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ETHICS IN CARDIOTHORACIC SURGERY

Ethical Obligation of Surgeons to Noncompliant Patients: Can a Surgeon Refuse to Operate on an Intravenous Drug-Abusing Patient With Recurrent Aortic Valve Prosthesis Infection?

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Introduction

Robert M. Sade, MD

One of the most frustrating situations confronting a physician is a noncompliant patient. When a patient receives clear instructions, acknowledges those instructions, fails to follow them, and then slips into even worse difficulty than he had before, we sometimes want to throw up our hands and retreat. Surgeons have a special difficulty in this area when, for example, a patient with peripheral vascular disease in need of a bypass operation finds himself unable to stop smoking and therefore unlikely to gain durable benefit from the operation.

Cardiothoracic surgeons are in a parallel situation when a patient who abuses drugs has an operation and then will not or cannot stop using drugs. Personal lifestyles are very difficult to change, whether or not a patient’s addiction is involved. Intravenous drug abusers find it particularly difficult to stop using, but resources are available to help those who wish to break an unwanted habit. Particularly nettlesome is the problem of the patient who abuses drugs intravenously, develops endocarditis, has a valve replacement, and then, after a drug-free period, reverts to drug use. Two experienced surgeons who have opposing views of what should be done in such a situation consider the following case.

The Case of James Smith

James Smith is 29 years old and married with 2 children who are 2 and 4 years old. He is frequently absent from home for extended periods and works odd jobs to support himself. He used marijuana when a teenager, and by his early 20s was regularly using cocaine, including intravenously. He is seen in the emergency department with a febrile illness, and is found to have severe aortic insufficiency due to an aortic valve infection.

The chief of cardiothoracic surgery, Dr William Jones, replaces the aortic valve with a St. Jude Medical prosthesis. Mr Smith does well postoperatively and is discharged with a warning about the possibility that the infection might come back if he ever uses intravenous drugs again. He understands that he might not be given a second valve if the infection recurs while he is using intravenous drugs. He signs an agreement to this effect.

Mr Smith is seen intermittently thereafter in the cardiology clinic, where he is found to be doing well, free of intravenous drug abuse. Several months after his last visit, which was 2 years after his valve replacement, he reappears in the emergency department with fever and shaking chills. He has signs of intravenous drug use and admits to using again, starting about 6 months earlier. On the cardiology service, echocardiography and magnetic resonance imaging show severe paravalvular aortic insufficiency, with several small extramural abscesses. The cardiology service’s discussions of the case reveal disagreement about whether or not the operation should be done. They send a consultation request to Dr Jones with the details of Mr Smith’s current condition and laboratory results. Their consult note asks Dr Jones whether or not urgent aortic valve replacement should be done, given the patient’s history.
Mr Smith reinfected his prosthetic aortic valve upon returning to his habit of intravenous drug abuse. He is 29 years old, and he was warned that this might occur. One might think that a surgeon is obligated to operate due to some ethical standard requiring him to do so. But, in fact, there is no such standard. There are plenty of ethical, logical, and moral reasons that allow a surgeon the right to say no.

Should all of society’s problems be up to the medical profession to repair? Ivan Illich wrote that classifying all the troubles of humanity as medical problems is actually antithetical to true health, in that it limits the ability of people to learn to cope with pain, sickness, and death as integral parts of life [1]. These adversities are natural components of the continuum of life to death. Physicians should not fool themselves into thinking that all problems can and should be fixed. This is not to say that one should never try. Health, he maintains, is not freedom from death, disease, unhappiness, and stress, which are inevitable, but rather the ability to cope with them competently. If this is true, then the more medicine and society direct individual behavior, the less autonomous and, therefore, the less healthy the individual may become.

In 1974, Faith Fitzgerald wrote about social responsibility:

In the 19th and early 20th centuries, if a person fell ill, had alcoholism or tuberculosis, or abused a spouse or child, it was a pity, but it was a pity for the person and a sadness for his or her family; it was their business. Over the past several decades, however, both the existence of these imperfections and the remedies for them have become society’s business, particularly since society began to accept the responsibility to pay for the consequences of the imperfections. Now treatment of drug addiction, prevention of domestic violence, handgun control, and the use of seat belts and helmets are society’s responsibility. Concurrently, however, because the imperfections are unhealthy, they are also the responsibility of doctors and nurses. Both health care providers and the commonweal now have a vested interest in certain forms of behavior, previously considered a person’s private business, if the behavior impairs a person’s “health.” Certain failures of self-care have become, in a sense, crimes against society, because society has to pay for their consequences. Society increasingly looks to health care providers for leadership in eliminating behavior that leads to disease [2].

