

# Virtual Mentor

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## ON CALL

### Resources and Responsibility

Commentary by Jake Richards

Mr. F was a veteran construction worker living with his wife and two children when, in 1989, he developed severe back pain and rapid onset of paresthesias, pain, and limited mobility in his lower extremities. He was diagnosed with a primary spinal epidural non-Hodgkin's lymphoma (NHL) and underwent laminectomy to relieve spinal compression. But the nerve damage was severe and Mr. F continued to experience peripheral neurological deficits, including persistent pain.

Mr. F's pain was managed on methadone, which has the advantages of being a long lasting agent as well as inexpensive. His chronic pain prevented him from returning to work, and the family's only source of income was his Social Security disability check, which was frequently not enough to cover all of their expenses. Mr. F's NHL recurred in 1998 as a localized cranial tumor ("the size of an orange"). After undergoing a partial skull excision with follow-up chemotherapy, Mr. F began experiencing depression; financial strains forced him to sacrifice or space out his pain medication refills. During these gaps, he started to rely on alcohol to treat his pain. Methadone accentuates the effects of sedative hypnotics, such as alcohol, so Mr. F quickly developed dependence. The financial stress combined with alcohol use led to his wife's leaving him, and, with only his disability for income, he became homeless.

Over the next 4 to 5 years, Mr. F moved among local shelters. Many shelters prohibit or enforce strict limitation on use of narcotic pain medications, and drove Mr. F to use high levels of alcohol as he attempted, in effect, to achieve the sedation of alcohol+methadone). In 2004, Mr. F was diagnosed with severe cirrhosis secondary to viral (B/C) and alcoholic hepatitis. In 2006, variceal rupture led to his first GI bleed, and he has been in the hospital ED six times since for upper and lower GI bleeds and many additional times for alcohol intoxication.

During one of his encounters for persistent upper and lower GI bleeding, Mr. F was admitted to the ICU with a severely low hematocrit and hypotension. Bleeding could only be controlled with local injections of epinephrine throughout the GI tract. The evening after admission, Mr. F developed refractory tachycardia requiring electrical cardioversion. The resident on call remarked that the patient's only hope was a liver transplant, even though he "obviously" was not eligible. The resident spent the rest of the night calling area hospitals pleading with them to consider Mr. F for a TIPS procedure.

It is evident from Mr. F's liver function tests that he received the TIPS procedure. He has been admitted to the ED at least three times since for alcohol intoxication and, each time, is treated as a "frequent flyer" with no consideration or mention of his fragile state (i.e., increased risk of hepatic encephalopathy, etc.).

### **Questions for Discussion**

Who is responsible for Mr. F's current state of health? To what degree should our resources be allocated to treating Mr. F? Are we simply waiting for him to die?

### **Commentary 1**

**by Jake Richards**

We can approach these three questions about Mr. F's care through the lenses of justice, utility, and recidivism. The principle of justice forces us to ask who is responsible for Mr. F's current state of health; utility focuses on the effectiveness of decision making and resources being allocated now, and what we know about recidivism in those who abuse alcohol cautions us to think even more carefully about future resource allocation [1,2].

In the early 1990s, there was widespread belief that alcoholics should have lower priority for transplantation than patients with "non-self-induced" causes of liver disease. The implication was that alcoholics were responsible for their self-destructive behavior and, hence, for their disease [3]. This attitude is expressed by the ED staff each time Mr. F presents with alcohol intoxication. Considering Mr. F's history, however, this perspective does not seem just. His alcoholism is secondary to inconsistent pain management, which was influenced by his financial and social position. His use of alcohol as pain control can be further reduced to the complications from NHL, which Mr. F cannot fairly be held personally responsible for. Was his illness "bad luck?" If it was simply bad luck, then does that give us the right to give up on him now? Moreover, if he *were* personally responsible, would we have the right to give up on him now? Or is medicine a practice in which compassion tempers justice?

On the other hand, chronic peripheral pain is a known complication of prolonged spinal stenosis, and there is no guarantee that a liver transplant would reverse his symptoms. Once Mr. F's pain caused social and financial problems, management of his situation exceeded the bounds of a 15-minute primary care visit. Furthermore, Mr. F relied on the ED for medical care. Rarely can an ED physician, who is pressured to triage and treat as many people as possible, set aside time to connect a patient like Mr. F with his family, the various shelters, and other social services to assure appropriate pain management.

Rather than looking at the past and attempting to establish responsibility as a means of guiding care and resource allocation, maybe it is more appropriate to focus on current decision making. According to the residents who followed Mr. F, a liver transplant was not even an option. But 7-year post-transplant survival rates of patients with alcoholic liver disease (60 percent) is comparable to (slightly better

than) those of patients transplanted for other causes (76 percent biliary cirrhosis; 57 percent hepatitis C; 49 percent hepatitis B; and 27 percent hepatocellular carcinoma) [4]. Mr. F also carries diagnoses of “non-active” viral hepatitis C (determined by quantitative DNA analysis) as well as a recurrent non-hepatic malignancy treated with two rounds of chemotherapy. Alcoholism has no effect on viral replication [5] and he does not have any signs of NHL recurrence, so these factors should be considered independently of his alcohol. Considering his diagnostic prognoses, should not a liver transplant be an option?

