

https://dspace.org/

Dual loyalty and human rights: a bioethical analysis of the situation in South Africa

Ferlito, Brandon Allister

2019
https://hdl.handle.net/10539/29707

Downloaded from a DSpace repository. https://dspace.org/

DUAL LOYALTY & HUMAN RIGHTS: A BIOETHICAL ANALYSIS OF THE SITUATION IN SOUTH AFRICA

BRANDON ALLISTER FERLITO

STUDENT NUMBER: 704750

A Dissertation Submitted to the Faculty of Health Sciences, University of the Witwatersrand (Wits), Johannesburg, in fulfilment of the requirements for the degree of Master of Science in Medicine (MscMed) in Bioethics & Health Law, Steve Biko Centre for Bioethics

Supervisor: Professor Ames Dhai MBChB (Natal), FCOG (SA), LLM (Natal), PGDip.IntResEthics (UCT), Ph.D. (Wits)

Director – Steve Biko Centre for Bioethics, Professor & Head Bioethics Discipline

14 August 2019

Dedication

I proudly dedicate this dissertation to myself.

“I want to thank me. I want to thank me for believing in me. I want to thank me for doing all this hard work. I want to thank me for having no days off. I want to thank me for never quitting. I want to thank me for always being a giver, and trying to give more than I receive. I want to thank me for trying to do more right than wrong. I want to thank me for just being me at all times. ” - Calvin Cordozar Broadus Jr.

Table of Contents

Dedication ……i

Declaration ……...iii

Abstract……iv

Acknowledgments……..v

List of Tables……...vi

List of Abbreviations……..……vii

Chapter 1……..……..1

Introduction

Chapter 2 ……....14

The Concept, History, and Problem of Dual Loyalty Conflicts in the South African Healthcare Context

Chapter 3……..….47

Description and Analysis of Dual Loyalty Conflict Cases in South Africa and the Role Played by Healthcare Professionals

Chapter 4……...90

Dual Loyalty Conflicts from the Perspective of Principlism and Human Rights Law

Chapter 5……135

Conclusion

Annexure A……..……..154

Ethics Waiver

Annexure B……...155

Turn-It-In Report

Declaration

I, Brandon Allister Ferlito (Student number: 704750) am a postgraduate student registered for the Master of Science in Medicine (MscMed) in Bioethics & Health Law at the Steve Biko Centre for Bioethics at the University of the Witwatersrand (Wits), in Johannesburg, South Africa.

- I am aware that plagiarism is the use of someone else's work without their permission and/or without acknowledging the original source.
- I am aware that plagiarism is wrong.
- I confirm that the work submitted for assessment for the above course is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.

Signature: _____ Date: _____

Abstract

In a wide range of clinical situations, backgrounds, and roles, healthcare professionals are subjected to requests from governments (and in some instances from other powerful third parties) to relegate patient for the interests of third parties, generally those of the state. Despite several international and national ethics guidelines and human rights law instruments, many healthcare professionals still find themselves facing difficult dual loyalty conflicts, which violate ethics and human rights law. Dual loyalty conflicts can be described as simultaneous obligations, express or implied, to a patient and to a third party. Therefore, healthcare professionals, when confronted with a dual loyalty conflict, must be loyal to both their patients, as well as a third party. This loyalty is often not compatible between the interests of patients and a third party's interests. Dual loyalty conflicts thus continue to remain a challenge for HCPs, particularly in South Africa. Therefore, a new Bioethics and Human Rights Law framework is imperative, if HCPs are to avoid or manage dual loyalty conflicts in ethically and legally sound ways.

Keywords: *Dual Loyalty Conflicts, Bioethics, Health Law, Principlism, Healthcare Professionals*

Acknowledgments

First of all, I praise God, the almighty, merciful, passionate and all-knowing, for providing me this opportunity and granting me the capability to proceed successfully.

This dissertation appears in its current form due to the assistance and guidance of several people. I would like to offer my sincere thanks to all of them.

At the very outset, I express my deepest sense of gratitude to Professor Ames Dhai, my esteemed supervisor, for her warm encouragement, thoughtful assistance, invaluable guidance, critical comments and correction of this dissertation. I simply cannot articulate in words how grateful I am for her supervision.

I would like to express my deep and sincere gratitude to my family for their continuous and unparalleled love, help and support. I am forever indebted to my family for giving me the opportunities and experiences that have made me who I am. They selflessly encouraged me to explore new directions in life and to seek my own destiny. This journey would not have been possible if not for them, and I dedicate this milestone to them.

I would also like to thank my friends, for their support; specifically, Kelly Kumalo who, despite having a dissertation of her own to write, was always readily available to hear my ideas and give critique thereof.

I also wish to thank all the staff at the Steve Biko Centre for Bioethics, Faculty of Health Sciences, University of the Witwatersrand for the teaching, support and enthusiasm they afforded me.

Financially, I would like to thank the University of the Witwatersrand for granting me the Postgraduate Merit Award (PMA).

Finally, I would like to thank all those who in their small, yet significant ways, supported me through this journey, either through words of encouragement or by prayer. Thank you!

All errors in fact or thinking and opinions expressed and conclusions arrived at, are mine as the author.

List of Tables

Table 1. Ways to prevent and manage dual loyalty conflicts according to The International Dual Loyalty Working Group

List of Abbreviations

ACHPR African Charter on Human and Peoples' Rights

AIDS Acquired Immunodeficiency Syndrome

ANC African National Congress

ART Antiretroviral therapy

ARV Antiretrovirals

AZT Zidovudine

CAT Convention Against Torture and other Cruel, Inhumane or Degrading Treatment or Punishment

CEDAW Convention on the Elimination of All Forms of Discrimination against Women

CEO Chief Executive Officer

CFME Clinical forensic medical examiner

CRC Convention on the Rights of the Child

CRPD Convention on the Rights of Persons with Disabilities

CSF Cerebrospinal fluid

DoH National Department of Health

Dr. Doctor

EC Eastern Cape

GRIP Greater Nelspruit Rape Intervention Project

HCP Healthcare Professional

HIV Human Immunodeficiency Virus

HPCSA Health Professions Council of South Africa

ICCPR International Covenant on Civil and Political Rights

ICERD International Convention on the Elimination of All Forms of Racial Discrimination

ICESCR International Covenant on Economic, Social and Cultural Rights

ICN International Council of Nurses

LP Lumbar Puncture

MASA Medical Association of South Africa

MEC Member of the Executive Council

MHCA Mental Healthcare Act No. 17 of 2002

MO Medical Officer

NEHAWU National Education, Health and Allied Workers' Union

NGO Non-Governmental Organizations

NHA National Health Act 61. of 2003

PE Port Elizabeth

PEP Post-Exposure Prophylaxis

SA South Africa

SA FED South African Federation for Mental Health

SADAG South African Depression And Anxiety Group

SAMA South African Medical Association

SAMDC South African Medical and Dental Council

SANC South African Nursing Council

SARS Severe Acute Respiratory Syndrome

SASO South African Students' Organization

SASOP South African Society of Psychiatrists

TAC Treatment Action Campaign

TRC Truth and Reconciliation Commission

UDHR Universal Declaration of Human Rights

UN United Nations

VEC Victim Empowerment Committee

WMA World Medical Association

CHAPTER 1: INTRODUCTION

1. Background Literature Analysis and Critique

Dual loyalty conflicts can be described in the context of healthcare as "simultaneous obligations, express or implied, to a patient and to a third party." [1] Therefore, healthcare professionals (HCPs) when confronted with a dual loyalty conflict, must be loyal to both their patients as well as a third party. This loyalty is often not compatible between the interests of patients and a third party's interests. [1, 2] Dual loyalty conflicts occur when a HCP is employed by a third party, often the state or a private organization, [2] to provide healthcare to patients, and a conflict of loyalties arises when the HCP's duties to a patient conflict with those of a third party. [3]

The healthcare profession has been held to a high ethical standard of complete loyalty to the welfare of patients. Currently, international codes of ethics mandate HCPs to be completely loyal to their patients. [1] The modern version of the Hippocratic Oath - The World Medical Association (WMA) Declaration of Geneva, [4] asks HCPs to pledge that "the health of [their] patient will be [his or her] first consideration." The WMA International Code of Medical Ethics [5] states that "a physician shall owe his patients complete loyalty and all the resources of his science." The Health Professions Council of South Africa (HPCSA) Code of Ethics, [6] as well the South African Nursing Council (SANC) [7, 8] Code of Ethics requires HCPs to make the interests of patients their first consideration.

Ethics has long called for HCPs to show complete loyalty towards their patients. [1] However, in the current world, HCPs are increasingly being challenged to decrease their loyalty to patients in favour of third parties. As a result, dual loyalty conflicts remain a challenge for HCPs as relegating patient interests to third parties risks violating the human rights of the patient. [1] As stated by Dhai, [9] "the control of

healthcare has been moved steadily away from healthcare practitioners to professional managers and bureaucrats, some of whom tend to see healthcare practitioners as obstacles rather than partners." Although there have been efforts to address these challenges through ethics and human rights, success has been marginal. [1]

The healthcare profession is set apart from other professions through a distinctive moral duty of care to promote and protect the lives of individuals, as well as to alleviate pain and suffering. [10] Ethics, especially in healthcare (bioethics), puts an emphasis on the significance of this 'moral duty of care' over and above the considerations of competing personal and third party conflicts. [10] Thus, HCPs are expected to exemplify ethics by adhering to a strict code of conduct which epitomises high ethical principles, protects and promotes patients' interests, and maintain professional integrity. [10] All HCPs have to uphold and abide by an oath or affirmation taken at graduation, e.g. the Hippocratic Oath and the Florence Nightingale Pledge. [9, 10] These codes were developed to ensure that HCPs are responsible and accountable to society and to always act in the best interest of patients. [10] These codes are also based on the notion of Principlism:

1. Autonomy - Respect for the decision-making ability of self-sufficient individuals.
2. Beneficence - The maximization of benefit to people in care.
3. Non-maleficence - The duty to avoid harm.
4. Justice - Fairness in treatment.

The loyalty of an HCP is therefore always with the patient, and when faced with dual loyalty conflicts, the patient's interests should always be chosen above and beyond those of a third party.[1] Notwithstanding, there are cases where dual loyalty conflicts

are ethically justified as they serve a social purpose. For example, HCPs "may be required to breach confidentiality in a relationship with a patient in order to protect third parties from harm or to notify a health authority of communicable diseases for health surveillance purposes." [1] What is critical to the moral appropriateness of such conflicts, however, is the impartiality and openness of balancing dual loyalty conflicts (beneficence) and how such conflict balance is or is not compatible with human freedoms (justice). [1]

Dual loyalty conflicts tend to become even more ethically difficult when HCPs act in a manner that supports the interests of the third party, instead of showing devoted loyalty to patients, and these actions violate the human rights of patients. [1, 11] The WMA states that human rights form an integral part of the healthcare profession. Principlism, together with respect for human rights, serves as the basis of the healthcare profession. [5, 12] When HCPs put the interests of their patient first - human rights are respected and protected. Several ethical codes and declarations state that it is in the scope of a HCP's professional duty to protect the human rights of patients. [13, 14] Both the WMA and the International Council of Nurses (ICN) have stressed the significance of human rights in healthcare practice. [1] The WMA Declaration of Tokyo [15] asserts that HCPs must avoid partaking in torture, thus linking a respect for human rights to ethics. These too are articulated and reinforced by the HPCSA [6] and the SANC. [7, 8]

Human Rights Law is described as the "rights of individuals in society that are …legitimate, valid, justified claims – upon his or her society – to various goods and benefits deemed essential for dignity and well-being." [16] These claims arise from an international agreement on common moral values. [1] Human rights were first articulated in the "Universal Declaration of Human Rights (UDHR)" [17] and then adopted through international treaties. The "International Covenant on Civil and

Political Rights (1966) (ICCPR)" [18] and the "International Covenant on Economic, Social and Cultural Rights (1966) (ICESCR)" [19] are two specific foundational human rights treaties which strengthen and reinforce the UDHR.

For HCPs, the most significant provision is Article 12 of the ICESCR, which states that: "Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity." [19] This is also articulated in the "African Charter on Human and Peoples' Rights" [20] (ACHPR) (1981) and the Constitution of the Republic of South Africa. [21] The most basic and rudimentary purpose of human rights is to protect individuals. For HCPs, a human rights framework offers a steady moral guide as it articulates the values of Principlism. This ought to enable HCPs to resolve dual loyalty conflicts with globally applicable moral principles. [1] Although human rights obligations are generally the responsibility of states; the "true power and legal standing of human rights norms have enormous implications for the behaviour of health[care] professionals." [22]

The worst human rights violations resulting from dual loyalty conflicts take place in closed healthcare institutions, such as mental health facilities and prisons, as this often as this requires a high-level demand for loyalty on HCPs, even when violations of human rights are evident. [1] Human rights violations at the request of a third party and enacted by HCPs can also take place in public, especially towards the vulnerable, e.g. the mentally ill, children and women as they are politically and socially marginalized. [1] Human rights violations can also occur from government implemented policies and health systems and this includes privately managed healthcare systems; HCPs are often ordered to withhold treatment (even emergency treatment) from specific groups of people in inequitable ways. [1] The issue gets worse when the integrity and behaviour of a HCP is restricted by pressure to submit to often authoritative interests,

especially those of the state. These pressures may be a result of legal demands, threats of personal or professional harm for insubordination or even the HCP's own sense of duty to a third party. [13]

The structure of employment relationships, including a high salary package, professional autonomy, and authority, are all aimed to encourage a HCP to turn a blind eye, even if such conflicts grossly violate human rights. The state's or third party's ability to apply pressure to secure subordination with its demands, all render it difficult for HCPs to maintain loyalty to patients' interests and thus respect and protect human rights. [1] Consequently, dual loyalty conflicts which result in human rights violations occur daily. This, therefore, underscores why it is critical that HCPs remember that their first obligation is to the wellbeing of their patients when confronted with dual loyalty conflicts. [1]

South Africa (SA) has a brutal history of dual loyalty conflicts, particularly in the healthcare sector. South Africans were subjected to a social and racial experimentation of segregation and discrimination known as apartheid, from 1948 to 1994. [23] One of the most prominent cases of dual loyalty conflicts during that time was that of Steve Biko, who died in detention on 12th September 1977. On the 11 September 1977, a maimed and untreated Biko was transported 1 250 kilometres (km) to Pretoria Central prison at the back on a Land Rover. Biko died shortly after arriving at the prison. During his detention, Biko was kept in unhygienic conditions, chained and was left unattended. [23] The HCPs tasked with his care only attended to him at the request of a third party; the police. They failed to put his interests first.

The case of Steve Biko illustrates the challenges HCPs face when confronted by dual loyalty conflicts. Their primary obligation is to the patient and not to any unjustified

requests by third parties. These cases, as well as many others, have spiked a global movement of propagation of ethics principles and Human Rights Law by several international bodies and HCPs in an attempt to avert further similar conflicts. However, despite these attempts, dual loyalty conflicts which breach ethics and violate human rights still occur daily. [24] To illustrate this, the Life Esidimeni tragedy, the most recent South African case of a dual loyalty conflict, which seriously breached ethics and grossly violated human rights, occurred in spite of this global propagation; many patients died, and others experienced serious morbidity because of a cost-cutting measure implemented by the Gauteng Provincial government. Approximately 2,000 patients were hurriedly transferred from Life Esidimeni to 27 non-governmental organisations (NGOs). [25, 26] A report by the Health Ombudsman of SA stated that all patients who died in these NGOs, died under unjust and unlawful circumstances. [26]

As should be the norm, many attempts were made by civil society organisations (e.g.,SECTION27, SA Depression and Anxiety Group), family members of Life Esidimeni tragedy victims, individuals and professional associations (e.g., The South African Society of Psychiatrists) to stop the Gauteng government from removing patients from Life Esidimeni and place them in organizations where appropriate care could not be provided. More than once, the courts were approached in attempts to intervene and avert the tragedy. However, these efforts were in vain. [27]

Doctor (Dr.) Makgabo Manamela (Director of Mental Health Services in Gauteng) and Dr. Tiego Selebano (Director of the Gauteng Health Department), two skilled HCPs who, in conjunction with Qedani Mahlangu, former Member of the Gauteng Health Executive Council (MEC), spearheaded the Life Esidimeni tragedy and were indicted as the main parties responsible for the tragedy. [26, 28] Dr. Manamela and Dr. Selebano

have both publically taken oaths that their primary obligation will be to patients, while Mahlangu, as a MEC at the time, swore to uphold SA's Constitution and all other laws of the Republic. [28, 21, 29] What is also clear from the Ombudsman's report is that Dr. Selebano and Dr. Manamela, together with other HCPs implicated in the tragedy, found themselves in a dual loyalty conflict, [9] which resulted in the gross human rights violations and deaths of more than 140 [30] innocent mentally ill patients. In addition, the implicated HCPs presented evidence to the Life Esidimeni Arbitration, in which they stated they under were often under immense pressure or were forced to follow orders by the MEC, even if it went against the best interests of the Life Esidimeni patients. [9, 31]

The Life Esidimeni tragedy and similar situations demonstrate what happens when HCPs engage in dual loyalty conflicts. This usually occurs where HCPs are recruited by, for example, the state.

1.1. Research Question

When confronted with dual loyalty conflicts, how should HCPs ethically and legally fulfil their obligation towards the best interest and positive welfare of the patient?

1.2. The Rationale for the Study

In a wide range of clinical situations, backgrounds, and roles, HCPs are subject to requests from governments (and in some instances from other powerful third parties) to relegate patient and human rights interests to the interests of third parties, generally those of the state. [1] Despite several international and national ethics guidance and Human Rights Law instruments, many HCPs still find themselves facing difficult dual loyalty conflicts, which violate ethics and human rights law. [1] Furthermore, while much

has been written on the South African situation, there has not been an in-depth bioethical analysis, with specific reference to dual loyalty conflicts confronted by HCPs in SA. This dissertation is, therefore, a systematic bioethical response to the knowledge gap.

1.3. Thesis Statement

South African HCPs confronted with dual loyalty conflicts currently find it difficult to ethically and legally fulfil their obligation towards the best interest and positive welfare of the patient.

1.4. Research Aim

To critically analyse cases of dual loyalty conflicts in the South African healthcare context, and to demonstrate how HCPs ought to ethically and legally respond when faced with dual loyalty conflicts form the perspectives of Principlism and Human Rights Law.

1.5. Research Objectives

1.5.1. To describe the concept, history, and problem of dual loyalty conflicts in the South African healthcare context.

1.5.2. To analyse specific cases of dual loyalty in South Africa and the role played by HCPs.

1.5.3. To analyse dual loyalty conflicts from the perspective of Principlism and Human Rights Law, with a view to develop guidelines for the South African situation, to assist HCPs to manage dual loyalty conflicts in ethically and legally sound ways.

1.6. Research Design

This dissertation took the form of both a normative and meta-ethical inquiry. Normative ethics was employed as it sets out to answer “how we ought to evaluate conduct and the reasons for doing so.” [32] Meta-ethics was employed as it explores the moral meaning of terms such as obligations, duties, and loyalty. This was done “in a systematic, critical fashion, and to justify the answers that are offered” [32] by applying the framework Principlism, the relevant health law information, and the jurisprudence on human rights law.

1.7. Research Method

Desktop and library-based research were used to collate, evaluate and apply relevant policies. No new information has been collected or analysed; human participants were not involved in the research. Furthermore, typical research methods and standards applicable to bioethical research were also applied. [33] Findings from the literature were discussed and critically analysed. This mainly involved the interpretation and critical analysis of pertinent literature to answer the research question and to achieve the research aim and objectives. [33] The interpretation and analysis of pertinent literature the definition and clarification of concepts. Sources of literature included but were not limited to research/journal articles; books; credible media articles; unpublished research; government legislation policies and guidelines; academic and non-academic search engines and databases.

1.8. Argumentative Strategy

This dissertation applied the ethical framework of Principlism and the jurisprudence on Human Rights Law as its argumentative strategy. It is argued that South African HCPs,

when confronted with dual loyalty conflicts, currently find it difficult to ethically and legally fulfil their obligation towards the best interest and positive welfare of the patient. This results in gross human rights violations, morbidity, and mortality. The main argument of this paper was based on the premise that HCPs breach their ethical and legal obligations towards the best interest, and positive welfare patients, when they are confronted with dual loyalty conflicts. Thus, this dissertation argued the following; firstly, based on the ethical framework of Principlism, when confronted with dual loyalty conflicts, HCPs ought to put the interests of patients over and above those of a third party, such as the state. Secondly, it was contended from a Human Rights Law perspective that patients' human rights can be seriously violated when HCPs fail to ethically and legally fulfil their obligation towards the best interest and positive welfare of patients when they are confronted with dual loyalty conflicts. The same principles and theories were also used to highlight the role that HCPs play to avert tragedies that result from dual loyalty conflicts. In this manner, an argument will be made for the difficulties faced in the healthcare context by HCPs when faced with dual loyalty conflicts.

1.9. Research Outcomes

This dissertation and the guidelines developed will be offered as a discussion document with recommendations to the relevant parties and stakeholders for policy and guidelines enhancement and/or development. Additionally, this dissertation will lead to publications in national and international journals. This will be done to enable a significant contribution to the current knowledge base, as well as to fill gaps within the knowledge base.

1.10. Limitations

A limitation of this dissertation study is that the use of empirical research was not employed. The significance of empirical research in bioethics and health law "is that it may reveal clinical, legal, emotional and philosophical factors influencing decision-making." [29] This dissertation probed 'how we ought to evaluate conduct and the reasons for doing so.' As a result, not employing empirical research "may misunderstand certain details of specific practices or decisions and/or omit some factors which have considerable moral relevance." [34] Notwithstanding this limitation, the normative and meta-ethical form of this research study is pertinent to the consideration of the research question, aim and objectives of this dissertation. Furthermore, "empirical research cannot, of course, replace philosophical analysis and cannot generate normativity." [34]

1.11. Ethics

As this dissertation did not involve human participants, an ethics waiver was granted by the Wits Human Research Ethics Committee (Medical).

1.12. Overview of Chapters

Chapter 1 has set out the background literature analysis and critique, the rationale for the study, the thesis statement and the research aim and objectives. Moreover, the research method and design, the argumentative strategy and the research outcomes were also outlined. Chapter 2 described and discussed, in detail, the concept, history, and problem of dual loyalty conflicts in the South African healthcare context. Chapter 3 described and analysed three cases in South Africa and the role of HCPs, with specific reference to dual loyalty conflicts. Furthermore, Chapter 4 provided an

analysis of dual loyalty conflicts from the perspective of Principlism and Human Rights Law and developed guidelines for the South African situation. This was in an attempt to assist HCPs to manage dual loyalty conflicts in ethically and legally sound ways. Chapter 5 sets out the discussion, conclusion, and recommendations.

1.13. Timing

Activity	Jan	Feb	March	April	May	June	July	Aug	Sep	Oct	Nov
Protocol development											
Protocol assessment & amendments											
Ethics application (ethics wavier)											
Reading for and writing up of dissertation											
Submit the dissertation for examination											

9. Funding

A University Scholarship (Postgraduate Merit Award) was secured for this program. Costs included that of printing, internet use, and binding:

Printing and photocopying – R3000

Internet Use – R1000

Binding – R1000.

Total – R5000.

These costs were covered by the Steve Biko Centre for Bioethics.

CHAPTER 2: THE CONCEPT, HISTORY, AND PROBLEM OF DUAL LOYALTY CONFLICTS IN THE SOUTH AFRICAN HEALTHCARE CONTEXT

2. Introduction

This chapter begins with a definition and a contextual, philosophical analysis of the concept of loyalty. The chapter then analyses the concept, history, and problem of dual loyalty conflicts. Although a global examination will be provided, specific reference will be given to the South African situation.

Chapter 2 responds to objective 1: To describe the concept, history, and problem of dual loyalty conflicts in the South African healthcare context.

2.1. Loyalty: A Contextual, Philosophical Analysis

This dissertation is, *inter alia*, about the nature of dual loyalty conflicts and human rights in the South African healthcare context, as well as the ethical and legal issues that arise from it. Thus, before any discussion around dual loyalty can take place, it is imperative to look at the concept of 'loyalty'. This will be done by attempting to answer one question: what exactly is loyalty?

2.1.1. What exactly is loyalty?

A person can be loyal to multiple stuff, and there are different ways in which the person can be loyal. The way a HCP feels and acts towards a patient is most likely to be very different from the way the HCP feels and acts towards his or her favourite coffee shop. Nonetheless, both are expressions of loyalty. [35] Loyalty may therefore "be defined as devotion and faithfulness to a: cause, country, group, or person." [36] For brevity, a cause, country, group, or person will collectively be referred to as the object or an

object. Josiah Royce, in his book The Philosophy of Loyalty [37], defines loyalty as “the willing and practical and thoroughgoing devotion of a person to a cause”. According to Royce, human beings can be seen as loyal when firstly, they have some object to which they are loyal; when, secondly, they express willing and thorough devotion to that object; and when, thirdly, they express their devotion in a more or less sustained and practical way. [37] There is, however, no consensus on what exactly loyalty is.

