

Obligation of non-maleficence: moral dilemma in physician-patient relationship

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ABSTRACT

This paper highlights the principle of non-maleficence from sections of the Hippocratic oath and those entailed in various declarations of medical ethics and conduct. The moral dilemmas associated with adherence or efforts at adherence to the principle were indicated with the use of prepared cases. The centrality of the paper is the moral conflict encountered by physicians in their efforts at maintaining the fiduciary relationship that they have with patients. The concepts of dignity, identity, harm and the definitions of brain death as different from biological death, ordinary and extraordinary health care and the principle of double effect were analysed in an attempt to resolve the moral conflict in physician-patient relationship. Cost-benefit analysis, detriment-benefit assessment and the notion of justice were also brought to bear in the effort to resolve the moral dilemma in physician-patient relationship as it borders on the obligation of non-maleficence.

INTRODUCTION

Relationships between two or more persons depict some sort of connection that is beyond mere exchange of pleasantries or show of civility. Rather, it indicates some sort of intimacy that usually emanates from contact and communication. Relationships are freely developed amongst individuals such as the cultivation of friendships and acquaintances, while other relationships are not as freely cultivated. In contrast, they are determined, such as relationships between brothers and sisters, cousins and relatives in general. Other

kinds of relationships could be entered into as a result of the demands of professions and duties, as is the case with the physician-patient relationship.

In the course of duty and relationship with patients the physician must adhere to certain principles of medical ethics (autonomy, non-maleficence, beneficence and justice), rules (fidelity, confidentiality, privacy and veracity) and virtues (compassion, kindness, respect, etc). A physician may be sanctioned if he breaches the principles and rules of medical ethics, but he may not necessarily be liable or compelled to uphold the virtues entailed in his line of practice and duty. It is, however, morally upright (but not obligatory) for a good physician to be compassionate, kind and to show respect for his/her patients. Respect for patients and the wishes of patients are two different issues that must not be confused.

KEY WORDS: *Hippocrate, justice, ethics, physician, patient*

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The principles and rules of medical ethics are derived from the Hippocratic oath and various declarations (Declaration of Geneva as amended in Sydney 1968, Declaration of Tokyo 1975, Declaration of Oslo 1970, Declaration of Helsinki 1975, etc) regulating medical practice. Despite the Hippocratic oath and various declarations, a certain aspect (non-maleficence) of the oath and declaration is sometimes breached in what seems to be in the “interest” of patients in circumstances that constitute moral dilemmas.

PRINCIPLE OF NON-MALEFICENCE

The physician-patient relationship is fiduciary. The patient believes and trusts that the physician would apply his professional expertise in his/her (the patient’s) interest and benefit. Even more importantly, the patient believes that his/her physicians (based on the principle of non-maleficence) would do nothing to harm him/her. The principle of non-maleficence runs through from the Hippocratic oath to current versions and amendments of medical ethics. In the Hippocratic oath (in the translation preferred by the British Medical Association), the aspect that is instructive and serves as guide to physicians in respect of non-maleficence states that:

I will follow that system of regimen, which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel.

In the declaration of Geneva, and as amended in Sydney 1968, physicians were expected and indeed mandated to:

... maintain the utmost respect for human life from the time of conception; even under threat, ... not [to] use medical knowledge contrary to the laws of humanity.

While the International Code of Medical Ethics (English text) states that:

A doctor must always bear in mind the obligation of preserving life.

In other words, the duty and obligations of physicians to their patients remain unequivocally that of beneficence and non-maleficence.

The principle of non-maleficence revolves around the concept of harm. Harm brings about pain and pain brings about distress. Harm may be incidental, intended and intrinsic.¹ According to Thomasma and Graber, incidental harm is brought about through carelessness and negligence, intended harm is calculated and inflicted pain, while intrinsic harm is such that harm is directly brought about. They explained further that to kill a person deliberately has the intrinsic effect of harming (the patient), thus it violates the negative duty not to harm. Physicians’ obligation not to harm is reflected in various codes and declarations of medical ethics.

