The phrase “first do no harm” (in Latin, primum non nocere) is fundamental to the ethics of medical treatment in the Western world and has endured for approximately 2,500 years. It is attributed to Hippocrates, who wrote that “The physician must ... have two special objects in view with regard to disease, namely, to do good or to do no harm.” These are the principles of beneficence (‘to do good’) and nonmaleficence (‘to do no harm’). The Hippocratic oath contains similar language. Many practitioners today still pledge that oath or at least receive a copy of it early in their training. The phrase is well known to almost any practitioner, yet despite its ubiquity, and perhaps even because of it, it is worth asking this question: What does “first do no harm” actually mean today? Has its meaning or importance changed over time? I will discuss the historical meaning of the phrase, its relationship to other ethical principles, the changing nature of harm, and the changing ethics of health care, as health care delivery and health care culture continue to evolve.

Why “Do No Harm”? The primary ethical principle that forms the foundation for medical care (and the foundation of every society throughout history) is the concept of beneficence — the obligation to do good for others. The ability to do good is also the obligation to do good. The word hospital shares the same Latin root (hospes) as the word hospitality. It implies a duty to shelter and take care of a stranger or guest. The desire to do good often compels health care practitioners to perform some action in virtually any clinical situation, regardless of its effectiveness or even lack thereof. It is a reflection of our training, if not our DNA. Even so, medical and surgical treatments are inherently dangerous. Moreover, countless studies around the world have demonstrated that physicians and the public perceive the benefits of almost every treatment to be far greater and the risks substantially lower than they really are. There is a biased belief in the good that will be done. This belief is based on hope, fear, an exaggerated sense of the power of medicine, surgery, and the expectation that doctors will do good, as well as a cultural and historical awareness of “miraculous” advances in medicine and surgery over the past 150 years. The development of antibiotics, insulin therapy, and antihypertensive treatment in the 20th century, for example, resulted in the cure of previously dangerous infections and transformed conditions such as diabetes and hypertension from fatal diseases into chronic illnesses. As the science advanced, the goals of treatment and the ethos of health care changed; death became the enemy, rather than an inevitable consequence of life. Fighting death, therefore, became an important, if not primary, goal of American health care. Moreover, patients were expected to fight death as well, no matter how awful the treatment or what harm it caused.

Why “Do No Harm”?” The primary ethical principle that forms the foundation for medical care (and the foundation of every society throughout history) is the concept of beneficence — the obligation to do good for others. The ability to do good is also the obligation to do good. The word hospital shares the same Latin root (hospes) as the word hospitality. It implies a duty to shelter and take care of a stranger or guest. The desire to do good often compels health care practitioners to perform some action in virtually any clinical situation, regardless of its effectiveness or even lack thereof. It is a reflection of our training, if not our DNA. Even so, medical and surgical treatments are inherently dangerous. Moreover, countless studies around the world have demonstrated that physicians and the public perceive the benefits of almost every treatment to be far greater and the risks substantially lower than they really are. There is a biased belief in the good that will be done. This belief is based on hope, fear, an exaggerated sense of the power of medicine, surgery, and the expectation that doctors will do good, as well as a cultural and historical awareness of “miraculous” advances in medicine and surgery over the past 150 years. The development of antibiotics, insulin therapy, and antihypertensive treatment in the 20th century, for example, resulted in the cure of previously dangerous infections and transformed conditions such as diabetes and hypertension from fatal diseases into chronic illnesses. As the science advanced, the goals of treatment and the ethos of health care changed; death became the enemy, rather than an inevitable consequence of life. Fighting death, therefore, became an important, if not primary, goal of American health care. Moreover, patients were expected to fight death as well, no matter how awful the treatment or what harm it caused.

