Ethics Roundtable: Can Health Care Mandate Drug Rehabilitation as a Precondition for Treatment?

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During the last 4 months, 10 cases of drug overdose accompanied by renal failure and hemolytic anemia were admitted to a local hospital. All of the patients required intensive care and long-term plasmapheresis. An unknown toxin in the local drug supply is suspected and is being investigated.

Eight of these cases are continuing plasmapheresis (two of them have died), which is placing a significant strain on the small dialysis and plasmapheresis center. The nephrologist is willing to accommodate these patients, but wants to know if it is ethical to require ongoing drug rehabilitation for these patients as a condition for their treatment.

An ethics consult is requested.

Social Work Perspective

Leslie Stilin Schmidt, MSSW, MA-Bioethics

In my response to this question I want to tease out a few issues; conditions of participation, coercion in and limitations on health care, and distribution of resources. To begin, let's start with the specific question, "Is it ethical to require ongoing drug treatment for these patients as a condition of their treatment?" When I think about a bioethics question, I like to think of a comparable situation(s) and apply the same question. In doing so, I want to assess if my answer comes from true discernment of the issue or initial judgmental response. The populations of patients I think are comparable are those persons who participate in normative self-destructive behaviors such as smoking, drinking, and overeating. If we take away the specifics of the case the question that remains is this, "Are persons who have contributed to their poor health by participating in behaviors the rest of society deems "unacceptable" entitled to the same health care as persons who participate in "acceptable" means of self-destruction as previously named?"

In addition, the case study forces us to question society's responsibility to finance the health care for those who may have or are perceived to have broken their contract with society. In other words, is society responsible to care of those individuals who have participated in potentially criminal/illegal behavior that has resulted in their need for care, or are we only responsible to care for those who have chosen a more normative self-destructive behavior? I think it is important to note, the *behavior* of both subsets is self-destructive and the consequence of said behaviors affects the health care system enormously. Do we believe there are self-destructive behaviors that are "worthy" of care and compassion and some that are "not worthy"? Do we (health care and society) therefore have the right to judge and with that judgment apply limitations, coercion, and or restrictions as a means of managing this population and controlling the associated costs? I contend the consequences of self-destructive behavior on the health care system are not distinguishable; therefore, persons participating in such behaviors can't be categorized as worthy and unworthy of care justification for treating them differently.

Let's take a moment to reflect on the populations that fill our hospitals' and clinics' waiting rooms. There we will find a sizeable number of patients who are in need of medical care and treatment for complications related to diseases founded in self-destructive behaviors. As we work with these patients, we ask "Is it ethical to require ongoing rehabilitation for (fill in the destructive behavior) as a condition of treatment in the clinic or hospital?" For example, the morbidly obese patient who has heart disease, diabetes, and peripheral vascular disease receives routine care without question and hospitalization for exacerbation as part and parcel of the disease. The obese patient could require multiple medications, routine blood work, heart catheterization, cardiac rehab, nursing home placement, vascular surgery, wound care, eye care, dialysis

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access surgery, hemodialysis, and transport to and from dialysis and so on. The list of services, treatments, and care needs could be unending and the costs enormous. Yet it has not been medicine's practice to place conditions of participation on these patients, we don't ask, "Is it ethical to require ongoing participation in a sanctioned weight loss and exercise program as a condition of treatment in the clinic or hospital?" Medicine does not tell the diabetic they need to join the gym, eat well, and lose weight as a condition of continued participation in clinic visits. It has not been our practice to tell the smoker they will not receive pulmonary services, supplemental O2, radiation, surgery, or chemotherapy until they participate in a smoking cessation program. We (society) are not outraged by caring for individuals with normative self-destructive behaviors. When we judge the worthy from the unworthy, we create a distinction that allows us to selectively apply compassion and care based on our self-righteousness.

If limiting their access to care is not right or just, can we coerce them into appropriate behavior? I struggle with the concept of coercion in therapy. I tend to believe that people have to want to return to wellness in order for any type of the therapy to work. I strongly believe persons with all types of ailments need to make the decisions *by themselves* and *for themselves* regarding the pursuit of ongoing therapy. I think forcing someone in to rehab creates a false sense of accomplishment and a false sense of security in the future. Forcing them in does not guarantee long-term recovery; it simply means they are safe for now. What happens in therapy is entirely up to the individual. Some might argue that coercion creates opportunity; opportunity for the addict that would not have otherwise presented itself. That may be true; an addict might take the opportunity and commit to rehab and stay sober, and unfortunately recidivism rates tell a different story.

