The Hippocratic Oath: Revisited

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Abstract

Traditionally, the model of the physician-patient relationship was rooted in the Hippocratic Oath that condoned paternalism. The current emphasis on autonomy and distributive justice has changed the relationship to such extent that one might argue that the Oath has become irrelevant. This article will discuss whether the obligations dictated by the Oath are specifically *Western* or not, what has changed in the current medical environment and what should replace this traditional Oath?

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Introduction

Arguably, until the 1960s, the model of the physician-patient relationship was rooted in the Hippocratic Oath and tradition that condoned paternalism. The current emphasis on autonomy and distributive justice has changed the relationship to such extent that one might argue that the Oath has become irrelevant. Many models have been suggested to adapt to current practice. The Hippocratic Oath, tradition, and ethics are commonly seen as the action-guiding principles that inspire the medical profession. However, currently, a number of medical ethicists have questioned their relevance to today's practice. For instance, RM Veatch and HT Engelhardt argue that the values and principles of the Hippocratic tradition should be viewed as specific of the limited fraternity of the neo-Pythagorean physicians in the ancient Greek world.[1,2] Therefore, they are irrelevant in today's multicultural world. Others, like ED Pellegrino, strongly oppose this view seeing in the Oath the foundation of *Western* medical ethics even if it needs adaptation to contemporary situations.[3] These positions raise a number of issues. First, one could argue that the obligations dictated by the Oath are not specifically *Western.* Second, one may ask what has changed in the current medical environment. And, third, what should replace this traditional Oath?

Discussion

The Oath is not typically Western

The code of King Hammurabi in the 17th century before the Common Era (BCE) set the first known rules guiding medical practice. Emphasis was placed on the avoidance of 'harm'. Vaidya's oath of the Hindu physician (15th century BCE) added to non-maleficence the proscription of eating meat, drinking, and of adultery. The Hebrew oath of Asaph and Yohanan (6th century CE) included the principle of sanctity of life (against abortion and euthanasia), the proscription of adultery and of taking bribes. It recommended *beneficence* and *confidentiality.* The oath of Sun Simiao (581-682 CE), the "Chinese Hippocrates", asked the physician to always consider the patient as if it were a relative. Beneficence, non-maleficence, and confidentiality were the key principles to adhere to. The seventeen rules of Enjuin (Japan, 16th century CE) included confidentiality, empathy, beneficence, non-maleficence, the prohibition of euthanasia and abortion, as well as of having obscene or immoral feelings when examining a woman.

In other words, most basic action-guiding rules have been common to the practice of medicine worldwide.[4] In sum, three of the four principles of Principlism advocated by Beauchamp and Childress, confidentiality (a component of autonomy), beneficence, and non-maleficence have been integral components of the good practice of medicine.[5] The principle of justice has generally been overlooked. Finally, even if it is true that Hippocratic medicine was a paradigm shift in the sense that it looked at the physical causes of diseases rather than at anything divine, this shift has been first ascribed to Imhotep, the so-called Egyptian Asclepios (2650–2600 BCE).

The original Oath has changed

The original Oath has undergone changes. To begin with, contemporary versions omit about two-thirds of the original one. From the first part, duties to one's teachers and the obligation to transmit medical knowledge have been maintained. The next part of the original Oath outlines the moral obligations of confidentiality, non-maleficence and of respect for life (prohibition of abortion and euthanasia). Emphasis is placed on "above all do no harm".

