education through calendars fits in well with the child to child programme, provided every school in the country can have a calendar for each classroom, but lack of resources may make even this simple objective unattainable. The overall pupil to teacher ratio in Lesotho at 54 to one is the highest in English speaking Africa. It is the rule rather than the exception for two classes to share one classroom; open air classes or classrooms with thatch or metal roofs supported on pillars are common. Where do you hang the calendar if the classroom has no walls? Nevertheless, mobilisation of schools and teachers in the health education process can help in the interpretation and spread of the message carried by the calendar.

Primary health care is about community health development through better nutrition, safe water, sanitation, community participation in health activities, and so on. It is very different from "first contact care" with which it is often confused even though maternal and child health as well as treatment of common ailments feature among the nine activities described by the World Health Organisation as comprising primary health care. It is dependent on health planners and managers as well as on the presence of workers in the community. On the other hand, a do it yourself approach in health is now being promoted by the United Nations Children's Fund (UNICEF) as GOBI (Growth monitoring, Oral rehydration, Breast feeding, and Immunisation). It places the health initiative on the shoulders of the parents. A health calendar aimed at the promotion of GOBI activities may even draw support from UNICEF. In its expanded form—GOBI-fff (food supplementation, family planning, and female education)—this approach shares out responsibilities between parents and planners since the activities represented by the three fs largely need governmental initiative.—G J EBRAHIM, Institute of Child Health, London.

References

1 National Development Service and UNICEF. *Communicating with pictures*. Kathmandu: UNICEF, Box 1187, Kathmandu, 1976.
2 Fuglesang A. Picture style preference. *Overseas Visual Aid Committee Bulletin* 1970;22:46-8.
3 Kwansa EVG, Cannon JA, Belcher DW, Hosu-Porbley M. Perception and comprehension of health education visual aids by rural Ghanaian villagers. *Ghana Medical Journal* 1972;11:387-96.
4 Leonard A. *Sin Palabras* (without words). New York: Cycle Publication, POBox 3923, Grand Central Station, New York, 1979.
5 Hudson W. Pictorial perception and educational adaptation in Africa. *Psychologia Africana* 1962;9:226-39.

Philosophical Medical Ethics

"Primum non nocere" and the principle of non-maleficence

RAANAN GILLON

Among the shibboleths of traditional medical ethics is the injunction "Primum non nocere"—first (or above all) do no harm. A recent textbook of psychiatric ethics calls it "the cardinal ethical principle sacred to medicine,"[1] and Veatch lists a representative collection of contemporary medical obeisances to this Latin tag.[2] While there is undoubtedly an important moral principle here, I shall argue that it does not have the simplicity, the absoluteness, or the priority that these words suggest.

No one seems to know the origins of the phrase "primum non nocere." It is not a literal translation of any part of the Hippocratic Oath, which requires doctors to do what they consider beneficial for their patients and to "abstain from whatever is deleterious and mischievous"[3]: nothing about "first" or "above all" do no harm there. Another possible source is a work in the Hippocratic corpus—the *Epidemics*.[4] However, the obscure literal translation of the relevant passage is simply: "To practise about diseases two: to help or not to harm"; and in the standard English translation Jones has "As to diseases make a habit of two things—to help, or, at least, to do no harm." A third possible source is a translation of the *Epidemics* by Galen, but he attached the "above all" to helping rather than to avoiding harm.[4] Thus the claim that avoiding doing harm must take priority in medical ethics does not even have the authenticity of Hippocratic tradition—though even if it did, as I shall argue, it would be untenable.

Imperial College of Science and Technology, London SW7 1NA
RAANAN GILLON, MB, MRCP, director, Imperial College Health Service, editor *Journal of Medical Ethics*, and associate director, Institute of Medical Ethics

Avoiding harm versus doing good

The claim that avoiding harm has priority over doing good is vigorously contested in moral philosophy. An interesting sample of the detailed arguments appears in a paper by Phillippa Foot in which she argues for the claim that "other things being equal, the obligation not to harm people is more stringent than the obligation to benefit people"[5] and in a detailed criticism of her paper by Nancy Davis,[6] who argues, primarily by counterexamples, that no such general priority can be defended. At first sight Foot's thesis is undoubtedly plausible. We seem to have what Kant called a perfect (though, many would add, only prima facie) duty to all other people not to harm them. On the other hand, we do not have a duty to benefit all other people; apart from everything else it is incoherent to talk of a duty which is impossible to fulfil. Thus at most we can have a duty only to benefit *some* other people (an imperfect duty), while we have a perfect duty to everybody not to harm them.