Individuals need to accept responsibility for their own health and not look to physicians and nurses to relieve them of their duty.

A distinguished professor with whom I discussed this case stated, “You’re not fixing the problem, you are fixing the heart!” Ludicrous though it might seem to surgeons who have been trained to fix the heart, Mr Smith’ primary problem is not his heart at all. It is his substance abuse. His destiny was sealed by this problem, which is as lethal as any metastatic cancer. Many longitudinal studies have documented this fact.

**Drug Abuse Mortality**

Robert Frater reviewed 57 known drug addicts with endocarditis who were operated on at Montefiore Medical Center from 1977 to 1989 [3]. The most common lesion was aortic endocarditis. The 30-day in-hospital mortality rate was 9%, yet during 5 to 10 years of follow-up, the mortality rate was about 90%.

A 33-year follow-up of 471 heroin addicts who had been admitted to a drug addiction program identified three clinical trajectories for these individuals: stable high-level heroine users, late decelerators, and early quitters [4]. A literature review showed mortality rates for the three groups of 50%, 38%, and 25%, respectively. Only 44% of the 471 addicts were early quitters; most continued to use drugs. A separate study of the same cohort showed the addicts lost an average of 18.3 years of life: 22.3% of the years were lost due to heroin overdose, 14% to chronic disease, and 10% to accidents [5]. The average future life expectancy of the addicts was 19 years vs 33 years for comparable men. The estimated monetary value of lost productivity was more than $174 million.

A study of 4200 intravenous drug users in Italy found increased mortality from cardiovascular, respiratory, and gastrointestinal disease as well as violence, overdose, and AIDS. Although most deaths were due to endocarditis, a significant number were due to cirrhosis in men and pneumonia in women [6].

A population-based study in Ireland found a steady rise in opioid-related mortality rates during a 20-year period, nearly doubling from 6% in the 1980s to 11% in the 1990s [7].

Joe and Simpson [8] studied the mortality rates and survival for opioid addicts who had survived to a 6-year follow-up interview. The mortality rate was 6.9 times greater than the general population. Approximately 29% of the deaths were due to violence, and 48% were directly related to drug use.

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**Pro: Dr Jones Can Refuse to Operate on Mr Smith**

J. Michael DiMaio, MD

In a London study of a cohort of 128 addicts, 43 died during a 22-year period. Most deaths were drug related, 18 specifically of drug overdose [9]. Review of the United Kingdom heart valve registry found that the 1-, 5-, and 10-year survival rates after operations for prosthetic valve endocarditis were only 67%, 55%, and 37%, respectively; a dismal prognosis.

The Drug Abuse Warning Network provides individual data from each state. Maine, for example, does not have a large urban population that might favor the availability of abusive drugs. Review of the data demonstrates that most deaths among drug abusers are due to accident, suicide, or unknown, not medical conditions [10]. No matter what is done for him, Mr Smith could die of any of these causes.

Protecting the Team
What about the team? Should a surgeon place 10 or more persons at risk, including nurses, perfusionists, and anesthesiologists? Few of them have the right or ability to protest the decision made by a surgeon who feels an obligation to help someone who fails to care for himself.

The risk of infection to health care workers is real. I submit a recent anecdote. While preparing this paper, I spoke to a faculty member at an academic center. He recounted a story about himself when he was a fellow in training. He was asked to help on a second-time valve reoperation for recurrent endocarditis. He was hesitant to scrub, because unlike the attending surgeon, he saw the futility of the operation. He was stuck by a needle and converted to a positive hepatitis C status requiring interferon therapy. The risks are definitely real.

The Good of Society
What about society? Utilitarianism is the idea that the moral worth of an action is determined solely by its contribution to its overall utility: that is, its contribution to happiness or pleasure as summed among all persons, sometimes described by the phrase “the greatest good for the greatest number.” According to utilitarian theory, the collective risk of harming many persons shifts the equation to the greatest amount of good to the greatest number of people. Spending time, energy, and resources, which are not unlimited, on one patient who has chosen to do himself harm does not serve the greater good.

Although a surgeon might think that he operates simply within a one-on-one relationship with a patient, he denies the good of many others within such a narrow framework [11].

Allocation of resources in society is also an issue. Time is not unlimited. This is true for the surgeon, but it is equally true for all the members of the operating and care teams. Expending this limited resource on Mr Smith is wasteful.

