Casualties of the health care system: Patients depressed by medicine's "moral dilemmas"

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I was asked to see Mrs. B, a fifty-six-year-old widow, for an evaluation of her "depression" and recommendations for treatment. Mrs. B was on a gynecological inpatient service for renal complications of metastatic cervical cancer. She was receiving her second course of chemotherapy, and she suffered from the side effects of the treatment, that is, nausea, vomiting, and loss of hair. When I went in to see Mrs. B, her son and two daughters were gathered around her bedside. It was clearly a close-knit family, perhaps in part related to the children's early loss of their father. It was evident that Mrs. B was and had been a caring mother, in addition to being a hardworking breadwinner ever since the death of her husband.

I introduced myself and explained that her gynecologist had asked me to see her for an evaluation of her depression. As soon as I said that, Mrs. B started crying, and her family moved closer to comfort her. She then looked up and said, "So you're the psych doc I told them I didn't need to see. I am not crazy!" She paused to wipe some tears away with a handkerchief given to her by her son and then said, "Yes, I am depressed, but who wouldn't be?" She paused again, then said in a louder tone, "I am not a mental case!" She then looked right at me and said in an angry tone, "Wouldn't you be depressed if they took your home away in order to pay your medical bills?"

I responded empathically, "Yes, I would be depressed if they took my home away to pay my medical bills." She stopped crying, realizing that I was trying to understand her situation. I continued, "I will talk to your social worker and see if there is any way we can intervene so that your home will not be taken away."

Mrs. B stated, "I've spent hours talking with my social worker, and she tells me that there is nothing that can be done to stop this process. She said the hospital's business office has to collect the money to pay my bills. The hospital forces the issue after your health insurance runs out. The next level of coverage is Medicaid, but you can't get that if you have savings and assets above a certain amount. Owning my own home puts me in a category of ineligibility for Medicaid coverage. The only recourse is that my house must be sold to pay off my medical bills. When I go below a certain level of financial assets, then I will be eligible for Medicaid."

This scenario demoralized all of us in the room, which underscores my belief that the central issue is a moral one.

Mr. N was an emaciated thirty-six-year-old, married, and the father of a nine-year-old son and a six-year-old daughter. Prior to the onset of his illness he had been a robust, energetic, professional golfer. He had been happy and full of life. Five years ago, the patient's internist noticed an unusual mole on the patient's left thigh during a routine physical exam. He suggested that it be excised and referred him to a dermatologist, who mentioned that the mole could be cancerous, and who tried to relieve Mr. N's anxiety by saying that probably it was not. The next day, the dermatologist called Mr. N's home and informed him that the mole was cancerous, a melanoma. Mr. N's anxiety was again heightened after he listened to the dermatologist, but it lessened when he was told, "Looks like we got it all, but we'll have to watch you closely over the next few years." The dermatologist reassuringly said that the majority of the cases had no subsequent problems.

Mr. N continued to play professional golf. He was a good player and had a yearly income in the range of $25,000 to $50,000, depending on the number of tournaments he entered and how he finished. He loved golf, and he felt truly fortunate to be able to blend avocation with vocation. He also was a golf pro at a country club near where they lived. His wife worked at home as a seamstress and clothes designer, primarily for children. She had a couple of outlets in local children's clothing stores. She added modest amounts to their family income, usually in the range of $5,000 to $10,000 a year. Mrs. N, like her husband, had also blended avocation with vocation.

When I first met Mr. N, Mrs. N was present in the room, and it was obvious that she was a concerned and loving wife. Mr. N asked her to leave following my introduction. I had been asked by the patient's doctor, an oncologist, to evaluate Mr. N's depression and make recommendations for treatment. Three and a half years after the original melanoma had been excised, the patient developed malaise, headaches, and bowel symptoms, which included constipation at first and then blood in his stools. Mr. N was scared to death when he went in to see his doctor — he feared the worst. After obtaining the results of a series of laboratory tests and X rays, the internist sat down with Mr. N and said, "I have some bad news." Both the doctor and Mr. N were teary-eyed when they confronted the reality that he had metastatic malignant melanoma. His original cancerous lesion had spread to his large bowel, liver, and brain. His doctor comforted him and referred him to an oncologist. He was hospitalized several times over the next one and a half years for chemotherapy and radiation. This slowed down the process somewhat, but it also gave him side effects from the radiation and chemotherapy, which included hair loss, more severe headaches, nausea, and vomiting. He had lost forty-five pounds in the previous nine months. At the time I first saw him, he was unable to keep food down.
Mr. N was understandably depressed. His grief reaction and sadness turned into a major depression after he filed for bankruptcy and sold his home to pay mounting medical bills. Mr. N chose this path himself, because he did not want to be on welfare; however, now he and his family were destitute. They lived in a small apartment in a poor neighborhood. His two children had to share a room, whereas before they each had their own room in their ranch-style home. During a subsequent visit, his wife showed me pictures of their former home, which was spacious and included a putting green for her husband and a swimming pool, which they all enjoyed. Their home had been in a country area with an acre and a half of ground.

Mr. N’s depression, resulting from his loss of health, was worsened by a health care system that in this man’s case literally added insult to injury. Mr. N, in contrast to Mrs. B, did have a major depression, but the signs and symptoms were hard to tease apart from his catastrophic illness and treatment. Nevertheless, he was started on antidepressants, and he did have therapeutic levels of nortriptyline by the end of the second week. He did seem a little brighter during the last month of his life, during which I saw him on a regular basis. This slight mood elevation was a Pyrrhic victory, at best, when the horrendous situation is viewed from an over-all perspective.

Reflecting on these two cases, I became quietly outraged: these two human beings should not have had to give up their homes in order to pay their catastrophic medical bills. Something is seriously wrong with the conscience of our society if we cannot care for people who are devastatingly ill. Why add further devastation to these sick individuals and their families by forcing them into homelessness and impoverishment? A humane and moral course would be for Mrs. B and Mr. N to be covered automatically by a national catastrophic health insurance system. Such a system would value and support patients’ human dignity and allow them to be ill and die in their own homes surrounded by their families, and not in hospitals as destitute patients feeling the loss of pride connected with being on welfare or receiving “second-class” medical care.

I concur with Lester Carl Thurow’s statement, “Health-care costs are being treated as if they were largely an economic problem, but they are not. To be solved, they will have to be treated as an ethical problem.” An ethical problem requires a moral solution.

I was motivated to write this because, as a psychiatrist, I do not like to be put in the bind of treating as a psychiatric illness a depression that is based on a “moral dilemma.” It is true that I responded, as best as I could, to the needs of the two patients, Mrs. B and Mr. N. But it was not enough: there is a larger issue. These two patients are symptoms of a societal disorder: a crisis in human values. They are also symptomatic of disorder in the medical profession, because if we cannot exert leadership and help remedy this immoral situation, we end up colluding with it.

In closing, I call for an independent commission to be set up by academic medical centers and professional organizations like the American Medical Association to urge the government to pass legislation as soon as possible to establish a comprehensive federal catastrophic health insurance system. If this were done, there would no longer be patients whose depression resulted from their being casualties of an unfair health care system.

References

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