So we can't place conditions of participation, we can't coerce; can we ration the resources? It seems a bit easier to suggest restrictions and limitations on the distribution of resources as long as the limitation does not affect us or our immediate families. However, when the limitation hits closer to home it immediately feels uncomfortable. Limiting health care funding to drug addicts may seem like a reasonable idea if we weigh our obligation as a society against the individual's contribution to society, their needs versus society's needs, and their sense of responsibility versus society's responsibility. Drug addicts tend to not be productive members of society; their contribution to the world around them tends to be negative, and when they are ill or need help, their treatment is costly. In some respects, they tend to be less than an asset, unless of course that drug addict is your son, daughter, or granddaughter. Then it is different. Then we hear phrases like "this time will be different," "this time they will stay sober," "this is it; they are on the right track now." Limits on health care that would in turn limit the drug addict's opportunity to seek treatment for the addiction and seek treatment for their corresponding medical condition therefore limit their opportunity to get sober and become a productive member of society. They may not be participating in society in a manner in which we agree yet they remain a member, a member still deserving of human compassion. That is not say that at some point in our future we will see some type of containment of resource but the challenge remains how do we decide who, when, and what will be rationed.

The decision by health care providers to place conditions on participation, to use coercion, or to limit the distribution of resources needs to be founded in a framework that does not involve an arbitrary distinction of the worthy versus the not worthy; a distinction that defines one behavior as more destructive than another when both are destructive to the health care system at large. In summary, the patients requiring plasmaphersis can be offered the best opportunity possible for drug treatment; they can be offered education about their prognosis both with and without drug treatment and they can be offered support; anything less would be an effort to treat them as less than human. Should the treatment prove to be unsuccessful, they ought to be treated as persons deserving of the same compassion as any other human being who is dying.

Ethics Perspective

Matt Stolick, PhD

Ethically speaking, this case has two prominent issues: just distribution of scarce medical resources and refusal to treat patients who fail to take adequate responsibility for their own health. First, there is a small dialysis and plasmapheresis center involved in this case. Were there a bigger center with larger capacity to handle a volume of plasmapheresis, this case would be less ethically challenging. In such a case the nephrologist's proposed mandatory rehabilitation plan would not be one of rationing scarce resources but instead one of cost containment. But this is in fact a case of a scarce resource. Although there are only 10 patients involved in this case, perhaps the local medical community should seriously consider creating an additional phlasmapheresis and dialysis center. Assuming it is not possible to build a new clinic in the short term, the nephrologist's ethical query should be considered, first from the general perspective of justice and fairness. Prohibiting treatment to "drug-using" patients, disallowing them treatments without first obtaining consent by, in effect, coercion to enter drug rehabilitation, is just only if every other patient seeking treatment is similarly required to first agree to undergo rehabilitation relevant to their conditions and if not forfeit the right to treatment in the future. Arguably, if drug-using patients are made to commit to rehab then every patient should be made to commit to rehab. A Kantian, one of only a handful of major moral theories, would not want this rule to be universalized for every

patient. This mainly because of the coercion and therefore disrespect of these patients who are ends in themselves. This seems fairly clear and is a powerful theoretical reason to pause before adopting the nephrologist's mandatory rehabilitation proposal.

The divisive assumption that some would argue distinguishes these drug users from all other patients is that these particular patients (drug users) are more "responsible for" their conditions and the actions that resulted in their conditions than are patients with other conditions. Without granting this assumption, this policy suggestion has no real moral foundation and is clearly unfair. To assume these drug-using patients are more responsible for their subsequent medical conditions than are diabetes patients, COPD patients, or heart disease patients, for example, is to beg the question, "What is it about drug abusers that makes them singled out as different than others who, say, smoke cigarettes or abuse alcohol for decades and suffer COPD, heart disease, or liver disease as a result?" Should we also anticipate for the long-term the need for developing a responsibility rubric to apply to each particular patient so as to require rehab from some, allowing others to basically proceed with their lives as they are living them, and to simply disqualify others? What would this look like?

