[2]

This duty does not give rise to strict liability. Liability in negligence will only arise where the standard of reasonable care is not met. This is a question for the court to determine, taking into account the common law test as modified by legislative reform in the civil liability acts (Table 1). In particular, in medical negligence cases relating to treatment, this is subject to the statutory peer professional standard, provided this is not irrational (or unreasonable in some jurisdictions) (see Civil Liability Acts, Table 1).

Particularly relevant to detention without consent, a person is only liable for an omission, that is for *not* doing something, where there was both a duty of care, a power to act and the failure to act did not meet the standard of reasonable care.[21]

### *Duty to rescue*

The law does not impose a duty to rescue others from harm. The meaning of rescue in this context is the prevention of harm that is not caused by the defendant. As noted above, touching someone to provide medical care requires a lawful justification. There can be no duty to act unlawfully, therefore where there is no consent, and necessity or legislation do not authorise treatment, there can be no duty to provide care. There can be no duty to provide treatment that a competent patient does not consent to even if, objectively, the treatment is indicated and in the patient's best interests.

In the context of a patient seeking to leave the ED against advice or before a complete examination, neither the hospital nor its staff will *cause* any adverse consequences of that decision. They can only be held liable for any adverse consequences if they had both the power, and a legal duty, to prevent that person leaving. The key case example is *Stuart v Kirkland-Veenstra*,[22] where members of Victoria Police observed a man sitting in a car with a pipe connecting the exhaust and the inside of the car. They spoke to him and after offering various forms of assistance, which were rejected, they allowed him to leave. Later that same day he took his own life. The High Court of Australia dismissed the allegation of negligence brought by the man's widow. The decision affirmed that there was no general duty to rescue another from harm. Further under the provisions of the then *Mental Health Act 1986* (Vic) (now repealed) police had no lawful authority to detain the man and could not, therefore, owe any duty to prevent him taking his own life or, in other words, to protect him from himself. One can only be duty bound to do what one can lawfully do. A duty of care is not equivalent to a power to impose care. In summary, generally speaking, where a person refuses treatment, including leaving the ED against advice, they will be responsible for the consequences of their actions.[23]

## Proposed decision-making pathway

A proposed decision-making pathway regarding detention or restraint without consent is shown in Figure 1.

## Importance of documentation

The aim of documentation is to provide an explanation and, where necessary, justification for decision-making and actions. It is essential for the provision of ongoing medical care as well as for medicolegal purposes. Where a clinician contemplated or performed restraint or detention of a patient, the clinician must document what they did and/or did not do and why? The 'why' should address the particular facts and circumstances of the case, an assessment of capacity and the grounds for suspecting the presence of relevant medical or mental health disorders. Such assessments should specify both what the assessor observed themselves and any other information that factored into the decision-making.

## Offering advice and safest plan in the circumstances

The law imposes a duty of care for clinicians both with respect to diagnosis and treatment and provision of advice.[2] This fundamentally creates a duty to warn patients of the material risks involved in decisions they take such as refusing medical treatment or leaving against medical advice.[24]

At a minimum, this should include discussion of the risks of serious harm, in language accessible to the patient, based on their condition and what is known of the risks of their declining treatment or leaving before they can be fully assessed. Other reasonable precautions should be considered, potentially including involving the next of kin or other responsible person to assist the patient with their decision-making (where permitted) and if desirable and practical, discharge into their care. Where the patient refuses the treatment plan offered by the clinician after understanding the risks, the clinician should offer reasonable alternative treatment if available. For example, prescribing oral antibiotics for an infection if the patient refuses admission for intravenous antibiotics. Steps taken and advice provided must be clearly documented.

## Revisiting the scenarios

Case 1: A 50-year-old intoxicated man. While this man probably lacked capacity for decision-making initially, as he sobered up this situation changed. It is likely that at the time he wanted to go out for a cigarette, he had capacity for that decision. Additionally, he was not leaving ED or refusing assessment; he just wanted a smoke. In these circumstances, there is no basis for restraint or forcible detention.