Loyalty is often looked at as a characteristic or as a trait. [35] Loyalty is also spoken of as a principle or as an ideal. [35, 38] Importantly, behind the different ways of understanding loyalty, there is the idea that a particular relationship exists between an individual and the object which he or she is loyal to. There is the individual – for brevity also called the subject - who is loyal, and object to which the subject is loyal to. [35] Simon Keller, in his book, The Limits of Loyalty [35], offers some important, yet often overlooked observations and distinctions around loyalty. He examines what philosophers say or assumes loyalty is and suggests and defends what exactly makes something or someone loyal or a ‘loyalty’. His examinations will be used in an effort to answer the question that was posed.

2.1.2. Loyalty and conscientiousness

Imagine the flowing scenario: An individual, who after having read and understood the framework of Principlism, decided that Principlism is correct, and as a result, this individual tries to always embody the notion of Principlism. It would be correct to say that if this individual is committed to and follows the notion of Principlism in his or her everyday life, he or she is conscientious. [35] Conscientiousness is defined as the ability to follow socially approved standards for impulse control, to be goal-directed, to plan,

and to have the ability to delay gratification. [39, 40] It would then be incorrect to say that the individual is loyal to Principlism. The individual's decision to follow Principlism is not based on loyalty, but rather on his or her conviction that Principlism is correct. [35]

The argument here is not that an individual cannot be loyal to 'abstract moral principles' or to frameworks, because one can be loyal to such things. Imagine if the scenario was different and the person decided to follow the notion of Principlism, not because he or she thinks its correct, but rather because he or she identifies with it, or because he or she, for instance, has been brought up in an environment that practices the framework of Principlism, and as a result, formed a special connection to it. [35] The individual follows the notion of Principlism because he or she thinks of it as his or her principle. It would then be correct to say that this individual is loyal to Principlism, and this is shown in his or her actions. Keller [35] seeks to demonstrate here that loyalty and conscientiousness differ. Just because an individual "deliberately follows a principled pattern of behavior, or is committed – perhaps fiercely – to a cause, does not mean that she is loyal." [35]

How a person acts is not enough to conclude that the person is loyal. If an individual keeps their promises and commitments, it may be because he or she is loyal to that which they made a promise and a commitment to. Acting towards something in a way that shows loyalty does not establish loyalty. Loyalty does not only depend on actions but on how one is motivated as well. [35]

2.1.3. Expressions of loyalty

Loyalty can be expressed in several broad ways. Keller [35] narrows his list down to five: “loyalty in concern”, “loyalty in advocacy”, “loyalty in ritual”’’ “loyalty in identification”, and “loyalty in belief”. Keller [35] makes mention that there may be other ways of expressing loyalty and that not every expression of loyalty falls under his five categories; the boundaries between the different types can be confusing. [35]

2.1.3.1. Loyalty in concern

HCPs may express their loyalty by promoting and protecting the welfare and interests of their patients, over and above those of a third party, say the state. To promote and protect the welfare and interests of a patient is to show care and concern about the patient’s welfare and interests, over and above those of a third party, and this includes being *motivated* to do such. When HCPs advance the welfare and interests of patients, HCPs are expressing loyalty out of concern. [35]

2.1.3.2. Loyalty in advocacy

Imagine a student who feels an allegiance to her Professor. Perhaps this allegiance stems from the fact that this student has always admired and liked the Professor, or perhaps the Professor did something kind for the student. At a conference, some of the student’s peers start talking about what an incompetent lecturer the Professor is.[35] The student disagrees, but had it been any other lecturer, the student would probably remain silent or even agreed. The student, however, feels obliged to say something in the Professor's defense. It would be natural to think that the student is acting out loyalty to the Professor. It would also be correct to think that if the student did not defend the

Professor, given that the student is loyal to the Professor, the student would be disloyal towards the Professor. [35] The loyalty expressed by the student stems more from wanting to advance the Professor's interests or by being concerned for the Professor. The student is not trying to advance the Professor's interests by defending the Professor. Rather, the student is expressing her loyalty to the Professor by being the Professor's advocate. Keller calls this kind of loyalty, loyalty in advocacy. [35, 41] Advocacy towards promoting the best interest of the patient can be likened to this category of loyalty.

2.1.3.4. Loyalty in ritual

At times, loyalty can be expressed through the participation in or recital of rituals. Loyalty can also be expressed in practices considered to symbolize loyalty. Patriotism can be seen as such a case; when a person expresses his or her patriotism by pledging allegiance to the country - acknowledging the flag or standing attentively while the national anthem is being sung. [35] When an individual does such rituals, they are participating or performing in rituals considered to express loyalty to the object. Thus, the individual isn't trying to advance the interests and welfare of an object or trying to be its advocate. Rather, they are affirming their loyalty in participation or performance; loyalty in rituals. [35]

George P. Fletcher [42] argues that the main idea of rituals in loyalty is to communicate loyalty - to make it visible or public; through participating in or performing of rituals, common loyalties are established and strengthened. [35] Keller however, counter argues – he says that the distinguishing characteristic of rituals in loyalty is that people participating in or performing such rituals see it as a manner of honoring and

respecting the objects of their loyalty. [35] The oaths taken at graduation to be loyal to the best interests of patients would fall under this category of loyalty.

2.1.3.5. Loyalty in identification

Another way we can express loyalty is through an inclination to identify ourselves with the object of our loyalty. We may feel and act if particular things that are true of the object, were true of ourselves. If a HCP, for instance, feels loyal her to patients in such a manner, the HCP may feel well herself when the patient is doing well after being ill, and like a failure or even ill herself when the patient isn't doing well. "Such reactions exist beyond any tendencies to want to advance the interests of the object of your loyalty, to serve as its advocate, or to venerate it through involvement in appropriate rituals." [35]

2.1.3.6. Loyalty in Belief

The final expression of loyalty has its main expression not in any specific wishes, feelings, or actions, but in the predisposition to shape or resist certain opinions and beliefs. For example, being loyal to a friend might lead us to believe, in particular, that the friend is not guilty of a crime against which he or she is accused. The loyalty expressed is loyalty in belief if, despite the proof to the contrary, we are inclined to hold on to or resist certain views. A way of establishing whether one is expressing loyalty in belief is to ask whether we would hold the same beliefs about an object to which there is no special connection, but the same evidence exists. By way of illustration, a friend might be expressing loyalty in belief if he or she believes that his or her friend is innocent despite evidence to the contrary, but would not believe the same about another random individual being accused of the exact same crime. This

is often the most common and problematic manifestations or expressions of loyalty. [35] This, however, will not be analyzed further.

2.1.4. Loyalty and self-awareness

A probing feature of “loyalty in belief” is that it is complicated to understand how we could express loyalty in belief with full awareness. It is also difficult to see how we could believe another person while admitting that our reasons for believing the other person does not depend on the question of whether the other person’s claim is true or false. [35, 43] Instead of perpetuating the idea that loyalty expressed as *loyalty in belief* is a problem, the above observation and the example below shows why it is possible for us to be loyal to an object and have our loyalty unknowingly influence our actions. [35]

Some individuals insist that they are not loyal to an object, but it is clear to others or based on their actions that they are. For example, an individual who hires his friend for a particular job insists that he does so based only on the merit, experience, and qualifications of his friend. After some time, however, the friend does not perform as expected and the individual who hired his friend realizes he might have been influenced by his loyalty to his friend. [35] This is seen frequently in the context of healthcare in SA where political decisions determine, e.g., who is employed as the Chief Executive Officer (CEO) of a hospital or even the leadership of Provincial Departments of Health. Moreover, it became clear with the Life Esidimeni situation that loyalty to the political leadership impinged on HCPs oaths towards acting in the best interests of their patients.

2.1.5. Loyalty as prioritizing interests

Philosophers who write about loyalty often ignore the possibility that in order to be loyal to an object, there must be a special concern between the object and the subject's interests. For example, Philip Pettit [35, 44] says that to be loyal is to commit ourselves to the welfare of an individual (or object). This could be said about HCPs and patients; HCPs may feel a special connection to their patients as those patients are an important factor in the healthcare profession, and thus, HCPs will commit themselves to the welfare of their patients. R.W.Ewin [35, 45] suggests that loyalty is, in some way, the attachment of ourselves, preferentially, to the interests of a specific person or group of people, and further says that loyalty is the motivation to assume another person's interests as our own. HCPs may preferentially attach themselves to the interests of their patients – to get the required healthcare – and may, therefore, be motivated to assume their patients' interests.

Keller [35] suggests that there are ways of being loyal that do not involve prioritizing the interests of an object; not all expressions or manifestations of loyalty are loyalty in concern. If being loyal to an object means prioritizing an object's interests, then it is consistent with 'loyalty in concern'. Nonetheless, that is not how it works according to Keller. Prioritizing an object's interests is not enough or needed for loyalty to an object. [35]

We can prioritize an object's interests without being loyal to it; prioritizing an object's interests might come as an order from a senior official at work for instance, or because it will benefit the subject some way or another. In both cases and others like it, we can prioritize an object's interests without being loyal to it. Furthermore, we can be loyal

to an object without prioritizing the object's interests. [35] This, therefore, raises serious concern around HCPs and their loyalty to patients. Are HCPs loyal to their patients? Or are HCPs only loyal to patients because of their profession and society, in general, demand them to be loyal? And if so, is it enough for HCPs to seem loyal? Or do HCPs have a duty (obligation) to be loyal to their patients?

2.1.6. Loyalty and the self

A different claim is made about the fundamental character of loyalty by individuals whose primary interest in loyalty comes from a need to embrace it or to show what a 'deep, rich and important notion it is'. The claim is this: for an individual to be loyal to an object, it must have an intimate or special connection with that individual's identity in some way or another. [35] Different authors provide different claims about the connection between loyalty and personal identity. Although there is no common consensus on the matter, Keller provides two vital cases on the matter.

2.1.6.1. Case one:

Fletcher [42] as cited by Keller [35], probably provides the most thorough account on the connection between our identity and loyalty; known as the 'historical self.' For Fletcher, the historical self consists of unique features of our history; features which cannot be chosen – such as family, religious upbringing and nationality. Liberal accounts of the 'self', according to Fletcher, do not consider our history; these accounts take the self as a complete person without considering any prior particular relationships we had with others, and in this they are wrong. According to Fletcher [42], the historical self, is then, a true sense and understanding of the self, and it is in the historical self that loyalty is grounded and founded. The source of loyalty is the historical self; it produces

a sense of duty of loyalty toward the object that fits the definition of the self. Again according to Fletcher, this is the *only* source of loyalty as the historical self-instills a sense of loyalty, which draws wholly from the historical self. Being loyal or expressing loyalty is a matter of personal identity; when we are loyal, we recognize ourself. [35 42]

2.1.6.2. Case two:

Richard Rorty [46] as cited by Keller [35] gives a slightly different account on loyalty and personal identity. Rorty claims that one is a 'centre of narrative identity'; it tells a story of one's identity, and it consists for the most part 'members of a particular community'. According to Rorty, a moral dilemma occurs when our loyalty to one object conflicts with our loyalty to another object, i.e. a HCP's loyalty to her patient conflicts with that of a third party. [35, 46] In such cases, says Rorty, when confronted with a 'dual' loyalty conflict, we will need to decide which object one is most fundamentally loyal to - which object is most important to the narrative of our identity. When an individual is deciding which object to be loyal to, they are 'alternating between alternative species'. [35, 46] It can be quite difficult to see precisely what claim is being made; which claim should be taken literally and which claim should be taken figuratively. The claim that for one to be loyal to an object, it must have an intimate or special connection with our identity in some way or another is somewhat true. Sometimes when deciding to be loyal, we recognize ourselves. Sometimes, choosing who or what to be loyal to boils down to whom or what is most important to the narrative of our identity. [35]

2.1.7. What is it like to be loyal?

Keller [35] gives an account of the nature of loyalty; what it feels like. He uses a well-thought-out example and provides three answers on what it is like to be loyal. This dissertation will use its own example; however, Keller's analysis will still be utilized.

A HCP is approached by the Provincial Health Department and is asked to take part in a Mental Health Marathon Project that will see mentally ill patients being transferred out of hospitals to community-based facilities. The project is part of the National Department of Health's policy on deinstitutionalization; to reintegrate mentally ill patients back into the community. The project is also a cost-cutting measure. The Provincial Health Department asks the HCP to sign the discharge forms of the mentally ill patients in her ward, so that they may be transferred to community-based facilities. The HCP is aware that if she is insubordinate and she does not sign the discharge forms, she might face disciplinary action and could lose her job. After considering all the options, the HCP decides, out of loyalty to her patients, not to sign the discharge forms. The HCPs feels that it is not in the best interest of the patients to have them transferred to community-based facilities; patients' interests would best be protected and promoted in the hospital.

If it is really the HCP's loyalty to her patients that motivates her choice – "loyalty as opposed to, for example, enlightened self-interest, political ideology, or simple commitment to a principle" [35] – then what must be going on in her mind? First, according to Keller, the HCP feels an emotional attachment to her patients. There is something which draws the HCP to not sign the discharge forms that is not completely answerable to rationality. Even though it might be a good option for her patients to be

transferred to community-based facilities, the HCP will have a strong emotional drive and desire to protect and stand by her patients, and possibly a strong feeling of revolt at the idea of not doing so. [35]

Second, what drives her to act as she does will be partly due to the consideration of her patients. The HCP is moved by the awareness that it may not be in the best interest of her patients to be discharged out of hospital and into community-based facilities. [35] The HCP's awareness and concern are not due to the fact that it is not in the best interest of patients to be discharged out of hospital and into community-based facilities, but rather that it is not in the best interest of *her* patients to be discharged out of hospital and into community-based facilities. This goes back to earlier discussions on loyalty in concern and loyalty in identification. Those particular patients have characteristics that will set them apart as individuals and somewhat be present in her considerations and motives. [35]

Third, in acting out of loyalty to her patients, the HCP will be motivated partly by thoughts of a connection to or a relationship with them. The HCP is the patients; she interacts with them closely daily and knows something about them; their lives, history, family and struggles. [35] Those are connections that the HCP does not share with most people, and that most people do not share with her patients. They are connections and relations whose force she feels as she decides what to do. What motivates the HCP to do the right thing by her patients is not just the "an awareness of their value or interests as such, but an awareness of their special relationship" [35] with her. [47]

2.1.8. The Motive of loyalty

All expressions of loyalty, according to Keller [35], contain three elements, as seen in the above example: (1) The emotional pull – whenever an individual is loyal to an object, he or she is emotionally driven, to regard and treat the object in a certain way. (2) Responding to the object itself - an individual's motive is focused on the object itself; it recognizes the uniqueness of the object, and (3) The specialness of the relationship – the motivation of the person relies on an important reference to a particular connection between the person and the object.

2.1.8.1. The Emotional Pull

An emotional attachment is found whenever we analyse our expressions of loyalty. When analysing our loyalty to a friend, for instance, we will find not just a judgment that we should conduct oneself as a loyal friend would, but also an emotional reaction that moves us to conduct ourselves independently of one's judgment. [35] For example, part of what makes a HCP loyal to his or her patients is the fact that the HCP has passions, such as caring for the sick, which draw the HCP towards caring for the patients. HCPs also have an emotional connection to their patients and the healthcare profession itself; 'an impulse to serve and take pride in it'. [35]

2.1.8.2. Responding to the object itself

When a HCP, for example, expresses loyalty to his or her patients, the HCP is aware of his or her patients as particular individuals. Keller [35] suggests that when responding to the object itself, i.e. a HCP responding to a patient, he is not suggesting that the HCP is only responding to the objects 'bare haecceity'. Rather, the HCP is "conscious of and drawn towards the [object] as a particular distinctive entity, not just by virtue of

its falling under some generic description." [35] Simply, Keller suggests that there is a difference between having our passions aroused by the thought of, for instance, 'the patients' and 'my patients'. [35]

2.1.8.3. The Specialness of the relationship

Once again, Keller [35] suggests that in order to be loyal to an object, we must be drawn to it by virtue of a special or unique connection that we have with the object. For instance, using the example in 2.1.7. - if the HCP is loyal to her patients, then her motivation depends not just upon them being human beings who do not deserve to be transferred to community-based facilities that may not be able to care for them adequately, but also upon them being *her* patients. Simply put, an individual who is loyal to an object must have a "motive whose nature depends upon, or makes essential reference to, a special relationship that individual." [35] When the individual is loyal to the object, what is presented within the individual's motivation is, inter alia, not only the object but the object as something to which the individual is connected to in a special way. [35]

2.1.9. What exactly is loyalty? A conclusion

After considering all of the above with respect to loyalty, Keller provides a final definition of what loyalty is: "Loyalty is the attitude and associated pattern of conduct that is constituted by an individual's taking something's side, and doing so with a certain sort of motive: namely, a motive that is partly emotional in nature, involves a response to the thing itself, and makes essential reference to a special relationship that the individual takes to exist between herself and the thing to which she is loyal." [35] To be loyal to an object is to have loyalty. To act out of loyalty to an object is to be

driven to action by the motive or motives described above. However, Keller does make it clear that none of this is ‘pithy’ or concise. There are some limitations or consequences on his account and definition of loyalty. [35]

First, if Keller’s account on loyalty is correct, then loyalty is a thin or loose concept. Just because an individual is loyal to an object, it does not really indicate how she is likely to think and behave. [35] There are several distinct ways one can be loyal; loyalty may involve any of different kinds of motives if there is a particular basic structure, and it may involve many different ways of acting. Our loyalty may or may not involve an inclination to act out of concern for the object’s welfare, to form and resist beliefs, to engage in particular rituals, etcetera (etc.) [35]

Second, loyalty is not an inherently evaluative concept. “Without some substantive argument, there is no guarantee that if something counts as a loyalty then it counts as something good or something that merits our approval or encouragement.” [35] Third, the scope of objects to which we can be loyal is large. We can be loyal to anything that grabs one’s attention and has an influence on our conduct in a particular way; if we are emotionally drawn to the object itself, and if our motive to take the object’s side and makes an essential reference to a special relationship that is shared between the subject and the object, then we are loyal to it. [35]

Fourth, it is possible to be loyal without being aware of it; we can be mistaken or otherwise lack knowledge about our own motivations. An individual may fail to realize that he or she is emotionally drawn towards the object; failing to realize that we are driven by consideration of the object itself, as opposed to some other consideration;

and we may be unaware of the essential role that our special connection to is playing in one's motivations. [35] Lastly, it seems that the "differences between different kinds of loyalty – between kinds of loyalty, not just objects of loyalty – are, potentially, of great ethical interest." If so, then there might not be much sense in the questions: can loyalty be a good thing or a bad thing? And why and what is it that makes loyalty so important? [35] The sensible questions will, rather, be about the ways in which loyalties differ, and the different ethical treatments that they should be given. [35]

2.2. Loyalty and the Healthcare Profession

I define loyalty in the healthcare profession as putting the interests of patients first, promoting and protecting their lives, as well as alleviating their pain and suffering. Loyalty in the healthcare profession can be seen as a fiduciary duty. A fiduciary duty is a legal or ethical relationship, usually between two parties. The fiduciary is the subject (HCP) the duty is imposed on, while the object (patient) is the party that is owed the duty.[48] Fidelity or loyalty is the most vital ethical value overseeing the healthcare profession, and it obliges HCPs to prioritize their patients' interests. [49] An example of this can be noted when HCPs who "contracted and/ or died of Severe Acute Respiratory Syndrome (SARS) in the 2003 epidemic clearly illustrated both the glory and cost of living with this principle." [49]

2.3. Loyalty: An African Perspective

It is imperative to define loyalty from an African perspective given the nature and scope of this paper. However, there is no definite understanding of loyalty from an African perspective. I will, therefore, attempt to define the concept of loyalty from an African

‘Ubuntu’ perspective. This will be done by defining, describing and conceptualizing the notion of Ubuntu, and then linking it to the definition of loyalty, as defined above.

2.3.1 The notion of African Ubuntu philosophy: a definition

Ubuntu is not simple to describe and conceptualize like many other African notions. Ubuntu as a notion among African cultures is frequently seen as an African worldview, [50] and is an influential feature “in the formation of perceptions which influence social conduct.” [51] Ubuntu was also described as a life philosophy that basically means personality, humanity, and ethics. [51, 52] Despite the diversity of African cultures, similarities can be discovered in fields such as convictions, procedures, traditions and value systems. Such areas reflect mostly the African view of the world; acknowledged as Ubuntu's concept and philosophy (humanism or humanity). Ubuntu has been supporting and sustaining communities in Africa for generations as an old philosophy and way of life, especially in sub-Saharan Africa. [51, 53, 54] In Africa, particularly in East, Central and Southern Africa, the concept of Ubuntu is discovered in multiple forms across cultures. Ubuntu is a cultural perspective of the globe that attempts to capture what it means to be human. [54, 55]

In the Southern African context, Ubuntu comes from an isiZulu (Nguni) maxim: *UmuntuNgumuntuNgabantu,* which when translated means, “a person is a person because of others”. [56] It is also usually translated as ‘I am because we are’. [57] Ubuntu emphasizes humanity; humanity towards others. In a more philosophical sense, Ubuntu can mean “the belief in a universal bond of sharing that connects all humanity.” [58] This can be viewed as African communitarian. In communitarian ethics, the focus is to lessen individual rights and to increase the focus on collective responsibilities. [59]

Ubuntu can, therefore, be defined as humanness, an inescapable life-force of "caring and community, harmony and hospitality, respect and responsiveness that individuals and groups display for one another." [51] Ubuntu is thus a literal translation for communal personhood and communal mortality. [60] Africans practice collectivism as they regard themselves not as individuals, but as individuals because of other individuals. Hence the aphorism: 'I am because we are'. It is the basic foundation in the way Africans think, behave and treat each other. [51, 60, 61] In the same way, Nussbaum [57] articulates the notion of Ubuntu as follows: "*Your pain is my pain, my wealth is your wealth, [and] your salvation is my salvation"* - slogans Africans practice daily. Furthermore, Ubuntu is not an abstract concept. It radiates in every part of African life. In African culture, it can be described as the ability to collectively express care, dignity, pain, compassion, humanity, harmony and the reciprocity on the concern of building and upholding the community with justice and care. [51, 56, 57, 60]

In essence, Ubuntu puts an emphasis on interconnectedness, common humanity and a duty to the next person other that stems from a common connection. [51] Fox [62] states that in Ubuntu, the importance "is placed on the human aspect, and teaches that the value, dignity, safety, welfare, health, beauty, love and development of the human being are to come first and should be prioritised before all other considerations, particularly in modern times, before economics, financial and political factors are taken into account." Ubuntu is for that reason, the fine art of being a human being. Ubuntu can also then be defined as "an all-inclusive, deep-rooted African worldview that pursues the primary values of intense humanness, caring, sharing and compassion, and associated values, ensuring a happy and qualitative human community life in a family atmosphere and spirit." [62]

2.3.2 Significance of the African Ubuntu philosophy in the understanding of loyalty

To serve others is to have Ubuntu; to serve humanity practically. Through the positive activities specified above, we are associated, connected and bound to others. A hands-on shared activity to ease human grief, pain and sufferings is the most ideal way one can show one's commitment or loyalty to society; to display Ubuntu. [51] Hence, by serving humanity, say, by easing or alleviating grief, pain, and suffering, Ubuntu is being displayed. A perfect example would be a HCP serving her community through her practice. HCPs have a distinctive moral duty of care to promote and protect the lives of individuals (or communities), as well as to alleviate pain and suffering. [10] Loyalty in an African healthcare perspective can be seen as a HCP putting the interests of the community (or individuals in a community first) and promoting and protecting the lives of individuals (or communities), as well as alleviating pain and suffering. This can also a duty; a duty to serve others. As a result, a HCP serving humanity through his or her practice is not only displaying Ubuntu but is being loyal to the community through the notion of Ubuntu.

It is a central principle in the philosophy of Ubuntu for those who are strong to help or assist those who are weak. Additionally, Ubuntu deals with numerous sentiments of empathy, identified with making life more accommodating for others; particularly to administer help and assistance to the hindered, to be specific the debilitated, the dispossessed, poor people and outsiders.[51] Again, this can be linked to the healthcare profession where care and compassion are at the core of the profession.

Compassion portrayed as an understanding and worry for another's pain and suffering is fundamental in both the notion of Ubuntu and the healthcare profession. It could be seen as a critical attribute to provide morally good care. Compassion is uniquely linked to caring; diminish distress and unhappiness - to change the earth such that life winds up ‘liveable and human’.[9] As such, care requires a demeanour of compassion and empathy towards patients. Caring HCPs can place themselves in the patient's circumstance of pain and suffering to such a degree, that they can precisely see the patient's care needs. [9] This can be linked to the definition of loyalty and to the duty of HCPs to be loyal to their patients. Caring involves a disposition of contribution and participation facilitated by practices of care. Caring HCPs are individuals who are involved with the requirements of patients and submit themselves to address those issues professionally. [9] In an African ‘Ubuntu’ sense, caring and compassionate HCPs are those who submit themselves to the needs of the community. When a HCP cares, heals and alleviates the pain and suffering of an individual from the community - the HCP is caring, healing and alleviating the pain and suffering of the community; thus practicing Ubuntu.

