A Responsibility to Chemically Help Patients with Relationships and Love?

GAVIN G. ENCK and JEANNA FORD

In "The Medicalization of Love," Earp, Sandberg, and Savulescu argue that the medicalization of human relationships and love may not necessarily be bad, on balance, and that therefore research into potential pharmaceutical interventions toward their neuromodulation should not be prohibited.[1] The value and usefulness of these pharmaceuticals are their predicted conduciveness to improving human well-being. This commentary raises an interesting implication that the authors' argument may have on the ethical responsibilities of medical professionals. Assuming that certain conditions of permissibility are met, we argue, it is reasonable to hold that clinicians may have an ethical responsibility to patients to prescribe pharmaceutical interventions for neuromodulation of human relationships.

Conditions of Permissibility

Let us assume for the sake of the argument that research programs do someday develop pharmaceutical interventions into love and relationships that are available to be used in patient care.[2] Although such interventions would be available, this would not necessarily mean that a clinician would be permitted to use them in all situations. In order to prescribe these pharmaceuticals, we suggest—building on earlier work by Earp and colleagues—that certain conditions of permissibility would have to be met.[3] These conditions concern issues relating to (1) aims and benefits, (2) consent, (3) authenticity, and (4) the necessity of prescribing these pharmaceuticals to an individual patient.

The aims-and-benefits condition requires, first, that a clinician's aim in prescribing the pharmaceuticals must be to improve a patient's well-being.[4] In order to improve well-being, the benefits of the intervention must outweigh the harms caused by the failure to diminish (or strengthen, depending on the case) the relevant relationship attachment, as well as potential side effects.[5]

The second condition holds that patients must understand, appreciate, and agree to use these pharmaceutical interventions into love.[6,7,8] Moreover, a patient must understand the efficacy limitations of the pharmaceuticals: he or she should not expect that the love drugs or antilove drugs would provide a silver bullet solution to his or her problems but should realize that they would only (at best) serve a conducive role in altering a patient's relationships or higher-level experiences of love.

The third condition requires that the patient's decision be authentic. The authenticity of a patient's decision is assessed in relation to his or her (or the couple's) higher-order values or goals. The decision to use a pharmaceutical intervention into love is authentic, we suggest, if it is consistent with patients' second-order desires (e.g., to end an abusive relationship or to repair a deteriorating relationship), when acting on these second-order desires is blocked

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by first-order desires (e.g., strong attachment to an abusive partner or diminishing attachment to a loving partner).[9]

The final condition of necessity requires that other nonpharmaceutical treatment and intervention options, such as couples counseling or psychotherapy sessions, are not feasible or have already been tried to exhaustion. Pharmaceutical interventions into love are then used when they are the only—or at least the most practical and effective—way to diminish (or strengthen) the given relationship attachment.

These conditions would entail that the intervention would (1) be expected to improve the individual's (and/or couple's) well-being, all things considered; (2) be undertaken voluntarily and under conditions of informed consent; (3) help the individual patient (or couple) fulfill his or her higher-order goals or values; and (4) be the only way (or the best way) of achieving those first three outcomes, compared against alternative methods that had already been tried or thoroughly considered.[10] On these grounds, we contend, the intervention would be permissible.

Medical Professionals' Ethical Responsibilities

Assuming that these conditions are reasonable, what would be the implications for medical professionals' ethical responsibilities? To answer this question, we must first ask: What is the basis for such responsibilities in general? In this commentary, we suggest that it is the fiduciary relationship between the clinician and patient. In this relationship, the medical professional and the patient are engaged in a process of healing, which, broadly construed, aims at improving patient well-being.[11,12,13] Well-being is constituted by physical, psychological, and social elements and is, primarily, defined by the patient.[14] Although there are limitations and constraints to a patient's ability to define well-being, it is ultimately the patient who must decide on the relative importance of health, happiness, and love and, in turn, what burdens, pains, and degrees of suffering are (or are not) tolerable to them.

