Briefing
Bioethical Principles of
Non-maleficence and Beneficence

The fundamental bioethical principles:

- respect for autonomy of the patient (self-determination)
- beneficence (do good)
- non-maleficence (do no harm)
- justice (equitable distribution of benefits/burdens)
- veracity (honesty)
- fidelity (truthfulness and medical confidentiality)

Each of these principles is a duty that is binding unless it is in conflict with equal or stronger duties.

Non-maleficence (primum, non nocere or "first, do no harm." - a simplification of Hippocrates' claim in the Epidemics, "As to diseases, make a habit of two things--to help, or at least to do no harm.")

The principle of non-maleficence is defined by Beauchamp and Childress as "the principle that we ought not to inflict evil or harm on others."

Non-maleficence refers to an obligation to avoid whatever might harm the patient. Frequently, the principle of non-maleficence is combined with or described under the opposite principle of beneficence (which states that one ought to do or promote good. The importance of the distinction between beneficence and non-maleficence can be seen with regard to the obligations placed on healthcare professionals, researchers and others. Beauchamp and Childress observe, "the obligation not to injure others intuitively seems more stringent than the obligation to rescue them."

Non-maleficence expresses the commitment to the protection of patients from harm. It also affirms the requirement of competence and the standard of duty of care. Professional negligence involves the departure from the recognised standard of care toward patients and includes intentionally imposing unreasonable risks as well as unintentionally imposing risks through carelessness. Healthcare professionals can be held legally and morally blameworthy if they fail to provide care that avoids or minimizes the risk of harm to patients. Failure to prevent harm to the patient from errors and malpractice represents failure to act in accordance with the principle of non-maleficence.

Withdrawing or withholding of life-sustaining treatment also raises issues around involving the principle of non-maleficence. However, competent adult patients have the right to forgo life-saving treatment at any time under the principle of respect for autonomy. Patients who are unconscious or mentally incompetent but who completed an advance directive or living will in the past can have their treatment wishes acknowledged. Decisions concerning incompetent patients, based on considerations of the burdens and benefits of treatment and best interests, recognise the principle of nonmaleficence as well as beneficence.

The doctor's code of 'do no harm' is a statement of non-maleficence. But some treatments can be double-edged. For example,
Opiates given to relieve a terminally ill patient’s pain may suppress respirations and hasten death. Provided relief of pain, not the death of the patient, is the goal, providing adequate pain control for patients with terminal illness can be justified under the principle of double effect. Failure to provide terminally ill patients adequate pain medication for fear of killing them may lead to painful deaths for patients and has been used as an argument by some for physician-assisted suicide.

Clinicians are not obligated to provide futile treatment. Treatment that will not cure the underlying condition nor make the patient more comfortable, or treatment in patients whose quality of life is so low that the treatment produces more harm than benefit, may justifiably be withdrawn or withheld. Decisions involving quality of life judgments and medical futility require a rigorous evaluation of burdens and benefits and best interests.

**Beneficence**

The principle of beneficence means that healthcare providers have a duty or obligation to promote the health and welfare of the patient, and not merely refrain from causing harm. Beneficence requires positive action, to *always act in the best interests of the patient or client*. The principle of beneficence is a primary goal of healthcare providers.

In some situations, the principle of respect for patient autonomy may conflict with the principle of beneficence. The obligation to do good towards others and to act in their best interests, without an appropriate balance of attention to the principle of autonomy, has led to considerable paternalism in health care. Because paternalism aims for the patient’s good it is recognised as a well-intended action, but its actual achievement in bringing about the best consequences is in doubt since it represents the health professional’s rather than the patient’s perception of the patient’s good. Paternalism is therefore justified only where patients are incapable of making decisions in their own best interests where a healthcare professionals’ education and experience gives them the ability to determine the patient’s best interests. Patients’ right of self-determination may need to be restricted where they pose a risk to themselves or others, especially if the action will prevent the harm. If the benefits outweigh the harm and the least autonomy-restrictive method to reduce the risk is employed then a paternalistic approach can be justified under the principle of beneficence.

Assisted suicide and euthanasia inevitably prompt discussion of respect for autonomy and beneficence as well as non-maleficence. The Hippocratic Oath says: ‘*I will use treatment to help the sick according to my ability and judgement, but I will never use it to injure or wrong them*.'