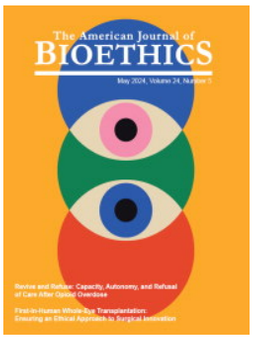

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Everyone With an Addiction Has Diminished Decision-Making Capacity

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an accurate assessment of their true understanding of risks. This is an important consideration but certainly not unique to the setting of opioid overdose. For example, patients with chest pain who refuse admission may also reluctantly repeat back stated risks without a full understanding of the risks of their actions. Opioid use disorder clearly can affect decisional capacity. However, many other clinical and social determinants of health can affect decisional capacity. As with any clinical scenario, assessment of decisional capacity is paramount to ensure an autonomous decision.

I applaud the authors' analysis of the ethical issues of capacity in the setting of opioid overdose. However, this analysis falls short of a clear recommendation to guide clinicians facing this troubling scenario. In this setting, as in all clinical settings, a patient who has decisional capacity has the right to make decisions about his/her health care. Even if the decision is a risky or inappropriate decision from the provider's perspective, the autonomous patient has a right to make that decision.

We value respect for autonomy, even if the patient's decision is not in accordance with our wishes. We allow patients to choose to make bad decisions, including smoking, not wearing motorcycle helmets, alcohol consumption, noncompliance with medications, and numerous others. Leaving prior to a recommended observation period after opioid overdose is a risky decision, but one that a patient with decisional capacity should be free to make.

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Everyone With an Addiction Has Diminished Decision-Making Capacity

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In "Revive and Refuse," Marshall et al. (2024) argue that many individuals who are revived from opioid overdoses have diminished decision-making capacity (DMC), given that so many of them have opioid use disorders (OUD). Additionally, they argue that under certain circumstances these individuals, even if they *do* have full DMC, may not be able to render an autonomous choice about whether to stay for a period of observation or not after being revived. In our opinion, the authors' argument misses the fact that everyone with an active addiction has diminished DMC, not just those immediately revived from opioid

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overdoses. Additionally, we believe that the emergent quality of the post-naloxone window argued for by the authors is not actually unique, that the distinction made between DMC and autonomy is trivial on a practical level, and that the concept of autonomy is underdetermined and vague.

For the authors, OUD is a disease that "may fundamentally distort patients' perceptions of risk, and undermine or at least alter their capacity for rational choice." They do not fully commit to whether or not this disease compromises DMC even in non-emergent clinical visits, but do give reasons for why DMC may be compromised in the specific setting of the naloxone-reversed patient. These reasons include residual intoxication, acute opioid withdrawal, and "neurochemical changes associated with OUD that present a threat to autonomous choice," including limbic and pre-frontal cortex adaptations that make it difficult, if not impossible, for these individuals to resist "first-order desires to get high" in the pursuit of higher-order desires such as health.

One of us (JWB) is a psychiatrist who specializes in substance use disorders (SUD) and who has worked with thousands of individuals with SUD, including many with OUD, and the other (GE) is a senior medical student. Every individual we have ever known with OUD can offer numerous reasons why they ought not use, but those reasons mean nothing when they start to go into withdrawal and crave their drug. The same is true for the other threats to DMC mentioned by the authors, including the possibility of intoxication during an outpatient visit or the neurochemical adaptations that can allegedly "hijack the brain." As such, we fully agree that DMC is compromised for individuals with OUD after they are revived, but far beyond that narrow window, we believe that DMC is in fact compromised all of the time with respect to opioids for individuals with OUD.

Given that reality, should we physically restrain or chemically sedate every patient with an OUD who is at imminent risk of using, whether they are out on the streets or sitting across from us in an exam room? Of course the answer is no, but given the authors' argument, the question is not so ridiculous. It seems that their view is that the period following post-naloxone revival is unique insofar as there is imminent risk of rebound apnea and death—the actual likelihood of which is indeterminate but probably low (Vilke et al. 2003; Kolinsky et al. 2017; Willman et al. 2017; Greene et al. 2019)—and that given the unique risk involved, in conjunction with the individuals' reduced DMC, we might consider certain scenarios where the "physician's duty to beneficence" trumps the patient's autonomy.

But opioid users are not at risk of death just in the setting of just having been revived. Given fentanyl's omnipresence in our street drug supply, any single use of street opioids is potentially lethal. As clinicians we've lamented watching patients with OUD leave after our outpatient meetings, knowing we might not see them again. Despite that very real fear and concern, we do not detain all individuals merely due to their OUD. And if we don't detain everyone with OUD for reasons of the diminished DMC inherent to the disease of addiction, we should not consider detaining newly revived individuals who wish to leave prior to a reasonable period of observation just because of their diminished DMC. All of these individuals are at a very real risk of dying, and an individual with OUD might in fact have a higher risk of dying after leaving a scheduled office visit compared with absconding from an ER after being revived from an overdose.

The authors also reflect on OUD patients who *do* have sufficient DMC. They consider a patient with DMC who nevertheless makes a non-autonomous choice, someone they label an "ego-dystonic refuser." The idea here is that for certain individuals the choice to leave the ED aligns, upon reflection, with their higher-order feelings of self and their own addiction, whereas for others the choice in the ED does not. Given the multifactorial, person-dependent, complex and often unknown etiologies of addiction, we are not convinced by this distinction. We also wonder if making such a distinction and such a complex judgment in an ED setting would be even remotely possible.

