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Running head: Limits of ethical principles' approach

Principles help to analyse but often give no solution – secondary prevention after a cardiac event

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Abstract. The aim of this paper is to investigate whether or not ethical conflicts can be identified, analysed and solved using ethical principles. The relation between the physician and the patient with ischemic heart disease (IHD) as life style changes are recommended in a secondary prevention program is used as an example. The principal persons affected (the patient and his or her spouse) and the ethical principles (respect for autonomy, non-maleficence, beneficence and justice) are combined in a two dimensional model. The most important person affected by the recommendations is the patient. His or her autonomy is challenged by the suggested life style changes, the purpose of which is to promote the future wellbeing and health of the patient. The spouse is indirectly involved in and affected by the process. He or she often feels neglected by caregivers. Ethical conflicts can both be identified and analysed using ethical principles, but often no solution is implied. Most (if not all) physicians would strongly encourage life style changes, but surprisingly there is no uncontroversial justification for this conclusion using principles.

Key words: analysis; communication; ethical principles; ischemic heart disease; life style change.

Abbreviations:

CABG = coronary artery by-pass grafting

IHD = ischemic heart disease

PCI = percutanous coronary intervention

INTRODUCTION

Given certain facts, different ethical theories and principles may justify different recommendations (Nilstun, Melltorp and Hermerén, 2000; Nilstun and Sjöquist, 2001). For instance, if the ethical theory of Immanuel Kant (1724-1804) is used, one formulation of the categorical imperative in Kant's ethics ("Act as if the maxim of your action were to become through your will a universal law of nature") will be decisive (Kant, 1785, chap. 2). Another candidate might be the utilitarianism advocated by Peter Singer. According to this ethical theory, when faced by a choice between two actions, we ought to "give equal weight in our moral deliberations to the like interest of all those affected by our action" (Singer, 1979, chap. 1). "Maximise the satisfaction of interests" becomes the key formula.

In this paper we will use as a starting point the well-known principles of Beauchamp and Childress (2001) to see what normative conclusions, if any, can be drawn using these principles in health care. The principles are respect for autonomy, non-maleficence, beneficence, and justice. They are often used in medical ethics (Gillon and Lloyd, 1994). As an example we will use the communication between patients with an ischemic heart disease (IHD) and physicians.

IHD is the major cause of death in the world (Murray and Loopez, 1997; Official Statistics of Sweden 1992, 1994; Official Statistics of Sweden 2002, 2004). In secondary prevention after cardiac events, such as acute myocardial infarction, coronary artery by-pass grafting (CABG), and percutanous coronary intervention (PCI), patients are faced with a problematic situation (Brady et al., 2001). From one day to another the individual's perspective is often changed. He or she is prescribed several drugs (Wood, 2001; Dalal et al, 2004) and encouraged to embrace a new life style. Examples of the latter are smoking cessation, diet changes and physical training (Carlsson et al., 1997; Quist-Paulsen and Gallefoss, 2003). Such recommendations give raise to ethical conflicts and even more so if it is implied that the patient is largely responsible for the disease because of faulty life style. For the clinician the importance of compliance is well known (Simons-Morton et al., 1998).

A search on Pub Med (June 2005) with the words "myocardial ischemia", "communication" and "ethics" gave 22 items. Few of these were relevant to the present issue, and only in very general terms. However, when we added the words "life style" only one relevant article was found (Ford and Reutter, 1990).

The aim of this paper is to investigate whether or not ethical conflicts can be identified, analysed and solved using the principles' approach.

Method

To elucidate the possible ethical conflicts in the interactions between the physician and the patient after a cardiac event a method, a matrix table, with two dimensions will be used: the persons affected and the relevant ethical principles. The most important persons affected are the patients and the spouses. They have often identical interests, but due to medical confidentiality the physician is required to communicate primarily with his or her patient, and involve the spouse only with the patient's consent. Thus it is advisable to discuss the patient and the spouse separately. Although physicians are often faced with ethical dilemmas, they are not affected in the same problematic way as patients and spouses are. Physicians are the subjects, the persons that recommend life style changes, and not the affected in this case. The ethical principles recommended by Beauchamp and Childress will be used (2001). The authors emphasise that the principle of non-maleficence is a separate principle. However, we will follow the recommendation by the WHO (CIOMS, 2002), and include the principle of non-maleficence in the principle of beneficence. The three principles may be formulated as follows:

Autonomy: The basis is the independence of every human being. Everybody has a right to be respected as to his or her own preferences, and to choose the life desired. In the clinical setting this means that the physician respects the patient's choices.

Beneficence: The basis is to maximize benefits and to minimize harm. Practical medicine involves a certain element of risk and to most measures there are possible adverse effects. Thus, only foreseeable risks and benefits can and should be balanced in the best interest of the patient.

Justice: The basis is a combination of equality and solidarity. In the clinical setting this means that the physician should try to provide equal access to medical service and that the interests of the less fortunate members of a society are cherished.

