Vitals

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Ethics Case

Endocarditis: Lessons from Knoxville

In a powerful New York Times feature – "Injecting Drugs Can Ruin a Heart. How Many Second Chances Should a User Get?" – journalist Abby Goodnough tells the interconnected story of Jerika Whitefield, a recovering addict and endocarditis survivor, and Dr. Thomas Pollard, a Covenant Health cardiovascular surgeon and president of the Knoxville Medical Society.

This situation's ethical question is often found in working with "difficult patients." Namely, do defensible limits exist on expending resources for patients who are non-compliant and likely to relapse?

Three Knoxville health systems – Covenant Health, Tennova Healthcare, and University of Tennessee Medical Center – provided valve surgeries to 117 patients diagnosed with endocarditis from IV drug use from 2014-2016. Ten patients had a second surgery, and two of those patients received a third surgery.

According to Dr. Pollard's data, 21 patients died from sepsis or respiratory failure after their heart surgery. A recent study from two Boston hospitals, MGH and BWH, suggests only seven percent of endocarditis patients who continued IV drug use survived another decade compared to 41 percent of non-IV drug users.

How do clinicians make their resource allocation decisions in Knoxville?

Major professional groups give little guidance on this issue. In the case of Jerika Wakefield, the surgeon appreciated the amount of support she had from her family. She was honest about her drug use, too. However, a surgeon explicitly told her to remain drug free because the mitral valve repair would only be offered to her once.

From Dr. Pollard's data, just one percent of the 117 patients had private insurance. Jerika Wakefield was covered through the Medicaid program.

Haunted by these decisions, Dr. Pollard pushed the three Knoxville health systems to work together and provide addiction treatment as part of their commitment to patients receiving mitral valve repair. The systems have been non-committal as they cite the financial challenges of fighting the opioid epidemic totality. Dr. Pollard approximates the cost at $55,000.

I believe the solution is integrating the cardiovascular team with evidence-based addiction recovery programs. Without this integration, as Dr. Pollard's example shows, instances of bedside-rationing can become problematic. They force the surgeon to bear the moral and professional responsibilities of an individual patient's non-compliance through quality metrics.