

## Maintaining the Classic Approach and Innovating in Valvulopathy Clinics: The Balance through Bioethics

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*It is classic: anamnesis and the stethoscope capture sounds of harmony for the clinical reasoning on the management of valvulopathy.*

*It is modern: careful dialogue and auscultation result in prudent echoes and resonances.*

*It is clinical: high technology does not disregard low technology.*

*It is of the bedside: the beneficence of renewal does not require the elimination of the classic.*

*It is of bioethics: the non-maleficence of the classic supports the conventionality of innovation.*

The heart adapts by remodeling<sup>1,2</sup>. Cardiology also undergoes remodeling by the hypertrophy of good practices based on the enlargement of technoscientific knowledge frontiers and the acknowledgment of humanization.

There is much to be pondered about the immutable realities (heart failure, infarct and arrhythmias) that must fit into the organ called heart; and also on the intents and estimates to which such realities are subject, within the organization of knowledge in Cardiology, which confers hopeful clear-mindedness and empowerment to the cardiologist.

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The resulting professional meaning is generated by propedeutic, therapeutic and prevention statements, negations and contradictions, amidst the classic and the innovation.

There is an innate rhythm involved in the onset and maintenance of efficient methods. They are impulse systoles and appeasement diastoles, not to mention arrhythmias caused by the premature excitement of hope in the interactive process of creation of new clinical practices.

### Key words

Heart valve diseases/history; bioethics.

There is a Holter of decades bearing records of this kind in valvulopathy clinics.

The classic, the innovation of the past that has been tested and attested by Time, is the basis of the culture in Medicine, used to shape the continuity of a new usefulness and efficacy. The good understanding of the classic brings the temporality of the coexistence as contemporary. That is an unquestionable fact in valvulopathy clinics. The phonomechanocardiography disappeared at the onset of echocardiography, but the auscultation through the stethoscope remains eternal.

The logic of the process of establishing the innovation is based on the recombinations it brings to the assets obtained at bedside, resulting from the integration of the physician's personal experience with the collective experience of literature. Reinforcement is provided when classical goals are favored by the multiplication of methods and new objectives arise as the aftermath of innovations<sup>3</sup>.

The XX century witnessed the fast acquisition of cardio-relevant images on a small screen<sup>4</sup>. Morphofunctional diagnoses dismissed, as a consequence, the direct looking at the heart on a workbench. In the XXI century, the renewal of indicators and markers, the new configurations of the gold standards remains a challenge for the clinical sense motivation (verificar com o autor o significado da frase).

Hearing, sight and touch - the triad of senses that gives the impact of benefit in decision-making on beneficence, non-maleficence at the bedside in valvulopathy clinics. Silence deafens the physician-patient relationship. The clinical eye myopia blinds the integrative reasoning, disregarding it. The scarcity of modesty in science and consciousness desensitizes the decision, dehumanizes it. These are deficiencies that disfigure the classic sense of valvulopathy clinics and damage anything that might arise from the innovations.

Each strategy to incorporate the bedside benefits requires adjustments in the classic ethical parameters<sup>5</sup>. Specifically, about what did not use to be done, now possible negligence because it is feasible, and the doing it with the modifications, which protects from recklessness. Moreover, new deeds usually bring to light cost-benefit concerns, due to the limited supply of health resources. It is the constant strife between technology and health management *versus* individual and collective benefit. One must not forget that the cardiology care comprehends a broad spectrum of medical services that ranges from primary to quaternary attention.

Ethical fluidity is maximized by the decrease in conflicts between new principles in Medicine and old individual clinical demands. The last published article - we now know! - the

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Manuscript received August 05, 2009; revised manuscript received August 05, 2009; accepted October 29, 2009.

most recent guideline - we now can! - the regional culture - we now understand! - require caution and good sense. This mutuality must work as an ethical tollbooth: from the passage of the innovation condition into the classic one. The bedside clinician learns to perceive the space and time of the novelty, as he experiences direction and velocity through the feedback of using it in his field of action.

