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A Bad Influence

Many years ago, while seeing patients in a hospital urgent care center, I overheard a sessional physician tell a middle-aged man: "You probably have what we call a vascular headache. I don't think it's serious, but if you begin to have severe pain or a fever and become very confused, I want you to come back here immediately."

Though I've found humor in this exchange over the years, what caused me to think of it recently was anything but funny: several recent high-speed motor vehicle accidents resulting in the deaths of many children and adults, all caused by people driving under the influence of ethanol (DUI)—people who were expected to act responsibly by not driving at a time when they lacked the judgment necessary to make that decision.

DUI accidents are among the worst—and most frequent—experiences an emergency physician has to deal with. Almost every such incident is characterized by angry or emotionally draining interactions with drunk and uncooperative drivers who are now patients, police officers who still sometimes demand blood alcohol levels for law enforcement purposes (although the results are likely to be inadmissible as evidence under those circumstances), and, worst of all, severely traumatized victims or their surviving relatives or friends. Emergency physicians are typically required to provide rapid and appropriate clinical care for all of the victims of such accidents, including the drivers, while exercising correct legal judgments, meticulously documenting the medical record, and dealing with everyone sympathetically and diplomatically.

Over the past several decades, most states have improved the situation considerably by incorporating consent for obtaining blood alcohol levels with the issuance of drivers' licenses, passing laws that consider refusal to allow testing as prima facie evidence of an ethanol level exceeding the limit, and providing or mandating special police DUI teams with appropriate legal authority to collect such evidence. But nothing has mitigated the physical and emotional pain to the survivors or the people who cause the tragic consequences of DUI when they finally become sober, and no law is likely to do so in the future, so long as it depends on a person whose judgment is impaired to exercise the judgment not to drive—just like the headache patient of many years ago who was asked to return after meningitis affects his mental status.

"Here, have a couple of drinks, and later, if you become really confused, don't drive home" doesn't make much sense as a deterrent, nor does relying on license revocations or sending drunk drivers to prison after they become sober. Will there ever be an effective way to deal with this problem? I believe that technology will solve the problem of DUI in the not too distant future, when automobile manufacturers will be required to equip all new cars with devices that detect and lock out drivers who have elevated blood alcohol levels. Of course, even if I am correct about this as the ultimate solution to DUI, for a few years after such technology has been mandated in new cars, the older and more dangerous vehicles unequipped with the new technology will remain DUI hazards unless they are required to be retrofitted with the devices prior to vehicle inspection and re-registration.

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Until then, emergency physicians must continue to provide the best medicine possible, comfort the victims, treat their friends and relatives with sympathy, and manage drunk drivers with professionalism, all while cooperating as much as possible with police and the legal system. □