The ethics of prevention: old twists and new

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SUMMARY

The medical profession's tendency to equate 'the greatest good for the greatest number' with proactive care is here challenged; and the idea that we can always get more for our money with an ounce of prevention than with a pound of cure is scrutinized from an ethical point of view. It is suggested that preventive measures are often exempted from such scrutinty because they make medicine appear selfless and are aimed at the postponement of death — always an urgent matter. Indeed, our screening efforts can assume the proportions of a crusade against life's natural termination and we must make sure that they do not emanate from the needs of medical science for publicity and funding. The costs of what has been called 'healthism', something that has almost become a new morality, are frequently underestimated and its side effects overlooked. There are conditions for which effective palliation, sometimes enormously expensive, is available. The automatic assumption that money spent on such palliation could be better used for, say, immunization, is not warranted.

Keywords: preventive medicine; ethics; reactive care.

Introduction

AT a recent symposium on 'Threats to Humane Medicine', held in memory of the late Petr Skrabanek at Trinity College in Dublin, Ireland, several speakers from the floor suggested that preservation of health has become a new kind of morality, imposing ethical demands on our patients. Since death is one of the more easily determined outcome measures, prolongation of life has become associated with success in the areas of prevention and health promotion, activities Skrabanek sometimes referred to as 'coercive healthism' or 'lifestylism'.[1] Together with James McCormick, he pointed out that these areas have been exempted from careful ethical examination.[2] This is most likely the case for two reasons: (1) by endorsing prevention, medicine is seen as behaving altruistically since it appears to be trying to put itself out of business and selfless behaviour rarely has its ethics scrutinized; and (2) the above-mentioned association between successful prevention and the postponement of death imparts urgency to health promotion, and under urgent circumstances ethical considerations take a back seat to questions such as, 'What are we going to do about the coronary epidemic?' It must be emphasized that the first reason given is no more than a perception and that the idea of medicine, as a corporate body, acting unselfishly was dismissed 2 decades ago: 'The medical establishment is not primarily engaged in the disinterested pursuit of knowledge and the translation of that knowledge into medical practice; rather in significant part it is engaged in special interest advocacy, pursuing and preserving social power.'[3]

If health is the newest morality, then submitting to preventive measures, diagnosis and therapy is part of what the upstanding citizen owes himself, his family, the State and even his God. The first three debts are illustrated by the frequently heard reason for encounter in primary care: 'I don't want to neglect myself.' Such a statement hints at the emotional and economic well-being of the speaker's dependents lurking in the background and at the presence of Society in the consulting room, demanding that the individual do his or her best to avoid using up too many health care resources. The last debt is exemplified by Judaism, wherein it is a duty to remain healthy in order to be able to serve God with bodily vigour and lucidity of mind.[4]

In what ensues, I shall examine some of the origins of the war on death as well as its costs. I shall than propose a heresy, maintaining that preferential allocation of funds to preventive measures on the basis of 'the greatest good for the greatest number' or 'an ounce of prevention is worth a pound of cure' is not always justified. My purpose is to deconstruct and challenge certain hallowed tenets of our profession and to stimulate discussion, not to give a balanced picture. We tend to go along with the public's view of physicians as people against death. Perhaps we should be using what have been slightingly referred to as our 'pastoral skills'[5] to help make peace with the inevitable. Plato has suggested that it may actually be better than life,[6] and Mann believes the perishableness of living things to be the source of time, which is 'related to, yes identical with everything creative and active; with every progress to a higher goal'.[7]

The war on death

It is clear that contemporary medicine is absorbed with the prolongation of life, perhaps even at the expense of matters concerning the patient more immediately and more importantly.[8] The Judaeo–Christian tradition attaches great moral value to the saving of life and allows ethical niceties to be overlooked when it is at stake. In the Jewish religion, there are only three instances in which persons are permitted to sacrifice themselves. For the rest, more than 600 positive and negative commandments are immediately suspended when death threatens.[9]