Non-maleficence in general, and medical non-maleficence in particular, recommends that one ought not to inflict evil or harm.² Albert Jonsen in his work *Do no Harm* itemised medical non-maleficence into four categories: physicians must (a) dedicate themselves to the well-being (not harm) of patients; (b) provide adequate care; (c) properly assess the situation, that is, risk/benefit analysis; and (d) make proper detriment-benefit assessments.³ The physician’s provision of ‘standard due care’ is central to the avoidance of harm. According to the American Law Reports, elements inherent in due care may be said to be violated and harm inflicted when and if the: (1) professional (physician) has a duty towards the affected party (patient); (2) professional (physician) breached that duty; (3) the affected party (patient) must experience a harm; and (4) this harm must be caused by the breach of duty.⁴ Based on these elements, the obligation of

medical non-maleficence could be defined as not imposing risks of harm as well as not inflicting actual harm.⁵ Veatch explains further that it is the responsibility and duty of physicians (and based on the fiduciary relationship between physician and patient) to keep patients away from harm.⁶ Mason and McCall Smith also indicated, in line with Veatch, that based on their ability and knowledge, physicians must not engage in medical procedures that may be harmful to their patients.⁷ This is because, and based on, the obligation of non-maleficence, the responsibility of physicians is to maximise health and not to inflict harm.

In real life situations physicians do inflict harm on patients but generally for the purpose of achieving some kind of good. According to Beauchamp and Childress, a harm we inflict such as a surgical wound may be negligible or trivial yet necessary to prevent a major harm such as death.⁸

Infliction of harm (that is, negligible harm) purposed at arresting harm for the purpose of realising good does not constitute a moral dilemma. This is because negligible harm is usually inflicted by physicians based on detriment-benefit analysis in favour of patients. However, infliction of harm is not always negligible. Sometimes, and increasingly regularly, physicians inflict fatal harm with the use of double effect medications in what seems to be in the patient's interest as well as to his/her benefit. The moral dilemma is this: could the infliction of fatal harm that breaches the obligation of non-maleficence ever be in the interest and benefit of patients?

The principle of double effect attempts to differentiate intended and non-intended effects of an action. The intended effect is good and primary; however, associated with the intended effect is the necessary but bad and unintended (secondary) effect. According to Beauchamp and Childress, the principle of double effect must satisfy certain conditions for it to be morally justifiable, and these conditions are:

1. The action itself (independent of its consequences) must not be intrinsically wrong (it must be morally good or at least morally neutral).
2. The agent must intend only the good effect and not the bad effect. The bad effect can be foreseen, tolerated and permitted but must not be intended; it is therefore allowed but not sought.
3. The bad effect must not be a means to the end of bringing about good effect, that is, the good effect must be achieved directly by the action and not by the way of the bad effect.
4. The good result must outweigh the evil permitted, that is, there must be proportionality or favourable balance between the good and bad affects of the action.⁹

Beauchamp and Childress explained further that some ethicists currently emphasise some of these conditions while they downplay others. However, traditional moralists still require that all conditions should and must be met before double effect treatments may be justified. It is important to state that the conditions indicated for the justification of double effect treatments have not eliminated the moral dilemma associated with the principle, as it pertains to the physician-patient relationship and the obligation of non-maleficence.

MORAL DILEMMA

In order to address the question raised, that is, if the infliction of fatal harm could ever be in the interest of the patient, it is appropriate and for proper comprehension to use prepared cases. This situates the moral dilemma with which physicians are faced in real life circumstances.

Case one

Okeke suffered from advanced and terminal skin cancer, which had resulted in extensive destruction of his body. He was constantly in

acute pain. If his physicians continued with the current and standard line of treatment, he would live for about a year and probably more, but all the time he would be in acute and unrelenting pain. However, and to relieve Okeke of pain and suffering, his physicians (based on Okeke's consent) decided to give doses of strong pain killers that had the unintended effect (principle of double effect) of shortening Okeke's life span by about six months. Harm inflicted on Okeke (though unintended) seemed to contravene the obligation of non-maleficence, which was indicated in the Hippocratic Oath (and other amendments and declarations) that: "I will give no deadly medicine to anyone if asked, nor suggest any such counsels." Herein lies the moral dilemma associated with double effects medical treatments (such as Okeke's).

