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A 30-Year-Old Patient Who Refuses to Be Drug Tested

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Jalal B. Jalaly, Kelly K. Dineen, and Ann M. Gronowski
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Guests:
Dr. Ann Gronowski, Washington University; Dr. Kelly Dineen, Saint Louis University School of Law; and Dr. Lachlan Forrow, Harvard Medical School.

Bob Barrett: This is a podcast from *Clinical Chemistry*, sponsored by the Department of Laboratory Medicine at Boston Children's Hospital. I'm Bob Barrett.

The practice of medicine is not always clear-cut. Healthcare providers are often faced with difficult decisions such as what test to perform on patients, what treatment should be given, and what type of follow-up is needed. Providers have a duty to enhance the wellbeing and minimize harm to their patients.

In turn, patients have a right to govern themselves, which may include refusing a doctor's orders. Ethical dilemmas in healthcare occur when these principles conflict. The June 2016 issue of *Clinical Chemistry* published a Clinical Case Study about a patient who refused urine drug testing. The case study explores the basics of biomedical ethics and discusses the difficult dilemma that drug testing can often pose for both doctors and patients.

Today, we have with us Dr. Ann Gronowski, Professor of Pathology and Immunology at Washington University who led the discussion for this case study, and her coauthor Dr. Kelly Dineen, an Assistant Professor of Health Law and Ethics at Saint Louis University School of Law. Dr. Dineen holds a joint appointment with the Albert Gnaegi Center for Health Care Ethics and is the co-director of the Bander Center for Medical Business Ethics. They are joined by Dr. Lachlan Forrow, an Associate Professor of Medicine at the Harvard Medical School and director of ethics support service at Beth Israel Deaconess Medical Center in Boston. And Dr. Gronowski, let's start with you, can you briefly tell us the details of this case?

Dr. Ann Gronowski: Sure. In this case, a 30-year old African-American man with sickle cell disease came to the hospital because he had joint pain, shortness of breath, a non-productive cough and chest pain. A chest X-ray and a CT scan showed that the patient had cavitary lesions in the lungs. In addition, a transthoracic echocardiogram showed some tricuspid valve regurgitation and a 3 by 2.8 centimeter mass at the base of

the posterior tricuspid valve, which is consistent with vegetation. His blood culture was positive for S. viridans. The patient was diagnosed with right-sided infective endocarditis and started on IV antibiotics.

Bob Barrett: So why was your team of clinical laboratorians called in?

Dr. Ann Gronowski: Well, infective endocarditis can be a complication of IV drug use. It's suspected when the right heart valves are infected by organisms such P aeruginosa or C albicans and while hospitalized, the patient had two subsequent blood cultures that were positive for P. aeruginosa and C. albicans.

In addition, during his stay, the patient was confrontational. He left the hospital frequently and sometimes he refused to have his vital signs monitored. He had a history of drug abuse and therefore because of his behavior and the infection that he had, there was concern that he was using his IV catheter to abuse drugs while in the hospital.

Confirmation of IV drugs can eliminate the need to search for other causes of symptoms and can affect treatment. However, the patient refused to submit a urine sample for drug screening, but his blood was drawn with no objections. A serum screen for drugs of abuse was ordered by the team that was caring for the patient, and at our institution, this test requires approval and it's generally only approved in cases where the patient cannot make urine.

Bob Barrett: So why is a urine drug screen as opposed to a serum drug screen important in this case?

Dr. Ann Gronowski: Well several factors affect our ability to detect drugs of abuse. These include how much drug is ingested, how often it's ingested, how it's taken, the test method that's used and the type of specimen. Urine, serum and saliva can all be used for drug testing, but urine testing is the preferred method because it's both non-invasive and more sensitive than serum or saliva.

Generally, the detection time for drugs of abuse in urine is longer than it is in serum. So urine is the preferred sample and we discourage the use of serum. However in this case, we discovered that the patient had refused urine drug screening and was unaware that the serum drug screening was ordered. So this raised some questions in our mind about what we should do.

Bob Barrett: Okay thank you Dr. Gronowski. Now let's turn to attorney and ethics expert, Kelly Dineen. Dr. Dineen first off, can you review for us the basic principles of biomedical ethics?

Dr. Kelly Dineen: Yes there are basically four principles that are most often appealed to in bioethics. The first one is respecting the person, which we also short-hand and call autonomy, meaning we respect their right to self-determination. The second one is beneficent, so maximizing the benefit or the good for the patient. The third one is non-maleficence or doing no harm or in truth, it tends to be minimizing harm whenever possible. And the fourth one is justice so, trying to reasonably distribute the benefits and burdens for patients in the healthcare system broadly and sort of individually as well.

