. ОБЩЕСТВЕНИ КОМУНИКАЦИИ И ИНФОРМАЦИОННИ НАУКИ
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THE PRINCIPLE-ORIENTED MEDICAL ETHICS ACCORDING TO BEAUCHAMP AND CHILDRESS – APPLICATION TO THE NEEDS OF PATIENTS WITH PTSD

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Abstract: *The article deals with the application of the four medical ethical principles of Beauchamp and Childress to patients with post-traumatic stress disorder (PTSD). Given the numerous challenges that PTSD sufferers face in everyday life, sensitive communication between medical, nursing and therapeutic staff is of central importance, especially in life-threatening situations such as sepsis. The principles of autonomy, non-maleficence, beneficence and justice form the basis for the ethical care of these patients. The first principle emphasizes respect for the autonomy of patients through comprehensive information and involvement in treatment planning. The second principle, the principle of non-maleficence, aims to avoid retraumatization and to choose safe, evidence-based treatment approaches. The third principle of beneficence promotes the psychological and physical well-being of patients through targeted treatment and the promotion of self-efficacy. Finally, the fourth principle of justice emphasizes non-discriminatory treatment, regardless of socioeconomic status. Applying these principles ensures ethically sound and patient-centered care that respects and promotes the individual well-being of patients. The article shows how these principles can be specifically applied to the needs of PTSD patients and discusses the challenges and limitations associated with this.*
Keywords: *Posttraumatic stress disorder, communication, trauma-sensitive communication, resource orientation, client-centeredness, ethics*

INTRODUCTION

People who have experienced posttraumatic stress disorder (PTSD) face numerous challenges in everyday life. Communication with patients plays a central role in this context. This applies in particular to medical, nursing and therapeutic staff. Against the background of this challenging initial situation, this article deals with how sensitive communication can take place with people affected by PTSD. The situation is all the more serious if they have or have experienced a life-threatening illness. An example of this is sepsis combined with a stay in the intensive care unit (Schellung/Epple, 43–45). The four medical ethical criteria according to Beauchamp and Childress have been chosen as the starting point. The structure of the article is derived from the interest in investigating this question. The first section explains the basics in this regard. This is followed by an application to the situation of patients with PTSD.

BASICS

Before we can address the actual question, the four principles should first be explained in their basic features. Beauchamp and Childress (1979) have developed a model of principle-oriented medical ethics. It is used in the medical, nursing and psychotherapeutic fields (Beauchamp 2010, pp. 36–37). A specific objective is to give the relevant professionals a framework that they can use as a guide. The focus is on maintaining and promoting the well-being of patients in the best possible way. This is particularly true for nursing staff, who typically spend significantly more time with patients than doctors and thus have an important influence on their recovery (Marckmann 2000, pp. 74–75). Beauchamp and Childress' principles are principles that follow "common sense" (Gerhard 2015, p. 153), and are sometimes referred to as middle principles. This addresses the assumption that most people would already agree with them

intuitively (Gerhard 2015, p. 153). The four principles will now be presented in detail in order to then apply them to the case of PTSD and make them more specific in the following chapter.

First principle: respect for the patient's autonomy

The first principle relates to freedom for patients – especially in a situation where they are restricted and dependent on care. The expectation is that they can make decisions as independently as possible (Beauchamp 2010, pp. 37–39). Beauchamp and Childress make a distinction in this context between negative and positive freedom (Beauchamp 2010, p. 37). Negative freedom means that, if possible, no manipulation or coercion should be exerted on the person being treated. This applies in particular to people who tend to have a stronger position than the patient (Beauchamp 2010, p. 37). Positive freedom means that people can make decisions as independently as possible. In order to do this, it is necessary to provide them with comprehensive information about their current situation and upcoming treatment. This includes, for example, realistic information about the opportunities and risks. In addition, no important information should be withheld, even if it could negatively affect the success of the treatment and the person (Beauchamp 2010, pp. 37–38). There are two important prerequisites for this. The first is an intensive relationship of trust between the patient and the treating staff (Quasdorf/Diel 2016, p. 7). In addition, the people should always protect the privacy of the person and allow them a highly personal decision-making space (Beauchamp 2010, p. 44). In practice, the so-called "informed consent" (Quasdorf/Diel 2016, p. 8) is used in this regard. This means that both the attitudes and the norms, values and interests of the patients are taken into account. They are asked about decisions for situations that could potentially arise during a medical intervention. This information can then be used to make a decision for the patient in the event that a situation arises in which they can no longer do this independently. An important prerequisite is comprehensive information. Active consent is necessary if the person is able to do this independently (Beauchamp 2010, p. 37).

