Dr Daly's principlist defence of multiple heart valve replacements for continuing opiate users: the importance of Aristotle's formal principle of justice

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In this journal, Dr Daniel Daly, an American bioethicist, uses a principlist approach (respect for autonomy, non-maleficence, beneficence and justice) to argue that intravenous opiate users should not be denied repeat heart valve replacements if these are medically indicated, 'unless the valve replacement significantly violates another's autonomy or one or more of the three remaining principles'.[1]

In brief outline, the paper seeks to use a widely accepted ethical theory—'principlism' as developed by Beauchamp and Childress over the last 40 plus years and eight editions of their ground-breaking book Principles of Biomedical Ethics[2]—to resolve clinical disagreement about the ethics of denying medically indicated life-prolonging treatment to patients who continue or resume intravenous opiate use.

The argument

Dr Daly's argument in very brief summary is that in the context of contemporary American medical practice, such treatment is ethically justified—perhaps even ethically required—if requested or accepted by an adequately autonomous patient and thus respects the patient's autonomy, if it is not harmful to the patient, if it is beneficial to the patient, and if it is fair and just in terms of Aristotle's formal theory of justice according to which equals should be treated equally while unequals should be treated unequally in proportion to the morally relevant inequality or inequalities. Dr Daly focuses his argument around a typical case description where these conditions are met and therefore where, he concludes, repeat heart valve replacements ought to be provided.

As Dr Daly notes, principlism 'is not without its problems; nonetheless it does provide a viable set of principles that are widely held by medical ethicists and inform the work of ethics committees at many secular medical facilities'.

DOI (declaration of interest): The writer of this editorial is a career-long supporter and defender of the use of 'principlism' or 'the four principles approach' as he prefers less grandiloquently to call it. However, like Beauchamp and Childress themselves, he accepts that the approach does not provide a universalisable method for dealing with conflict between the prima facie principles and or their specifications; nor does it provide a universalisable approach to dealing with disagreements about the scope and extent of these principles and their specifications—to whom or to what do they apply and to what extent? A third disadvantage of the approach is that while the meanings and their practical implications for medical practice of three of the principles and many of their specifications are now increasingly widely understood and agreed—notably beneficence, non-maleficence and respect for autonomy—the meaning and specifications of the principle of justice/fairness in medical practice are by no means widely agreed.

Six types of theory of justice

Beauchamp and Childress outline no fewer than six *types* of substantive theories of justice[i] the relative merits of which, they write, '[w]e will not attempt to assess….Rather, we use them as resources, with special attention to recent egalitarian thinking and proposals about the distribution of health care and public health resources'.[3] The chances of widespread agreement by doctors and other healthcare workers to settle on any one of those six types of substantive theories of justice in the foreseeable future are remote.

What does seem plausible however is that doctors and other healthcare workers are likely to agree that fairness/justice is an essential prima facie moral obligation of doctors and other healthcare workers—whichever substantive theory, or indeed mere notion of justice/fairness they themselves espouse. And they will find it difficult to disagree with Beauchamp's and Childress's claim that Aristotle's formal principle of justice according to which equals should be treated equally and unequals unequally is a 'minimal requirement' of all theories of justice.[4] The main reason for the wide variety of substantive theories of justice is of course radical disagreement about *which* equalities and inequalities are the morally relevant ones in different cases and types of case.

Notwithstanding Beauchamp and Childress's salutary warning[5] about the insubstantiality of Aristotle's formal principle of justice in the absence of agreement about the applicable substantive theory of justice, it has seemed to this writer that the formal principle can in itself become of considerable practical value in healthcare if 'across the globe we extract from Aristotle's formal theory of justice a starting point that *ethically requires* us to focus on equality and always to treat others as equals and treat them equally *unless* there are moral justifications for not doing so. Where such justifications exist, we should say what they are, explain the moral assumptions that justify them and, to the extent possible, seek the agreement of those affected'.[6]