The argument usually made in favour of physicians when they help to relieve pain and suffering with double effect drugs that hasten death is that it is the physician's obligation to alleviate pain and suffering. Patients (and indeed everyone) have the right not to suffer when it can be avoided. According to Cassell, it was the responsibility of physicians to manage pain and suffering of terminally ill patients.¹⁰ Liebeskind and Melzack posit further that by any reasonable code, freedom from pain should be a basic human right, limited only by our knowledge to achieve it.¹¹

Pellegrino indicates that relief of pain should not generate much moral debate, arguing that if a physician is unable to achieve cure he should at least be able to relieve suffering.¹² The inference is that it is unfortunate, if in the physician's efforts to alleviate pain and suffering, some kind of harm (even if fatal and unintended) may be inflicted on patients. Physicians cannot, therefore, be held morally responsible as their first line of duty to patients is to relieve pain and suffering. Perhaps it should also be added that double effect treatments (as in the case of Okeke) do not just relieve pain but also enable patients die (even if death was hastened) in

dignity. Dignity is an integral part of all humans that must be retained at any point of our existence, even at the moment of death.

However, it is argued on the other side of the divide that physicians must at all times adhere to the code of medical ethics not to inflict harm, that is, the obligation of non-maleficence. Based on Kant's duty ethics, it is argued that what is good is good in itself, since good is without qualification.¹³ Perhaps, this argument could be pursued further to state that what is good (if it is really good and good in itself) cannot and is not capable of producing evil, except if the good was corrupted, in which case it was not really good in the first instance. In other words, it is wrong to inflict harm (even if unintended) whatever the reason(s) for the primary and initial intension. This is because what is good is unconditionally good, hence, action done from duty has its moral worth, not from the results it attains or seeks to attain, but from a formal principle of doing one's duty whatever that duty may be.¹⁴

The duty and responsibility physicians owe to patients and society is to do well (beneficence) and not to inflict harm (maleficence). Ironically, Kantian ethics could also be used the other way round to support the principle of double effect (infliction of harm) if one focused on just duty or act and ignored the consequences in line with deontological ethical theories. This is because (and according to Kant) our actions have moral worth in themselves, in which case it would seem that only physicians' intended actions should be morally evaluated in double effect treatments and the unintended consequence (e.g., hastened death) should be ignored as of no moral consequence or even relevance.

Christian moralists urged strict physicians to adhere to the obligation of non-maleficence based on their perception of freedom. According to this perception, man does not have the freedom to decide when to return back to his creator, as no one (neither physician

nor patient) ought to play God.¹⁵ Hence, it was morally wrong for any human to decide to embrace death, or for anyone to assist someone else in embracing death when God has not occasioned or determined it. They therefore argued in addition that human life is sacred and must not be terminated, that pain and suffering are not enough reasons for anyone to play the role of the creator.¹⁶ Based on Christian theology, meaning could be derived from pain and suffering, as suffering gives man the opportunity to participate in the suffering of Christ.¹⁷ However, eastern theological perspectives (Buddhism, Confucianism, Hinduism, etc) are not in agreement with the views expressed by most Christian moralists. They support and encourage physicians to relieve pain and suffering by whatever means, even if such medications have the unintended effect of hastening death. In most traditional African religions, pain and suffering are to be stoically endured to the very end. This may be connected with the strong belief in reincarnation, ancestral worships and second burial rites. Anyone who hastens his/her death, or gives consent for his/her death to be hastened, is not entitled to second burial rites and would consequently not be allowed into the ancestral realm.

Case two

Bode, a 50-year-old truck driver, was involved in a near fatal accident, and although Bode survived, his brain artery was ruptured. Bode was taken to a teaching hospital where he underwent unsuccessful surgery. He eventually slipped into coma and persistent vegetative state (PVS). Bode's family members consented to gastronomy for him. PVS patients could survive on life support equipment for many years without hope of regaining consciousness. After a few days, Bode's family members thought it was senseless for their loved one to remain in this state. According to one of his family members, he was neither alive nor dead. Hence, they

requested that his physicians withdraw the feeding tubes and other life support equipment so that he could be given a befitting burial in line with African burial rites. These very important rites cannot be undertaken while he remains on life support. After the physicians reviewed Bode's case, they obliged the request of his family members and withdrew the life support equipment and he died quietly. The moral question is: Did Bode's physicians breach the obligation of non-maleficence? Surrogate decision-making, as was the case in Bode's situation, or advance directives such as a living will, if Bode had made his decision known while he was healthy, do not change the moral question inherent in withholding and withdrawing life support fluids and equipment from PVS patients.

