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Is Withholding Moderate Wine Intake Recommendations as a Secondary Treatment for Patients with Cardiovascular Disease Ethical?

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## Physician's Responsibility to Act for the Patient's Welfare VS Patient Involvement in Treatment Decisions

The physician has the obligation, inherent in his or her promise to act for the patient's welfare, to use only those diagnostic and therapeutic modalities *beneficial* and *effective* for the patient. What the physician recommends must be effective-it must physically change the natural history of the disease-and it must also be beneficial-it must be to the patient's benefit (1). Moderate alcohol, specifically wine, intake has been shown to be effective in reducing mortality from cardiovascular disease, but may not be beneficial if it places the patient, as well as others, at risk for alcohol related health problems and mortality. Utilitarian and Teleological Principles hold that of all the alternatives open to a physician at a given time, the one he or she ought to select is the one that produces the greatest balance of good over evil for all beings (1). Determining whether alcohol intake will be more detrimental than beneficial to a patient with cardiovascular disease and to society should involve an assessment of a patient's risk factors for alcohol consumption.

When alcohol abuse or the potential for alcohol abuse is identified in a patient with cardiovascular disease, the decision to recommend moderate wine consumption as a secondary treatment over the risks for alcohol related health problems, becomes more complex. It is believed that it is always right to involve patients in decisions that have important implications for them, such as the choice of treatment that involves tradeoffs between near and distant benefits-as alcohol intake will-or when the patient is particularly averse to risk from a given treatment-such as alcohol (2). Recognizing the need to establish good relationships between physicians and patients and families, a physician should provide complete, honest answers to questions regarding treatment options (1). However, since there are no numerical estimates of "safe" drinking limits with immunity to alcohol related health problems and dependency, and due to the possibility that advice given by physicians regarding "light" or "moderate" drinking, might be misconstrued by patients (3), the physician must decide if recommending moderate alcohol intake as a secondary treatment option for patients with cardiovascular disease also meets his or her medicolegal obligation to act for the patients welfare.

### Tradeoffs Involved with Alcohol Consumption

In spite of their high level of risk factors, such as cholesterol, diabetes, hypertension and a high intake of saturated fat, French males have the lowest mortality rate from ischaemic heart disease and cardiovascular disease in Western industrialized nations (36% lower than the U.S.). This low mortality rate specifically from cardiovascular disease is attributed to regular wine consumption. In contrast, mortality from all causes is only 8% lower than the U.S., due to a high level of cancer and violent deaths and mortality by cancer and violent death is increased in French drinkers compared with abstainers (4). The relationship between alcohol intake and mortality or coronary heart disease is represented by a J-shaped curve, where the lowest point on the curve (light/moderate drinking) reflects optimum exposure to alcohol, while the increased risk in abstainers and heavy drinkers reflects the consequence of sub-optimum alcohol intake (5). However, the abstainers represented in these studies consistently show an increased prevalence of conditions likely to increase morbidity and mortality compared with occasional or light drinkers, indicating that the J-shaped curve may not be representative of the relationship between moderate alcohol intake and mortality or coronary heart disease.

Even in studies where a significant inverse association between alcohol consumption and the risk of myocardial infarction was observed (6) and where investigators concluded that light-to-moderate alcohol intake in patients with prior cardiovascular disease is protective against recurrent events—the issue as to whether medical professionals should recommend light-to-moderate alcohol intake as a secondary prevention remains disputable. The controversy stems from the increased mortality associated with higher levels of alcohol consumption, and the socioeconomic issues related to chronic alcohol abuse (7).

### Adverse Effects of Alcohol Consumption and Risk Factors for Alcohol Dependence

Adverse effects of alcohol consumption are far more numerous than beneficial effects. They include several types of cancer (oropharyngeal, esophageal, liver, laryngeal and breast cancer), other diseases of the aerodigestive tract, diseases of the heart (alcohol cardiomyopathy, hemorrhagic stroke, arrhythmia and hypertension), addiction-related mental disorders, accidents and injuries, as well as social harms associated with the abuse of alcohol—such as income lost, domestic violence, child abuse and neglect, brawling and accidents (8, 9). Alcohol is a major factor in suicides, homicides, violent crimes, and fatal motor vehicle accidents (10). Since medication with alcohol may bring about dependence, especially in susceptible individuals (11), an assessment of risk factors for alcoholism and an evaluation of all patients for alcohol abuse should be performed prior to recommending alcohol as a secondary treatment for cardiovascular disease.

Some risk factors for alcoholism that physicians should recognize are asocial behavior, external control (meaning that the subject thinks that his or her behavior is determined mainly by chance or by other people, implying lack of self control, self-efficacy and personal autonomy), becoming highly stimulated when intoxicated by alcohol, and trait anxiety (11). Other signs and symptoms suggesting inappropriate alcohol use are repeated episodes of depression, unexplained weight loss and episodes of engaging in high-risk behavior (12).

In spite of the high prevalence of alcohol problems among medical patients, several studies have shown that fewer than half of the patients with alcohol problems were identified by their physicians (13). The many health problems, the 100,000 deaths and the economic cost of \$100 billion in the U.S. associated with alcohol use (13), make screening and detection of alcohol risk factors and dependence critical, and make recommendations of wine intake for these cardiovascular disease patients harmful and inappropriate.

### Alcohol Abuse Screening and Future Liability

A number of questionnaires have been developed for the detection of alcohol disorders. These include the CAGE questionnaire, the MAST (Michigan Alcoholism Screening Test) and the AUDIT. The CAGE questionnaire has been proven to be a very useful and optimal test for identification of alcohol dependence in both men and women (10, 14).

CAGE is a mnemonic for the following four questions: (C) Have you ever felt you ought to cut down on your drinking? (A) Have people annoyed you by criticizing your drinking? (G) Have you ever felt bad or guilty about your drinking? (E) Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye opener) (10)? Studies have shown that when CAGE questions are made as part of the HEADSS assessment, alcohol abusers are

more likely to give accurate responses and less likely to bring about defensiveness and denial in the alcoholic (10). By screening cardiovascular disease patients and identifying possible alcohol dependence early on, a physician can make a more informed decision on whether recommending wine intake as a secondary treatment will be beneficial or simply negligent.

### Conclusion

Moderate wine intake may be effective at reducing mortality rate from ischaemic heart disease and cardiovascular disease but has been proven far from beneficial for patients with risk factors for or current alcohol dependency. The lack of recommendable "safe" drinking limits-free from causing alcohol related problems and dependency-ethically justifies withholding wine intake recommendations in some patients with cardiovascular disease at risk for alcohol dependence and qualifies recommendation of this secondary treatment for alcohol dependent cardiovascular disease patients as negligence. Risk factors for and signs and symptoms of alcohol dependence, as well as short alcohol abuse screening questionnaires, such as the CAGE questionnaire, are all tools physicians can use to identify cardiovascular disease patients for whom wine as a secondary treatment is inadvisable. What is not legally justifiable is ambivalence to alcohol screening based on the uncertainty that alcohol interventions are effective or that compliance is low (15). If appropriate medical advice is not given, physicians are laying themselves open to litigation initiated by aggrieved defendants on the grounds that their alcohol misuse should not have been neglected (15).

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