Injured and drunk in the emergency department

We are missing the opportunity to get impaired drivers off the road and into alcohol treatment.

Managing injured, intoxicated drivers is an issue of significant importance to emergency departments. Emergency physicians see more than their share of victims of vehicle crashes in which alcohol played a key role. In 2005, alcohol was a contributing factor in over 28% of all police-reported fatal motor vehicle collisions in British Columbia—127 people were killed and 3400 were injured.

Injured, intoxicated drivers treated in emergency departments are likely to have a history of heavy alcohol consumption, a high incidence of alcohol abuse, and alcohol dependence. They often have a history of impaired driving and continue to drive drunk even after their visit to emergency. Other jurisdictions have shown that licensing sanctions combined with remedial programs resulted in the greatest reduction in alcohol-related driving incidents.[1]

However, in Canada injured, intoxicated drivers are rarely subjected to any licensing sanctions because they are rarely convicted of impaired driving. Two studies have been completed in Canada that evaluated the proportion of injured, alcohol-impaired drivers who are subsequently convicted of an impaired driving Criminal Code offense. Results from the first study, undertaken in British Columbia, found that 11% of injured, intoxicated drivers who are treated in hospital are convicted of impaired driving.[2] In the second study, characteristics and conviction rates were entered into the regional trauma registry for injured, alcohol-impaired drivers admitted to hospital in the Calgary Health Region. The conviction rate was 15%.[3] These low conviction rates are in stark contrast to the conviction rates of injured, impaired drivers in other comparable democracies—jurisdictions that have different laws, policies, and procedures. In Victoria, Australia, for example, more than 90% of injured, intoxicated drivers are convicted of impaired driving. In Sweden 85% of alcohol-positive hospitalized drivers are convicted of impaired driving.

There is a reason why the conviction rate of injured intoxicated drivers is so low in this country. The current blood seizure provisions of the Criminal Code are complex and unworkable. As a result, the overwhelming majority of impaired drivers who kill and injure other road users are not charged, let alone convicted, of the serious crimes they commit. The current law has made hospitals a safe haven for these offenders. The primary reason for the dramatically higher conviction rates in Sweden and Victoria, Australia, is the broad legal authority given to the police to demand breath and blood samples. Even impaired patients not convicted of impaired driving could still be reported to the Office of the Superintendent of Motor Vehicles (OSMV). BC's Motor Vehicle Act requires that health professionals report a patient to the OSMV if that patient has a condition that may affect driving and the practitioner has advised the patient not to drive and the practitioner is aware that the patient continues to drive. In over 25 years of practice in a busy emergency department I have never seen a patient who fulfilled this requirement for mandatory reporting to the OSMV. Following the letter of the law, I would have to see patients after a car accident, advise them not to drive, see them again in the emergency department, and be told that they were continuing to drive in spite my advice.

In 2005, BC introduced a remedial program that all criminally convicted drinking drivers are required to complete. Also, the superintendent can require the program be taken based on driving record (for example, Motor Vehicle Act drinking driving convictions) or when medical evidence exists of alcohol addiction (such as a report from a GP), even if there is no criminal conviction. If a driver doesn't complete the course, his or her driver's licence will be canceled or remain canceled. As a condition of relicensing, the superintendent may require the driver to install an ignition interlock device in their vehicle. The program will be evaluated in 2009.

Counseling should start as soon as possible. Visits to the emergency department can be a window of opportunity in which alcohol counseling can be very effective. Unfortunately, this counseling is not readily available. Although some hospitals have inpatient chemical dependency resource teams, it is often difficult to arrange for a patient to receive alcohol counseling in the emergency department.

When an injured, alcohol-impaired driver is treated in the emergency department, the opportunity to apply the strategy of a combined approach of licensing action and counseling is, therefore, almost always missed.

The Emergency Medical Services Committee has drafted a number of resolutions for consideration by the BCMA that would do a great deal to help solve this serious problem. We urge the Department of Justice of the Government of Canada to amend

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aspects of the Criminal Code related to the offence of impaired driving in the circumstance in which the alleged intoxicated driver has been injured and is being treated in a hospital. Changes to the legislation need to be implemented so that injured drivers with alcohol abuse problems can readily be reported to the OSMV. We recommend that alcohol and drug abuse counseling be promptly available to every patient injured in a motor vehicle crash and who has a blood alcohol level greater than 17.3 mmol/L. This alcohol counseling should be made available to patients in the emergency department prior to discharge and be offered to patients in hospital if they are admitted and on an outpatient basis if they are discharged. We all know of the carnage that drinking drivers can cause. Effective strategies are required to deal with this problem, and we should all push hard to have these strategies implemented.

—Roy Purssell, MD
Chair, Emergency Medical Services Committee

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Dr Mimi Divinsky: 1953–2007

Miriam Divinsky was born in Winnipeg in 1953, the middle of three girls: Judy, Miriam (Mimi), and Pamela. Her family then moved to Vancouver where Mimi spent her childhood and undergraduate years. Passionate about ballet, Mimi toyed with becoming a professional ballerina; instead, she studied medieval and French history at UBC. In 1975, Mimi entered UBC medical school, where I first met her over our cadavers; we were side by side, my last name being Elwood and Mimi's being Divinsky.

Mimi moved to Toronto's Women's College Hospital for her family medicine residency. She then practised family medicine in downtown Toronto and adopted Toronto as her home. She was a Fellow of the College of Family Physicians of Canada and a lecturer in the Department of Family and Community Medicine at the University of Toronto. Mimi died in February of 2007, at the age of 53, after coping with the ups and downs and ravages of multiple myeloma for 8 years.

Mimi's family chose these words for her tombstone: "Her goodness made the world a better place." There are so many stories of how Mimi's goodness made the world a better place—if you Google Mimi Divinsky you will discover some of them, though she would never have told you about them herself—her work for the homeless, the poor and hungry, for those who have been sexually assaulted, and for the Medical Reform Group. Mimi's goodness was who she was; this was how she practised family medicine. Her patients adored her and she adored them—with her caring, compassion, and empathy—and her ability to listen to the underlying story that her patients were telling her.

Mimi was Canada's pioneer in "narrative medicine." That term was coined in 2000 by Rita Charron,[1] but Mimi had always been doing narrative medicine. Even in first-year medicine, Mimi would spend our anatomy lab coffee breaks reading William Carlos Williams's poetry or *The Problem of Pain*[2] while the rest of us swotted our anatomy textbooks. Mimi read more books—humanities, philosophy, history, literature, art, dance—than anyone I know. Mimi not only read her books, she underlined the important sentences and made notes in the margins and inserted relevant newspaper clippings and other related articles between the pages. She remembered all the details of what she read in her books—she breathed and exuded their ideas—which she would discuss with intellectuals and philosophers.

In 2003, when Rob Wedel and I started working together on gathering Canadian family physician stories, we met Mimi to explore ways that she might become involved in the project. Mimi had just cut back on her practice of family medicine because of her illness. She was grieving her loss of the practice of medicine and she was struggling with the necessary transition forced upon her; she wasn't sure how much longer she would live. She was thrilled to join the project because it resonated deeply with her and the issues that she cared about.

For this project, Mimi compiled an extensive bibliography of narrative medicine literature—all the books and journal articles that she had ever read on the subject. She hoped that her bibliography would become a resource for physicians wanting to learn more about narrative medicine for themselves and for those wanting to incorporate narrative into teaching medical students and residents. The History and Narrative Medicine Project has uploaded Mimi's bibliography onto its searchable database web page.