Addicted to the good life: harm reduction in chronic disease management

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ABSTRACT

- Individual values sometimes lead patients to make lifestyle choices that have negative effects on their health.
- Doctors tend to feel responsible for delivering best-practice health outcomes to such patients, but also feel inclined to respect their patients' values.
- The adoption of a harm reduction model may provide a strategy for delivering the best care that is compatible with each patient's chosen lifestyle.

MJA 2006; 184: 235–237

Many patients continue to make poor lifestyle choices despite suffering negative health effects. Patients with chronic obstructive pulmonary disease continue to smoke, patients with diabetes continue to eat chocolate, and patients with ischaemic heart disease continue to lead sedentary lives. In each case, the need for lifestyle change may be clear to both doctor and patient, yet patients remain unwilling or unable to change their behaviour.

For clinicians, tension may arise between their acceptance of patients' freedom to choose unhealthy behaviour, and their conviction that providing "best care" for their patients includes promoting lifestyle change when indicated. We propose that the concept of harm reduction — familiar in the field of substance misuse — provides a potentially useful ethical framework to help resolve this tension.

Harm reduction

The concept of harm reduction (also known as "harm minimisation", "risk reduction" and "risk minimisation") initially arose in the context of drug addiction. Harm reduction strategies begin with the premise that some level of unhealthy behaviour is inevitable in a community, but then attempt to develop strategies to minimise the harms people suffer as a consequence.

Harm reduction focuses on the harmful outcomes of behaviour, rather than the behaviour itself. For example, if we cannot stop a patient taking drugs, we can nonetheless promote strategies to prevent them overdosing in a neglectful environment, or developing blood-borne infections.

Harm reduction strategies have often been controversial, probably because of their association with behaviour considered by many to be illegal or immoral. Nevertheless, there are clear parallels between issues of lifestyle change in drug addiction and in chronic disease. In both cases, people who suffer the effects of entrenched habits may be unwilling or unable to change. This similarity raises the possibility of a beneficial role for harm reduction in chronic disease.

Chronic disease

There is good evidence that lifestyle change is the most effective way to minimise the health burdens of many chronic diseases.[1] Unfortunately, individual clinicians can take only limited responsibility for lifestyle interventions, and doctors probably overestimate their role and responsibility in obtaining lifestyle outcomes in individual patients.[2]

If patients are unwilling or unable to change their lifestyle habits, there are still ways to reduce the harms associated with their choices. For instance, a 50-year-old smoker with blood pressure of 140/85 mmHg and cholesterol level of 6 mmol/L may obtain as great a reduction in cardiovascular risk from the daily use of an angiotensin-converting enzyme (ACE) inhibitor and a statin as he would from giving up smoking.[3] Ideally, patients would take up both interventions, but for those who are unwilling to give up smoking, it seems reasonable at least to reduce associated harms by using medications. In our terminology, the use of statins and ACE inhibitors to decrease the cardiovascular risks of smoking would be a harm reduction strategy.

Similar strategies may reduce risk in other people with chronic disease who are unwilling to make lifestyle changes: an obese person who will not decrease his or her food intake can decrease the risk of developing ischaemic heart disease by substituting foods high in omega-3 fatty acids; a person with impaired glucose tolerance can decrease the chance of developing diabetes by using metformin rather than by lifestyle change; and a person with diabetes and poorly controlled blood sugar can reduce the risk of disabling microvascular complications through ACE inhibitor therapy and regular eye screening — even in the absence of better sugar control.

These strategies are already common in clinical practice. We believe that explicitly acknowledging that they are part of a harm reduction strategy allows us to escape from the "best-practice" paradigm with people for whom best practice is impractical.

Ethical considerations

From colleagues, we have encountered both theoretical and practical objections to the application of harm reduction strategies in chronic disease. As clinicians we wish to focus on practical issues, but we also acknowledge our theoretical assumptions.

We have characterised harm reduction as a valid strategy for managing habits of behaviour that we regard as inevitable. However, in applying harm reduction strategies to those who are unwilling, rather than unable, to change their habits, a critic may suggest that a mere preference for unhealthy behaviour violates the

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1 Case study showing use of a harm reduction strategy

A 62-year-old man with type 2 diabetes drank heavily every night, financed by a compensation payout after a back injury several years previously. Consequently, although his diet and medication-taking behaviour were reasonable in the morning, they were very unreliable in the evening.

Despite a maximum morning dose of oral hypoglycaemic drugs, his glycosylated haemoglobin (HbA_{1c}) level remained above 11%.

His general practitioner counselled him about his lifestyle to the point of extreme mutual frustration, but he remained unwilling to change his drinking behaviour.

Eventually, it was agreed by both to ignore his drinking and elevated HbA_{1c} level, and instead to use aspirin, a statin, antihypertensive and oral hypoglycaemic drugs once daily in the morning. He had regular foot checks and retinal screening.

