Commentary:

Withholding treatment from a drug addict: poor prognosis or just deserts?

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It is good that an ethics consultation was requested in this case. To begin with, some further information would help. We are told that Mr H has a ‘history’ of methamphetamine use - but not the extent of it, his periods of abstinence, or the length of relapses. It would also be helpful to know about his past hospitalizations – for example, were they for detoxification, or to treat the heart condition, or both? There is initially a clear suggestion that he is at serious risk of death if he doesn’t receive a transplant – which is surely a powerful prima facie reason for giving him one, if possible. But if this really is no longer on the cards, it is especially important to consider the LVAD option. It should also be asked whether a transplant could be considered for after an LVAD, especially if Mr H can demonstrate his willingness to maintain abstinence. All resource and cost implications should be spelled out explicitly.

Additionally, we need more information about the patient’s lack of ‘cognitive awareness’, that prevents him from participating in discussions of his treatment options. On what criteria was this judgement reached? Is it likely to persist for long, or is it a temporary result of his acute clinical condition? Finally, it would be good to have more information about his wife’s ability to fulfill
her claim to be ‘a committed and capable care-giver’, especially in view of the fact that she is soon to have a sixth child.

More centrally, the reason given for rejecting both the transplant option, and eventually the LVAD option, is the patient’s history of methamphetamine use. The doctors need to ask clearly and honestly in what way(s), if any, this is genuinely relevant to his treatment. Two possible reasons suggest themselves, though there may be others. The first and most obvious reason concerns prognosis: i.e. that his past drug use, and/or the likelihood of future drug use, make the prospect of the success of these interventions unlikely. The other possible reason (which the doctors may be reluctant to acknowledge) is that a history of harmful drug use makes the patient a relatively undeserving candidate for complicated and no doubt expensive treatment. It might be thought unfair on patients who have not brought their health problems upon themselves, if they are given equal consideration for treatment to those who have caused their own problems by their behavior. People whose problems were not caused by irresponsible choices are not responsible for their need for treatment. They may therefore be thought more deserving of treatment.

Perhaps the cardiologist genuinely thinks that prognosis is the only issue. However, he/she should ask whether this might be a smoke-screen for a more ‘punitive’ attitude – which may be hard to admit to. What would the team’s view of treatment be, if faced with a similar case of CHF, but where there is no history of drug use or other risky behavior? Indeed, what would be their view be of a patient who has knowingly and voluntarily allowed his or her health problems to come about, but incurred them while doing something admirable, such as looking after people
with infectious diseases? What about a patient with a similar prognosis (both with and without a transplant or LVAD) as Mr H, but who also has an unrelated condition that is likely to cause death in the not-too-distant future? Asking questions like this may help doctors recognize a punitive dimension to their decision-making, if it exists.

If there is a punitive aspect, then can this be defended? A possible argument is that we each have a duty to minimize our need of medical treatment, in order to make room for patients who are genuinely unable to avoid needing treatment. This duty needs to be backed up by a sanction – namely, that (say) drug users should be given a lower priority for treatment, than others. However, to operate fairly, this policy should be transparent rather than covert. And even then, it would be extremely difficult to decide which lifestyle criteria to operate. Even if one could, in theory, operate such a system, it would soon become enormously complicated and arbitrary.

Besides, it is clear that this patient is in great need, and need should be a paramount consideration. This brings us back to the difference the possible treatments would make to his prognosis. This question is particularly pertinent with respect to the LVAD. Can the cardiologist really say that such a treatment would be entirely futile, due to Mr H’s drugs history? It is possible that Mr H has already damaged his heart so much by his drug use that a LVAD would be of no significant net benefit to him – even if he abstains from drugs in future. But another possibility is that although a LVAD would be of significant net benefit if he remains permanently abstinent, his chances of remaining abstinent are judged to be low. A history of repeated relapse might be considered good grounds for this prediction.
If the decision not to offer LVAD is based on a prediction of future harmful drug use, the team needs to be very sure that this prediction is well grounded, given the enormous harm – the patient’s decline and death – that the treatment might prevent. It is, I suspect, very hard to make accurate predictions of a patient’s prospects of abstinence or relapse. Mr H’s presumed insights into addiction are probably not sufficient to prevent relapse, since relapse is (arguably) a conscious choice to use drugs again, for the pleasure it brings, in spite of knowing the dangers. At the same time, we must remember that many people do recover from serious addictions, because they eventually decide that enough is enough. If or when Mr H becomes aware of the very serious threat to his life that his drug use poses, we cannot rule out that he will make this decision.

A further important point is that expected treatment/non-treatment outcomes lie on a continuum, whether in terms of likelihood and/or degree of benefit. If Mr H has a 50% chance of significant, even if sub-optimal benefit from treatment, this should be taken seriously, especially if the alternative is a likely early death.

I suggest then that, at the very least, the LVAD be given to Mr H. If he recovers his competence to make decisions, the treatment may give him time to consider the gravity of the situation he is in, and perhaps to plan abstinence from drugs more decisively than previously. In view of this possibility, and the poor prognosis without treatment, this is the least the team can do.