Moral equals

Dr Daly's paper wisely and precisely focuses on the Aristotelian formal principle of justice without specifying any substantive theory and argues that continuing or resuming intravenous opiate users who recurrently develop endocarditis are morally speaking 'equals' in the context of having affordably remediable life-threatening diseases that they have at least in part brought upon themselves. Since other patients with life-threatening conditions repeatedly caused by their own behaviour would—in the context of contemporary American medicine—be treated with repeated life-saving treatments—in his motor cycling example with far more expensive life-saving treatments—so similarly should intravenous opiate users be treated with repeated life-saving treatments. In the absence of reasons to believe that provision of repeat valve replacements would conflict with any of the other three prima facie principles, then only if a *substantive* theory or specification of a theory of justice that rejected such repeated treatments had been socially agreed within the societal context in which doctors practised

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[i]What they call the four traditional theories of justice based on utilitarianism, libertarianism, communitarianism and egalitarianism, along with more recent capability theories and well-being theories—see ref 2, pp 270–281

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would it be morally justifiable for doctors to refuse to provide repeated life-saving heart valve renewals to continuing users of intravenous opiates.

Of course some of the substantive theories of justice outlined by Beauchamp and Childress might offer cogent reasoning for *not* providing repeat cardiac valve replacements to continuing or resuming intravenous opiate users. Welfare-maximising utilitarian theories of justice might present arguments that such provision would fail to maximise welfare. Libertarian theories of justice might provide arguments to the effect that while intravenous opiate users are at liberty to indulge in their self-harming behaviour, there is no obligation on others to treat them if they do. Communitarian theories might afford reasons based on failure of reciprocity and communal duty. Dr Daly's counterargument is that none of these substantive theories have been societally agreed and meanwhile the moral norms of contemporary American medical treatment require affordable and readily available life-saving medical treatments to be provided for patients who autonomously request or accept them and for whom such treatments provide net benefit over any harms incurred, even if the patients' intentional behaviour has caused or partly caused the malady for which the treatment is necessary. If other patients in equal need of life-prolonging treatments are normally provided such treatments at similar or greater expense even if their behaviour has caused the malady to be treated, then it is formally unjust to refuse to provide these patients too with readily available life-prolonging treatment.

Dr Daly wisely avoids specifying the theory of justice that he espouses for his argument, recognising that societal agreement about the chosen theory is unlikely to be available. However, a possible universalisable and potentially widely agreeable specification of *formal* justice that would support Dr Daly's case might be as follows:

A possible specification

In cases where, in a particular social context, a life-prolonging therapy is readily and affordably available and routinely provided to autonomously consenting patients for whom the therapy is medically assessed as providing a net benefit despite the harms and risks of harm involved, doctors should provide that therapy whether or not the malady to be treated has been caused or partly caused by the patient's intentional behaviour.

Of course it would be open to opponents to propose a contrary specification in which self-causation of a malady would exclude or deprioritise treatments for such patients—that is, patients who caused their own maladies should *not* be treated as equals—but in the absence of societal agreement to such a specification the current norms of medical practice to treat such patients should prevail (as they prevail in the treatment not only of repeatedly reckless motorcycle riders, as in Dr Daly's example, but also of patients who attempt suicide or other self-harm, victims of known-to-be-violent-sports accidents and indeed of maladies resulting from a host of intentionally chosen lifestyles).

In the absence of an agreed universalisable *substantive* theory of justice, the appeal to a potentially widely agreed universalisable *formal* theory of justice has the advantage of focusing on the issues of equalities and inequalities that lie at the heart of all theories of justice—even though as already stated substantive theories radically disagree about *which* equalities and inequalities are the ethically important ones. The value of focusing on the Aristotelian formal principle of justice, as Dr Daly shows so clearly, is that if proponents of a specific solution to a contended issue in medical ethics can show its coherence with the other three principles and can also show that a patient or a class of patients would be treated formally unjustly—unethically treated as moral unequals—then it is up to opponents of that specific solution to demonstrate why the unequal treatment that they advocate is morally justified.

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REFERENCES

1 Daly D. Principlist approach to multiple heart valve replacements for patients with intravenous drug use-induced endocarditis. *J Med Ethics* 2022;48(10):653–6.
2 Beauchamp T, Childress J. *Principles of biomedical ethics*. 8th ed. New York: Oxford, 2019.
3 See reference 2 P 281.
4 See reference 2 P 268
5 See reference 2 P 268–9.
6 Gillon R. Raising the profile of fairness and justice in medical practice and policy. *J Med Ethics* 2020;46(12):789–90.

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