Primum Utilis Esse: The Primacy of Usefulness in Medicine

LAWRENCE J. NELSON

Health Policy Program, University of California, San Francisco, School of Medicine

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The famous and oft-quoted maxim "Do no harm" should not be thought of as the first principle of medical ethics. The documents of the Hippocratic tradition and clinical experience indicate that a more appropriate and helpful first principle would be "Above all, be useful." The concept of usefulness implicitly rests at the very heart of medicine itself and the physician-patient relationship. The failure to adhere to this concept undermines the physician-patient relationship, dissolves the distinction between quacks and physicians, and destroys the integrity of the medical profession. The determination of useful medical treatment belongs to both physicians and patients. Any decision to initiate, continue, or discontinue diagnostic or therapeutic action has both a medical and a personal value component; the former properly belongs to physicians and the latter to patients. Practicing medicine with the intent of producing benefit and being useful to the patient is far more fundamental than practicing medicine to avoid harm.

Primum non nocere (Above all, do no harm) surely occupies a venerable position among the principles of medical ethics. In fact, it is not uncommonly referred to as the first and most important principle governing the ethics of the medical profession: "And the prime rule for the physician must be, as always, primum non nocere" [1]. Physician Bernard Meyer claims that traditionally medicine has been guided by the precept "Do no harm" which transcends even the virtue of uttering truth for its own sake [2]. In a discussion of truth-telling in medicine, Robert Veatch concludes that the prevention of harm is probably the dominant, normative ethical theory operating in medicine today [3].

In this essay I will argue not only that "Do no harm" should be dethroned as the first principle of medical ethics, but also that it did not belong on the throne in the first place. An examination of the historical roots and philosophical foundations of this famous and oft-quoted maxim will show that primum utilis esse (Above all, be useful) should instead be acknowledged as the first principle of medical ethics. The concept of usefulness is an integral part of the very meaning of medicine and of the physician-patient relationship. The requirement that physicians above all be useful to their patients can itself prove more useful in locating exits from the labyrinth of certain ethical problems in medicine than the famous injunction to avoid doing harm.

THE HIPPOCRATIC BACKGROUND

The Latin expression primum non nocere has been widely accepted as the most senior and significant principle of medical ethics. The source of primum non nocere is usually thought to be the Hippocratic Oath. However, the Oath does not contain this
expression, though it does have a statement which is somewhat similar: "I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them" [4]. Neither this nor any other section of the Oath makes mention that the physician ought not harm the patient "above all." This particular statement in the Oath simply says that the physician should attempt to help or benefit the patient by using medical treatments and to refrain from using these treatments to harm or wrong the patient. If the physician can be said to have a first duty, it would likely be to benefit the patient by means of positive therapeutic actions rather than to merely abstain from harmful action. A physician who only avoided harming patients and never did anything of definite benefit for them would not really be practicing medicine, which ultimately must aim at making the sick better.

The precise phrase "Do no harm" appears in the Hippocratic treatise *The Epidemics* (translated literally and somewhat roughly): "To practice about diseases, two things: to help or not to harm" [5]. Other translations of this phrase from *The Epidemics* are "to do good or to do no harm" [6], "to be useful or not to damage" [7], and (Jones' popular version) "to help, or at least to do no harm" [4]. According to Jonsen [5], the Greek text itself offers no justification for the emphatic "above all" phrase which the Latin version of the Hippocratic expression possesses or for Jones' addition of "at least." The precise origin of *primum non nocere* as a conjoined phrase is unknown, but a prominent medical historian believes that it is rooted in the Hippocratic text quoted above [5]. Galen, the second-century A.D. commentator on Hippocrates, does use the Latin word *imprīmis* (above all) in his version of the phrase in *The Epidemics*, but he adds it to the first term rather than the second, i.e., *Above all, to help* or not to harm [5]. According to Galen, then, the physician ought to be concerned above all with being useful to and helping the sick. If the physician is unable to benefit the sick, only then should he specifically turn his attention to not harming the patient.

C. Sandulescu professes to offer a strict philological interpretation of the passage from *The Epidemics* which parallels Galen's.

