The Hippocratic commitment to patients: A declining trend in modern medicine

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As in many medical schools, the final year medical students at the International Medical University (IMU) formally and solemnly recite our version of the Hippocratic Code. The core premise of the Hippocratic Code has stood the test of time, more than 2000 years.

In ancient times, before Hippocrates, disease and illness were attributed as a sign of divine dismay, and the Gods needed to be appeased to achieve a cure. Hippocrates and his followers showed courage in breaking away from this paradigm. They moved away from the divine and supernatural, to focus on the biology of the body. In the process they put the patient at the centre of their focus. They collected detailed case histories, dismissed religious and supernatural explanations and developed remedies in the form of diets, exercise and mixed minerals and herbs based on their understanding of ill health.

It is proclaimed in the Oath, "In every house where I come, I will enter only for the good of my patients". This commitment to the patient without compromise, has become a global ideal, and has become fundamental to the core values held by the medical profession, and to patient's expectations of their doctors.

The Hippocratic Code has been accepted across the world, through the ages. It was brought to the west by the Romans and to the east by the Muslim caliphates.

The Hippocratic commitment and devotion to the patient as a person in ancient times, enabled doctors then, to gain the patient's trust. Doctors were forbidden to have sex with patients, they attempted accurate prognosis and avoided making promises that could not be kept. They also emphasised the importance of privacy and the confidentiality of the doctor-patient relationship.

In the past the Hippocratic commitment to patients was in the context of medicine's limited ability to cure illnesses, and the absence of significant medical technology in medical practice. Public authorities, including the soldiers and police also had little interest in seeking the limited skills of doctors to either protect or oppress the citizens.

The Hippocratic Oath commonly viewed as the foundation of the medical profession, is really the prevailing ethos rather than a professional approach. Medicine in ancient Greece was influenced by the classical philosophy of Plato and Aristotle. Hippocrates was a doctor and also an outstanding philosopher of his times. The Hippocratic Oath was a concise statement of the moral code of ancient Greek medicine and points to the relationship of doctor, patient and illness. The dynamics of this triangle in modern times can be affected by so many factors, such as science and technology, the media, economic considerations of cost-benefit, effectiveness, and efficiency, with subsequent consequences.

The Concept of Modern Medical Ethics

In modern times, the shaping of the ethical concept of medicine as a profession, in the English language was done by the Scottish physician-ethicist John Gregory (1724-1773) and the English physician-ethicist, Thomas Percival (1740-1804). Medical practice in eighteenth century Britain and North America was entrepreneurial. There was a constant tension between the Hippocratic commitment to the sick on one hand, and entrepreneurial self-interest on the other.

The medical market place at the time was over supplied, and competition was fierce, as the outcome of failure was poverty. Doctors attempted to stand out from competitors by "peculiarities" of dress, speech and manners. There was also tension between doctors and the "Trustees" and managers who ran hospitals on behalf of the employers.

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Gregory was concerned that the entrepreneurial, self-interested medical practice of the time, introduced biases that distorted clinical judgement and decision making. He was also concerned about the competence of medical practitioners.

Gregory set out to give the concept of a profession, intellectual and moral content, and proposed the ethical concept of medicine as a profession, which had three components. Firstly, the doctor commits to being scientifically and clinically competent. Secondly, the doctor commits to the protection and promotion of the patient's health-related interests as the doctor's primary concern and commitment, keeping self-interest systematically secondary. Thirdly, doctors commit to maintaining and passing on medicine to future patients and doctors and society as a public trust, not as a merchant guild that protects the self-interests of its members as its primary concern and commitment. The first two components of the ethical concept of medicine as a profession emphasises the core professional virtue of integrity and self-sacrifice respectively. In the third component, Gregory had referred to the Royal Colleges of the time, which despite the Royal Charter existed only for the self-interests of its members.

Percival took up the direction of Gregory in the third component, and expressed it in clear, conceptual terms. He discussed and developed the ethics of when doctors should retire from practice. In his words,

> *"Let both the physician and surgeon never forget, that their professions are public trusts, properly rendered lucrative whilst they fulfil them, but which they are bound, by honour and priority, to relinquish, as soon as they find themselves unequal to their adequate and faithful execution." (Percival, 1803)*

In the history of western medical ethics, Gregory and Percival were the first to use the word 'patient' instead of 'the sick'. This has important implications from the ethical concept of medicine as a profession. Fulfilling the three components required by the ethical concept of medicine as a profession, as proposed by Gregory, turns medical practitioners into professional doctors.

The reality of medicine as a profession is the function of the combination of the exercise of clinical skills, decision making and behaviours of doctors. External forces such as funders or governments do not create the profession nor can they affect or destroy it. Doctors as a group are in charge, and should hold themselves accountable to uphold the values of the ethical concept of medicine as a profession. From this is developed the doctor-patient relationship as a fiduciary relationship of protection and promotion of the patient's and research-subject's health related interests.

