

The **Seven Sins of Medicine**, by [Richard Asher](#), are a perspective on [Medical Ethics](#) first published in [The Lancet](#) in 1949.^[1]

Considered as poor personal conduct by Doctors (or more typically, medical students) The Seven Sins describes behavior that in itself might not be grounds for professional complaint or discipline but would be considered discourteous, especially in any situation outside of the pompous doctor - sick patient scenario.

Still very relevant in medical study and practice, they are:

1. **Obscurity:** Asher endorses the use of clear communication and plain language whether writing or speaking. Obscurity may be used to cloak one's own ignorance, or due to an inability to communicate with those outside of the medical profession. "If you don't know, don't admit it. Instead, try to confuse your listeners." is not uncommon.

Regardless of the intention, whether to misdirect from incompetence or to foster a feeling of superiority, the patient and those surrounding them are often left confused and uncertain.

2. **Cruelty:** This sin is perhaps one of the most common perpetrations committed by doctors and medical students. Whether it be the physical thoughtlessness of a half-dozen students palpating a painful tumor mass, or loudly taking (or presenting) a patient's history in a crowded room, one of the first things that is unlearned by a medical professional is to treat the patient as they themselves would like to be treated.

3. **Bad Manners:** Often overlooked, rudeness or poor taste in humour is condoned within the hospital setting. At the end of the day, many Doctors and students are simply rude to patients that do not suit them. Whether it is a snapping at an uncooperative patient or making a cruel joke about them after leaving the room, the impact of these "coping mechanisms" (as they are considered to be by many) must be taken into account.

4. **Over Specialisation:** In a growing trend by the medical establishment, over-specialisation and under-generalisation is a growing problem in the wider medical community. Ignoring aspects of one's education in favor of more interesting aspects is a behaviour that is pathological and outright negligent in a student. Failure to diagnose or to treat a patient because "their signs and differential fall outside of my field, let's turf them to another service" ought to be a seriously considered Supervisory & Training issue.

5. **Love of the Rare:** (aka "If you hear hoof-beats, think horses. Not zebras") The desire for rare and interesting diseases causes many medical students and young doctors to seek the bizarre rather than seeing a mundane diagnosis.

6. **Common Stupidity:** As well as the standard definition for this sin, the specific example of "using empirical procedures rather than tailoring for the patient" or the young doctor "flying on autopilot" must be mentioned. Ordering another test that is redundant, and for which the results may already be interpreted from the history, before starting treatment is such a situation. For example: requesting a haemoglobin count before beginning transfusion, despite the fact that the patient appears obviously anaemic.

7. **Sloth:** Laziness. Also includes ordering excessive numbers of tests, rather than simply taking the time to take an adequate history.

For further information see Dr Bruce Rowat's essay.^[2]

References

¹ Lancet 1949 Aug 27;2(6574):358-60

² Rowat, Bruce M.T. (2001). "[Richard Asher and the Seven Sins of Medicine](#)". *Humane Health Care (Volume 1, Number 2)*. <http://20>.

Autonomy

Autonomy is a general indicator of health. Many diseases are characterised by loss of autonomy, in various manners. This makes autonomy an indicator for both personal well-being, and for the well-being of the profession. This has implications for the consideration of medical ethics: "is the aim of health care to do good, and benefit from it?"; or "is the aim of health care to do good to others, and have them, and society, benefit from this?". (Ethics - by definition - tries to find a beneficial balance between the activities of the individual and its effects on a collective.)

By considering Autonomy as a gauge parameter for (self) health care, the medical and ethical perspective both benefit from the implied reference to Health.

The core idea of personal autonomy is to have personal rule of the self while remaining free from controlling interference by others. The autonomous person acts in accordance with a freely self-chosen and informed plan. A person of diminished autonomy, by contrast, is in at least some respects controlled by others or is incapable of deliberating or acting on the basis of his or her own plans. For example, institutionalized persons, such as prisoners or the mentally retarded, may have diminished autonomy.

In public health, the concept of autonomous decision making is related to informed consent. Virtually all medical and research codes of ethics now hold that physicians and researchers must obtain the informed consent of patients and research subjects before undertaking procedures. These consent measures have been designed to enable autonomous choice by patients and subjects, but they serve other purposes as well, including the protection of patients and subjects against harm and the encouragement of medical professionals to act responsibly in their interaction with patients and subjects.

Distributive justice concerns what some consider to be [socially just](#) with respect to the allocation of [goods](#) in a society. Thus, a community in which incidental inequalities in outcome do not arise would be considered a society guided by the principles of distributive justice. Allocation of goods takes into thought the total amount of goods to be handed out, the process on how they in the civilization are going to dispense, and the pattern of division. Civilizations have a narrow amount of resources and capital; the problem arises on how the goods should be divided. The common answer to this question is that every individual receives a fair share. Often contrasted with [just process](#), which is concerned with just processes such as in the administration of law, distributive justice concentrates on just outcomes and consequences. A prominent contemporary theorist of distributive justice is the [philosopher John Rawls](#), although this subject matter has now received wide treatment across philosophy and the social sciences (see James Konow, 2003).

Beneficence

James Childress and Tom Beauchamp in *Principle of Bioethics* (1978) identify beneficence as one of the core values of health care ethics. Some scholars, such as Edmund Pellegrino, argue that beneficence is the only fundamental principle of medical ethics. They argue that healing should be the sole purpose of medicine, and that endeavors like cosmetic surgery, contraception and euthanasia fall beyond its purview.

In public health, the governing ethical theory is utilitarianism, meaning "doing the greatest good for the largest number of people." Beneficence is strongly tied to the utilitarian theory of ethics. It is one of four principles considered in medicine and public health under the principle-based approach to ethical analysis. The other three principles are: respect for autonomy, nonmaleficence, and distributive justice. Beneficence is the professional duty to do or produce good. By "good" is meant the performance of acts of kindness and charity. "Doing good" is considered virtuous conduct. Ultimately, beneficence is the duty to do more good than harm through public health actions because, in practice, no action in public health will have exclusively beneficial effects. For example, if a public health agency becomes aware of a person infected with a bacterium that could be spread through the air, then, there is, on the one hand, a duty to respect the person's right to confidentiality and freedom of movement. But, on the other hand, there is a greater duty to prevent the spread of the bacterium to other people. Thus, more good would be achieved by protecting the public health, which can be accomplished only by breaching the duty to maintain the infected person's confidentiality and freedom of movement. Such breaches would occur only to reduce the risk associated with permitting the infectious person to put others at risk of infection (e.g., through quarantine or confinement, with a consequent loss of privacy in terms of the diagnosis). The ethical dilemma for decision makers in public health lies in weighing the pros and cons between at least two conflicting options: protecting the individual's rights or protecting the public health. Such breaches of an individual's rights are rare in public health and are undertaken only with maximum discretion.

Non-Maleficence

In practice, however, many treatments carry some risk of harm. In some circumstances, e.g. in desperate situations where the outcome without treatment will be grave, risky treatments that stand a high chance of harming the patient will be justified, as the risk of not treating is also very likely to do harm. So the principle of non-maleficence is not absolute, and must be balanced against the principle of beneficence (doing good).