The Hippocratic oath contains similar language. Many practitioners today still pledge that oath or at least receive a copy of it early in their training. The phrase is well known to almost any practitioner, yet despite its ubiquity, and perhaps even because of it, it is worth asking this question: What does “first do no harm” actually mean today? Has its meaning or importance changed over time? I will discuss the historical meaning of the phrase, its relationship to other ethical principles, the changing nature of harm, and the changing ethics of health care, as health care delivery and health care culture continue to evolve.

**Autonomy**

In recent decades, the principle of autonomy — the right of patients to make their own decisions — has been ascendant. The physician must still do good and avoid harm, but the patient ultimately has the right to decide. Patients may choose to accept a greater risk of harm, either from treatment or from the decision to forgo treatment.

Rather than absolving clinicians of responsibility, however, autonomy raises the bar even further. We are responsible for communication. It is incumbent upon clinicians not just to know the risks, benefits, and alternatives, but also to teach them to our patients. This forms the basis of the principle of informed consent. We must not only respect the choices that others make, but we must respect others regardless of the choices they make. This is especially important when their choices differ from those we would make for ourselves.

Not giving patients and families accurate information and not respecting them or their choices is harmful. Abandoning them as a result of their choices is unconscionable.

**New Kinds of Harm**

Harm can take many forms. Some are intrinsic to a specific treatment or medication, but others are caused by care delivery more broadly. Some are age-old, and some change with the times. In the mid-1800s, physician Ignaz Semmelweis discovered that the high incidence of maternal death from sepsis after childbirth in Europe was caused by poor hygiene among physicians. Nearly 200 years later, health care—acquired infections are a major cause of harm and death, along with antibiotic-resistant microorganisms.

Increasingly fragmented care across settings, and fragmented responsibility among an increasing number of care providers for a single patient and a single episode of illness, systematically introduce error, risk, and harm. Discharging sick patients from hospitals causes harm, as evidenced by the rising rates of hospital readmissions with decreasing lengths of hospital stays. Lower staffing levels in health care settings also increase the risk of harm. The proliferation of “information” in the form of medical records generated for the purpose of maximizing reimbursement minimizes the effectiveness of communication among providers, reduces productivity and thus access to care, and causes harm. Likewise, defensive medicine practices, which expose patients to unnecessary testing and treatment, are offensive and harmful. Defensive medicine is especially reprehensible insofar as its purpose is not to benefit the patient.

**Economic Harm**

The cost of health care in this country is so high, and so out of step with the rest of the world, that even paying for insurance causes severe financial hardship for many. In the extreme, the high cost of care may force some patients to choose between financial ruin caused by treatment or death without it. A cruel and immoral irony is that the patients without insurance — those who can least afford the cost of care — are charged more for it.

**Trained To Harm**

As doctors and nurses, we are trained as apprentices to do things a certain way, with the expectation that we must always do things that way. We develop habits that are intended to persist decades beyond our formal training. We assume that things are done that way because they have been done that way, and thus we follow them or their choices is harmful. Abandoning them as a result of their choices is unconscionable.

**Growing Pains of Economic Harm**

The cost of health care in this country is so high, and so out of step with the rest of the world, that even paying for insurance causes severe financial hardship for many. In the extreme, the high cost of care may force some patients to choose between financial ruin caused by treatment or death without it. A cruel and immoral irony is that the patients without insurance — those who can least afford the cost of care — are charged more for it.

**Growing Pains of Economic Harm**

As doctors and nurses, we are trained as apprentices to do things a certain way, with the expectation that we must always do things that way. We develop habits that are intended to persist decades beyond our formal training. We assume that things are done that way because they have been done that way, and thus we follow them or their choices is harmful. Abandoning them as a result of their choices is unconscionable.

**Growing Pains of Economic Harm**

As doctors and nurses, we are trained as apprentices to do things a certain way, with the expectation that we must always do things that way. We develop habits that are intended to persist decades beyond our formal training. We assume that things are done that way because they have been done that way, and thus we follow them or their choices is harmful. Abandoning them as a result of their choices is unconscionable.

