

Virtual Mentor

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Clinical Case

The “Slip”

Commentaries by Mark D. Fox, MD, PhD, MPH, Arthur L. Caplan, PhD, and Jeffrey S. Crippin, MD

Jenny is a third-year medical student on her internal medicine rotation at the Veterans Administration Hospital. The rotation has been a great learning experience; her patients are generally friendly and grateful for the care they are receiving. One of Jenny’s favorite patients is Mr Hackman, a 53-year-old veteran who has been diagnosed with alcoholic cirrhosis and is currently on the transplant waiting list. Every afternoon Jenny talks with Mr Hackman, and he often shares stories with her about the past. Jenny takes a genuine interest in the stories about his family and supports his attempts at sobriety. During one of their sessions, Mr Hackman revealed that he had taken a drink at a friend’s house 2 months prior. He swore that this was “the only drink I’ve had in the last 2 years.” He pleaded with Jenny not to tell anyone about his transgression because he knew that alcohol abuse could affect his status on the transplant list.

Commentary 1

by Mark D. Fox, MD, PhD, MPH

This case highlights a crucial aspect of Jenny’s professional development. She should be commended for the rapport she has established with Mr Hackman. He obviously trusts her, as evidenced by his willingness to disclose information that has potentially devastating consequences. The conflict posed by Mr Hackman’s request for confidentiality is heightened by the apparent blurring of personal and professional boundaries. Thus, Jenny’s dilemma must be considered within the context of both personal and professional obligations. Moreover, because of the potential impact on Mr Hackman’s transplant candidacy, Jenny’s actions have broader social implications regarding the allocation of scarce resources.

There is often a naïve presumption of “absolute confidentiality” on the part of both patients and clinicians. In fact, this presumption sometimes leads clinicians to promise more than they can deliver with respect to confidentiality. Clearly there are circumstances in which the risk to the patient (or an identified other) warrants, or even requires, breaching patient confidentiality. One of the developmental tasks for clinical trainees is to divine the limits of confidentiality and to place assurances regarding confidentiality in an appropriate contextual framework.

In this case, Mr Hackman raised the issue of confidentiality only after disclosing potentially incriminating information. Fortunately, Jenny has not painted herself into a corner with any untenable promises. Nevertheless, it is worthwhile to consider the

rationale for expectations of confidentiality, and doing so is necessary for discerning the appropriate course of action for Jenny.

The presumption of confidentiality serves a functional purpose. Clinicians can only provide optimal care when armed with complete information, and patients are more likely to disclose intimate details if they believe the information will be kept in confidence. There is, however, a more fundamental grounding of our commitment to confidentiality: in essence, it is part of a larger pledge to not take advantage of those entrusted to our care. The patient-physician relationship, even when it involves a physician-in-training, is necessarily characterized by a fundamental asymmetry of power. This asymmetry gives rise to a compelling obligation that the physician not use the information in ways that can harm the patient.

Several other aspects of this case are worth further exploration. First, it is not clear that Mr Hackman divulged the information to Jenny in the context of a therapeutic relationship. It appears that their regular conversations may be more social than therapeutic in nature. (This is not meant to suggest that these interactions are not significant or relevant to Jenny's education.) If Jenny were simply his friend rather than on his medical team, Mr Hackman might reasonably expect her to keep his confidence and support him in his efforts to maintain sobriety. Because their relationship is framed primarily by the clinical context, Jenny's obligations are shaped foremost by her professional commitments. Whether Jenny's responsibilities would be different if she were a student on the transplant, rather than the internal medicine, service remains an open question.

Another potentially troubling feature of this case concerns the nature of Jenny's relationship with Mr Hackman, inasmuch as he is identified as one of her "favorite" patients. While it is perfectly natural to feel a particular affinity for, or develop a special connection with, certain patients, we are nevertheless obligated to treat them the same as we do all of our other patients. It would be disconcerting if Jenny felt a greater obligation to preserve Mr Hackman's confidentiality simply because of their personal relationship.

