FIRST DO NO HARM: STILL RELEVANT AFTER ALL THESE YEARS?

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Conflicts

• None to declare

• Opinions expressed are those of thepresenters
References


Route (1)

- What do we see as the problem?
- Historical context
  - Roots
  - Change over time
- Balancing imperatives – no absolutes
  - Trouble with invoking the principle
- Postulate an ‘out and back’ shift in modern eras
Route (2)

• Notion of harm
  • Risk
  • Undue harm
• Whose perception of harm?
• What can harm embody – patients as whole beings
• Surprising return to needing the guidance of the principle in everyday decision-making
Primary claims

- The invocation has likely been incorrectly attributed.
- It is mis-used in the modern age.
- The wise practitioner recognizes the principles’ utility and limitations – this has likely always been the case.
- For most of our cohort’s lifetimes, *primum* need not have been attached to the principle.
- Increasingly, we should invoke the spirit of this principle in our decision-making.
The problem

• People invoke the maxim as a hallowed truth, made more reverent by grounding it with reference to the birth of the practice of medicine.

• Attribution is likely incorrect anyway.

• Application historically and currently may be substantively and contextually different.

• Over-simplification in its application risks rendering it meaningless.
Public discourse

• Used to justify rejection of public health measures (vaccinations)
• Used to argue multiple sides of end of life debates (assisted death)
• Confused regarding the complexities of multiple treatment options, including doing nothing (surgery)
• Scientific advancement (NICU)
Derived comfort…

• The principle has been exceedingly useful
  • Research
  • Practice of medicine
  • Public health
  • Rigorous drug approval process

• Its relevance is re-emerging, and in a helpful way
Historical context

• Defining Primum Non Nocere and establishing its roots
• Hippocratic Oath and contextual interpretation
• How the maxim came to be used through time
• What stimulated its emphasis
• Similarities in other traditions
The Hippocratic Oath

- I swear … to bring the following oath and written covenant to fulfillment…
- …I will use regimen for the benefit of the ill in accordance with my ability and my judgement, but from [what is] to their harm or injustice I will keep [them].
- ... And in a pure [hagnos] and holy [hosios] way I will guard my life [bios] and my techne.
- I will not cut, and certainly not those suffering from stone, but will cede this to men [who are] practitioners of this activity.

The Edwin Smith Papyrus

1803, H Humphrey. London.
“Breathing a Vein”
A doctor prepares to lance a patient’s arm. Red figure Aryballos, ca. 470 BCE, Paris, Louvre.
http://upload.wikimedia.org
Vomiting Man: From A cup by the Brygos Painter (ca. 490-480 BCE)
"Alexander [of Tralles] the Wise Doctor (latrosophist = professor of medicine)"; France, late 8th c
Pre-anesthesia amputation: St Thomas Hospital, Southwark
http://www.mpiwg-berlin.mpg.de/resrep00_01/images/Jahresbericht_img.large/140.jpg

Boston, October 16, 1846: first public surgical operation using ether
(painting by Robert Hinkley)
Beneficence/non-maleficence

• Gillon nicely describes moral obligation to not harm all others and any others
• No moral obligation to benefit all others or any others
• Positive duty however to benefit specific others - eg. in health care roles
Balance on a continuum

• Further, adhering to face-value maxim would lead to therapeutic nihilism.

• But we can weigh risk of harm in the context of opportunity for benefit.
www.ancient.eu

Medicine-Ancient History Encyclopedia
What is harm

• Harm in whose eyes

• Who is the subject of harm (in therapeutic context)
  • Individual
  • population

• Harm matrix
  • Risk of occurrence
  • Degree of harm
Conscious Craniotomy

Seeker7.hubpages.com
A History of Gruesome Medical Cures
M & M conferences

• Only in the early 1900’s that Dr. Ernest Codman (Mass General) stimulated interest in addressing medical harm in a systematic way.
  
  • published and classified errors and their outcomes
  
  • Created the “End Result Hospital”
  
  • Too novel and critical for the day. Ostracized.
    