More explicitly, the sound-minded physician should work in *[sic]* the advantage of the sick people, recovering their health or he must abstain from every intervention in order not to inflict supplementary pains to the patient. To be useful or to be therapeutically reserved concerning the sick, this is the alternate obvious sense of the already quoted Hippocratic text [7].

Sandulescu points out that *primum non nocere* includes only the second term of the actual Hippocratic formula and that it did so because this concentrated, synthetic form better fit the Latin vocabulary. This linguistic fit, he claims, explains its frequent use over the centuries, but the true significance of *primum non nocere* can only be found in the whole of the Hippocratic passage "to be useful or not to damage." Another Hippocratic work, *About the Fractures*, reiterates the same theme found in *The Epidemics*: Be useful to the patient; if you cannot be useful, it is better to abstain from further treatment [7].

Even considering Sandulescu's philological reason for the absence of the first term of the Hippocratic formula, i.e., to be useful, in the Latin maxim *primum non nocere*, it is difficult to understand why the formula was not only truncated, but also why it underwent such a radical metamorphosis of emphasis. If we are to accept Galen's addition of *imprīmis* to *utīlis esse* rather than *non nocere* as a valid and accurate interpretation of the meaning of the original Hippocratic text, then *primum non*
nocere] has clearly forsaken its Hippocratic parentage. From this point of view, therefore, the most authentic Hippocratic first principle of medical ethics would seem to be “Above all, be useful—or do no harm.”

Primum non nocere] not only forsakes its Hippocratic lineage, but it also proves to be a less fitting and useful principle in the actual practice of medicine than its suggested successor, primum utilis esse. In the clinical setting, the sick people we call patients want first and above all to be helped. Louis Lasagna has suggested that the proper medical and moral stance for today's physician is not to avoid harm at all costs, but to optimize treatment [8]. Keeping patients from harm is surely not irrelevant to medicine, but it should not be medicine's primary concern and most fundamental orientation. The concept of usefulness has not yet received the attention in discussions of the teleology and ethics of medicine that it properly deserves. “Above all, be useful” more faithfully represents the original Hippocratic ideal and present clinical reality of medical practice.

THE SIGNIFICANCE OF USEFULNESS IN MEDICINE

The principle “Above all, be useful” rests implicitly at the very heart of the physician-patient relationship. People visit physicians when they are sick, and not plumbers or truck drivers, precisely because there is (or should be) good reason for them to believe that the physician can be of definite help to them in their efforts to be rid of the sickness afflicting them. A sick person comes to a physician because the latter possesses knowledge and skills which the patient needs in order to regain health and wholeness. Yet not all sick people can be helped by physicians and made well. Some diseases and illnesses (as well as some persons' lifestyles) are beyond the therapeutic reach of even the most sophisticated and technologically advanced medical prowess. If one considers death to be a necessary and fitting part of the human condition, then there is at least one health “problem” which medicine should not even attempt to solve [9]. Nonetheless, even in the midst of medical fallibility, ignorance, and error, no one can properly be called a physician who cannot offer healing and caring, to one degree or another, to those suffering from disease. Above all, then, physicians should be able to help the sick.

The requirement that physicians should first of all attempt to help the sick has its own tradition vividly expressed in the various oaths medical practitioners have sworn throughout the ages. Two different sections of the traditional Hippocratic Oath and its Christian counterpart mention that the physician is to work for “the benefit of the sick.” The Hippocratic treatise Precepts echoes the Oath by enjoining the physician “to prescribe what will help towards a cure, to heal the patient,” and the text of another treatise, Ancient Medicine, flatly states that “the art of medicine . . . was discovered for the treatment of the sick” [4]. The medical student's oath found in the Charaka Samkita manuscript of ancient India addresses the issue of benefit in very explicit terms: “Day and night, however thou mayest be engaged, thou shalt endeavor for the relief of patients with all thy heart and soul.” The Glasgow Oath also emphatically binds the physician to helping patients: “I will exercise the several parts of my profession, to the best of my knowledge and abilities, for the good, safety, and welfare of all persons committing themselves, or committed to my care and direction” [10]. The different versions of the Hippocratic Oath all include the injunction to abstain from harming patients, but this is always mentioned after the exhortation to be of benefit. Neither the Oath of Charaka nor the Glasgow Oath contain a “do no harm” statement.
Authentic adherence to the principle "Above all, be useful" embodies the crucial differences between medicine and quackery. Physicians are properly distinguished from quacks and charlatans by their empirically acquired, scientifically tested knowledge and skill. Eric Cassell points out that Hippocrates has been called the father of modern medicine primarily because he introduced the use of science as the basis for the diagnosis and therapy of disease and rejected medical practice founded on magic, superstition, or mystical-religious beliefs [11]. The Hippocratic tradition itself inveighs against quackery and insists that physicians practice medicine based on scientific fact rather than speculation [4]. The Hippocratic focus on science rather than speculation can be seen in the treatise *Precepts*:

However, knowing this [that healing is a matter of time and opportunity], one must attend in medical practice not primarily to plausible theories, but to experience combined with reason . . . [for] conclusions which are merely verbal cannot bear fruit, only those do which are based on demonstrated fact [4].

Quacks, in contrast, only pretend to have the knowledge and skill necessary to practice medicine, i.e., to help and heal sick people. They offer "treatments" which are actually useless for curing or containing disease, and therefore are not authentic treatments at all. Quacks are identified by their pretense to medical knowledge and skill and by the paucity of positive, scientifically verifiable results following from their efforts. On the other hand, someone possessing real medical knowledge and skill can do something useful for the sick individual which can be seen in the patient's improvement and which usually can be referred to and linked with demonstrated facts. The physician can offer treatment of tangible benefit to the patient while the quack offers only what is useless.

Modern physicians want to clearly distinguish themselves from quacks just as the ancients did. In 1912 the American Medical Association published a book called *Nostrums and Quackery* which exposed the numerous fake remedies and phony practitioners available at the time. The preface to this 693-page tome exclaims: "When the veil of mystery is torn from the medical fakes, the naked sordidness and inherent wrongfulness that remains suffices to make quackery its own greatest condemnation" [12]. A more contemporary example of medical concern over quackery is found in the laetrile controversy. One physician has recently suggested that the "true ethics of American medicine" does not allow physicians to idly observe thousands of desperate cancer patients being exposed to a drug of "unknown effectiveness, unknown safety and poor manufacturing quality" [13]. He warns that the image of the physician will "scarcely be enhanced if we stand imperiously on our ivory towers while they [the American public] wallow in a mire of uncontrolled quackery." A tightly controlled clinical trial of laetrile, he suggests, seems the most ethical and humane thing for medicine to do to remedy the current situation. From this point of view, medicine has a positive moral duty to expose quackery by subjecting its alleged remedies to the rigor of scientific validation.

Laws licensing physicians are designed to permit only scientifically trained and qualified persons to practice medicine and to prevent quacks from bilking the public with phony cures. Daniel Callahan has rightly observed that the purpose of these laws is not only to protect the public from incompetent physicians, but also to protect physicians themselves from the presence in their midst of untrained, unqualified quacks [14]. The state's action of preventing quacks from plying their useless and
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dangerous trade protects physicians as well as patients. Both are harmed by those who can do nothing useful medically for sick people in need of help.

"Above all, be useful" as a first principle of medical ethics strongly suggests that any invasion of a patient's bodily integrity must be justified by some legitimate diagnostic or therapeutic goal which the patient willingly chooses in his or her quest to get well. Persons are not to be medically tinkered with by physicians merely for their own education and profit or to keep them busy. Competent physicians should be able to articulate good reasons for holding that their interventions will be of tangible benefit to their patients. This should become an increasingly rigorous requirement as the mortality and morbidity of the intervention increases. A patient's body and mind (that is, the patient's very self as an embodied consciousness) ought not to be interfered with by physicians or anyone else unless something useful for that patient can reasonably be expected by sticking his veins, giving him drugs, initiating psychotherapy, or putting him under the knife. A person's bodily, personal integrity demands that all medical intrusions into it be adequately justified by the usefulness and suitability to the person's condition of the information or effects that will be produced. (This argument is purposefully limited to therapeutic interventions and does not directly pertain to medical research. Certainly persons who are given adequate information can freely and legitimately allow themselves to be involved in research which will not be useful to them personally.)