The availability of the valve prosthesis, in its attractive pioneering history since Charles Hufnagel (1916-1989), on September 11 1952 and Albert Starr (1926-...)-Miles Lowell Edwards (1898-1982), in 1961, opened up new perspectives of beneficence.

The prosthesis remains the imperfect advantage that demanded tolerance to new risks, morally admissible due to the prognosis of the natural history of valvulopathy and ethically expressed by criteria that were born with the characteristic of never being definitive.

The valvular prosthesis is, half a century later, a classic method. The rite of passage attracted the coexistence between the desired benefits with the malefaction that can be labeled as ethical iatrogeny.

This term designates that adversity included in the "conduct pamphlets", which is impossible to be disregarded in spite of the good practices.

The statistics guarantee that there is no benefit without risk; it is true, but one must not forget that the bad outcome can be a consequence of malpractice, and thus, non-ethical iatrogeny. The ethical iatrogeny represents the concept that the upper threshold of medical precision coincides with the imprecision of Medicine. The dysfunction of the bovine pericardial prosthesis due to time-dependent biological processes is an example of ethical iatrogeny and does not depend from ethical deviations in the physician-patient relationship.

The ideality in Medicine, the need and desire of always being one step further ahead, must be satisfied with what has been conventionally called state-of-the-art, a reductionism to "do it, do not do it, might do it".

At the assessment of the equivalence between the clinically evident and the literature evidence, the valvulopathy clinics is the master that teaches that these "safety strategies", based on the verb "to do", are born from the fear of the inexistence of the therapeutic ideal. It is value and circumstantial truth supported by the polemic potency of literature entanglements, by the imprecision/uncertainty mentioned by William Bart Osler (1849-1919), by the inevitable ambiguity in constant search of meanings in effects and precision evidence.

Thus, bioethics became welcome at the bedside<sup>6</sup>. From this privileged lookout in the clinical scenario, vigilant and sympathetic, it is the penetrating view of the human condition on the physician-patient relationship and a potent floodlight for the appreciation of classic and renewable frontiers of knowledge regarding valvulopathy stuff. A definitive symbiosis,

in favor of a better individual equation between beneficence, non-maleficence, autonomy, and why not, appeals to paternalism. The intimacy of the principles at the biological, environmental and cultural differences, so frequently present in valvulopathy clinics, produces respect to the complexity of Medicine, generating safeguards against its pointless use.

Bioethics seasons with ingredients of interdisciplinarity and the substitution of the natural history by the postoperative history, in valvulopathy clinics and simmers on the ethical flame the use of the available in the synthesis of progress, not necessarily of opportune analysis. Humanization is thus fed.

Bioethics, as an adjuvant in the agglutination of multiuse knowledge of propedeutic and therapeutic tools, concurs to select the scientific "truths" with the biggest potential for clinical success in the combined view of the physician and the patient, in valvulopathy clinics. A right on the rise, attained by society.

In this context, the capillarized bedside bioethics of valvulopathy became an essential amalgamation of the connectiveness between technologies. It incorporates the low technology of Hippocratic anamnesis and the bicentennial stethoscope used by the classic observer-collector physician and the innovations with technology differentiation (few astonishing discoveries and many subsequent systematizations) of the research-stratifying Medicine, in different scenarios of different "Brazils". The bioethics clarifies attitude singularities amidst various clinical inquiries.

Finally, the bioethics brings equilibrium to the decision-making in the presence of true unforeseen clinical events of etiopathogenic and physiopathological randomizations of the Brazilian patient with valvular heart disease.

The bridge to Potter's future, less than 40 years after this same book, the "ABC of bioethics", is already a bridge to the present in order to reach an immediate end in clinical chances<sup>7</sup>, passing by the increasing unrealism of "book cases".

Such facts allow the free transit of anamnesis and the stethoscope, symbols of the physician-patient relationship, without any perceptive of retirement.

The clinical bioethics has the full support of the clinic of valvulopathy. The novelty becomes a classic!

#### Potential Conflict of Interest

No potential conflict of interest relevant to this article was reported.

#### Sources of Funding

There were no external funding sources for this study.

#### Study Association

This study is not associated with any post-graduation program.

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