I Forbid, Therefore I Assist

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“*We forbid in the present to keep hopes in the future*”

Benefit without malefaction, an ideal in Medicine; non-maleficence more than beneficence, a bioethical reality in physician’s daily routine1-3.

It has been a long time since Hippocrates (460 B.C. - 377 B.C.) left us the message, “… *do not harm the patient …*” It has become a symbol of medical ethics and, having been sent from generation to generation, it has acquired a status of bioethics principle1. It is a piece of advice on responsibilities and a strategy of safety.

Every process of medical science requires being careful against retrocession in humanization. Negligence towards sociable and more humane caring for is also a way of iatrogenesis.

For the non-maleficence principle, the physician must abstain from causing an intentional damage5-7; the intention to safeguard from iatrogenesis, a sworn-in duty at graduation, is carried out by the bed under some ways: do not start the evidently harmful (including class 3 procedures), to avoid whatever is doubtful and that is more like class 2b than class 2a (absence of beneficence), and do not insist before a bad outcome, despite being class 1 procedure (non-maleficence having priority over beneficence).

By acting exactly the same as a superego, non-maleficence is an ethics filter to select and keep those with a probability of being punished based on Article 29 of Medical Ethics Code as an act of imprudence. Avoiding applying what most colleagues would not do is not necessarily non-maleficence, but highly majority, it is the concept that has taught us since College. It is basic in medical guideline conception.

Non-maleficence discourages the raptures of creativity aside ethical principles, evidences through researches and common sense. Thus, it is an alert so the wings of Hermes caduceus are not used when there is the temptation for atheoretical. Curiously, the lesser they are used, the more ethic miles are accumulated.

Non-maleficence practice scenario uses to have two environments: the circumstantial and the required.

In the first one there is the encounter of the patient and his/her clinical situation with an ethic profile, honesty, secrecy and efficiency from the physician. Unfortunate conjunctures happen and make Medicine Ethic Councils to apply warnings and censure.

In the second environment, the adaptations of behaviors after selection of understandings and abilities are carried out; adjustments take place based on either convictions on distinction between necessary (amputate and gangrened limb) and unnecessary (not for a clearly allergenic medication in the history of that patient) evil, or in socioeconomic conveniences of that physician-patient relationship. *Primum non nocere* kidneys under acute failure, without using radiological contrast; the stomach just ill-taken by a medicamentous gastritis, suspending anti-inflammatory drug; operative field interrupting the use of medication that has been preventing from a thromboembolism. Bioprostheses shall be preferable to metallic one that cannot be protected due to personal and infrastructure conditions for a good lengthened anticoagulation control.

In the name of clinical prudence, it is avoided “pushing” the patient in a slippery slope8,9, by recommending restrictions; they sound as anti-negligence. In fact, part of them seems as not outline precious limits of real usefulness; sometimes, it is the memory of an unsuccessful case that provides sufficient “practical base” for the physician, so he/she does not want risk a repetition.

So, restrictions give rise to reflections on justified paternalism. In general they are abstentions of habits by the patient, just as minimizing any opportunities of a risk becoming an event. They use to be objectively verbalized, without much consideration and with occasional social damages to the patient. Privilege with clinical evolution, with patient’s life and opinion from relatives is a classic behavior, but surely subjected to conflicts with the definition of damage in the *New Dictionary of Medical Ethics*: nothing is harmful unless it is felt as bad for who suffers, meaning that damage is a subjective concept.

Prohibitions are justified for the attention from the physician with the chance, the unknown and uncertainties, which are three ghosts haunting professional practice. We would say that not doing is a way of knowing how to experience a difficult stage intending the pleasure, obviously not the one of the moment, but that of a risk-free future. The patient who, after all, agrees that the sacrifice was worthy, thus gratifies the physician, but we should not
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forget that there was no control group, nor the patient was control of himself/herself. Depriving himself/herself from something customary can, nevertheless, be understood by the patient as more harmful than delaying the cure. There are patients seized with influenza who are compliant and those who are disobedient with recommended rest, wishing to remind us on motivation plurality that permeates the exercise of autonomy.

So, the daily routine of a physician witnesses resignations: the one connected to the own denial to imprudence, in favor of non-maleficence, and the one connected to patient's behaviors, in terms of anti-negligence.

“Don’t run, don’t eat, don’t travel, don’t work, don’t play, don’t stress” are used to being recommended, when safe elements for a proactive procedure are not available yet. It is the guidance for the moment, labeled as “of common sense”, related to a dedication – perhaps an euphemism for excess of authority or even egocentrism in some occasions – with the “in the view of the doubt.” It is a “just for a while” procedure.

