ISSN: 2469-5823

Silburn A, Int Arch Nurs Health Care 2025, 12:209
DOI: 10.23937/2469-5823/1510209
Volume 12 | Issue 1
Open Access

International Archives of Nursing and Health Care

COMMENTARY

Rethinking Medical Oaths and Codes in Modern Practice: Flexibility, Compliance, and Cultural Considerations

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Abstract

Background: Traditional medical oaths, including the Hippocratic Oath, have long symbolised ethical commitment in medicine, yet their largely unchanged content no longer aligns with contemporary clinical, legal, and cultural realities. Practices such as abortion, medically assisted dying, and culturally responsive care expose tensions between static ethical declarations and modern expectations.

Aim: This commentary critiques the limitations of traditional oaths and proposes a revised framework that incorporates ethical flexibility, cultural safety, and meaningful accountability.

Discussion: Historical and modern oaths contain rigid prohibitions that conflict with legally accepted and clinically justified practices in many jurisdictions. Their lack of enforceability further diminishes their practical relevance. Additionally, the absence of cultural safety perpetuates monocultural ethical assumptions that inadequately serve diverse patient populations. Comparative examples from reproductive health, medically assisted dying, and culturally diverse care contexts illustrate how contemporary practice outpaces existing ethical declarations.

Conclusion: To remain relevant, medical oaths must evolve. Integrating ethical flexibility, cul-tural safety, and enforceable accountability can transform these declarations from symbolic ar-tefacts into meaningful guides for equitable and context-sensitive clinical practice.

Keywords

Medical ethics, Oaths and codes, Modern medical practice, Cultural considerations, Ethical standards, Patient care

Introduction

Medical oaths, most notably the Hippocratic Oath, have traditionally served as declara-tions of ethical commitment, marking the professional identity of physicians. Rooted in ancient Greek philosophy and often recited ceremonially at the onset of medical training, these oaths attempt to codify enduring moral principles. However, their content has remained largely static, even as medicine has evolved to encompass unprecedented ethical complexity, including practices such as abortion, medically assisted dying, and culturally responsive care. This commentary contends that the relevance and utility of medical oaths must be re-evaluated in light of these developments. It proposes a tripartite revisionist framework: first, the promotion of ethical flexibility responsive to pluralistic moral norms; second, the integration of cultural safety as a foundational principle; and third, the introduction of mechanisms for enforceable accountability. Through comparative case studies and historical analysis, this paper argues for the transformation, not abandonment, of professional oaths to align more closely with the legal, ethical, and cultural demands of contemporary clinical practice.

Discussion

Traditionally, oaths like the Hippocratic Oath were seen as moral compacts between the physician, the gods, and society. They contained prohibitions such as “I will not give a woman an abortive remedy” and denounced euthanasia outright [1]. Yet these views have not aged well: the legalisation of abortion and euthanasia in countries like the Nether-lands [2,3] underscores the divergence between static oaths and evolving ethical norms. The modern physician operates in a world where such procedures may be legal, evi-dence-based, and compassionate responses to patient suffering.

Citation: Silburn A (2026) Rethinking Medical Oaths and Codes in Modern Practice: Flexibility, Compliance, and Cultural Considerations. Int Arch Nurs Health Care 12:209. doi.org/10.23937/2469-5823/1510209

Received: January 08, 2026 : **Accepted:** February 07, 2026 : **Published:** February 10, 2026

Despite this, declarations such as the World Medical Association's (WMA) Declaration of Geneva still adopt firm stances: "I WILL NOT USE my medical knowledge to violate hu-man rights" [4], a phrase often interpreted as opposing medically assisted dying [5]. Yet clinical and legislative movements worldwide suggest that such blanket moral declara-tions are increasingly unrepresentative of patient and professional values [6].

Historical cases such as the Code of Hammurabi, where malpractice was punishable by mutilation, show early attempts to link ethics with consequences [7]. In contrast, modern oaths lack any binding enforcement, relying instead on social or symbolic accountability. The result is ethical ambiguity, such as clinicians are expected to adhere to abstract moral declarations with few tangible consequences when they fail to do so.

