Case Scenario
A 33-year old white male (we’ll call Mr. Smith) with a history of chronic pain secondary to systemic lupus erythematosus, rheumatoid arthritis, and fibromyalgia presented to the Medical Center of Central Georgia Emergency Room after overdosing on approximately 20 Darvocet tablets (each containing 650mg of acetaminophen) at one time. He had been receiving a narcotics prescription for his chronic pain from his primary care physician but stated that his doctor had stopped prescribing these medications for him. He went to a rheumatologist earlier the same day of his hospital admission and received a prescription for Darvocet. Mr. Smith stated that he had been depressed and was tired of hurting. When asked if he was trying to kill himself, he stated that he just wanted to stop hurting.

The major medical issue for this patient was liver damage from acetaminophen overdose. His initial acetaminophen level was 212. This level was well into the critical level which is considered >40. A repeat acetaminophen level was done, and it was 126. On admission to the ER, Mr. Smith was given activated charcoal by mouth. After careful consideration of the timing of the overdose, the acetaminophen blood level, and consulting poison control, the ER physician decided to give him Mucomyst (N-acetylcysteine), the antidote for acetaminophen poisoning, intravenously. The staff internal medicine service was consulted to take over his care, and the ER physician initially caring for Mr. Smith left the hospital after his shift ended. Several hours later, Mr. Smith complained of shortness of breath, itching, and breaking out in a rash around his neck. He felt that he was having a severe allergic reaction to the Mucomyst. During this time, his vital signs remained stable. The internal medicine resident caring for him then ordered to stop the Mucomyst and consulted an ER physician for advice for this situation. The ER physician felt that an anaphylactic response was a scary situation but was one that could be treated…acute liver failure from acetaminophen toxicity could not be treated except with liver transplant, something that was likely not going to happen for this patient. Therefore, it was decided that it was in Mr. Smith’s best interest to be given Benadryl, IV steroids, and an H2 receptor blocker for the allergic response and to restart Mucomyst. Not understanding the severity of his medical situation and saying he felt fine, Mr. Smith became very angry and adamantly refused the Mucomyst. The consulting ER physician decided to go in and try to explain the situation to him. The patient only got more and more angry. The ER physician decided that Mr. Smith came into the hospital after trying to kill himself with an overdose and was refusing life-saving therapy; therefore, a form 1013 was completed, and Mr. Smith was forced into 4-point restraints by hospital law enforcement because of his violent thrashing and refusal of care. He was then treated with IV Mucomyst involuntarily. Mr. Smith had an uneventful stay in the medical ICU, and his acetaminophen levels dropped to normal within 2 days. He was discharged two days after his admission.
Ethical Conflict
The ethical tenets of patient autonomy, paternalism, beneficence, and non-maleficence are wrapped in this case.

In every patient encounter, physicians should strive to allow a competent patient to make his or her own healthcare decisions. This is the basis of the patient’s right of autonomy, or self-government. Moral philosophers define autonomy as “the moral right to choose and follow one's own plan of life and action.” Respect for a patient’s autonomy allows a physician to often stay out of the way from interfering with the goals of the patient. A physician is allowed to interfere with a patient’s desires or actions only when those desires will directly cause harm to the patient or infringe upon the rights of others. However, in many instances, the root of the problem between a physician and a patient making a seemingly poor decision regarding his or her health boils down to miscommunication. I feel that poor communication played a large role in Mr. Smith’s overdose case discussed above. I do not feel that Mr. Smith truly understood how serious his acetaminophen level was and the repercussions of such a high level. He adamantly stated, “I feel fine” and resolutely expressed that he did not want the Mucomyst. He did not understand that his “allergic reaction” to the Mucomyst was being treated and hopefully prevented with medications and that he likely would not feel the shortness of breath and itching he felt before. I also do not feel that he understood that the physicians caring for him truly had his best interest at heart. He felt attacked, robbed of his personal rights, and manipulated.

In cases similar to the one described above, there arises a great tension between autonomy and paternalism. Paternalism is the idea that “beneficence is a higher value than autonomy.” In other words, a physician may rarely make the decision to forego a patient’s autonomy and treat him or her appropriately if the patient’s desired decision is clearly going cause harm to him or her or others. The physicians in Mr. Smith’s case choose to override his decision to reject life-saving therapy and treat him anyway. In this case, I feel that the physicians made the right decision. Nevertheless, it is always hard as a healthcare provider, even if morally and legally in the right, to infringe upon a patient’s autonomy.

The principles of beneficence and non-maleficence should be at the core of every physician’s heart in the practice of medicine. To always strive to do what is best for the patient and to do no harm to the patient is what every honorable physician desires. In the middle of the Hippocratic Oath, the writer states concerning his patients that “I will do no harm or injustice to them.” Every physician has also committed “[t]o keep the good of the patient as the highest priority.” I believe that the physicians caring for Mr. Smith had a good understanding of these two ethical principles. They felt that they would be doing the patient harm by not treating him with potentially life-saving therapy. If they had agreed with the patient’s wishes and not treated him, Mr. Smith would likely have gone into fulminant hepatic failure and possibly died a slow, painful death. The physicians would obviously have felt disheartened and could have easily been held liable for the patient’s demise if he not been treated and had a poor outcome.
Relevant Laws and Regulations
Involuntary treatment often refers to psychiatric treatment for someone with limited decision-making capacity. In 1975, the U.S. Supreme Court ruled in O’Connor vs. Donaldson that involuntary treatment and/or hospitalization in unconstitutional and violates an individual’s civil rights. Although the ruling differs slightly from state to state, there are several loopholes for involuntary treatment if there is imminent danger to an individual or others.6

Potential Consultants
1. The emergency room physician who was consulted in this case could have discussed the case with the attending physician on the internal medicine service.
2. An emergency psychiatric consult could have been obtained. These physicians are sometimes more adept at communicating to patients and gaining useful information about how patients are feeling inside. Maybe Mr. Smith would have responded well to a psychiatrist’s approach. A psychiatrist could have also helped answer a few questions not vividly clear to me: Was Mr. Smith trying to commit suicide when he took the 20 Darvocet tablets? Did Mr. Smith understand the gravity of his situation, liver toxicity, liver failure, etc.?
3. An ethics committee ideally could be consulted in situations like those presented in this case, but with emergencies, this scenario is not always possible.

Possible Decisions and Outcomes
1. Patient autonomy over beneficence—Mr. Smith’s autonomy could have been honored and the Mucomyst been withheld. He could have been treated with other medications as supportive care. I disagree with this approach. I agree with the consulting emergency room physician that liver failure cannot be treated except with transplant. An anaphylactic response to Mucomyst can be relatively easily treated…even if it required intubation.
2. Paternalism over patient autonomy—This was the decision made in Mr. Smith’s case, and I agree. The risks of not treating him for acute acetaminophen poisoning outweighed his right to self-government. He was possibly suicidal and was refusing life-saving therapy, and therefore his decision-making capacity could have been called into question.

Proposed Regulations
I believe that physicians should be reminded of the importance of communication with patients when they face emergency cases with serious ethical implications. If good rapport can be established with patients initially (which is many times difficult in the emergency room setting), I believe that more patients would agree with the physician’s judgment in emergency situations.

1 http://en.wikipedia.org/wiki/Autonomy
5 http://en.wikipedia.org/wiki/Hippocratic_Oath
6 http://en.wikipedia.org/wiki/Involuntary_treatment