that transplant is still an option. When it is not, they are tethered to the LVAD whether they like it or not. It is destination therapy by default.[1] It is not clear if this is the case for Mr. H, but it is certainly possible, given his mental status.

Psychosocial considerations are paramount for all LVAD patients and their families. Does Mrs. H have a realistic idea of how dependent Mr. H will be for at least three months after discharge from the hospital? Postoperatively, someone needs to be present at all times. She or another caregiver will have to help Mr. H with dressing, bathing, and bedtime; prepare for and accompany him to doctor's appointments; and so on.[2] Are there solid plans in place to help and support Mrs. H as the caregiver for her husband, her newborn, and her five other children? Is drug rehabilitation feasible given Mr. H's other medical issues? What about the family's financial well-being? Simply hoping that social and financial support will somehow work out is naïve and can impose an undue burden on vulnerable patients and their families.[3] We have obligations to help families marshal the support they need and, if it is not there, to refrain from offering destination therapy.

If Mr. H continues to use methamphetamines, his risk for medical complications increases. Renal failure also increases his risk for infection, morbidity, and mortality postoperatively. My worry is that the LVAD would encumber Mr. H with further complications and comorbidities, merely prolonging a painful and difficult dying process. I suspect continued medical management and/or palliative care would be less burdensome.

Recommendation

Depending on the particularities of Mr. H's case, there are compelling ethical reasons both to implant and not to implant the device. If both options are equally ethically supportable, the rationale for both should be outlined in the ethics consultant's chart note and relayed to all parties. Still, with such a complicated and potentially burdensome treatment, I do not think a simple appeal to Mr. and Mrs. H's preferences solves the issue. Just because Mr. and Mrs. H want the LVAD does not necessarily mean that it should be offered. When we add the complications of addiction and renal failure to the predictable risks of LVADs, the likelihood of medical complications increases and may outweigh the burdens. If the family's psychosocial and financial situation is also uncertain, I would likely support the transplant team's decision not to implant the LVAD. My recommendation hinges on the rationale for withholding mechanical circulatory support and the evidence to support that position.

Notes

1. Dudzinski DM. Ethics guidelines for destination therapy. *The Annals of Thoracic Surgery* 2006;81(4):1185–8.
2. Casida JM, Marcuccilli L, Peters RM, Wright S. Lifestyle adjustments of adults with long-term implantable left ventricular assist devices: A phenomenologic inquiry. *Heart & Lung: The Journal of Acute and Critical Care* 2011; 40(6):511–20.
3. Chang A, Dudzinski D. One way out: Destination therapy by default. In: Ford P, Dudzinski D, eds. *Complex Ethics Consultations: Cases That Haunt Us*. New York: Cambridge University Press; 2008.

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Commentary: Withholding Treatment from a Drug Addict: Poor Prognosis or Just Deserts?

Piers Benn

It is good that an ethics consultation was requested in this case. To begin

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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 table, 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, which prevents him from participating in discussions of his treatment options. On what criteria was this judgment 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 caregiver," 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, although there may be others. The first and most obvious reason concerns prognosis: that is, that his past drug use, and/or the likelihood of future drug use, makes 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 to patients who have *not* brought their health problems on 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 or 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 case of CHF that is similar but in which there is no history of drug use or other risky behavior? Indeed, what would 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 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 decisionmaking, 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

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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 drug 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 the 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, because 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/nontreatment outcomes lie on a continuum, whether in terms of likelihood and/or degree of benefit. If Mr. H has a 50 percent chance of significant, even if suboptimal, 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.

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Commentary: Ethics and Medical Judgment: Whose Values? What Process?

John R. Stone

The scene opens as the healthcare ethics committee (HEC) and cardiologist (Dr. C) are discussing Mr. H.

Dr. C: A LVAD as destination therapy—with all due respect to Mr. H and his family—has not a chance in hell of prolonging or improving his life. Meth and noncompliance will cause more complications. How could his wife provide

For helpful background regarding futility or nonbeneficial care, I express my appreciation to graduate students in our master's of science in healthcare ethics program. Their analyses and literature reviews were quite informative. Their accounts also reinforced the importance of Iris Marion Young's work.

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