Jenny's ultimate response to this dilemma may rest in part on her understanding of the requirement for abstinence from alcohol for transplant candidates with alcoholic liver disease, regardless of whether she is a part of the transplant program or not. Jenny is under no obligation to relay inconsequential information to other members of the health care team. For example, the fact that Mr Hackman is a Cincinnati Reds fan or prefers chocolate ice cream to vanilla holds no consequence for the anticipated outcome following a transplant. The impact of various psychosocial factors on outcomes following transplantation is admittedly not well-characterized, but a minimum of 6 months of sobriety has become widely accepted as a prerequisite for transplant eligibility.

To some, the sobriety requirement may seem to have a punitive quality—penalizing alcoholics for their role in contributing to their disease. Others may view it as a means of rationing a scarce resource; abstinence serves as a hoop for patients to jump through to be eligible for a transplant. If Jenny were to perceive either of these

rationales as the basis for the abstinence requirement, she may feel justified in honoring Mr Hackman's request for confidentiality.

The requirement for abstinence from alcohol, however, is not rooted in a view of alcoholism as a moral failure. Rather, it reflects the recognition of the chronic nature of the disease, with a high risk of relapse. Although alcohol relapse has not clearly been shown to compromise post-transplant outcomes, there is a substantial risk of recidivism post-transplant and a trend toward decreased survival [1,2]. The rate of relapse cited in various studies ranges from 20-33 percent [1-3]. Abstinence for 6 months or longer has been identified as the best predictor that relapse will not occur [1,3].

As stewards of a scarce resource, transplant professionals have an obligation to exercise prudence not only in the selection of candidates for the transplant waiting list but also in the allocation of donor organs to recipients. Optimal allocation of donor organs seeks to balance considerations of medical urgency with the probability of a successful outcome. In addition, because of the limited number of transplantable organs, access and allocation necessarily entail consideration of unknown others. That is, while Mr Hackman may well experience a survival benefit from a transplant (despite his continued alcohol use), there may be other patients, eligible for the same donor organ, who would fare better. This consequence of organ scarcity poses a significant challenge to the Hippocratic ideal of beneficent action on behalf of the patient entrusted to your care. Therefore, Mr Hackman's use of alcohol, albeit allegedly as an isolated indiscretion, is certainly relevant to his suitability for transplantation at this time and needs to be communicated to the transplant team. Moreover, it is often a primary care provider, rather than the transplant staff, who is privy to these details during the waiting period.

While Jenny succeeded in initially establishing rapport with Mr Hackman, she now faces a difficult professional challenge about how best to communicate this information to the transplant team. Ideally, Jenny could help Mr Hackman appreciate the potential impact of his continued use of alcohol on his transplant outcome while playing a pivotal role in providing emotional support when he discloses his indiscretion to the transplant team.

One final consideration relates to the notion of nonabandonment. Regardless of the impact of Mr Hackman's disclosure on his transplant candidacy (he could either be deferred or rejected from the wait list altogether), Jenny has an obligation to provide ongoing care for his chronic condition (within the scope of her clerkship). In the midst of navigating these challenging personal and professional concerns, Jenny must also communicate to Mr Hackman her commitment to participate in his care.

References

1. Lim JK, Keeffe EB. Liver transplantation for alcoholic liver disease: current concepts and length of sobriety. *Liver Transpl.* 2004;10(Suppl 2):S31-S38.
2. Bjornsson E, Olsson J, Rydell A, et al. Long-term follow-up of patients with alcoholic liver disease after liver transplantation in Sweden: impact of structured

management on recidivism. *Scand J Gastroenterol*. 2005;40:206-216.

3. Miguet M, Monnet E, Vanlemmens C, et al. Predictive factors of alcohol relapse after orthotopic liver transplantation for alcoholic liver disease. *Gastroenterol Clin Biol*. 2004;28:845-851.