Either way, there are numerous instances in which individuals make decisions that are not fully autonomous but are potentially lethal, and we nonetheless "allow" them to make these choices. Examples include individuals with alcoholic cirrhosis heading to a bar or a battered romantic partner choosing to return home instead of accepting a referral to a shelter. It is often painful—to put it mildly—to see individuals make these decisions. While patients' decisions such as these might go against what we believe to be the best course of action for the individuals' health and safety, we do not force treatment except under the most specific and careful of circumstances, none of which apply to an individual with OUD who meets certain requirements of DMC and wants to leave the ED.

Can you imagine telling a patient in a busy ED who has DMC that you are morally obliged to keep them in the hospital, against their wishes, because

their present decision conflicts with higher-order beliefs that you, who has just met them, know that they hold about themselves, and therefore they have surrendered autonomy in this situation?

Finally, while not unique to this paper, much of the argument presupposes an underdetermined notion of autonomy. To their credit, Marshall et al. do offer a description of what they mean by autonomy: a "robust" ability to choose, a "process of reflective self-evaluation," and the ability to "harmonize individual goal-directed choices" with more stable, self-defining values. This notion of autonomy as self-determination emerges from Kant's conception of morality as a practice unique to rational beings capable of self-governance. Compared to the way in which Kant's conception has been refracted into contemporary bioethics, though, Kant's own argument is much more subtle. For Kant, autonomy, or self-governance, is something that human's *may* enact, but only insofar as they transcend their consequentialist, desire-based actions of self-interest and instead act in accordance with an unconditional moral law derived from the nature of reason itself (Kant 2015).

But we are not of the belief that the transcendence that would be required in a Kantian world is possible, and instead look to Spinoza for a more realistic appreciation of the human condition as it relates to autonomy. For Spinoza, self-governance is always a matter of degree—a goal, but not a fact or a starting point (Spinoza 2005). In Spinoza's conception, we are born dependent on others, overwhelmed by emotions and bodily needs, and while we may gain more control and understanding of these affects and needs as we age, it is certainly not a given that one achieves autonomy over circumstance and ignorance. We make choices the reasons of which we are unaware, acting on the whim of emotions and conflicting beliefs, and only in the rarest cases does a human consistently act with autonomy.

Given their heavy reliance on the concept of autonomy throughout their paper, Marshall et al. should have spent more time detailing what constitutes a sufficiently "robust" ability to choose or a sufficient ability to unify immediate choices with the stable values that one might hold over time. Without this clarification, we do not see how one can convincingly make a judgment about whether a given choice is autonomous versus non-autonomous. After all, many individuals without OUD make short term choices that are discordant with their long-term values—such as a person in a committed, loving relationship who succumbs to passion with a third party—and we do not question their ability to make that choice autonomously. How many individuals out there even reflect upon or are aware of such stable values specific to their self-conception?

If one takes seriously Spinoza's point that autonomy is an idealized goal of life, realized to greater or lesser degrees, then the limitations on autonomy that we observe in patients with OUD, compared to patients without OUD, represent a difference in degree and not a difference in kind. And, importantly, this difference in degree, when it comes to degree of autonomy, is not universally fixed or necessarily of a lesser degree in patients with OUD compared to those without OUD. For all humans, innumerable factors influence an individuals' "robust" ability to choose. Some of these factors include the genetic and social factors that go into brain development, or the present circumstances of an individual.

The authors reference the effects of chronic opioid use on the mesolimbic system and the role of this system on decision making. Who is to say, though, whether the effects of chronic opioid use in an individual with OUD "hijack" this circuit, and decision making in general, to a greater degree than the multifactorial influences on decision making—genetic, environmental, and epigenetic—at play in another individual without an OUD. And who would dare feel confident to make such a judgment in a fast-moving ED?

It must be sheer hell to be an ED provider who sees unending waves of either dead or newly revived individuals with OUD. These physicians bear too heavy of a load on the front lines of a horrifying and wearying opioid epidemic. And as healthcare providers, of course we want to do what we believe is in the best medical interests of our patients. In view of this goal, the desire to hold newly revived patients long enough to guarantee they will stay alive through a particular episode is totally understandable. Nonetheless, for the reasons we have elucidated above, the arguments for possibly doing so fall short.

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Hospitals Are Not Prisons: Decision-Making Capacity, Autonomy, and the Legal Right to Refuse Medical Care, Including Observation

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Marshall and colleagues (2024) contribute to the literature on autonomy and decision-making capacity by focusing on the case of individuals with opioid use disorder who refuse to remain in the hospital for observation after being revived from an opioid overdose. The authors argue that although these patients may be able to evidence decision-making capacity as traditionally understood (Appelbaum and Grisso 1988), the effects of opioids and addiction may mean that these patients lack capacity and should in some instances not be permitted to refuse observation post-revival. This commentary will address overlooked aspects of their arguments.

LEGAL IMPLICATIONS

Competent adults have the legal right to make their own medical decisions, including decisions to refuse medical care (even if the result is disability or death). State laws often direct that capacity is to be presumed, but healthcare providers may assess a patient's decision-making abilities when there is doubt about a patient's capacity. If a patient is determined to lack capacity, their advance directives should be consulted or a surrogate decision maker will decide on their behalf, and these alternatives to contemporaneous patient decisions are facilitated by law. Further, state legislatures are increasingly adopting supported decision-making laws that entitle more individuals to make their own decisions despite cognitive impairments (Wright 2019; Wright 2020).

Because the authors do not engage deeply with law and legal scholarship, it is unclear how they would recommend emergency physicians handle revived patient's advance directives (if completed and available) or interact with the patient's surrogates or supporters, especially if the decisions made in advance, with decisional support, or by another person may be to refuse observation after the patient is revived from an opioid overdose.

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