None of the principles are absolute, they are prima facie i.e. an obligation must be fulfilled unless it conflicts on a particular occasion with an equal or stronger obligation (Beauchamp and Childress 2001). However, there are authors who have argued that although all principles are equal, but the principle of respect for autonomy is "more equal

than others” (Orwell, 1996). In the application of the principle, balancing is needed. Beauchamp and Childress indicated how this should be done, but the advice is of limited help to the practitioner. The conflict between the principles derives from the fact that they have no common root, but are founded in what is called “a common morality”, which in their opinion is global.

The interplay between the two dimensions is illustrated in Table I (Nilstun, 1990).

Affected persons	Autonomy	Beneficence	Justice
Patients	A	B	C
Spouses	D	E	F

Table I: A matrix table for ethical analysis in two dimensions: affected persons and ethical principles (the letters A to F denote the different combinations).

For each of the cells in the matrix table we will present the possible ethical conflicts related to encouraging life style changes. To avoid misunderstanding, we would like to emphasise that some combinations are more important than others.

Results

Patients see the cardiac event as a life-threatening situation. The physician usually views the situation differently depending on the clinical evaluation. Still the situation involves giving the patient a new start in life – a break with old habits. It is all too easy for the physicians to just recommend what they believe is in the best interest for their patients, independent of their own will. Thus, the physician may adopt what is called “a paternalistic attitude” in such situations (Bremberg, 2004). Ethical problems related to paternalism are the most important issues in our context, and in the following sections we will address them by applying the above-mentioned method.

Affected persons

Patients

A: The ideal situation is self-determination for the patient and only the adequately informed individual is truly autonomous. However, the patients with IHD will experience a decreased autonomy when their life style is questioned and should be altered. This implies recommendation, often repeated persuasions. Even if the patients are given ample information about risks and disadvantages of a certain habit, e.g. smoking, they will certainly feel an element of coercion. Often the patients see the habits as important parts of themselves. As phrased by Solzhenitsyn: "Fumo ergo sum" (I smoke, thus I exist) (Solzhenitsyn, 1997). Albeit smoking cessation is associated with a reduced mortality after an AMI, only approximately one third of the patients quit smoking after such an event (Rigotti, 1994; Wilson, 2000). The somewhat low compliance may in part result from the patient's feeling that his or her autonomy is diminished. The patient sees the doctor as acting, prescribing, and ordering. The patient him- or herself is passive.

If applied as the only principle relevant, the conclusion would be to respect the patients right to self-determination. One could even question whether any recommended life-stile changes would be compatible with this principle. However, only the fully informed patient is truly autonomous, which stresses the need for a knowledgeable patient.

B: The prescribed medication and the life style changes are hopefully of use to the patient. They should be evidence based, thus proven to be beneficent in trials where different treatments are tested on large populations. But the patient may not be interested in the fate of some anonymous cohorts, he or she wants to be ascertained that the treatment will be profitable in such a way that it will justify the costs, financially as well as emotionally. The disadvantages of the prescribed medication may be on the level of placebo but to the patient who experiences or fears side effects this is not a great comfort. A reasonable balance is often difficult to make for the physician. For the patient, it is even more so.

If applied as the only principle relevant, the conclusion would be to minimise harm and maximise benefit. Not only advice should be given, but the physician should be forceful if necessary. All relevant guidelines should be followed regardless of the patients wish.

C: Independent of social group, every patient wants to be treated individually. In the clinical reality this is often difficult, if not impossible. Still direct discrimination may be of little concern in this situation – at least in theory. But to abide by the requirement of solidarity may be more difficult. The IHD-patients that suffer a worse prognosis quite often belong to socially disadvantaged parts of society. Orth-Gomer, Unden and Edwards found that non-survivors in a group of middle-aged men differed from survivors by, for instance, lower education, and lower social class (1998). Williams et al found that low levels of social and economic resources identify an important high-risk group among medically treated patients with coronary artery disease (1992). Extra care should be exercised, according to the requirement of solidarity, to assure that these patients are not further stigmatized by the medical system.

If applied as the only principle relevant, the conclusion would be not to discriminate and to show solidarity. The physician should make sure that the individual patient present has exactly the same opportunity as any other patient, regardless of factors such as age, sex and costs of the intervention.

Spouses

D: Many spouses feel that the physician does not respect their opinion. Often it is not even asked for. Ideally, the physician should be interested in the information that spouses could provide, and thereby show respect for them as persons. Kettunen et al found that 30 % of spouses experienced that health care professionals were neglecting them and spouses felt "willingness to talk with close relatives" being "totally insufficient" in 33 % (1999). Similar results were found by Hentinen in a study of spouses of patients with myocardial infarction (1983).

If applied as the only principle relevant, the conclusion would be to respect the spouses' right to self-determination. But what are the obligations of the physicians? In our opinion, it is not the physician's primary task to respect the will of the spouse if in conflict with the patient. Though, as a person he or she should be respected and treated "never simply as a means, but always at the same time as an end" (Kant 1785). The scope of the principle of respect for autonomy, gives priority to the patient in medical ethics.