It would be good for us to reflect on how utterly at the mercy we each are to what John Rawls referred to as the "natural lottery" (genetics and physical characteristics we are just born with) and "social lottery" (the place, time, social situation, family into which we are born) of life. People do not set out in life to become dependent on and abuse drugs (whether street drugs like heroin or prescription drugs like Oxycontin) or to eat themselves into diabetes and morbid obesity. The need here, before making assumptions about personal responsibility for the ills we suffer, especially self-destructive behavior, is to listen to the stories of these people and perhaps to recognize that those who are "responsible for," to one degree or another, their illnesses and diseases is a large and ever-increasing group. In another, deeper sense, of "responsible for," which are not dealing with here, we are all fairly responsible for what ails us, the very things we enjoy doing are the very source of our undoing, the strange irony of human life. I recognize that there is some sense in distinguishing between "faultless" diseases—say, Parkinson's or leukemia, which seem essentially "blameless," versus the other diseases for which we have some culpability for exacerbating (as in smoking leading to COPD and lung disease) if not entirely precipitating (e.g., wrecking one's liver through drinking). But the question that must be asked once we deny treatment to anyone is "Where do you effectively draw the line between nature/nurture/self-determination and "deserving" medical treatment as a result?" And if such a bright line rule is impossible to create, then shouldn't every person be entitled to treatment, regardless of their perceived culpability in creating or exacerbating their conditions?

Reflecting a bit more deeply on this case also brings up a technicality. It seems wrong to call these cases "overdoses." The more appropriate descriptor is "poisonings." If it is true that these cases and medical conditions have been caused by not using too much of the drug in question but rather because of a harmful toxin in the local drug supply, then the toxin itself and not overuse created the medical need. Those who say that it was still the drug user's choice to start using drugs in the first place, and to continue this practice, so that they are responsible for being poisoned, even if called "common sense," still do not overcome the deeper technical truth. A drug-user will see the difference between an overdose and getting a tainted drug, as it seems the former is about self-control and lack thereof, but the latter is more about the lengths society makes the users of certain drugs go to procure them when they are strongly controlled (e.g., many pain medications, marijuana, heroin).

Although the utilitarian (seemingly the strongest advocate of the nephrologist's proposal) thinks this mandatory rehab for continued treatment will lead to more treated and cured drug addicts and fewer poisonings and overdoses and thus more good for society overall, this case would be stronger with actual empirical data to show these ultimatums to enter rehab are actually effective for drug users and for society. This because, among other reasons, there could actually be the opposite effect caused by such a proposal, whereby as a result of such an ultimatum, drug-users rebel and become more entrenched in their drug use against such coercive efforts. This results in their feeling validated, not ashamed and ready to change, in their antisocial drug-using resentment against society. They would see rehab as a coercive weapon used against them as if they were objects, not people who deserve basic respect. It would make more sense to intervene in ways that would facilitate drug-users to reflect on and rethink their unhealthy habits. Such interventions, perhaps ones made in the drug users own milieu and by those he or she trusts, lead drug addicts to rehabilitation noncoerced and will arguably be more effective long-term. The difference in this approach is that the initial choice was the free decision of the participant rather than the result of coercion. Consider this, the drug user benefiting from voluntary but not mandatory rehabilitation, as an example of only one of the problems for this proposal for mandatory rehabilitation. If it in itself is true, then that means that by enforcing mandatory rehab as the less effective type, there will be at least as much if not more need than we currently have, socially speaking, in caring for drug users. As a utilitarian, then, the nephrologist has a very heavy burden of proving that this approach will have more long-term benefits than burdens.

I find myself again and again thinking as a Kantian in response to this case. I am suspicious of the utilitarian assumption that the positives would outweigh the negatives in the short and long term after mandatory drug rehabilitation is imposed and inevitably some drug user dies because he or she is denied life-sustaining treatment by refusing to

enter drug rehabilitation. To my mind, the glaring assumption is that these patients bear more responsibility for their diseases than do other patients with different diseases, especially chronic ones, which are clearly the result of a lifetime of unhealthy choices and lifestyles. I believe that this is a questionable assumption, but one necessary to justify the proposal of the nephrologist in this case. If these patients are not more responsible for their disease (or, in this case, poisoning) than are other patients, then this proposal is unfair and unjust and should not be instituted.

