risks before beginning or continuing such lifestyle abuse?

I am forced by these concerns to hesitate before wholeheartedly accepting Kluge's argument.

Shabbir M.H. Alibhai, MD
Richmond Hill, Ont.

References

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We are obliged to respond to the article by Dr. Kluge because it contains factual errors about the policies of our liver transplant program at the University Hospital, London, Ont.

Kluge argues that patients who become ill as a result of lifestyle abuse do not deserve the same rights of access to care as patients who have led healthy lifestyles. He uses the example of an alcoholic who needs a liver transplant. He refers to our guidelines for allocating donor livers and cites an obscure publication (Canadian Health Care Management Dispatch DP 53.2 [1990]), from which he declares that "drinkers have been placed at the bottom of the list." That is incorrect.

Our policy with respect to liver transplantation is simply and concisely stated. To be considered for transplantation patients must "demonstrate that they are capable of complying with medical advice and routines." In the case of patients with a history of alcohol abuse, this compliance condition requires confirmed abstinence from alcohol outside of hospital for 6 months or more and a psychosocial profile that convinces us that a return to drinking is unlikely. Alcoholic patients who satisfy these criteria are placed on the transplant list, and their priority ranking is determined by the same criteria as those applied to all the patients on the list — namely, how sick they are, whether their blood group is compatible with that of the donor and how long they have been waiting. The cause of the liver disease is not a factor.

This policy was approved by the hospital ethics committee and the board and has proven useful in balancing the responsibilities of the program to the patients and to society. Kluge's misunderstanding seems to be rooted in a series of media reports containing less and less accurate interpretation by people progressively farther from the source of the policy. In the publication Kluge cites, a hospital spokesperson expanded on the policy but did not suggest that it prioritized candidates for transplantation according to lifestyle. Nevertheless, the publication stated that the policy "puts many alcoholics at the bottom of the list." Kluge further misinterprets the policy to suggest that past alcohol abuse automatically puts people at the bottom of the list. In reality, noncompliance prevents people from being placed on the list, and compliant people are treated equally without regard to their past lifestyle choices.

As well, Kluge incorrectly states that lifestyle considerations are rarely discussed in making decisions about organ transplantation. Our weekly Liver Transplant Conferences are multidisciplinary, and it is unusual to accept or reject a patient for transplantation without lifestyle entering into the discussions.

The issues Kluge raises are complex, and everyone is entitled to an opinion. In Kluge's words, however, "the right to free speech is conditioned by the presumption that this speech will be truthful." The above misunderstandings could have been avoided with some source checking rather than reliance on third- and fourth-hand reports. In areas such as this, small changes in wording profoundly affect the meaning.

Cameron N. Ghent, MD, FRCPC
David R. Grant, MD, FRCSC
William J. Wall, MD, FRCSC
University Hospital
London, Ont.

I found it an interesting thought in Kluge's article that irresponsible people should not be treated the same as responsible people.

However, I think that Kluge only touches the tip of the iceberg with his examples of smoking and drinking. I suggest that there are many more forms of lifestyle abuse. Sports injuries, for example, are self-inflicted, and participation in sports is not a necessity of life. Another example is travel, a dangerous pastime that one could live without. And let us not forget sex — certainly a risky form of lifestyle abuse.

Should we penalize the nondrinker in whom coronary artery disease develops and the nonsmoker with Alzheimer's disease, which seems to be less common in smokers?

I understand now that to be ethical means to be judgemental rather than compassionate, and this saddens me.

Arnold J. Verster, MD
Beamsville, Ont.

Dr. Kluge's article has far-reaching implications beyond the rarefied atmosphere of transplantation.

Opinions relating to societal disbursement of resources apparently now fall into the realm of "ethics." The allocation of medical resources is considered separately from all other economic allocations (e.g., expenditures for senators, royal commissions and professional athletes).

Why disguise opinions as pseudoscience? As an emergency physician at a large hospital I encounter down-and-out patients and social Darwinist attitudes daily. The owners of these attitudes are usually healthy, empowered and apparently superior members of the species.

Whatever happened to compassion, humanity and tolerance?

Michael S. Dettman, MD, FRCPC
Vancouver, BC

I grant Dr. Kluge's argument that people who choose to practise unhealthy habits should not expect

equal treatment with purer souls when their transgressions cause their organs to fail. Kluge commends the University Hospital for placing drinkers at the bottom of the liver-transplant list.

