Balance Ethics

By: Brad Kozel

The advancement of medical technologies has allowed humanity to triumph over diseases that once caused widespread suffering. The advances have redefined the way people in the developed world approach life. Mary-Jo Delvecchio Good wrote convincingly about the ‘biotechnical embrace’ as the societies interplay with the medical field. The piece portrays a society that is infatuated with the advances and the curative potential of medicine. With these advances come the difficult moral conflicts about what is right and good regarding these advances. The moral conflicts are complex and highly tied to each person’s view of the world, yet still doctors must practice and policies need to be created to govern these new technologies. In my view application of classical ethics in medical situation has not provided enough flexibility in a rapidly changing world. Technologies and pharmaceuticals are developed so quickly that it is nearly impossible for medical professionals, let alone laypeople, to stay abreast of the advancements. This inherently leads to specialization within the medical field and bewilderment from patients who are faced with difficult medical decisions. In light of the erosion of the trusting relationship between patient and physician (DeVries, *et al*, 1998) it is imperative that patients understand the manor in which doctors, managed healthcare organizations and pharmaceutical companies determine what is good and right in healthcare. The theory that I have developed is based on several of the tensions that have jumped out at me in the readings. I believe that balance ethics, as I call it, avoids the pitfalls of several of the classical theories in that it is specifically for biomedical ethics and it seeks to address the incongruences that have emerged.

 In the broad view, balance ethics is a highly relativistic theory that is heavily influenced by Utilitarianism ethics pursuit of the ‘greatest happiness principle’ (Bennett-Woods, 2005). The theory is also influence by the strong emphasis of context that exists within Feminist ethics and the ethic of care (Bennett-Woods, 2005). The theory is built around a series of principles and themes that are salient to biomedical ethics specifically. Each principle or theme has a counter weight. The moral action is the action that best balances these principles/themes. It is important to note that depending on the particular context of the case a ‘balance’ may not mean equal contribution of each opposing side. Below I present each of the balancing acts and a few examples of how the theory might be employed.

Autonomy vs. paternalism. The victory of autonomy as the primary principle in biomedical ethics was artfully displayed in Paul Root Wolpe’s piece, *The Triumph of Autonomy in American Bioethics: A Sociological View* (DeVries, *et al*, 1998). The lesson learned from this reading is that autonomy is a closely guarded principle in America in relation to all walks of life; as a result it is inevitable that autonomy will be a strong presence in medical decision-making. The counter weight to autonomy in this balancing act is the paternalistic principle that requires physicians to have a measure of control over what treatments or courses of actions are best given the particular case. The multiple influencing factors of a particular case would determine where the fulcrum would be placed between the two principles. For example if a patient is unconscious and needs life saving treatment the paternalistic principle would completely out weigh autonomy. And by contrast if the medically acceptable treatment options were numerous the physician would yield to the patient. These examples are obvious and occur regularly in the course of healthcare. The real balance must be struck when the physician and patient may have differences of opinion on the course of action. Balance around this tension is important because it seeks to build understanding and trust between the caregiver and the sick individual. In order to honestly seek this balance I imagine that an intermediary may be necessary to help patients and doctors communicate the technical aspects of treatment and the prognosis. The intermediary could work with the doctor helping to determine what the patient’s true wishes are in relation to treatment. If these two principles cannot be balanced then the power differential between doctor and patient is askew and there is a danger of moral conflict.

Individual vs. the collective. This tension weighs the needs of one patient against the benefit provided to the many. For example, the suffering caused in the application of a clinical trial may lead to the development of a cure. This is only ethical given the manor of suffering compared to the potential in the cure. It would be unethical to risk causing death in pursuit of a cure for hemorrhoids but would be okay given the potential for a cure for cancer. This is an especially important balance when looking at how pharmaceuticals are developed and tested. In this case the individual does not need to be viewed as a person but could be any entity. If the interests of an organization can be deduced, than those interests can be weighed against the interests of the people that organizations serves. The high cost of treating AIDS in Uganda (Petryna *et al,* 2006) viewed through this lens is not in balance and thus unethical. The high cost of ARVs for Ugandans leads to a social and familial strife (Petryna *et al,* 2006). The drug comes with the cost and so the balance is shifted towards the individual (the company selling the drug or the person illegally distributing the drug at a profit) as opposed to the sick population.

Majority interests vs. minority interests. Balance is sought in policies that can practically serve the many but do not infringe on the needs of the few. This balance is an edited view of the Rawlsian ‘veil of ignorance’(Bennett-Woods, 2005). Policies are in need of flexibility when new or extreme circumstances are encountered. Policies development should strive to capture as much of the populous as possible but also have mechanisms that constantly test this balance. The Gupta piece on illegal alien organ transplants is a good starting point for an example of striving for this balance (2008). The policy that is eventually created to address the gap illuminated by Gupta should be constantly scrutinized by ethicists taking the ethnographic view of the illegal alien organ sharing. The outcomes of interviews with families and physicians could shed light onto how society feels about the balance. When balance is in place the result is the principle of distributive justice. The resources placed were the need is the greatest.