What about money? This would certainly be a very costly operation, its reoperative nature potentially including renal failure requiring dialysis and other complications. As surgeons, we can argue that saving money is not our job, but I would strongly argue that it is. We all have a sense of what things cost. We may substitute a less expensive suture or stapler if we believe that it will save money and not cause any difference in patient care. We allocate scarce organs for transplantation because we try to watch out for the greater good of society. Mr Smith’s case is not different. Even if the number of valves is theoretically unlimited, other resources are not. Certainly, if we do not begin to understand how to allocate health care resources more wisely, others will force it upon us.

We do not have an obligation to treat this patient if he is a poor steward of the gifts he has received. Mr Smith is not unlike someone who has, for example, received a kidney or heart transplant and has stopped taking his graft-preserving medications. We are not obligated to endlessly supply new operations, valves, or organs if the person is a poor steward of the resources charged to his care.

Where does one draw the line? The only principled response is to do the first operation. By that, we mean that there is no principled reason to do more than one operation. One may argue that it is fair to give him one more chance, but that same argument can be made for two, three, or four operations, and there is no end. This is not a slippery slope argument, it merely suggests that a surgeon is obligated to do something once; if it is done right, the obligation falls to the patient to care for his gift.

The Surgeon as a Professional
Finally, a surgeon is a professional with professional obligations. He has the right and responsibility to assess the situation, circumstances, probabilities, and likely outcomes, and to determine whether he believes an operation is futile. Just because the patient wants a procedure does not require a surgeon to perform it. As thoracic surgeons, we do this every day based on information from the Society of Thoracic Surgeons (STS) database as well as hospital and personal statistics, and finally, we put it all together with our carefully considered judgment. In this case, Mr Smith and society would not receive benefit from an operation. Therefore, Dr Jones has every right to say no!
Con: Dr Jones Cannot Refuse to Operate on Mr Smith

Tomas A. Salerno, MD

Valve endocarditis represents one of the leading causes of operative mortality in cardiac surgery, ranging from 8% to 37% [12–14]. Poor outcomes are related to drug resistance, delay in surgical treatment, presence of concomitant risk factors and multiple end-organ dysfunction, acute congestive heart failure, prosthetic valve reinfection, and severity of valve injury [15–17]. Surgeons are frequently asked to operate on patients who have acquired endocarditis of a native or prosthetic valve resulting from intravenous drug use. Without surgery, the prognosis of this condition is poor, especially when vegetations, annular abscesses, intracardiac fistulas, and severe valve insufficiency develop [15]. Valve surgery for infectious endocarditis carries, among others, the risk of subsequent prosthetic valve reinfection, irrespective of the type of prosthesis used. If prosthetic valve endocarditis occurs, the outcome without an operation is often dismal despite aggressive medical therapy [16].

When surgeons face the scenario of a patient with endocarditis related to drug use, what often comes to mind is that all efforts at salvaging the patient’s life could be futile should the patient return to drug use. Such is the case of the hypothetical patient, James Smith, discussed in this article. This 29-year-old father of 2 children presented to the emergency department with a serious infection of the aortic valve consequent to his history of intravenous drug use. The surgeon, Dr Jones, operated on the patient, who did well postoperatively. Before discharge, however, Mr Smith was warned that the continued use of drugs could lead to recurrent endocarditis and prosthetic valve reinfection, a potentially life-threatening condition. The patient signed an agreement that he would not receive a second valve operation should he continue to use drugs and develop prosthetic valve endocarditis. Two years later, the patient reappeared with endocarditis of the prosthetic valve and history of recurrent drug use. The same surgeon was consulted for urgent valve replacement.

The question then becomes: Should the surgeon operate again on this patient? To answer this question, it is important to understand not only the disease process but also the medical issues related to drug addiction and its treatment options. Furthermore, the points of view of a psychologist and a lawyer, in addition to that of a surgeon, may provide further insight into this complex issue.

Definition of Drug Addiction

In 2001, the American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine jointly defined addiction:

Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving [18].

Drug addiction is a complex but treatable disease, characterized by compulsive drug craving and drug usage that persists despite serious consequences. It may become chronic, with relapses after prolonged periods of abstinence. For this reason, it may require on-going surveillance and repeated treatments.