Now everybody thinks, "Let's do all of these things" right? And if you can take an action in healthcare that honors all of them, great, there is no problem. They also often conflict and it doesn't cause a problem. The most classic example of that would be something like consented to surgery for an abnormality. So surgery itself is inherently harmful, right? But the benefit to be gained from correcting the abnormality is sort of worth the harm, the risk that you go through. And if it's consented to, then we know that it's consistent with that patient's desires. So that also doesn't cause an ethical conflict.

We run into trouble is when, one action causes a conflict and it's not as easy to resolve. For example if you have a conflict between the desire to improve the patient's health, but the patient doesn't want the intervention. That's a very common conflict that pits, sort of, the patient's self-determination and autonomy against what might be in the best interest of the patient.

And in ethics, we tend to say that one principle doesn't necessarily trump the other, in practice though, particularly given the legal history of the treatment of autonomy as being sort of the default that we go to if two conflict, and that has to be resolved. In the legal system, the law and in practice tends to honor autonomy over beneficent. So to the extent that an adult patient capable of consenting or refusing can refuse a treatment for any reason even if it means an earlier death or their life will not be saved as a result.

Bob Barrett: So it sounds like in this case, the principle of patient autonomy and the principle of a physician's duty to enhance the patient's wellbeing were in conflict. Is this a common ethical dilemma in medicine?

Dr. Kelly Dineen: Absolutely. This conflict arises every time for example that a treatment recommendation is met with refusal by the patient. So for the most part as I mentioned, autonomy tends to trump, and that is in part because of law's

validation of sort of the historical and social deference to individual's right to self-determination.

In this case, the patient has cited a general consent that allowed blood testing. However he had clearly voiced an objection to drug testing through refusal of urine drug testing. So overriding his objections to drug testing in general, may be very problematic, at least ethically if not legally.

Bob Barrett: Why is drug testing often a difficult ethical dilemma?

Dr. Kelly Dineen: Well, I think it presents a particularly problematic situation because, first, people with substance use disorders are highly stigmatized in the society, right?

In this particularly case, the patient was also African-American and had another highly stigmatized disorder, sickle cell disorder. So the impact of that kind of compounded stigma is likely pretty serious and really not measured well by anyone. But even more important than that, the results of a drug screen for illegal drugs, right, so we weren't talking about alcohol here. We were talking about drugs that are currently illegal. So, those results implicate far more than just health status or perceived irresponsible heath choices, they implicate criminal behavior as well.

So, it is completely reasonable for patients to fear repercussions on multiple fronts. So, this is why it is especially important to be mindful as health care providers of how our own biases—right? we're all just humans living in a society, we're all prone to implicit bias—to be aware of how those things can adversely affect decision-making.

And to get back to what I spoke about earlier, was to think about, what will this result actually do for the patient and come up with solutions that might bridge the gap and allow you to continue a good treatment plan without making the patient feel like they were tricked in any way.

Bob Barrett: Okay, Dr. Dineen. Let's move over now to Dr. Lachlan Forrow. He is an expert in medical ethics and provided a commentary on this case. Dr. Forrow, let's start with this, what are some of the most common ethical problems that you see facing hospital-based physicians?

Dr. Lachlan Forrow: I think, the starting point is just to think about what are the ethical responsibilities of hospital-based physicians, which are to take care of each patient in the best possible way. Meaning, achieve the best possible medical care in a way that's respectful of the patient as a person. That gets framed as helping the patient the best way, as beneficence,

kind of responsibility and respect for the patient and what they would want as autonomy.

The most common ways in which those questions about respect for autonomy and helping the patient the best way come up in the hospital these days is hospitals across the country have patients who are unable to voice for themselves what they would want. And then it's hard to know the best way to take care of them. Often they haven't formally designated health care proxy or the decision-maker. And what's tragic is, almost all of those are completely preventable ethics issues because if earlier upstream in the outpatient setting, or in a prior hospitalization, when the patient was able to talk to us we would have understood the patient as a person and what they wanted and then we wouldn't have the ethics dilemma in the first place.

I think the second category of ethics issues that come up for doctors in hospitals these days are sometimes, when the best plan of care for patient is actually not supported by our health system, the patient's health insurance, their financial and other barriers, and that's again a whole group of cases that often are completely preventable if we actually had a more rational health care system, health insurance policies, that would allow us to have available to patients including after discharge, care plans that honestly often are less expensive than the hospital and better for the patient.