What is generally ignored by the coercive healthists is that the gains of a lifetime spent in the pursuit of health care are not large where longevity is concerned and people at average risk are involved. Using computer modelling, a group of investigators once determined that, for the ordinary person, decades of cholesterol awareness would lead to the prolonging of survival by 3 weeks![10] Even in the high-risk group, in whom a potential gain of 1.5 years was calculated, the reward was paid near the end of life when quality has deteriorated and many pleasures have been forgone. In all screening programmes, most individuals will never contract the disease of interest[11]; and disciplined subjects who comply with long-term preventive regimens requiring the ingestion or non-ingestion of certain substances 'forever' will seldom live to reap the benefits of their compliance. Instead, they will die of something unrelated to the target of prevention before they 'would have' incurred the outcome condition.

'We must reconsider the wisdom of using individual longevity as the dominant criterion of social and medical ethics. We must be prepared to recognize that excessive concern with security, with comfort and with avoidance of pain and of effort has dangerous economic and biological implications — that such concern may, in fact, amount to social and racial suicide.'[12] It is not clear whence today's war against death arose. If it was imposed on medicine from without, then physicians, after pointing to the dangers inherent in it, have little choice but to go along. However, they must make sure that it does not emanate from

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Submitted: 24 October 1995; accepted 15 March 1996.

medical science and the need for funding and publicity. The public should be disabused of the exaggerated importance it attaches to physicians and constantly reminded of the fact that the majority of people, in any given period, are healthy by all definitions of the word.[13] Thus, the question of whether we do more harm than good must be continually before us and we should have a care lest ethical stances are imposed on society out of groundless medical considerations.

Beyond the phsyician–patient relationship

Questions pertaining to ethics can arise in medicine outside the operating theatre or the consulting room. It has been pointed out that the connection between a physician and his or her employer within the framework of a health maintenance organization can, at times, predispose the physician to doubtful behaviour.[14] For example, if the physician is awarded a premium for seeing more patients or for ordering fewer ancillary tests and referrals, then a very thin line is being walked between the good of the patient and that of the provider. Higher reimbursement for procedures than for lending an ear can lead to abuses of the system and the patient, particularly where fee-for-service arrangements are insured by a third party.

Moreover, there is the damage the medical profession can cause to 'innocent bystanders'. Cholesterol awareness has harmed the livelihoods of people engaged in the meat and dairy industries even though it is held that 80% of the population of the USA can eat what they like without risk.[15] In Israel, a few years ago, a false alarm about the danger of mechanical ileus associated with eating persimmons caused heavy losses to farmers who had invested a year of hard work in their crop. It was later conceded that the danger had been exaggerated, but the correction came too late. A penchant for rushing into print and giving sensationalist interviews probably underlies this kind of abuse.

Ethical implications of the needs:resources ratio

At about the time the Clinton Plan was being debated in the USA, a Swedish commission was examining the gap between the population's minimal health requirements and the available means of payment.[16] In both countries, the goal was to provide a modicum of universal coverage and the question of what to insure people against had strong ethical implications. The Americans chose to speak of the need for rationing care, an idea connoting restrictions on freedom of choice in matters of health and comprising a distinct threat to rugged individualism. The Swedes, for their part, adopted an approach more in line with a welfare state ideology, using the term prioritization when discussing needs.[16] They also insisted on equality in receiving benefits and laid down three basic guidelines that touch on ethics: (1) all human beings are of equal value; (2) society must pay special attention to the weakest and most vulnerable of its members; and (3) cost-efficiency and gaining the greatest return for the amount of money spent must be the order of the day.[16]

For many people, the third guideline translates into an emphasis on screening, prevention and health promotion. However, as Skrabenek and McCormick pointed out, the uncomfortable reality is that many preventive strategies carry the possibility of doing more harm than good while others are merely ineffective.[2] They carry not a negligible price tag because they must be repeated at stated intervals, never precisely determined, or employed on a continuous basis. They impinge on personal freedom, bring people to medical attention, expose them to further and more invasive studies in the event of a positive result, whether true or false, and append a label of disease to an asymptomatic subject who previously regarded him- or herself as healthy.