The prohibition of abortion is interesting to unpack. In Ancient Greece, abortion as such was not illegal. Prosecution would occur only when it was deemed to have circumvented the male's rights to his offspring. In that context, the Oath was a pledge to respect paternal rights rather than a moral protection of the principle of the sanctity of life. In addition, as shown in Plato's *Theaetus*, midwives rather than physicians were the ones procuring abortion. In other words, the injunction referred to the obligation of limiting one's practice to what one has been trained

for. The same interpretation applies to the Oath's puzzling prohibition of surgery.[6]

Gone are the ethics based on paternalism and of "above all" do not intentional harm. Until the 1960s, Western medical associations were in control of the professional identity and managed secure monopoly powers in medical education and hospital practice. Current social concerns of justice, right to health care, and universal health care system have shifted the focus from the strictly physician-patient dyad to situations where governments seek, in the name of distributive justice, to control the increasing costs of health. It follows that the Hippocratic tradition of independent professional and moral identity is under siege. This shift towards the obligation to apply cost containment principles, however, may affect the welfare of individual patients.[5]

The search for models of physician-patient relationship

From the above, one would agree that some parts of the original Oath have become irrelevant and that the environment of medical practice has changed drastically. F Jotterand argues that medical professionalism must be founded in "a philosophy of medicine that explores the values internal to medicine, rather than in the Hippocratic Oath and tradition".[6] The joint American and European *Charter on Medical Professionalism* of 2002 is an attempt to reaffirm some of the fundamental principles necessary for the practice of medicine. It aims at ensuring that medical professionals and health care systems are committed to the patient's welfare and to the basic tenets of social justice. Its three fundamental principles are: 1) the primacy of patient's welfare; 2) respect for patient's autonomy; and 3) social justice.[7]

Thomasma as well as Jotterand argue that these principles are as ambiguous and substance-less as the Hippocratic ones. Jotterand contends "the move from ethical reflection to legal and economic concerns is insufficient to sustain the moral identity of the medical profession". What is needed, they both argue, is a search for the normative and moral basis of the profession through a critical examination of ethics in medicine. What has been done so far, so they claim, is to analyse the ethical questions concerning the practice of medicine. What needs to be done is to analyse and judge the decisions resulting from a combination of the harm/benefit ratio of technical procedures, the moral components (e.g. autonomy, honesty), and the socio-economic factors (i.e. distributive justice) commitments, the requirements of the professional identity, and what internal values should be nurtured.[5]

Veatch has critically analysed four possible physician-patient relationships, namely, the priestly model (i.e. paternalism), the *engineering* model (i.e. the physician strictly plays the role of a technician), the *collegial* model (i.e. shared decisions are made by equals), and the *contractual* model. The latter lists patients' rights and the corresponding physicians' duties that are to be included in negotiating the contract.[8] The contractual model has been widely criticised for its "legalistic" overtones and for not representing the reality. The physician and the patient do not sit down and establish a list of mutual duties, responsibilities, and conditions of the contract. Emmanuel and Emmanuel insist on the power relationship in the physician-patient relationship where the physician easily could abuse his power. To avoid this, they suggest a *deliberative* model that addresses power as an ethical component in the relationship. In her role, the physician must work to prevent abuse while enhancing the patient's autonomy.[9]

In his analysis of the various models that have been proposed H Brody concludes that any model requires two tests: 1) does it have a solid foundation in ethical theory; and 2) does it fit with the reality of contemporary practice?[10] Like Jotterand, Brody refers to MacIntyre's *After Virtue,* opposing so-called *bottom-line* ethics – all that matters is the outcome, follow the rules and respect others' rights – to an ethics based on the principle that the *way* we do things also matters.[11] The way we do things should strive at excellence, integrity of character, and dialogue geared at the patient's welfare.

Conclusion

As it stands, the Hippocratic Oath can no longer be viewed as *the* action-guiding inspiration of current medical practice. However, the last word has not yet been said. The quest for a model based on respect for autonomy that at the same time aims at the individual patient's welfare while taking into account the requirements of distributive justice is an arduous task. Furthermore, its focus on the individual's autonomy has led others to refocus the physician-patient relationship through, for instance, a *communitarian* approach or through a perspective centred on care. To only apply the rules – bottom-line ethics – is not a solid ethical foundation. What is needed is to focus on the integrity, consistency, and excellence of character in the physician-patient relationship. Virtue ethics is appealing for its ability to provide a normative basis to the values internal to medicine.

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