Such modality of caution towards supposed event unleashing agents through the combination of clinical circumstance with patient's life's peculiarities, has a presumed primum non nocere the heart as an example: when it is included in the list of organs suspected from causing thoracic pain, it is not advisable to ask for it in a physical activity other than propaedeutical, until etiopathogenic clarifying. The intention for zero risk-event would fit in the “... do not harm the (organ of the) patient...”

The French philosopher René Descartes (1596-1650) got to the conclusion that a clear conscience of his thinking proved his own existence. Aware of the patient's risk, the physician proves the reason for his/her existence. By paraphrasing the famous Cogito, ergo sum, “I think, therefore I am”: I forbid, therefore I assist... the patient to not assist the event.

Prudence due to prohibition

“The cardiologist has a prohibition that bioethics itself recognizes”

Prudence ethics that worries about predictable consequences protects the intention of a zero risk-event. Such dedication is usually practiced for the future, inclusive, with a professional defense component.

Behavior associated to chance assessment are frequently the Achilles’ heel through which society submerges the physician in ethics courts.

Uncertainties on the future determine the prohibition, as one never knows if the one before us is that “only” 1% that will confirm statistics.

The scenery of restrictive behavior is usually a clinical situation in which propaedeutical trinity, sound, figures, images, does not give sufficient diagnostic clarity.

Characters interact. The physician plays a usual role and the patient his/her debut. Remind that the physician is always involved in additional forces at the value of a justified prohibition, not only due to the clinical experience of the “science of uncertainties and art of probabilities”, but also through conditioning to the Medical Ethics Code, in which 112 (77%) from the 145 articles have it is vetoed to the physician as a caput.

Era-procedure

The aphorism of Peter (Summary I) is an era-procedure of era-prohibition-type10,11. It provides a historic dimension on conflicts, between the patient’s wish and the physician's authority. The restrictive procedure represented the responsibility of the physician in preserving the life of the cardiac woman by speaking louder than the instinct for lineage. Paternalism exerted in terms of the absence of conciliatory solution of interests.

Since then the extraordinaire improvement of risk of pregnancy-benefit to cardiopathy relationship has transformed aphorism into an object of interest of Medicine. Currently, a mother’s heart has always fit in Cardiology.

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<th>Summary I - Peter’s Aphorism</th>
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<td>Michel Peter lived for 69 years (1824-1893); professor of Medicine College of Paris, he won the Capuron Award from Academy of Medicine of Paris, in 1875, for his observations on cardiopathy and pregnancy. He became and eponym and a symbol of the relationship between paternalism and limitations of Medicine.</td>
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<td>“… in practice, with cardiopathy, from the hygiene point of view, it will be preferable that the woman does not get married; if she does, she should not be a mother; if she got it once or twice, in case of a well-succeeded birth, she should abstain from breastfeeding...”</td>
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The lesson learnt is: what physicians produce scientific progress and make beneficence available by means of competent care contributes to make objectives in physician-patient relationship compatible. It is the greatest achievement of the physician, fruit from his desire in improve Medicine, as it cannot be forgotten that the physician makes Medicine and not Medicine that makes the physician.

Progresses strengthen the principle of autonomy, especially in elective care; conditions are created to foresee benefits, be committed with the means and honor the decision made in the presence of mishaps in the way; it is a way to encourage certain hidden competences in who was brought up under heteronomy.

Paternalism seems to be more present in emergency situations12, even because the system is usually structured in heteronomy prevalence.

Every one does the adaptations that may understand as convenient in this bioethical scale between paternalism and autonomy.
Moment-procedure

“The cardiologist does his/her best to look at the moment of the heart to see the future of the patient”

Moment-procedure is the one that would be “just for a while.” It has been applied in the beginning of an observation period, expectation of usefulness in anticipation to the ideal clinical-laboratorial clarifying, or in the sequence of a treatment, among adaptations. Moment-procedure includes the common sense opinion, the one that reacts through the perception of the iceberg tip and expects the refining of diagnosis plurality and admissible treatment in the submerged part.

Such conformity with the possible may provide security to the patient, as a link between his/her customariness of health and the awareness that the disease, in fact, took place.

Moment-procedure is a priority commitment of the physician with means, but that makes itself sensitive to patient’s expectation for the result, regardless of the necessary period to compose a specific treatment. Furthermore, it is “eternal as long as it lasts,” in the condition of temporary with the same ethical responsibility as definitive.

Moment-prohibition-type is moment-procedure that, among obscurities, favors zero risk-event. At that point, the intention is to avoid discomforts until death13.