    • *Qual Saf Health Care* 2002; 11:104-105 doi 10.1136/qhc.11.1.104
Sound clinical judgement

• Brewin (*Lancet*) – no primacy, but useful
  • Be aware of the possibility that your action could cause more harm than sought-for benefit
  • Be attentive to treatment side-effects on patients
  • Formally study possibility of harm (eg RCT)
  • If not much chance for benefit, assure no harm
  • Gut sense that people might view treatment harm as worse than harm arising from non-treatment
Patient’s eyes

- Risk of harm in doing nothing

- Physiologic harm in context of desired and possible benefit
  - Physiologic and other

- Whole person harm in context of desired and possible benefit
  - Physiologic and other
Amputation in the Middle Ages
Sharpe (1)

- Describes the mid-century response to medical paternalism
- Commitment to benefit and non-harm was buttressed by acknowledgement of the right of self-determination (Enlightenment liberalism)
- Medical ethics arose to address this emerging complexity
- Law and ethics entrenched patients’ right to make informed choices about the risks they are willing to bear
Sharpe (2)

- Traditional commitment to ‘me’ as the patient wasn’t enough safeguard against harm to ‘me’.
- Incorporate my perspective about how I perceive harm and benefit to myself.
Last half of 20th century

• Enamoured by tremendous advances in medical capabilities
• Appreciative of expansion of care programs
• Reliance on informed consent and possibly lulled by a fascination with ‘respect for autonomy’
• Little recognition of institutionalized harm in care delivery
• Comforted by rigors of research and regulatory approvals
Last half of the 20th century

- Could readily focus on provision of beneficial care/interventions and the achievement of benefit as perceived by the autonomous patient.
Sharpe (3)

- Exploration of Pellegrino’s thesis (with Thomasma) about the healing relationship
  - Fact of illness – inheres vulnerability of patient
  - Act of profession – declaration of special knowledge, which can help, and which the practitioner will apply in the person’s interest
    - Meeting ground entails trust
  - Act of medicine – what is wrong and what can be done about it?
    Then what *should* be done.
Sharpe (4)

• So in the context of the healing relationship, what does ‘do no harm’ mean?
  • “healing is a moral enterprise oriented to patient well-being.”
  • An admonition to the healer to not abuse their authority or expertise
  • A call to the healer to be faithful to the trust platform that was mutually made
Claim

- Increasingly, over the past 15 or 20 years, the practice of medicine and the business of healthcare ought to use the invocation to consider first the potential for harm to the persons that we purport to help.
The need for the principle (1)

- Iatrogenic harm
  - Despite care being initiated for benefit
  - Preventable harm
- Risk of unnecessary treatment (FFS era)
- Risk of denials of care (managed care era)
  - NY Times story (March 2, 2015)
The need for the principle (2)

- Dramatic advancements in what is technically possible, alongside death-defiance
- The hegemony of functioning physiology (‘we can and we must keep the organs going’)
- Discounting:
  - Nature of personhood
  - Arc of one’s life
  - Medicine as a mere intervenor
Longevity and health

• New concept of the ‘disabled aged’
• Expected longevity increases are celebrated
• Focus is increasingly on years to live with substantial functional impairment
• Case for special moral consideration when the functional decline involves challenged sentience and uncertain agency, along with our commitments to decency and dignity for the uniquely vulnerable
Meanings

- In the literal sense of primum non nocere (perhaps its origins)
- In its sense as medicine was defining itself and establishing its credibility
- In the absorption of the patient’s informed voice as integral
- In Pellegrino’s account of the healing relationship
- In the emergence of an increased risk of harm to the whole person by ‘doing something’ (medically)
www.history.com

(7 Unusual Ancient Medical Techniques)
Primum, non nocere

• There is still no justification for it to be, or to newly become, the over-riding imperative.

• But remains deeply entrenched within the notion of overall person-benefit within a trusting (and informed) relationship

• Justification for a renewed call to consider carefully the risk of person-harm as we weigh care and intervention options with our patients.
Discussion

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