Second principle: principle of non-maleficiency

This principle is also known in English as "nonmaleficience" (Beauchamp 2010, p. 8). Another example is the measures that deprive the patient of their freedom that have already been mentioned. For example, no violence may be used and no neglect may occur. The harm may not just be accepted passively. However, this cannot always be avoided in individual cases. This is sometimes difficult in practice. Among other things, it may be necessary to perform an operation that saves the patient's life, even if this requires injury (Beauchamp 2010, pp. 38–39).

Third principle: principle of doing good

The third principle is called "beneficience" (Beauchamp 2010, p. 39). It is thus in a way an antipode to the principle of non-maleficence. There is a passive and active component. The main aim is to avert and avoid harm to the patient. In particular, impairments should not be caused to the patient, either consciously or unconsciously. This applies to both the psychological and the mental level (Beauchamp 2010, p. 39). In the active orientation, the treating persons should act in such a way that the patient's well-being is promoted (Beauchamp 2010, pp. 39–40).

Fourth principle: principle of justice

Finally, there is the principle of justice, which primarily addresses questions of fairness. This is primarily about questions of the distribution of questions and resources. For example, the treatment of patients should be based exclusively on their medical and nursing needs - and on what is optimal for their recovery. The income and behavior of patients should not be used as a yardstick (Beauchamp 2010, pp. 41–42). Accordingly, the principle of equality also plays an important role. The principle is therefore also opposed to treatment based on two classes, for example the preferential treatment of patients who have private health insurance over those with statutory insurance. As a result, questions of arbitrage are also addressed here (Beauchamp 2010, pp. 41–42). The principles can only be considered separately in theory. In reality, they are closely interrelated and influence each other (Gerhard 2015, pp. 151–152). Both conflicting goals and homogeneous goals are conceivable. In each individual case, the principles

must be weighed up against each other for the specific case, taking all details into account and with a particular focus on the patient's well-being. For example, it can be problematic to fully preserve a person's autonomy if they tend to harm themselves and pose a danger to caregivers and other patients. In this case, the use of measures that restrict freedom may be necessary. This involves balancing the principle of preserving autonomy with that of preserving and promoting the patient's well-being.

APPLYING THE PRINCIPLES TO PATIENTS WITH PTSD

Now the principles of Beauchamp and Childress should be applied to the context of patients with PTSD.

First principle: respect for the autonomy of patients

The first important reference point is the education of PTSD patients. Here, care should be taken to educate and inform them comprehensively. This can help to reduce existing uncertainties and fears. They should be given enough time and support so that they can make an informed and conscious decision on this basis. The communication of risks should always be transparent and comprehensible, but also requires a special degree of sensitivity (Beauchamp 2010, p. 37; Yule et al., 2013, pp. 451–452). It is also useful to involve patients intensively in the planning of further treatment after the education. Their preferences, but also norms and values, should be taken into special consideration. This can, for example, affect the choice of therapy, but also decisions that may need to be made for them if they are unresponsive (Beauchamp 2010, p. 37; Cahill/Anderson, 2013, pp. 364–365). In addition, particular importance must be attached to respecting the wishes of the patient. This applies in particular to the choice of therapy and the question of whether or not treatment should be carried out. If a person refuses treatment, wants to carry it out in a modified form or wants to stop it, this should be respected in every case. This also applies if there is a risk of significant health risks. However, particular attention must be paid to ensuring that the person makes their decision consciously in a calm state and not out of emotion. In this context, it can also be helpful to record the central norms, values and decisions, for example in the context of a living will, the preparation of which is also recommended beyond this specific context (Beauchamp 2010, p. 37; Cahill/Anderson, 2013, pp. 364–365).

Second principle: principle of non-maleficence

With regard to the second principle of nonmaleficence, care should be taken to structure treatment and communication with patients in such a way that the risks of retraumatization are kept as low as possible. This can be done, for example, by using trauma-informed approaches and sensitive communication and interaction techniques (Beauchamp 2010, pp. 38–39; Cahill/Anderson, 2013, pp. 363–364). It is also important to choose safe and evidence-based treatment approaches. In this way, the patient can be given a sense of security, and potential risks can potentially be better assessed based on previous experience. This makes it possible to anticipate possible outcomes and consider alternative courses of action in advance of the intervention. The communication of safety and evidence-based treatment also plays an important role here (Beauchamp 2010, pp. 38–39; Cahill/Anderson, 2013, pp. 363–364).