Scientific Possibility vs. Social reality. This balance is meant to deal with the ever-advancing technical fields in medical care. The balance should be struck when there is moral conflict between what science can do (product of inquiry in medical sciences) and which technologies should be aloud to translate into standards of care. This balance is ever changing, culturally and politically influenced. On a large scale this might shape federal policy on stem cell research or factor into deliberations on a specific case in courts. Locally it could be used to develop a policy that reflects the values of the community. I am reminded of our first reading that outlined the arc of various issues in biomedical ethics in the literature. In vitro fertilization started off as a relatively controversial topic as it brushed up against human intervention in the creation of life (DeVries *et al*, 1998). Never the less it gained traction and eventual prominence in certain regions of the country. The societal value placed on a procedure such as IVF is regionally based as evidenced by only 15 states requiring by law that insurance companies cover assistive reproductive technology (National Conference of State Legislatures, 2014). The local application of this balance is essential for its function to determine a moral action.

Business of healing vs. the healing business. There is balance needed around the huge amounts of money made by some in health care and the very poor that receive little or no health care. This balance also could address the erosion of trust between the patient population and physicians. The climate of drug company advertising leads to a skepticism in physician motives. This was never so clear to me than when I read about the ghostwriting actions of pharmaceutical firms (Petryna *et al,* 2006). The very existence of this practice calls into question the motives of these companies. Are they in the business of healing the sick or are they in the healing business because it is lucrative? Or is it foolish to try and separate the two given the economic and regulatory structure of the United States? Light and Lexchin present compelling claims in their piece, *Will Lower Drug Prices Jeopardize Drug Research? A Policy Fact Sheet* that these two concepts are out of balance (2004). The authors point out that price competition has not led to innovation of new treatments for untreated conditions but the development of drugs that already have a treatment. A realignment of the company’s principles could lead to profits and a wider array of treatments.

Balance ethics seeks to determine a moral act based on considering as many factors as possible. I think that aspects of balance ethics are applicable to large-scale policy but also to individual ethical cases. Depending on the particular case it could be best to employ more than one balancing act and to test the two against each other. For example, the first balancing act of autonomy vs. paternalism requires that physicians are trusted authorities on care. It is important that the patient believes that the physician only has the well being of the patient in mind when making paternalistic decisions. It is possible that if the physician is engaged in ‘the healing business’ by collecting on bonuses from a pharmaceutical companies it could call into question the Doctors values. In this way the balances can influence each other. In the end I hope that this theory has some different angles in which biomedical ethical issues can be viewed.

Bibliography

Bennett-Woods, Deb. (2005). *Ethics At a Glance.* Regis University. Retrieved from https://umasscrcrth619.edu20.org

Crigger, Bette-Jane. (1998) AS Time Goes By: An Intellectual Ethnography of Bioethics. In DeVries, R., & Subedi, J. (Eds.). (1998). Bioethics and Society: Constructing the Ethical Enterprise. Prentice Hall. Retrieved from <https://umasscrcrth619.edu20.org>

Good, Mary-Jo Delvecchio. (2001). The Biotechnical Embrace. *Culture, Medicine and Psychiatry* 25: 395-410. Retrieved from <https://umasscrcrth619.edu20.org>

Guillemin, Jeanne. (1998) Bioethics and the Coming of the Corporation to Medicine.In DeVries, R., & Subedi, J. (Eds.). (1998). Bioethics and Society: Constructing the Ethical Enterprise. Prentice Hall. Retrieved from <https://umasscrcrth619.edu20.org>

Gupta, Charu. (2008). Immigrants and Organ Sharing: A One-Way Street. *American Medical Association Journal of Ethics.* April 2008. Volume 10, Number 4: 229-234. Retrieved from <https://umasscrcrth619.edu20.org>

Heaky, David. (2006) The New Medical Oikumene. In Petryna, A., Lakoff, A., & Kleinman, A. (Eds.). (2006). Global pharmaceuticals. Duke University Press.

Light, Donald. Lexchin, Joel. (2004). Will Lower Drug Prices Jeopardize Drug Research? A Policy Fact Sheet. *The American Journal of Bioethics. 4(1)* Retrieved from <https://umasscrcrth619.edu20.org>

National Conference of State Legislatures. (June 2014). State Laws Related to Insurance Coverage for Infertility Treatment. Retrieved on August 26th 2014, from <http://www.ncsl.org/research/health/insurance-coverage-for-infertility-laws.aspx>

Reynolds, Susan, *et al.* (2006) Treating AIDS: Dilemmas of Unequal Access in Uganda. In Petryna, A., Lakoff, A., & Kleinman, A. (Eds.). (2006). Global pharmaceuticals. Duke University Press.

Wolpe, Paul Root. (1998) The Triumph of Autonomy in American Bioethics: A Sociological View. In DeVries, R., & Subedi, J. (Eds.). (1998). Bioethics and Society: Constructing the Ethical Enterprise. Prentice Hall. Retrieved from https://umasscrcrth619.edu20.org