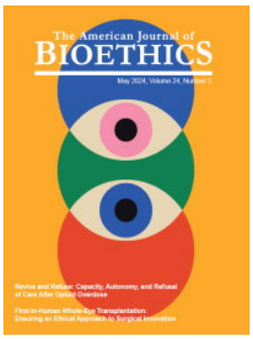

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OPEN PEER COMMENTARIES

Autonomy-Based Obligations to Patients in the Emergency Department Following Opioid Overdose

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INTRODUCTION

Marshall et al. (2024) persuasively argue that some patients with opiate use disorder (OUD), who refuse observation after naloxone resuscitation in the emergency department (ED), "may be making non-autonomous choices, even when meeting common criteria for DMC [decision-making capacity]." In response, Marshall et al. endorse a two-pronged approach: first, emergency physicians (EPs) should employ a more demanding ("thick") conception of DMC; second, EPs should "facilitate compliance" by "restack[ing] the deck"—i.e. introducing and leveraging incentives and disincentives to "enable autonomous choice."

While we are sympathetic with Marshall et al.'s proposal in the context of the relevant patient population, it is not *in general* ethically appropriate either to employ a thick conception of DMC or to stack the deck in favor of providers' recommended interventions. And this calls out for explanation: why are Marshall et al.'s strategies appropriate for some patients in some circumstances, but inappropriate for others?

In this commentary, we will offer just such an explanation. We will begin with two illustrative cases in which employing a thick conception of DMC and deck-stacking (respectively) would constitute unacceptable violations of patient autonomy. Next, we will distinguish three autonomy-based obligations that can both help vindicate the thick conception of DMC and deck-stacking in the patient population of interest to Marshall et al., while also explaining why these strategies are at times impermissible in other kinds of cases.

TWO CASES OF AUTONOMY VIOLATION

First, consider Henry. Henry presents to the ED with hernia pain. The surgical team offers to admit Henry and perform a corrective procedure. Without surgery, Henry's pain will continue, and he will almost certainly end up back in the ED. But Henry declines, stating that he is not willing to wait two hours for the procedure.

In such a case, it is clear that we should accept Henry's declination—it would be inappropriate to impose surgery given the relatively low stakes of his refusal. But, importantly, employing a thick conception of DMC—on which a patient qualifies as capacitated only if they can relate their decision to a set of stable values, beliefs, or goals—makes this verdict difficult to secure. Very plausibly, Henry's choice is not connected to any "stable or enduring set of values." Consequently, on a thick conception of DMC, Henry lacks capacity and hence lacks the authority to decline treatment. But, again, this strikes us as the wrong verdict and wrong because it is an unacceptable violation of Henry's autonomy. So employing the thick conception of DMC is not always appropriate.

Next, consider Joan, the life-long Jehovah's Witness who is declining a blood transfusion that would save her life. Suppose that, in addition to being a Jehovah's Witness, Joan is deferential by nature and eager to please members of the medical team. Joan is declining blood products on the basis of her long and deeply held religious commitments. But, given her dispositions, the medical team is confident that they could convince her to agree to the transfusion by stacking the deck—for instance by telling Joan they are worried about what would happen if she did not receive a blood transfusion or by appealing to the concerns of her friends and family. But surely such manipulation is wrong and wrong because it would constitute an unacceptable violation of Joan's autonomy. So, deck-stacking is not always an appropriate way to influence a patient's choice.

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THREE AUTONOMY-BASED OBLIGATIONS

Now, consider Ned, who represents the sort of case that is of primary interest to Marshall et al. Ned is brought to the ED for evaluation after overdosing on an opiate and receiving naloxone. The team recommends that Ned stay in the ED for several hours to be monitored for rapid rebound apnea and pulmonary edema. Ned appears to understand the risks of leaving. Nevertheless, he declines to stay. Again, we agree with Marshall et al. that it is appropriate both to employ the thick conception of DMC and to stack the deck in favor of keeping Ned in the ED. But why are these strategies ethically appropriate in Ned's case, yet are inappropriate in the cases sketched in the previous section?

