

# ETHICS ON CALL



## Dopesick Decision-making

By Mark John Neavyn, MD

The nurse approached with that exasperated “I-got-this-patient” kind of look. He described a patient who was picked up by EMS for unresponsiveness, was bradypneic with miotic pupils, and awoke with disdain after receiving 2 mg of naloxone intravenously. The patient, Ms. H, was brought in despite her wishes to avoid the ED. She refused to share with nursing or EMS what was taken and how much. The nurse asked for a restraint order because the patient is high, but I get the sense that the nurse would like nothing more than to look the other way while the patient absconds to the opium den whence she came.

### Evaluation of Autonomy

The principle of respect for patient autonomy allows patients to refuse lifesaving therapy in the emergency department. The major concern for Ms. H is the likelihood of renewed opioid toxicity as naloxone occupation of the mu receptors begins to fade. Before we can allow a patient to refuse care, we must be certain the patient has the capacity to make medical decisions.

Assessing capacity includes: 1.) determination of whether the patient can communicate a choice; 2.) judgment of the patient’s ability to understand the explanation of the medical condition and the proposed treatment and alternatives; 3.) measurement of the patient’s appreciation of the medical condition and what the outcome will likely be with or without the treatment; and 4.) determination of the presence of reason

and rationality in the patient’s decision-making process. This last component of decisional capacity is arguably the most vulnerable to physician interpretation and is at the crux of the dilemma with Ms. H.

Certain withdrawal states can cause delirium such that reason and rationality is lost. The most common drug withdrawals in this category include sedative-hypnotics, alcohol, and dopamine agonists such as amantadine and bromocriptine. Opioid withdrawal in an otherwise healthy adult is uncomfortable, but does not affect a patient’s sensorium in the same way. The craving for opioid, however, can be overwhelming. Add to that craving a severe physical illness and a patient’s motivation to avoid further discomfort can compete with reason and rationality.

Naloxone-induced opioid withdrawal is messy in both a gastrointestinal and bioethical sense. The suggested initial dosing of naloxone in opioid-dependent patients is 0.04 mg IV bolus titrated to respiratory rate greater than 10. Often, opioid-dependent patients are given excessive amounts of naloxone, inducing acute opioid withdrawal syndrome. Naloxone is administered emergently in the setting of severe bradypnea. Consequently, we justify adverse effects by avoiding respiratory failure. However, this cavalier attitude toward excessive doses of naloxone can be harmful, particularly in the setting of multidrug ingestions because the patient remains somnolent while experiencing opioid withdrawal symptoms. This is a recipe for aspiration and a complicated airway.

If we exclude multidrug ingestions and focus solely on opioid overdose, we are still left with a major complication from judicious naloxone use: How do we determine decisional capacity if the patient is in pain and actively vomiting? The patient is motivated to seek relief from those symptoms outside of the emergency department. By actively causing pain and discomfort, regardless of the motivation to do so, we have placed the patient in a vulnerable position and have threatened the patient's autonomy. The patient is forced to decide between the ongoing noxious symptoms caused by the healthcare provider or leaving against medical advice and seeking relief elsewhere.

### Handling Refusal of Care

Refusal of care in the emergency department is a common occurrence. As emergency medicine physicians, our medical decision-making is often hurried and filled with distraction. A heuristic approach to these medical decisions can improve our response times and decrease our vulnerability to mental distraction. Unfortunately, our assessment of decisional capacity in the setting of intoxication and withdrawal cannot be neatly illustrated in an algorithm.

When assessing a patient's decisional capacity, we must take into account the medical question we are asking the patient. Is the patient being asked to consent for emergent surgery for a life-threatening condition, or is the patient being consented for simple, uncomplicated laceration repair? A patient can lack capacity in critically important decisions, but maintain capacity to weigh in on lesser questions. Capacity is not binary. This is an important distinction in the setting of intoxication and withdrawal states, which are also moving targets as a patient's level of intoxication invariably declines over time. Given enough time, intoxication transforms into a withdrawal state in the drug-dependent patient. Between these two vulnerable periods lies a window of capacity in which the patient is able to rationally illustrate the decision regarding a specific medical intervention.

### Ethical Judgment

My major concern for Ms. H was the risk of renewed opioid toxicity. I had to be sure the patient was firmly within the window of capacity before she was allowed to leave against medical advice. I sat and spoke with the patient and let her know I understood the discomfort she was experiencing and that, while she was under my care, I would make sure she was more comfortable. The patient lacked concern for ongoing opioid toxicity; she did not believe that her life was in danger. The patient expressed several times that she wanted her withdrawal symptoms to be resolved. Using the components of decisional capacity described earlier, I was concerned that she did not appreciate the severity of her medical condition and the consequences of refusing treatment.

Unfortunately, since she was not forthcoming with her ingested drug, it may have been possible she had more information regarding her current medical condition than I did. Without knowing precisely what she ingested, I could not fully determine the chance of recurring opioid toxicity.

In addition, her decision to choose treatment of withdrawal over treatment of potential overdose recurrence could be a potentially rational one, depending on whether she had been using a long-acting opioid. The determination of decisional capacity for Ms. H. was tenuous and required supporting evidence.

This case illustrates not only the difficulty of determining capacity in opioid-dependent patients but also what is at stake in the determination. During my discussion, the patient developed increasing anxiety and tachypnea, but she was distinctly lacking other more obvious symptoms of withdrawal. I put her back on the pulse oximeter; her oxygenation was 90 percent. After a quick auscultation of her chest, I realized the patient had developed noncardiogenic pulmonary edema. If this patient had managed to leave the emergency department prior to developing this known complication of opioid toxicity, she almost certainly would have died. Conversely, if the patient had been restrained because she "lacked capacity," she would have become increasingly agitated as the drowning sensation of noncardiogenic pulmonary edema set in, which may have led to a disastrous outcome. In the end, a tincture of time allowed us to monitor and treat this patient appropriately.

It is vitally important that we consider the patient's autonomy before administering an excess of naloxone. By using heroic doses of naloxone instead of small easily titrated boluses, not only do we create a potentially complicated airway but also risk stripping the patient of autonomy.

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### About the Author:

Dr. Mark Neavyn is an emergency physician and medical toxicologist. He is the director of medical toxicology and attending emergency medicine physician at Hartford Hospital in Hartford, Connecticut and is a member of that hospital's ethics committee in addition to the SAEM ethics committee. Dr. Neavyn has particular interest in the ethical treatment of intoxicated patients, in both recreational use and intentional self-harm, when fundamental principles of autonomy, beneficence, non-maleficence, and/or justice are in question.