**Growing Pains of Economic Harm**

As doctors and nurses, we are trained as apprentices to do things a certain way, with the expectation that we must always do things that way. We develop habits that are intended to persist decades beyond our formal training. We assume that things are done that way because they have been done that way, and thus we follow them or their choices is harmful. Abandoning them as a result of their choices is unconscionable.

**Growing Pains of Economic Harm**

As doctors and nurses, we are trained as apprentices to do things a certain way, with the expectation that we must always do things that way. We develop habits that are intended to persist decades beyond our formal training. We assume that things are done that way because they have been done that way, and thus we follow them or their choices is harmful. Abandoning them as a result of their choices is unconscionable.

**Growing Pains of Economic Harm**

As doctors and nurses, we are trained as apprentices to do things a certain way, with the expectation that we must always do things that way. We develop habits that are intended to persist decades beyond our formal training. We assume that things are done that way because they have been done that way, and thus we follow them or their choices is harmful. Abandoning them as a result of their choices is unconscionable.

**Growing Pains of Economic Harm**

As doctors and nurses, we are trained as apprentices to do things a certain way, with the expectation that we must always do things that way. We develop habits that are intended to persist decades beyond our formal training. We assume that things are done that way because they have been done that way, and thus we follow them or their choices is harmful. Abandoning them as a result of their choices is unconscionable.

**Growing Pains of Economic Harm**

As doctors and nurses, we are trained as apprentices to do things a certain way, with the expectation that we must always do things that way. We develop habits that are intended to persist decades beyond our formal training. We assume that things are done that way because they have been done that way, and thus we follow them or their choices is harmful. Abandoning them as a result of their choices is unconscionable.

**Growing Pains of Economic Harm**

As doctors and nurses, we are trained as apprentices to do things a certain way, with the expectation that we must always do things that way. We develop habits that are intended to persist decades beyond our formal training. We assume that things are done that way because they have been done that way, and thus we follow them or their choices is harmful. Abandoning them as a result of their choices is unconscionable.

**Growing Pains of Economic Harm**

As doctors and nurses, we are trained as apprentices to do things a certain way, with the expectation that we must always do things that way. We develop habits that are intended to persist decades beyond our formal training. We assume that things are done that way because they have been done that way, and thus we follow them or their choices is harmful. Abandoning them as a result of their choices is unconscionable.

**Growing Pains of Economic Harm**

As doctors and nurses, we are trained as apprentices to do things a certain way, with the expectation that we must always do things that way. We develop habits that are intended to persist decades beyond our formal training. We assume that things are done that way because they have been done that way, and thus we follow them or their choices is harmful. Abandoning them as a result of their choices is unconscionable.
extreme, a lack of action equals neglect. It is a mistake to think that doing no harm is a passive duty — it is an affirmative obligation that requires constant diligence.

**Do No Harm Today**
In 2016, doing no harm means lifelong learning and a willingness to embrace necessary change.

More explicitly, to do no harm requires routinely reviewing, reducing, and discontinuing medications. It means avoiding antipsychotic drugs and other medications altogether when their sole purpose is to make people with dementia or delirium behave. It means avoiding physical restraints in all settings. It means an obligation during care transitions to participate in an active handoff of care between practitioners, with scrupulous medication reconciliation to avoid medication errors. It means knowing your patient well and accepting responsibility as your brother’s or sister’s keeper. To do no harm means to advocate for high-quality, affordable, universal health care for all. It means active listening, cultural competency, being present and engaged, teaching patients and families, and guiding them through the fragmented, byzantine, and potentially dangerous American health care system.

It means striving to be the best that we can be, the best that anyone can be for their mother or father. We have an obligation to do good. We also have an obligation to be good — to be good people, and to be good at what we do. We have an obligation to care. These are the ethics for us and our time.

Dr. Evans is a full-time long-term care physician in Charlottesville, VA, and medical director of two skilled nursing facilities. A past Society president, he serves on the Caring for the Ages Editorial Advisory Board. Read this and other columns at www.caringfortheages.com under “Columns.”