It surely qualifies as a “worst of times” for medicine. Although it may be hard to believe today, beginning in the decade of the 1960s, dialysis therapy was rationed in the United States of America! The grim statistic for those outside the pale would be 100% mortality. In the group selected to receive life-saving treatment, one attribute was conspicuous by its presence?proof of service to society.[1] In fact, the infamous ?Seattle committee? excluded people from treatment if they were not ?self supporting.[2] The rationing process itself was roundly and appropriately criticized for its transparent ?prejudices . . . measuring people in accordance . . . (and solely by) middle class values.[3] Those values also imposed a racial stigma, imbedded in service and self-support criteria. Someone commented dryly that Henry David Thoreau?s myriad eccentricities would have eliminated him from eligibility. The definition for ?service? in Seattle wasn?t inclusive enough for Thoreau?s civil disobedience, ardent abolitionism, as well as his proclivities towards poetry and environmentalism. In the context of allocation decisions, these economic and sociological measures represent ?social value? criteria. They have absolutely no place in the compassionate allocation of medical resources?whether the resources in question are scarce or not.

In 1972, Public Law 92-603 guaranteed federal coverage for end stage renal failure in the U.S. and ended the rationing of renal replacement therapy. Did it also end any and all rationing applying social value criteria? Suspicion remains as to more subtle variations on the theme in the U.S., particularly in the realm of organ transplants. But wait a moment?there may be more to this
saga if a larger geographical net is cast. Americans all too often remain content myopically to survey their own land of plenty. Well, it appears that social value criteria are not only able to cross international borders, but they are remarkably durable and consistent. Data from the Republic of South Africa are most distressing in this regard.

In a recent article, observers in South Africa report a resuscitation of selection by social value criteria, again in the realm of dialysis.[4] As in Seattle, a South African Assessment Committee applied social value criteria to 2,442 patients who needed dialysis to survive end stage kidney failure. Nearly 53% of those in need were rejected. Those chosen for ?life? were younger (67% of those applying between the ages of 20 and 40 years were accepted; only 7% of those older than 60 made it) and more frequently employed (55% of those in the ?employed? group were treated; only 7% of the unemployed applicants received dialysis). Even though marital status and gender did not impact selection, race did. Seventy-five per cent of white renal failure patients were accepted, but only 44% of the ?colored? and 43% of the blacks were deemed eligible. During the period of this study, the number of renal transplants decreased and the absolute number of people accepted for dialysis did also, adding to the tragic burden of disease. The authors? bottom line was chilling: ?almost 60% of patients were denied renal replacement treatment because of social factors related to poverty? (emphasis mine).

H.L. Menken once quipped that for every complicated question, there exists a simple answer?that is always wrong. So might there be more to this tragic story than social valuation? In fairness, transportation and distance, co-morbid conditions, access to water and available trained personnel also impacted a complicated equation. On the surface at least, these appear to be more objective criteria. A ?brain drain? of skilled professionals is a reality and has been the result of an exodus of necessary personnel from South Africa to the United States, United Kingdom, and Australia. This might affect the total number of slots for dialysis as well as the number of transplants. However, it would not affect the insidious racial breakdown. Unless the decreased number of non-whites chosen for treatment can be explained by another objective variable (for example, more people of color had advanced AIDS or cancer thereby engaging a medical benefit criterion), the grimmer side of man?s nature again has surfaced in a time of medical resource scarcity. Unfortunately, when push comes to shove in allocation decisions, social valuation seems to insinuate itself globally?and the vulnerable pay the ultimate price.

Unless international efforts explicitly reject social valuation, as more and more innovations become scarce in less affluent locations, this cruel criterion will continue to choose death for many who can?t speak for themselves. A skewed valuation seems to follow a literary course from the earlier allusion to Thoreau to South Africa?s own Alan Paton. In Cry, The Beloved Country, his character Arthur Jarvis bemoaned the 1913 Natives Land Act of South Africa. He observed that only one tenth of the land was set aside for four fifths of the people?those of color. It appears that the same formula, now under the guise of social value, has set aside life-saving treatment for young, affluent whites. Today?s disproportion, however, impacts life, not land. By utilizing social valuations, this committee is repeating history?s tragic mistakes, and thereby choosing death for those disempowered by color.
References


[2] Ibid.

[3] Ibid.


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