

# **The Decline of Hippocratic Medicine**

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## **The Hippocratic School**

Euthanasia was a common practice by the physician of ancient times. The term euthanasia means “good death.” One physician would care for his patient with compassion, alleviating pain and suffering; another would provide the poison draught to cause the patient’s death.

The Hippocratic School was a group of concerned physicians (ca. 400 BC) who declared the physician a healer and rejected the role of executioner. The Oath of Hippocrates was the first attempt to establish a set of ethical principles to guide the practice of medicine. The original Oath of Hippocrates <sup>1</sup> began with a covenant to the gods, followed by duties and obligations to teacher and to patients, and ended with a promise not to break the Oath, under punishment of dishonor. The physician declared a covenant with his patient to do good and not to harm and to always act in a just way to others. The principle of “primum non nocere,” first do no harm, from where the modern concepts of beneficence and non-maleficence are derived, became one of the guidelines in the doctor-patient relationship.

The Hippocratic School introduced the concept of the practice of medicine as a moral commitment. The principles of beneficence and non-maleficence enjoin the physician to act for the good of the patient, since the patient’s interest supersedes the physician’s. The physician is expected to go beyond doing good, to serve to the point of sacrifice. Any intentional harm inflicted on the patient is a maleficent act and defeats the helping and healing ends of medicine. The principles of beneficence and non-maleficence require the physician to evaluate the potential benefits and compare the risks of the proposed intervention, advise the patient and consider the patient’s opinion before treatment is instituted. The practice of medicine became a transcendent, moral activity.

The Hippocratic principles were embraced by the Hebrew-Christian tradition. By the early Middle Ages, the Islamic tradition had also accepted the Hippocratic principles of moral medical practice. The principles of beneficence, non-maleficence, and justice guided medical ethics through the Middle Ages to present times. The Hippocratic principles remained unquestioned until recent history. <sup>2</sup>

## **The Practice of Medicine**

Three characteristics of medicine as a human activity make it a moral enterprise: (1) the nature of illness, (2) the act of profession; the nonproprietary nature of medical knowledge, and (3) the act of healing in the context of a professional oath. (Pellegrino’s theory of medicine, 1994).<sup>3</sup> The immediate *telos* of the physician patient encounter is helping and healing through the science and art of medicine.<sup>4</sup> The morality of the medical encounter includes moral intent, moral choice and moral action. The ends of medicine are the ends of the doctor patient encounter: health, cure, and care. A covenant based on trust traditionally defines the doctor patient relationship.

## **Medical Ethics in Practice**

Clinical ethics is a practical discipline; it is problem solving. There is an ethical dilemma which demands a decision. The physician and the patient must make a moral choice. It is essential that the judgment be grounded on a set of values and an objective authority or principle that determines the morality of the action.

The “four principles approach” proposed by philosophers Tom L. Beauchamp and James F. Childress is the ethical process most frequently applied in medical ethical decision making today. The philosophers call their ethical theory a principle based common morality. Common morality is defined as the set of norms that all serious persons share. The philosophers claim that “all persons serious about living a moral life grasp the core dimensions of morality. They know not to lie, not to kill or cause harm to innocent persons. To violate these norms without a morally good reason is immoral...The common morality contains moral norms that bind all persons in all places.”<sup>5</sup> Moral medical decisions are based on the following four principles: (1) respect for autonomy (a norm of respecting the decision making capacity of autonomous persons), (2) non-maleficence (a norm of avoiding the causation of harm), (3) beneficence (a group of norms for providing benefits and balancing benefits against risks and costs), (4) justice (a group of norms for distributing benefits, risks, and costs fairly). This set of principles is thought to reflect the values of the common morality<sup>6</sup>

These four principles are binding unless they conflict with one another. Principles in conflict, according to Beauchamp and Childress, provide an opportunity for compromise and negotiation. The conflict is settled by balancing the demands of one against the other and the consequences of either act. The physician may decide, based on rational judgment, that one principle outweighs and therefore, overrides the other. When this is the case, the physician/ethicist must “form a considered opinion that one obligation is weightier in these circumstances than another.”<sup>7</sup> Principles are described by the philosophers as a *reflection of the culture*.<sup>8</sup> This makes principles subject to change with the culture. We live in a morally heterogeneous society without consensus of values; without a common view of human nature and what it takes to live a good life. Moral deliberation becomes an inconsistent process, case specific, dependent on the situation.

