What are the physician's legal obligations towards intoxicated patients? Can informed consent ever be obtained from intoxicated patients? What should the physician do when the intoxicated patient refuses examination or treatment? Can a physically aggressive patient be restrained or sedated? Does the doctor have a legal duty to arrange for supervision when an intoxicated patient is discharged?

There are few patients more disruptive in an emergency department (ED) than those intoxicated with alcohol or drugs. They are often belligerent and noisy, they are always difficult to assess, and on occasion they may threaten the safety of hospital staff. Their mere presence in the ED often raises the stress level of physicians, staff and other patients alike. There may be a desire to deal with them as quickly as possible, so they can be discharged and the department can return to its normal level of function. However, it is important that this sense of urgency not lead to errors in diagnosis that could result in possible harm to the patient and medico-legal difficulties for the doctor and other ED staff.

The courts in Canada have made it clear that the staff working in the ED of any public hospital that offers itself as a 24-hour care facility has a duty of care to all who present for medical services—including those who are intoxicated. This duty applies equally to physicians working in or on call for the department. It is important, therefore, to consider how to fulfill that duty of care, and to recognize that it comprises several other duties: to attend, diagnose, treat, and provide discharge instructions and follow up advice as appropriate.

DUTY TO ATTEND
Sometimes ED staff members ask, “Do we have to see this person?”—especially if the patient has been attended in similar condition on previous occasions. But, even though it is not always pleasant to attend an intoxicated patient, it is the obligation of the most responsible physician to be satisfied that the assessment of the patient is adequate, whether done by the physician or delegated to another health professional.

DUTY TO DIAGNOSE
An intoxicated, uncooperative patient may present unique challenges in the context of clinical assessment and diagnosis.

If, despite reassurance, the patient remains disruptive, emergency physical restraint may be necessary to enable the appropriate assessment to proceed. The importance of immediate assessment to determine if a medical emergency exists must be weighed against the patient’s right to consent to or refuse examination, investigation and treatment. A patient who is able to understand the nature and anticipated effect of the proposed intervention and the alternatives, and appreciate the consequences of accepting or refusing, can be considered to have the mental capacity (competence) to either accept or refuse investigation and treatment, even if they are also under the influence of alcohol or drugs. Where a patient does not have capacity, and there is an imminent threat to life, limb or health, a physician has the duty to do what is immediately necessary even without consent. However, consent should be obtained from the patient or substitute decision maker as quickly as is practical. It is
important to document, as soon as reasonably possible, the considerations and efforts leading to the decision to act without consent.

Occasionally, intoxicated patients may pose a danger to the physician and/or hospital staff. Only when the immediate risk to staff outweighs the risk of delay to the patient might it be considered reasonable to postpone assessment and treatment. Where there is a genuine threat, and all reasonable measures have failed to reduce that threat, it may be appropriate to restrain the patient physically and/or with medication, or to contact hospital security and/or the police.

**DUTY TO TREAT**

When the assessment is complete and a diagnosis made, the patient has the right to be told not only the diagnosis and recommended treatment, but also the risks and benefits of treatment, as well as the risks of refusing such treatment. As with assessments, it is important to remember that a competent patient has the right to refuse treatment, even if the decision seems unwise or even irrational. Some physicians have asked whether all patients intoxicated by alcohol or drugs should be considered incapable of giving consent. The answer is “no.” Assessment of capacity is a clinical one, involving the factors mentioned earlier. It is not based on a laboratory value such as a blood alcohol level.

Physicians have sometimes asked whether it is appropriate to fill out a form for involuntary confinement of intoxicated patients who refuse treatment the doctor considers appropriate. Such forms are generally mandated by the mental health act of a province, and it is important to comply with all of the criteria set out in the legislation. It is unlikely that patients with simple intoxication will meet the criteria. Only where a clear mental illness coexists with intoxication, and all the criteria are met, would involuntary admission be appropriate. Similarly, where it has been necessary to restrain a patient, hospital staff may ask the physician to complete a form for involuntary confinement. If the patient does not meet the criteria in the applicable mental health legislation, physicians should resist such requests. At the same time, it is wise for the physician to document the basis for concluding that a patient is either capable or incapable, and the reasons restraint measures were deemed necessary.

**DUTY TO ADVISE OR INSTRUCT**

Whether the patient has accepted or refused treatment, a physician is expected to provide appropriate discharge instructions. These might include issues such as the need for follow up and symptoms that would mandate a more urgent reassessment. Even if a patient insists on being discharged against medical advice, he/she should still be given appropriate advice. It is important to document the advice given. Some physicians go so far as to ask other ED staff to witness the advice given to a patient leaving against medical advice, although this is not always necessary or practical.

One important consideration is whether the patient is fit to drive. The patient may have arrived at the ED in his/her own vehicle, and...
might be planning to drive home. If the physician has concerns about the patient’s ability to drive safely, those concerns should be expressed directly to the patient. It may be appropriate to ask hospital staff to attempt to contact relatives or friends of the patient to provide a ride. The physician’s concerns should be made clear to the staff so they will understand the importance of obtaining help for the patient. If, despite taking these steps, the intoxicated patient insists on driving, it may become necessary to notify the police of this potential danger. It is important in this case for the physician to have carefully assessed the patient to ensure such a step is necessary in the circumstances. No confidential medical information (such as diagnosis or laboratory test results) should be given to the police. This is not the same as the legislated duty to report to the driver licensing authority.

**FAMILY AND FRIENDS OF THE PATIENT**

The intoxicated patient is often accompanied by family, friends or police. The family members and friends can be helpful in calming the patient, and it may be possible to discharge the patient into their care or to have them provide transportation. However, at times they are also intoxicated and may not only be unhelpful but possibly also obstructive and noisy. ED staff has a duty to protect the safety and well-being of patients, and if the behaviour of non-patients is disruptive it may be necessary to ask them to leave or even to have them removed. However, it is important to maintain a professional attitude when dealing with persons accompanying the patient.

The prevalence of drug and alcohol use makes it almost certain that a physician working in an emergency department will be faced with assessing intoxicated patients. When doing so, an awareness of the particular risks for both the patient and the physician may help to prevent adverse outcomes.