Psychologist’s View

Mr Smith did not receive the benefits of an appropriate treatment plan that would target detoxification and relapse prevention and ensure that the patient had an adequate support system for his problem. The physicians involved in the care of this patient should have sought the expertise of a psychiatrist and a clinical psychologist specializing in drug rehabilitation. He should have been treated as a dual-diagnosis patient. Comprehensive alcohol and drug addiction treatment centers provide dual-diagnosis programs specializing in detoxification and relapse prevention. Mental health professionals work with the patient to provide him with emotional tools and psychopharmacology treatments to help him achieve abstinence and prevent relapse.

Many times, due to lack of insight and judgment, addicts patients delay medical assistance until their medical conditions reach high levels of severity. Telling an addict that if he uses drugs again that he will not be further treated (regardless of medical risks) sounds like telling a child not to play with other kids because we disapprove of their type of play. In recovery, an addict patient cannot do it alone, so the agreement or demands made of this patient is akin to punishment.

Other issues may also arise: Some professionals may tend to be omnipotent caretakers, and end up deluding themselves into believing that they can do it all, rarely asking for help from other professionals. That might have happened in this case.

Lawyer’s View

One of the greatest risk factors for developing endocarditis is a previous heart operation for endocarditis, along with many other factors, such as poor dental hygiene. Therefore, recurrent endocarditis may result from a problem unrelated to the addiction, even if the patient remains engaged in drug use. Should physicians require lifestyle agreements and contracts or refuse to treat a patient if a condition arises that could be potentially linked to a lifestyle violation or to some other cause?
Furthermore, who should decide which lifestyle habits constitute a violation and which do not? In the end, the patient would pay, perhaps with his life, adding to the suffering of his 2 innocent children!

In some medical circumstances, such as that of an alcoholic liver transplant patient, clinicians may have a keen interest in making sure that scarce replacement organs go to those who will care for them the best. Performance contracts are used, and prospective organ recipients must demonstrate lifestyle changes to qualify for a transplant. From a logical and ethical point of view, in organ transplantation the scarcity of organs affects patient selection. In contrast, our case of recurrent endocarditis involves the need for emergency care without withholding essential care from other patients with similar medical problems. The disease mechanism may or may not have been related to a disfavored lifestyle or a breach of “contract,” whether enforceable or unenforceable. This should not be viewed as a closed question—to operate or not to operate. Rather, the surgeon should operate or transfer the patient to another surgeon.

Another important issue is the legality of “contracts” between patients and health care professionals. Such contracts should not be incorporated in medical practice, because they could be fraught with both ethical problems and potential legal consequences. Surgeons should provide treatment within the prevailing standard of care to patients, regardless of any contract or previous agreement. Should the patient not abide by care guidelines and recommendations despite the best efforts of health care providers, the consequences are on the patient. But greater consequences would be visited on the health care providers who feel empowered to decide whether a patient is morally worthy of their care.

From a legal standpoint, was any consideration given to the promise not to engage in high-risk behavior? Was the patient able, at the time of the contract, to fully understand the potential consequences of engaging in risky practices? Did he fully understand the potential consequences of not receiving treatment should recurrent endocarditis of the prosthetic valve develop, possibly related to recurrent drug use? Also, could such a contract be enforceable in a court of law? If someone came to the emergency department with an urgent, life-threatening medical condition, and physicians failed to render care on the basis of such a document, there could be a significant risk of exposure to litigation for failure to render necessary care.

A contract alone would not insulate the surgeon from a malpractice suit, and the risks of that suit under these circumstances could very well be significant. Such a case would probably not be defensible on the basis of that contract. This would make a strong case for physicians, already exposed to litigation when the care needed is rendered, not to venture into decision-making processes based on anything other than medical need. Worse yet, the unwilling physician’s actions could result in a claim for punitive damages for his intentional refusal to provide lifesaving care based on legally unjustifiable reasons. Although compensatory damages are routinely awarded and punitive damages are seldom given, they too could be awarded and could be very significant.

The better choice is for the physician to either provide the indicated care or make sure that the patient’s care is transferred to another appropriate clinician. For example, Florida Statute 755.1105 states, “a health care provider can refuse patient’s directives, but must transfer care to someone else.” Should a health care provider not be able to provide care to the patient, Florida Statute 395.1041 requires one to stabilize an emergency condition. A federal statute, the Emergency Medical Treatment and Labor Act [19], also deals with access to care.

**Surgeon’s View**

We, as physicians, have the ethical responsibility to treat and heal. If we venture into the moral background of patients, then we would spend more time passing judgment on lifestyle choices instead of making the medical decisions we have been trained for.