Consider medicine's vast armada of drugs. The etymological root of pharmacology is the Greek word pharmakon meaning drug, remedy, poison, and charm. It does not require much imagination to see that many drugs available to physicians and their patients are a curious combination of remedy, poison, and charm. Simply put, most drugs used in medicine are not completely benign. According to physician Herman Blumgart:

Even the most commonly used agents such as quinidine, digitalis, the thiazides, and hormonal agents such as thyroid, insulin, steroids, and progestins carry considerable risk... In the use of many drugs, the upper therapeutic range is perilously close to the level that causes toxic and other untoward effects [15].

Most drugs, then, are legitimately called therapeutic because they are expected to do more good than harm (though some kind of harm—pain, discomfort, organ dysfunction, etc.—is also expected). Therefore, on balance they will benefit the patient and be useful in restoring health.

The example of drug therapy reflects an important component of medical practice: many, if not most, diagnostic and therapeutic maneuvers are only proportionately useful to the patient, that is, they almost universally carry the threat of harm as well as the promise of benefit. Often these procedures actually do produce harm of one kind or another, e.g., anti-cancer drugs frequently cause nausea and vomiting. If physicians were to strictly adhere to primum non nocere, a great many of medicine's tools would be permanently banned. If physicians should strive above all to do no harm (above even producing proportionate benefit), then medicine would have to abandon much of what is presently held to be appropriate, standard therapy. In treating patients, physicians are forced to make judgments about which surgery, procedures, and drugs are likely to yield the most benefit and the least harm. The Hippocratic work Joints contains a passage which reflects the ancient tradition behind this practice: "What you should put first in all the practice of our art is how to
make the patient well; and if he can be made well in many ways, one should choose the least troublesome. This is more honorable, and more in accord with the art" [16]. Medicine’s primary goal, therefore, is not to avoid harm but rather to be useful to the patient by making him or her well and to end up doing the patient more good than harm.

Useless treatment is really mistreatment. Doing that which is useless definitely harms the patient and can also harm others such as the patient’s family and society in general. Useless treatments poison patients’ trust that the physician will be of benefit to them in their diseased and vulnerable state. Useless treatments also violate the patient’s bodily integrity. Any significant, direct intervention into the body of another must be justified, particularly when that intervention generates tangible danger of harm. A patient’s family has similar legitimate expectations that the physician will do only that which will help mom, dad, brother, sister, or grandparent. When a physician does anything useless to a patient, both the patient and those close to him are being cruelly deceived, not in words but in actions.

The major harm of useless treatment to society (besides the possibility of a general erosion of trust in medicine) comes in the form of unnecessary and burdensome costs. Any medical treatment, whether useful or useless, tends to be quite expensive. Medical costs are skyrocketing, and unfortunately there seems to be no end in sight. Clearly, medicine cannot be responsibly practiced if absolutely no attention is paid to the costs of what is being done. Although control of the cost of medical care is an extremely complex and difficult task which does not belong exclusively to physicians [17], they ought not to shirk their responsibility to take the problem seriously. Balancing the costs and benefits of a medical procedure such as computed tomography is not an easy task: how, for example, is one to put a dollar value on the reduced mortality and morbidity achieved by CT as compared with present procedures [18]?

However difficult the task may be, medicine should be careful about what it accepts as useful, standard practice. If medicine will not and should not accept laetrile without a rigorously controlled clinical trial [13], why should it accept any unproven procedure or drug? Unfortunately, there is evidence that quite a few useless procedures have crept into medicine’s repertoire within the last twenty years. Howard Hiatt has identified a number of procedures once practiced widely in this country but now abandoned: gastric freezing for peptic ulcers, colectomy for epilepsy, bilateral hypogastric-artery ligation for pelvic hemorrhage, renal-capsule stripping for acute kidney failure, sympathectomy for asthma, internal-mammary-artery ligation for coronary-artery disease, adrenalectomy for essential hypertension, lobotomy, and wiring for aortic aneurysm [19]. Hiatt notes that most of these practices did not disappear because they were replaced by better procedures (which he rightly believes would have been a medically appropriate reason), but rather because they were finally shown to be useless. No controlled studies evaluated these procedures when they were first introduced. Gastric freezing of peptic ulcer, for example, was supported by an uncontrolled study which ultimately proved to be an unreliable indicator of the therapy’s true value [20]. This same pattern has occurred with other new therapies as well [21–23].