Using this strategy, the risk caused by his behaviour was minimised, although the behaviour itself did not change. ◆

notion that such behaviour is inevitable. Our position is that such behaviour is, in practice, inevitable as long as patients have the opportunity to exercise free choice. We have also chosen to defer to the traditional notion that a clinician's primary ethical obligation is to their patient.

Objection 1: Harm reduction is wrong because it condones or even promotes unhealthy behaviour

Some people feel that tolerance of unhealthy behaviour is tantamount to its promotion. One formulation of this argument holds that harm reduction strategies may perpetuate the unhealthy habits of individuals by lessening the suffering that results from their behaviour. This notion is easily dealt with because the alternative is paradoxical: people can hardly be better protected from the unpleasant consequences of chronic disease after they have already suffered those consequences. This is one reason that we feel it is useful to adopt a perspective focusing on the consequences of behaviour, rather than the behaviour itself.

A more subtle formulation of this argument holds that, by tolerating unhealthy behaviour in some people, we encourage it in others. Objections of this sort are particularly common in the context of drug addiction, where harm reduction programs are said to broadcast implicit messages to the broader community encouraging illicit drug use. We feel that such arguments highlight a need to distinguish health care of the population and of the individual. At the population level, it is true that we ought not to promote unhealthy lifestyles. But at the individual level, there is no need for encouragement of a healthy lifestyle to exclude support for established health problems.

The obligation to focus primary care on individuals supports the idea of harm reduction for those who will not change their habits.

Objection 2: Doctors who accept harm reduction neglect their professional obligation to deliver evidence-based best practice

Patients who make unhealthy lifestyle choices may be subject to moral opprobrium, which may "rub off" on doctors who are seen to tolerate their patients' standards. Most doctors share the conviction that their patients deserve the best available care, and that lifestyle change is the best standard of care. But it is also a reality that lifestyle change has a high rate of failure, and that *patients*, not doctors, are the active players in their personal habits.

Moreover, most of the evidence in favour of lifestyle change comes from large, randomised controlled trials of patients who are compliant with treatment. Poorly compliant patients are difficult to study, and there is therefore a lack of evidence as to what may constitute best practice for them.

We regard it as a strength rather than a weakness that a harm reduction approach to health care acknowledges patient values in assessing best practice. Unhealthy lifestyle choices may be unpopular, but they are often legitimate insofar as they are legally enacted by competent adults. For some, the risk may well be worth the reward. Harm reduction takes a neutral stance on the content of patient values and, in doing so, focuses our attention on our patients' immediate health care concerns.

Objection 3: It is wrong to resort to pharmacotherapy when lifestyle change would be at least as effective

The issue of harm reduction in chronic disease is directed at patients who are unwilling to modify their lifestyle. This inevitably shifts the emphasis of care towards pharmacotherapy. Yet, doctors are often criticised for using drugs when a change in lifestyle could achieve a similar or even superior medical outcome. US psychiatrist Peter Kramer has described such disdain for medication as "pharmacological Calvinism", because it denies people certain benefits on the basis that they have not been earned through a process of suffering.[4] Clearly, this argument requires its own moral defence. In the meantime, the view from the medical profession must be that medicines are simply a tool for improving patient outcomes. The best possible outcomes are likely to arise from combining drug therapies and lifestyle interventions, but this is an option that patients may legitimately decline.

Conclusions

There is currently tension in clinical medicine between the ideologies of evidence-based best practice and disease self-management. This conflict is practical: while some patients will both want and accept disease management that accords with evidence guidelines, others will prefer to negotiate regimens that accommodate their existing lifestyle preferences (see case study, Box 1).

We have argued that the paradigm of harm reduction may offer an appropriate alternative way of thinking about people who are unwilling or unable to adopt particular changes of lifestyle. It is important to emphasise that we are not suggesting that doctors cease to promote healthy changes in lifestyle, or cease to regard those changes as best practice, if the evidence supports such claims. We believe that all patients deserve the opportunity and support to make beneficial choices. We are simply emphasising that patients need to make these choices *for themselves*, and that it is not *wrong* to adopt other treatments if the evidence-based best treatments conflict with patient values.

2 Suggestions for practice

- Initiate any elements of best practice that patients will accept.
- Focus on reducing the harms associated with ongoing risks.
- Continue to monitor openness to change.
- Initiate any elements of best practice that subsequently become available. ◆

In practice, clinicians should initiate any elements of best practice that patients will accept. However, once clinicians become aware of the limits to patients' willingness to undertake lifestyle change, they should put aside the lifestyle interventions that patients refuse and consider strategies for harm reduction. They should then continue to monitor patient preferences and renegotiate health care goals as those preferences evolve (Box 2).

Competing interests

None identified.

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(Received 11 Aug 2005, accepted 16 Dec 2005) ❑