While it seems entirely plausible to claim that we owe non-maleficence, but not beneficence, to everybody, it does not follow from this that avoidance of doing harm (non-maleficence) takes priority over beneficence. All that follows is that the scope of non-maleficence is general, encompassing all other people, whereas the scope of beneficence is more specific, applying only to some people. Thus we can accept that each of us has a (prima facie) moral duty not to harm anybody else without being committed to believing that this prima facie duty must always take priority if it conflicts with any duty, including any duty of beneficence we may have to particular people or groups of people.

No necessary priority for non-maleficence

The implausibility of the priority of non-maleficence can be shown by considering counterexamples. Medical practice often involves doing or risking harm to achieve a greater benefit for an

individual—certainly the patients concerned would often vigorously contest a proposal that such risks should not be taken on the grounds that non-maleficence has moral priority over beneficence. (Equally, of course, in some cases they would consider the risk of harm to weigh heavier than the prospect of benefit.) At an interpersonal level vaccination programmes harm a few (those who suffer serious or fatal side effects) for the greater benefit of many. Driving motor cars harms some (the accident victims) for the benefit or at least pleasure of many. Taxation in proportion to means usually harms the taxed to benefit, among others, the sick, the hungry, and the poor—yet few would go along with Nozik[7] and claim that it was wrong to harm people by taxing them for these beneficial purposes.

Various ways of meeting such counterexamples to retain the principle that non-maleficence has moral priority over beneficence have been proposed. They include the doctrines of double effect, of the moral priority of acts over omissions, doings over allowings, negative over positive duties, and ordinary over extraordinary means. I shall return to some of these in subsequent articles. Meanwhile suffice it to say that the claim that the general principle of non-maleficence necessarily has moral priority over any other moral principle, or even that it necessarily has priority over beneficence, cannot be sustained without considerable qualification; and many would argue that it cannot be sustained at all.

Therapeutic nihilism

In the case of medical ethics it is even more difficult to sustain, for in many clinical circumstances it simply makes no sense to separate beneficence and non-maleficence (some philosophers believe that it never makes sense to separate them and see non-maleficence as merely an aspect of beneficence.[8]) As the Hippocratic Oath says, the moral objectives in medicine are both beneficence—to help sick and suffering people—*and* to prevent harm in terms of both preventing deterioration of existing illness, damage, and disease and finding ways to prevent them in the first place. In both sorts of activity harm may be necessary to achieve benefit, risk of harm to achieve probability of benefit. A patient with a melanoma on her foot may have to lose a leg to save her life; a patient with Hodgkin's disease may have to undergo exceedingly unpleasant risks, including perhaps sterility, to have a reasonable chance of survival. Beneficence and non-maleficence in medical practice usually have to be considered and "weighed" together. If, however, the injunction "first (or above all) do no harm" were really to govern medicine such balancing would be prohibited and doctors would have to avoid intervening whenever there was a risk of harming their patients (or others)—which would be almost always. That way lies therapeutic nihilism, or minimalism, regardless of the potential benefits to be attained by risking more. Indeed, an American physician has suggested that it is just such a principle which guides the Federal Drugs Administration and prevents it from allowing American doctors to prescribe drugs which have been thoroughly investigated and accepted (despite their inevitable risks) in other countries.[9]

In inveighing thus against "primum non nocere" I am not opposing acceptance of the extremely important moral principle that one should avoid harming others. It is not, however, an absolute principle; it does not necessarily have priority in cases of conflict with other moral principles; and when there is also a moral obligation of beneficence the principle of non-maleficence has to be considered in that context. Similarly, and like the principle of beneficence itself, the principle of non-maleficence may conflict with the principles of respect for autonomy—for example, the patient may want to take bigger risks of harm in the pursuit of benefit than the physician would advise—and at least occasionally it may conflict with the principle of justice (the patient with Lassa fever may refuse to go to an isolation hospital, yet justice to others may override non-maleficence and require his compulsory isolation). All these complexities and qualifications are negated by the simplistic and apparently bogus formulation "primum non nocere": but stripped of this oversimplification the prima facie principle "non nocere" is a vital one for medical ethics.