“Clinical efficacy is an important consideration with any new technic” [18]. Surely this is an understatement. What could be more important to medicine than the clinical efficacy of any procedure or drug? Cost, availability, and safety are important considerations too, but without clinical efficacy these factors are irrelevant. A new procedure (or an old one, for that matter) may be quite inexpensive, easily available,
and extremely safe, but unless it is clinically effective, it has no place in medicine. However, Hiatt points out that clinical validation of a practice is not by itself adequate reason for its dissemination; it must be shown to be more effective than other practices available for the same medical problem [19]. In sum, even though randomized clinical trials cannot always be done [24–26], medicine should make every reasonable effort to verify empirically the clinical usefulness of its practices, especially since once a practice becomes popular (for whatever reason), it is hard to abandon. The controversies surrounding laetrile [13], universal fetal heart monitoring [27], and coronary-artery bypass graft surgery [28–30] have all been fueled by the lack, or alleged inadequacy of, controlled clinical trials. David Rutstein has suggested that it may be unethical not to perform a controlled human experiment since the absence of controlled trials may allow harmful (or useless) practices to become commonplace [31].

However, it should be noted that controlled clinical trials are not the sole foundations of proper medical practice. Robert Gordon has suggested that there can never be enough clinical trials to answer more than a few major questions in medicine definitively. For this reason, "cookbook medicine" will never become a reality: most patients will not completely resemble the population of completed clinical trials, physicians will have to interpolate and extrapolate from published results, and physicians will have to fall back on their clinical experience and intuition [32]. In short, medicine is not practiced solely on the basis of hard data, appearances of the modern medical center notwithstanding. Nevertheless, physicians should strive to base their therapeutic interventions as much as possible on scientific evidence rather than on anecdote and what is popularly and often uncritically accepted.

The integrity and character of the medical profession rests on its ability to be of definite, demonstrable benefit to the sick and to avoid doing that which is useless and harmful. Conscientious physicians should never do what in their best clinical judgment is useless—even if requested to do so by the patient himself, his family, or an overzealous colleague. Physicians who treat patients with something they know or have reasonable cause to suspect is useless run the risk of transforming themselves into common quacks, diluting the integrity of the profession, and betraying the relationship which binds them and their patients together.

THE MEANING OF USEFULNESS

Even if it is agreed that the first principle of medical ethics should be "Above all, be useful," there are many problems in determining exactly what makes a treatment, drug, or surgical procedure useful. Some of these problems have been mentioned already; for example, the difficulty in scientifically establishing the efficacy of certain procedures. One critical factor in making usefulness a useful concept (as it were) in medical practice has been neglected up to this point, i.e., the usefulness of anything can be determined only if the purpose or goal at stake is specified. For example, is a fork useful? The appropriate answer depends on what you want to use the fork for—eating a salad or driving a nail into a board. Similarly, the usefulness of a medical treatment will depend on the goal to be achieved and on the context surrounding its pursuance.

In ordinary medical practice, the goals of treatment are generally obvious to both physician and patient and accepted without question, and it is not uncommon for neither party to specifically articulate these goals. The car accident victim wants his lacerations sutured to prevent excessive blood loss, his broken limbs set properly so
he can use them again, and his pain relieved. The pregnant woman intending to carry to term wants to deliver a healthy baby and be healthy herself before and after delivery. The person with strep throat wants the appropriate antibiotic to end the infection, and so on. In most cases of medical care, the purpose or goal of treatment is clear to both physician and patient, and both agree to take the actions necessary to secure that goal. However, with the confluence of certain kinds of diseases and certain kinds of persons having unique characters, value systems, preferences, fears, and prejudices, the goal of medical treatment in any one case may become quite obscure. The fallacy is to generalize from relatively easy, straightforward cases in which physicians' and patients' perceptions of the usefulness of treatment are congruent to those cases in which the issue of usefulness is quite complex, controversial, and open to multiple interpretations.