To answer, it will be helpful to distinguish three kinds of autonomy-based obligations relevant to clinical care. To be autonomous is to be self-governing—to have the capacity to govern one's life in accordance with one's commitments (goals, preferences, values, etc.). Given this, there are two ways in which practitioners can *respect* a patient's autonomy: they can ensure that the patient exercises control over (i.e. governs) their care or they can ensure that treatments accord with the patient's commitments. In addition, practitioners are well-positioned to benefit patients by *promoting* their autonomy—for instance, by bolstering autonomous capacities or structuring a patient's circumstances to facilitate autonomous choice. Each of these correlates with a distinct autonomy-based obligation—the obligation to respect autonomy-as-sovereignty by ensuring that a patient is in control; the obligation to respect autonomy-as-authenticity by ensuring that a patient's treatment is consistent with their commitments; and the obligation to promote patient autonomy by increasing the degree to which a patient or their decisions are autonomous. And these (pro tanto) obligations must be traded off both against one another and against other obligations relevant to patient care.[1]

THICK AND THIN DMC AND DEGREES OF AUTONOMY

With these autonomy-based obligations clarified, we can better see why the thick conception of DMC can be appropriate in cases like Ned's but inappropriate in cases like Henry's. In Ned's case the risks of allowing him to leave are high—his life is at risk. Given this, Ned's decision must be clearly and robustly autonomous for our reason to respect his autonomy-as-sovereignty to outweigh our obligation to protect his health and well-being. So, when the stakes are high, a thick conception of DMC is appropriate because it assesses a *higher degree* of autonomy than does the standard (thinner) conception. The thought then is that Ned can refuse observation only if his decision is s*ufficiently autonomous*; and, since the stakes of refusal are so high, 'sufficiently autonomous' is best assessed by a thick conception of DMC.

In Henry's case, in contrast, it would be inappropriate to hold him to the standard of a thick conception of DMC. For Henry, there is much less at stake, and so our reason to protect his well-being by keeping him in the hospital is not strong enough to outweigh our reason to respect his autonomy-as-sovereignty by allowing him to refuse treatment. In this way, our proposed framework allows us to recognize the autonomy considerations that are at stake even when a patient is not making a *fully* autonomous decision. If we insist—as Marshall et al. repeatedly suggest—that the decisions of patients who fall below the threshold of a thick conception of DMC are "non-autonomous" then it is difficult to account for the reason to defer to patients' decisions in cases (like Henry's) in which the stakes are low. Better, we think, to explicitly acknowledge that autonomy comes in degrees and then select a thick or thin conception of DMC based on the level of autonomy we wish to assess in light of the stakes of the relevant choice.[2]

DECK-STACKING AND AUTHENTICITY

Distinguishing these autonomy-based obligations can also help make clear why deck-staking can be appropriate in cases like Ned's, but inappropriate in cases like Joan's. First, at baseline, there are barriers to accepting care that patients like Ned face which can be unproblematically addressed by stacking the deck—shorter observation periods, treating withdrawal, creating a less stigmatizing environment of care, and proactively addressing fear of law enforcement are

[1]For more on the distinction between autonomy-as-sovereignty and autonomy-as-authenticity, see Brudney and Lantos (2011), Enoch (2022), and Schwan (2021). For a canonical discussion of autonomy as a value (to be promoted) and as a demand (to be respected), see Darwall (2006).

[2]Importantly, *risk-sensitive* approaches to DMC are well-positioned to capture these tradeoffs between well-being and autonomy considerations. For a recent, forceful defense of a risk-sensitive approach to DMC, see Kim and Berens (2023). For concerns about capacity assessments obscuring such tradeoffs, see Fogal and Schwan (forthcoming).

autonomy-promoting approaches that reduce disincentives to accepting care. Joan (we can imagine) does not operate at Ned's baseline, which explains why such deck-staking would be inappropriate in her case. It is because of the obligation to promote autonomy, and the less-than-fully-autonomous nature of Ned's refusal, that these strategies are appropriate.

Second, it is unlikely that Ned's decision to leave implicates any deep commitments or values, and so offering incentives—such as "food, comfort, or pain relief while in the ED, connecting patient to longer-term resources to address other wants or needs, such as food security or shelter" and "a direct appeal specifically to the relationship between the patient and physician" (Marshall et al. 2024, 20)—is unlikely to risk inducing Ned to choose in a way that is contrary to his commitments. But the same cannot be said of Joan. Introducing incentives to persuade Joan to accept care would be to violate her autonomy-as-authenticity. The appropriateness of deck-stacking, then, is in large part a function of whether the deck is being stacked in favor of options that are most consistent with the patient's commitments.

CONCLUSION

Marshall et al. offer a helpful, two-pronged approach for treating patients with OUD who refuse observation after naloxone resuscitation. But their recommendations are not generalizable to all clinical settings. Distinguishing the three autonomy-based obligations can help explain when and why their recommended strategies are appropriate, and might help guide practitioners' treatment of patients in settings beyond the ED.

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