Furthermore, within Ubuntu, there is a deliberate exertion and duty to propel and advance the interests of others. These acts help to “bring sense not only to one’s own life but also to the lives of others.” [51, 53] HCPs helping others exhibits Ubuntu and by helping others through his or her practice, the HCP can be seen as loyal to the interests of the community, and this may be understood as loyalty from an African perspective.

2.4. Dual Loyalty Conflicts: A Contextual, Bioethical Analysis

This section will examine the concept of dual loyalty conflicts. Dual loyalty occurs when an individual holds conflicting allegiances or obligations between two objects, which usually results in unwanted or adverse consequences. [63, 64] The term 'dual loyalty' is a peculiar, descriptive concept; it states the obvious – that an individual can have loyalty, obligations or commitments to more than one object. [65] As a reminder, the term 'object' is collectively being used to refer to cause, country, group, or person. Still, the concept invokes a tone which questions the 'justifiability' of having more than one loyalty; [65] that is a dual loyalty, especially when it comes to a HCP and her patient/s.

The concept "suggests that this…is somehow inherently questionable or problematic, and the term is often used to describe the potential threat posed by" [65] HCPs having conflicting loyalties, obligations or commitments. The concept of dual loyalty in the healthcare profession "is somehow inherently questionable or problematic" [65] as for many generations, the healthcare profession has been held to a high ethical, and more recently, a legal standard to abide by an ethos of complete loyalty to the patient – this was first codified by the Hippocratic Oath [1] and the Florence Nightingale Pledge and then later modified by healthcare profession bodies globally. [9, 10]

The primary encounter of having conflicting and potentially harmful and contradicting loyalties is an encounter that many individuals face, in both their personal and professional lives. The history of dual loyalty – as discussed in a section below, "goes beyond the modern invention of the citizen." [65] Additionally, a dual loyalty conflict has no bias; any individual could encounter conflicting obligations or loyalties. As a result, dual loyalty conflicts can be used to refer to the "emotional experience of being pulled

in different directions," [65] to the moral dilemma of choosing an overriding obligation or commitment. Although there are many definitions of dual loyalty conflicts, this dissertation does not seek to articulate all those definitions. This dissertation will, therefore, use the following definition for dual loyalty conflicts, as its main definition: dual loyalty conflicts can be defined as "simultaneous obligations, express or implied, to a patient and to a third party". [1]

It would be important to note that it can be easy to mistake the terms 'conflicts of interests' and 'dual loyalty conflicts' as one and the same. However, Williams makes it clear that these are not the same. According to Williams, a dual loyalty conflicts also involves a conflict of loyalties, commitments or obligations between an object and the subject. Conflicts of interests "are usually between one's own interests and those of another individual, institution or group", [66] whereas dual loyalty conflicts are conflicts between two external objects (a patient and a third party) whose interests are usually incompatible.[66] An example of HCPs who provide unnecessary healthcare services for profit or who inflate the prices of certain healthcare services, solely for financial gain and benefit, are undoubtedly in a conflict of interest situation – putting their own interests ahead of the interests of their patients. On the contrary, a dual loyalty conflict is putting the interests of a third party over and above the interests of the patient.

Rodin [67] provides an account on the difference between "conflicts of interests" and "dual loyalty conflicts": (1) conflicts of interests are conflicts between the private interests of the HCP and the patient's interests [67, 68] and (2) dual loyalty conflicts are conflicts between two or patients or between a patient and a third party that split the loyalty of an HCP. [67 68] Although HCPs may sometimes have more than two

competing loyalties, e.g. to a patient, the family of the patient and the hospital, the word ‘dual loyalty conflict’ will be used for brevity throughout this dissertation to include all such conflicts.

2.5. What is a Dual Loyalty Conflict?

Within the context of the healthcare profession, dual loyalty conflicts are the ethical and legal question of how should HCPs ethically and legally fulfil their obligation towards the best interest and positive welfare of the patient, when confronted with having to simultaneously satisfy the interests of a third party. A dual loyalty conflict is an ethical, moral and a legal dilemma frequently encountered by HCPs. Dual loyalty conflicts can occur, either expressly or implied, when a HCP is employed by a third party, often the state or a private organisation, [2] to provide healthcare to patients, and a conflict of loyalties arises when the HCP’s duties to a patient conflict with those of a third party. [3]

Such conflicts are recognized as dual loyalty conflicts as the HCP “is caught between two different players who often have different or discordant aims and objectives.” [68] HCPs who, at the cost of their patients, favour a third party's interests may eventually breach their ethical and legal commitments. Dual loyalty conflicts hence presents as a particular moral and legal challenge for HCPs, as the relegation of patients’ interest’s risks breaching the ethics of their profession and violating the “human rights of the very person who is entitled to the health professional’s strongest loyalty” [69], as discussed in chapters 3 and 4.

Dual loyalty conflicts can be *express*, for example, i.e. a third party instructs a HCP to not provide healthcare services, e.g. private hospitals or care centres instructing HCPs to deny patients without medical aid or financial affordability emergency medical treatment or *implied* i.e. reminding HCPs to not provide certain (limited or expensive) healthcare, e.g. a Computed Tomography Scan, to patients. This commonly happens in state facilities. [69] Dual loyalty conflicts may also be *real* e.g. putting pressure on the HCP or perceived e.g. the HCP feels that the third party wants her to relegate the patient's interest, even though there has been no communication. These examples can be seen in the cases discussed in Chapter 3. [69] Nonetheless, regardless of the type of pressure exerted and even if it is only perceived by the HCP, such forms of conflicts still have the potential to violate human rights of patients. Dual loyalty conflicts constantly draw HCPs "into a moral and ethical conflict, where they end up second-guessing what they know to be their primary duty: giving patients the best possible care." [69]

For a dual loyalty conflict to exist, according to Rodwin, [67] there has to be a HCP, a patient and a third party to whom the HCP is also loyal. The relevant aspect of dual loyalty conflicts is that the concurrent loyalty or obligation to the patient and the third party must be conflicting. Simply, the obligations to both objects do not have a common or shared goal, which should be to put the interests of the patient first. "If they were parallel obligations the health professional, patient and third party would be heading towards a common goal" [68] and therefore is not a dual loyalty conflict.

An example of where obligations conflict is when Sibongile Manana, the former MEC for health in Mpumalanga, instructed Dr. von Mollendorff to withhold antiretroviral (ARV) treatment from rape victims. The ARVs were provided to rape victims at no cost.

[70, 71] The then MEC was enraged that the rape victims were accessing free lifesaving ARVs, at the time when then-President Thabo Mbeki questioned Human Immunodeficiency Virus's (HIV) link to AIDS (Acquired Immunodeficiency Syndrome) and the efficacy of ARV treatment.[70, 71] Dr. von Mollendorf's view was that it obeying the policy of the South African government to deny rape victims medication "unjustifiably subordinated his obligation to affirm his patient's right to the highest attainable standard of health." [70] Dr. von Mollendorf was fired from his post for his position.

Thus, the potential for a dual Loyalty conflict to exist, the following must be present:

1. The existence of a simultaneous obligation by a HCP, a patient, and a third party to whom the HCP also has an obligation.
2. The incompatibility of such concurrent obligations. [64]
3. The existence of some degree of pressure, express, implied or perceived on the HCP from a third party.
4. The separation of the HCP's role as a HCP to his or her patient or patients. [64]

2.6. Dual Loyalty Conflicts and the Healthcare Profession

Even though dual loyalty conflicts can occur in many other settings, it is rife in the healthcare profession, especially in the South African context and for good reason: (1) Perpetual resource shortages (2) Family dynamics play a huge function and (3) Cultures and traditions often clash. [66]

The absence of funds in healthcare can lead to many dual loyalty conflicts. HCPs often have to decide which patient requires, for instance, an operational or medical

procedure for which a waiting list is applicable or for which there is a restricted supply of an expensive, life-saving drug. Although HCPs would want to do what's best for each patient; that is to promote and protect the lives and the interests of patients, as well as to alleviate pain and suffering, they are unfortunately forced to decide whose interests matter the most. [66] This type of conflict can be seen as a dual loyalty conflict as the HCP has to decide which patient needs a scarce resource more; that is which patient's interests should be advanced first due the third party's (often the state) failure to provide an adequate supply of the scarce resource in question.

Furthermore, HCPs also face conflicts between patients and their relatives. Sometimes a patient will instruct the HCP not to disclose to the family their diagnosis or prognosis. In other situations, the family would ask the HCP not to provide the patient with bad news of their diagnosis or prognosis. [66] The HCP thus feels a loyalty to both objects; the patient and family. "The former goes without saying but the latter is important, too, because the patient's situation affects the health and well-being of other family members." [66] Family members need to learn all too often about the diagnosis and prognosis to provide appropriate palliative care to the patient. The HCP in such situations "has to decide which loyalty should prevail if they cannot be reconciled." [66]

HCPs value their professional autonomy and independence; "they are trained to make judgments about what is best for their patients, and their professional ethics requires that they put the interests of their patients above all others." [66] At the same time, HCPs are operating in a very distinct ethos scenario. In particular, society places greater importance on patient loyalty than on autonomous thinking. As necessary as it may be

to fulfil their objectives, society can conflict with a HCP's judgment of what is best for a patient. Thus, there is often a clash of cultures and traditions. Examples of dual loyalties that occur as a result of this 'higher value' are vast. [66] What follows is a fractional list of such conflicts: [66]

I. "A patient versus the police or prison. This is probably the best known and most analysed type of dual loyalty conflict."

II. "A patient versus the army. Military [HCPs] are often required to determine when an individual is fit to enter or return to active duty. They may encounter great pressure from military authorities to use minimal criteria for making such determinations, for example, the physical condition of the individual, and to ignore psychological and other factors. As military personnel, such physicians have loyalties and obligations to their superiors as well as to their patients, and these can directly conflict."

III. "A patient versus a hospital. Although [HCPs] are expected to consider the needs of their own patients first, hospitals and other healthcare institutions have to meet the needs of all patients. In doing so they develop policies and make decisions that result in the denial of optimal treatment to many. [HCPs] working in the institution are expected to implement these policies and decisions even though their own patients are disadvantaged as a result. They have to decide whether to advocate for special treatment for their patients at the expense of other patients or institutional sustainability."

IV. "A patient versus an insurer. In order to get coverage for life, health or travel insurance, individuals often have to undergo a medical examination. In such cases, the examining physicians are accountable to the insurance company to give an accurate report, even if it means that the patients are denied coverage

as a result. [HCPs] need to determine how they can best fulfil their loyalty to their patients in these circumstances."

V. "A patient versus an employer. [HCPs] are subject to some of the same pressures as their military counterparts to consider first the well-being of the company rather than the employees they examine and treat. For example, they may be reluctant to attribute employee illness or disability to unsafe working conditions for which the company is responsible. If the health professionals are in the employ of the company, they risk dismissal if their loyalty to their patients is seen to outweigh their allegiance to the employer."

VI. "A patient versus a sports team. Team [HCPs] have the responsibility to determine whether an injured athlete is fit to resume competition. Their concern for the best interests of the athlete can conflict with the desires of the team officials, the other players and sometimes even the injured athlete to get back into the match for the good of the team."

VII. "A patient versus the public. Recent epidemics of infectious diseases such as severe acute respiratory syndrome (SARS) and swine flu as well as the ongoing HIV/AIDS challenge have highlighted the conflict between individual rights and those of the public. Here again [HCPs] face dual loyalty conflicts. In the interests of public health, they may have to restrict individual liberties, for example by imposing quarantine on infectious individuals or by revealing confidential information about patients' health status to public health authorities or sexual partners."

There is obviously no shortage in the healthcare profession of dual loyalty conflicts. Unfortunately, many HCPs who encounter dual loyalty conflicts often choose to

advance the interests of third parties instead of that of their patients. This usually results in ethical breaches and human rights violations.

2.7. The Problem of Dual Loyalty Conflicts

The problem of dual loyalty conflicts continues to remain a challenge for HCPs. Although there have been efforts to address these challenges through ethics and human rights law, success has been marginal. [1] Additionally, dual loyalty conflicts tend to become even more ethically difficult when HCPs act in a manner that supports the interests of the third party, instead of showing devoted loyalty to patients, and these actions violate the human rights of patients. [1]

2.8. Dual Loyalty Conflicts: A Historical Background

Historical backgrounds are indispensable for any normative and meta-ethical analysis of an ethico-legal question, and dual loyalty conflicts and human rights are no exception. Knowledge of the health sciences became the era of a new kind of scientifically skilled health professionals in the 15th and16th centuries. [72] Throughout this era HCPs partook in the healing and caring of the ill as well as in serious unethical and immoral conduct (dual loyalty conflicts) and gross human rights violations.

Since the 16th century, there have been major changes within medical ethics and standards for HCPs. By the 20th century, there was already an emphasis on the need for ethical practices by HCPs and the need for HCPs to embody a virtuous character. Additionally, there was an emphasis on the principles of beneficence and non-maleficence to be upheld. [72] The 20th and 21st century, since World War I, has been a time for rethinking and improving international standards for the healthcare

community, along with the emergence of universal human rights. It took the occurrence of a number of significant historical events, especially after World War II to bring the ethical and legal challenges associated with healthcare and dual loyalty conflicts to the attention of the world. [72]

There are many historical examples of dual loyalty conflicts from several countries over the past decades. The historical examples include but is not limited to: the Second Sino-Japanese War (Unit 731) (1937–1945), [73] Nazi Doctors during World War II (1939–1945), [74] "Tuskegee Study of Untreated Syphilis in Black Males (1932 -1972)" [75] The case of Steve Biko (1977), [23] Project Coast (1980s - 1990s). [76] More recently these include but are not limited to the United States both in Abu Ghraib (2003-2006) [77] and Guantanamo Bay (2002 to present) [77] and the Life Esidimeni Tragedy (2016 – 2018). [27, 28, 78, 79]

2.9. Dual Loyalty Conflicts: An African Perspective

Having attempted to define loyalty from an African 'Ubuntu' perspective, the same will be done for dual loyalty conflicts. How would dual loyalty conflicts be understood from an African 'Ubuntu' perspective? According to Wilson [68], the most important factor to consider when answering such a question is the scope or definition of the 'patient' when in an Ubuntu setting.

Within the notion of Ubuntu, the definition of the patient goes beyond illness, pain or suffering. This is so as the patient's humanity is ultimately and intimately linked the patient's community. Their illness is the community's illness. Their pain is the community's pain. Their suffering is the community's suffering. Wilson [68] gives an

example of the HIV/AIDS pandemic. The dying patient leaves behind a family and/or children and the loss of that patient is the community's loss of human capital. As a result, the illness is not only confined to the patient, but to the community as well. As the HCP is a member of the community, he or she "shares the same interwoven existence." [68] Therefore, if the definition of the patient includes that of the community, who is a third party when it comes to Ubuntu? Wilson [68] argues that the third party would not be a party within the community. This makes sense as earlier it was established that within Ubuntu there is a deliberate exertion and duty to propel and advance the interests of others, within that community.

Additionally, a party within the community, according to the notion of Ubuntu, would most likely act in ways that would promote and protect the interests of that particular community; interests influenced by Ubuntu.[68] A third party would then be a party whose interests are not influenced by Ubuntu. This party would come from outside the community and not "share the same interwoven existence." [68] A party such as government and any other party whose interests are not protected or influenced by Ubuntu.

The examination and exploration of dual loyalty conflicts will now take place using Bloche's [80] understanding of dual loyalty conflicts. Bloche [80] divided dual loyalty conflicts into three groups: (1) pursuing public health goals that arise when public health is in conflict with individual patient interests; (2) pursuing non-health-related social ends where HCP's clinical ability is non-health-related; and (3) assigning health-related rights, responsibilities and opportunities where HCPs operate as gatekeepers to healthcare. Bloche [80] gives an example of vaccinations an issue of dual loyalty in

the pursuit of public health objectives. Using the principles of bioethics and an individualistic point of view, it could be argued that compulsory vaccination ignores the autonomy of the individual in order to protect the health of the larger community.

From an Ubuntu perspective, it would be in the interests of the patient being vaccinated to protect the community, so there would be no dual loyalty problem. Another example is the quarantine in medical facilities of extremely drug-resistant (XDR) tuberculosis-infected patients until they can no longer infect others. [68] This again violates patient autonomy from an individualistic point of perspective, but from an Ubuntu point of perspective, it is in the interest of establishing a good society. Another instance presented by Bloche is the case of human subject research. Bloche [80] indicates that these topics carry the medical hazards for potential patients of the experimental procedure. If the experiments were consistent with creating a good community, this would not present an issue from Ubuntu's point of view, but if the experiments were to benefit another remote community, they would be exploiting the index community.

Steve Biko's case is an example of the second category of Bloche [80] where the loyalties of the HCP are stretched between patients and promoting non-health-related social ends. Steve Biko was arrested and detained a prison in Port Elizabeth (PE) and interrogated frequently at the headquarters of the police. He got a head injury during one of those interrogations. [68] The medical treatment by Drs. Lang and Tucker were later defined as "callous, lacking any aspect of empathy, care or humanity," 68] and led to the death of Biko in a prison cell days later. These HCPs had a prima facie duty towards their patient, which was granted in the apartheid era to the racist norms commonly followed in SA. [68] Clearly, these doctors' activities did not demonstrate

Ubuntu's valued values of "peace, harmony, stability, solidarity, mutual reciprocity, and compassion". [68]

Another instance of using clinical skills for other non-health-related social purposes would be the situation where an aggressive psychiatric patient is being sedated against his will. [68] This practice is prevalent in psychiatric units and is protected in section 32 of the "Mental Healthcare Act (MHCA) (No. 17 of 2002)". [81] In this case, patient autonomy is overridden to protect the patient and the family; it causes serious harm to the patient. This would be consistent with Ubuntu thinking, considering the community's interests. [81]

2.10. Conclusion

The Concept of loyalty, as well as the concept, history, and problem of dual loyalty conflicts in the South African healthcare context, is undoubtedly not easy to define and conceptualize. What is easy to see, however, is to understand the effects both loyalty and dual loyalty can have, particularly in the healthcare context. The next chapter will describe and analyse cases of dual loyalty conflicts and the role played by HCPs, specifically in the South African healthcare context. This will be done by detailing three specific cases of dual loyalty conflicts, notably - the Steve Biko case, the Life Esidimeni tragedy, and Dr. von Mollendorf case.

CHAPTER 3: DESCRIPTION AND ANALYSIS OF DUAL LOYALTY CONFLICT CASES IN SOUTH AFRICA AND THE ROLE PLAYED BY HEALTHCARE PROFESSIONALS

3. Introduction

This chapter will describe and analyse cases of dual loyalty conflicts and the role played by HCPs, specifically in the South African healthcare context. This will be done by detailing three specific cases of dual loyalty conflicts, notably - the Steve Biko case, the Life Esidimeni tragedy, and Dr. von Mollendorf case. The first two cases underscore the negative consequences of dual loyalty conflicts, especially when HCPs actively and knowingly participate in these conflicts. While the last of the three highlights the role that HCPs play to avert tragedies that result from dual loyalty conflicts. In this manner, an argument will also be made for the difficulties faced by HCPs when confronted with dual loyalty conflicts.

Chapter 3 responds to objective 2: To analyse specific cases of dual loyalty in South Africa and the role played by HCPs.

3.1. Case 1: The Life and Death of Steve Bantu Biko

The Steve Biko case is one of the most appropriate illustrations of dual loyalty conflicts and human rights violations in the healthcare sector. The role of a HCP is to promote and protect the lives of individuals, as well as to alleviate pain and suffering. [10] The fundamental purpose of the healthcare profession is to serve the needs of patients – to put the interests of patients over and above the considerations of competing personal conflicts. [10]

However, due to the awareness that the knowledge and skill of HCPs can be used for other none-therapeutic purposes, the role of HCPs has extended to serve a variety of other social purposes; to show loyalty to these other social purposes. “These social ends typically involve taking third party interests into consideration, alongside the interests of patients”. [82] This, according to Lukhozi [82] has been the defining factor in the Steve Biko case. Third-party interests that may demand the loyalty of HCPs include the military, police, family members, even state health departments. [3] Others may include those in the “administration of justice, in forensic psychiatry and forensic medicine”, [82] as well as those in the management of healthcare– as seen with the LE tragedy (discussed in the next section). These third-party interests are usually not compatible with the interests of patients, and thus dual loyalty conflicts, such as the Steve Biko case, occur.

3.1.1. Clinical Forensic Medicine Defined

The term forensic is defined as “pertaining to courts of law”, [82] and it comes from the Latin word “forensis” –which may mean forum or court of law. [83] Clinical forensic medicine is a subdivision of medicine “where medical knowledge is combined with legal processes [or procedures] for the purpose of the administration of justice.” [82] These legal processes or procedures incorporate investigations of violations like assault, driving intoxicated or under the influence of both legal or illegal substances and child neglect and abuse. The clinical forensic medicine specialist can be included at any phase of the legal process or procedure. [82] These phases can include examination promptly after an individual has committed a crime or has been a victim of a crime (e.g. taking of blood samples or the examination of a sexual assault victim), assessing the accused before imprisonment, before providing evidence, giving proof

or pleading to a charge (e.g. fitness to stand trial) or after conviction. Whatever the circumstance may be, in clinical forensic medicine, the examination or assessments of subjects is living on human beings, which is in strong contrast with forensic pathology, “where medico-legal investigations are conducted on the dead – e.g. autopsy to ascertain the cause of death.” [82]

As such, examining or assessing of living human beings indicates that the clinical forensic medicine specialist must consider and respect the human rights of the individual in question. [82] Several international human rights instruments make it clear that a HCP, irrespective of speciality, must respect the human rights of patients, as Human Rights Law forms a fundamental part of the healthcare profession. [5, 12] This will be expanded on in Chapter 4. Still, some human rights are limited as soon as an individual “is in police custody, e.g. the right to freedom of movement”. [82] The HCP, particularly the clinical forensic medicine specialist, ought to be aware of all his or her obligations [or loyalty] in such situations.

Clinical forensic medicine “does not include forensic pathology, forensic nursing, and forensic psychiatry, which are well established separate disciplines.” [82] The National Department of Health (DoH) has the sole responsibility to provide clinical forensic medical services in SA. These HCPs appointed by the DoH were commonly referred to as district surgeons until October 2010. It was suggested that district surgeons be called clinical forensic medical examiner (CFME). This suggestion was proposed in a draft amendment to “National Health Act (NHA) No. 61 of 2003” [84] - Regulations Regarding the Rendering of Clinical Forensic Medicine Services, No: 33655. However, the term CFME was subsequently “dropped when the draft regulations were signed

into law on the 2nd March 2012." [85] The NHA now refers to such HCPs as 'medical practitioner' [85]. Nonetheless, the term district surgeon is still prevalent in South Africa to date [82] and to avoid confusion, the term will be used in this dissertation.

The role of district surgeons in South Africa is primarily for the "determination of a fact for use in court, collection of samples for further analysis at forensic laboratories or giving expert opinion in courts of law." [82] In clinical forensic medicine, the most significant responsibilities are mainly non-therapeutic. Instead of alleviating pain and suffering, the focus and duty is on gathering proof. Despite this, the healthcare of prisoners and victims may overlap with clinical forensic medicine in some circumstances.

