



Responses to Editorial ‘Who Gets the Ventilator’

Reader: Editorial Might Reinforce Common Belief About Alcoholism

I appreciate the thought-provoking editorial by Drs. Flood and Shafer in the December *ASA Monitor*. It reflects thoughts and conversations I have had over the last 18 months of the pandemic. However, I respectfully take issue with one example used in their discussion of public health policy:

“An example would be giving an alcoholic lower priority for a liver transplant than another equally matched.”

While I understand the point the authors wish to make, their example reinforces the common belief that alcoholism is the result of poor choices, ignoring the considerable evidence that alcoholism is a disease over which an individual has very little choice.

Thomas Specht, MD
Truckee, California

Response From the Editors:

We appreciate the thoughtful commentary by Dr. Specht. We agree that alcoholism is a disease that is likely passed at least in part genetically. A person may have no greater choice in having this risk than a patient

with familial polyposis has in getting colon cancer. A better example might have been an alcoholic who continues to fail sobriety testing and so would have lower priority on a liver transplant waiting list than an alcoholic with years in recovery.

The risk of failed abstinence in the future might be a rational reason to give the liver to a person with no such history. However, let's say that the risk of failed abstinence is exactly balanced in the other individual by a genetic predisposition for cancer. If the risks are exactly balanced, is there any role for considering whether it is right that one person's alcoholism, unmitigated to the point of liver failure, might deprive another person without a history of alcoholism of a new liver?

As should be clear from our editorial, we truly don't know. ■

Pamela Flood, MD
Steven Shafer, MD
Stanford, California

Reader: One Option Missing in ‘Who Gets the Ventilator’ Scenario

Thank you for your thought-provoking editorial in the December *ASA Monitor*. I would argue that there is another option

that you didn't offer in the article and is not a choice in the reader poll. Although this would not be a popular choice for many physicians in the U.S., I believe that the correct and ethically appropriate choice would be to place neither Harriett nor Hubert on a ventilator. With an APACHE IV score of 32 and a COVID mortality rate approaching 80%, most physicians in any other country in the world would not offer the option of mechanical ventilation to either patient in this setting.

In your hypothetical situation, you discuss the socially responsible choice. I believe the most socially responsible choice is to preserve the last ventilator for the next COVID patient who has a reasonable chance of survival. This is truly the patient who has the most to gain and an ethical choice not fraught with the issue of personal choice or patient responsibility for health care outcomes. In current practice, we treat all patients non-discriminately without regard for lifestyle choices such as smoking and obesity, so why should personal choice for or against vaccination be any different?

As I'm sure your readers are aware, the U.S. spends a huge portion of health care dollars and resources surrounding end-of-

life care. If we don't learn anything else from this pandemic, perhaps it can be that ethical and compassionate care at the end of life can be simply the choice to do nothing medically and provide comfort to those undergoing the natural process of death when the chances of survival are low. ■

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