Third principle: principle of doing good

The principle of beneficence is also important. When working with PTSD patients, the main aim is to increase the patient's psychological and physical well-being. On the one hand, this includes treating the PTSD symptoms in a targeted manner, and on the other hand, the general quality of life or promoting the conditions for this. Furthermore, a holistic approach should be chosen in which the individual interventions are coordinated with one another in a meaningful way. This includes in particular the targeted coordination of measures with regard to their effects on the psychological, physical and social levels. Spirituality can also play an important role for some patients (Beauchamp 2010, pp. 38–39; Cahill/Anderson 2013, pp. 363–364). It is also useful to promote people's belief in their own efficacy. Appropriate measures on a psychological level should also aim to give patients the opportunity to use their own resources and to become aware of their individual strengths when it comes to dealing with

challenging situations. In addition, patients should be able to learn and train intensively to deal with challenging situations and the associated stressors and to shape their lives in this context with increasing self-determination (Beauchamp 2010, pp. 38–39; Ca-hill/Anderson 2013, pp. 363–364).

Fourth principle: Principle of justice

The last principle can also be used effectively with patients with PTSD. Care should be taken during treatment to act regardless of their socioeconomic status and place of residence. This includes not giving preference to privately insured patients. Differences in treatment should be made solely on the basis of medical and psychotherapeutic circumstances. Freedom from discrimination is a central principle in this context. Resources should be distributed in such a way that patients with PTSD have access to all necessary therapies and support options (Beauchamp 2010, pp. 41–42; Cahill/Anderson 2013, pp. 365–366). If barriers exist, for example related to mobility and financial possibilities, a solution should always be designed or cooperation should be sought with suitable bodies, such as the psychosocial counseling center of a municipality (Beauchamp 2010, pp. 41–42; Cahill/Anderson 2013, pp. 365–366). By applying these principles, ethically sound, patient-oriented, centered, goal-oriented care can be guaranteed. Attention must be paid to maintaining and promoting individual well-being as well as respecting the rights and dignity of the individual, in every situation and at all times.

CONCLUSION AND LIMITATIONS

There are important limitations that must be taken into account. Beauchamp and Childress' model is only accessible to a limited extent to empirical testing. This is especially true given that it was created as principles of common sense. In addition, it is not a conclusive presentation of important principles. The critical discussion by Tschoetschel (2022) can be used here. For example, there are different principles with regard to the weighting of autonomy depending on the cultural region in which the patient care takes place. He distinguishes, for example, between liberal and rights-oriented states, the welfare-oriented Scandinavian ones and the traditionalist ones in southern and eastern Europe. This means that the meaning and weighting of autonomy also plays an important role. In traditionalistic cultures, a paternalistic solution is tended to be sought, in which the doctor makes the decision. Corresponding different weightings also relate to cultural factors (Birnbacher 2022, pp. 329–330). In addition, the criteria are not formulated concretely enough to offer concrete recommendations for action and applications in a specific case constellation. This is especially true for the necessary applications that a doctor, nurse or psychotherapist must make here. They therefore only offer indications that would also be partly taken into consideration without the model (Birnbacher 2022, pp. 330–331).

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ПРИНЦИПНО ОРИЕНТИРАНАТА МЕДИЦИНСКА ЕТИКА СПОРЕД БОШАМ И ЧАЙЛДРЕС – ПРИЛОЖЕНИЕ КЪМ НУЖДИТЕ НА ПАЦИЕНТИТЕ С ПТСР

Резюме: *Статията дискутира прилагането на четирите медицински етични принципа на Бошам и Чайлдрес при пациенти с посттравматично стресово разстройство (ПТСР*). *Като се имат предвид многобройните предизвикателства, пред които са изправени страдащите от посттравматично стресово разстройство в ежедневието, деликатната комуникация между медицинския, сестринския и терапевтичния персонал е от основно значение особено в животозастрашаващи ситуации като сепсис. Принципите на автономия, невредимост, благодеяние и справедливост са в основата на етичните грижи за тези пациенти. Първият принцип набляга на зачитането на автономността на пациентите чрез изчерпателна информация и участие в планирането на лечението. Вторият принцип – принципът на милосърдие, цели да се избегне ретравматизирането и да се изберат безопасни, основани на доказателства подходи за лечение. Третият принцип на благодеяние насърчава психологическото и физическото благополучие на пациентите чрез целенасочено лечение и насърчаване на самооценката. И накрая, четвъртият принцип на справедливостта набляга на недискриминационното лечение, независимо от социално-икономическия статус. Прилагането на тези принципи гарантира етично обосновани и ориентирани към пациента грижи, които зачитат и насърчават индивидуалното благосъстояние на пациентите. Статията показва как тези принципи могат да бъдат конкретно приложени към нуждите на пациентите с посттравматично стресово разстройство и обсъжда свързаните с това предизвикателства и ограничения.*

Ключови думи: *посттравматично стресово разстройство, комуникация, чувствителна към травмата комуникация, ориентация към ресурсите, ориентираност към клиента, етика*

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