In the past few decades, respect for individual autonomy has become the principal moral obligation of the physician. “The traditional benign and respected image of the physician as both moral and technical authority has been replaced by the physician as protector, facilitator, and advocate for the self-determination of the patient.”<sup>9</sup> Social and cultural influences promoted this transformation: the secularization of the culture, the moral heterogeneity of modern society, the increasing power of medicine through technology, the distrust of authority, especially of social and professional institutions, and others. At times, it appears that the patient’s autonomy trumps the physician’s own self-determination.

## **Situation Ethics**

Situation ethics proposes that circumstances could justify actions; actions that would be forbidden in one situation would be permissible in another. Fletcher claimed that decision making should be based on the circumstances of a particular person or situation and not based on a rule or a law.

Situation ethics affirms the only absolute is love. Given the fundamental principle of situation ethics is love for the fellow human being; with few constraints, the individual act is permissible when the outcome of the act is a loving consequence. Situation ethics rejects the natural (moral) law and affirms the ends justify the means.<sup>10</sup> In his book *Situation Ethics*, Joseph Fletcher states, “The situationist enters into every decision making situation fully armed with the ethical maxims of his community and its heritage, and he treats them with respect as illuminators of his problem. Just the same he is prepared in any situation to compromise them or set them aside if love seems better served by doing so.”<sup>11</sup> Fletcher supported euthanasia of the severely ill and those closer to death.

This ideology fosters the attitude...forget the rules, there are times when one must do what is right. This sentiment is commonplace in our culture and is used to justify acts that would otherwise not be permissible. We see this attitude even at the highest levels of government when the law is not enforced because it is the “right” thing to do.

### **The New Professionalism**

In the past several decades, in the United States, the practice of medicine has undergone significant transformation. Astonishing gains in medical knowledge and sophisticated technology have modified the practice and markedly increased the demands of the patient population on the profession. A medical industry developed; the physician was encouraged to join the marketplace. The physician became a medical practitioner; the patient became his client. In time, the doctor patient encounter was converted into a business-like interaction. The practitioner sold a product (medical care) to the client (patient). The morally based interaction between patient and physician based on trust was replaced by a relationship between provider of a service and client. This transformation of the doctor patient interaction into a business transaction altered the doctor patient relationship. The consequence has been a rising distrust of the public for the profession and the ever more powerful health care industry.

Classically, a profession was identified by the requirements of extensive study, a pledge to labor for the benefit of others and a code of ethics. A new code of ethics, *Medical Professionalism in the New Millennium: A Physician Charter*, a statement issued in 2002, published in the *Annals of Internal Medicine*, declared the fundamental principles of physician professionalism to be: (1) the primacy of patient care, (2) patient autonomy, and (3) social justice.<sup>12</sup> Since publication in 2002, the Charter has been endorsed by 130 organizations and approved by most American medical specialties. Many medical schools have embraced and adopted the guidelines in the teaching of professionalism to medical students. In a recent article,<sup>13</sup> the authors of this new code of ethics explain that the Charter has resulted in improved physician professional behavior. In the case of social justice, an ethical obligation to society, the authors state that more must be done. The physician must work toward the “fair distribution of healthcare resources.” The physician would no longer be the individual patient’s advocate, but must be responsive to the healthcare of society. In this document, the moral obligation of the physician to his patient, which is the basis of the doctor patient encounter is based on the respect for autonomy of the individual patient. In addition, the obligation to the “fair distribution of healthcare resources” competes with the fiduciary

obligation of the physician to his patient. The Charter has become the new code of ethics for the medical profession, essentially replacing the Hippocratic tradition.

