ETHICS IN ACTION

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CASE PRESENTATION

A 23-year-old male patient presents to the emergency department grossly intoxicated, with somewhat incoherent statements of being depressed and suicidal. He was found lying in a park and brought in by emergency medical services. Based on protocols at this center, the patient was examined for any signs of medical instability and allowed to sober up prior to psychiatric evaluation. In evaluating the patient, the emergency physician obtains a history that this patient drinks quite heavily on a regular basis and has a history of depression, with previous hospitalizations for suicidal ideation. The patient is found to have stable vital signs with no evidence of additional medical complications, and a breathalyzer alcohol reading of 0.305. He is allowed to sleep after initial examination, with a plan for the oncoming emergency medicine team to evaluate him again after six to seven hours of metabolism to allow his alcohol level to fall below the legal limit of 0.08.

Three hours into the patient's clinical course, the patient states that he wishes to go home so that he can resume drinking. He denies that he is suicidal or depressed and states that "this is as sober as I get." He is still slurring his words, suggestive that he still has a significant amount of alcohol in his system, but appears to have gross insight into his condition and medical background. The patient also states that he is feeling "shaky" and is noted by the emergency physician to be mildly tachycardic (heart rate of 110) and diaphoretic. When the emergency physician presents his concern that the patient is in the initial stages of alcohol withdrawal, the patient becomes more belligerent, stating clearly that he will take care of himself by drinking more at home and does not want further emergency department care.

DISCUSSION

This case presents a number of ethical and medical issues of interest to emergency physicians. The primary ethical and concomitant medical issue is whether an inebriated patient can refuse medical therapy in an informed manner. Under the principle of autonomy, if this patient were not intoxicated and had insight into his medical condition, he would be able to refuse care over the recommendations of his physician. The issue here is that the patient appeared to still be impaired based on his likely having a significant amount of alcohol in his system. On the other hand, for a patient like this one who consumes significant amounts of alcohol regularly, it may be completely normal for him to have intact decision-making capacity with a level of alcohol above the legal limit. The statement by the patient that he can treat himself for alcohol withdrawal may indicate either a lack of insight into the danger of this condition or, ironically, an acute insight into his personal physiology and the ability to self-treat!

For emergency physicians, the necessity to come to a conclusion on decision-making capacity is of fundamental importance in determining whether the patient can refuse care in an informed manner. Unfortunately, the time pressures of emergency medicine make an in-depth exploration of the judgment of patients a difficult task. For a patient to be considered to have decision-making capacity, he should be able to articulate an appropriate moral or values-based framework for his decision, state how his refusal or consent fits within this framework, and relay his comprehension of the consequences of his decision in the context of the moral or values-based framework.[1] Authors on this subject have also concluded that a "sliding scale" is appropriate in assessing decision-making capacity in acute care settings – the higher the consequences of refusal of care, the more stringent the evidence should be for acceptance that such refusal is being chosen in an informed manner.[2]

In this case, it is a professional judgment of whether or not the patient meets these criteria for informed refusal of care. It appears that he might be motivated by a wish to be left alone, but at the same time, that motivation seems most clearly coupled with a value of wanting to drink again to excess. This hardly seems to qualify as an appropriate moral or values-based framework. But the danger clearly exists that physicians may be imprudent in judging the appropriateness of the values used by patients in refusing care, lapsing into paternalism. It is only through professional training, awareness, and humility that emergency physicians can appropriately assess the value structure by which a patient expresses informed refusal.

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The next question to consider is how far it is ethically appropriate to go in putting into effect a treatment plan in a patient who is refusing care. Here the principle of proportionality has appropriate application. Proportionality, at its essence, calls for a response to a situation to be comparable to the consequences of failure to act.[3] For example, it would be lacking in proportion to physically restrain an alert patient who refuses a lumbar puncture in the evaluation of a headache. Instead, discussion and gentle persuasion on the evidence supporting this intervention, documentation of the patient's refusal to consent, and alternative evaluation and treatment plans would be ethically preferable. In this case of an intoxicated patient refusing care, there may be a need to use more forceful persuasion or even restraint to avoid the significant and potential life-threatening consequences of alcohol withdrawal and delirium tremens. Treatment provided should ideally be kept proportionate by tempering withdrawal symptoms but still allowing the patient to communicate with medical providers on his psychological state.

CASE OUTCOME AND LESSON LEARNED

To convey the seriousness of the situation, the emergency physician asked security to stand outside the room, but did not ask for restraints, and told the patient that he felt compelled to treat him with benzodiazepines both for withdrawal symptoms and to allow future assessment of his psychological state. The emergency physician also asked the patient if he wanted something to eat and a room in a quieter part of the emergency department, and offered to walk outside with the patient and security so that the patient could smoke a cigarette before starting treatment. The patient accepted this plan, was given multiple doses of benzodiazepines, and was admitted to the hospital for further medical and psychiatric evaluation.

The main lesson of this case is that emergency physicians need to be prepared to rapidly assess decision-making capacity, likely with a sliding-scale expectation of evidence for informed refusal, and show creative flexibility in devising a proportionate response when necessary. As with much in emergency medicine, practical solutions are necessary to solve a theoretical conundrum. ◗

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ADIEM UPDATE

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We are well into the new academic year for the Academy for Diversity & Inclusion in Emergency Medicine, and we are looking forward to great things. Since SAEM's Annual Meeting in May in Atlanta, many of the ADIEM leadership had the pleasure of participating in the National Medical Association's Scientific Assembly in Toronto, Canada. Ugo Ezenkwele, ADIEM's vice chair, is NMA's EM chair, and Tyson Pillow, ADIEM's secretary/treasurer is also NMA's secretary/treasurer.

Sheryl Heron, MD, MPH, ADIEM president (left), and Gina Porter, MD, ADIEM resident member

From left: Andrew Sama, MD, president of ACEP; Ugo Ezenkwele, MD, ADIEM vice president; and William Durkin, MD, MBA, president of AAEM

The theme of the conference was obesity as related to emergency department patients. It was apropos given the increasing attention to the obesity epidemic in the United States. As in years past, there were presentations by the presidents of the American College of Emergency Physicians (ACEP) and the American Academy of Emergency Medicine (AAEM), Dr. Andrew Sama and Dr. William Durkin. The conference was four days in duration, with a rich array of diverse evidence-based topics, ranging from the management of complications from bariatric surgery to dealing with obese patients in trauma. In addition, residents showcased their research on health disparities and scientific interventions for their reduction.

The success of our work on issues concerning LGBT persons in EM has resulted in an accepted submission spearheaded by Dr. Joel Moel to the ACGME conference in March 2014. Congratulations to Joel Moll and Paul Krieger on this effort. Our goals for the year continue to be: 1) to boost our membership; 2) to emphasize the value of ADIEM to our members; and 3) to serve as advisors and mentors for students, residents, and faculty across the spectrum of EM. We encourage everyone to get involved and share thoughts on the ADIEM community website. ◗