The Meaning of "Do No Harm": A Medical Student Perspective

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The Experience

The maxim, "First, do no harm" is strongly associated with the medical profession. It is a fundamental statement about the role of the physician in patient care. A patient should not be worse off after treatment than they were before. In modern medicine this can be a difficult standard to adhere to.

As a third year medical student with only one month of clinical experience, the surgical intensive care unit (SICU) was a daunting environment. I followed one patient for the duration of my rotation in the SICU who was a victim of a crush injury. It seemed that in some ways I knew everything there was to know about this gentleman. I knew all about his electrolytes, acid-base status, and liver enzymes. Yet on another level, I knew nothing about my patient. What was his life like? What were his values? For a time, I didn't even know his name… only his medical record number. One night as I lay in bed looking at the ceiling, I wondered if what we were doing could be considered harm.

A full complement of advanced technology was utilized to ensure his survival: mechanical ventilation, dialysis, tube feeding, surgical interventions and a long list of medications. What would he say if he could see himself in the SICU with a tube coming out of every orifice? All that I had learned in my first two years of medical school about history taking, patient communication, and open-ended questioning, did not prepare me for this experience. My patient was unconscious, and unable to share in the decision-making process. He had remained intubated and sedated since his emergency surgery on arrival.

I believe that if we cause unnecessary suffering, we have done harm. However, suffering is in the eye of the beholder and can be a complex concept. Cassel explores the problem of suffering in his article "The Nature of Suffering and the Goals of Medicine." He asserts that patients can suffer in physical and non-physical ways, and that physicians make an error by focusing primarily on physical suffering.1 Patients can suffer if they lose functional status, if they are no longer able to fulfill their roles or if they feel that they are a burden on their family. Furthermore, an individual in physical pain may not necessarily experience suffering.

For example, I read the story of a patient with breast cancer who believed that God had made her ill as punishment, as she had been unfaithful to her husband.2 It can be argued that this patient was not suffering from her symptoms as much as she was suffering emotionally, as her condition was complicated by feelings of guilt. Human beings are multifaceted and frequently we only peer into our patients' lives through one of those facets.

It was never possible for me to learn in what ways we may have been exacerbating or relieving my patient's suffering. The success of life support techniques seduces us into causing suffering for patients at times when they are at their most vulnerable. One study found that 75% of patients on a general internal medicine service would prefer to die at home, but of the patients in that study that died, 66% died in an institutional setting.3 There is room for improvement when it comes to doing no harm. One way to do this is to give patients the kind of death that they want, which will require a cultural change in medicine. We must acknowledge that death is the natural and inevitable conclusion of life, and not a failure of our profession.

For patients, like the gentleman I cared for in the SICU, that never get the opportunity to communicate their values and preferences regarding medical care, the solution is different. We must have the uncomfortable, but necessary conversations with our patients about what their values and preferences are if they were ever unable to speak for themselves while they are healthy. Preserving life does not necessarily mean that harm has been avoided. If a patient is condemned to a life of disability and chronic pain, is that harm? That is a matter of opinion. The most important opinion, that of the patient himself, was unfortunately unavailable. Sometimes our patients suffer because of our inability to accept death.

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Perhaps a husband would never want to live if he suffered a brain injury that would permanently alter his personality. For someone that watched a family member die waiting for a kidney transplant, perhaps they would never want to live a life dependent on dialysis. Perhaps a surgeon would never want to live without hands steady enough to operate. The only way to know is to ask the question.

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