For example, which treatment for breast cancer is useful? The answer depends not only on whom you ask (physician or patient), but also on whose evidence you are willing to accept. All in all, the debate surrounding the "proper" or "best" treatment of breast cancer is certainly one of the most convoluted in medicine today [33]. Yet one thing can be clearly identified: the decision to have a radical mastectomy or a simpler, less drastic treatment involves a weighing of values that cannot be determined by scientific fact alone. A surgeon may believe that the most useful treatment is radical mastectomy, i.e., extensive surgery is the best way to contain the disease and maximize the length of survival, but an individual patient may not see it this way at all. She may rather assume a possibly greater risk of death and live with a less disfigured body by choosing the simpler treatment. Clearly, conceptions of what constitutes useful medical treatment (as in the case of breast cancer) can and do legitimately vary among both physicians and patients.

Physicians offer people a particular kind of benefit in consonance with their proper role as established by tradition, education, skill, and licensing. Individuals can be benefited in multiple ways, but not all of these are appropriate to the physician. A physician qua physician offers medical benefit to those in need of it; that is, physicians prevent, cure, and alleviate disease. In other words, physicians strive to restore, preserve, and enhance health. Although health and disease are troublesome and elusive concepts, they do at least roughly identify the proper concerns of the physician.

Even though exact definitions of sickness, disease, and health are still lacking, one thing can be said confidently: medicine should not do just anything to anyone upon demand from that person, another person, or society. A physician who would radiate, medicate, or manipulate someone merely upon request would be behaving in a grossly unprofessional and unethical manner. Persons demanding pills, hospitalization, surgical procedures, or diagnostic tests for their own purposes usually do not receive much assistance from conscientious physicians. There must be a legitimate medical reason present before physicians should medically intervene in someone's life—even if that person requests or demands their intervention. Medicine upon demand is unacceptable: it would disintegrate the integrity of the medical profession and inevitably produce great harm. Medical reasons must justify medical interventions which have an appropriate connection with mental/physical health construed at least somewhat conservatively.

Both Pedro Lain Entralgo and Leon Kass suggest that the scope of action of the physician qua physician is becoming dangerously wide. According to them, the proper scope of medicine is the health of the sick person, not the goodness,
happiness, pleasure, or gratification of the patient. “The proper function of the
doctor as such is not to make men good or happy, but healthy. As a doctor, he can
and ought to go no farther than this” [34]. Kass asserts that the pursuit of any goal
other than health by physicians is a “perversion of the art,” the goodness or
worthiness of the goal notwithstanding [35]. He gives some examples of practices
which he believes are not acts of medicine: performing artificial insemination,
arranging adoptions, performing vasectomies and abortions for non-medical reasons,
dispensing antibiotics or other medications simply because the patient wants to take
something, and some activities of psychiatrists and cosmetic surgeons. While one
could argue that Kass is adopting an overly conservative view of health and the end
of medicine, his concern over the ever increasing range of so-called medical
interventions is more than justified. The ethicist Paul Ramsey has also expressed
care over the conflict between the social use of medical instruments and the
medical use of medical instruments [36]. It is not fanciful speculation to wonder if
medicine itself is taking on the function of soma in Brave New World.

To modify a phrase of Ramsey’s, the good things physicians do are made complete
only by the things they refuse to do [36]. There are some things that physicians should
not do because such actions would run counter to a basic norm inherent in the
functioning of the physician qua physician. Edmund Pellegrino calls the canon of
these norms “professional medical ethics”; it deals with the obligations of the special
interrelationship between persons called the medical encounter which is independent
of the problem for which the patient seeks assistance [37]. The proper domain of
medicine, therefore, is composed of certain activities which are peculiarly useful in
the protection and promotion of the health of human beings while the borders of this
domain are formed by the principles of professional medical ethics which seek to
insure the quality of the medical encounter and prevent the disintegration of
medicine’s integrity. Physicians must have some definite voice in determining what is
useful medical treatment since they have to prescribe the pill, wield the knife, and
bear the ethical and legal responsibility for what they do.

