Called to the emergency center for a psychiatric consult on a 46YO female threatening to leave AMA to have a cigarette, the team encounters an ethical dilemma because the woman presents with an ulcerating lesion on her right great toe. Upon entering the patient’s room, the smell of gangrene was readily apparent. The team learns that the patient had removed her IV insulin lines four times because she wanted to go outside and smoke a cigarette. The patient had been informed that she could not leave the hospital on insulin IV on account of sunlight’s effect on insulin. The critical nature of the patient’s lesion is explained in clear detail with the threat that if left untreated, the lesion would spread and could result in loss of foot or limb. The patient acknowledges the severity of her situation but demands she be allowed to have a cigarette “to calm [her] nerves.” Since it has been three hours since her last cigarette, she “is on edge.” The patient refuses Nicotine patches as “they don’t work.” Due to the severity of the lesion on the patient’s foot, the team decides that it is inadvisable for the patient to risk leaving the hospital without a surgical consult and wound treatment. Despite subjective observance of a misplaced sense of priorities in the patient, the patient’s mental status and level of awareness is deemed sound enough to declare her competent in decision making. Because the hospital still provides a “smoke room” for psychiatric patients on 6 East, a compromise was reached with the patient that she could be transferred for surgical evaluation and allowed to continue insulin therapy while retaining indoor smoking privileges. By meeting the demands of the patient in transferring her to an area where she could smoke, did the team compromise the ethical standards of non-smoking to care for an acute medical condition?

The patient, a type II diabetic with a recent HbA1C of 13.6 and POC glucose of 534, presents to the EC with a 3 month history of the ulcerating lesion on her toe. She had refused medical treatment in the past due to time and scheduling. She presents to the EC because family
was concerned about the appearance of the lesion and the smell. The patient’s past medical history also includes hypertension and dyslipidemia. She has no past surgical history and family history is positive for congestive heart failure, diabetes, and hypertension. The patient is noncompliant with home medications for her diabetes, cholesterol, and blood pressure. Social history is positive for smoking 2 packs of cigarettes per day for the past 30 years. She occasionally consumes alcoholic beverages but denies illicit drug use. The patient’s physical exam is notable for extreme agitation, elevated blood pressure of 146/95, and prominent gangrenous lesion on her right great toe. The rest of her physical exam was within normal limits. The patient reported no known drug allergies and is non-compliant with home medications of metformin, beta-blockers, and Simvastatin. She does take one daily aspirin of 81mg.

By January of 1992, the Joint Commission on Accreditation of Healthcare Organizations, JCAHO, declared that all hospitals would be smoke-free environments in order to receive federal funding. The hazards of cigarette-smoking and the effects of second-hand smoking are stipulated facts well supported by research and is not the focus of this ethical dilemma. In the spring 1998 issue of *Tob. Control*, 96% of U.S. hospitals were found to be compliant with JCAHO’s non smoking-policy. Of the hospitals surveyed, 41.4% enacted policies more restrictive than required by JCAHO standards. The limiting factors on hospital policies involved hospitals with psychiatric and substance abuse facilities. The question of whether psychiatric patients should be allowed to retain smoking privileges as inpatients in the hospital is an ethical question of some debate but is beyond the scope of this current situation. The question did arise among the medical team. The team’s attending physician was noted to routinely discontinue all smoking privileges for inpatients of 6 East. The basis of that decision is the known health detriment of cigarette smoking combined with the effects of cigarette smoking.
with mental illness and smoking contaminants impact on the metabolism of psychiatric medications. The argument is balanced by the fact that many psychiatric patients are dependent on cigarettes and see smoking as a fundamental need in maintaining some level of mental and/or emotional stability. In addition, the burden of the smoking ban resides on the hospital staff that must deal with the complaints of patients not allowed to smoke. The hospital does allow ambulatory patients the ability to leave the hospital for smoking breaks in designated areas. For psychiatric patients that cannot leave 6 East, a designated smoking room is available if the patient has received smoking privileges from a doctor. Hospitalized patients are offered nicotine patches to help with withdrawal symptoms. In 2002, a study of smoking patients and compliance revealed that “one-quarter of smokers admitted to a smoke-free hospital reported smoking during their hospital stay, although only 4% of smokers admitted violating policy by smoking indoors.” In addition, “within 48 hours of admission, 55% of smokers reported cigarette cravings and 29% of smokers reported difficulty refraining from smoking.” The study further reports that those with strong nicotine cravings and withdrawal symptoms were more likely to smoke during hospitalization and also to continue smoking after discharge. The study also reveals that abstinence from smoking during hospitalization held a strong independent factor in smoking cessation after discharge. Nevertheless, the debate regarding allowing psychiatric patients the ability of a smoking room and privileges is not the focus of this dilemma.