I would not only try to sympathize with the nephrologist but also somehow have him remember that he or she serves all kinds and types of people who have in many ways damaged their livers and not taken adequate care of themselves. I would invite him or her to reflect on the various ways a liver is destroyed by human beings. He, as a nephrologist, with a primary duty to his or her patients, is thinking more like a parent in this case, or policy maker, or rationer, but not as a patient advocate whose primary virtue should be care, not justice; after all, his mandate as a doctor is "first, do no harm," not "first, consider the policy implications of any proposed treatment plan." Given the poisoning aspect of this situation, this case would ideally motivate the community to locate and eliminate the toxin that has infiltrated its environs, perhaps opening up another plasmapheresis clinic but also generating community response to problematic drug abuse therein. Cutting certain patients off from plasma because they got a bad batch of drugs, because they were poisoned, is the move of a judge, not of a caregiver.

Legal Perspective

Russell W. Adkins, JD

Dealing with noncompliant patients can be frustrating. The patients' continued drug abuse endangers their own health. Perhaps more importantly, the patients are using (and arguably squandering) limited resources.

This scenario raises important public policy issues: Can a health care provider require a patient to enter a drug abuse treatment program? What are the providers' options if the patient fails to cooperate in drug abuse treatment?

Some may argue that the physician should condition treatment on the patient's responsible use of society's gifts. The better view, though, is that a physician should treat his or her patient without weighing overall societal impact. Otherwise, one can envision treatment conditioned on adherence to any variety of dietary and lifestyle restrictions.

Under the facts presented, the U.S. Congress has resolved any debate over the conflicting public policy concerns. Federal law requires the health care providers to treat the patients' self-inflicted medical condition.

The Rehabilitation Act of 1973 is intended to protect disabled persons from discrimination based on their actual or perceived disabilities. The Act prohibits health care providers who receive federal funds from excluding an individual from the benefits of its programs or activities based on the patient's current use of illegal drugs. *See* 29 USC §705(20)(C)(iii). This requirement is stated better and more directly in the implementing regulations:

> Drug and alcohol addicts. A recipient to which this subpart applies that operates a general hospital or outpatient facility may not discriminate in admission or treatment against a drug or alcohol abuser or alcoholic who is suffering from a medical condition, because of the person's drug or alcohol abuse or alcoholism. 34 C.F.R. §104.53

The Rehabilitation Act prohibits any withholding of care, or any condition on providing care. Drug abuse treatment should be encouraged, and appropriate consults may be ordered, but limiting or refusing care is not a legal option under the facts as presented.

Physician Perspective

Gregory T. Carter, MD, MS

As a physician who has worked for a Catholic health system (Providence) for 20 years, attended a Jesuit medical school (Loyola), and had 12 years of Catholic education prior to that, I am well versed in the concept of distributive justice. This is one of the core ethical themes in Catholic theology, and Catholic health care ethics, and it stands closely alongside other stalwarts of Catholicism, including the sanctity of human life. Of course we live in a world now where these ethical themes are tragically butting heads with financial shortages, and not the entire world is Catholic. Nonetheless, this concept of distributive justice has led to some interesting posturing during the current presidential election where the candidates all want to tell voters that "yes, they will have access to the full spectrum of health care" but at the same time, we will be tightening our finances to decrease the deficits.

Ethics and finance are odd bedfellows though and we are approaching at a time when society will have to grasp these painful concepts. There may simply not be enough health care funding to take care of everyone's needs. Thus should we cover patients who are willingly creating and contributing to their own poor health? It is somewhat ironic that freedom of choice and will is so highly valued and is maximized when the government refrains from interfering in the private choices of individuals. Yet those very same individual freedoms are curtailed by an individual's own actions. Yet could large portions of our population endure daily

subjection to the commands of others (i.e., the government, aka "big brother"). If the government gives us all detailed instructions on how we should live our lives, does that also give them the authority to threaten us all with negative consequences (i.e., limited health care) if we disobey. I think that would be wrong. I say give these eight patients plasmapheresis and try and save their lives. Please also send them to drug rehabilitation but do not mandate it as a condition for their poisoning treatment. The fact of the matter is that society has already let them down a long time ago by not getting them in to drug rehab sooner. If we can forgive the sins of Wall Street with a huge tax-payer funded bailout, then we can surely forgive these folks the much more poignant but less costly sin of self-neglect and self-abuse.

