ETHICS ON CALL

Discharging Intoxicated Patients Requires a Clear Hospital Policy

By Jeremy Simon, MD, PhD

It is Friday night, a belligerent drunk man who is 40 years of age comes into the emergency department. For his safety as well as the safety of those around him, he is placed within a secure perimeter with security guards and an elopement watch. Approximately 10 minutes after being placed in a stretcher, he is deeply sedated, but the initial exam and frequent re-evaluations give no indication that the sedation is the result of anything but alcohol intoxication, and he gradually becomes more arousable.

After several hours, the patient is awake again. He is no longer belligerent, but he appears visibly intoxicated. He is irritable, slurs his speech, is unsteady on his feet, and is interacting inappropriately with the other patients in his area. Soon after waking, he calls over the ED attending and asks to be allowed to leave.

Emergency physicians have powers granted that most people do not have. In certain circumstances we can take people we know very little about and without further authorization or review prevent them from leaving the hospital, effectively imprisoning them. We have this authority when patients present an imminent danger to themselves or others. In such cases, our ethical duty to protect supersedes our duty to respect autonomy, and, the law, in general, correlates with this understanding of our duty

The clearest case for using this authority is in the acutely suicidal or homicidal patient. The law in every state provides for the involuntary commitment of such patients, and the ED is often the first point of contact with the medical system for such patients. The right to hold such patients against their will applies even when they do not lack decision-making capacity. It is the content of their decisions, and not their means of reaching them, that is the problem.

Another patient we often hold in the hospital over their protests are demented or otherwise intellectually impaired individuals. Usually this is because they lack capacity to refuse the treatment needed; thus, they cannot leave against medical advice and must be admitted for treatment regardless of their wishes. (This is not to say that every patient who lacks capacity must be admitted if they do not want treatment, just that in some cases it is the appropriate pathway.) Other times these patients must be admitted, not because they need treatment, but because there is no safe discharge plan. In effect, they are a danger to themselves if released.

The patient in our example can be difficult to place into this framework. While intoxicated people have a reduced ability to care for themselves and certainly can end up getting hurt, this is generally a risk we as a society do not try to remove. Certainly mild to moderately drunk people are not picked up by

emergency personnel simply because they are inebriated. A person seen walking on the street in the state our patient is in upon awakening would likely be directed home, not taken into some sort of protective custody.

It would seem, then, that our patient is not such a danger to himself that he cannot be allowed to leave. However, that is not the only consideration here. First, if the patient is in location where he is likely to return to a car or if he is known to have driven to the area where he was found then we must be concerned about the risk he poses to others. While the risk is not exactly comparable to that posed by a homicidal patient—where the potential harm is both intended and directed at a specific target—it may still be one we are responsible for managing. Also, given that we already are responsible for the patient's safety, the bar for considering us absolved of this responsibility (by being allowed to let him go) may be higher than the bar that allows us to avoid taking responsibility for him in the first place (by allowing him to go on his way on the street).

In the face of these competing imperatives, the general practice is to observe intoxicated patients until they can leave, by foot or car safely. However, a recent court decision in New York somewhat complicates things, at least in that state. In Kowalski v. St. Francis, New York's highest court ruled that a physician had neither the obligation nor the right to hold an intoxicated patient against his will after the person had brought himself in. In that case, a man who was allowed to leave the ED while still intoxicated was injured after leaving and sued the hospital for allowing him to leave. The hospital and doctor were not held to be liable as they had no duty to prevent the patient from leaving.

This case would seem to undercut the practice of holding patients until they can leave safely. However, before applying this case to practice, EDs should keep a few things in mind. First, this case was decided in New York and is not directly relevant to other states. Second, it related to a patient who brought himself in, and may not apply to patients who needed to be brought in against their will. Finally, in a situation where a patient may cause harm to others after discharge, the physician may have a duty to protect the public.

Ultimately, it is important for every hospital to have a clear policy on discharging intoxicated patients based on professional standards and local law.

About the Author:
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