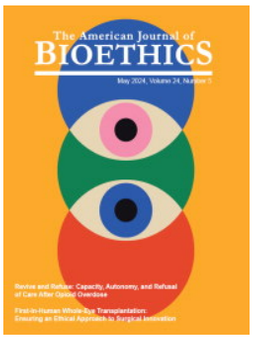

The American Journal of Bioethics

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/uajb20

Opioid Overdose and Capacity

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To cite this article: Catherine A. Marco (2024) Opioid Overdose and Capacity, The American Journal of Bioethics, 24:5, 33-34, DOI: 10.1080/15265161.2024.2327298

To link to this article: https://doi.org/10.1080/15265161.2024.2327298

Published online: 18 Apr 2024.

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THE AMERICAN JOURNAL OF BIOETHICS
2024, VOL. 24, NO. 5, 33–34
https://doi.org/10.1080/15265161.2024.2327298

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Opioid Overdose and Capacity

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In this issue, Marshall et al discuss the importance of capacity and autonomy in the setting of opioid overdose, in *Revise and Refuse: Capacity, Autonomy, and Refusal of Care After Opioid Overdose* (Marshall et al. 2024). This discussion is particularly relevant in the current environment where opioid overdose is a public health crisis in the United States. The number of opioid deaths continues to rise annually (National Institute on Drug Abuse 2024; Ahmad, Rossen, and Suppon 2023), and disproportionately affects younger age groups (Shekhar et al. 2024).

The issue of autonomy in the setting of recent opioid overdose is significant. Patients who have been resuscitated after an opioid overdose face significant short-term complications, including recurrence of CNS depression, respiratory depression, pulmonary edema, arrhythmia, or even death. The long-term complications are also abundant and may include pathophysiologic complications (including risk for repeat overdose, infections, endocarditis, thrombotic events, HIV infection and numerous others) as well as psychosocial complications (including addiction, homelessness, unemployment and others) (Tipping et al. 2023).

Why then do patients often request early discharge after resuscitation? From the health care perspective, this request seems illogical and ill-advised. It seems obvious that patients with a potentially life-threatening illness should seek medical care for this condition. Reasons for refusal of care in this setting may include a false sense of security, fear of withdrawal, distrust of the medical establishment, feelings of shame or embarrassment, fear of loss of confidentiality, and numerous others that we may not fully understand.

A recent study found widely divergent approaches to refusal of care following treatment of opioid overdose (Joseph et al. 2020). Wide variation in practice confirms the challenges of balancing beneficence and respect for autonomy. Some clinicians believe that making such a risky decision allows one to question their capacity, which involves an element of paternalism. We may project our opinions to the patient and erroneously assume they lack capacity if they disagree with such an important medical decision.

Equally valid is the challenge of accurate assessment of capacity in this setting. As with all patients, assessment of capacity is an essential element of informed consent or informed refusal of care. Other clinical scenarios in which a patient wishes to refuse care also necessitate an assessment of capacity. Disagreement with our recommendation is not necessarily evidence of lack of capacity. Some patients in their enthusiasm for departure may appease the clinician by reciting back risks of leaving without a complete comprehension of the risks. The ability to repeat stated risks may not be

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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.

DISCLOSURE STATEMENT

No potential conflict of interest was reported by the author(s).

FUNDING

The author(s) reported there is no funding associated with the work featured in this article.

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THE AMERICAN JOURNAL OF BIOETHICS
2024, VOL. 24, NO. 5, 34–37
https://doi.org/10.1080/15265161.2024.2327289

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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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