Balancing risks and benefits

Perhaps its greatest importance is as a counterbalance to the doctor's primary special obligation to benefit his patients. Such benefit must always be assessed in the context of the risks and sometimes inevitabilities of harm which medical attempts to benefit so often entail. Moreover, just as I argued in the last article that benefit has to be assessed in the light of the principle of respect for autonomy, so too does harm. People's perception of harm, like their perception of benefit, is idiosyncratic, an integral part of the way they see themselves and of their life plan. One aspect of people's life plans is what the American lawyer Charles Fried calls their risk budget,[10] whereby people decide (however inchoately) the sorts of ends they wish to achieve and the sorts of risks—including risks of death—which they are prepared to take in pursuit of those ends. Although there are doubtless some general similarities, especially within fairly homogeneous societies, each person's risk budget is unique. Therefore it is important when applying the principle of non nocere to be aware of the individual's own assessment of what counts as harm. Once again this constraint on the principle of non-maleficence can be justified either on utilitarian grounds of maximising welfare or on Kantian grounds, in which respect for persons and their autonomy is the fundamental justification.

Albert Jonsen, an ex-Jesuit and a leading American medical ethicist (as they tongue twistingly insist on calling themselves), discerns several important moral strands entangled within the (sanitised) principle of non nocere. One reminds doctors that medicine is essentially a moral enterprise in which the infliction of harm, which is so frequently required in medical practice, can be justified only in the interests of "human benefit." (It is important here to distinguish between benefit to the patient—the primary special obligation of a doctor—and benefit to others, whether these be the patient's family, other patients, or people more generally.) A second strand reminds doctors that in assuming care they also assume an obligation to exercise "due care" (and once again such factors as an adequate medical training, regular postgraduate updating and audit can be seen as being required by the principle of non-maleficence). Two more strands remind doctors of the need to balance intended benefits against risks and inevitabilities of harm, physical, psychological, and social, as evaluated not only by the doctors but also by the patients and by society. Another strand reminds doctors of the problem that the Roman Catholic doctrine of double effect was designed to answer—notably, that one needs a way of assessing how to act when a proposed good action also has a risk or certainty of unintended but clearly foreseen bad effects. Finally, tentatively and "paradoxically" Jonsen suggests that sometimes it may be "legitimate to invoke the 'do no harm' maxim as a justification for termination of life"[4] (the context makes it clear that he is referring to withholding of treatment for the dying and irretrievably comatose).

Non-maleficence then is a crucial principle of medical ethics, though it usually needs to be considered in the context of coexisting obligations of beneficence and respect for autonomy and occasionally in the context of justice. "Primum non nocere," on the other hand, like, "The patient's interests always come first," is a phrase best consigned to the medical history books.

References

1 McGarry L, Chodoff P. The ethics of involuntary hospitalization. In: Bloch S, Chodoff P, eds. *Psychiatric ethics*. Oxford: Oxford University Press, 1981:217.
2 Veatch RM. *A theory of medical ethics*. New York: Basic Books, 1981:159-62, 344 (footnote 8).
3 British Medical Association. *The handbook of medical ethics*. London: BMA, 1984:69.
4 Jonsen AR. Do no harm: axiom of medical ethics. In: Spicker SF, Engelhardt HT, eds. *Philosophical medical ethics: its nature and significance*. Dordrecht: Reidel, 1977:27-41.
5 Foot P. The problem of abortion and the doctrine of double effect. Reprinted in: Steinbock B, ed. *Killing and letting die*. Englewood Cliffs: Prentice-Hall, 1980:156-65.
6 Davis N. The priority of avoiding harm. In: Steinbock B, ed. *Killing and letting die*. Englewood Cliffs: Prentice-Hall, 1980:172-214.
7 Nozik R. *Anarchy, state and utopia*. Oxford: Blackwell, 1974.
8 Frankena WK. *Ethics* (2nd ed). Englewood Cliffs: Prentice-Hall, 1973:45-8.
9 Gifford RW. "Primum non nocere." *JAMA* 1977;**238**:589-90.
10 Fried C. *An anatomy of values*. Cambridge, Massachusetts: Harvard University Press, 1970: 155-82.