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Commentary 2

by Arthur L. Caplan, PhD

Jenny is facing what seems to be a difficult moral dilemma. On the one hand, she is duty-bound to act as an advocate for Mr Hackman, making sure he receives the best possible medical treatment. In this case, that means she must help ensure that Mr Hackman receives a new liver. On the other hand, she is obligated to be a responsible steward of scarce, life-saving medical resources. If she honestly believes that Mr Hackman will not benefit from access to a donated cadaver liver or lobe of a liver obtained from a living donor, or that there are others who would be better beneficiaries, then she must inform the medical team about her concerns regarding Mr Hackman's alcohol use.

This looks like a genuine professional dilemma. But it may not be. Doing what seems the difficult thing—"snitching" on her patient—may turn out to be the best thing she can do to help him secure the treatment he needs.

What might lead Jenny to believe that her desire to help Mr Hackman must yield to her duty to be a responsible health team member, stewarding the limited supply of livers available for transplant, is Mr Hackman's "confession" that he has had a drink. In many liver transplant programs and perhaps at Jenny's institution, a period of sobriety, usually 6 months, is an absolute requirement for transplant eligibility. Still, despite the fact that Mr Hackman seems to have put himself at a severe disadvantage in the competition to secure a liver, certain facts may make it easier for Jenny to decide how to discharge her conflicting ethical duties.

Having a single drink, sometimes referred to as a "slip" in alcohol abuse programs, is not uncommon. Many people on the road to sobriety slip, as the literature on the treatment of alcoholism quickly reveals [1]. Moreover, views and attitudes about sobriety and alcoholism that prevail among health care professionals are not consistent with what those experienced in the field of drug and alcohol abuse consider efficacious treatment [2]. A single drink is not the end of the line as far as sustained sobriety after a liver transplant goes.

Presumably Jenny can share the information she has about Mr Hackman with a member of the transplant team who is well informed about alcohol abuse and recovery. It is difficult to imagine that a psychiatrist, psychologist, or social worker

affiliated with a liver transplant team would be overly concerned about a report of a single instance of taking a drink on the part of someone on a waiting list.

Jenny can and should tell Mr Hackman she is going to suggest that a more experienced person talk with him about his slip. She can also assure Mr Hackman that a single drink, if that is all that has happened, is not going to lead directly to his being dropped from the transplant list or even weaken his priority in gaining access to a liver.

It may also be of interest to Jenny to know that there is not a lot of data to support the view that a history of alcohol abuse adversely affects the success of liver transplantation. Nor is there much evidence that periods of sobriety—by themselves—are key to the success of liver transplantation. Having a strong social support network has been shown to be the most important factor in achieving success among alcoholics who receive liver transplantation [3]. Mr Hackman has made it clear that he has strong support from friends and family alike. These facts make his chances for doing well with a new liver better than average.

Although Mr Hackman did not tell Jenny about his slip in confidence, he later asked her not to say anything. But any factor that bears on his chances of successfully surviving and flourishing with a liver transplant must be addressed. To act ethically, Jenny must tell Mr Hackman that this is so. Then she needs to inform an appropriate member of the transplant team.

Jenny must also tell Mr Hackman that a single slip is not at all uncommon, that the transplant team will be familiar with this situation, and that one slip should not adversely affect his chances of receiving a transplant. In fact, his willingness to talk about this incident with his doctors and his family shows that he is precisely the sort of candidate that is likely to do well after a surgery. Admitting his mistake with a renewed commitment to sobriety may be just what the transplant team is looking for in prospective patients.

References

1. Sobell LC, Sobell MB, Connors GJ, Agrawal S. Assessing drinking outcomes in alcohol treatment efficacy studies: selecting a yardstick of success. *Alcohol Clin Exp Res*. 2003;10:1661-1666.
2. Roche AM, Parle MD, Stubbs JM, Hall W, Saunders JB. Management and treatment efficacy of drug and alcohol problems: what do doctors believe? *Addiction*. 1995;90:1357-1366.
3. Karman JF, Sileri P, Kamuda D, et al. Risk factors for failure to meet listing requirements in liver transplant candidates with alcoholic cirrhosis. *Transplantation*. 2001;71:1210-1213.