So those are two categories of cases that hospital-based physicians faced virtually every day.

Bob Barrett: In general, how do you suggest approaching cases where the duty to respect patient autonomy conflicts with the duty to enhance the patient's wellbeing?

Dr. Lachlan Forrow: When it seems like -- and I say "seems" because it's not always true that respecting a patient's autonomy, what the patient would want, conflicts with our duty to enhance the patient's wellbeing, the first question is, "Is there really a dilemma here? Are we really correct in our sense of what would enhance the patient's wellbeing? And are we really clear about what the patient wants, or would really want if he or she understood the choices and what might be ahead?"

One of the most common examples of that in the United States today, for example, is a patient or the family member may be pushing or insisting on highly burdensome interventions designed to prolong life. And yet nobody has either, during this admission or earlier on, had an honest conversation with the patient about the fact that their illness is progressive, ultimately fatal, and that saving their life in

the long-term is not even an option beyond the immediate moment.

And then also, sometimes our sense of what really is best for patient in our own definition of -- or guess about the patient's wellbeing. If we really understood the patient herself and what really was most important to her, we might end up with a very different sense of their wellbeing.

So for example, regularly -- not just in hospitals but nursing homes and other facilities, not just doctors but family members, really prioritize for the patient's wellbeing issues like safety, which is a natural well-meaning concern.

But if you speak to older adults in the United States, safety is for most of them not their most important goal, not the most important thing from their sense of their wellbeing. Independence often is much more important to them. And so in fact, if we say a patient's wellbeing should be defined by what's important to them, sometimes there isn't even the conflict we think there is.

Bob Barrett: Well, let's gets specific. In this particular case, is there another approach that might have been taken?

Dr. Lachlan Forrow: I think, absolutely. I'll make two observations. First, the way the issue is framed in this case was that it was important to know -- or have air-tight evidence, that was important to have air-tight evidence about whether or not this patient was actively using illegal drugs in ways that threatened his health and our ability to help him.

Then to find that out, the staff believed that we needed either blood serum or urine tests to prove whether or not he had been using illegal drugs. But actually the care plan that the staff implemented based on the positive drug test, which is a 24 hour sitter, could have been implemented independent of any drug testing, the suspicion was already there. Or the staff could have approached the patient who made it clear that he didn't want his blood tested for drugs.

I think it would be reasonable to assume that if he knew his urine was going to be tested for drugs, he wouldn't have wanted that either. Despite that, one could sit with the patient and say, "We're concerned enough that you have been using drugs that you're going to have to need to have a 24 hour sitter, unless you agree to the test which shows that in fact the drugs aren't in your system." That would have not involved a violation of the patient's autonomy or wishes. So often I think there is a third path, a different choice that doesn't require us violate patient autonomy.

But I would say actually in this case, the most fundamental clinical issue is the patient's addiction. In my own hospital regularly, we have patients who come in with endocarditis or life-threatening complication of addiction, and we identify the medical problem as their endocarditis, when in fact, the life-threatening disease the person has is addiction, and we could drug test or do other things, so that we can have the best basis for treating the endocarditis, we're not treating the true disease.

And if we haven't actually taken an approach, that has a chance of succeeding in treating the person's addiction, even if we succeeded in this hospitalization, the patient is virtually certain to leave, virtually certain to use drug he's addicted to again, and that's a fatal illness that we haven't even addressed.

So, if we were framing this person's care in terms of what I think is the underlying truly fatal disease he has, which is addiction, everything about the way we interacted with him ought to have been designed to maximize the chances of establishing an alliance with him to deal with the addiction. And violating his autonomy doing tests he didn't agree with, my concern is that that would further alienate him and make admittedly small but not zero chance of lifesaving treatment of his addiction that should have been the priority.

Bob Barrett: And thank you so much Dr. Forrow. That was Dr. Lachlan Forrow, Associate Professor of Medicine at the Harvard Medical School and Director of Ethics Support Service at Beth Israel Deaconess Medical Center. He was joined by Dr. Kelly Dineen an Assistant Professor of Health Law and Ethics at Saint Louis University School of Law and with Albert Gnaegi Center for Health Care Ethics and the Bander Center for Medical Business Ethics. And by Dr. Ann Gronowski, Professor of Pathology and Immunology at Washington University in Saint Louis who led the discussion for this podcast about a 30-year-old patient who refused to be drug tested. That case study appeared in the June 2016 issue of *Clinical Chemistry*.

I'm Bob Barrett. Thanks for listening!