## **The Right to Death**

In the mid-19<sup>th</sup> century, Charles Darwin, in his theory of evolution, described individuals as fit and unfit. The fit individual would persevere; the unfit would eventually be eliminated through natural selection.

The Eugenics Movement, offspring of Darwinism, developed in Europe a few decades later. In Great Britain, Darwin's cousin, Sir Francis Galton, introduced the concept of eugenics as science. Eugenics was a bio-social movement which advocated the use of practices aimed at improving the genetic composition of a population. Eugenicists argued that many of the maladies of man were due to inferior inherited traits. The "fit" middle and upper classes were encouraged to have large families; the "unfit" poor, especially minorities and immigrants were to breed less.<sup>14</sup>

By the late 19<sup>th</sup> century, the concept of a "right to death" had surfaced in Europe. In 1920, in Germany, the monograph *Permitting the Destruction of Unworthy Life* was published. With the intent to benefit society, the authors proposed that the killing of human beings should be legalized for those whose lives were determined to be unworthy. Euthanasia was supported by the concepts of unworthy life and burden to society. The killing of the unfit was spoken in terms of "compassion" and "release from suffering." This ideology was quickly adopted by the medical profession. Advocates of euthanasia, few at first, gradually increased in number, many were academics in the legal and medical professions. The systematic, organized killing began in the 1930s. The impetus for the program was medical economics. It is important to note that this program was not instituted by the Nazi government, but by the medical community. The Nazi government supported and sanctioned the program and decriminalized the killing.<sup>15,16</sup>

## **Euthanasia and Physician Assisted Suicide in the USA**

In the United States, in the early 1900s, the Eugenics Movement was embraced by the scientific community. Compulsory sterilization of "defectives" was carried out. Eugenicists espoused an elitist northern and western European white supremacy. Funding for eugenic research was provided by the Rockefeller, Carnegie, and Ford Foundations. Margaret Sanger, the founder of Planned Parenthood, was a leader in the Eugenics Movement in the United States.<sup>17</sup>

The Euthanasia Society of America (ESA) was founded in 1938 in New York; the organization preached the elimination of those considered unfit. For many years, many attempts since that time have been made to legalize euthanasia. In 1974, Joseph Fletcher, clergyman and ethicist known as the Father of Situation Ethics, assumed the presidency of the ESA.<sup>18</sup>

Physician assisted suicide (PAS) has been gaining ground in the United States. At the present time there are 5 states where PAS is legal and one state that forbids prosecution of physicians involved in PAS. Euthanasia and PAS are legal in several countries in Western Europe.

## **Comment**

Those in favor of PAS preach compassion for the suffering individual and a death with dignity. Our society, true to its utilitarian roots, views pain and suffering as disgraceful and undignified, and insists that the pain and suffering experience be removed by any means. The *telos* is happiness and pleasure. Compassion for the individual person's pain and suffering is said to justify the use of euthanasia or assisted suicide. True compassion is suffering with the person, sharing his burdens, resulting in a desire to succor and remedy. True compassion does not justify the taking of an innocent life.

Taking the suffering person's life is not the solution to the pain and suffering that are part of illness or the dying process. There is no dignity in euthanasia or PAS. The medical professional ought to use his skills to care for the ill or dying patient with love and compassion, treating physical, emotional, and spiritual pain and suffering with respect, preserving the person's dignity. With effective comfort and dignity care, the dying person is allowed to make peace with family and friends and prepare for death.