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Commentary 3

by Jeffrey S. Crippin, MD

To tell or not to tell? That is the dilemma facing Jenny as a member of the team caring for Mr Hackman. Clearly, Jenny has an emotional attachment to Mr Hackman, and this is very common in clinical medicine. But when clinical decisions potentially impact the care of other patients, objectivity must guide the physician's decision.

As you, Jenny, approach this case, you must clarify several issues before deciding what to do. First, what are the medical facts and allocation policies regarding liver transplantation in patients with alcoholic liver disease? What are the survival figures for patients with alcoholic liver disease who receive new livers? What is the rate of alcohol recidivism for transplant recipients like Mr Hackman? Does the admission of alcohol use permanently eliminate Mr Hackman from consideration for a transplant? Will he get a second chance if he is removed from his current spot on the list? What are the implications for other patients on the waiting list if Mr Hackman remains on the list and receives a transplant? Should you withhold this information and “protect” Mr Hackman's chance of getting a transplant? Careful examination of these questions will lead you toward a thoughtful and informed decision.

In the early days of liver transplantation, alcoholic liver disease was the most frequent indicator for liver transplants. Hepatitis C has now become the major indication, but many hepatitis C patients also have histories of alcohol dependence. Survival figures for patients with alcoholic liver disease who have received transplants have been excellent, comparable to the success rates among those who received liver transplants because of non-alcohol-related reasons. In fact, survival rates after transplant for patients with alcoholic liver disease are better than those for patients who received livers because of chronic hepatitis C alone. The major concern in transplant patients with alcoholic liver disease is recidivism—how many patients return to drinking following the transplant. Dr Thomas Starzl, the “father” of liver transplantation in the United States, proposed that a liver transplant was the “ultimate ‘sobering’ experience” [1]. This comment suggests that patients with alcoholic liver disease do not drink following a transplant. Unfortunately, this has not been proven true. Recognizing this, transplant centers now require a period of abstinence before a transplant. This period of abstinence demonstrates 2 important things to the transplant team. First, alcohol abstinence remains the most effective treatment for alcoholic hepatitis, so many patients improve during the period of abstinence and, as a result, their need for a transplant is not as urgent. Second, the period of abstinence shows some degree of commitment by the patient. The longer the pretransplant abstinence lasts, the greater the chance of long-term abstinence. At least 5 years of sobriety is necessary before a reasonable chance of long-term abstinence is present [2]. Due to the severity and complications of their disease, many patients do not have that much time. Yet many centers require at least a 6-month period of sobriety, often with random drug and alcohol screens, before a patient is placed on the waiting list.

Liver transplantation, in general, is plagued by the recurrence of the original disease in the liver allograft. Hepatitis C is the best example of this because Hepatitis C viremia is not eliminated at the time of the transplant, making infection of the allograft inevitable. The cause of recurrence is different in alcoholic liver disease where the disease reappears only if the transplant recipient relapses to alcohol dependence. Multi-centered studies have examined the experience of disease recurrence [3-6], many using patient interviews and recall, eg, "Have you had alcohol since your transplant?" Obviously, this method is dependent on patient recollection and honesty. The studies found that the prevalence of alcohol ingestion increased with the length of time since the transplant, with the rate of recidivism reaching 50 percent after 5 years in some series [3, 4]. Fortunately, the incidence of "problem" drinking, ie, drinking to the point of medical complications, was relatively rare, affecting only 10 percent of patients [6]. Thus, there may actually be some truth to the "ultimate sobering experience" observation by Dr Starzl years ago.

