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Mini Review

Bioethics frameworks applied to Rheumatological practice

Abstract

Introduction: Clinical Bioethics has gained significant relevance in rheumatologic practice over the past decades. The characteristics of rheumatologic diseases - chronic pain and motor limitations - give special importance to the physician-patient relationship.

Content: This text presents a brief historical review of the development of this medical specialty and the origins of **Clinical Bioethics.** It defines and evaluates the principlism theory of Bioethics and analyzes the introduction of the reference frameworks theory in resolving ethical conflicts.

Conclusion: The practice of Clinical Bioethics grounded in bioethical frameworks has enhanced the quality of care for rheumatologic patients through a technologically competent approach, combined with empathy and compassion in the physician-patient relationship.

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Introduction

Rheumatology is one of the most recent medical specialties. The characteristics of this field suggest that it may be the most clinically oriented of all specialties, requiring from the practitioner deep knowledge and experience in the fundamentals of internal medicine. Musculoskeletal diseases present unique features. In most cases, diagnosis is made using officially established clinical and laboratory criteria, and in many conditions, the diagnosis is based exclusively on clinical evaluation. The physician-patient relationship is of particular importance in the practice of this specialty, and virtues such as empathy and compassion are essential for the proper care of chronic diseases, often characterized by painful and sometimes disabling syndromes.[1]

Clinical Bioethics was introduced into biomedical care and ethical deliberation by the obstetrician André Hellegers, professor of gynecology and obstetrics at Georgetown University in Washington, in the early 1970s.[1] Hellegers founded the Kennedy Institute of Ethics and began to address practical and deliberative aspects of ethical conflicts using the theoretical framework developed by Potter.[2]

In the following decades, the practice of Clinical Bioethics gained significant momentum after the publication of the book by Beauchamp and Childress,[3] which defined the four paradigmatic bioethical principles in medical care: autonomy, non-maleficence, beneficence, and justice. The aim of this text is to contextualize the application of Clinical Bioethics in rheumatologic practice.

A brief history of Rheumatology

The practice of rheumatology as a medical specialty began in the 1920s. A key milestone in the development of rheumatology as a recognized specialty was the work of Dutch physician Jan van Breemen (1875–1961), who founded the International League Against Rheumatism (ILAR) in 1928.[4] Another major milestone in rheumatology's history was the establishment of a well-structured, pioneering rheumatology department at the Mayo Clinic, led by Dr. Philip Hench.[5]

The year 1948 was paradigmatic for the diagnosis and treatment of musculoskeletal diseases and can be considered a major turning point in rheumatology's recognition as a formal medical specialty worldwide. Three fundamental discoveries accelerated the growth of the new specialty:

Hargraves et al.[6] demonstrated the LE cell phenomenon. They observed changes in the cell nucleus when leukocytes were incubated with serum from a patient with systemic lupus erythematosus. The serum factor responsible for the phenomenon was named the antinuclear factor (ANF). Rose and Waller[7] discovered the rheumatoid factor by observing the agglutination of sheep red blood cells sensitized by serum from a patient with rheumatoid arthritis, thus developing an important and pioneering laboratory test for the diagnosis of rheumatoid arthritis.

Still in 1948, the groundbreaking use of corticosteroid therapy in a patient with rheumatoid arthritis was described by Hench et al.,[8] generating enormous hope for a cure for an immunologically mediated disease and radically changing the therapeutic approach to rheumatologic conditions. From that point on, there was rapid development of drugs for the effective control of rheumatologic diseases, beginning with powerful anti-inflammatory agents and, more recently, with the introduction of numerous immunobiologic therapies, significantly improving the quality and effectiveness of treatment for immune-mediated diseases.

Principlism in bioethics

The outcry of American citizens in the 1970s-sparked by media and medical journal reports revealing human research studies with evident ethical violations-prompted the government to appoint a commission to study the fundamental ethical principles in human research: the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.[9] The commission's official document, the Belmont Report, identified three core ethical principles for research involving human subjects: autonomy, beneficence, and justice.

Philosopher Tom Beauchamp and theologian James Childress,[3] both members of the commission, published in 1979 a highly influential book in the field of Bioethics-Principles of Biomedical Ethics-in which they proposed applying the Belmont Report principles to broader ethical deliberation in clinical practice, while also adding a fourth principle: non-maleficence.