Additional considerations may also arise: Some health care professionals, at times, tend to feel like omnipotent caretakers, leading them to believe that they can do it all and that they do not need help or advice from other professionals. The clinical scenario described here seems to be one such situation. Treating drug addicts can be overwhelming and frustrating. However, addiction should be treated as a separate disease process, and a multidisciplinary approach may enhance chances of success.

Finally, isn’t the position of the surgeon refusing to treat the same as that of a physician dealing with a smoker whose lung cancer has been cured, but who would be declared ineligible for further treatment should he continue to smoke and develop a recurrence? Or that of a physician dealing with a morbidly obese patient who would be denied treatment should he develop a complication resulting from recurrent overeating? Does a physician have the authority, the time, and the mission to be a law enforcement agent? After all, should physicians decide not to treat medical conditions that result from exposure to certain risk factors or unsafe behaviors, what would be left for us to treat? A vast number of medical conditions, including heart diseases and infectious disease, may result from exposure to well-known environmental factors. Does the willingness of a patient to be exposed to those factors disqualify him from receiving indicated medical or surgical treatment? In our opinion, that should not be the case.
Concluding Remarks

Robert M. Sade, MD

In constructing the hypothetical case of James Smith, we intended to present a situation in which a substantial number of cardiothoracic surgeons would support one or the other choice: operating or not operating on Mr. Smith. A balance had to be achieved among a number of factors that might influence surgeons in deciding which side to support; for example, the number of operations and reoperations, the characteristics of the underlying addiction, and the degree of sympathy for Mr Smith in terms of his young age and being the father of 2 young children. With slight variations in the scenario, surgeons who initially agreed with Dr DiMaio’s or Dr Salerno’s position might reach the opposite conclusion. For example, how would Dr DiMaio react to a psychiatry consultant telling him that a clinic using new and highly effective methods for curing drug addiction had just opened, and that Mr Smith should therefore be given another chance at an operation? Similarly, how would Dr Salerno react if he were presented with Mr Smith after he had maximal treatment for addiction on several occasions, relapsed each time, and now needed a fourth valve replacement? Both might well change their current choices.

Dr Jones’s dilemma is clearly complex. Yet, Mr Smith’s story brings to front stage some basic principles of medical ethics. The primary obligation of physicians is to their patients [20, 21]. We have other obligations, of course, to ourselves, to the institutions in which we work, to our colleagues, and to society, but these are all secondary: Consideration of the patient’s well-being must come first. In addition, social worth has no place in medical decision making [22]. This became a crucial principle of medical ethics when the bottom of the slippery slope of social worth as an evaluative factor was reached in Europe in the 1930s and 1940s [23]. We often stereotype drug addicts as occupants of the lowest rung of the social ladder, but this social judgment must play no role in deliberations about whether an operation should be done.

A colleague recently related a personal anecdote that is relevant to the matter of surgeons making medical judgments based on social considerations.

When I was a young surgeon, I encountered a mentally retarded man with a unique occupation. He attacked drunken tourists, clubbing them senseless from behind, and robbing them. But then he developed aortic stenosis, impairing his physical activity sufficiently to stop his violent forays. He would readily demonstrate his methodology if asked. He wanted to go back to work. I remember the way he thanked me when I told him that he did not need an operation. I never saw him again.

An incident about 10 years later made me question the earlier decision. I lived in a close-knit suburban community at that time. During an armed robbery, an exceptionally kind neighbor, who was a minister, was killed. The killer was apprehended and was seriously wounded; he was brought to the hospital, making the evening news. Another neighbor who was a good friend called me as I was still at the hospital, and requested that I let the robber die. I was in total disbelief that he would ask me to do that. I lost that friend and made several other neighborhood enemies. It was outrageous to ask me to be judge, jury, and executioner. But that was precisely what I was in the previous case [anonymous personal communication].

As with social worth, several other aspects of Mr Smith’s story are not relevant to making the decision to replace his aortic valve for the second time. He has returned to using intravenous drugs, and this lapse is the most likely cause of his reinverted valve. He has done it to himself, many would say, so does not deserve a second valve. But deciding what is deserved or undeserved is a moral judgment that we, as physicians, are not in a position to make. We see human frailty in action every day. People engage repeatedly in risky activities that we and they know have a high probability of damaging them; for example, riding motorcycles despite previous accidents and injuries, eating too many saturated fats after coronary bypass grafting operations, or continuing to smoke after resections of lung cancer. We may disapprove of their activities or habits, but when they return with hemopneumothorax after another accident, severe angina from atherosclerotic graft occlusion, or a new lung cancer, we may wag a finger and scold them and we may become frustrated with reappearance of old behaviors, but we care for them without hesitation, including reoperating when indicated.