The debates around abortion and euthanasia exemplify the ethical evolution that medical oaths struggle to accommodate. In abortion, legalisation in countries such as Australia, the UK, and Canada reflects broader societal support, yet resistance persists in many re-gions due to religious or cultural interpretations of morality [2,8]. Medical codes tied to ancient doctrine risk alienating clinicians who practice in accordance with their country's laws and their patients' needs.

Similarly, medically assisted dying has become an accepted part of palliative care in the Netherlands, Belgium, and parts of Canada. These jurisdictions have adopted robust frameworks involving patient consent, capacity assessment, and procedural safeguards [3]. In contrast, international declarations such as those by the WMA still oppose eutha-nasia outright [5], creating discord between ethical declarations and the legal, cultural, and clinical realities of care.

This discord erodes the authority of oaths. Instead of guiding practice, they become arte-facts of tradition, respected but ignored.

Cultural considerations are increasingly central to ethical care. However, terms such as cultural sensitivity, cultural humility, and cultural safety are often used interchangeably despite critical differences. Cultural sensitivity refers to awareness of cultural differences; humility implies self-reflection and openness to learning, but cultural safety, first intro-duced in Aotearoa New Zealand, goes further. It prioritises the patient's definition of what feels respectful and safe [9]. This shifts power away from the provider and toward the pa-tient, embedding ethics within lived experience.

This distinction matters. For example, many Middle Eastern women express a preference for female practitioners due to religious norms [10], and Aboriginal men may discharge themselves early due to family obligations being unmet by clinical routines [11]. Cultural safety addresses these realities. As Komesaroff and Kerridge [12] argue, Western bioethics is often self-focused and monocultural, failing to reflect the diversity of beliefs in modern medicine. Australia's revised 2021 Good Medical Practice code begins to incorporate cul-tural safety by explicitly acknowledging the need for respectful and context-aware care for Aboriginal and Torres Strait Islander patients [12].

Revising oaths and codes without embedding cultural safety risks perpetuates an ethical monoculture.

What then should replace or supplement traditional oaths? The following proposes a framework with three pillars:

Ethical flexibility

Modern oaths must reflect the evolving legal, social, and clinical realities of medicine. Instead of fixed prohibitions, they should promote context-sensitive de-liberation, including recognition of valid dissent and patient autonomy.

Cultural safety

Ethical declarations must move beyond neutrality and actively promote equity. This requires embedding culturally safe practices and acknowledging structural disparities in healthcare.

Enforceability

Codes and oaths must go beyond ceremony. Mechanisms for accounta-bility, education, and review-without being punitive-should be part of ethical governance.

These reforms need not discard tradition but rather reinterpret it. Much like how the Ge-neva Convention evolved in response to modern warfare, medical ethics must evolve with modern medicine.

Conclusion

Traditional oaths and codes of ethics, while symbolically powerful, no longer reflect the pluralistic and legally complex world of modern medicine. Their rigidity, lack of enforce-ability, and cultural insensitivity limit their utility. This commentary calls for a revised approach, one that integrates ethical flexibility, cultural safety, and meaningful accounta-bility. Only through such a multidimensional lens can oaths regain their relevance and continue to guide clinicians in delivering equitable, compassionate, and ethical care across global contexts.

Declarations

Abbreviations

Not applicable

Ethics approval and consent to participate

This study did not require ethical approval as it involved a retrospective analysis of publicly available and anonymised infor-mation, with no direct involvement of human subjects.

Consent for publication

The author consents to the publication of this article.

Availability of data and materials

Not applicable

Competing interests

The author declares that they have no known competing interests or personal relationships that could have appeared to influence the work reported in this paper.

Funding

The author declares that they did not receive funding for this article.

Authors' contributions

The author solely contributed to the conception, design, analy-sis, and drafting of the manuscript.

Acknowledgements

Not applicable.

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