Professional medical ethics creates some boundaries for the domain of useful
medical treatment, while the personal values of individual patients create others. In
other words, as there are some things which physicians ought not to do for their
patients, there are some things which individual patients do not want done for them
by physicians. As the breast cancer example indicates, the physician and the patient
may have very different views on the usefulness of proposed treatment, and the
patient may properly find the physician’s assessment of the relative risks and benefits
subjectively unacceptable. Patients must have a respected voice in determining the
usefulness of medical treatment, since it is their bodies, their very selves, which must
bear the consequences of the treatment.

Any decision to initiate, continue, or discontinue diagnostic or therapeutic action
has both a medical and a personal value component, though in certain circumstances
one should receive preference over the other. The former properly belongs to
physicians and the latter to patients (depending upon circumstances, possibly to their
families as well). Either one of these components alone is a necessary but not a
sufficient condition for adequately justifying medical interventions. In other words,
patients can and should place limits on what physicians can do to them, and
physicians can and should place limits on what they will do for patients.

Any decision to stop medical treatment once it has begun also possesses these two
essential ingredients. Such a decision does not belong exclusively to either physicians
or patients, although many insist that it belongs only to one or the other group. Most of those writing about this issue tend to fall heavily on one side or the other. Physicians, as exemplified by the following three authors, are wont to insist that the decision to stop treatment is exclusively theirs. Franz Ingelfinger, referring to the controversy over allowing defective newborns to die, states "the onus of decision-making ultimately falls on the doctor in whose care the child has been put" [38]. He suggests that the physician has the most valid prerogative to weigh the pros and cons of continuing measures that sustain the life of a hopelessly afflicted patient. Howard Lewis echoes the same position:

The decision to prolong life by artificial or other unusual measures in the face of what obviously appears to be a fatal illness is one of a physician's most difficult and lonely tasks. Consultation may be of great help to him, but in the last analysis only he must decide the issue [39].

Vincent Collins asserts "it is evident that prolonging life is not a theological or legal responsibility but clearly a medical responsibility" [40]. Collins, however, also comes out strongly against physicians doing what is useless in prolonging life.

To continue an act or proceed with therapy which produces no improvement, which does not achieve or have the potential to achieve "full human life," and which is demonstrably ineffective in its objectives, is imprudent, illogical, and irrational. This is the essence of medical practice.

While one wonders what he means by "full human life," it is clear that Collins understands the end of medicine to essentially involve benefit and demonstrable usefulness.

On the other side of the issue are those who hold that the decision to stop medical treatment is an ethical judgment belonging exclusively to patients or their families. Robert Veatch flatly states: "The physician should never be placed in the position of deciding to stop or omit treatment" [3]. He would likely defend this claim by suggesting that the determination of an expendable treatment and the circumstances under which treatment should be discontinued is "clearly a question of ethical and other value judgment" over which the physician has no expertise [41]. Thomas Shannon, another ethicist, agrees with Veatch.

Although the patient's condition is a complex accumulation of medical facts and personal values, the decision to terminate or continue treatment is basically a moral or religious one and must take into account the patient's own perspective [42].

Shannon criticizes existing guidelines for the care of the terminally ill for failing to make the distinction between medical and moral dimensions in the decision to terminate treatment. Since termination of treatment is a moral rather than a medical decision, he suggests that it properly belongs to the patient, not the physician. Support for this position has come from medical quarters too. Imbus and Zawacki have reported their experiences in a burn unit which has adopted the policy of allowing patients whose injuries are so severe that survival is not only unexpected, but also unprecedented, to decide whether or not they want to undergo maximal therapeutic effort. "Our approach... is based on our conviction that the decision to begin or to withhold maximal therapeutic effort is more of an ethical than a medical judgment" [43].
The assumption which all of these authors unfortunately make is that the decision to terminate medical treatment must be either medical and belong to the physician or ethical and belong to the patient. A position attempting to protect the integrity of both the medical profession and the persons it serves rejects such an “either-or” approach and recommends the use of a “both-and” methodology. In the case of stopping treatment on a critically ill patient, for example, the decision does not totally belong to the patient or his family because they cannot legitimately demand useless or medically inappropriate treatment from their physicians. The same decision does not belong totally to physicians because patients differ in their preferences, values, and notions of an acceptable quality of life. Some patients may want to forego extensive surgery which may offer them a few more months of life while others may eagerly embrace it.

