Should self-destructive behavior affect a patient's access to scarce medical resources?

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CASE SCENARIO

A 35-year-old man with moderate plaque psoriasis and psoriatic arthritis that has been well controlled on methotrexate (MTX) 20 mg weekly for the last 4 months presents for follow-up. He recently heard about adalimumab, and asks about starting treatment with this drug. He explains that although he has abstained from drinking while taking MTX, he craves alcohol. He had previously been on acitretin for years, during which time he was usually abstinent, but during the transition from acitretin to MTX, he was frequently intoxicated. Today, his skin is clear. He has not had any side effects while on MTX, but he states, "I want to live the way I want to," including engaging in binge drinking.

What is the clinician's best course of action?

A. Agree to switch the patient to adalimumab because he wishes to freely drink alcohol and have less laboratory monitoring.
B. Continue MTX because it has controlled his disease and has not caused any adverse effects.
C. Advise the patient that he can safely drink less than 100 g of alcohol per week while taking MTX, but will still need laboratory monitoring.
D. Tell the patient that you cannot continue treating him unless he enrolls in an alcohol treatment program.

DISCUSSION

Although the Food and Drug Administration approved tumor necrosis factor (TNF)-α inhibitors for psoriatic arthritis and plaque psoriasis in 2002 and 2004, respectively, MTX remains the first-line systemic therapy for these disorders. Biologics are reserved for patients with psoriasis who are poorly controlled on MTX or when there are contraindications to its use. Heavy alcohol consumption (>100 g/wk) while taking MTX increases the risk of MTX hepatotoxicity[1] and there is no reliable test for monitoring hepatic fibrosis or progression to cirrhosis. Therefore, despite having normal liver function test results, hepatic fibrosis and fatty infiltration can proceed undetected.

There would likely be no ethical dilemma if MTX and TNF-α inhibitors were equal in cost. However, MTX at 20 mg weekly costs about $1200 per year, accounting for the retail price of medication, monitoring laboratory tests, and office visits, whereas adalimumab currently costs nearly

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$39,000 per year in the United States.[2] The physician is faced with the quandary of prescribing a low-cost, well-tolerated, and effective treatment for the patient's disease or acceding to the patient's request for an extremely costly alternative that, although likely to be as effective, and potentially safer if he drinks excessively, is far less cost-effective.

One aspect of the clinician's ethical dilemma is whether the patient is responsible for his choice to drink heavily, and therefore should be less deserving of a scarce resource such as an extremely expensive medication that would not likely be considered at this point, were it not for his desire to drink heavily. Another is that although biologic drugs for psoriasis are not in scarce supply, the funds available in private or public health insurance to pay for the medication—assuming that the patient is not going to pay out-of-pocket—are not unlimited and therefore, there needs to be some mechanism to fairly apportion access. Although not technically a zero-sum game, unfettered access to such expensive medical resources means that either funds for some other necessary service will have to be restricted or that employers or society at large will ultimately have to pay more for insurance in the future. Hence, there are guidelines and algorithms to determine who shall access expensive or scarce resources, such as biologic medications, organs, or imaging. Physicians and patients have come to accept this fact as a fixture of modern health care.

The arguments for limiting access based on the patient's moral responsibility are rooted in the transplantation literature, with alcohol and substance abuse behaviors commonly cited.[3,4] Some have argued that alcoholics should have lower priority for liver transplants than patients who develop cirrhosis from autoimmune, infectious, or congenital disorders over which they had no control. Proponents of rationing based on moral responsibility would argue that alcoholics are responsible for the consequences of their alcohol abuse, and that those who do not drink excessively have exercised moral judgment to not do so. However, those who care for alcoholics are acutely aware that there is a complex interplay of genetic, psychological, social, and economic factors that underlie this disease, making voluntary control of alcohol consumption difficult. Alcoholism is generally regarded as an addictive disorder, not a lifestyle choice or character flaw. No guidelines can ensure that such judgments could be made accurately and fairly or be applied consistently, and therefore, access based on moral responsibility is a flawed model. Furthermore, such arguments are considered morally and socially unacceptable in the case of HIV-related disease or treating the medical consequences of morbid obesity or smoking. Indeed, current transplantation guidelines in the United States and United Kingdom specifically do not discriminate against alcoholics or consider patient responsibility in allocation of priority for organs.

Another strong argument in favor of not allowing moral judgments to interfere with medical decision-making is that the patient must feel comfortable in truthfully communicating his lifestyle choices to the physician, with the understanding that the physician will nonjudgmentally make medical decisions that are in the patient's best interests. The physician has a professional responsibility to the patient to act in his best interests if the latter's lifestyle necessitates a more expensive and potentially less toxic treatment. Physicians should be able to set aside their own personal prejudices or religious beliefs in advocating for the patient, or arrange for the patient to see someone who can.

Medicine is not practiced solely in the confines of the examination room. Physicians have responsibilities to society as well. In addition to autonomy, beneficence, and nonmaleficence, distributive justice is a central principle of contemporary medical ethics.[5] Health care providers have an obligation to use resources wisely and minimize waste to maximize access to these resources. The egalitarian approach to allocation of access to scarce resources, ie, "to each according to need," is not currently possible in the US health care system, where despite the Affordable Care Act, health insurance is neither universal nor egalitarian. The libertarian principle of distributive justice, that patients should be able to choose what treatment is best suited for their lifestyle as long as they have the resources or insurance to pay for it, would only be practical if personal or insurers' pockets were infinitely deep. The utilitarian or consequentialist principle of maximizing benefit to society by providing the greatest good for the greatest number would provide the fairest and most morally acceptable access to biologic drugs, as long as value judgments regarding the moral or economic worth of individuals to society do not enter into the decision.

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