Although clinicians have many professional ethical obligations and responsibilities to patients, at least one responsibility is for them to provide patients with the best possible care.[15] Although this responsibility is limited by contingent conditions of medical necessity, professional expertise, the availability of treatments and therapies, and safety (for both patient and professional), it provides a reasonable expectation that, all things considered, a clinician *should* provide patients with the best possible care.[16]

In the context of the present discussion, this ethical responsibility to provide patients with the best possible care suggests that clinicians may have a responsibility to prescribe pharmaceutical interventions into love, insofar as the previously stated conditions of permissibility have been met. Providing patients with the best possible care requires offering medical treatments and interventions that at least aim at improving a patient's overall well-being. As indicated by ample empirical evidence—reviewed by Earp and colleagues in previous articles[17,18,19,20,21]—ending a dysfunctional relationship or improving a well-suited relationship bond that might otherwise break down is likely to improve a patient's well-being. This improvement may occur relatively quickly, as in the case of someone ending an abusive relationship, or it may confer long-term benefits, as when a deteriorating relationship is repaired or strengthened.

Of course, clinicians do not have a responsibility to attempt to address every

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problem faced by patients who engage in conduct that is likely to threaten their well-being (such as remaining in an abusive relationship or failing to improve a relationship that could, with effort, be salvaged). As a common saying in healthcare goes, patients have the right to make poor decisions. Nonetheless, it is still possible to hold that, in some cases, clinicians do have an ethical responsibility at least to offer pharmaceutical methods for altering behavior and/or relationship attachments that are harmful to their patients. Consider, as an analogy, the practice of offering to prescribe pharmaceutical treatments to aid in smoking cessation. If a clinician judges that such treatment is the best method, in conjunction with other strategies, to aid the patient in giving up a harmful habit, then she or he may have a responsibility to offer such a prescription, even if the patient is likely to refuse the offer. Likewise, if a clinician judges that a pharmaceutical intervention into a relationship-affecting neurological system would, all things considered, be most conducive to the patient's well-being, then the clinician (we suggest) has a responsibility to offer such an intervention.

Of course, there are numerous potential dis-analogies between these cases as well. That is, even though both smoking and harmful relationship attachments may have negative consequences for health (and for well-being more broadly construed), the role of each of these phenomena in patients' lives, self-understandings, and experiences of the world are likely to be very different. Accordingly, it may be much easier to determine how, why, and under what conditions a given smoking habit may be damaging to a patient's well-being than it would be for a bad relationship. If pharmaceutical interventions into relationships are ever to be employed in the way we have suggested, then, clinicians will need to develop a strong set of criteria for determining—in careful consultation with their patients—whether a given relationship attachment is in fact harmful (all things considered), and whether intervention with drugs is the best available treatment.

Notes

1. Earp BD, Sandberg A, Savulescu J. The medicalization of love. *Cambridge Quarterly of Healthcare Ethics* 2015;24:323–36.
2. This assumption of being available for use in patient care means that these pharmaceutical interventions into love will have passed the requisite safety trials and measures. We would caution, however, that nearly all psychotropic pharmaceuticals have side effects and that efficacy is often hard to establish. Moreover, as Terbeck and Chesterman argued recently, the sheer complexity of human neurology and high-order brain functions means that there will likely never be a psychotropic pharmaceutical that does not have side effects; hence it would be important to determine that the risk of these side effects was outweighed by the benefits of the intervention. See Terbeck S, Chesterman LP. Will there ever be a drug with no or negligible side effects? Evidence from neuroscience. *Neuroethics* 2014; 7(2):89–194.
3. Earp BD, Wudarczyk OA, Sandberg A, Savulescu J. If I could just stop loving you: Anti-love biotechnology and the ethics of a chemical breakup. *American Journal of Bioethics* 2013:3–17.
4. Earp, Sandberg, and Savulescu offer empirical evidence indicating the profound effect relationships and love have on human well-being.
5. See note 3, Earp et al. 2013.
6. Appelbaum PS. Assessment of patients' competence. *New England Journal of Medicine* 2007;357(18):1834–40.
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8. Jonsen AR, Siegler M, Winslade WJ. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*. 7th ed. New York: McGraw-Hill Medical; 2010.
9. See note 3, Earp et al. 2013.
10. See note 3, Earp et al. 2013, for further discussion.
11. Cassell EJ. *The Nature of Healing: The Modern Practice of Medicine*. Oxford: Oxford University Press; 2012.

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12. Pellegrino ED. Toward a reconstruction of medical morality. *American Journal of Bioethics* 2006;6(2):65–71.
13. Although the process of healing aims to improve patient well-being, it does not follow that a patient's view of what is necessary to improve well-being is appropriate or feasible in all situations or that the use of treatments and interventions always improves patient well-being.
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