Another potential consideration in Jenny's decision is the severity of Mr Hackman's illness. Deceased donor liver allocation is currently based on the severity of the would-be recipient's illness. The model for end-stage liver disease (MELD) uses 3 easily obtainable lab values (serum bilirubin, serum creatinine, and INR) to generate a "score" as a means of predicting a 3-month mortality risk. The higher the MELD score, the higher the risk of death, and the higher the patient's place on the transplant list. Therefore, if Mr Hackman's MELD score is high, he may be "too sick" to survive any additional time on the waiting list. Many centers tell patients that the 6 month "clock" starts over after each use of alcohol, meaning they must remain abstinent another full 6 months before returning to the waiting list. If Mr Hackman has a predicted 80 percent risk mortality in the next 3 months, waiting to get back on the transplant list may not be an option, and Jenny may think she is giving him a death sentence if she reports his "slip" into alcohol consumption. If his MELD score is relatively low, however, coming off the list could allow Mr Hackman to seek additional counseling or treatment that could ultimately lead to a prolonged period of abstinence, both before and after the transplant. Jenny's decision to tell the transplant team might ultimately be better for Mr Hackman if his state of health permits him to survive the consequence.

Jenny must also consider the potential effect of her decision on other patients. Mr Hackman is 1 of over 18 000 patients on the nationwide liver transplant waiting list. If he gets the transplant, someone else does not. This reality often prompts people to ask "whose life is worth more?" This is *not* how transplant teams make decisions regarding the waiting list. Rather, the question that the transplant team must answer is "does any single patient have an acceptable risk of mortality and an acceptable potential for posttransplant survival?" Alcohol recidivism is only 1 of many factors taken into account. Medical comorbidities, previous surgeries, and psychosocial support are equally important and carefully considered.

Finally, Jenny must carefully consider her own emotional attachment to Mr Hackman and his family and take an objective look at her feelings. How long has she known him? Did she just meet him a few days ago at the time of a hospital admission? Does

she think she knows him better than the hepatologist involved in his care over the last 4 years? Is she certain, beyond a shadow of a doubt, that he is telling the truth? Could the one admitted instance be a sign that other episodes have occurred? What triggered the ingestion of alcohol? Was it a stressful situation, indicating that Mr Hackman turns to alcohol in times of crisis? Or was he with a group of old friends and just could not say “no,” indicating that his chance of long-term sobriety may be small?

All of the above must be carefully considered in Jenny’s decision. It is not as simple as it may seem. Yes, Mr Hackman may ultimately die of complications from liver disease. People die of liver disease—an estimated 30 000 Americans annually. Not all patients receive liver transplants—only 5000 per year do. This is the harsh reality of liver transplantation. Thus, Jenny should not allow her emotions to sway her decision. Careful consideration of all the issues, particularly following discussion with the rest of the transplant team, will lead to a decision that will ultimately reap the greatest benefit for all involved.

References

1. Starzl TE, Van Thiel D, Tzakis AG, et al. Orthotopic liver transplantation for alcoholic cirrhosis. *JAMA*. 1988;260:2542-2544.
2. Vaillant GE. The natural history of alcoholism and its relationship to liver transplantation. *Liver Transpl Surg* 1997;3:304-310.
3. Tome S, Lucey MR. Timing of liver transplantation in alcoholic cirrhosis. *J Hepatol*. 2003;39:302-307.
4. Mackie J, Groves K, Hoyle A, et al. Orthotopic liver transplantation for alcoholic liver disease: a retrospective analysis of survival, recidivism, and risk factors predisposing to recidivism. *Liver Transpl*. 2001;7:418-427.
5. Burra P, Mioni D, Cillo U, et al. Long-term medical and psycho-social evaluation of patients undergoing orthotopic liver transplantation for alcoholic liver disease. *Transpl Int*. 2000;13 Suppl 1:S174-S178.
6. Tang H, Boulton R, Gunson B, Hubscher S, Neuberger J. Patterns of alcohol consumption after liver transplantation. *Gut*. 1998;43:140-145.

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