PRIMUM NON NOCERE MALEVOLUS

A REFLECTIVE REPORT ON ETHICAL ISSUES FACING A HOUSE OFFICER BY

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Being a Foundation Doctor often involves following orders and performing seemingly menial tasks; this experience can be disempowering, with ethical decisions left to more experienced clinicians. But occasionally, amongst our frantic duties, we can overlook simple ethical issues. This essay will present examples of these, which I will use to present some basic ethical and moral responsibilities of a doctor, which should underpin all our encounters.

PART 1: LIMITATIONS OF THE MODERN PRINCIPLES OF BIOMEDICAL ETHICS

"Principlism" is a theory first published in 1979 by Beauchamp and Childress. According to this methodology, any ethical problem is solved by applying the four principles of respect for patient autonomy, non-maleficence, beneficence, and justice.[1] I have found Principlism useful as a 'check-list' to ensure several angles of ethical reasoning have been considered, and in my experience this is how Principlism is commonly used in the clinical setting. However, it relies heavily on intuitive decisions once the principles are 'balanced,' and there are often a variety of solutions which can be arrived at. Senior clinicians will have their own intuitive ways of doing this, informed by experience, but these processes are often inaccessible to a junior.

PART 2: TWO EXAMPLES OF ETHICAL PROBLEMS

CASE ONE: THE TENDENCY TO OVERTREAT IN HOSPITAL PALLIATIVE CARE

Whilst on-call and covering the medical wards at night, I was asked to see an elderly man with pneumonia. He was hypovolaemic and in a drowsy condition. I spent considerable time fumbling over collapsed veins inserting cannulas, administering fluid challenges, and taking samples of blood. I then read his notes and found he had been deteriorating over several days. He had not responded to intravenous antibiotics, and his kidneys were failing. He had been assessed by Critical Care the previous day, who concluded that due to several co-morbidities, he was unsuitable for dialysis on the intensive care unit.

My senior then arrived. He sat the patient's wife down, explained the situation to her, and agreed to cease non-essential therapy. This allowed the patient a peaceful death and was a more holistic approach.

Window of St Luke the Physician, Worcester Cathedral

CASE TWO: TRUTH-TELLING

During my time on a surgical firm, another older man was admitted, with altered bowel habits and rectal bleeding, for further investigations. A colonoscopy was performed, revealing an extensive tumour of the large bowel. The impression was invasive cancer. However, I was told by my seniors not to discuss this with the patient, but rather to wait until further reports and investigations had been performed.

Later that morning I was confronted by the patient, and later the relatives, and asked directly what the test had shown. On this occasion I described some basic appearances of the tumour within the limits of my expertise, but that I was not experienced enough to report more fully. I also discussed the possible diagnoses and which tests would be required. I was therefore honest without conveying the full impression of my seniors.

PART 3: APPLYING ETHICAL PRINCIPLES

Principlism alone hasn't helped me in these situations. In the first example I lacked the intuitive ability to engage in the Principlist framework at all. In the second example I feel my actions were appropriate, and could easily use Principlism to justify them. However, Principlism could also be used to argue the converse, depending on the moral agent. I propose a simple but crucial Hippocratic basis for ethical decisions, involving true harm avoidance. I will then elaborate on the Hippocratic principle of helping the patient, using moral rationale of similar antiquity.

THE PROBLEM OF HARM

The maxim *Primum non nocere*, meaning "first do no harm" is popularly thought of as an essential Hippocratic approach to medicine. However, such a succinct phrase is not found in Hippocrates' writings, which were originally written in Greek, casting doubt on whether the Latin phrase can be considered Hippocratic. More likely it is a mid-nineteenth century formulation, departing from true Hippocratic tradition.[2]

In the 4th century BC, Hippocrates wrote:

"As to diseases, make a habit of two things - to help, or at least to do no harm."

[A Latin translation of the above: "*si subvenire alicui non vales, saltem noli eum nocere*" isn't nearly as concise as the ancient language usually allows!] This truly Hippocratic phrase implies the first principle of a physician is to do good, rather than avoid harm altogether. In the Hippocratic Oath, this ordering of priorities is maintained:

"to help the sick for the good of my patients according to my ability and my judgement, and never do harm to anyone."

Beauchamp and Childress seem to follow the opposite order, placing autonomy and non-maleficience before beneficience. It is possible that this departure from tradition has led to a more risk-averse practice of medicine. To prohibit '*nocere*' is rather wasted if it will shackle the physician from practicing their art. I believe the confusion lies with the definition of "harm."

To clarify the situation, I propose that two types of harm are considered, following these two Hippocratic quotations. The first I will term "Collateral Harm." By this I refer to physical damage. For instance, almost every intervention has side-effects, which are a necessary but inadvertent harm to the patient, and always to be balanced against the benefits of an intervention.

The second type I will term "Malicious Harm." This is an injustice, a wrong or evil inflicted intentionally upon the patient. This type of harm is absolutely prohibited. An example of this is given in the Hippocratic Oath immediately after mentioning avoiding harm; the prohibition of giving a deadly poison, even when requested. Malicious Harm is at odds with the aims of medicine. Therefore *Primum non Nocere Malevolus* would be a better clarification on the maxim for harm avoidance.

One way to distinguish between these types of harm is by looking at the disposition of the physician, and the intention of his actions. For example, a dying person can be given morphine as pain relief, which may hasten death in large doses. But unless a drug has been given to intentionally injure the patient, then the physician has done no Malicious Harm in prescribing it.

In Case One, the harm of over-treating was not Malicious, because I had good intentions. What I had not taken into account was minimising Collateral Harm, which is essential in Palliative Care; to quote Hippocrates "... at least to do no harm."

In Case Two, I had caused worry to the patient (Collateral Harm) by discussing the provisional diagnosis. However, to withhold this would be Malicious Harm, by neglecting my duty of care (E.g. GMC good practice of respecting the patient's right to information).

Now that I have applied a correct understanding of harm avoidance, how can I enhance the true Hippocratic principle of 'doing good'? To do this I will look at the disposition of the physician and the intention of his actions, in a similar way to how Malicious Harm can be differentiated:

DOING GOOD

Virtue Ethics is an excellent way of preserving and fostering the intention of helping patients. It is an ancient ethical system first developed by Greek philosophers Socrates, Plato and Aristotle[3]. They proposed that the moral character of the agent is important in finding the right solution to a problem. Put simply, good people are more likely to do good things. By exploring how a virtuous character can be developed by habitual practice, one can find the qualities which will lead to being a good doctor. The classically defined virtues are courage, prudence, temperance and justice. These are termed 'cardinal' virtues, after the Latin *cardo* or *hinge*, since they are the hinges upon which the door of the moral life swings.

Virtue Ethics considers the motivation behind the action to be of crucial importance. To have dealt best with Case One, the way my senior did, requires a virtuous character with elements of compassion, prudence and temperance. In Case Two, withholding truth would be excluded, since a virtuous doctor has qualities of trustworthiness and integrity. Good virtues guide a doctor in discerning the best way to give information to the patient. Ultimately, a virtuous doctor will put their patients first, thus avoiding Malicious Harm.

PART 4: CONCLUSION

Medical ethics is not merely a checklist produced when common 'ethical issues' arise; it is a necessary daily tool to inform practice. My clarified maxim *Primum non nocere malevolus* provides a better foundation of the most basic aim of medicine, and Virtue Ethics helps avoid this malicious intent by exhorting virtue. I have begun to appreciate that there is a need to develop an informed conscience, and for a desire to do the best for one's patients. I encourage a more holistic implementation of medical ethics, guided by the great moral philosophers of the past.

REFERENCES

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