What is crucial in responding to any alleged breach of the obligation of non-maleficence (as in Bode's case) should start from the concept of personhood in relation to PVS patients. Persons have certain values, rights and privileges by the very nature of their personhood. These values, rights and privileges are not usually associated with non-human beings such as animals. Hence, in analysing the concept of person, Edge and Grooves asked, "What types of beings can be thought of as humans."¹⁸ In response, Fletcher and Feinberg provided an answer as to what they thought were the criteria that qualify a person as a bearer of rights, which are:

- (a) Possession of certain beliefs, values and intuitive awareness.
- (b) One for whom something could be in his/her interest.
- (c) Possession of the concept of time, that is, of past, present and future.
- (d) Ability for social interactions with others.^{19 20}

In other words, when these vital criteria are no longer present in humans, they do not have rights and privileges usually associated

with persons; in which case physicians may not be considered to have breached the obligation of non-maleficence when they either withhold or withdraw life support from PVS patients. However, it is not in dispute or in contention that the physician has inflicted harm, whether compassionate or unintended harms. It contravenes the International Code of Medical Ethics, which states that "... a physician must always bear in mind the obligation of preserving human life." Moral dilemma once again surfaces in physician-patient relationship.

Efforts at resolving the moral dilemma in withholding and withdrawing life support for PVS patients may be found in the definition of death. Death may be defined from two perspectives: brain stem death and biological death. Brain death may be defined as a condition of unreceptivity and unresponsiveness, no movement or breathing, no reflexes and flat EEG of confirmatory value.²¹ However, brain dead patients could be sustained on life support equipment, such as a ventilator, feeding tubes, IV fluids, for years. In which case biological organs remain functional in so far as life supports remain in place and not withdrawn, but the patient would never regain consciousness. The moment artificial life support equipment is removed the patient dies biologically. In other words, biological death is when bodily organs cease to function. It means one could lose intuitive awareness in its entirety (brain death) and yet retain some sort of existence that could be sustained artificially. It is the inability to definitely resolve the concept of death that gears some physicians to resort to extraordinary care while others do not and the moral dilemma remains. What is to be done?

To resolve the question, it is mandatory for one to demarcate where ordinary care ends and when extraordinary care begins. Perhaps this would assist physicians to arrive at decisions regarding withholding and withdrawing life support. Loosely defined, ordinary health care has to be beneficial and must

be made available. According to Pope Pius XII, life may be prolonged with the use of ordinary care, subject to the circumstances of persons, places, time and culture. He explained further that ordinary health care should not constitute grave burden to self or another. While extraordinary health care, which may involve intravenous fluids, nasogastric feedings, etc, for PVS patients may be regarded as optional, ordinary care may be regarded as obligatory. It would seem that extraordinary care begins where ordinary care has become useless and of no benefit. It seems, however, that the demarcation of ordinary care from extraordinary does not really resolve the moral dilemma inherent in the physician's obligation of non-maleficence in physician-patient relationship, as what constitutes extraordinary care still remains unclear. For instance, what may constitute extraordinary care in developing countries may be regarded as ordinary care in developed countries.