Chaplain Perspective

Karrie A. Oertli, DMin

This case provides an interesting backdrop for several ethical principles, those of distributive justice, coercion, and attending to those with self-destructive behavior.

The principle of distributive justice applies here. The director of this center has asked for this consultation to determine whether he can require something of these persons to provide continuing care, based in part on this principle. The center has limited resources. There are questions as to what the individuals (who I will call "the eight") are contributing to society. There is concern for how care for them impacts the common good. The clinic is small and has resources that are being strained by the addition of the eight in need of plasmapheresis. We do not know how the eight are contributing to society. We also do not know how the treatment of the eight—or the denial of treatment to them if they do not participate in drug rehabilitation—would affect the common good. What if the eight were local priests, seeking to offer help, who overdosed on a tainted drug slipped to them in a "welcoming" drink?

In regard to limited resources, the center cannot continue to provide services to the eight without denying service to others. If the eight were not using the center's services, more resources would be available to the wider community. If others with more pressing health issues presented for care, it makes sense to withhold treatment from these. Based solely on this principle, care could be withheld if one were willing to also determine that the others were more worthy of the care because they offered more to society and the common good.

The director of the center would become the person who determines compliance or sets policies that will outline the requirements of compliance. This person would determine who is best served by the services it offers. Certainly, policies can be written that outline who will or won't be provided services based on available resources. Will the director require all patients in the center to maintain a certain level of compliance as a condition of treatment? For this decision to be ethical, the director would have to apply the same criteria, regardless of why care is needed. Unless such policies were applied equally, it would seem that those who are involved in socially unacceptable activities would be punished by unequal treatment.

Regarding the aspect of coercion in this case, are the eight being treated with plasmapheresis for renal failure and hemolytic anemia, or are they being treated with plasmapheresis for drug abuse? If the contract between the eight and the center was clearly for treatment of drug abuse, there would be no coercion in requiring them to remain in a drug rehabilitation program. That would be the point. However, the contract was between the center and the eight in need of plasmapheresis for a medical condition of renal failure and hemolytic anemia, without concern for its underlying cause. Thus, requiring the eight to have ongoing drug rehabilitation as a condition of treatment seems coercive. While it may be meaningful to offer the support of drug rehabilitation, it should not be required as a condition of treatment because the contract is not for drug rehabilitation.

This does not ease the challenge of working with patients who engage in self-destructive behavior. Relating to the principle of distributive justice, if resources are used for those who might squander resources, they could be required to seek rehabilitation as a condition of treatment. Once again, the dilemma remains as to who would make the decision regarding their behavior and how it may disqualify them from treatment. In health care, we commonly care for those who participate in self-destructive behavior (e.g., the person with diabetes who refuses to take insulin correctly; the person diagnosed with COPD who continues to smoke; the person with a cardiac diagnosis whose diet and lifestyle continue to contribute to the disease). We might enlist palliative care to assist. More often than not, we choose not to take self-destructive behavior into account when offering care.

An underlying and important factor in this case is that of societal prejudice toward addicts. In the United States, the general attitude seems to be that those who overdose on drugs are less worthy than others. Generally, society seems to find it easier to justify community decisions to deny services to such persons. We can more easily spot those who do not conform to certain moral or ethical standards. Some then also do not want to extend care to them because of their lack of adherence to such standards.

On a personal note, I struggled to write a response to this case both as a chaplain and as a person who has had recently an unforeseen health catastrophe after a lifetime of very good health. As a chaplain, I came to this case with a specific religious conviction that the human person has inherent value. I advocate for those who have few means and are often not in the group that society might consider essential to the common good. The question for me remains, "How does one determine who is worthy and who is not?" As a person

with an unprecedented, ongoing health challenge, I identify with those who need expensive and, at times, limited care. Gratefully, I have resources and have not been asked to involve myself in rehabilitation to receive them. But it terrifies me to think that such a requirement could be imposed so easily, based on another's determination about my suitability to continue to receive care. My personal experience of having to depend on the decisions of others has deepened my value of human beings. It has also clarified how we powerful health care professionals must pay careful attention to humans in making ethical decisions. Perhaps because of my religious conviction that everyone has value and because of my own situation, I have to believe that the requirement for the eight to be in drug rehabilitation to continue to receive treatment is unethical.

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