

Hippocrates Revisited

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A fundamental principle upon which the physician-patient relationship has come to rest is that of “*primum non nocere*,” translated from Latin to “first, do no harm.” It is often erroneously attributed to the Hippocratic Oath that graduating medical students swear by at more than 60% of United States medical schools (Tung and Organ, 2000), which actually lacks that phrasing, although it certainly acknowledges the principle of non-maleficence. Some sources attribute the Latin language of “*primum non nocere*” to the Roman physician Galen, c. 129–200 C.E. (Weitzel, 1996).

In fact, Hippocrates, c. 460-377 B.C., did write a similar phrase in his native Greek, in his work *Of the Epidemics*, in describing the lofty expectations and responsibilities of the physician, “the physician must be able to tell the antecedents, know the present, and foretell the future; must mediate these things, and have two special objects in view with regard to disease, namely, to do good or to do no harm” (Hippocrates, 400 B.C.). In this brief and profound disjunction between beneficence and non-maleficence, Hippocrates laid the foundation for the physician-patient relationship. Although it is unclear what he meant by the responsibility of the physician to have these “two special objects in view with regard to disease,” the interaction of these “objects” can itself determine what that obligation entails.

The relationship between the act of doing good and the absence of doing harm is complex, but they seem to be independent concepts. Beneficence and non-maleficence (as well as autonomy and justice) are *prima facie* duties, which is to say, their violation is ethically wrong unless it is justified by another *prima facie* duty (Beauchamp and Childress, 1994). What makes this violation ethically wrong is debated, whether it be a universal, implicit, common morality (Beauchamp and Childress, 1994), the result of the explicit consensual relationship between the physician and the patient (Engelhardt, 1996), or a fiduciary responsibility based on that agreement (Sharpe, 1997). Regardless of the basis of the morals of these tenets, their application is certainly problematic. Their frequent contention often serves as the source of many bioethical dilemmas, where the desire to do good competes with the risk of harm, such as the ethics of clinical research, emergent obstetrical procedures, and living organ donation. The physician-patient relationship depends on the equilibration of these two conflicting principles.

Practically, the issue is the question of how a physician ought to decide between action, on the one hand, and

passive inaction on the other, when the outcome of either choice is not reliably predictable. The obligation to do good would motivate him to act, whereas the obligation to do no harm prevents action that may cause harm.

Assuming that the outcome is unknown, action on the physician’s part could cause harm or benefit to the patient, while passive observation could equally result in harm or benefit. This is to exclude most clinical scenarios, where reliable data indicates predictive values and a risk-benefit ratio is somewhat calculable. However, in cases with unknown or unclear statistics, there are two possible outcomes that can be reached by either of the two paths. It is obvious that with more predictive data, more justifiable – and therefore, more ethical – decisions can be made; however, without any information other than the 50% chance of one of two possible outcomes, can the physician make an ethical decision, or is he left to trust his instincts and roll the dice?

The fact of the matter is that even with hard, reliable data, the physician makes many choices that combine his own clinical knowledge, practical experience, and intuition. Ultimately, however, it is the “moral judgment” of the physician that determines his decision in an ethical dilemma (Sulmasy, 1998). However, there seems to be an argument for the desire to actively intervene in an attempt to benefit the patient as opposed to withholding active treatment for fear of maleficence.

It seems that at the very heart of the practice of medicine, one can find implications that, in unpredictable scenarios, action supersedes non-action. Although it is impossible for the physician to foretell the future, as Hippocrates expects, it seems intuitive that passive observation on the part of the physician leaves the medical problem that exists to resolve itself. In fact, in such a case, the lack of active intervention on the part of the physician is comparable with his absence altogether – if he is not acting, what aid does he offer the patient? The patient is left to fend for himself against the disease.

Obviously, in many cases, pathology is in fact self-limiting, and the patient is able to cure his disease even without the active aid of the physician; conversely, in unfortunately too many cases, the action of the physician is actually detrimental to the health of the patient. Furthermore, well-informed observation can often be the best (and most affordable) route to take, even if the ego of the physician is harmed by his helplessness.

Nonetheless, it seems that the pro-active decision to

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treat in an attempt to benefit the patient, even at the risk of harm, would be morally palatable relative to the alternative – passive observation in order to avert the risk of potential harm. If the decision is to act or not act, and the two possible outcomes of either scenario are benefit or harm, should we expect the physician to stand idly by and observe, in the hopes of a positive outcome? This hardly seems morally acceptable. *Anyone* can passively observe and hope for the best. Physicians enter the field of medicine because it is a field of active beneficence, which gives rise to an inherent desire, motivation, and responsibility to heal, not just to allow the patient to heal himself. The decision to treat versus to observe is obviously based on the rigorous education and training the physician endures, but in the uncertain cases with no other facts and a decision with two possible outcomes, the moral physician should certainly choose action over passivity.

Furthermore, the future of medicine would certainly suffer if fear of possible maleficence would prevent action and possible beneficence. Active clinical research would certainly be affected, where the potential benefit and harm is essentially unknown, but both clinician and patient – via informed consent – choose action. This topic presents a variety of other bioethical issues not to be discussed here, but the relative point is that without patients volunteering to participate in clinical research for fear of the possibility of harm, the potential benefits would never be realized and the progress of medicine would come to a halt. It is that active volunteering on the part of the patient and the active motivation to heal on the part of the physician that drives to motor of research and thereby determines the future of medicine. The argument presented is not that physicians ought to always act as opposed to refraining from action; that sort of blanket statement would certainly spawn many malpractice suits. Rather, the often-quoted principle of “*primum non nocere*” is misleading. Ideally, neither beneficence nor non-maleficence would dominate; they would co-exist in a delicate equilibrium. Unfortunately, their frequent opposition forces medical practitioners into an ethical dilemma. It seems that in such a dilemma, the principle of “*first, do good*” should actually prevail, and not the accepted dogma of “*first, do no harm.*” Practically, in the situation of an unknown outcome, this may mean, “*first, attempt to do good,*” but the principle still holds. The active attempt to do good must triumph over the passive attempt to not cause harm.

Despite changing technology, economics, and science, the principles of bioethics have more or less remained constant over time. The role of the physician is to heal and not to harm, with respect to the patient’s autonomy and just allotment of that care. Despite the fact that the

autonomous patient is significantly different from the patient of a paternalistic medical system, the responsibilities of the physician still rely on the principles of beneficence and non-maleficence. In situations where these principles conflict, the physician is left to make his own intuitive moral decision, but it is possible that the obligation of providing active healthcare outweighs the risk of harm that may occur. The physician is obligated by the oath he takes upon graduation from medical school – whether it be the classic Hippocratic Oath, the Declaration of Geneva, or another oath altogether (Dickstein, et al., 1991; Tung and Organ, 2000; Davey, 2001) – to provide that care, and inherent in this responsibility is risk. So long as that risk is justifiable relative to the potential benefit, the action of the physician ought to be considered morally acceptable, and in fact, commendable.

With further advances in medical technology and our understanding of the basic science of disease, it may become possible for physicians to foretell the future, as required by Hippocrates. Until then, the physician’s responsibility to his patient lies in the basic tenet of beneficence, with simultaneous – but sometimes secondary – concern for non-maleficence. This hierarchy can resolve ethical dilemmas that may arise in the course of the treatment of disease.

NOTE

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