E: Although not directly involved in the contact between physician and patient, the spouse is indirectly affected. The patient's reactions, e.g. aggression and irritation after a visit to the physician may decrease the quality of life for the spouse. Moreover, changes in diet and smoking cessation are more or less thought to involve also the spouse. Most patients suffering from IHD are male, often middle-aged or older (Lerner and Kannel, 1986; Rosengren et al., 2001; Rosengren et al., 2004). In the involved population the female spouse usually prepares food in the household. In this way, changes in diet also involve the spouse. Generally, the equilibrium in the family is affected if one of its members has to change life style (Lukkarinen and Kyngäs, 2003; Stewart et al., 2000). The needs that patients and spouses rate as important may differ quite a lot (Moser et al., 1993). The situation for the spouses also changes if the patient enters an intense relation with the medical system, e.g. when his or her focus of interest swerves from the circumstances at home to the hospital as a new home.

If applied as the only principle relevant, the conclusion would be to minimise harm and maximise benefit. Theoretically, the principle not to harm anybody seems simple, but because of the indirect interaction between the physician and spouse, even this principle may be difficult to apply. The physicians are usually ignorant of how the spouse is affected by their action. But the physician obviously has no obligation to generally benefit the spouse.

F: The spouse may feel that the situation is unjust. Sometimes he or she tries to get in direct contact with caregivers but is usually rejected with reference to medical confidentiality. However, in some countries the situation is different (Ruhnke et al., 2000).

If applied as the only principle relevant, the spouse should be allowed to state his or her experiences and views of the situation to the physician without any limits. Otherwise the spouse would be discriminated against. But this is usually not feasible in real life.

Patient and physician: balancing the costs and benefits

There is an ethical conflict in the patient-physician encounter after a cardiac event like a myocardial infarction, a CABG or a PCI. On the one hand the physician should respect the autonomy of the patient, but on the other hand, the life style of the patient is often partly the cause of his or her disease. A good start for everybody is to agree that there is

in fact a conflict. What is called “a low compliance” will be the result of the patient’s protest if the will to change is not the patient’s wish, but experienced by the patient as the physician’s order. The patient who feels that he or she is not the acting agent will be looking for other solutions. These might be found in alternative medicine. An eloquent example is that in Sweden (with 9 million inhabitants) natural remedies were sold for approx 120 million € in 2001 (Swedish Medical Products Agency, 2004).

Most likely physicians and patients will accept the analysis made above. But will they agree on a particular solution to the conflicts identified and analysed? Theoretically they probably will, but in practice the solution recommended by most physicians is problematic for their patients. All physicians who have confronted such situations have also experienced the low compliance by many patients.

The Belmont report from 1978 identified the ethical principles of autonomy, beneficence and justice. Tom Beauchamp and James Childress have ever since the first edition of Principles of Biomedical Ethics in 1979 been among the most influential voices in bioethics. However, they have not been without critics, notably Sören Holm, Bernhard Gert, H. Danner Clouser and Charles Culver. Beauchamp and Childress bring up several points in the criticism formulated by Clouser and Gert: “because moral agents confronted with bioethical problems receive no directive guidance from principles, they are free to deal with the problem in their own way. They may give a principle whatever weight they wish, or even no weight at all” (2001, p. 388).

In our case, the main conflict seems to lie between autonomy and beneficence. Paternalism could be defined as “the intentional overriding of one person’s known preferences or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose preferences or actions are overridden” (Beauchamp and Childress, 2001, p. 178), but “determining which paternalistic actions are justifiable requires persons with good judgment in the handling of contingent conflicts” (p. 187).

In the case of the spouse, the ethical conflict is even more complicated as he or she is indirectly involved and beneficence to the spouse is partly made impossible by respect for the autonomy of the patient. The fact that the spouse is often deeply affected by the every day measures of the physician opens for an important challenge in medical ethics. In many cases the physician cannot possibly know what the consequences are for the spouse when the patient’s life-style patterns are disrupted. Even if the principles are said

to be based on “common morality … the set of norms that all morally serious persons share” (Beauchamp and Childress, 2001, p. 3), the use in practical medicine of this set of norms may indeed be difficult.

Concluding Remarks

Beauchamp and Childress apply ethical principles in almost all situations related to health care (2001). We share their opinion about the usefulness of the principles in the identification and analysis of ethical conflicts. But we do not agree with them about how the principles should be specified and balanced. Given a problematic situation in health care, involved persons living in one culture might come to a different conclusion than those living in another. Thus the conclusion that every man, from a biomedical-ethical point of view, is an island may not be valid in all cultures. In our opinion, there is no generally accepted method for specification and balancing. The arguments, however, are in the presented model made explicit and this is the main advantage of the principles’ approach.

To avoid misunderstanding we would like to emphasise that in the case of IHD, most, if not all physicians will agree about recommending life style changes. They and other caregivers live with a constant challenge to optimise the patients’ quality of life, but this can only be successfully achieved if the patient is truly a part of his or her own care.

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