Believers in the ideology of situation ethics are many in our postmodern culture. Moral relativism, increasingly commonplace in our society, advances extreme individualism; each is his own judge of morals and values and all morals and values are equally worthy. This hegemony of the individual is reflected in the increasing dominance of individual autonomy in medical ethical decision making. Because the individual reigns supreme, his demand for a service from the physician that could even be a request to end his life must be honored. The autonomy of the individual patient who requests to die is paramount and must be respected. I believe the influence on the culture by these many factors has contributed to the prevalent deviant view that killing the patient is a form of "treatment" of the pain and suffering of disease.

The atrocities committed by physicians in Germany during the Nazi regime were condemned by society and the medical profession. Only 70 years later, society is calling on the medical professional to again become the agent of death to his patient.<sup>19</sup>

## Endnotes

1. Cameron, Nigel M. de S., *The New Medicine*, Bioethics Press, Chicago, Illinois, 2001, pp. 24-25
2. Cameron, Nigel M. de S., *The New Medicine*, Bioethics Press, Chicago, Illinois, 2001, pp. 162-163. Maurice Levine writes in *Psychiatry and Ethics*, George Braziller, New York, 1972, p. 324:  
"The most fascinating recent comment on the Hippocratic Oath is one which originated with Margaret Mead, the great anthropologist. Her major insight was that the Hippocratic Oath marked one of the turning points in the history of man. For the first time in our tradition there was a complete separation between killing and curing. Throughout the primitive world the doctor and the sorcerer tended to be the same person. He with the power to kill had power to cure...He who had power to cure would necessarily also be able to kill. With the Greeks, the distinction was made clear. One profession...were to be dedicated completely to life under all circumstances, regardless of rank, age, or intellect –

the life of the slave, the life of the Emperor, the life of a foreign man, the life of a defective child...but society always is attempting to make the physician into a killer – to kill the defective child at birth, to leave the sleeping pills beside the bed of the cancer patient...”

3. Pellegrino, Edmund, D., *The Philosophy of Medicine Reborn*, eds. Engelhardt, H. T. and Jotterand, F., University of Notre Dame Press, Notre Dame, IN, 2008, p.269.
4. Ibid., p. 270.
5. Beauchamp, Tom L., Childress, James F., *Principles of Biomedical Ethics*, Oxford University Press, New York, NY, 2001, p. 3.
6. Ibid., pp. 12.
7. Ibid., pp. 401-408.
8. Ibid., pp. 392-397.
9. Pellegrino, Edmund D., Thomasma, David C., *The Virtues in Medical Practice*, Oxford University Press, New York, NY, 1993, pp. 65, 73.
10. Titus, H., Smith, M., Nolan R., *Living Issues in Philosophy* (9<sup>th</sup> ed., 1995), Oxford University Press, UK, pp.131-132.
11. Fletcher, J., *Situation Ethics: The New Morality*, Westminster, Philadelphia U. S., 1966, p.26.
12. *Medical Professionalism in the New Millennium: A Physician Charter*, *Annals of Internal Medicine*, 2002; 136: 243-246.
13. ACP celebrates 10<sup>th</sup> anniversary of A Physician Charter, 2012  
<http://mdredux.blogspot.com/2012/08/acp-celebrates-10th-anniversary-of.html>
14. Porter, R., editor, *The Cambridge Illustrated History of Medicine*, The Press Syndicate of the University of Cambridge, Cambridge, UK, 2006, pp. 326.
15. Willke, J. C., *Assisted Suicide and Euthanasia*, Hayes Publishing Co., Cincinnati, OH, 1998, p. 6-8.
16. Lifton, R. J., *The Nazi Doctors: Medical Killing and the Psychology of Genocide*, The Perseus Books Group, 2000.
17. Grant, G., *Killer Angel*, Ars Vitae Press, Franklin, TN, 1995, p. 54, 70-71.
18. From Euthanasia Society of America to the National Hospice & Palliative Care Organization (1938-Present)

<http://www.hospicepatients.org/euthanasia-soc-of-america-to-natl-hosp-and-palliative-care-org.pdf>

19. See endnote 2.