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When can Physicians Fire Patients with Opioid Use Disorder for Nonmedical Use of Prescription Medications?
***Levi Durham. Journal of Clinical Ethics, 2024*[1]**

Short summary

This article discusses the circumstances under which it may be appropriate to dismiss hospitalized patients with Opioid Use Disorder (OUD) who are illegally injecting drugs in the health care facility from medical care. Based on a case about a 35-year-old patient with OUD who is injecting opioids while in hospital, the authors analyze physicians' responsibilities to their "non-adherent" patients. Durham argues that only under circumstances where the benefits outweigh the expected harms of involuntarily discharging the patient is it acceptable for a physician to 'fire' their patient from medical care.

Introduction:

PR, a 35-year old patient with OUD, is in hospital for treatment of multi-antibiotic-resistant bacteria. PR also receives medication treatment of his OUD. PR enjoys regular visits from family and friends. During his hospital stay staff discover that PR is injecting opioids that someone is bringing in for him. As a result of this discovery, the hospital administration decides to prohibit PR from having visitors. In addition to this, an ethics consultant recommends involuntary discharging of PR to prevent harm to staff and to avoid criminal activity in the hospital.

Key Arguments

Durham argues that:

a) ***Involuntary discharge of a patient with OUD should be a last resort only***. It may be considered in three situations: 1) in cases where the patient is exhibiting abusive behavior; 2) if the patient threatens other people in the hospital, or 3) if the patient is violent toward other people in the hospital.

   Physicians have responsibilities to provide care that promotes the well-being of the patient and to not abandon the patient. A total prohibition of visitors is very likely to cause great harm to PR's well-being given that he values visits highly. When considering whether to involuntarily discharge a patient, it is important to carefully weigh the responsibilities to the

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patient against risks to health care providers, other patients, and to the patient's well-being. If the risk of harm to a patient's well-being associated with the involuntary discharge is greater than the benefits to the hospital staff and premises, it is inappropriate to move forward with such an approach. Durham argues that this is indeed the case for PR, because he does not represent a risk to other patients and because it is possible to mitigate the risk of harm to PR's well-being. Risk of harm to his care team can be addressed through precautionary measures aimed at minimizing the risk of infection or injury from syringes that he might have left in the room. Involuntary discharge of PR on the ground that he is non-adherent to treatment may be considered abandonment.

b) ***In some circumstances a patient's risky behavior can outweigh clinicians' responsibility to promote patient well-being***. ***In such cases, involuntary discharge of the patient with OUD may be acceptable as a last resort.*** First, it is argued that dismissing a patient from care during a life-sustaining treatment (like the one PR is going through) could be considered abandonment. Dismissing a patient from care should be a last resort only and should be proportional with the risk of harm if the patient stays in hospital. If the patient poses a significant risk to other people, including the health care team, and everything that could possibly mitigate this risk has been done, it may be reasonable to dismiss the patient from care. Situations that may prompt involuntary discharge could include verbal or physical abuse, sexual harassment and/or engaging in illegal activity that poses a risk to other people in the hospital.

c) ***Steps can be taken by staff to accommodate patients with OUD.*** These steps include 1) engaging sitters to supervise patients at risk of using illegal substances, to minimize the chance of them being able to inject themselves; 2) reducing or restricting visitor access; and 3) fostering of trust between the provider and the patient by allocating extra time to work with the patient with a view to find best possible options for treatment.
With regards to 1) and 2) it is important to weigh the benefits of these steps against the harms to the patient's privacy and/or to the trust relationship between the patient and the health care provider.

Conclusion

Physicians should strive to take the least disruptive approach to manage patients with OUD who are exhibiting behaviors that interfere with their treatment/care plan. Patients with OUD who are non-adherent to treatment should not be dismissed from hospital care on this basis alone. Involuntary discharge of patients with OUD should only take place as a last resort, when all other steps are exhausted and only in situations where the patients is exhibiting behaviour that poses a risk to other people in the hospital.