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Hippocrates revisited: Opening address at the European Hip Society Meeting, Athens, 2010

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Hippocrates – born on the island of Kos in 460BC – was an ancient Greek physician of the age of Pericles. He is credited with establishing medicine as a profession distinct from the other fields it had traditionally been associated with, notably theurgy and philosophy. He is considered the father of clinical medicine.



Hippocratic medicine was humble and passive. Treatment was gentle, kind to the patient, and emphasised the importance of keeping the patient clean and sterile. There were detailed specifications for 'lighting, personnel, instruments, positioning the patient and techniques of bandaging and splinting' in the ancient operating rooms. The Hippocratic school embraced the clinical doctrines of medical history, clinical inspection, observation and documentation. After the Hippocratic period – with the exception of Galen 129 to 200AD – the practice of taking clinical case histories died out, and the Hippocratic methods were not revived and further expanded until after the renaissance in the nineteenth century.

He is perhaps best known for the Hippocratic oath, which is regarded as the first statement of the moral conduct to be used by physicians, and providing for the first time a complete separation between killing and curing. Formerly, throughout the primitive world, the doctor and sorcerer tended to be the same person, with the power to kill and the power to cure.

Many of us will have taken some form of the Hippocratic oath as part of our graduation ceremony. It is perhaps worth revisiting some of the principles embodied in the modern version of the oath and to examine them in the context of hip surgery today.

'I will apply, for the benefit of the sick, all measures that are required, avoiding those twin traps of overtreatment and therapeutic nihilism.'

One may feel that there is little chance of 'therapeutic nihilism'. Sadly, however, I have often met young patients crippled with arthritis of the hip who have been told they are too young for hip replacement. They are condemned to sacrifice a potentially highly productive period of their lives – professionally, recreationally, socially and the priceless interaction with their children – which could easily be salvaged. Patients need to understand the potential risks, and armed with the appropriate information, they then need to be promoted to the senior partner in the subsequent decision-making process.

Overtreatment always remains a potential problem where financial rewards are directly dependent on and proportional to activity level. In addition commercial companies are always keen for us to use new technologies – often at considerable expense – which offer no material additional benefit to the patient.

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As Lord Cohen said 'The ability to do an operation is not a good reason for doing it'. Financial incentives should not influence surgical decision-making, and we should be aware that non-medical colleagues already discuss how the so-called 'wallet biopsy' (a quick assessment of what the patient can afford) will influence the extent to which the subsequent programme of surgical treatment is 'unbundled'.

'I will remember that there is art to medicine as well as science, and that warmth, sympathy and understanding may outweigh the surgeon's knife or the chemist's drug.'

We must never forget that we are doctors first and foremost. Ignorance and fear are the architects of suffering. Listen to the patient. It may well be that reassurance will suffice – despite the numerical evidence of some hip score to the contrary. Sympathy and understanding will always greatly alleviate the anxiety and suffering of the patient presenting for surgery.

'I will not be ashamed to say "I know not", nor will I fail to call in my colleagues when the skills of another are needed for the recovery of a patient.'

The well-being of the patient is always of prime importance. As Will Mayo said, 'The best interest of the patient is the only interest to be considered'. Mercenary considerations should never compromise the best interests of the patient. The surgical ego – a variably impressive organ – should not prevent the surgeon from seeking the best treatment for his patient where appropriate, even if this means referring the patient to another hip surgeon. Thus complex primary hip replacements and difficult revisions should be carried out by surgeons with a special interest and expertise in these areas.

The patient should never be placed at risk where a surgeon explores new techniques or technologies which he hopes will favourably differentiate his practice from his colleagues.

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'I will remember that I do not treat a fever chart or a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability.'

Every hip belongs to a patient – who has fears, expectations and aspirations, and a wider constituency in the community including family and friends. We are overwhelmed with data and statistics. We should not merely aim for the acceptable, but should strive for perfection in every case. Remember that if only one hip out of every 100 fails, for that patient – and for their family and friends – the failure rate is 100%.

Three professional skills determine the hip surgeons' management of the patient with hip pathology: decision making, technical execution and problem solving. In the UK today, all too often patients are referred for hip replacement on the basis of screening with a hip score, such as the Oxford Hip Score, by GPs or extended-role practitioners (nurses and physiotherapists). This is the surrogate for decision making. The hip surgeon is in danger of being side-lined as no more than a technician. As treatment centres proliferate, administrators may well ask why should hip replacement surgery not be carried out by suitably trained dexterous non-medical practitioners – as already occurs in many branches of surgery (carpal tunnel release, lens extraction, etc).

It is essential that we defend our professional status as doctors and clinicians, who are also surgeons, and continue to treat our patients as whole human beings.

'I will prevent diseases wherever I can, for prevention is better than cure.'

Appropriate intervention by paediatric hip surgeons should reduce the need for reconstructive and replacement surgery in later life. Tissue engineering and regenerative medicine may resuscitate the need for the osteotomy skills of our predecessors, for success will depend on restoration of alignment and normal biomechanics of the hip.

I would therefore suggest that the moral doctrine of Hippocrates remains relevant today. Let us again embrace it as hip surgeons, as we strive to optimise the management of our patients crippled by hip pathology.