Each moment-prohibition is always a touch in physician-patient relationship kaleidoscope. It happens due to the necessary professional sensibility of who will be the object of restriction. The resulting image “of the moment” determines the modality of the bond: the profiles are either perceived as “doctor, I’ll do whatever you tell me to,” or as “doctor, I cannot take that.”

Moment-prohibition, even for the fact of being far from being the “etiopathogenic” solution, is always a test for autonomy practice. As it builds in a diffuse logics, a certain credit magnitude to pros and cons takes place, which can be differently surmised by the patient; there are those who dare choosing cons and say, “I’ll only stop having my beers if the exams show something” and those who acquiesce and simply take pros with ellipses of what if... or for the sake of conscience....

Moment-prohibition that was rejected by the patient for being strict for his/her routine may sound, subsequently, as “he/she did not follow my guidance,” in the view that tends to paternalism, or as “he/she decided to take the risks,” in autonomy’s view.

For that reason, moment-prohibition must represent a physician-patient consensus, by allaying a “paternal” dedication through zero risk-event with a right for free will. So, the logics of prohibition remains in the field of ethics and, as much as possible, far from the view of a taboo, whose disrespect requires “purification” through a scapegoat...., for example, the physician.

The intention of determine a way that leads to the more or less under consensus objective results in pact. They are bonds that are set after presuppositions of prohibition having been weighed. Adaptations are facilitated through good practices of communication. Balance is the harmony of the advised with the wished.

Event at non-compliance

“But the patient wanted it like that, he had the last word, justifies the doctor, but the relative says right after, “yes, and the last word to you, before dying...”

The physician-patient/family relationship uses to shake when the decision from the patient of non-complying with the prohibition recommended by the physician, materializes in the event that he/she understood as something that “only happens to the others.”

Clashes of word against word produce verbal splinters and the fragments from letters and syllables joint themselves in new words and throw back the abuse. Friction between the opportunity the patient has to exert his/her free will and the inability in being authentic at the moment of the event, results in a kind of wound that exposes the plurality of human nature11.

In those occasions, the guilty person hunting season starts and one of the weapons listed has the difference of level of information between physician and patient as ammunition. The sight points at the target of an inefficiency image and the trigger lock is the Medical Ethics Code. When it backfires, the claimer feels as a victim of corporativism. It is part of the game.

Would the assertion that the physician knows more about diseases and the patient knows more about the sick person be an equalizer argumentation?

In a view of partnership with symmetry, the model patient of the physician who values the principles of bioethics is the one who enjoys the mission of the advisor-physician and, at the same time, feels well-informed by the consultant-physician without the feeling of being subjugated by impositions by the executor-physician.

The lack of familiarity with the risk run by the “disobedient” would represent a censure to physician’s respect for the right for autonomy exerted by the patient14. The heteronomical thought works as follows: the non-physicians are lay people; patients are non-physicians; therefore patients are lay people. The autonomic compensation of such syllogism is that people have values and responsibilities on the decision.

In a discussion, the concept of lay person and the verbalization of the values adapt in accordance with interests (Summary II).

Power unevenness allegations are also observed4. Each physician sees himself/herself with a level of authority to apply a moment-prohibition before professional responsibility; it may represent since keeping the thankful patient in a ready medical care to the figuration of being
It is the behavior in physician-patient relationship that reinforces the pertinence of Anna Karenina principle for the physician-patient relationship. According to the Russian writer Leon Tolstoy (1828-1910), *all good results are alike, but every bad result is peculiar in its way.*

Ways are not few in Medicine, connected to the disease, the physician, and to the patient. Combinations are infinite, not only because each patient has his/her own disease, but also because there are differences of behaviors among physicians and even for the same physician in different occasions.

It is important to remember that there is no vaccine against indictment based on the Article 29 of Medical Ethics Code against a professional who was honest in doubt, secret concerning the agreement and efficient at managing the limitations of Medicine. Secondary victories infest unjustifiable protests, a hectic activity of claimers, in which the physician is the one who shivers.

Without the protection of social immunity, the physician needs his/her own system of ethical immunity; his/her defenses are crystallized in the quality of information he/she recorded in the patient’s record.

For that reason the remembrances on decisions taken in the presence of a moment-prohibition, and the adaptations that form many versions, either vanish or liquify before dissatisfaction towards the event. So, the resilience of the patient’s records is always welcome. Reliable and solidary, as due to the interdependence of interests, it is important that it is a wish of fidelity with simplicity and of prudence with justice.

Patient’s record is the life certificate that records a moment-procedure that intended to postpone the death certificate, or better, that intended to “prohibit it for a while.”

### References