Case 2: A 25-year-old woman with an accidental opiate overdose. This

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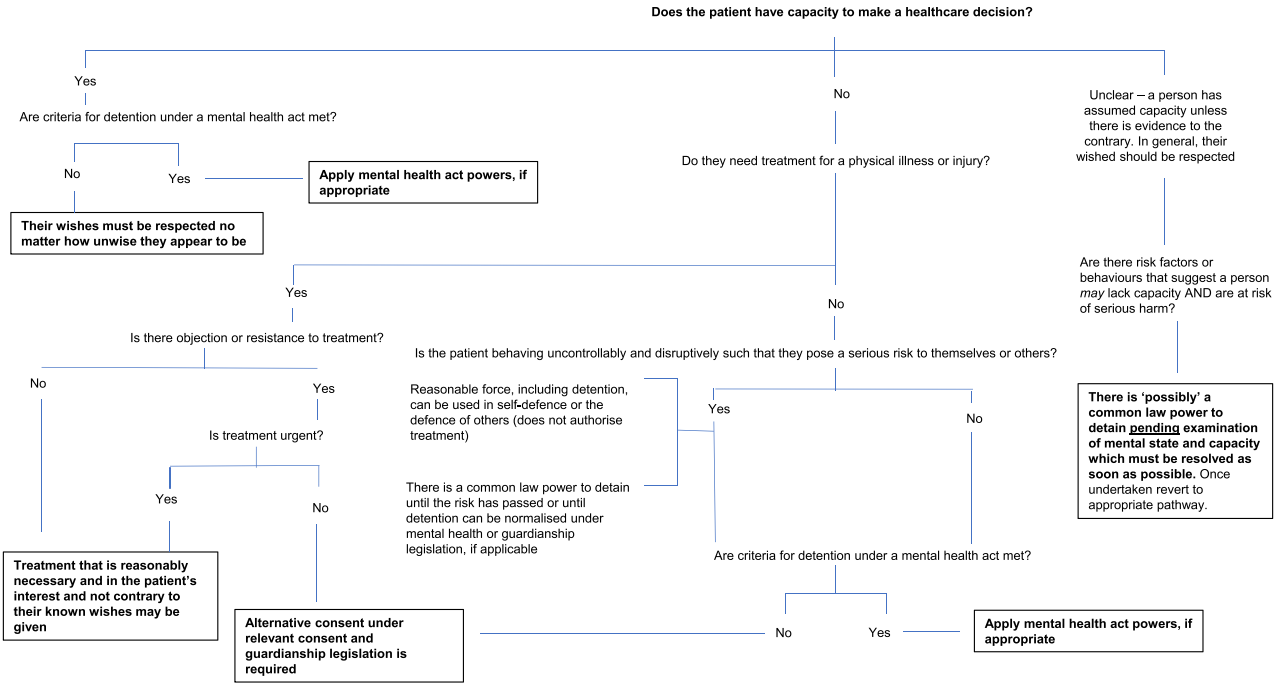


**Figure 1.** *Proposed decision-making pathway.*

woman is fully conscious and not confused. The circumstances are fairly clear that this was an accidental overdose. There is no suggestion of suicidal ideation. In these circumstances, there is no basis for restraint or forcible detention; however, there is a duty to warn her of the possibility of recurrence of toxicity after the naloxone wears off and to be with others so that they can call help for her, if needed.

Case 3: A 20-year-old man with a head injury. This man clearly lacks capacity and there is no suitable substitute decision-maker with him. He clearly needs urgent investigation and treatment for a possible intracranial bleed, that is a threat to his life. Clinicians can proceed to treat him, including restraint, if necessary, with the defence of necessity and potentially, in some states, also under urgent treatment provisions of the guardianship and consent acts.

Case 4: An 85-year-old woman who has fallen. This situation is complex, but not emergent. This woman may have capacity for the decision to go home. ED clinicians should involve family/carers and, if available, geriatricians to clarify capacity. If the presumption of capacity cannot be rebutted, her wishes should be respected. That said, aware of the risks, ED clinicians have a responsibility to put in place processes for further assessment and care such as negotiating additional family or carer support, directly communicating with the GP and/or arranging a geriatrician assessment in the community.

Case 5: A 55-year-old schizophrenic man with an ST-elevation myocardial infarction. The fact that this man has a mental illness does not mean that he lacks capacity for decision-making, unless there are reasonable grounds to conclude that his mental illness, at the time of the decision, is impairing his ability to understand and process the information provided to him.[25,26] If possible, ED clinicians should involve his treating mental health team to clarify capacity. In some jurisdictions, there are formal processes in place for supported decision-making for patients with mental illness which may be helpful. If there is no reasonable evidence that he lacks capacity, his wishes should be respected. ED clinicians would have a duty to warn him of the risks of his decision, to advise him that he can change his mind and return to the ED at any time and to put in place the safest plan he will accept, such as treatment with antiplatelet agents and review by his GP the next day.

## Conclusion

The decision to detain or restrain a person against their will is a complex one and should not be taken lightly. Consent, rather than clinician-perceived risk of an adverse outcome, is the overriding principle. Assessment of decision-making capacity is the key consideration. Capacity is assumed unless there is reasonable evidence to rebut it, and it is time and decision specific. A person with healthcare decision-making capacity, even if mentally ill, has the right to make decisions that may have adverse consequences for their health, including the risk of death. A decision-making framework could help clinicians in this complex process, with each case being determined on its individual facts and circumstances.

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### *Competing interests*

AMK is a section editor for *Emergency Medicine Australasia*.

### *Data availability statement*

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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