Many of the arguments against allocating care to certain groups in society focus on the principle of recidivism, or the likelihood of repeating self-destructive acts. While alcoholic recidivism does occur it has been shown not to affect compliance to treatment or graft outcome [6]. Neither a liver transplant nor a TIPS procedure will affect Mr. F’s severe paresthesias, the pain in his lower extremities, or his ineffective pain management. It is not surprising that he continues to consume alcohol. Should this abuse preclude his access to limited and costly resources when, to be fair, he is in this situation because adequate resources were never made available to effectively treat his primary problem of lower extremity pain. At that point, he was not abusing alcohol or participating in any other known self-destructive acts. Why was the health care system unable despite his countless visits to the ED to effectively treat his pain? Did anyone try? Was Mr. F evaluated for surgical pain control intervention? Was he referred to a chronic pain clinic?

A liver transplant is not an option for Mr. F, and TIPS is not a cure—it is simply a band-aid. It will stop the bleeding, but at the cost of increasing his risk of alcohol toxicity because alcohol is effectively shunted through the liver and to the body (particularly the brain). More importantly, the TIPS will not reduce his pain. Justice, utility, and recidivism—many will use these approaches to inappropriately justify Mr. F’s care, but a true examination of his predicament highlights the lack of accountability on the patient’s part and on the part of health care professionals over the years—and it will cost Mr. F his life.

### References

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Jake Richards is the pseudonym for a third-year medical student at Harvard Medical School in Boston.

**Commentary 2**  
**by the MSS Committee on Bioethics and Humanities Response**

Mr. F' story is tragic, but unfortunately not uncommon. Two important issues are raised by his case: responsibility for health status and scarce resource allocation.

In terms of responsibility, as the case commentary highlights, it is often suggested that individuals who are “morally responsible” for their illnesses (and, therefore, their health needs), and may have been able to avoid them through different decision making, have a weaker claim on social resources than do individuals whose health needs are no fault of their own. Wikler describes an approach towards assessing individual responsibility for health needs in 2002. To be assigned individual responsibility for one's needs, Wikler said:

- (a) the needs must have been caused by the behavior
- (b) the behavior must have been voluntary
- (c) the persons must have known that the behavior would cause the health needs and that if they engaged in it their health needs resulting from it would receive lower priority [1].

Such criteria are not easily satisfied, especially in cases of substance abuse and the influence of barriers to health care related to lower socioeconomic status. In the present case, for example, was Mr. F's health need created both as a result of his alcoholism and as a consequence of the medical system's inability to offer effective pain management? The patient's homelessness and continual lack of health resources such as primary care, can also be considered contributing factors. In other words, analysis of the case from a micro (patient) and macro (society and medical system) perspective results in two sources of accountability, and either by itself is insufficient in accounting entirely for the decisions patients make. And, as the case commenter suggests, delivering care based on determined responsibility is not within the norms or goals of medicine. The medical profession is one in which needs are evaluated and met whether or not an individual is deemed “deserving” of care.

This egalitarian approach, however, is not always practical when allocating scarce resources and evaluating cost-effectiveness. Here the question is should higher priority be given to people who can be treated more efficiently and cheaply. Immense costs and resources are required to treat Mr. F adequately. Does that mean that he should not be treated or that he has less claim on scarce, valuable resources?

Alternatively, one can turn to potential benefit as a basis of determining just allocation. In other words, if resources such as a liver transplant or continuous monitoring of pain control were dedicated to this patient, how much would it prolong or improve his quality of life? How does this compare to allocating these resources elsewhere, such as giving the liver transplant to a nonalcoholic patient without hepatitis, or taking the immense resources required to treat his chronic pain and applying them in the treatment of ten or more patients whose compliance and follow-up care is better guaranteed? While these notions of “fair chances and best outcomes” are important to consider (and as the author describes, they are basis of current transplant allocation guidelines), it must also be recognized that they may compound existing inequalities. For example, as this case illustrates, patients of lower socioeconomic status tend to have higher comorbidities and worse prognoses than their wealthier counterparts who may have continuous primary care, better educational opportunities, and fewer barriers to compliance. Moreover, resources are not easily fungible in the way this “solution” suggests. Dollars and resources “saved” on one patient are not shifted to the care of tens of other, less complex cases. Health care financing just doesn’t work that way.

In sum, this case clearly illustrates how the complex dynamics between micro (patient-doctor) and macro (society) perspectives influence medical decision making. While a simple resolution may not be easy to determine, the case emphasizes the importance of considering social influences on a patient’s health including reduced socioeconomic status, homelessness, stereotyping, and lack of primary care and support structures.

### **Reference**

1. Wikler D. Personal and social responsibility for health. *Ethics and International Affairs*. 2002;16(2):47-55.

### **Call to Readers**

To encourage responsible ethical debate and critical thinking, the AMA-MSS Committee on Bioethics and Humanities invites medical students to submit written responses to this case. Responses should be 800 words or fewer and should be sent as an e-mail attachment to [oncall@ama-assn.org](mailto:oncall@ama-assn.org). Readers who submit comments must identify themselves by name, date of birth, and medical school so that their medical student status can be verified, but they may use a pseudonym as a signature to their comments. Letters will be published at the discretion of the AMA-MSS Committee on Bioethics and Humanities. Additional announcements will be posted on the committee’s website: <http://www.ama-assn.org/ama/pub/category/15539.html>.

Medical students who wish to submit cases and commentaries on upcoming Virtual Mentor themes should visit the On Call [Guidelines for Submission](#).

*The facts of this case have been changed so that it does not describe the actual experience of the student-author or of a specific patient. Resemblance of the resulting case to the actual experience of a specific student or patient is coincidental.*

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