Certainly, the Swedish commission, when speaking of the weakest and most vulnerable members of society, had people with rare but treatable disorders in mind. For example, a person with Gaucher disease can benefit greatly from alglucerase, which costs upward of $100 000 a year.[17] This high cost poses an ethical question to those responsible for defining a basket of services. Their decisions are usually guided by the principle of 'the greatest good for the greatest number', something that applies better to promoting cholesterol awareness than to administering alglucerase.

On the other hand, preventive measures have to be taken for hundreds and sometimes thousands of individuals to save one life. In the affluent nations, many of the diseases for which immunization, the least controversial aspect of proactive care, is recommended were rare even before a means of preventing them was found. These include epiglottitis and meningitis caused by hemophilus influenzae type b, tetanus, diphtheria and the fatal complications of measles and HBV infection. For the last mentioned, mortality does not exceed 5000 per year in the USA, a number far lower than the toll taken by AIDS, the spread of which could be drastically curtailed by non-medical means. Even though one-sixth of all Americans are said to be uninsured and at high risk for not complying with immunization schedules, thus providing a reservoir of susceptibility, we do not hear of devastating outbreaks of long-forgotten disorders. When such do occur, they are more likely to be reported as rarities. I do not imply that immunization should be discontinued, but that we require a sense of proportion in viewing what it actually achieves at enormous expense.

Reactive care, often looked down upon as being necessary only because we have been remiss in taking preventive measures and educating the public, deals with disease, discomfort, disability, fear and anxiety.[8] It has little to do with the war on death and is extended to those requesting our help, thus having a firm ethical basis. The contention that it is necessarily more expensive than a proactive approach remains open to question.

References

1. Skrabanek P. *The death of humane medicine.* London: Social Affairs Unit, 1994.
2. Skrabanek P, McCormick J. *Follies and fallacies in medicine,* 2nd edn. London: Tarragon Press, 1994.
3. Holman HR. The 'excellence' deception in medicine. *Hosp Pract* 1976; **11:** 11, 18, 21.
4. Maimonides. Quoted in: Munk E. Foreword. In: Jakobovits I (ed). *Jewish medical ethics.* New York, NY: Bloch Publishing Company, 1975.
5. Weatherall D. *Science and the quiet art.* Oxford: Oxford University Press, 1995.
6. Plato. Quoted in: *Ann Intern Med* 1995; **123:** 408.
7. Mann T. This I believe. *Glamour* November 1952: 108.
8. Landau EL, Gustafson JM. Death is not the enemy. *JAMA* 1984; **252:** 2458.
9. Wigoder G (ed). *The encyclopedia of Judaism.* Jerusalem: The Jerusalem Publishing House, 1989.
10. Taylor WC, Pass TM, Shepard DS, Komaroff AL. Cholesterol reduction and life expectancy. *Ann Intern Med* 1987; **106:** 605-614.
11. Van Dam J. Prevention of colorectal cancer by endoscopic polypectomy. *Ann Intern Med* 1995; **123:** 949-950.
12. Dubos R. *The dreams of reason: science and utopias.* New York, NY: Columbia University Press, 1961.
13. Thomas L. Your very good health. *N Engl J Med* 1972; **287:** 761-762.
14. Yardney J. Physician disclosure of financial incentives. *Ann Intern Med* 1993; **119:** 95.
15. Becker MH. The cholesterol saga: whither health promotion? *Ann Intern Med* 1987; **106:** 623-626.
16. Caplan AL. Straight talk about rationing. *Ann Intern Med* 1995; **122:** 795-796.

17. Alglucerase for Gaucher's disease. *The medical letter on drugs and therapeutics* 1991; **33:** 82.
18. Sherker AH, Robinson WS. Hepatitis B and hepatitis D (delta agent). In: Hoeprich PD, Jordan MC, Ronald AR (eds). *Infectious diseases,* 5th edn. Philadelphia, PA: JD Lippincott, 1994.

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