Irrespective of the setting, the duties of a district surgeon "include either the drafting of a medico-legal report, recording and documenting such findings and/or interpreting these findings for purposes of legal proceedings." [82] These assessments or reports ought to be carried out impartially. However, this is often not the case. Every so often, the suspect in question may not want to reveal implicating information to the police, whereas, at the time same, the police and /or prosecuting authority may want to acquire evidence or information that may attest a specific allegation. [82] Consequently, the police and /or prosecuting authority may also try to obtain evidence or information in a way that relegates the suspect's rights. Although the focus and obligation of the district surgeon is on the collection of evidence, rather than alleviating pain and suffering, he or she must not advance the interests of either side and ought to perform his or her duties impartially. Conversely, district surgeons have been misconstrued "by

many in society as performing duties that merely serve the interests of law enforcement agencies and prison authorities". [82]

3.1.2. The Role of District Surgeons

Cooke, [86] describes the role of a district surgeon as ones that "provides a form of continuing care". To begin with, before the court appearance of the accused, the district surgeon engages with the accused. This is usually directly following a crime committed by the accused. At this initial stage, the district surgeon may, for example, be 'requested' to collect evidence – such as blood samples from the suspect. Thereafter, they engage with the accused/detainee/suspect in court throughout the trial. [86] During this stage the district surgeon may, for example, be 'requested' by the judiciary to examine the accused's fitness to stand trial or is requested by the defence's legal team to examine the accused alleging the crime. [86] Thirdly, if the accused is found guilty, the district surgeon may be 'requested' to determine the convict's fitness to be imprisoned. Lastly, once (or if) the convict is imprisoned, the district surgeon is again 'requested' to attend to the healthcare needs of the prisoner. These healthcare needs may be "minor medical ailments, and/or complaints of ill-treatment by prison officials." [86] It is only at the last stage of this legal process that the district surgeon '*performs*' the duties of a traditional HCP. It can be argued that during these three stages, the district surgeon puts the interests of the state over and above those of the accused (or the patient). However, during those stages, the accused usually is not a patient, unless he or she requires constant medical care. Furthermore, even after the prisoner's release on parole, the district surgeon "is still involved by way of monitoring compliance with parole conditions and rehabilitation e.g. screening for substance abuse." [82] There is a vital duty for "sagacious and unbiased factual expression" [86]

whenever a district surgeon engages with an accused or detainee, “at whatever point in the continuing care or at any point of the criminal –justice system.” [86] The respect for individuals, their autonomy and their human rights “is a fundamental principle for practitioners in clinical forensic medicine from which other obligations can be derived.” [82]

Most surgeons in the district are general practitioners interested in clinical forensic medicine or law. No post-graduate training exists in SA as a necessity for district surgeon appointments; no particular training is given or needed. [82] They are employed on a part-time basis to perform clinical forensic medical duties. In SA as well as in the remainder of the globe, district surgeons have traditionally acquired their abilities through what Cooke [86] calls self-education. These skills are acquired through experience along with learning from colleagues. Cooke [86] terms this ‘mutual respect and goodwill’ which are “good values and ought not to be frowned upon per se, except where they influence the district surgeon’s objectivity when performing his or her duties.” [86]

Nevertheless, the relationship between the South African district surgeons and the police was especially difficult considering the political atmosphere they practiced before 1994. Between 1948 and 1994, South Africans underwent a social and racial segregation and discrimination experiment known as apartheid. Apartheid was an undemocratic system in South Africa led by a white minority government. Many district surgeons were complicit in the political atmosphere of the day, so much so that their choices on the treatment of prisoners and suspects ended up being polluted by racial

preference. This led to the ridicule of the district surgeon system, which was described as prejudicial, unsympathetic and incompetent. [23, 24, 87]

The nonexistence of formal "training and a common forensic medicine ethic amongst district surgeons implied that ethical dilemmas, especially loyalty conflicts, were resolved in an arbitrary manner or inadequately resolved." [82] This was to the disadvantage of the prisoner, who happened to be black and politically connected. This was more so when the attending district surgeon was a white practitioner, and intensely identified himself or herself with or strongly supported the apartheid government – This can be linked to the notion of loyalty in identification, discussed under section 2.1.3.5. Furthermore, this district surgeon would treat the vulnerable black detainee as treasonous, without any evidence to the contrary – the district surgeon would strongly believe that the black detainee was treasonous. Again, this notion can be linked to the notion of loyalty in belief, discussed under section 2.1.3.6. The lack of ethics and clinical forensic medicine practice led in the well-being, healthcare and justice of (specifically) black political inmates being at the mercy of the attending district surgeon. In addition, if the attending district surgeon was white and a racist, a black detainee would receive treatment like that of an enemy of the state. Healthcare, particularly the medical sciences, during that time, had become "as tainted by apartheid as had any other sphere of interaction of people in South Africa". [87]

This is undoubtedly demonstrated by Steve Biko, the leader of the Black Consciousness Movement in South Africa, being imprisoned and subsequently pass ed. The district surgeons who visited him while in prison were accustomed to incorrect attitudes and procedures that were unethical and often illegal. [87] "They

demonstrated total failure to recognize and act in accordance with their ethical obligations." [82]

On this inability to recognize dual loyalty conflicts, the following chapter will expand by addressing the facts surrounding the death of Steve Biko. This discussion will be based on Lukhozi's [82] ethical analysis of Steve Biko's death. The attending district surgeons either ignored their duties at each turn during the incarceration of Steve Biko or managed dual loyalty conflicts wrongly. In addition, the Steve Biko case shows the significance of ethical rules for not only clinical forensic medicine in South Africa, [82] but for the healthcare profession.

3.1.4. Case History

Stephen (Steve) Bantu Biko was born in the Eastern Cape (EC) town of Ginsberg on 18 December 1946. Biko was a South African anti-apartheid activist and was involved in politics from a young age. Due to his political activism, he was expelled from high school. He then enrolled at St. Francis College in Mariannhill, KwaZulu-Natal. After matriculating from high school, Biko went to study medicine at Natal University in 1966, where he became active in the politics of the day – Biko was active in the National Union of South African Students, the South African Students' Organization (SASO), and led the newly formed Black Consciousness Movement in South Africa. [23, 88] Biko was appointed the president of SASO in 1969, and in 1972, three years later, Biko was expelled from Natal University because of his political activism. Again in 1972, Biko co-founded another black activist group called the Black People's Convention and became the leader of the group. [23, 88]

Biko was seen as an enemy of the state by the apartheid regime and was banned in 1973, from writing, talking in public, talking to press officials or talking to more than one individual at Any Given moment. His freedom and movement were restricted to the EC. [23, 88] Biko was arrested four times in the early 1970s and detained for several months. On August 19, 1977, police arrested Biko for an unspecified period under Section 6 of the 1967 Terrorism Act in PE, EC. Nineteen days later, Biko was transferred for questioning to police headquarters in PE, and the next day, the attending district surgeon, Dr. Ivor Lang, was told to examine Biko as he acted strangely and refused to answer any questions the police requested. [23, 87] Dr. Lang examined Biko while the police were present and concluded that Biko was "ataxic, with slurred speech, a swollen upper lip, and various bruises." [23, 87] Yet, Dr. Lang issued a medical certificate claiming to "have found no evidence of any abnormality or pathology on the patient." [23, 87]

The next day, Dr. Benjamin Tucker, the principal district surgeon in PE, examined Biko again together with Dr. Lang. Both Drs noted that Biko had complaints of "a vague pain in his head and back." [23] In addition, Dr. Lang found that Biko was displaying signs of serious brain injury. A Private practice neurologist examined Biko the following day at the prison and "found signs of left-sided weakness and difficult speech; a lumbar puncture (LP) revealed blood-stained cerebrospinal fluid (CSF)." [23] Although his examination did not find anything suggesting serious brain injury, he informed the police that Biko was displaying signs of neurological damage and recommended that Biko be referred to a neurosurgeon. Dr. Lang' recommended that Biko be moved to a hospital, but this was refused by the police. Biko was not started on any treatment even after Dr. Lang communicated the neurologist's findings to Dr. Tucker. [23, 87]

A neurosurgeon was consulted on September 10 and agreed with the neurologist's results; that the bloody CSF were signs of brain damage. The neurosurgeon recommended that Biko be closely observed. Dr. Lang visited and observed Biko and concluded that his condition remained the same. Surprisingly, Dr. Lang noted that neither he nor the neurologist found any pathologies – consistent with his first medical certificate; that Biko's LP was normal. [23] In spite of "his own previous recommendation that he be transferred to another hospital' and the neurosurgeon's recommendation that Biko be observed in hospital, Dr. Lang allowed Biko to be moved back to the police cells, where he was left lying on a mat on the floor." [23, 87] Even though Dr. Lang continuously found pathologies, he on numerous occasions acted in contradiction to his diagnosis. Such behaviour simply cannot be explained by incompetence. Instead, what is obvious is that a total breach of professionalism and ethics and a total disregard for a black political prisoner's life occurred. [23]

On the afternoon of September 12, Biko was found "collapsed, glassy-eyed, hyperventilating, and frothing at the mouth." [23, 87] Dr. Tucker examined Biko and was of the opinion that Biko's condition remained unchanged. Dr. Lang recommended that Biko be transferred to the local provincial hospital, but police refused and informed Dr. Lang that Biko would be transferred to Pretoria, 1,100 kilometres away - This was agreed by Dr. Lang. Biko was taken to the Central Pretoria Prison, a twelve-hour trip without medical help, restrained, and lying naked on the ground behind a Land Rover police officer. [23, 87] The district doctor in Pretoria, who was provided with no information about his medical situation, examined Biko many hours later. The only treatment that Biko received was intravenously with fluids and vitamins. [23] Six hours after arriving in Pretoria, Steve Biko died on the afternoon of September 12, 1977,

after being left totally unattended on the ground of an empty cell. [23, 87] “It was in this way that South Africa was robbed of one of its foremost political thinkers.” [23]

Biko died of a brain haemorrhage that was later determined to result from wounds that he had suffered while in police custody. Steve Biko was interrogated for hours on end. Biko suffered severe head injuries during these interrogations; almost definitely because of police battering. [23, 88] Despite noticeable external wounds and apparent symptoms of serious head injury, the district surgeons who treated Biko on many occasions either failed to fulfil their responsibilities or failed to recognize their loyalty, obligations, and duties [82] to Biko (as a patient). This led to his death under the custody of the police. The obligation district surgeons were in conflict with other commitments; these conflicts were not identified and managed properly. Under no circumstances can these frequent activities and “non-actions by the district surgeons be justified.” [82] Two decades after the death of Biko five former policemen admitted to murdering Biko in 1977. The policemen supposedly applied to the Truth and Reconciliation Commission (TRC) for amnesty after inquiries involving them in the murder of Biko, but in 1999 amnesty was rejected. [23, 82, 89]

3.1.5. Dual loyalty conflicts in the Steve Biko case

The behaviour of Drs. Lang and Tucker were unjustifiable. Both had failed to properly examine Biko, failed to try to obtain even a basic medical and health history from him, and failed to provide appropriate care or therapy. Rather, they agreed with the security police's orders, neglecting to put their patient's best interests above all other factors. On September 6, Dr. Lang wrote a fake medical certificate and on September 10, incorrect medical record notes. [23, 82] Dr. Lang also made no effort to guarantee the

safety of Biko and permitted him to return to prison cells. Dr. Tucker allowed the transfer of Biko to Pretoria to take place in a police vehicle instead of an ambulance and without a medical report. [82]

This unprofessional behaviour can be explained by the doctors' obligations caught in a classical situation of dual loyalty conflict, one in which their obligation to their patient, Steve Biko, was in conflict with their obligation to the state. In fact, Dr. Tucker subsequently admitted, "I had become too closely identified with the interest of the organs of the State, especially the police force, with which I dealt practically daily…. I have come to realise that a medical practitioner's primary consideration is the well-being of his patient". [23, 90]

3.1.6. The death of Steve Biko: The complicity of the healthcare profession

The TRC switched its attention on 16 and 17 June 1997 to the healthcare profession of the country and its role during the years of apartheid [89, 91]. The apartheid government created a culture of gross violations of human rights, many of which were perpetrated by their own animals. [91] Healthcare institutional bodies such as the DoH, the "South African Medical and Dental Council (SAMDC) and the Medical Association of South Africa (MASA)" [82] were all complicit to breaches of ethics by district surgeons. [89] It was the suspicious conditions surrounding Biko's death that caused major pandemonium in the South African healthcare profession. None of these key institutions in healthcare during that time took any responsibility for the insufficiencies of the healthcare system in which these HCPs (district surgeons) practised. [89]

The DoH was accountable for ensuring that district doctors – who, after all, were DoH workers – were conscious of their ethical obligations towards prisoners. It ought to have given practical instructions for district surgeons to act in circumstances where ethical behaviour violations seemed inevitable. It was alleged that SAMDC had the responsibility for calling doctors to account for professional misconduct, as well as educating its members about legislation and ethics. [89] There are well-documented instances where the SAMDC has failed to take adequate action on professional misconduct. [89] One of these was when the district surgeons involved were not found guilty of professional misconduct in Biko's care. Shortly after Biko's death, routine inquiries into unnatural deaths began. The Biko's investigation lasted two weeks. The police invloved in his 24-hour interrogation were unable to explain Biko's physical and mental deterioration. [92] The doctors confessed clinical mistakes and that medical records were falsified. Ultimately, it was discovered that no one could be blamed for the death of Biko and that during a police scuffle the serious head injury he died from was suffered.

The magistrate, however, discovered some proof of the doctors' misconduct and referred the matter to SAMDC. [92] Since the SAMDC consisted mainly of government officials, it was hardly surprising that the SAMDC found no evidence of inappropriate behaviour after three years of procrastination and despite the gross medical negligence of the physicians. No disciplinary action was instituted against them. [92] MASA reached the same conclusion; it did its utmost best to sweep the matter under the mat. The EC branch of MASA discovered that the physicians involved had not behaved unethically, and MASA's Executive Committee decided that they had no power to reopen it since the matter had been dealt with at the branch level. Despite

local and global demonstrations, the medical fraternity had closed ranks. [91] The SAMDC and MASA provided little assistance to those who upheld human rights, thereby discouraging HCPs from challenging the norm. None of these organizations gave guidance to help district surgeons' deal with negative circumstances where proper treatment of prisoners was almost impossible. [89]

In submitting the MASA's submission to the TRC, the medical profession acknowledged its acquiescence to these inequities. [93] From its establishment in 1927 until 1981 "MASA was relatively silent on human rights initiatives and was part of the apartheid system... The period [1982-1988] started with justification and defence of apartheid medicine." [93, 94] The TRC's report condemned MASA for not drawing attention to: "(a) the effects of the socioeconomic consequences of apartheid on the health of black South Africans, (b) the fact that segregated healthcare facilities were detrimental to the provision of health, (c) the negative impact on the health of millions of South Africans of unequal budgetary allocations for the healthcare of different 'racial' groups, (d) the fact that solitary confinement is a form of torture and (e) the severe impact of detention on the health of children." [93, 94] The report also criticizes comparable deficiencies on the part of the SAMDC, the body responsible for licensing, morality and practice norms. [93]

The TRC hearings heard countless reports in the healthcare industry of gross human rights violations. Many other instances of district surgeons' misconduct accountable for prisoner healthcare have been noted, particularly police interrogators' complicity in torture. [93] This included advising perpetrators on how to not leave tell-tale signs on their victims and how to falsify medical records and death certificates, omitting any

mention of torture and its effects. Other doctors working in hospital emergency wards regularly broke patient confidentiality by reporting to police patients with gunshot injuries. [93]

Despite many complaints, the doctors involved in state-sanctioned human rights violations were not disciplined or even investigated by the SAMDC. The police and their political masters were equally reluctant to criticize MASA. In 1980, the MASA Executive Committee voiced its full support for the exemption of Biko's doctors from SAMDC.[93] However, pressure from some of its members and international medical organisations compelled MASA to reconsider the situation of Biko and lastly acknowledge that there was a need to improve medical care for prisoners. Nevertheless, MASA was also very unwilling to criticize those involved for mistreating doctors who opposed apartheid, like Dr. Neil Aggett, who died while in police custody under suspicious circumstances. White-dominated medical organizations such as SAMDC and MASA were complicit in human rights violations because of their reluctance to criticize those responsible or even acknowledge the prevalence of such violations until the end of apartheid in 1990. [93]

The complicity of human rights the medical profession during apartheid cannot be explained by ignorance of the perpetrated human rights abuses. Several authors, including Trefor Jenkins [95] and Max Price [96] heavily criticized those involved through their published works. Whether doctors realized that healthcare during apartheid was contrary to the fundamental values of medical ethics is harder to determine [97], the TRC found, however, in trying to answer this question, "[d]uring the period under review, ethics was taught on an ad hoc basis and, for the most part, students were not

examined on these topics. There was, therefore, no uniformity in the way in which health professionals were made aware of, or given guidance on, incorporating issues of medical ethics and human rights into daily practice." [93, 94] The committee criticized the DoH, the South African Defence Force, and South African police and prisons in particular for failing to provide appropriate training, support, and ethical advice to HCPs in their work on issues such as conflicts between their duties to employers and patients.

The failure of the SAMDC to provide ethical guidance on the treatment of detainees, especially Steve Biko, resulted in an outcry in SA, as well as abroad. However, until two autonomous groups of doctors brought the matter to the Supreme Court in 1984, the SAMDC did not alter its stance on Biko's doctors. Phillip Tobias, Frances Ames, Trefor Jenkins, Yosuf Veriava, Tim Wilson, and Dumisani Mzamane were among those doctors. Through the court, the pressure these doctors brought led in an inquiry. [92] At the same moment, the Court decided to hear both appeals. Eight years after Biko's death, the Court, in a historic decision, instructed the SAMDC to hold a disciplinary hearing for all doctors implicated. The judges held that the doctors were not only entitled to say that some peers were negligent, but that it was the responsibility of physicians to do so. Drs. Both Lang and Tucker were discovered guilty of unethical conduct. Dr. Lang only got a caution and a reprimand, and before he retired he continued to practice for five years. Dr. Tucker was struck off the role but was successfully reinstated after he appealed the initial decision. He publicly apologized for his actions. [92]

It is only the responsibility of not individual HCPs to uphold the basic principles of medical ethics, but for the entire medical profession. MASA was a member of the WMA in good standing except for the years 1976-1981 and presumably subscribed to its core ethical statements. [93] These include the 1948 Declaration of Geneva, [4] which states, “I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patients,” the 1975 Declaration of Tokyo, [15, 98] which prohibits the involvement of doctors in torture and other cruel, inhuman or degrading therapy or penalty of “detention and imprisonment, and the 1981 Resolution on Physician Participation in Capital Punishment, which states that it is unethical for physicians to participate in capital punishment....” [93] These ethical principles have not been properly promoted by MASA, SAMDC, many medical schools and medical officers in the army and prison, either in the medical profession or in public. [93]

3.1.7. Problem statement

Based on Lukhozi’s comprehension [82] an analysis of detailed actions or non-actions by the district surgeons who attended Steve Biko will be conducted.

The actions and non-actions of the district surgeons relate to:

i. **“Steve Biko being examined in cuffs and shackles on the floor, chained to a wall.” [82]**

In 1998, the TRC’s report [89] detailed how the attending district surgeon examined Biko in a prison – examined in cuffs and shackles, chained to a wall, in spite of his physical condition. During his examination, Biko remained on the floor, laying on a piece of mat. Additionally, even after his examination, Biko remained on the floor, chained to the wall; he sustained numerous injuries on his hands and feet. The

wounds were compatible with the physical restraint that were unnecessarily excessive on Biko. [82]

ii. "Steve Biko being left to lie naked on the urine-wet mat." [82]

According to the TRC report, [89] Biko was left to lie naked on a urine-wet mat. This sight would have been enough reason for any HCP to question the physical and mental well-being of a patient, in addition to the nursing care the patient was or was not receiving. However, "Steve Biko remained in such conditions after being seen by the district surgeon." [82] Although the nursing care of a patient or prisoner is not directly the responsibility of a district surgeon in this instance, it would be reasonable to conclude that where such healthcare is required, the doctor ought to facilitate such care. [82] By way of illustration, a doctor can recommend that the nursing staff provide adequate care such as changing the bedding of a patient or prisoner. It, therefore, begs the question: Were the nursing staff present and were they even allowed to provide such care to Biko during his detention? [82] The previous chapter, under section 2.10., refers to Loyalty in the healthcare profession - which can be seen as a fiduciary duty. A fiduciary duty is a legal or ethical relationship usually between two parties. The fiduciary is the subject (HCP) the duty is imposed on, while the object (patient) is the party that is owed the duty. [48]

The attending district surgeon [and by extension the nursing staff] had a duty of loyalty, competence and care towards Biko. The role of HCPs is fiduciary in nature and is to provide competent care that will alleviate pain and suffering. The loyalty always lies with the patient or prisoner. However, given the nature and scope of district surgeons and how closely they work with police, they often find themselves in a dual loyalty conflict, and this may be expressed as *implied* i.e. reminding HCPs not to provide

certain (limited or expensive) healthcare.[69] In contrast, a dual loyalty conflict may also be *real* e.g. putting pressure on the HCP, or *perceived* e.g. the HCP feels that the third party wants him or her to relegate the patient's interest, even though there has been no communication.[69]

iii. "Steve Biko being transported on the back of a van and a mat used as a stretcher." [82]

Steve Biko, severely ill was transported 1,100 kilometres from PE to Pretoria. While it is a common practice in SA for patients to be transferred from one province to another for (highly) specialized care, these transfers are often long and tedious.[82] As such, these transfers are arranged so as to minimise the likelihood of reversing the positive effects of the care the patient already received. Necessary provisions should be taken at all times to ensure that when patients are transferred from one facility another and even more so if the transfer is long-distance – such as the transfer embarked on for Biko, these provisions should include, inter alia, "well-equipped ambulances and appropriate personnel, often a professional nurse who accompanies the patient." [82] The HCPs from both facilities should communicate and by using referral and discharge documents. [82] This can be linked to the fiduciary duties of care and competence. Apropos to the Biko case, he was transferred, in a critical condition, without the necessary provisions, at the back of a Land Rover. Upon arrival at the facility in Pretoria, a police officer gave the receiving doctor a verbal brief.

iv. "Biko being given a drip and vitamins on arrival at the Pretoria facility."

[82]

The TRC report stated that Steve Biko was examined by a district surgeon, who concluded that Biko is "a detainee who is on a hunger strike and also faking illness." [89] The district surgeon then prescribed Biko a drip and multivitamins. The district surgeon who received Biko blindly accepted the police's diagnosis – who were not qualified to make any inference on the health condition of a patient. As a result, the district surgeon treated Biko based on the information given to him by the police. The district surgeon did not place Biko's interest first and failed in his obligation of care, competence, and loyalty. Granting "intravenous rehydration and vitamin supplementation may be of benefit to a detainee who is on a hunger strike, if otherwise healthy." [82] Here, the district surgeon may claim that he has acted to promote good while not violating the alleged determination of the detained person not to eat any food. Notwithstanding the unique role of a district surgeon could have prompted him to put the interests of the State ahead of the patients. This would be even more cogent where the district surgeon was white and racist. [82]

The TRC [82, 89] held hearings on a spectrum of human rights violations that took place during the apartheid era. The DoH's role in these human rights violations emanated from various fronts, one being South Africa's forensic medical services. [82] The TRC recognized the problems and dilemmas encountered by SA district surgeons - owing to the reality that district surgeons' main role is not healthcare provision [89] and as demonstrated by the district surgeons who treated Steve Biko, they are therefore subjected to dual duty conflicts. [82] It was established that "the most common offence was a failure to carry out their duties within internationally accepted guidelines of

medical ethics." [89] Failure to treat patients with basic human dignity, failure to carefully examine and treat patients, incorrect paperwork and infringement of patient privacy were among the violations also mentioned in the TRC's report. In the case of Steve Biko, all these violations were undertaken. [82]

An argument could be made that district surgeons, although HCPs, in their roles as district surgeons, have a duty to promote the interests of the judiciary, the police services and /or the state, over and above those of prisoners or patients. Still, another argument that can also be made is that district surgeons, in their role as district surgeons remain HCPs and as such, have a duty to the patient's interest, despite speciality, and not those of a third party. These duties have led to dual loyalty conflicts by the district surgeon between the patient and a third party. The Steve Biko case shows plenty of ethical problems a district surgeon should be conscious of when dealing with arrested individuals in order to prevent ethical violations arising from them. There is no reason for justifying the behaviour towards Steve Biko's by the district physicians. [82]

McLean and Jenkins [87] point out that the case of Biko is an instance of a tough ethical situation, not because it is hard to understand what the morally right course of action is "because it is hard to do what one ought to do." The responsibility of the physicians engaged in Steve Biko's case was evident, but fulfilling that obligation was hard. They had become so comfortable to working with the government and police and treating the detainees not as patients, but as detainee; they had relinquished their professional obligations and duties.

3.2. Case 2: The Life Esidimeni Tragedy

The Life Esidimeni tragedy clearly demonstrates the consequences when HCPs put the interests of a third over and above those of their patients. Patients' interests are increasingly being challenged by third parties, and when HCPs elect to support third party interests, instead of those of patients, difficult and often fatal dual-loyalty conflicts arise, as seen with the Life Esidimeni tragedy.

3.2.1 Case history

On March 31, 2016, Qedani Mahlangu, Gauteng's former MEC for Health, decided to terminate the agreement for the Life Esidimeni Health Centre. Life Esidimeni (place of dignity), was a healthcare centre contracted by the GDoH to provide specialized mental health services to its patients. The former MEC claimed and cited two reasons for the termination; 1. To save money and 2. To deinstitutionalize. Between March to June 2016, approximately 2000 mental patients "who were receiving highly-specialised chronic psychiatric care" [26] were rapidly transferred out of Life Esidimeni to NGO's and to psychiatric hospitals.

Jack Bloom, the Democratic Alliance Shadow MEC on Health in the Gauteng Legislature, raised a question regarding the transfer of patients to the former MEC. On the 13th September 2016, the former MEC announced that 36 mentally ill patients had died since the transfer [26]. The announcement by the former MEC led to an outcry both locally and internationally and this, in addition to public interest, subsequently led to an investigation by the Health Ombudsman, Professor Malegapuru Makgoba as requested by the Minister of Health, Dr. Aaron Motsoaledi. During the investigation which took place between October to December 2016, the Health Ombudsman's

report: “NO GUNS: 94+ SILENT DEATHS AND STILL COUNTING” found that in fact, 94 mentally ill patients died. [26].