This work gave rise to what became known as Principlism in Bioethics, establishing a practical and pragmatic framework for resolving ethical conflicts in biomedical practice-a previously unprecedented approach, which explains the profound impact of the publication on both academic and professional communities. In the following decades, the medical literature began to reflect a trend and movement against principlism. Gracia[10] emphasizes that principlism represents only one approach to ethical deliberation and highlights other important methods, such as contextualism, casuistry, narrative ethics, and hermeneutics.

Bioethical frameworks

In a text published in 2006, Hossne[11] notes that, over time and in the face of increasingly complex situations, the reductionism and relative insufficiency of principlism became apparent. He argues that the principles were originally "identified" not for Bioethics, but rather for ethics in research involving human subjects. These principles, later adopted by Bioethics, were thought to have the theoretical capacity to resolve all ethical dilemmas through structured deliberation. However, the author emphasizes that the "principle-based theory," although important and foundational, proved insufficient for deep and comprehensive philosophical reflection. While the principles remain relevant within biomedical ethics, they fall short when applied to other areas of Bioethics, such as the life sciences and environmental ethics.

It is also worth recalling that these principles were not new-they have long been recognized and applied throughout the history of medicine. Beneficence and non-maleficence (*primum non nocere*) appear in the Hippocratic Oath, and justice was central to both Greek and Roman medical and legal traditions. Hossne also argues that these principles are heavily based on deontological and legalistic foundations. As such, important conditions, concepts, and ethical commitments are excluded, espite being essential variables that must be taken into consideration. He highlights that dignity, vulnerability, and solidarity are not addressed within the principlist framework. According to the author, the principles should be redefined as "ethical references"-guiding points for ethical reflection-while incorporating other fundamental values such as: dignity, solidarity, fraternity, confidentiality, privacy, vulnerability, responsibility, survival, and quality of life.

Discussion and conclusion

Humanism and technology are often placed at opposite ends of a spectrum, especially in the field of healthcare. It is frequently stated that technology dehumanizes, leading to the creation of numerous "humanization" programs in medical practice. But how can we humanize Medicine, a discipline whose very practice is inherently human? The concept of humanized practice should be understood as an authentically professional attitude, intrinsically linked to the idea of competence and excellence in Medicine. There is a pursuit of the ideal that everything affecting the patient can be identified by technology. Advances in disease knowledge are extraordinary, but often the human being is forgotten, and mistakenly, we end up treating diseases of people rather than people who, by circumstance, are ill.[11]

Balint,[12] a Hungarian psychoanalyst, was a pioneer in describing in his most important publication the significance of the physician as a "medicine," emphasizing the profound influence of the professional in the process of "healing" or care in medical practice. The author highlights that, like any drug, the physician can enhance positive effects in treatment but can also cause side effects and toxicity. The physician-patient relationship in rheumatology plays a fundamental role in positive patient outcomes and adherence to treatment, functioning-as Balint suggests-as a "drug" that, in certain situations, can be more impactful than the traditional prescribed medications themselves.

Levi and Leme de Barros[13] provide a definition of Clinical Bioethics that should guide the conduct of all medical professionals, particularly rheumatologists: "Clinical Ethics (Clinical Bioethics) deals with the desirable behaviors within the relationship formed between healthcare professionals and their patients, creating conditions such that, on one hand, the personal values of the individuals involved are preserved and respected, and on the other, the delivery of care, which is the special object of this relationship, can achieve the highest possible effectiveness."

The concept of the "theory of ethical references" proposed by Hossne[11] has had a strong influence on the practice and teaching of Bioethics in Brazil since its publication. This Brazilian author has identified the following key references: vulnerability,[13] prudence,[14] equity,[15] alterity,[16] solidarity,[17] spirituality,[18] and altruism.[19] Regarding vulnerability,[13] the author emphasizes that this reference is rarely mentioned in texts concerning professional medical ethics or other health professions and is scarcely cited in Anglo-Saxon bioethical literature, but it plays an important role in resolving ethical conflicts in less developed continents and regions of the world. In particular, patients with chronic diseases in the field of rheumatology exhibit clear vulnerability, which must necessarily be observed and protected.

In conclusion, it can be affirmed that the references of Clinical Bioethics are fundamental concepts in caring for patients whose autonomy is limited due to the characteristics of rheumatologic diseases-chronic pain and motor limitations-requiring an approach that is technologically competent but, above all, empathetic and compassionate.

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Conflicts of interest

The author declares that there are no conflicts of interest.

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