In this particular situation, a patient with a potential medical threat to limb and life threatened leaving the hospital against medical advice so that she could smoke a cigarette. To what extent does the burden of health care fall on the medical provider to comply with patient demands for the greater good of treating the acute medical condition? Would it have been medically sound to only offer the patient the nicotine patch, detail for her the concerns with not
seeking medical treatment, and allow the patient to leave the hospital AMA if she so chose? To what degree should a physician be willing to negotiate with a patient to act in his or her perceived best interests? In the acute setting, surgical consult and treatment of the gangrenous lesion is paramount and emergent as delay of care poses a serious threat to loss of foot, leg, and potentially life.\textsuperscript{5} The hazards of cigarette smoke have also to be considered but are of longer-term consequence. Nevertheless, allowing the patient to smoke presents a health hazard for not just herself, but also other patients and hospital staff exposed to the second-hand smoke. While this exposure is limited with the smoking room, adequate ventilation does not completely remove second hand exposure and still presents a risk to by-standers. In addition, smoking presents a potential problem as to wound healing and may exacerbate her other medical conditions.

The patient does not have any documented or perceived psychiatric illness aside from the dependence on cigarettes and noncompliance to medical recommendations for her health. Her decision-making capacity is deemed to be intact albeit not in her best medical interests from the views of her providers. Given the option of transferring to 6 East for medical care, surgical evaluation, and smoking privileges, the patient chooses to act in the interests of her health and did not place her health in jeopardy by leaving AMA. The patient refuses Nicotine patches for control of cravings and withdrawal. She was verbally abusive to nurses and staff in the emergency center when she did not receive permission to go outside and smoke, but when given the option of smoking on transfer to 6 East, the patient is again calm and compliant.

The case demonstrates the powerful hold of nicotine on the patient decision-making capacity. In addition the case presents an interesting point of ethical conflict on the patient care team. In multiple settings, the team has observed the attending physician stand by principles of non-smoking among psychiatric patients. Yet, in this particular case, the noted emergent need
for surgical care of the gangrenous lesion caused the physician to negotiate with the patient and allow smoking privileges. The patient is transferred to 6 East as a medical patient not admitted to psychiatric service. The patient is to be monitored for diabetic control and surgical care, but because the patient is not in direct care of the psychiatric team or consult nurse, ongoing smoking cessation efforts are not likely to occur. Whether such efforts would be efficacious is questionable given the patient’s history, non-compliance, and adamant stand on smoking.

From a particular standpoint one could view the patient as having held her health and life hostage for the sake of a cigarette. Seen in this light, the psychiatric team became negotiators in a hostage situation. Certainly, this is an extreme viewpoint, but it is more or less accurate. The patient dictated terms of her health care refusing treatment if her demands were not met (cigarette smoking privileges.) On one hand the doctor is called “to first do no harm” and to offer help to those in need of medical care. To achieve the second part, the psychiatric team was forced to allow the patient to continue with a harmful activity, namely, smoking. Ultimately, the decision was made based on the more serious of the patient’s two conditions.

In discussing the situation with the patient, alternative solutions are evaluated. The patient, while retaining competency, could refuse medical treatment and could leave the hospital AMA. The patient could theoretically get an appointment with a surgeon on an out-patient basis. Because of the patient’s long-standing history of non-compliance and a 3 month delay in wound care already, the medical team believes that the patient is not likely to seek active care in a timely fashion. Because of the high level of glucose in her bloodstream and the ongoing detriment of hyperglycemia, the patient required insulin. Taking her off the insulin to allow her to ambulate outside for a cigarette at her convenience would not be feasible given her time demands for a cigarette every two hours. The patient refuses to use the Nicotine patch to ward
off cravings and withdrawal symptoms. This option simply does not provide the desired effect that smoking gives her. Because the patient is deemed to be competent, she can not be restrained and treated medically without her permission despite attempts to operate in her best interests. Under less severe circumstances, the smoking room option would likely not be brought to the offering table. As already noted, the attending physician does not readily permit the use of the smoking room even to inpatients on the psychiatric service. Time definitely plays a factor in this situation. The length of time it took the patient to be admitted to the EC and be seen by a physician adds onto the time since the patient’s last cigarette. The length of time required to stabilize and treat the patient’s hyperglycemia exceeds the patient’s ability to go without a cigarette. Within the allotted 15 minutes before the patient was planning to leave AMA, the physician’s team was required to reach a compromise that would enable the patient to get the necessary treatment under conditions that she would agree.

Given the constraints and severity of the ethical situation described, the best answer to the dilemma is achieved by doing what is necessary to ensure that the patient complies with medical care. In this particular instance, granting smoking privileges enables the patient to retain a sense of control and permit hospital admission for surgical consult. Given the patient’s history of non-compliance and the severity of the gangrenous lesion, the physician team’s best chance to help is during the current visit. Delay in surgical treatment would almost certainly result in loss of foot, limb, or potentially life. Because the patient is considered competent in decision making capacity, it is fully within her right to refuse medical treatment. From a medical standpoint, delaying treatment of gangrene because of a smoking break appears unconscionable. So too, if all it takes to get a patient to comply to much needed medical care is allowing that person to have a cigarette, is it conscionable to stand on principle and deny the patient the smoking break? The
solution to this problem was considerably easier because an available indoor smoking room existed. Had such an option not been available, it is conceivable that the patient would have left against medical advice and have been lost to follow-up. In this situation, choosing to care for the urgent medical need required the physician team to forsake values of non-smoking.
References