The ethical concept of medicine as a fiduciary profession, becomes the platform that influences the doctor's character and behaviour, and the ethical principles become a guide in clinical practice, research and teaching. It is also useful in guiding doctors in the face of economic and other conflicts of interests. The doctor's self- interest must always be subordinate to the patient's interest. This is a continuous and major challenge to all doctors so long as they practise medicine.

Medicine's limited capabilities in the past over 2000 years probably helped to sustain the Hippocratic commitment to patients. Medicine started to change dramatically in the nineteenth century as anaesthesia was introduced, hygiene became better understood and antisepsis was applied in surgery. This enabled operations to be performed into the abdomen, chest and brain. X-rays, electrocardiograms and lots of other innovations added to medicine's capability, and to mounting costs of care.

As medicine's capabilities grew, it moved from being a cottage industry to an industrial scale enterprise. It made economic sense to put operating rooms, equipment and gadgets into the central setting of hospitals, which became increasingly complex and increasingly expensive.

Increasing public expectations pushed governments to provide medical care to all citizens. Germany was the first to do so in 1883 with a national health insurance covering their citizens. Other Europeans countries followed Germany's example, which very much later was followed by Asian countries like Japan, Korea and Taiwan.

Healthcare spending 120 years ago was probably less than one percent of the Gross Domestic Product. In many countries this has now increased by ten-fold and in the USA probably twenty-fold. In these circumstances it is only to be expected that the State has become involved in setting priorities and imposing limits on resources allocated to healthcare.

The amazing advances in science and technology resulting in medicine's increasing capabilities is a double edged sword. The increasing capabilities to diagnose and treat comes with escalating costs. This then puts pressures on doctors and health professionals being caught in positions of budgetary constraints and may have to withhold life extending care to patients, breaking the promise of fidelity to patients.

Doctors are expected to balance care to individual patients with the need or priorities of the community, in terms of utilisation of resources. Doctors are expected to control costs to help manage health care spending. This inevitably results in some form of rationing, which tends not to be publicly acknowledged.

This rationing process tend to occur in a covert manner all over the world. Our political masters in government will claim that patients will not be deprived of treatment when needed despite budgetary constraints. In reality how can this be true? Waiting time for treatment of complex illnesses increases and the disease progresses. The current scandal of waiting time in the Veterans Administration health system in USA is another example of attempts to ration care in a covert manner. In the 1970's in the United Kingdom, there were hardly any patients over the age of fifty years on long term dialysis. Yet it was claimed that no rationing

occurred. It so happened apparently that the GPs do not refer patients over the age of fifty for dialysis treatment.

The commercialisation and commoditisation of medicine and healthcare is inevitable in a market economy. The entrepreneurial bent of doctors who own healthcare facilities, expensive equipment and treatment modalities in a fee-for-service environment is rich with conflicts of interest. Similarly the interaction between doctors and the pharmaceutical and medical devices industry poses problems of conflicts of interest. Doctors who have contracts or arrangements with managed care organisations, third party administrators and insurance companies are often persuaded to avoid costly treatments or to limit care. A similar situation with managed care in the USA in the 1990's caused popular public outrage against managed care.

As medicine's capabilities have increased dramatically, society has come to depend on doctors to perform a broad range of functions that does not sit well with the Hippocratic commitment of looking after the patient's interest.

The advances in science of infectious diseases have resulted in laws that confine the sick against their will, and the practice of compulsory vaccination of the healthy population to stop disease outbreaks. Here the values of public health appears to be in conflict with medicine's fidelity to individual patients.

Would examining a prisoner to ensure fitness for execution be in the prisoner's interest?

Would resuscitating and treating a sick prisoner to ensure fitness for execution be in the patient's interest?

In the war on terror after nine eleven, doctors were involved in the process of interrogation. Torture was involved in the so called "enhanced interrogation" process, and doctors were involved not only in evaluating the prisoner's physical condition as part of the process, but doctors were also involved in planning the torture process in the so-called "enhanced interrogation".

Attempts to rationalise the involvement of doctors in torture by claiming that prisoners are not doctor's patients, further highlight the cynical and distorted view that has been taken of a doctor's role. In using clinical skills and practice in the assessment of the health of individuals, doctors are bound by our ethical code. Using legal gymnastics to redefine what constitutes "torture" in the interrogation process is a cynical attempt to legalise what are actually criminal activities. It is difficult to see how the doctor's involvement in this can even be considered in the interest of the "patient".

In a similar view, it is difficult to see how the doctor's assessment of soldier's fitness to be involved in combat or assessing the mental state of murderer's accountability for crimes committed, can be viewed to be consistent with the Hippocratic tradition. In both cases, the clinical assessments put the "patients" at grave risk of being killed in combat or by execution.

The Social Purposes of Medicine

The community expects medicine to have various social purposes including healthcare cost containment, criminal justice, national security and support for common values. When these values clash or contradict each other, doctors are expected to choose between them.

It is important that the social purposes of medicine be openly discussed and debated by doctors and non-doctors. This can help clarify the roles doctors have to play for the greater good, beyond caring for individual patients. This will be helpful for doctors as well as for the public.

There is the need to understand the boundaries between acceptable and improper exploitation of clinical relationships for public purposes. While the consideration may be the importance of the social purpose, there are implications for trust and trustworthiness in clinical relationships.