Over 140 patients tragically died. [30] The Ombudsman’s report found that the patients “had died under unlawful circumstances.” [26] The Ombudsman’s report found that the majority of the NGO’s were unlicensed and were unable to afford any kind of care to mentally ill patients. The NGO’s lacked capacity to care for patients in terms of staff, equipment and resources. [26] In order to prevent the GDoH from transferring patients from Life Esidimeni and putting them in organizations that could not care for them adequately, civil society organizations, family members and professional associations pleaded with the department not to do so. Ultimately, they had no other choice but to take legal action against the GDoH, twice. [26]

In June of 2015, the South African Society of Psychiatrists (SASOP) wrote to the former MEC about the risks involved of moving the patients. SASOP warned that the move would result in “unintended, costly, negative consequences.” [26] This, according to SASOP would result in greater health costs as patients would have to be re-hospitalised. In addition, SASOP also warned that community-based care facilities (the NGO’s), were not equipped to care for mentally ill patients. However, the Department allegedly ignored this letter and in October 2015, the former MEC announced the termination of its contract with Life Esidimeni. [26] In response, in November 2015, the South African Depression And Anxiety Group (SADAG), SASOP, the South African Federation for Mental Health (SA Fed) and families of patients again pleaded with the GDoH to “slow down and follow the correct procedure to ensure proper care for the patients.” [26] However, these pleas fell on death ears.

As a result, in December 2015, ligation was instituted against the Department. The GDoH was presented with documents which laid down the problems with the NGO's, citing that patients needed specialized psychiatric healthcare which could not be provided by the NGO's. Furthermore, an expert psychiatrist provided evidence that "Life Esidimeni had accommodated people who had already unsuccessfully been to other facilities." [26] The expert psychiatrist also gave evidence that although deinstitutionalisation was desirable, Life Esidimeni was the facility for patients to receive their care. However, ligation against the Department was dropped as an agreement was reached in which the GDoH "committed to a consultation and a safe process, in the best interests of the mental healthcare users." [26] The GDoH pledged that until all sides agreed on the process, no patient would be transferred. The Department went back on its commitment and announced that all its patients at Life Esidimeni would be removed from the facility in February 2016.

In response to the announcement by the Department, Section27 and others initiated another round of litigation against the GDoH in March 2016 to prevent 54 individuals being transferred to an NGO. Many of the patients were adult patients with severe mental disabilities such as schizophrenia and as such, needed specialized care which the NGO's could not provide. [26] Additionally, the Section27 and others also received proof that some of the NGO were children's facilities. The Department then argued that patients were evaluated and found that professional care was no longer required. Even though the GDoH agreed to consult with stakeholders as per its first agreement, the decision to move the patients was made without consultation. [26] The GDoH claimed they were under no obligation to consult and the courts agreed with the

Department, saying that the GDoH had not reneged on its previous agreement. The High Court of Johannesburg ruled in favour of the department and consequently, the Department continued “with its plans to discharge and place those who still need medical care to different facilities.” [26]

Ironically, it turned out that the patients transferred to the NGO were diagnosed as having severe intellectual disability, which meant that they were “entirely dependent on others for care.” [26] Thus, the GDoH “had misled the court and allowed the transfer of patients to a facility that was not able to meet their needs.” [26] The Life Esidimeni catastrophe arose at a moment when family members of the patients met constantly with the GDoH to demand safe, dignified healthcare and marched three times against the Department. Their concerns received no response. Furthermore, the staff of Life Esidimeni also tried to prevent the move, while the management of Life Esidimeni offered to sell the facility to try and stop the move. [26] Despite two rounds of ligation, numerous attempts from stakeholders and pleas from family members, the Department went ahead and transferred the mentally ill patients. [26] Thus, the Department was well-advised, by many stakeholders, of the consequences that would arise from ‘deinstitutionalising’ patients out of Life Esidimeni. Again, despite South Africa’s progressive mental health legalisation and policies, the decision to move close to 2000 mentally ill patients resulted in patients’ health worsening and the deaths of more than 140 innocent individuals. [30]

What is even more shocking with regards to the Life Esidimeni case is that there were HCPs who were complicit in the tragedy. Dr. Makgabo Manamela (director for Mental Health services in Gauteng) and Dr. Tiego Selebano (head of the Gauteng department

for health), two qualified HCPs, who together with Qedani Mahlangu, spearheaded the Life Esidimeni situation and were indicted as the major role players responsible for the tragedy. [27, 28] Dr. Manamela and Dr. Selebano have publically taken oaths that their primary obligation will be to patients; while Mahlangu, as a MEC at the time, swore to maintain the Constitution of South Africa and all other Republic legislation. [28, 21, 29] What is also clear from the Ombuds Report is that Dr. Selebano and Dr. Manamela, together with other HCPs implicated in the tragedy, found themselves in dual loyalty conflicts, [9] which resulted in the gross human rights violations of, and deaths more than 140 [30] innocent mentally ill patients. In addition, the implicated HCPs presented evidence to the Life Esidimeni Arbitration, in which they stated they under were often under immense pressure or were forced to follow orders by the MEC, even if it went against the best interests of the Life Esidimeni patients. [9, 31] While these three most senior officials have been identified "as the most culpable, several other health professionals were also implicated." And although HCPs have been indicted in the tragedy, "many others attempted to avert the predicted disaster by drawing on ethical values in medical practice and their technical and clinical skills." [99]

3.2.2. Problem statement

The HCPs faced a dual loyalty conflict – they had to choose between being faithful to their employer, the MEC and the GDoH, and their duty as HCPs to guarantee patients' best interests. The HCPs should have done what is required of them ethically – to put patients' interests over and above those of the Department. A HCP's true ethical conduct is exposed in the way he or she balances his or her own interests are against those of conflicting interests. "Practice in healthcare, whether at policy decision-making level, management, administration or the patient-practitioner relationship does

entail the effacement of self-interest even to the point of personal risk." [9] For many decades, the healthcare profession has remained the most trusted profession in society, although this is not the case in SA, given its brutal history. Societies that recognize the importance of health and healthcare spend an enormous amount of resources to ensure that certain individuals are equipped with the best available specialized knowledge and skills. HCPs are therefore entrusted with the task to promote and protect the lives and health of society. HCPs are given exclusive control over the practice of their expertise, which is excised with "extensive autonomy in most professional matters, such as setting standards of patient care''. [9]

The core value of the HCP is to promote and protect health, and this is usually achieved by preserving the health of individuals, whether at a policy decision-making level, a management level, at an administrative level or at a direct level. [9] This implies that HCPs have a moral obligation to use their expertise for the good of society; HCP sought to commit themselves to the promotion of patients' best interests, "and if necessary, to sacrifice their own interests in order to achieve this goal." [9] In this context, altruism remains a moral duty. [1, 4] Three primary reasons were suggested for this duty. First, the presence of a patient who is ill, dependent, vulnerable and exploitable creates such a moral claim; second, the HCP holds the expertise and knowledge in trust for the patient's benefit; and third, the HCP has made a public promise (oath or affirmation) to promote and protect the patient's best interest. [9] This is what makes the healthcare profession a real profession. The WMA states that HCPs "need to know and exemplify the core values of medicine, especially compassion, competence, and autonomy." [91] In addition, these values function as the basis for ethical practice in healthcare, together with respect for human rights.

Although empathy, expertise, and autonomy are not solely healthcare values, due to the above factors, it is anticipated that HCPs will show them to a greater degree than other experts. [9]

HCPs are expected to encompass a high degree of empathy, expertise, and independence, as the absence such can lead to morbidity or mortality, [9] as witnessed with the Life Esidimeni tragedy. Expertise, together with sound ethical conduct is what makes a true HCP. Furthermore, at any level, practice in healthcare is "considered a moral and social contract between the profession and the public." [1] Primary to this is "professionalism and professional integrity." Professionalism in healthcare can be defined as: "… an occupation that is characterised by high moral standards, including a strong commitment to the well-being of others, mastery of a body of knowledge and skills, and a high level of professional autonomy." [9]

Professionalism lays down the standard of expectations from patients and society at large. HCPs are "important agents, through which scientific knowledge is applied to human health, thereby bridging the gap between science and society." [9] It does, however, go beyond clinical or technical excellence. It is also about human feelings, emotions, and experiences of being human, which is often displayed in moments of fear, anxiety, and doubt. [9] This heightened vulnerability is what underpins the trust that society in HCPs. [9] With this heightened vulnerable, especially with mentally ill patients, comes a "heightened ethical duty because the mentally ill patients were not able to exercise their autonomy or express and protect themselves." [9] Furthermore, professional conduct in healthcare is regulated to protect society from malpractice;

setting professional and ethical norms to guarantee quality service and providing professionals with “responsibility, accountability, identity, and professional status.” [9]

However, as seen with the Life Esidimeni tragedy, healthcare has been moved steadily away from HCPs “to professional managers and bureaucrats, some of whom tend to see healthcare practitioners as obstacles rather than partners.” [9] This can result in dual loyalty conflicts. Dual loyalty conflicts are particularly problematic where HCPs who choose to support the interests of the State, instead of that of patients can result in harming and doing wrong to patients. [1] Therefore this begs the question: Does politics trump ethics and professionalism? The moral, ethical and professional obligations duties conferred on HCPs require them to conduct themselves responsibly and to be accountable for their actions. [9] Healthcare professionalism and ethics are governed and influenced by the law; specifically human rights law. [9]

Importantly, politics must never influence morality and ethics in the healthcare profession. What came strongly from the Life Esidimeni Arbitration is the testimonies of implicated HCPs, who testified that their issues were raised, in the end, however, unethical practices were undertaken in fear of superior forces. They testified that the department had a culture of fear exercised by the former MEC. Nevertheless, the HCPs could have challenged the MEC, “rather than succumbing to the pressure she exerted.” [91] Unfortunately, the HCPs ruthlessly went ahead with the transfer of patients, despite being advised by professionals not do so. Drs Selebano and Manamela stated that they understood the risks raised by concerned professionals, and yet they allowed the NGOs to take over the highly delicate care of the patients, who were entrusted to them by families to be taken care of. The HCPs decision to put

a third party's interests ahead of the interests of their patients had fatal consequences, literally.

3.3. Case 3: Daring to care - a doctor's persecution in Mpumalanga

Claassens [100] in her doctoral thesis submitted to Stellenbosch University, articulately summarizes the accounts of the Dr. Thys von Mollendorff case based on the personal accounts of Dr. Thys von Mollendorff himself which he titled - Daring To Care. [101] I will use the summary of Claassens [100] and the personal accounts of Dr. Thys von Mollendorff [101] to describe case 3.

In 2000, Dr. Thys von Mollendorff, a medical superintendent at the Rob Ferreira Hospital, Nelspruit, was called to perform surgery on a young girl – she was gang-raped. He took the four-year-old to the theatre, where he performed life-saving surgery. [100] He then performed reconstructive surgery a few months later, hoping to maintain her dignity. The experience prompted his choice to permit an NGO - the Greater Nelspruit Rape Intervention Project (GRIP), to offer free counselling and antiretroviral therapy (ART) to an increasing number of assault casualties at the hospital. [100]

Dr. von Mollendorff got fired from his job as a result of allowing GRIP to provide the much-needed counselling to rape victims and antiretrovirals (ARVs) to prevent the transmission of HIV/AIDS (Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome) in rape victims. This spurred a domestic debate with many questions as to why the state had not yet approved the use of ARVs to prevent victims from contracting HIV/AIDS. Dr. von Mollendorff was faced with a dual loyalty

conflict, caught between loyalty to the Minister of the DoH and his loyalty to his patients. [100]

3.3.1. Case History

NGOs worked with the DoH in 1997 to create a program to avoid the transmission of mother-to-child HIV. The SA Ministry of Health initially encouraged such programs. Before the end of 1999, representatives of the SA government began voicing worries about the safety of ARVs. Previous President Thabo Mbeki scrutinized Zidovudine's (AZT) safety and efficiency in 1999. Manto Tshabalala−Msimang, the political head of health at the time, told the National Assembly after two weeks that research showed that the impact of AZT was insufficient. [101] At the time, the HIV infections rose from 26% to 30% at antenatal facilities in Mpumalanga over a period of three years, estimated. The Nelspruit branch of the neighbourhood Victim Empowerment Committee (VEC) visited the Rob Ferreira Hospital to investigate whether a care room was established for rape victims and survivors, as set out in the National Policy Guidelines for Victims of Sexual Offenses. Before the end of 1999, the outpatients' department had identified an unused office, which was renovated to become such a room. [100, 101]

A Rape Indaba took place in Nelspruit on February 16, 2000, and different government agencies attended, as well as the local VEC and different NGOs. A group of volunteers set up a co-organizing committee called GRIP at the end of the Indaba, working as an NGO with a constitution and fundraising projects. [100, 101] GRIP was allowed access to the hospital in the same way other NGOs could and the care room was formally opened on April 17. GRIP would provide rape victims with emergency counselling and

a courtesy pack containing a facecloth, soap, toothpaste, and a toothbrush as well as a sanitary towel and a pair of underwear, free of charge. Although a patient would receive counselling, at that stage, no ARVs were provided. [100, 101]

The SA government had meanwhile started to challenge the link between HIV and AIDS when Mbeki supported the findings of AIDS denialists, a tiny cohort of scholars and activists who argued in Africa AIDS is not caused by HIV, but rather by poverty, poverty-related illnesses, and medicines used to treat HIV. Mbeki's view about the reasons for AIDS in Africa received momentum in African National Congress (ANC) in May 2000 and began to have an effect on national and local health policy and strategies. The Minister of Health and the Executive Council agreed in August 2000 to supply antiretroviral nevirapine to a few pilot locations. [100, 101] This decision disregarded the national AIDS office's suggestion to give nevirapine to all HIV−positive pregnant mothers. [100, 101] Back in Nelspruit, GRIP felt an ethical duty provide post-exposure ARVs, in conjunction with counselling to rape victims. The National Policy Guidelines made it possible at that time to refer victims of rape for voluntary counseling and testing (VCT). [100, 101] GRIP started holding post-exposure ARV starter packs in stock. Victims of rape could then be immediately provided with antiretroviral treatment for up to three days, after which they could be referred to a clinic or pharmacy to obtain a month's therapy supply if they tested negative. [100, 101] This service was also free of charge and funded for by GRIP – therefore guaranteeing the best possible care for rape victims, which included follow−up visits to preclude reactions of the treatment, and repeat HIV−tests. The DoH during that time did not have HCPs to deliver this type of service. [100, 101]

The then MEC for Health Sibongile Manana was called by a National Health Department official in September 200, to inquire about the care room and the provision of post-exposure prophylaxis (PEP). Manana wasn't aware of the care room's existence up till at that point, and because of this criticized GRIP for giving ART to victims, purportedly blaming GRIP and von Mollendorff for harming black people and undermining government's national policy. She subsequently banned the provision of PEP, attempted to remove GRIP from the hospital's premises and accused senior management of gross wrongdoing. [100, 101] On March 1, 2001, the accusations were withdrawn, permitting GRIP to continue counselling services, however not ART. Although the National Policy on Sexual Offenses expressed that emergency treatment for rape victims to prevent the transmission of HIV ought to be accessible. The Department of Health of Mpumalanga did not reply to the VEC's letters requesting ART for rape victims. No guidance on ART was provided to hospital management. A suggested meeting failed between Manana and a few local hospital superintendents. [100, 101]

In 2011, the South African government was harshly criticised by the South African Medical Association (SAMA) for "a lack in direction in the roll-out of an antiretroviral program." [101] SAMA approached the SA government to give ART to South Africans using public health facilities. At that time, SAMA chairman Dr. Kgosi Letlape asserted that South Africa was the only nation without such a program worldwide. At that stage, Dr. Anant Chetty, Chairman of the Human Rights, Ethics and Law Committee of SAMA, stressed that experts should not be unwilling to recommend ART and indicated that the moral and ethical rights of doctors are enshrined in the constitution of the country-their clinical autonomy is fully maintained by HPCSA and universally by world

health associations. [100] Following a meeting with Minister of Health Manto Tshabalala−Msimang, which turned out to be unsuccessful, SAMA continued its attempts to promote therapy for individuals living with HIV / AIDS, regardless of the government's position on the issue. The clinical and professional autonomy of doctors was attacked with Dr. Thys von Mollendorff's dismissal. Letlape referred to Dr von Mollendorff's dismissal as a prime example in which HCP's ethical and moral duty to their patients were extremely interrupted, grossly violating patient's rights, which are enshrined in the Constitution of the Republic. [100, 101] The WMA in 1986, unequivocally reprimanded political meddling in the provision of healthcare series and said that HCPs have a moral obligation to act to the greatest advantage of their patients; a vulnerable group in the South Africa society. [100, 101] SAMA in this manner adopted both the WMA's guidelines on HIV, "Human Rights and Ethical Guidelines as well as the Doctors" and "Patients' Rights and Responsibilities", geared for South African society. [100, 101] These guidelines echo and enrich the human rights found in the South African Constitution. It likewise echoes HCP's obligations to society. The ART program was launched only a year later by SAMA at the Western Cape GF Jooste Hospital.

An alliance including the Treatment Action Campaign (TAC) sued the State in August 2001 for not providing ART to any HIV-positive pregnant females to avoid transmission of mother-to-child HIV. The National Education, Health and Allied Workers ' Union (NEHAWU) took Rob Ferreira hospital senior management on September 1, 2001, requesting that the senior medical officer (MO) who supported GRIP and the ART provision be brought to them, saying' bring the doctor, we want to kill him!' [100, 101] The MO was then chased off hospital by NEHAWU members with sticks. It was clear that Manana abused her power as MEC and used her influence at NEHAWU to influence

NEHAWU to intimidate GRIP the senior management at the hospital. Manana said on October 13, 2001, that no external influence would be tolerated. She then demoted an Ehlanzeni regional manager for being associated with the provision of ARVs. [100, 101]

Manana suspended von Mollendorff on 6 November 2001 on charges of gross misconduct and insubordination to grant GRIP access to ART in a manner “the provincial Department of Health considered a violation of national and provincial policy.” [92] Dr. von Mollendorff was subjected to a disciplinary hearing at the office of the Premier and was found guilty after two weeks of allegations brought against him. Dr. Von Mollendorff was advised on February 22 to meet with a departmental official where he received a letter saying that his job was terminated. On March 8, the WMA realised a statement saying, “it is unacceptable that patients are being denied treatment for solely political or economic reasons.” [102] Dr. von Mollendorff said “I am frustrated because there is a serious shortage of state doctors. I feel ethically bound to serve patients and I cannot turn my back on life-saving drugs.” [102] Later on Amnesty International encouraged the Minister to stop the badgering of HCPs in Mpumalanga and to maintain ethical standards.

Dr. von Mollendorff was terminated as the superintendent of Rob Ferreira Hospital on Friday, 22 February 2002. [100, 101, 103] The Mpumalanga Health Department requested authorization for GRIP to work at the hospital, and several monthly reports were submitted to the department before Manana had a ' change of heart. She accused GRIP of illegally occupying space in the hospital and unlawfully dispensing scheduled medication. Manana also accused GRIP of placing the health of black people in danger. Her attempts to evict GRIP from the hospital were futile and as a result, she

turned her attention to von Mollendorff, Manana actions echoed those of a bully. [100, 101]

A group of academics released an announcement in a newsletter distributed by TAC [104] and the Indian Journal of Medical Ethics [105] that HCPs must have the professional flexibility to take care of their patients without impedance. It is necessary to safeguard and secure the professional judgment and discretion of HCPs in making clinical and ethical choices regarding the treatment of patients. HCPs must have the professional liberty to talk to and protect patients' well-being against all those who may deny or restrict the care needed for sick or wounded persons.

Dr. von Mollendorff decided to appeal his termination, on 17 May 2002 lost his appeal when neither he nor his lawyer had been notified on the change of date for his appeal. He referred the case to the Labour Court. Stamp Lowe, a Member of Parliament, expressed that "the government still refuses to acknowledge that HIV causes AIDS, and stands by while its Mpumalanga Health MEC fires Von Mollendorff for allowing the provision of free antiretroviral drugs to rape survivors, which is not just bizarre and surreal, but, frankly, a crime against humanity". [100] Von Mollendorff was awarded a leadership prize later that year and was acknowledged as selfless and brave by Matthews Phosa, the former Mpumalanga Premier [100, 101]

Moreover, Human Rights Law experts from the University of the Witwatersrand, Johannesburg, remarked that the dismissal of Dr. Von Mollendorff was morally impermissible. According to these specialists, the MEC ought to have rethought her actions in the light of HCPs universally recognized moral and ethical obligations.

Furthermore, they affirmed that political interference in the provision of healthcare was unambiguously reprimanded by the WMA as far back as 1986. [100, 101] An announcement by the South African Academy of Family Practice communicated its disapproval of Dr. Von Mollendorff's dismissal.[104] Dr. Von Mollendorff, as a HCP, was acting on his ethical duty to put the well−being of his patients first. Not permitting rape victims' access to counselling and ART did not put the interests of his patients over and above competing interests. Therefore, the termination of Dr. Von Mollendorff employment was arbitrary and would help to create an atmosphere in which physicians in the public sector felt demoralized and unable to fulfil their ethical responsibilities towards their clients. [100, 104]

In February 2002, Tshabalala−Msimang confirmed that the Health Department would not take any decision on the ARV-program until May 2002, contrary to recommendations made in a report sponsored by her very same department. [100, 101] Thereafter, the Department suddenly agreed to settle its case against von Mollendorff on March 10, 2003. The department also agreed to remunerate him financially and pay his legal fees. This was after it was discovered that the Mpumalanga Department of Health misused R6 million allocated for HIV/AIDS services. A report by the Attorney General of SA found the health department guilty of fraud and corruption. [100, 101]

In April 2002, Six doctors – Professor Louis-Jacques van Bogaert, Dr. Ames Dhai, Professor Graham Howarth, Professor David Hanekom, Professor Ghoyga and Dr. Donna Knapp van Bogaert, released a statement in the South African Medical Journal [106] warning their peers not to become complicit in a new wave of crimes by denying pregnant women antiretroviral drugs, which they said they had a moral obligation to

prescribe. HCPs who opposed apartheid abuses have been victimized, they said “We will not accept history repeating itself. More than a decade after the official end of apartheid, we wonder how some of our colleagues became involved in atrocities. Was it cowardice or complicity? Over and over we say, ‘never again’… fundamental principles of medical ethics were in issue, and the state’s intervention in the antiretroviral debate opened the way to more human rights abuses.” [106]

3.3.2. Problem statement

Dr. von Mollendorff had to choose between being faithful to his employer, the Mpumalanga Department of Health, and his duty as an HCP to guarantee the best interests of his clients; HIV-counselling and ART. [100] Claassens [100] makes interesting observations. She argues that Dr. von Mollendorff had alternative actions to choose from, in addition to the action above:

i. He could have kept the status quo, i.e. Ignoring his duty to his patients and showing loyalty to his employer by not enabling GRIP to advise or treat victims, OR
ii. To change the current situation by allowing GRIP to counsel and treat victim while simultaneously informing his employer about GRIP and receiving their approval, OR
iii. Challenging the status quo by enabling GRIP to advise and treat victims with the consent of its employer, OR
iv. Advocating for his patients’ human right to receive healthcare, thereby bringing into awareness the lack of counselling and ART services in the hospital, and

changing hospital practices (advocacy by HCPs will be briefly discussed in the next chapter), OR

v. Not allowing GRIP to offer any services, but rather allowing MO's to offer counselling and ART services to patients, with or without the department's endorsement, OR

vi. To only allow GRIP to offer counselling services and not to offer ART services before the South African policy guidelines endorsed ensured the safety of ART, OR

vii. Permitting another NGO to just offer counselling services.

At that time, ART was acknowledged globally as an appropriate prophylaxis to prevent HIV transmission. However, it was not yet freely accessible in SA. The SA government stated that it needed to make certain that ART would be safe, particularly for the African 'Black' population, since the safety and efficiency were, at the time, mainly established in other population groups. Additionally, the SA government claimed not to have the human resources and the ability to initiate an appropriate ART program. [100] The National Policy Guidelines had already incorporated the treatment of rape victims and therefore the VEC in Nelspruit acted correctly when it recommended a care room for victims at the Rob Ferreira Hospital complex. The care room together with the ART and counselling services it offered would guarantee that already a stigmatized and vulnerable group would receive the best possible care and that their human rights were being upheld. [100] Various NGOs have been admitted to the Rob Ferreira Hospital Complex and von Mollendorff has made every effort to make the state aware of their plans and operations. [100, 101]

He tried to organize a meeting with the regional hospital superintendents and the MEC, and he also wrote numerous letters to the DoH requesting guidelines on the use of ART, particularly in for victims of rape and pregnant women infected with HIV. The VEC stated that instead of acting against it, he acted in accordance with national policy. [100, 101] Then again, one ought to likewise consider that from the government's point of view, it would turn into a greatly chaotic public health if all HCPs acted against strategies and in accordance with their own will; disobeying rules, guidelines and policies. [100]

Globally, HCPs are under immense strain to deliver the highest quality of healthcare, proficiently and adequately. Healthcare systems are always being transformed and the HCP-patient relationship is constantly being challenged as third parties are attempting to control HCPs and meddle with the HCP-patient relationship, making it greatly troublesome for HCPs to put their interests far beyond that of third parties. The Dr. von Mollendorff case shows the difficulties faced by HCPs when faced with dual loyalty conflicts.

