ETHICS MAN **Daniel K Sokol**

"First do no harm" revisited

Following the dictum means balancing moral principles

Clinicians of every ilk enjoy aphorisms. Favourites include "time is brain" and "common things are common."

Yet, surely no medical saying is better known than "first do no harm" or, to use the Latin phrase, "primum non nocere." PubMed shows that there are currently 393 articles with "do no harm" in the title.

Contrary to popular belief the phrase does not appear in the Hippocratic Oath or the Hippocratic corpus (Hippocrates wrote in Greek, not Latin). Rather the saying is attributed to Thomas Inman, as recently as 1860.[1] That same year Oliver Wendell Holmes Senior famously remarked in a lecture to the Massachusetts Medical Society, "If the whole materia medica, as now used, could be sunk to the bottom of the sea, it would be all the better for mankind—and all the worse for the fishes.'[2] He observed that the injuries caused by overmedication were often masked by the disease.

"First do no harm" remains an important injunction against overtreatment. Yet, like many axioms or aphorisms, it is a crude piece of advice. Clinicians inflict harm all the time, whether it is by inserting a cannula, administering chemotherapy, performing a tracheotomy, opening an abdomen, or drilling into the skull. Most attempts to benefit a patient require the infliction of harm or, at the very least, involve risks of harm. The clinician's hope is that the benefits will outweigh the harms. A literal reading of "first do no harm" would, therefore, lead the clinician to do nothing at all.

A more accurate formulation is "first do no net harm." The Latin translation does not roll off the tongue: "primum non plus nocere quam succurrere" ("above all, do not harm more than succour").

At an individual level, clinicians must balance their obligation to benefit the patient (the principle of beneficence) against their obligation not to cause harm (the principle of non-maleficence). These twin obligations go hand in hand and are weighed against each other.

At times, it is difficult to evaluate which trumps the other, as the risks and benefits are unclear. There is considerable debate, for example, on the appropriateness of decompressive craniectomy after severe traumatic brain injury. The procedure involves removing part of the skull to allow the injured brain to swell to reduce intracranial pressure. The operation may lower the chance of death but can leave survivors with profound disabilities.

The decision will be informed by the clinical facts, but the harm-benefit analysis will also involve value judgments about what constitutes an acceptable risk or an acceptable quality of life. The same applies, for example, in decisions on whether to perform a tracheotomy on a critically ill patient. If a terminally ill patient might survive an additional six months with aggressive care, should the tracheotomy be done?

A wise clinician will say, "It depends partly on what the patient wants." The perception of what constitutes a harm and a benefit varies from person to person. In many situations the patient can tell the medical team how he or she balances the harms and benefits. Given this variability, the principles of beneficence and non-maleficence are best assessed in light of the principle of respect for autonomy. However, in cases of severe injury, including those where decompressive craniectomy is contemplated, patients may be unable to express their autonomous preferences. Well drafted advance directives can obviate such problems, but these documents are rare in Britain.

The application of "first do no net harm" also arises at the interpersonal level. In vaccination programmes the balancing exercise is usually straightforward. The benefits to the many will outweigh the harms to the few. In other contexts the exercise will be fraught with difficulty. In a recent article in the *Journal of Clinical Ethics* a doctor recalled a dilemma she faced when working in a hospital in Port-au-Prince, Haiti, after the 2010 earthquake.[3] Four patients presented in respiratory distress. There were no ventilators and only one oxygen tank. One patient was a neurologically devastated 15 year old girl with treatable pneumonia. Another was a 40 year old woman with HIV, suspected tuberculosis, and three young children at her bedside imploring the staff for help. Another was a 25 year old nurse with a probable pulmonary embolism resulting from major bowel surgery. The fourth patient was a beautiful 18 year old girl with acute decompensated heart failure.

The doctor's first choice was the nurse, even though the 15 year old was the most medically salvageable in the short term. The doctor asked, "Did I make a medical judgment based on a co-morbidity or a value judgment based on my own latent biases? I am honestly not sure." This dilemma shows that balancing harms and benefits is not a purely clinical exercise.

On close inspection "first do no harm" is a flawed dictum.[4] "First do no net harm" is better but still needs to be interpreted in the context of other moral principles, such as justice and respect for autonomy.

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