The determination of useful medical treatment should be a matter of negotiation between physician and patient with neither party having the power to force the other to act against his or her own conscience. A physician qua physician has (or should have) certain ethical principles which guide his or her medical practice. These need to be clearly articulated in the medical encounter. A physician qua person also may have certain ethical convictions which are peculiar to him or her as an individual and which ought not to be generalized to physicians as a class. For example, some physicians will not perform abortions because they hold such actions to be unethical. They should not be forced to perform such a procedure, but one should not necessarily conclude from this that no physician should ever perform an abortion. A patient qua patient, on the other hand, does not have any particular ethical principles while a physician qua physician does because of the special human relationship that exists between doctor and patient. If this analysis is correct, then there is such a thing as professional medical ethics while there is no corresponding “professional patient ethics.” However, patients as individuals do have their own values which must be taken into account in the medical encounter even though these values may seem irrational or bizarre and may lead to a decision which the physician, if in a situation similar to that of the patient, would not make himself.

I suggest that a workable physician-patient relationship could be constructed along these lines and that it be called a contractual fiduciary relationship. The notion of contract is included not with the intent of suggesting a businesslike relationship, but rather because it connotes that two equal parties are involved, both of whom have interests, rights, obligations, and the ability to place limits on the relationship. The fiduciary aspect recognizes the fact that the two parties are not equal, since the physician does possess the medical knowledge and skill which the patient lacks and needs and which require the patient to trust the physician. The physician should loyally work for the best interests of patients and allow patients to specify their own best interests rather than arbitrarily impose his or her own values on the patients.

In many cases of common medical practice, patients will not be active negotiators because they have no problem with their physician's determination of what is the most useful treatment for them. This is perfectly acceptable as long as the fact that many patients do not actively negotiate the fiduciary contract is not taken to mean that they never should have any voice in decisions affecting their medical treatment.

CONCLUSION

Practicing medicine with the intent of producing benefit and being useful to the patient is far more fundamental than practicing medicine to avoid harm. The first duty of physicians is to be useful to their sick and diseased patients. The goal of any
medical procedure, however uncertain its actual achievement may be, must be identified before its usefulness can be determined. The justification for any decision to initiate, continue, or discontinue medical treatment must take into account both the medical and the personal (i.e., the patient's) perspectives on what will be useful treatment. Unless their professional ethics or their personal ethical convictions are being seriously threatened or compromised, physicians ought to accept their patients' notions of usefulness and alter their medical care accordingly, since, after all, it is each patient's own life and body which are directly affected by medical interventions. However, if a patient desires treatment which a physician conscientiously judges to be useless or otherwise in violation of his or her professional ethics or personal ethical convictions, then the physician ought not to provide that treatment, nor should he or she be forced by the state, hospital, or other institution to treat that patient.\(^1\)

A great deal more discussion and argument than this essay can provide needs to be directed at these obviously controversial issues. Was the plastic surgeon who recently made an entertainer look like the late Elvis Presley behaving in a medically and ethically appropriate manner? Should surgeons perform hysterectomies upon demand or for birth control purposes? Can obstetricians properly refuse to care for welfare patients having numerous children unless they agree to be sterilized at the time of their delivery? Should physicians vigorously resuscitate a patient whose death is imminent at the request of a family member or even the patient himself? The answers to these questions contain the essence of the character and meaning of medicine. Ultimately, the integrity of physicians \textit{qua} physicians rests on their ability to refuse to perform certain kinds of medically useless and ethically unjustifiable actions.

\(^1\)Exactly which "personal ethical convictions" a physician may legitimately use as a reason for refusing treatment is an important issue demanding further investigation, since not every ethical conviction can be justifiably imposed prima facie on another unconsenting party. For example, an emergency room physician could believe that it is morally acceptable to allow known heroin pushers to die without receiving needed medical treatment. However, this belief, its sincerity notwithstanding, appears to run counter to both professional medical ethics and the legal norm of due process. It can also be plausibly argued that if a physician withdraws from the care of some individual, he or she is responsible for securing the services of another attending physician.

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