Case three

Omole, seven days old, with extensive physical deformities coupled with severe mental retardation and other health complications was born to Mr. and Mrs. Kimba. The couple had no formal education and were casual factory workers who earned about ₦20,000 a month (about US\$150) with which they sustained themselves and their three children (besides Omole) aged five, seven and nine years. According to Omole's physicians, if he was kept on special diet and given monitored health care, all the while he must remain in hospital, he would probably have lived to his fifth birthday but not more. The Kimbas would be required to pay about ₦15,000 a month (about US\$115) for Omole's upkeep and health care (Nigeria and indeed most African countries have no national health insurance schemes). If Omole must live to see his 5th birthday, the options open to the Kimbas are: (a) sustain Omole in hospital, in which case their other children must have

to drop out of school, move to a one-bedroom apartment and considerably reduce the quality and quantity of their diet; (b) request that the physicians allow Omole to die since (i) Omole could never really live a normal life, and (ii) his brief existence would only bring more grief and distress for everyone, that is, to himself and family members. The Kimbas decided to take option B, which they communicated to Omole's physicians. The physicians consented to his parents' request, medication was discontinued and Omole died two days later. Could Omole's physicians be said to have breached the obligation of non-maleficence?

Attempts to make a moral judgment of the physicians' role in Omole's death should take into account the concept of justice based on utilitarian and Kantian ethics. From a Kantian perspective, an action is morally evaluated to be just if approval of that action could be universalised for everyone.²² While utilitarian ethics focuses on the greatest happiness for the greatest number in evaluating moral and just actions, the idea of justice in traditional, and to a great extent contemporary, Africa is essentially interpersonal and social with a basis in human welfare.²³ In the light of these definitions, was Omole justly treated? Omole's physicians may have acquiesced to Omole's parents because it was the just thing to do based on utilitarian ethics, which promotes the interest of the majority over that of the minority; in this case, the welfare of Omole's parents and siblings over Omole's welfare.

The physicians' position and judgment may be further strengthened based on the low quality of Omole's life. Again, in line with classical utilitarianism, they may have evaluated that it would be morally wrong for the Kimbas to sustain Omole's interest (an individual who would with luck on his side probably live to see his fifth birthday) over those of five persons. This is because, for Omole's sake, his siblings would not only have to drop out of school; their lives may also

be in danger from malnutrition. The physicians may even stretch their arguments further, that it is morally wrong for Omole's siblings to bear the consequences of their parents' decision to prolong Omole's life, and if anyone must bear the consequences it should be the couple alone and not their children (Omole's siblings). Their children's interests should not be undermined if they decided to bear the consequences of prolonging Omole's life, and since it seemed that nothing could be done without undermining the interests of Omole's siblings, then Omole should be allowed to die in order to protect the interests of the other children. Consequently, the physicians may have concluded that they acted justly and morally under the circumstances. However, it is not in doubt that Omole's physicians inflicted harm, even if on compassionate grounds, hence, the moral dilemma remains.

CONCLUSION

Efforts at resolving the moral conflict or dilemma associated with PVS patients must be accompanied with conscious efforts at resolving the lacuna that exist between brain death and biological death. Without bridging this lacuna, the moral dilemma associated with withholding and withdrawing artificial life support for PVS patients would always remain contentious as far as the physician's obligation of non-maleficence remains total and binding on all physicians under all circumstances, that he shall respect human life and studiously avoid doing it harm.²⁴ Perhaps it should be added that even if the developed world with functional and viable health insurance schemes could afford almost indefinitely to sustain PVS patients on life support, it would be morally wrong for physicians in developing countries, where health resources are scarce, to embark on extraordinary healthcare, when the same resources could be more beneficially used for ordinary care in line with cost-benefit analysis. This means that physicians in

developing countries are confronted with harsher forms of moral dilemmas than their counterparts in the developed countries if they must adhere in totality to the obligation of non-maleficence.

On the use of double effect medications in relieving pain and suffering, it might be necessary to know the innate quality of human life in general and particularly the quality of human life at the moment of death. This is because the breach of the obligation of non-maleficence is sometimes based on the concept of dignity and identity, which must be retained even at the moment of death since mental suffering often accompanies physical pain in terminal illnesses such as cancer.²⁵ According to Weisman and Hackett, it is the responsibility of physicians to help the dying patient preserve his/her identity and dignity as a unique individual despite the disease, or, in some cases, because of it.²⁶ But the recurring question remains: could a physician be held morally, if not legally, liable when in the course of duty he breaches the obligation of non-maleficence? It seems the moral dilemma remains: whichever way the pendulum swings, the physician must at all times be conscious of the dictum: *aegroti salus suprema lex* (that is, the good of the patient is the highest law).²⁷

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