Mr Smith’s relapse is just such a human failing, whether it is due to unwillingness or to inability to refrain from using drugs. His failure is not different from the biker, the overeater, or the smoker, and we should similarly care for him without hesitation. From a physician’s perspective, it does not matter whether a patient with an unambiguous medical need is addicted to traveling on 2 wheels at high-speed in the open air, to eating rich foods, to smoking cigarettes, or to abusing drugs: We are ethically bound to use available resources to provide indicated, proper treatment. In view of the human frailty we as physicians observe daily, a patient’s agreement, promise, or contract not to return to abusing drugs cannot justify refusing an indicated operation.

In my opinion, the claim that surgeons must be good stewards of health care resources and therefore should not reoperate on Mr Smith fails, because if we have any obligation of stewardship, it must be directed primarily to preserving the well-being of our patients, not the well-being of society, as we noted above in discussing...
social worth. Admittedly, some believe that physicians have equal or greater obligations to society than to individual patients, but I believe that belief is mistaken [20].

Mr Smith has two medical problems. Dr Jones has treated the infected valve with his first operation, and before hospital discharge must be sure that the second problem, drug addiction, has been addressed medically. To care adequately for Mr Smith after replacing his infected aortic valve, Dr Jones should ensure that the patient fully understands, within the limits of his intellectual capacity, that the medical consequences of continuing intravenous drug use are a high probability of recurrent infection and increased risk of complications and death after any subsequent valve operation. In addition, the surgeon must ensure that the patient receives, or at least is offered, the most thoroughgoing care that is available for his addiction. This means that Dr Jones must consult substance-abuse specialists before Mr Smith is discharged after his first hospitalization and ensure that the patient is offered enrollment in a program for comprehensive drug addiction treatment, including detoxification and relapse prevention. The fact that no such offer was made to Mr Smith after his first operation requires prima facie that he be offered a second operation.

For the sake of discussion, let us assume that Mr Smith was enrolled in a detoxification program, but he returned to drug abuse nevertheless. Under those conditions, when deliberating on whether to offer Mr Smith a second operation, many factors must be considered, including, for example, availability of resources such as the necessary materials and manpower, the balance of benefits and harms to the patient, and the patient's personal preferences. His drug addiction is relevant only for its medical implications, such as early and late survival statistics. His drug addiction is irrelevant insofar as it places him in a particular social group or class that might stir passions of antipathy, aversion, or contempt. The American Medical Association Code of Medical Ethics discusses resource allocation criteria, and includes this statement: “Nonmedical criteria, such as . . . social worth, patient contribution to illness, or past use of resources should not be considered” [24].

As medical professionals, we are subject to the same burdens of bias and moral prejudgment as other human beings. As surgeons, however, we have an obligation to suppress prejudgment when making surgical decisions. The welfare of our patients must come before any consideration of their social worthiness.

An aid to deciding whether to offer an operation to Mr Smith is to imagine a parallel case, retaining all the features of his case, including availability of resources and predicted survival, but substituting for Mr Smith a 29-year-old black woman with 2 young children. The woman has systemic lupus erythematosus (SLE) with chronic glomerulonephritis, requiring treatment with immunosuppressive agents. She does not smoke, drink, or use recreational drugs. Yet, her life expectancy is substantially reduced by the combination of SLE, immunosuppression, and cardiac valve infections; it is roughly comparable to that of an intravenous cocaine drug abuser with infective endocarditis.

It seems likely that every surgeon would offer this woman a second operation. Any surgeon who would make such an offer, however, must make the same offer to Mr Smith. The facts that she leads a praiseworthy life and her acquisition of a cardiac valve infection is “innocent,” and that he is a member of a despised group, drug addicts, and his infection is “self-inflicted” are of no relevance to the surgical decision. In making treatment decisions, Dr Jones must free his mind of biases and moral prejudgment. He must do this to discharge his first responsibility—the care of his patient.

If a surgeon applies the comparison test and finds that he would operate on the innocent patient, but still cannot, in good conscience, offer an operation to the drug addict, he can consider alternative courses. He can seek advice from experienced, trusted colleagues or an ethics committee in thinking through the many complexities of the case, or he can refer the patient to another surgeon. He should not, however, simply declare that an operation is not indicated and close the book. He owes more than that to every patient.

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