The Dr. von Mollendorff case brings into light the plight of HCPs who are courageous enough to abide by their moral and ethical obligations to patients, society and the healthcare profession. It also brings into light the consequences of HCPs who are brave enough to whistleblow and expose unethical and corrupt practices which usually result in gross human rights violations. While the SA government proved its support for the whistleblowing idea and recognized the need to provide legal protection to whistleblowers with the implementation of the Protected Disclosures Act, Act 26 of 2000 [107], aptly named "The Whistle Blowers Act", this was apparently not the case

with Dr. von Mollendorff. The Act implemented provisions for staff to report illegal or irregular behaviour by employers and fellow staff, while at the same time offering security for staff who blow the whistle. It is evident from the Protected Disclosures Act that those who whistleblow are protected from occupational detriment; harm or damage. [107] In contrary, Dr. von Mollendorff was not afforded this protection, and this often why HCPs are reluctant to whistle-blow or to show loyalty to their patients in fear of victimization or occupational detriment, etc.

A more recent example of a case where a HCP put the interests of patients first and whistle-blew but was not afforded protection of the Act is that of Dr. Kiran Sukeri, a psychiatrist at the Tower Psychiatric Hospital in Fort Beaufort, Eastern Cape. Dr. Sukeri brought to light the horrific conditions and treatment patients were being subjected to. [108] He submitted a complaint to Health Ombudsman of SA, the SA Human Rights Commission and the SA Society of Psychiatrists. SA Professor Malegapuru Makgoba's Health Ombudsman performed an inquiry and subsequently suggested that Dr. Sukeri be suspended, finding that the allegations he made about Tower Psychiatric Hospital were ‘unreliable’. At the press briefing, Makgoba said: “The Health Professions Council of South Africa should consider the immediate suspension of Dr. Sukeri until his fitness for office can be determined”.[109] This is just a clear example of the consequences of HCPs who act in the best interests of patients and receive punishment for their loyalty. A further discussion on this matter will be offered in the following chapters.

3.4. Conclusion

With regards the first two cases above, it would be natural to assume that those HCPs had been caught in dual loyalty conflicts. While with regards to case three, it would also be natural to assume that those HCPs were able to identify their primary loyalty (their patients) and were able to mitigate any result that may have arisen from having a dual loyalty conflict. I have illustrated how dual loyalties come into conflict with the description of these three cases. These conflicts go beyond the traditional medical ethics scope – and extend into the realm of Human Rights Law and gross human rights violations.

The first two cases highlight the negative consequences of dual loyalty conflicts, especially when HCPs actively and knowingly participate in dual loyalty conflicts. While the last of the three cases highlight the role that HCPs play to avert tragedies that result from dual loyalty conflicts. HCPs should always and always put the interests of patients first over and above those of personal and competing conflicting interests. However, there is a fine line between dual loyalty and a conflict of interests – as seen in case three. Often, it seems it is not easy to distinguish the two. In the next chapter, I provide an in-depth normative analysis, making reference to these three cases, from the perspective of Principlism and Human Rights Law, with a view to develop guidelines for the South African situation, to assist HCPs to manage dual loyalty conflicts in ethically and legally sound ways.

CHAPTER 4: DUAL LOYALTY CONFLICTS FROM THE PERSPECTIVE OF PRINCIPLISM AND HUMAN RIGHTS LAW

4. Introduction

HCPs ought to act ethically and legally during the conduct of their duties and obligations. This is particularly crucial as their job includes dealing with people who are sick and often vulnerable. In this section, I explore Principlism's ethical structure and highlight the multiplicity of professional duties and obligations. Additionally, I also explore Human Rights Law. I then argue that the ethical framework of Principlism, together with the respect for Human Rights Law, is better suited to provide both an ethical and legal framework for the healthcare profession with regard to dual loyalty conflicts. This argument will set forth why Principlism together with the respect for Human Rights Law, is better suited for HCPs to manage, and even avoid dual loyalty conflicts in ethically and legally sound ways.

This chapter responds to objective 3: To analyse dual loyalty conflicts from the perspective of Principlism and Human Rights Law, with a view to developing guidelines for the South African situation, to assist HCPs to manage dual loyalty conflicts in ethically and legally sound ways.

4.1. Principlism

The discussion around Principlism as promulgated by Beauchamp and Childress ought to provide a non-exhaustive overview of the development and history of medical ethics. This discussion and explanation of Principlism ought to show how Principlism, together with the respect for Human Rights Law (to be discussed later), can be applied by HCPs in SA to prevent and manage dual loyalty conflicts.

4.1.1. Principlism: Beauchamp and Childress' Principles of Biomedical Ethics

There are four principles, according to Beauchamp and Childress, which form the foundation of biomedical ethics: "*Respect for Autonomy, Beneficence, Non-maleficence* and *Justice*." [110] Beauchamp and Childress "propose these four principles as bases for decision-making in situations providing ethical dilemmas." [110] The four principles do not, however, represent a complete ethical theory due to their "inherent abstractness." [110]

Beneficence and non-maleficence are historical principles in medical ethics that are already recognizable in professional codes such as the Hippocratic Oath [111, 112] and the Florence Nightingale Pledge. [113, 114] Autonomy and justice have gained importance in the discourse of bioethics of the 20th century. [110] The four principles, according to Beauchamp and Childress provide "an analytical framework intended to express general norms of the common morality that are a suitable starting point for biomedical ethics." [110] Instead of being precise instructions on which of the four principles should take precedence when addressing ethical dilemmas and morally challenging situations, the principles provide a general moral framework or guideline which HCPs, when confronted with ethical dilemmas, can utilize to make a decision.

This, therefore, leaves room for the HCP's own judgment and interpretation because further specification and balancing is required. Specification means that the principle(s) being used have to be specified so that it may be applicable to a solid ethical dilemma. Balancing requires the HCP to weigh the different principles against each other in order to come up with a solution. [110, 117] Beauchamp and Childress acknowledge that not all ethical dilemmas or morally challenging problems have one,

specific solution, “because moral ambiguity is a pervasive feature of moral life.” [110] This would make perfect sense in the case of dual loyalty conflicts and human rights.

Beauchamp and Childress derive the four principles from what they term ‘common morality’ “which are ordinary, shared moral beliefs that all persons committed to morality hold in common.” [110] Theories around common morality [110, 118] mostly include a plurality of principles and these express that common morality. Although susceptible to exceptions, these common moral beliefs do not change over time. [110, 117] Nevertheless, the extracted principles can be adjusted to remain the same –“from them, overtimes, more specified moral beliefs rules are developed.” [110] This simply means that although communities or individuals may create and adapt different specifications, the underlying principles of common morality stay the same. According to Mehring [110], this flexibility is shown by the principles’ prima facie nature and by their specification and balancing which then makes them non-absolute. As a result, common morality “is a pretheoretic moral point of view that transcends local customs and attitudes.” [110]

Even though Beauchamp and Childress do not support moral relativism, their design of the principles based on common morality is a system of pluralism within the limits of the “fundamental principles that form the core of morality itself.” [110, 119] The common morality is therefore common to all cultures, though the specification may be different. Autonomy, non-maleficence, beneficence, and justice are the four principles Beauchamp and Childress claim to be the foundation of a biomedical ethical framework. The four principles, which are equally important, can eventually be used and applied in specific cases by analysing the case/dilemma in question, in light of each of the four principles and then comparing the results with regard to the case at hand. [110, 117] This will either lead to a decision or will inevitably lead to an ethical or

moral dilemma. It is important to note that while no principle is superior to the other and while there is no hierarchy of principles, in certain circumstances, a principle(s) can be overridden in order to give way to the most compelling principle. [121]

4.1.1.1. *Respect for autonomy*

The principle/notion of autonomy states that an individual is entitled to determine his or her own fate with no interference from another individual. This requirement for the respect of an individual's autonomy is based on Immanuel Kant's second categorical imperative which entails that we ought not to use others as a means to an end. [110, 122] Autonomy consists of two elements: A person must have the ***liberty*** and the ***agency*** to make a meaningful decision. [100, 117] Liberty is defined as complete independence from outside or controlling influences, while agency is defined as the capacity for intentional action. [121] The choice to make a meaningful decision "does not mean that an individual is obliged to choose." [110] Rather, it means that any person has the right to, for example, choose his or her treatment; it is not a duty. In recognizing an individual's right and capacity to make a decision, a HCP has a negative obligation not to control or limit the individual and has a positive obligation to enable or allow that individual to act autonomously; without interference. [110]

Even though this might prove to be difficult in practice, a HCP ought to be fully aware that a patient should never be forced to "choose or to be informed if she [or he] *chooses* not to use her [or his] right." [110] A HCP ought to also be aware that consent to healthcare can come in various forms; implicitly or tacitly. Additionally, the HCP should also know that the capacity or incapacity to make a decision should not mean that that individual has the competence to make a decision. The capacity to execute a task is described as competence. [117, 123] While the term capability refers to the ability

to do something particular or accomplish it. [110, 117, 124] In a medico-legal context, Capacity is described as being capable of performing a job or making a choice. Capacity is determined HCPs, whereas competence is determined by courts of law. Even though there are different levels to being competent, Beauchamp and Childress advocate for a threshold of competence to determine one's level of competence, for a meaningful performance of a task; such as making decisions.[110, 117] The use of standards for incompetence over standards of competence is favoured by Beauchamp and Childress "because of the general presumption that in the absence of a determination of incompetence and incapacity, [an individual] should be considered competent and should be treated as such." [121]

The discourse around autonomy has mostly been dominated by the notion of informed consent. Beauchamp and Childress make it clear that there are only four principles, and that informed consent is a specification of the principle of autonomy. [110, 177] They do nonetheless discuss informed consent in great detail. The Nuremberg Trial [125], brought substantial attention to the notion of informed consent since its formulation – attention has moved away from minimizing harm to individuals to ensuring the autonomy of individuals. According to Beauchamp and Childress, informed consent has the following elements: "competence, disclosure, understanding, voluntariness, and consent." [117] To ensure the autonomy of individuals, HCPs ought to asses these criteria before carrying out any procedure. [110, 117]

4.1.1.2. *Non-Maleficence*

Non-maleficence is one of the oldest principles in medical ethics. It is embodied by the phrasal idiom stems from the maxim *primumnon (or nil) nocere*, meaning 'Above all (or first) do no harm.' [110, 117] Although this phrase does not come from the Hippocratic

Oath or the Florence Nightingale Pledge, the principle of non-maleficence can be inferred from the Hippocratic Oath, '*pledge to refrain from what is to [ill's] harm or injustice*' [111] and from the Florence Nightingale Pledge, "*will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug"*. [113]

Beauchamp and Childress clearly differentiate between non-maleficence and beneficence as both require a unique set of obligations: beneficence requires one to actively do well, whereas non-maleficence requires one to abstain from inflicting harm or evil. For the principle itself, these obligations are prima facie and non-absolute. Furthermore, non-maleficence contains the duty for HCPs to provide care, which entails undertaking the necessary and significant care to avoid causing harm, as would be reasonably expected from a prudent person. [110, 117]

A HCP may be justified in relinquishing his or her duty to provide care, but only if the goal he or she purses justifies the risks he or she takes. Beauchamp and Childress further elaborate on several specifications on the notion of non-maleficence concerning the treatment of individuals in healthcare. [110, 117] They provide a key difference between obligatory and optional treatment. That is, a HCP has a prima facie obligation to treat every single patient unless providing treatment would be futile or the burdens of providing treatment/healthcare outweigh the benefits of such treatment/healthcare. The HCP must also have the patient or his or her surrogate's informed consent. [110, 117] The HCP's motives, the patient's decision and the consequences of an act, should be considered before coming to a final decision as to whether or not to treat a patient, for example. Overall, to do no harm; non-maleficence, in no way means that the HCP is obliged to do good or to provide healthcare in all situations – in certain, exceptional situations, healthcare is optional. [110, 117]

4.1.1.3. *Beneficence*

Not only should HCPs not inflict harm on individuals, but they ought to also take positive steps to ensure the health and wellbeing of their patients. Beneficence requires "a moral obligation to act for the benefit of others" [110, 117] - this has a tone of loyalty of it. Contrary to the rules or obligations of non-maleficence, the rules of beneficence does not need to be impartially followed – an act that is beneficent is considered to be praiseworthy and desirable. However, it would be nonsensical and unrealistic to expect people to apply this principle every time, especially to strangers and even familiar people. Nonetheless, because the healthcare profession has been held to a high ethical standard of complete loyalty to the welfare of patients, "this being its gaol, rationale, and justification" [110, 117], beneficence is wholly assumed form HCPs.

Should beneficence interfere with an individual's autonomy, as an example, HCPs often resort to paternalism. There are two kinds of paternalism: soft and hard. Soft paternalism refers to when a HCP overrides the choice of a patient whose competence (ability) to make autonomous decisions is in doubt. While hard paternalism simply refers to when a HCP overrides a competent patient's autonomous decision 'substantially'. [110, 117] Hard paternalism, according to Beauchamp and Childress, is only justified in certain circumstances or in situations where the patient is "at risk of a significant, preventable harm, [t]he paternalistic action will probably prevent the harm, [t]he projected benefits to the patient of the paternalistic action outweigh the risks to the patient, [t[here is no reasonable alternative to the limitation of autonomy, [and t]he least autonomy-restrictive alternative that will secure the benefits and reduce the risks is adopted." [110, 117]

Such limitations to a patient's autonomy based on the principle of beneficence could also in a dual loyalty conflict situation. Thus, a HCP ought to balance their understanding of a patient's interest against the patient's own will and/or a third party's interests. Only in specific, limited situations can a HCP act based on paternalism. For example, a prisoner on hunger strike or a patient refusing life-saving treatment or "order to protect third parties from harm or to notify a health authority of communicable diseases for health surveillance purposes." [1]

Beneficence involves placing the interests of the patient first – that is, balancing interests against hazards and harms. It is an HCP's duty to prevent hazards and damage to the patient or to prevent going against the interests of the patient. The character of beneficence rests on these three principles: prevention of unnecessary pain infliction, prevention of mortality, and prevention of other people's incapacitation. The three values do not kill in the event of non-maleficence, do not cause unnecessary pain, and do not disable others. [28]

4.1.1.4. *Justice*

The most contentious principle of Beauchamp and Childress' four principles is that of justice. The principle of justice stipulates that access to healthcare and its services be fairly distributed. Formal equality (fairness) is not the only requirement for justice-equals ought to treated as equal and ditto – however, material principles should also be available to ensure equal distribution. [110, 117] Additionally, there are theories that can be applied in order to achieve justice in healthcare, and these include the egalitarian theory by Rawls [120] or the cosmopolitan theory by Pogge [126] or the Capabilities Approach by Sen. [127] However, Beauchamp and Childress make it very clear that one theory alone cannot address the problems of equality or fair distribution

in healthcare. In determining just or fair distribution in healthcare, the fair-opportunity rule, which states that individuals should get no more or no less the social benefits they deserve. [110, 117]

Moreover, “radical inequalities in distribution should be eradicated unless a disadvantageous person benefits more from them than without them.” [110, 117] Inequalities, even differentiations based on ethnicity, nationality, gender or race are considered problematic in healthcare. On the other hand, that does not mean HCPs should exploit vulnerable individuals because of their vulnerability – as was the case in the Life Esidimeni saga and the Steve Biko case. Beauchamp and Childress define vulnerability as “a state where persons lack critical resources or forms of social power and are unable to resist or refuse pressures, especially to [agree to partake in research], which may put them at a significant [and an increased] risk of harm.” [110, 117]

Overall, Beauchamp and Childress are of the opinion that it is unwise to categorically exclude vulnerable individuals from important research and as a result, rob such individuals of an equal opportunity. However, for prisoners, they deem such paternalism necessary. [110, 117] In order for the provision of healthcare public policy (government) has to allocate finances appropriately, ration healthcare services fairly and set priorities. In the same breath, it is of interest to note that Beauchamp and Childress recommend that the rationing of scarce resources by medical utility rather than by social utility. [110, 117] “In biomedical ethics and clinical decision analysis, the satisfaction or economic advantage gained from the outcome that results from a particular decision” [128] is known as medical utility. Social utility is a service or feature that benefits most of any specified society's population.[129]

Although Beauchamp and Childress openly support the utilitarian and egalitarian theories of justice and clearly reject the libertarian of justice, they also make it clear that they "do not offer a solution to the question of equal distribution of healthcare but rather raise awareness for elements that may play a role." [117]

4.2. Human Rights Law

There are few professions that are directly affected by Human Rights Law such as the healthcare profession. The primary reason for this is that the healthcare profession "(albeit with honourable intent) encroaches upon precisely those aspects of human life that are protected by the law." [131] The realisation and protection of rights such as the right to life, dignity, and health are among the main objectives of the law. In the case of dual loyalty conflicts, as seen with the three cases discussed in the previous chapter, serious and even deadly human rights violations can occur when the HCP put the interests of the third party over and above those of patients. Although dual loyalty conflicts are typical ethical and moral issues, dual loyalty conflicts tend to become even more difficult when HCPs act in a manner that supports the interests of the third party, instead of showing devoted loyalty to patients, and these actions violate the human rights of patients [1, 11].Therefore, no discussion around how to avoid, mitigate or manage those conflicts can take place without discussing human rights law.

Human rights are grounded on the principle that "all human beings are born free and equal in dignity and rights." [16] Despite the prevalent view, human rights legislation is not a new development– from the start, ideas about rights and duties have been a crucial part of all social orders. Since the end of World War II, a unified effort has been

made by States worldwide to choose which rights have a place with all people and how best to advance and secure them.

4.2.1. What are Human Rights?

Every human being has dignity and value intrinsic. Recognizing and respecting the human rights of individuals is one way to recognize their intrinsic dignity and value. Human rights are a set of values, principles or standards of equality and equity. [132] Human rights acknowledge our autonomy and self-determination in making decisions about our lives and making progress with our human potential. Human rights are also “about living a life free from fear, harassment or discrimination.” [132] Human rights can be characterized and described widely as the multiple fundamental rights concurred by people from all over the globe are essential. These include, but are not limited to, the rights to health, life, dignity, education, and appropriate living standards, as well as the right to a fair trial, liberty from torture and other cruel and inhumane treatment, liberty of expression and religious freedom. [132]

These and all other human rights are the same for every person, everywhere – for all genders and sexes, for all ages and social class and status, irrespective of our background, geographic location and beliefs. This is what makes human rights ‘universal’ and ‘all-inclusive’. [132]

4.2.2. Who has a responsibility to protect human rights?

Human rights allow us to connect through a set of shared rights and duties. An individual's ability to make the most of his or her human rights is based on other people's freedoms. This means an obligation and responsibilities towards other people are included in human rights. [132]

Individuals are responsible for ensuring that their rights are exercised with regard to the rights of others. When an individual, for example, makes use of his or her right to freedom of expression, he or she should do so without infringing on someone else's right to privacy. People have an obligation to ensure that the rights of others are not disregarded for their own. For example, if someone enacts their right to speak freely, they should do as such without infringing the privacy or religion of another person. [132]

States also play a role in the rights of individuals. The right to education, for instance, suggests that everyone has the right to a decent education. That implies governments have a duty to provide their individuals with excellent quality educational equipment and services. [132] States have a specific obligation to guarantee that individuals can benefit from their rights, as this empowers people to appreciate and enjoy a life in which they appreciate and secure their rights. [132] For instance, the right to health states that everyone is entitled to the “highest attainable standard of physical and mental health.” [19] This implies that states have an obligation and to a certain extent, a duty to realise this right. Whether countries do this, it is widely recognized that this is the duty of the state and that citizens can call them to account if they fail to uphold or safeguard their fundamental human rights. [132]

4.2.3. What do human rights cover?

Human rights cover almost every area of human life; health, life, dignity, education, etc. There are however different types of human rights – also called- fundamental rights. Of important note, as with Principlism, the division of human rights does not imply a hierarchy of rights, is not watertight and does not apply strictly. However, there are human rights which are non-derogable – meaning that those rights cannot be

suspended, suppressed or revoked under any circumstance, even in a state of emergency. [132]

Human rights are categorized into three distinct generations. Human rights of the first and second generation are potential claims of individual citizens against the state and "are firmly accepted norms identified in international treaties and conventions". [132] Human rights of the third generation reflects potential claims against the state by both people and organization and are "the most debated and lacks both legal and political recognition." [132, 133]

a) First-generation human rights (also called civil and political rights)

First-generation human rights are fundamental human rights that the state or anyone else for that matter may not violate. These rights are highly individualistic and are built badly to safeguard the person from the state. First-generation rights include, *inter alia*, the rights to life; human dignity; equality; freedom from torture and inhuman or degrading punishments; privacy; language and culture; freedom of religion, speech and association, are just a few of the rights that fall under this division. [131, 132] These rights demand a 'hands-off' attitude.

b) Second-generation human rights (also called socio-economic rights)

Second-generation human rights are rights where there is "an obligation placed on the [state] to render assistance." [131, 132] These rights will ensure the state's equal circumstances and treatment. Unlike human rights of the first generation, they are not entirely owned by the person, but they set up beneficial responsibilities on the state to respect, fulfil and realize them. Second-generation rights include, *inter alia*, the rights to health; work; education; housing and shelter; social security, are just a few of the rights that fall under this division. [131, 132, 134]

Unlike the ‘hands-off’ approach required of first-generation human rights, when it comes to second-generation human rights, the state is obliged to assist in the realisation of these rights. [131, 132, 134]

c) Third-generation human rights (also called collective-developmental rights)

Finally, third-generation human rights usually relate to groups, and include “the right of people to self-determination; the right to peace; the right to development; the right to humanitarian assistance; the right to be in an environment that is not harmful to ones’ health or wellbeing; the right of sexual minorities, ethnic, religious, linguistic, etc” [132] Third-generation human rights cannot be exercised or realised individually; only by groups or groups of people. [131, 132, 134] “This is often in recognition of the fact that these groups have been disadvantaged and marginalised throughout history and consequently need greater protection of their rights.” [132] Therefore, they are called the rights of collective development. For example, disabled people's rights and prisoners’ rights. Rights that can only apply to a person are called individual rights, such as the right to a fair trial. [131, 132, 134]

4.2.4. Why are human rights important?

Human rights are a significant part of how individuals in society communicate with others at all levels of family life, community, schooling, workplace, politics, and interactions around the world. It is essential that individuals try to comprehend what human rights are everywhere. If individuals better comprehend human rights, promoting justice and the well-being of society will be simpler for them. [132] Human rights are an essential part of how individuals associate with others at all levels in society - in the family, schools, and the work environment, in governmental issues and in worldwide relations. Individuals ought to comprehend what human rights are. When

individuals better comprehend human rights, it becomes easier for them to advance justice and the prosperity of society. [132]

4.3. Human Rights Law in Healthcare

The lens of human rights often reveal issues of severe neglect, social segregation, and discrimination that often brings about abuse and gross human rights violations against recipients of healthcare. This is perilous, as the human rights violations against vulnerable groups such as people living with disabilities (mental or physical), prisoners, and people living with HIV, just to mention a few, are especially rampant in the healthcare environment. [136]

The notion of human rights in healthcare "calls for a focus on the most marginalized and vulnerable in the formulation of health law and policy, guidelines and training for healthcare providers, and advocacy and litigation to address [human rights] violations." [136] The worst human rights violations which stem from dual loyalty conflicts take place in healthcare practices that occur in closed institutions, such as mental health facilities and prisons, as this requires a high-level demand for loyalty on healthcare professionals even when human rights violations are obvious. [1] On the other hand, human rights violations at the request of the third party and enacted by HCPs can also take place in public, especially the towards the vulnerable, e.g. the mentally ill, children and women as they are politically and socially marginalized.[1] Human rights violations can also occur from government implemented policies, health systems and this includes privately managed healthcare systems; HCPs are often ordered to withhold treatment (even emergency treatment) from certain groups of individuals in inequitable ways. [1] The issue gets worse when the integrity and behaviour of an HCP is restricted by pressure to submit to often authoritative interests, especially those of

the state. These pressures may lead from legal demands, threats of professional or personal damage due to insubordination, or even the feeling of obligation of the HCP towards a third party itself. [13]

The International Working Group [1] goes on to list six common types of human rights violations that may occur as a result of a dual loyalty conflict. Nevertheless, this is not an exhaustive list: if below is a direct quote, use quotation marks, please

a) “Using medical skills or expertise on behalf of the state to inflict pain or physical or psychological harm that is not a legitimate part of medical treatment;
b) Subordinating independent judgment, whether in therapeutic or evaluative settings, to support conclusions favouring the state or other third parties;
c) Limiting or denying medical treatment or information related to the treatment of an individual to effectuate the policy or practice of the state or other third parties;
d) Disclosing confidential patient information to state authorities or other third parties in circumstances that violate human rights;
e) Performing evaluations for state or private purposes in a manner that facilitates violations of human rights;
f) Remaining silent in the face of human rights abuses committed against individuals and groups in the care of health professionals.” [1]

Conflicts of dual loyalty shed light on the serious abuses of healthcare ethics and human rights. A framework that seeks to prevent abuse by resolving dual loyalty conflicts in a fair and transparent manner is therefore crucial. [1]

4.3.1. Applicable Human Rights Law in healthcare

Although there is a vast and wide array of human rights, this dissertation does not seek to articulate them all. There are principles and standards in Human Rights Law

that is specifically related to healthcare, and in extension, dual loyalty conflicts. Additionally, these principles and standards can be found at an international, regional and national level.

