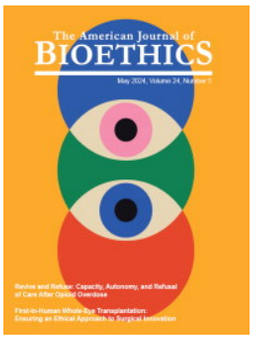

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OPEN PEER COMMENTARIES

Autonomy and Its Constrictive Effects on Our Ethical Lenses and Imaginations

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Marshall and colleagues (2024) bring to broader academic and public attention a genuine and difficult dilemma to which emergency physicians are confronted with. The dilemma could be summarized as:

1. respecting the autonomy of patients with opioid use disorder at face value, so to speak, when they refuse to stay for a subsequent period of evaluation after taking a fast-acting antidote such as naloxone, or
2. refusing to take such decisions for genuine expression of autonomous choices and thus envision alternate clinical approaches not solely based on respect for autonomy.

I wish to commend the authors for naming, characterizing, and explaining this important ethical tension since the specific clinical contexts they report are part of our societies. In this sense, these situations, as well as the response to the needs and sufferings of persons with opioid use disorder, concern all of us. The current opioid crisis looms large, and it is notably by exposing the situations it creates in our health institutions, that more of us, including voters and policymakers, will understand the sufferings and challenges created.

To substantiate their concerns about the extent and quality of autonomy and decision-making capacity in this group of patients within this specific clinical context, the authors provide ample evidence from wide-ranging conceptual and empirical literatures, which I will not directly question. Simply put, there is a compelling case to be made about the compromised decisions of persons with opioid use disorder based on evidence from neuropsychology, neuroscience, ethics, and the analysis of the conditions of autonomy and decision-making capacity. My purpose in this commentary is to reflect on the lens adopted by the authors, heavily focused on considerations related to autonomy and decision-making capacity. I want to bring forth the value of building from and extending this descriptive lens, notably in terms of imagining ethical responses.

EXPANDED DESCRIPTIVE LENSES?

Although I have not been part of the reported situations, I suspect there are important additional aspects at stake to grasp these situations more fully. For example, we do not really know about the reasons why physicians live—in their own words—these situations as important ethical dilemmas. We also do not have a comprehensive account of how these dilemmas emerge, notably in the unavoidable web of human relationships, institutional obligations, and socio-political and economical facts. The physician's commitment to the patient's wellbeing and their duty to care properly for them readily comes to mind as a core feature of the ethical landscape (Pellegrino 2001). Now, while it is true that taking into consideration the autonomy of persons with opioid use disorder in those situations is also part of a beneficent and responsible attitude, the ethical commitments of physicians loom larger. In addition to the welfare of the patient, ethical concerns are likely related to why this patient group is being treated unfairly. If they are too easily considered to be autonomous, there is a risk that they will not get what they need in terms of support and services. They will not be treated fairly or equitably if we adopt narrow concepts of autonomy and decision-making. As the authors explain, other commitments of physicians become more salient when patient autonomy is undermined, especially when the clinical condition at stake challenges said autonomy and decision-making capacity. These commitments are part of the experiences and lives of physicians and other clinicians we will gain from better understanding to grasp what this pandemic is and entails.

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POTENTIAL IMPLICATIONS OF EXPANDED DESCRIPTIVE LENSES?

Now, why do I stress the importance of these other commitments? Because I fear that a "reduction" of the moral aspects of the reported situations to concerns for autonomy and decision-making capacity can have important epistemic, practical, and methodological implications.

First, from an epistemic standpoint, describing these situations more holistically could help us understand the frustration and perplexities experienced by emergency physicians. Surely, many physicians struggle with not being able to take care of patients with opioid use disorder properly and feel like the situations reported are not being adequately addressed. Such experiences—I do not want to put words in the mouths of physicians, since these experiences should be studied—risk undermining therapeutic relationships and commitments if neglected (Cho et al. 2022). Additionally, to bring back these clinical situations to their larger economic and political context, we would benefit from hearing these stories, the moral experiences at stake, and their implications in terms of, for example, moral distress and frustration generated. Likewise, as pinpointed by the authors, we need a better account of the experience of persons with opioid use disorder because we could learn from them, as well as the reasoning and rationales at the basis of their sometimes-surprising behaviors (Hassan et al. 2023). Accordingly, experiential accounts of stakeholders involved in those situations are needed and research should be undertaken to expound them holistically. Society needs to know what clinicians are being faced with because patients and their physicians are integral parts of our communities.

Second, linking back to the first point and tying into some of the more practical recommendations presented in the target paper, perhaps a better understanding and communication of the experiences of frustration will be the route to imagining effective solutions? In fact, what if issues such as boredom and feelings of time wasted in the emergency department are "reasons" why persons with opioid use disorder leave the emergency department prematurely? What if there are physical changes which could be made to accommodate them? What if providing distractions and forms of entertainment could be a strategy? What if peer support could overcome some of the difficulties in deadlocked conversations between patients and physicians? What if institutions could offer, in creative forms (e.g., dedicated spaces or environments), an antidote not only to the drug, but to the dismissal of the observation time? Finally, what if the individualistic aspects of autonomy and decision-making capacity—along with the very values and consumerism they can reflect—are part of broader cultural underpinnings of the opioid crises many countries are experiencing?

Third, methodologically, the link to moral experience could be facilitated if forms of collaborative research and patient-partnerships methods are used to help supplement clinical practices and potentially clinical guidelines beyond legalism and deontology, as the authors already lead us to think. Participatory research, including in the context of substance use disorder, suggests the clinical and ethical value of peer navigation (Ntizobakundira et al. 2023), patient partnerships (Karazivan et al. 2015; DelNero and McGregor 2017), peer support (Parkes et al. 2019; Lennox, Lamarche, and O'Shea 2021), peer mentorship (Collins et al. 2019), and other forms of engagements. These approaches could also help all of us expand our understanding of problems and further our imagination of solutions.

It is detrimental to silence discrepancies between how things are and how we imagine and want them to be. The authors need to be commended for openly exposing clinical realities that many of us are not fully aware of because it is by revealing their human impact that we can begin to address such situations meaningfully. From their contribution, a vast program of research and innovative interventions should be supported. Through this, it will become possible to break free from the shackles of quotidian moral thinking. Further creative work will enrich the landscape beyond the horizons of autonomy and decision-making capacity and contribute to solutions to a terrible and devastating multifaceted epidemic.

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OPEN PEER COMMENTARIES

Revive and Respect: Using Structural Competency and Humility to Reframe Discussions of Decision-Making Capacity

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In the target article, "Revive and Refuse: Capacity, Autonomy, and Refusal of Care After Opioid Overdose," Kenneth D. Marshall and collaborators (2024) highlight important complexities in the care of patients with opioid use disorder (OUD). As physicians, bioethicists, and social scientists with expertise in addiction, street, and emergency medicine, we relate to the important clinical and ethical concerns motivating the article. However, we worry that the authors' central argument—that patients with OUD may be acting non-autonomously when refusing observation after revival with naloxone even when they demonstrate an understanding of the attendant risks—could harm patients. The authors minimize the tangible risks of restraint and forced treatment, and the serious physiologic consequences of withdrawal for this patient population.

In our theoretical and clinical work, we view this complex clinical scenario through a lens currently underutilized in bioethics: structural competency and the associated concept of structural humility, originally articulated by Helena Hansen and Jonathan Metzl (Metzl and Hansen, 2014). Using a structural analysis recognizes the imbalance in power and

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