There are, however, two counterarguments. The first is the need for *caritas* (charity), which was once our prime reason for practising medicine.

The second argument is utilitarian. The possibility of a reprieve from near-certain death on condition that the patient demonstrate a willingness to give up the harmful habit could prove to be powerfully therapeutic. Samuel Johnson remarked that when a man knows he is to be hanged in a fortnight, this knowledge concentrates his mind wonderfully. Rehabilitation from the use of alcohol and other drugs depends largely on successful motivation, and impending loss of life motivates wonderfully.

Alan G. Clews, MB, ChB
Fulford Harbour, BC

Dr. Kluge's article presents a fertile model for health care in Canada.

The linkage of lifestyle choices and their "controllable and foreseeable" consequences with access to care may deny intravenous drug users and sexually promiscuous patients treatment for AIDS; skydivers and highway speeders treatment for trauma; obese people treatment for diabetes, hypertension and joint replacements; exercise addicts treatment for injuries from excessive exercise; out-of-condition weekend athletes treatment for strains and fractures; and workaholics treatment for coronary conditions. The possibilities for exclusion are almost endless. Of course, congenital and genetically inevitable illnesses will always receive attention. In all other cases, however, triage will take on a whole new meaning.

"To continue to treat irresponsible patients the same as responsible ones is to violate the principle of equality and justice." Carried to its natural conclusion, Kluge's proposition would allow us to downsize our health care system tremendously, as we all learn to make optimal lifestyle choices and to age in complete health, eating margarine on the rocks with the seagulls and the surf.

James D.F. Harris, MD
London, Ont.

[The author responds:]

Judging by the responses that my musings have drawn, there are some Canadian physicians who are unwilling to accept that, sooner or later, all of us are held responsible for the consequences of our actions.

Dr. Taylor is correct that 13-year-olds lack maturity and should not be subject to the same ethical rules as 19-year-olds or 45-year-olds, even in the allocation of health care. We do not start out as responsible agents. We grow into maturity, and although we cannot be held responsible for what we did when we were morally immature we can be held responsible for what we do when we attain adulthood. The law is predicated on this fact, as is the notion of moral responsibility in all other social areas. Health care is no different.

That tobacco addiction is extremely powerful does not mean that it is unbreakable or irresistible. If it did, then the smoking-cessation programs would be based on a premise known to be false from the start, which would stamp them as fraud. The same applies to alcohol addiction.

I suggest that in both cases it *is* possible to break the addiction. Therefore, the fundamental premise of my argument remains: at some time in our lives, as we become morally responsible, we should examine our lifestyle to see whether it puts not only us but also others at risk.

It is fashionable to talk about second-hand smoke and the health threat that this poses to others. Fetal alcohol syndrome falls into the same category. These threats are considered real. Is the threat to the availability of health care resources of caring for diseases associated with smoking or alcohol abuse any less real? Resources used to deal with such diseases are unavailable for other health care purposes. If smoking, drinking and other lifestyle abuses are not threats to the availability of health care resources, then why are provincial and federal health care providers so anxious about these behaviours?

To Dr. Alibhai I pose a return series of questions: If the medical profession cannot identify in usable terms the amount of drinking that leads to adverse health effects why does it deem immoderate drinking to be unacceptable? If "moderate" and "immoderate" cannot be quantified for use in practice, is it not simply bad medicine to make this claim? Similarly, if medicine cannot connect previous smoking patterns with subsequent health impairment, does this mean that the longitudinal studies of smokers' health and reports of the impact of second-hand smoke are simply "hot air" and that the anti-smoking campaign is based on unusable data? As for the physician–patient relationship, would a good physician who knows something about the sequelae of smoking and inappropriate drinking really be fooled by the deceptive words of a patient? If so, does this mean that the diagnostic tools of the modern physician in this area are so weak that they can be brought low by a lie?

Drs. Ghent, Grant and Wall challenge my facts about the liver transplant program at the University Hospital. However, the hospital policy is entirely in agreement with what I have said. Ghent and colleagues say that "in reality, noncompliance prevents people from being placed on the list" — not at the bottom but never on the list! At least at the bottom these people would have a chance. Therefore, lifestyle abuse *does* figure in allocation decisions at the hospital. This stands in radical variance to what Drs. Alibhai, Verster, Dettman and Clews appear to argue for: compassion, humanity and tolerance.