In the context of healthcare, international and regional human rights tools are important as “they are the only source of law that legitimizes international scrutiny of […] health [care] policies and practices within a sovereign country, and also because they provide fundamental protections that cannot be taken away by the ordinary political process.” [137] These legal instruments include the “International Bill of Rights”, which consists of the “United Nations (UN) Declaration of Human Rights (UDHR)” [17], “the International Covenant on Civil and Political Rights (ICCPR)” [18] with its two optional protocols and the “International Covenant on Economic, Social, and Cultural Rights (ICESCR)”. [19] Even though the UDHR is not, on its own, a legally binding tool, it establishes a basic set of universally applicable human rights.

Additional international legal instruments include the “Convention Against Torture and other Cruel, Inhumane or Degrading Treatment or Punishment” [138]; “Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)” [139] ; “Convention on the Rights of the Child (CRC)” [140]; “Convention on the Rights of Persons with Disabilities (CRPD)” [141]; “International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)” [142]; “UN Standard Minimum Rules for the Treatment of Prisoners.” [143] “International Human Rights Law is designed at global and national levels to encourage and safeguard human rights.” [144] Regional tools of human rights include the “African Charter on Human and Peoples’ Rights (ACHPR)”. [20] These legal instruments to ban countless and different types of violence in various healthcare settings. [12]

The Republic of SA has its own set of legal instruments of human rights relevant to healthcare, derived from global and regional legislation. [145, 146] SA, having signed and/or ratified the aforementioned international and regional legal instruments, "[is] obliged to respect, protect and fulfil the rights enshrined in them". [21, 137] The Bill of Rights, under section 39(1) (b) of the Constitution of SA, [21] legal institutions in SA "must consider international law", and section 231(2) and (4) State that the Republic is bound by international law. Therefore, SA is legally and morally obliged to respect the tools of global and regional law. Relevant to human rights applicable to healthcare in SA is the Constitution, the highest law in the country. Below is a list applicable Human Rights Law in healthcare and the relevant human rights instruments, as conceptualized by Cohen and Ezer: [136]

a) Right to life

UDHR 3, CRPD 10, ICCPR 6(1), ACHPR 4, SA Constitution 11.

b) Right to dignity

UDHR 1, CRPD 3,ACHPR 5, SA Constitution 10

c) Right to health (Right to the highest attainable standard of health)

UDHR 25, ICESCR 12, CRPD 25-26, ICERD 5, CRC 24, CEDAW 12(1), ACHPR 16, SA Constitution 27.

d) Right to non-discrimination and equality

UDHR 1-2-7, ICCPR 21(1), ICCPR 26, ICESCR 2(2), CRPD 5-12, ICERD, ACHPR 2–3, ACHPR 19, SA Constitution 9.

e) Right to liberty and security of person

UDHR 3, CRPD 14, ICCPR 9(1), ACHPR 6, SA Constitution 12.

Right to privacy and confidentiality

UDHR 12,CRPD 22,ICCPR 17(1), CRC 16(1)SA Constitution 14(d).

f) Right to bodily integrity

UDHR 5, CRPD 16-17, ICERD 5(b), ACHPR 4, CRC 19(1), SA Constitution 12.

The ICCPR and ICESCR do not specifically acknowledge the right to physical integrity, but the right to physical integrity has been interpreted as a part of and related to the right to personal safety, the right to liberty from torture and cruel, unfair and degrading treatment, and the right to the greatest achievable standard of health. [136]

g) Right to information

UDHR 19, CRPD 21, ICCPR 19(2), ACHPR 9(1), SA Constitution 32.

Right to freedom from torture and cruel, inhuman and degrading treatment

UDHR 5, CRPD 15, ICCPR 7, ACHPR 5, SA Constitution 12 (d)(e).

h) Right to participate in public policy

ICCPR 25, ICERD 5(c), CRPD 29, ACHPR 13(1), CEDAW 7, CEDAW 14(2).

i) Right to a remedy

UDHR 8, ICCPR 2(3), ICERD 6, CEDAW 2, ACHPR 26, ECHR 13, SA Constitution 33.

Although not exclusive, an important source of health-related international human rights law is the “right to the highest attainable health standard” contained in Article 12

of the ICESCR. [19] While the right to health relies on the realization of other rights, Ferlito and Dhai [78] make a compelling argument that the realisation of certain rights such as the rights to life and dignity is dependent on the realisation of the right to health.

Despite the reality that the right to health is generally understood to concentrate exclusively on beneficial guarantees for the gradual realization of the "availability, accessibility, acceptability and quality" [19] of healthcare, it jointly includes adverse guarantees to ensure that the State and third parties are free from abuse and discrimination, as well as violations of human rights that arise from dual loyalty conflicts, within a healthcare setting.

4.4. Principlism and Human Rights Law: A conclusion

Although Principlism (bioethics) complements human rights law, they are distinct from each other. Together, however, they provide a powerful tool to articulate and mobilize around issues in healthcare – this will be made more visible in the following sections by presenting the argument as to why Principlism and Human Rights Law are better suited to provide both an ethical and legal framework for HCPs to manage, and even avoid dual loyalty conflicts in ethically and legally sound ways.

4.5. Obligations and Duties– a conceptual analysis

The description of three specific cases in Chapter 2 has demonstrated how dual loyalties come into conflict. These go beyond the traditional ethical scope – and extend into the realm of human rights law, and gross human rights violations. However, what is interesting is the use of specific terminology: duties and obligations. These terms, duty, and obligation have been appearing frequently throughout this dissertation.

Even though duty and obligation are often used interchangeably, there is a difference between the two, and in lieu of the content of this dissertation, it important to explore this difference. Lukhozi [82] succinctly analyses the difference between a duty and an obligation, and that analysis with be used here.

Pelligrino defines duty as a something that is compulsory to do. [82, 147] Whereas Josephson [82, 148] defines duty as an obligation or a requirement to conduct oneself in a certain manner. Benjamin [82, 149] makes the argument that duty is an action to which one is obligated. “One who has a duty has an obligation to perform or not to perform something. Both duty and obligation are requirements to perform something.” [82, 149] Duties and obligations can be distinguished by defining a duty as “that which is owed as opposed to an obligation which refers to that which is binding.” [82] Below is a list of the differences between a duty and an obligation as described by Thepterosaur, [150] and conceptualized by Lukhozi: [82]

a) Duty is felt by the HCP, whereas an obligation is imposed onto the HCP.
b) A duty is assumed by a HCP, whereas an obligation is imposed by a superior.
c) Duty is ‘ought’ and obligation is ‘must.’
d) A duty can give rise to an obligation and an obligation can destroy a duty.
e) A duty means respect for one owed, but an obligation does not.
f) Autonomy is the foundation of duty, whereas subordination is the foundation of obligation.
g) Duties are internal, obligations are internal.
h) When a duty is accomplished it is fulfilling and when an obligation is executed it is liberating.

The Health Sciences is allied with both duties and obligations for HCPs. Chapter 2 of South Africa's Constitution (Bill of Rights) [21] makes provisions and guarantees rights to all its citizens. These provisions require the HCP to respect, endorse and enforce those rights. HCPs, therefore, have a statutory obligation to respect, indorse and enforce the human rights of patients. However, the defense of human rights should not be regarded as a mere legal obligation imposed on the HCP but should also be regarded as a duty by the HCP from within, as Human Rights Law is so fundamental to the health profession. As previously mentioned, there are human rights which are non-derogable – meaning that certain rights cannot be suspended, suppressed or revoked under any circumstance, even in a state of emergency. [132] With regards to healthcare and dual loyalty conflicts, I argue that the following non-derogable human rights must always be respected by HCPs when confronted with a dual loyalty conflict – HCPs have a legal and moral duty to respect these human rights in all circumstances:

a) "Right to life."
b) "Right to dignity."
c) "Right to equality."
d) "Right to be free from torture and other inhumane or degrading treatment or punishment."

Moreover, I further argue that when confronted with a dual loyalty conflict, the right to health ought to be considered as a non-derogable right. In such situations, HCPs also have a moral and legal obligation to respect and uphold the right to health. Consequently, it is evident that the HCP has a combination of duties and obligations towards those seeking healthcare. Therefore it is not surprising that the words 'obligation and duty' are frequently used interchangeably. This interrelation is

demonstrated by the argument of Josephson [150] that “duty is an obligation to act in a certain way. When the obligation is based on moral and ethical considerations, it is a moral duty. It, therefore, becomes too simplistic to assume that obligations stem from the law, while duties stem from moral intuition. Often there is an overlap between the two.

So how do duties and obligations relate to the concept of loyalty (or dual loyalty)? In Chapter 2 the concept of loyalty was defined as: “Loyalty is the attitude and associated pattern of conduct that is constituted by an individual’s taking something’s side, and doing so with a certain sort of motive: namely, a motive that is partly emotional in nature, involves a response to the thing itself, and makes essential reference to a special relationship that the individual takes to exist between herself [or himself] and the thing to which she [or he] is loyal.” [35]

4.6. A Principlism and Human Rights Law Approach to Dual Loyalty Conflicts

It is necessary to briefly examine the nature of the association between law and ethics. According to Dickens [151], “the law is described as the minimal ethic which prescribes what people must do or not do.” What is lawful, however, may not be ethical, and what is considered ethical may not be lawful in fact. Dickens [144] notes that in some cases the disobedience of the law is ethically justifiable, as in a HCP who breaks patient confidentially to protect the public, i.e. notifying the relevant parties on the discovery of a notifiable disease such as measles or Ebola. The Law may reflect principles of ethics such as non-maleficence and “can furthermore prohibit certain behaviours such as assault and murder, compel obedience and advance ethical values of care and protection” [152] It does not, however, allow for decision-making, as is the case with

ethics. In the end, the law determines the behaviour and attitude of HCPs towards the patient (a duty) and ethics determines the treatment of the patient (an obligation).

HCPs played an important and unique role in society throughout history. As HCPs, particularly nurses and doctors, are trained in the health sciences, they have often been the gatekeepers between life and death. People have therefore turned to these HCPs in times of weakness, often wounded, sick or having a cherished family member in dire of care and assistance. Modern healthcare has created a wide range of complex and multidimensional ethical dilemmas, such as dual loyalty conflicts.

Throughout history and during modern times, HCPs have been involved in unethical conduct and in the process, grossly violating human rights and displaying monumental abuse of power, entrusted to them by society - as seen with the case studies in the previous chapter. In everyday practice, HCPs, particularly in the public sector, often display unethical behaviour and a lack of professionalism. In response to these actions, various human rights instruments and frameworks i.e. UDHR [17], ICESCR [19], ICCPR [18] , CRPD [141], ACHPR[20], SA Constitution [21] , as well as medical ethics, especially principlism (bioethics) can be seen as a commitment to put patients ' interests and needs first. These frameworks help to defend human rights and to provide ethical guidance in the daily work of HCPs. Too often, however, HCPs are not prepared to deal competently with these situations, particularly South African HCPs, as they find often find themselves in dual loyalty conflicts, which deliberately or inadvertently violates human rights.

4.7. Why a Bioethics and Human Rights Law Approach to Dual Loyalty Conflicts for the South African Context?

Based on the above, guidelines ought to address both human rights legal instruments and ethical framework, such as principlism, in order to ensure that HCPs have the right knowledge to provide care that steers clear from a dual loyalty conflict and violation of human rights. Additionally, HCPs should acquire essential skills, through such guidelines, in dealing with specific ethical problems, especially in ethically challenging situations such as treatment of critically ill patients, euthanasia, prisoners or detention centres or healthcare corruption. In this context, vulnerable groups, i.e. the mentally ill, should also be given special emphasis, as they risk less than optimal care. For those seeking healthcare, achieving the highest possible health standard is inherently related to other human rights, i.e. the rights to life and human.

Nevertheless, a report by the International Dual Loyalty Working Group [1] includes rules for HCPs, as well as suggestions on institutional processes for dealing with cases of dual loyalty conflicts.

Table 1. Ways to prevent and manage dual loyalty conflicts according to The International Dual Loyalty Working Group [66]:

Action	**Steps**
Recognition of dual loyalty situations.	HCPs cannot assume that in any given situation they have only one loyalty – they must be conscious of the fact that more than one person or organization has a claim of their loyalty.

Knowledge of the relevant principles and guidelines.	The decisions made by HCPs should not be based on their feelings or intuition on which loyalty should prevail, but ought to be mindful of suitable ethical principles and professional guidelines. For HCPs working in environments where dual loyalties prevail, this is particularly essential.
All relevant facts are taken into consideration. In particular situations, principles and guidelines must be applied, which often differ from one from another.	This requires HCPs to be familiar with the medical and other associated conditions of the dual loyalty conflicts and consider the right course of action.
Consultation with colleagues.	HCPs should consult colleagues who are or have encountered the same dilemma when it is unsure which loyalty should prevail. This is particularly crucial when professional ethics and institutional policies conflict.
Independent ruling.	While as a consequence of hospital policies, HCPs often agree with constraints on their patient's treatment, these policies sometimes seem completely insufficient and oppose not only care demands, but also patient rights.

Explaining their choice and justifying it.	In circumstances where patient loyalty must give way to another loyalty, HCPs should educate their clients and clarify why, preferably before the choice is made, so that patients can arrange alternatives.
Reducing harm to patients.	HCPs should do their utmost, for example, to protect patients from additional disadvantages when loyalty to a third party takes precedence.
Resisting influence to change decisions.	HCPs and their professional bodies should be alert to attempts to limit their capability to put their patients ' interests first, be it from the state or organizations like hospitals, managed care organizations, and insurers.
Defence of professional independence.	When HCPs choose to assist patients against a third party, they may be under heavy institutional pressure to change their choices. While a HCP ought to always be willing to review this or her behaviour and recognize errors, he or she should retain their professional autonomy and not subvert his or her judgment by external factors.
Patient advocacy.	It should not be a matter of self-interest to defend professional independence but should be a way of promoting patient interests against financial and bureaucratic interests of third parties.

Employment contracts which recognize HCPs' professional obligations to patients.	These are best jointly negotiated, as individuals are comparatively powerless when dealing with big organizations.
Clear procedures for dealing with public health emergencies.	It should be performed in a way that is ethically justifiable rather than arbitrarily or ad hoc to curtail individual patient interests for the advantage of public health.
Informing patients about relevant professional obligations to third parties.	Both HCPs and healthcare organizations should ensure that patients are well informed of any constraints on their interests and needs that might be imposed on access to healthcare, such as breaches of confidentiality or treatment limitations due to limited funding.

These and additional procedures can reduce the magnitude of dual loyalty conflicts and can mitigate the patient's harm in situations where the HCP's first obligation is not to the patient. [66]

Although the report also makes mention of Bioethics and Human Rights Law and makes reference to the South African situation, their guidelines do not necessarily use Bioethics and Human Rights Law together. And since conflicts of dual loyalty are both ethical and human rights issues, their resolution can benefit from ethical and human rights analysis instruments. [1]

4.7.1. Preventing and managing dual loyalty conflicts using Principlism and Human Rights Law

This section will now apply Principlism and Human Rights Law to dual loyalty conflicts and derive possible solutions to preventing and managing dual loyalty conflicts, in ethical and legally sound ways.

Moreover, reference will be made, sporadically, to the three cases discussed in the previous Chapter. Additionally, the 2005 “United Nations Educational, Scientific and Cultural Organization’s (UNESCO) Universal Declaration on Bioethics and Human Rights” [153] (UDBHR) will be utilized.

The UDBHR deals with health sciences ethical problems. The aim of the statement is to provide a universal structure of guiding principles and processes for countries in formulating bioethics policies and to acknowledge the significance of human rights law in the health sciences. It also supports the establishment of an ethics committee to evaluate scientific developments and provide advice on ethical and legal issues in healthcare contexts. It has been drawn up by UNESCO in consultation with the Intergovernmental Committee on Bioethics. [153]

The Universal Bioethics and Human Rights Declaration is directed specifically at Africa and other developing nations. This instrument demonstrates that worldwide bioethics and human rights have become a component of today's bioethics discourse. There is clearly a certain affinity between human rights and bioethics, which makes such a connection desirable. The importance of this link is that human rights promote a universal normative development of bioethical principles. [153]

The UDBHR represents 28 principles, including respect for human dignity, human rights, and basic liberties, as well as the priority of individual interests and welfare over scientific and social interests. The UDBHR has the widest scope of any previously existing bioethics document. [153]

Applicable principles of the Universal Declaration on Bioethics and Human Rights, in relation to dual loyalty conflicts:

"Article 3: Human dignity and human rights" [153]

1. "Human dignity, human rights, and fundamental freedoms are to be fully respected.
2. The interests and welfare of the individual should have priority over the sole interest of science or society."

Article 3 of the UDBHR can be seen as the most pertinent article as it deals specifically with the human rights, interests and welfare of the patient – which is protected by international, regional and local law as cited in Table.2. When confronted with dual loyalty conflicts, a HCP ought to always respect the human rights and fundamental freedoms of the patient. Additionally, as per section 2 of the article, the HCP ought to advance the interests and welfare of the patient over and above any competing interests of a third party i.e. the state. In extension, the role of the HCP (an active practitioner, an instructor, a manager or even a political figure), should not have any influence or confounding effect on the HCP's moral duty of care. The healthcare profession is set apart from other professions through a distinctive moral duty of care to promote and protect the lives of individuals, as well as to alleviate pain and suffering. [10] Bioethics puts an emphasis on the significance of this 'moral duty of care' over and above the considerations of competing personal and third party conflicts. [10]

By way of illustration, the HCPs implicated in the Life Esidimeni tragedy, particularly Dr Makgabo Manamela (director for Mental Health services in Gauteng) and Dr Tiego Selebano (head of the GDoH) are two qualified HCPs who took a public oath [27, 28, 29], swore to promote and protect the lives of individuals, as well as to alleviate pain and suffering. In addition, they swore to uphold the human rights of patients, as well as to respect the laws of the Republic, as well as laws applicable to their profession. What is interesting to note is that both these HCPs were in senior, political, administrative roles. However, it is my view that a HCP's moral and legal duty as a HCP does not simply end because he or she is not in a clinical role. A HCP moral and legal duty is continuous, irrespective of the setting. Moreover, during the arbitration of the Life Esidimeni tragedy, Drs Manamela and Selebano confused that they were put under immense pressure by the then MEC for Health in Gauteng, Qedani Mahlangu, to hurriedly execute the Gauteng Mental Health Marathon Project. [27, 28, 29] Both HCPs knew the deadly consequences of rushing the project, but still went ahead and put the interests of the state over and above those they swore to protect and promote. They were confronted with a dual loyalty conflict and consciously chose to advance the interests of the state, which resulted in the gross human rights violations and deaths of over 140 [30] innocent mentally ill patients.

HCPs, when confronted with a dual loyalty conflict, ought to always advance the interests of the patient – their only loyalty ought to be with the patient. Nevertheless, a plausible, yet unjustifiable argument can be made that HCPs are often under immense pressure to advance the interests of third parties or face persecution, unemployment and/or harassment. However, in the cases of Drs Manamela and Selebano, there are laws in SA, namely the "Protected Disclosures Act, Act 26 of 2000" [154] which protects any individual who whistle blows against corruption and unjust

practices. The Act [154] states: "…employees in both the private and public sector [ought to] to disclose information regarding *unlawful or irregular conduct* [italics mine] by their employees or other employees in the employ of their employers…"

Additionally, the Act [154] was enacted to "…provide for the protection of employees who make a disclosure which is protected in terms of [the] Act; and to provide for matters concerned therewith." Drs Manamela and Selebano could and should have utilized this route to expose the MEC and GDoH, and thus preventing harm and mortality – thus, being loyal to the interest of patients. More so, both the SANC [8] and the HPCSA [6] have revenues for HCPs who feel the need to whistle blow. Article 3 should be the guiding article for all HCPs when confronted with a dual loyalty conflict, no matter how difficult it may be or what the consequence will be.

A perfect illustration is that of Dr. Kiran Sukeri, a psychiatrist at the Tower Psychiatric Hospital in Fort Beaufort, Eastern Cape. Dr. Sukeri brought to light the horrific conditions and treatment patients were being subjected to. [108] He submitted a complaint to Health Ombudsman of SA, the SA Human Rights Commission and the SA Society of Psychiatrists. The Health Ombud of SA Professor Malegapuru Makgoba conducted an investigation, and subsequently, he suggested the suspension of Dr. Sukeri, finding that the allegations he made about Tower Psychiatric Hospital were unfounded. Makgoba stated at a media briefing that: "The HPCSA should consider the immediate suspension of Dr. Sukeri until his fitness for office can be determined". [109] Dr. Sukrei was probably well aware what the consequences of his actions will be, but he acted in the best interests of patients and showed loyalty to both patients and his profession – this ought to be the conduct of all HCPs. You need to explain a little bit more on the problem with the Ombuds briefing.

"Article 4: Benefit and harm" [153]

1. "In applying and advancing scientific knowledge, medical practice and associated technologies, direct and indirect benefits to patients, research participants and other affected individuals should be maximized and any possible harm to such individuals should be minimized."

Article 4 speaks directly on the principles of beneficence (*preventing unnecessary pain, preventing mortality and preventing others from becoming incapacitated*), and non-maleficence (*do not kill, do not cause unnecessary pain or disability*). HCPs, in their daily practice, ought to always ensure that their decisions benefit the patient and that their actions will not harm the patient. In simpler terms, when confronted with a dual loyalty conflict, HCPs ought to ensure that the patients' interests are always advanced (beneficence), and this should automatically result in non-maleficence. Although Beauchamp and Childress [117] make it clear that there is no hierarchy of principles; in certain situations, non-maleficence obligations could take priority over beneficence obligations, even though the latter results in "highest net utility as regards outcomes". [121] Thus, HCPs ought to make sure that above everything else, they do not harm the patient, and this includes when confronted with a dual loyalty conflict. I argue that the primary purpose of a HCP's loyalty to a patient is to above all or first, do no harm. The HPCSA's "Guidelines for Good Practice in the Healthcare Professions**:** Core Ethical Values and Standards for Good Practice" [6], sums it up appropriately:

*2.3.2 "**Best interests or well-being: Non-maleficence:** Healthcare practitioners should not harm or act against the best interests of patients, even when the interests of the latter conflict with their own self-interest [or that of a third party's]."*

*2.3.3 "**Best interest or well-being: Beneficence:** Healthcare practitioners should act in the best interests of patients even when the interests of the latter conflict with their own personal self-interest [or that of a third party's]."*

When HCPs do not show complete loyalty to the interests of patients, deadly consequences can occur. By way of illustration, again using the Life Esidimeni tragedy, had HCPs showed complete loyalty to the patients, over 140 [30] deaths could have prevented. Article 4 of the UDBHR is, inter alia, about "applying and advancing scientific knowledge, medical practice and associated technologies [...]" and by extension, healthcare policies.

Deinstitutionalisation was cited as one of the reasons the GDoH hurriedly moved patients out of Life Esidimeni, despite calls not to do so from various organisations, families and professional groups. GDoH claimed that it was the implementing the "National Mental Health Policy Framework and Strategic Plan 2013-2020 on deinstitutionalisation." [26] The Policy identifies key activities that are considered important in transforming mental healthcare services in SA. This should be done by "ensuring that quality mental health services are accessible, equitable, and comprehensive and are integrated at all levels of the health system, in line with World Health Organization recommendations" [155]. One of these key activities is the implementation of deinstitutionalisation. Page 16 of the policy document states that "deinstitutionalisation has progressed at a rapid rate in South Africa, without the necessary development of community-based services." [155] The policy also states that deinstitutionalisation ought to happen slowly, over several years, after developing and encouraging community care, in consultation with key stakeholders. Evidence from the Ombudsman's report shows that the DGoH's process of deinstitutionalisation was contrary to that of the policy's process [26, 155]. Additionally, the HCPs implicated in the

saga tragedy testified that they were aware of the consequences if they went ahead with the deinstitutionalisation. Nonetheless, they went ahead, and they cited pressure from MEC and therefore they put the interests of the state ahead of the interests of the patients. [9, 31] They had grossly violated the human rights of patients. Moreover, by advancing the interests of the state, they (Drs Manamela and Selebano) also violated the Hippocratic Oath and the Florence Nightingale Pledge - the principle of non-maleficence can be taken from "*pledge to refrain from what is to [ill's] harm or injustice*"[111] (Hippocratic Oath) and from "*will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug"* (Florence Nightingale Pledge). [113]

HCPs ought to remain loyal to the interests of patients, no matter the pressure they may experience from third parties. A perfect illustration is that of Dr von Mollendorff. von Mollendorff was faced with a conflict – he had to choose between being faithful to his employer, the Mpumalanga Health Department, and his HCP duty to guarantee the best interests of his clients; HIV−counselling and ART. [100] Despite the severe intimidation he received, threats of dismissal and several rounds of disciplinary hearings, he and other HCPs who endured the same were steadfast in their conviction that their first and only loyalty lies with their patients. They respected and upheld patients' human rights; particularly the rights to health, life and dignity. The conduct of Dr von Mollendorff and others ought to be the conduct of all HCPs in SA.