Increasingly medical technology is used for public purposes such as national security and criminal punishment. In this situation medicine's credibility as a caring entity is put at grave risk by pushing doctors to break their pledge of fidelity to patients.

Increasingly we have seen economics come to dominate over medicine, science and technology, and medicine has become dependent on social institutions for economic viability. Cost containment has been imposed on doctors who then can no longer be exclusively committed to their patients.

That medicine has become deprofessionalised and transformed into a vast industry has caused concerns to many in the medical fraternity around the world. In an effort to reconsider medical professionalism, a collaboration of a number of medical societies in the USA and Europe developed the Physicians' Charter on Medical Professionalism in 2002. This Charter calls for a renewed sense of professionalism and sought to ensure that all medical professionals and the healthcare system are committed to patient welfare and the basic tenets of social justice.

The Charter's emphasis on a duty-based ethics approach, focussed on competence is important in the modern complex settings of healthcare. This approach can be viewed as a necessary adaptation to the demands of the market place ethos, and the healthy competition that will occur. Doctors should be accountable to the public, and patients are empowered to manage their own health. Medicine can become more democratised. This can all be considered desirable. However medicine then becomes reduced to be an occupation like any other.

The ethics of medicine then becomes reduced to the minimalist ethics of business and commerce.

Many doctors appeared to have accepted this view, and their main concern that the doctor's responsibility primarily focusses on technical competence, disclosure of interest, and a contractual relationship with patients. Many are concerned that they may be deprived of the rich rewards, their education and expertise entitled to them.

There is a minority among doctors who are concerned with the ethos of the market place, that commoditisation and commercialisation of medicine distorts the fiduciary relationship they have with their patients. They are the few that want to dedicate their lives to something other than their own self-interest. The values and ethics of this group of doctors conform to the traditional ideal of a profession with the emphasis on virtue ethics. To them medicine is a vocation, never merely a job. There are many capable, dedicated and sensitive doctors who feel that they are practising medicine in a dark world, lacking of a soul.

The majority of doctors exist between these two groups. They compromise to survive, and worry whether this compromise is defensible. They realise that they cannot be professionals in the pure and pristine ideal of the professional concept.

This is the group that long and yearn for a more ethically sensitive system and look for leadership from their professional societies. They hope for medical statesmanship that does not appear to exist anymore. Unwilling as they maybe, they adapt to the values imposed by the market and commercial model of healthcare.

The Goals of Medicine

In considering the social purposes of medicine, we must be reminded of a report by the Hastings Centre, New York entitled "The Goals of Medicine: Setting New Priorities".This report was the result of an international consultation conducted in several countries in four continents, over four years by the Hastings Centre, New York in 1996.

This report proposed the four goals of medicines, which represent the core values of medicine, namely:

- The prevention of disease and injury and promotion and maintenance of health

- The relief of pain and suffering caused by maladies

- The care and cure of those with a malady, and the care of those who cannot be cured

- The avoidance of premature death and the pursuit of a peaceful death

A relook at the Goals of Medicines can be helpful for us to look at future priorities for the ways the health care systems are organised, how doctors should be trained and for development of thrust areas in biomedical research.

While we can expect medical knowledge and skills to be used for the good, it can also be used for evil or unacceptable purposes. While the goals of medicine may be open to various interpretations, we must apply it for the common good.

The report also emphasises that medicine should aspire:

- to be honourable and to direct its own professional life

- to be temperate and prudent

- to be affordable and economically sustainable

- to be just and equitable, and

- to respect human choice and dignity

The values and issues emphasised in this report are crucially important for the future of medicine.

The Importance of Trust

The late Stephen Covey in a lecture in New York in 2010 cited that 27% of people trust healthcare leaders, and 28% of people trusted hospitals. Three or four decades previously 73% of people trusted doctors and hospitals. Apparently the situation is similar in Britain.

Stephen Covey had further stated that "… the ability to establish, grow, extend and restore trust with all stakeholders (patients, families, colleagues and communities) is the number one leadership competency in healthcare today."

The loss of trust of this scale is deeply disappointing, even as so many doctors and health professionals are dedicated and work so hard for patients, as so much more is spent on healthcare, and medicine has so much to offer. However this is the reality, and healthcare now is so exceedingly complex and so multifaceted.

Medicine exists to serve society and has to adapt to the priorities and values that shapes our contemporary and dynamic society. I believe that working for Health is a moral issue, and similarly in medicine we have to find a philosophy of medicine that explores the values that is at the core, and is internal to medicine. This can then be a moral philosophy, and the Hippocratic tradition and medical ethics can provide guidance in this process. The moral philosophy of medicine must be linked to a philosophy of medicine, which can be a foundation of the medical profession in facing the challenges of modern society. This is work that needs to be done, and leadership is urgently needed if medicine is to continue to claim its status as an esteemed profession that deserves the trust of patients and the community.

Will there be people of virtue, dedication and talent that can lead us in this process to uphold the values of medicine that is consistent with medicine's traditional values that can exist in our contemporary, dynamic society?

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