

EDITORIALS

Should we let them die? The moral dilemmas of economic restraints on life-support treatments

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An increasingly vigorous confrontation is arising between the individuals who develop and apply medical technology and those who pay for it. While advances in medical technology and in biomedical knowledge have made medicine a great force, the possible overuse of technology, the fear of technologic disasters and limited resources have prompted demands from the public for some measure of control over the use of life-saving technology. Physicians are being told that the goal of providing services to everyone "without discrimination" belongs to the past, and that, because of limited resources, some people may have to be refused expensive treatment. As a result, the medical profession, though trained to provide treatment, now seems ready to discuss some rationing of highly technical life-support treatment, such as dialysis.

The artificial kidney was the first effective means of replacing an organ. In the early years dialysis was performed only by physicians because new access to the vascular system had to be established each time; the procedure was often carried out at night so the physicians could perform their usual duties during the day. In the 1960s technical improvements solved many of the early problems, and dialysis machines were produced in large numbers. Society was in favour of this life-support system and devoted abundant resources to its application. Thus, in less than a decade dialysis evolved from an out-of-the-ordinary to an ordinary treatment and was available not only to patients with end-stage renal disease but also to those with associated conditions, such as diabetes, malignant disorders and even old age.

As a result of this expansion the principle that access to dialysis is the right of every individual who needs it has imposed on the physician some complex ethical decisions about starting and stopping treatment, the quality of life, the competence of patients to manage their own treatment, and the right to die with dignity. A question frequently asked today is Why are we

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providing dialysis to everybody? Traditionally the physician's answer would be unequivocal: because the physician is committed to the guidelines set by Hippocrates and reaffirmed throughout the ages, most recently by the World Medical Association and the Canadian Medical Association (CMA). According to the Hippocratic oath the doctor should "prescribe regimen for the good of [his] patients according to [his] ability and [his] judgement"; obviously, Hippocrates had not even considered the possibility of withholding treatment. More recently the World Medical Association adopted the rule that the ethical doctor must always bear in mind the obligation of preserving human life and that he or she owes complete loyalty to the patient.¹ The CMA's code of ethics enjoins the physician to consider the patient's well-being first and to "recognize that the patient has the right to accept or reject any medical care recommended to him".² I believe that the rule should be reworded as follows: "Only the patient has the right to accept or reject any medical care recommended to him". Until society draws up explicit rules concerning the rationing of dialysis the only person who has the right to decide whether dialysis should be started and whether life with a machine is worth living is the patient. Thus, in developed countries as long as a patient wants to live with dialysis the treatment should be made available; nobody, not even the doctor, should have the right to pass judgement about the quality and value of the patient's life.

Once a treatment has been started it is morally wrong to discontinue it for financial reasons. Even in the early years of dialysis, when resources were scarce, patients had the full support of the team once they had been accepted into the program. On the other hand, when patients have decided to start treatment we should provide every guarantee that if things do not go well they can discontinue it. From time to time we should remind patients of their rights in this respect.

When patients agonize over whether to continue having life-support treatment, professionals such as the hospital's chaplain, a psychiatrist or a social worker should be available to help them decide, and doctors and nurses should be comfortable discussing with the patient the realistic option of dying.

With few exceptions, I believe that the ministries of health and individual hospital boards will avoid explicit rationing of dialysis services like that described in a

letter I received recently from two chronic care hospitals in Toronto; the hospitals stated bluntly that they will not accept chronic care patients who are also on dialysis. Such explicit restrictions will probably become more and more common as we become a society of isolated individuals with less and less compassion for those who suffer. In the meantime, most of the restrictions will continue to be implicit; for example, through fixed budgets for dialysis units, which are part of the hospital's overall budget, restrictions of the sites of care or the number of hospital beds and restrictions of specialty positions. By insisting that the dialysis budget be included in the hospital's overall budget, governments are creating a situation in which one of two things may happen, depending on the strength and aggressiveness of the nephrology department: either the dialysis program will continue to provide its services to everybody at the expense of other departments' budgets, or nephrologists will provide their services only to selected patients, and the remainder will have to look for other hospitals or die. I fear that nephrologists, instead of telling patients the real reason behind their inability to treat them, will violate the patients' trust and "cover up" the government's economic restraints by propounding plausible medical reasons why the treatment should not or cannot be started.

Although I do not accept that we should undermine health care in favour of the other priorities, such as national defence, we must recognize that strong forces in society now oppose the expansion of the health sector and demand restrictions in expenditures on health care. The medical profession should meet the challenge implicit in these restrictions, but only in the following way: *By accepting responsibility for the choice between waste and saving but not the choice between life and death.* However, in accepting this responsibility the profession must find some means to make the public aware of this distinction so that it will not, in its confusion, blame us for limitations in medical care. To

do this the medical profession must first help in reducing health care costs. We must direct ourselves towards a system that increases efficiency by rewarding the discriminating use of diagnostic and therapeutic procedures. In my field this means promoting home or self-care dialysis (the costs of which are listed in Table 1),³ reusing dialyser filters, centralizing services to avoid duplication, and transplanting kidneys in suitable patients. However, we should not overlook the fact that the increase in the numbers of patients undergoing home dialysis and receiving transplants will increase the demand for back-up facilities at the hospital.

Meanwhile, if politicians insist on restraints in health care costs they should tell the public that society can no longer fulfil their expectation of superior medical care for every patient. To meet this change, the public and its representatives must develop and declare a philosophy by which choices can be justified and health care assigned its place on their list of priorities.

Once patients and other concerned citizens realize that the availability of quality care is in danger they should band together and use the lobbying power of their associations to persuade governments to provide the necessary funding to meet the established needs of patients with end-stage renal disease. Local and national kidney foundations should pressure the government for more support. As their advisers, nephrologists have a special role and a special responsibility to describe the problems clearly.

I suggest the following steps to meet the current impasse. The ministries of health should allocate the dialysis budget to a separate program outside the hospitals' overall budget.

Nephrologists should demonstrate to the public and to the governments that their fight for more and better services is not motivated by a desire to make more money and build larger "empires" but is an expression of genuine interest in the welfare of patients.

In the future, continued financial restraints may change the rules that govern our relationships with our patients. For now, however, we must respond to the challenge of the times by clearly defining the present threat to life-support treatment, describing it to governments and the public and doing what we can to make the medical care system more efficient. However, under no circumstances should we allow compromise of the ethics of medicine or be tempted to betray our patients' trust by rationing life-support systems to "save money".

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References

1. *The Handbook of Medical Ethics*, Br Med Assoc, London, Engl, 1981: 63, 65, 67
2. *Code of Ethics*, Can Med Assoc, Ottawa, 1978
3. BULGIN RH: Comparative costs of various dialysis treatments. *Perit Dial Bull* 1981; 1: 88-91

Table 1—Costs of various types of dialysis treatment in hospital or at home

Treatment	Annual cost (\$) per patient*
In hospital	
Peritoneal dialysis	36 600
Hemodialysis†	23 472
At home	
Intermittent peritoneal dialysis	22 536
Self-care hemodialysis†	14 688
Hemodialysis‡	14 052
Continuous ambulatory peritoneal dialysis	13 296

*Includes nurses' salaries, physicians' compensation, and costs of supplies, laboratory tests and equipment (amortized).

†Dialyser reused three times on average.

‡Limited reuse of dialyser.

One man's view

*No life that breathes with human breath
Has ever truly long'd for death.*

—Lord Alfred Tennyson (1809–1892)