"Article 5: Autonomy and individual responsibility" [153]

1. "The autonomy of persons to make decisions, while taking responsibility for those decisions and respecting the autonomy of others, is to be respected. For

persons who are not capable of exercising autonomy, special measures are to be taken to protect their rights and interests."

Autonomy is described as a fundamental ethical concept in healthcare. Individuals have the right to make their own decisions on issues pertaining to their health. [156] In addition, individuals also have the right to engage in the decision-making process of their healthcare. Beauchamp and Childress [117] claim that respect for the autonomy of an individual establishes self-determination, frequently expressed through informed consent. (see Article 6 in the next section). "A number of scholars have attempted to position respect for autonomy above all others, claiming autonomy is more equal than others, a view rejected by Beauchamp and Childress." [82]

When it comes to dual loyalty conflicts, autonomy is both morally and legally complicated to manage, particularly for those who under arrest or convicted criminals and those with limited mental capacity.

HCPs should take special measures to safeguard patients ' rights and interests and autonomy when faced with a dual loyalty conflict. How about protecting their own autonomy in order to render management without external pressures and interference? This, however, was not the case when it came to the Steve Biko tragedy. Although an individual's autonomy and self-determination are severely limited when in police custody, a HCP's primary loyalty ought to be with the individual, irrespective of the individual's legal status. Additionally, extra steps ought to be taken when a HCP is confronted with a dual loyalty conflict involving a mentally ill person, as they often require complex, delicate care (See Article 7 below). Respecting the autonomy of an individual is respecting their human rights. Furthermore, HCPs must be supported with regard to their autonomy being protected in the context of dual loyalty conflicts.

“Article 6: Consent” [153]

1. “Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information. The consent should, where appropriate, be express and may be withdrawn by the person concerned at any time and for any reason without disadvantage or prejudice.”

Consent (informed consent) is closely related to the concept of autonomy. Informed consent derives its meaning from the concept of autonomy, which takes into account regard for individuals and their human rights. According to article 6, patients should be given the opportunity to choose to participate in any preventive, diagnostic and therapeutic medical intervention. [153] SA law enacts the concept of autonomy and informed consent. Section 12(2) of the Constitution, [21] the National Health Act [85] (NHA) (chapter_2) and the Mental Healthcare Act [157] (MHCA) (chapter 3) are all specifically concerned with autonomy and informed consent. Individuals may not have the capacity to consent under certain conditions, such as mental incapacity.

In relation to dual loyalty conflicts, HCPs ought to always seek the consent of patients; that is, to put their interests and wellbeing first at all times, regardless of the patient’s mental status. For example, patients were moved out of Life Esidimeni facilities to NGOs without their consent. [26] HCPs put the interests of the state over and above the interests and wellbeing of the patients. An argument can be made that patients were mentally ill, and therefore had diminished mental capacity to provide autonomous, informed consent. However, on behalf of these patients, the NHA provides for certain people to consent: “A person authorized by the court (e.g. a

curator); or in order of priority, the patient's spouse, partner, parent, grandparent, major child or brother or sister." [157]

The MHCA [85] makes it clear that consent to care and treatment may only be provided by the patient, except where a court of law authorizes care and treatment or where the patient's mental state may cause severe harm or death to others or cause severe property damage. The Act also says that patients should be encouraged to consent to each phase of their healthcare and be engaged in it. Thus, HCPs ought to also seek informed consent from patients, even if they are pressured from a third party to do the contrary.

"Article 7: Persons without the capacity to consent" [153]

Special protection shall be granted to individuals who do not have the ability to consent in accordance with national and international legislation:

1. "Authorization for research and medical practice should be obtained in accordance with the best interest of the person concerned and in accordance with domestic law. However, the person concerned should be involved to the greatest extent possible in the decision-making process of consent, as well as that of withdrawing consent."

Article 7 of the UDBHR has been discussed in conjunction with Article 6 above. Nevertheless, in accordance with ethics, the Constitution [21], the NHA [85] and the MCHA [157], HCPs ought to take special, necessary steps to ensure that when they are confronted with a dual loyalty conflict, especially when it concerns the vulnerable; those who do not have the capacity to give consent.

“Article 8: Respect for human vulnerability and personal integrity” [153]

1. “In applying and advancing scientific knowledge, medical practice and associated technologies, human vulnerability should be taken into account. Individuals and groups of special vulnerability should be protected and the personal integrity of such individuals respected.”

Article 8 of the UDBHR has been strategically placed in accordance with Articles 6 and 7, which deal with consent and persons without the ability to consent, in order to cover situations in which these two principles are not sufficient. [158] Individuals who do not have the capacity to consent are those who are in principle autonomous and able to consent, but who are influenced by factors that hinder their independence in any type of control. [158] Scientific development has led to countless changes in social relations, raising ethical dilemmas of all scales, in particular with regard to the deterioration of socioeconomic disparities in peripheral countries. When consideration is given to the various socio-cultural contexts in which bioethics and human rights are discussed and applied, the issue of vulnerability becomes an even greater challenge. [185]

In the UDBHR, integrity refers to the whole person and the fundamental aspects of human life which must be respected. It is therefore not related to an individual's virtue, honesty, moral character or good behaviour. Integrity is a negative right to which all persons are entitled, i.e. it refers to one's non-interference in the other's private sphere. According to the Declaration of Helsinki [159], the integrity of the patient is an inviolable attribute, which cannot be disrespected. In the context of dual loyalty conflicts, this simply means that HCPs should not engage in any conflict that could violate patients human rights by disrespecting a patient’s human vulnerability and personal integrity. I

further argue HCP's has an obligation to protect patients from the actions that can disrespect a patient's human vulnerability and personal integrity.

The Steve Biko case is a perfect illustration of Article of 8. The HCPs charged with Biko's healthcare ought to be aware of his vulnerabilities, as all HCPs ought to be. Biko was particularly vulnerable as a political prisoner. Had those HCPs been aware of Biko's vulnerabilities, his human rights, as well as their ethical and legal duties and obligations, Biko's vulnerability the personal integrity would have to be protected and respected. They failed to put his interests and welfare over and above those of the then apartheid government. Again, when confronted with a dual loyalty conflict, especially when it comes vulnerable persons, HCPs must take all necessary steps to ensure that the patient's interests are promoted and protected over and above those of a third party.

"Article 10: Equality, justice, and equity" [153]

1. "The fundamental equality of all human beings in dignity and rights is to be respected so that they are treated justly and equitably."

Justice means equality and fairness – 'Justice as fairness'. [160] Justice is a fundamental concept in healthcare; it is the fair, equal distribution of healthcare. [161] Justice is the method in which people are treated fairly and equally in the healthcare and bioethics environment, leading in the capacity to attain the greatest achievable level of physical, mental and social well-being. [162]

When loyalty conflicts present itself to HCPs, they ought to ensure that any unreasonable requests when third parties are not unjust or risk causing unfair practices to the patient. Dr von Mollendorff, despite the harsh condition and treatment, has was subjected to, ensured that patients were being treated fairly and equally; he

and other HCPs ensured that patients needing ART received such treatment, despite all odds that were stacked up against them. Dr von Mollendorff and others remained true to their oath, respected the human rights of patients, and as a result, ensured justice to patients whose interests and welfare were being threatened by third parties.

"Article 11: Non-discrimination and non-stigmatization" [153]

1. "No individual or group should be discriminated against or stigmatized on any grounds, in violation of human dignity, human rights, and fundamental freedoms."

When third parties request HCPs to denounce their loyalty to patients or when HCPs themselves denounce their loyalty to patients in favour of third party interests, they are discriminating against and stigmatizing patients, on grounds, in my opinion, that patients are not worthy of spoken loyalty. Pushing the argument here

The patient's interests and welfare ought to always be put ahead those of a third party, irrespective of race, gender, sex, political affiliation, religion, creed, and age or income status. The primary obligation of a HCP's loyalty to a patient is to ensure that a patient's interests and welfare, as well as their human rights and fundamental freedoms are promoted and protected.

4.8. How Should Healthcare Professionals Apply Bioethics and Human Rights Law to Dual Loyalty Conflicts?

When confronted with a dual loyalty conflict which may violate patient's human rights, a HCP ought to follow a process, as set out by Arras which is the use one or more principles in any conflict or situation. Principles often ensure more particular laws specifying the sort of prohibited or allowed action. [82] Principles generate guidelines

for actual circumstances. The following steps are described by Arras, [163] namely “identification, justification, specification and then balancing”.

Arras [163] describes that the appropriate principles are recognized in a method that limits the range and scope of the principle. Also, the specification reduces the conflict between different principles. However, a number of principles still appear to be in conflict sometimes. This is when a method of balancing begins - weighing the conflicting principles against each other. [82, 163] Since according to Beauchamp and Childress [117], none of the principles are absolute, any principle can be overridden.

The balancing of principles will take into consideration, among other things, the need to uphold the principle, and it will be a measure of last resort to override a principle. Therefore, if there is consistency (coherence), the prevailing principle/s is/are justified. [82]

In order to achieve coherence, “the judgment should be connected and supported by relevant principles, values, ideas and previous cases”. [164] The goal is to balance the judgment/conclusion with all appropriate variables. The belief is that coherence is justified if all the variables in the mix are in equilibrium. Therefore such a reflective equilibrium should be as wide as possible. This implies that judgments are examined from any angle. [82]

Arras [164] argues that for the sake of maximum consistency, all components in the reflection mixture can be cut and modified. Arras [164] sees this broad methodology of reflective equilibrium as non-foundationalist. This implies that one can cut and fine-tune any other element in the mix. Therefore, the formulation of the statement of a right action states that ”an act is right if and only if it has features that according to

relevant principles establishes rightness, and can be shown to be in equilibrium after reflection." [82, 163]

4.9. Additional Guiding Principles

Mehring [110] cites four main guiding principles that HCPs ought to apply in armed conflict situations. Nonetheless, these principles can be applied by HCPs in any situation. These principles are humanity, neutrality, independence, and impartiality. These principles can be used in addition to the above. Moreover, these principles form the basis for all HCPs, as dual loyalty conflicts is an evitable encounter in the healthcare setting. Although adhering and applying to the principles may assist HCPs when confronted with dual loyalty conflicts, and provide added protection to patients, it may also make HCPs vulnerable in certain situations. [163]

1. **Humanity**

The principle of humanity is deemed to be the moral basis for the healthcare profession. I argue that humanity is the basis for respect for Human Rights Law as well. [163] According to Pictet, humanity is treating any individual "solely as a human being." [165] This is in an accord with Kant's philosophy of not treating an individual as a means to end. [122] The principle of humanity is usually expressed via the bioethical principles of beneficence and non-maleficence – to do good and not to do harm, and via human rights law. Therefore in practice, the principle of humanity requires the HCP to put the interests and welfare of the patient over and above those of a third party. As a reminder, there are instances when putting a third party's interests over and above those of the patient are warranted (i.e. notifying the relevant parties on the discovery of a notifiable disease such as measles or Ebola) [1] Firstly, this requires an attempt to prevent and alleviate pain and suffering. [132] Secondly, it requires that the HCP protect

the lives and human rights of patients. During a dual loyalty conflict, the meaning and importance of the principle of humanity is enhanced because of the deadly consequences of dual loyalty conflicts. Nevertheless, all persons should be treated with humanity regardless. [132]

2. Impartiality

Next, to humanity, impartiality is a further important principle for HCPs when confronted with dual loyalty conflicts. Impartiality contains three facets: non-discrimination, proportionality, and subjective impartiality – all of which has its linkage in human rights law. The principle of impartiality requires HCPs to respect human life and human rights and to always be fair and non-discriminatory regardless of whether a HCP is confronted with a dual loyalty conflict. [132]

3. Neutrality and Independence

Neutrality and independence principles are playing an increasingly significant role in healthcare. “Neutrality means renunciation of participation and abstaining from” [132] engaging in a dual loyalty conflict. Nonetheless, staying neutral in a political, religious, ideological or racial sense can be a challenge for all HCPs, especially when confronted with a dual loyalty conflict. In many instances, neutrality can only be ensured through independence. Independence simply means that HCPs ought to be free from economic, religious, political or any other outside influences. HCPs, when confronted with a dual loyalty conflict ought to refuse unethical and illegal requests from third parties, “and so act independently to the benefit of the [patient].” [132]

4.10. Conclusion

Dual loyalty conflicts continue to remain a challenge for HCPs, particularly in SA. Ethics has long called for HCPs to show complete loyalty towards their patients. [1] However, in the current world, HCPs are increasingly being challenged to decrease their loyalty to patients in favour of third parties. Dual loyalty conflicts thus present as a particular challenge for HCPs, as relegating patient interests to third parties risks infringing human rights of the patient. [1] As a result, a Principalism and Human Rights Law approach to such conflicts, as suggested here, may greatly assist HCPs to manage and even avoid dual loyalty conflicts in ethically and legally sound ways.

Chapter 5: Conclusion

Dual loyalty conflicts continue to remain a challenge for HCPs, particularly in SA. The lack of training, guidelines, and frameworks, particularly involving Bioethics and Human Rights Law are apparent in the South African context (see chapter 3). A new Bioethics and Human Rights Law framework are imperative if HCPs are to avoid or manage dual loyalty conflicts in ethically and legally sound ways.

My recommendation for such a framework is largely derived from the ethical framework of Principalism and Human Rights Law. Although principlism (bioethics) complements human rights law, there are distinct from each other. Together, however, they provide a powerful tool to articulate and mobilize around issues in healthcare. None is given priority over the others.

Nevertheless, although the guidelines proposed in this article appear clear and simple to apply, comprehensive training in ethics, health law, and human rights law still need to be provided to future and current HCPs. This will help to better identify appropriate tasks and discern challenging circumstances and dilemmas. The guidelines mentioned above is not a matter of implementing simple rules but needs the HCP draw on his or her own experiences and training. This will guarantee that history is not repeated and that lessons are correctly applied by HCPs. Even if this dissertation benefits only one healthcare professional, I am sure that it will include at least some degree of moral sensitivity and the capacity to judge morally. [82]

REFERENCES

1. The International Dual Loyalty Working Group. Dual Loyalty and Human Rights in Health Professional Practice. Physicians for Human Rights and School of Public Health and Primary Healthcare, University of Cape Town, Health Sciences Faculty. 2002; 1-3

2. McQuoid-Mason D, Dhai A. Professionalism and the healthcare practitioner-patient relationship. In Bioethics, Human Rights and Health Law. Principles and Practice. JUTA. Cape Town. 2011; 35-47.

3. Pont J, Stöver H, Wolff H. Dual loyalty in prison healthcare. American Journal of Public Health. 2012 Mar;102(3):475-80.

4. The World Medical Association Declaration of Geneva. 2017. Available: https://www.wma.net/policies-post/wma-declaration-of-geneva/ [Accessed 23.02 2018].

5. World Medical Association. Medical Ethics Manual. 2015: 1 - 73. Available: https://www.wma.net/what-we-do/education/medical-ethics-manual/ [Accessed 23.08.2018].

6. The Health Professions Council of South Africa Guidelines for Good Practice in the Healthcare Professions. 2008. Available: http://www.hpcsa.co.za/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_1_guidelines_good_prac.pdf [Accessed 21.03.2018].

7. Nurses' Pledge of Service – SA. Available: http://www.sanc.co.za/aboutpledge.htm [Accessed 21.032018].

8. The South African Nursing Council Code of Ethics for Nursing Practitioners in South Africa. 2013. Available: http://www.denosa.org.za/upload/news/SANC%20Code%20of%20Ethics%20for%20Nursing%20in%20South%20Africa.pdf [Accessed 21.03.2018].

9. Dhai A. Opinion on ethics and healthcare with specific reference to the circumstances surrounding the deaths of mentally ill patients in the Gauteng Province. 2018. 1-62

10. Dubai Health Authority. Health Regulation Department: Code of Ethics and Professional Conduct. Dubai: Government of Dubai. 2014:1-32. Available: https://www.dha.gov.ae/Documents/HRD/RegulationsandStandards/guidelines/Code%20of%20Ethics%20and%20Professional%20Conduct%20-%20final.latest.pdf [accessed 21.03.2018].

11. London L. Dual loyalties and the ethical and human rights obligations of occupational health professionals. American journal of industrial medicine. 2005. 1;47(4):322-32.

12. Hunt MR. Establishing moral bearings: ethics and expatriate healthcare professionals in humanitarian work. Disasters. 2011.1;35(3):606-22.

13. Brennan TA, Rothman DJ, Blank L, Blumenthal D, Chimonas SC, Cohen JJ, Goldman J, Kassirer JP, Kimball H, Naughton J, Smelser N. Health industry practices that create conflicts of interest: a policy proposal for academic medical centers. Jama. 2006. 25;295(4):429-33.

14. Mann JM. Medicine and public health, ethics and human rights. Hastings Center Report. 1997. 6;27(3):6-13.

15. The World Medical Association Declaration of Tokyo. Available: https://www.wma.net/policies-post/wma-declaration-of-tokyo-guidelines-forphysicians-concerning-torture-and-other-cruel-inhuman-or-degrading-treatment-orpunishment-in-relation-to-detention-and-imprisonment/ [Accessed 24.03.2018].

16. Henkin L. The age of rights. Columbia University Press; 1990.

17. United Nations General Assembly, Universal Declaration of Human Rights. 1948. Available from: http://www.un.org/en/udhrbook/pdf/udhr_booklet_en_web.pdf [Accessed 24.03.2018].

18. United Nations Committee on Economic, Social and Cultural Rights. 2006. Available from: http://www.refworld.org/docid/45377fa30.html [(Accessed 24.03.2018].

19. United Nations General Assembly. International Covenant on Economic, Social and Cultural Rights. 1966. United Nations, Treaty Series, vol. 993. Accessed: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx [Accessed 24.03.2018].

20. Organization of African Unity (OAU), African Charter on Human and Peoples' Rights (Banjul Charter).1981. Available: http://www.achpr.org/files/instruments/achpr/banjul_charter.pdf [Accessed 24.03. 2018].

21. Constitution of South Africa. 1996. Available from: http://www.gov.za/sites/www.gov.za/files/Act108of1996s.pdf [Accessed 24.03.2018].

22. Shklar JN. The faces of injustice. Yale University Press; 1990.

23. Moodley K, Kling S. Dual loyalties, human rights violations, and physician complicity in apartheid South Africa. AMA journal of ethics. 2015.1;17(10):966.

24. Pont J, Stöver H, Wolff H. Resolving Ethical Conflicts in Practice and Research. J Public Health. 2011;2012(102):475-80.

25. Politicians must account for the deaths of 94 psychiatric patients in South Africa. TheConversation. 5 February 2017. Available: http://theconversation.com/politicians-must-account-for-the-deaths-of-94-psychiatric-patients-in-south-africa-72422 [Accessed 21.03.2018].

26. Makgoba MW. The Life Esidimeni disaster: The Makgoba report. Available: http://www.politicsweb.co.za/ documents/the-life-esidimeni-disaster-the-makgoba-report [accessed 10.05201].

27. Ferlito BA, Dhai A. The Life Esidimeni tragedy: The courts are also to blame. South African Medical Journal. 2018.1;108(3):155-6.

28. Ferlito BA, Dhai A. The Life Esidimeni tragedy: some ethical transgressions. South African Medical Journal. 2018.108(3):157-.

29. Dhai A. The Life Esidimeni tragedy: Constitutional oath betrayed. South African Journal of Bioethics and Law. 2017;10(2):40-1.

30. Bornman J. Life Esidimeni death toll rises to 143. News24. 10 November 2017. Available: https://www.news24.com/SouthAfrica/News/life-esidimeni-death-toll-rises-to-143-20171110 [Accessed 23.02.2018].

31. Masilela B. Suspended HoD dodges blame for Life Esidimeni fiasco. IOL. 5 December 2017. Available From: https://www.iol.co.za/news/south-

africa/gauteng/suspended-hod-dodges-blame-for-life-esidimeni-fiasco-12276212 [Accessed 21.03.2018].

32. Sugarman J, Sulmasy D.P. The Many Methods of Medical Ethics in Methods. In: Sugarman J, Sulmasy D.P, editors. Methods in Medical Ethics. 2nd ed. Washington DC: Georgetown University Press, 2010:3-19.

33. University of the Witwatersrand, Johannesburg, Steve Biko Centre for Bioethics, School of Clinical Medicine, Faculty of Health Sciences. Guidelines for Developing and Submitting a Research Proposal. 2017:1-18. Print

34. Strong K, Lipworth W, Kerridge I. The strengths and limitations of empirical bioethics. J Law Med. 2010:18(2):316-319.

35. Keller S. The limits of loyalty. Cambridge: Cambridge University Press; 2007.

36. Gilani SA. 2017. What is loyalty? ResearchGate. Available: https://www.researchgate.net/post/What_is_loyalty [Accessed 08.07.2018].

37. Royce J. The philosophy of loyalty. Vanderbilt University Press; 1995.

38. Kleinig, John.Loyalty. The Stanford Encyclopaedia of Philosophy. Edward N. Zalta (ed.). Available: https://plato.stanford.edu/archives/win2017/entries/loyalty/ [Accessed 08.07.2018].

39. Jackson JJ, Wood D, Bogg T, Walton KE, Harms PD, Roberts BW. What do conscientious people do? Development and validation of the Behavioral Indicators of Conscientiousness (BIC). Journal of Research in Personality. 2010 Aug 1;44(4):501-11.

40. Roberts, B. W., Jackson, J. J., Fayard, J. V., Edmonds, G., &Meints, J. (2009). Conscientiousness. In M. R. Leary & R. H. Hoyle (Eds.), Handbook of individual differences in social behavior (pp. 369-381). New York, NY, US: Guilford Press.

41. Stroud S. Epistemic partiality in friendship. Ethics. 2006 Apr;116(3):498-524.

42. George P. Fletcher, Loyalty: An Essay on the Morality of Relationships. Oxford: University Press;1993.

43. James W. The will to believe and other essays in popular philosophy. Harvard University Press; 1979.

44. Pettit P. The paradox of loyalty. American Philosophical Quarterly. 1988 ;25(2):163-71.

45. Ewin RE. Loyalty and virtues. The Philosophical Quarterly (1950-). 1992 Oct 1;42(169):403-19.

46. Rorty R. Justice as a larger loyalty. Ethical Perspectives. 2005;4(3):139-51.

47. John Ladd, entry on ‘‘Loyalty’’ in Paul Edwards (editor-in-chief), The Encyclopedia of Philosophy (New York: Macmillan and the Free Press, 1967), pp. 97–98.

48. Fiduciary Duty of Doctor and Patient | LegalMatch Law Library. Available from: https://www.legalmatch.com/law-library/article/fiduciary-duty-of-doctor-and-patient.html [Accessed 08.08.2018]

49. Hui EC. Doctors as fiduciaries: A legal construct of the patient. Hong Kong Medical Journal. 2005;11(6):527-9.

50. Le Grange L. Ubuntu, ukama and the healing of nature, self and society. Educational philosophy and theory. 2012;44(s2):56-67.

51. Nzimakwe TI. Practising Ubuntu and leadership for good governance: the South African and continental dialogue. African Journal of Public Affairs. 2014. 7(64):30-41

52. Brack G, Hill MB, Edwards D, Grootboom N, Lassiter PS. Adler and Ubuntu: Using Adlerian Principles in the New South Africa. Journal of Individual Psychology. 2003;59(3).

53. Mnyaka M, Motlhabi M. The African concept of Ubuntu/Botho and its socio-moral significance. Black Theology. 2005;3(2):215-37.

54. Ntibagirirwa S. Cultural values, economic growth and development. Journal of business ethics. 2009 Feb 1;84(3):297-311.

55. Murithi T. An African perspective on peace education: Ubuntu lessons in reconciliation. International review of education. 2009 May 1;55(2-3):221-33.

56. Khomba JK. Redesigning the Balanced Scorecard model: an African perspective (Doctoral dissertation, University of Pretoria).

57. Nussbaum B. Ubuntu: Reflections of a South African on our common humanity. Reflections: The SoL Journal. 2003;4(4):21-6.

58. Jimu IM. Shared sociability and humanity. Journal of Pan African Studies. 2016;9(4):404-12.

59. Hall RT. Communitarian ethics and the sociology of morals: Alasdair MacIntyre and Émile Durkheim. Sociological Focus. 1991;24(2):93-104.

60. Msengana NW. The significance of the concept" Ubuntu" for educational management and leadership during democratic transformation in South Africa (Doctoral dissertation, Stellenbosch: University of Stellenbosch).

61. Sulamoyo D. " I Am Because We Are": Ubuntu as a Cultural Strategy for OD and Change in Sub-Saharan Africa. Organization Development Journal. 2010;28(4):41.

62. Fox W. A guide to public ethics. Juta and Company Ltd; 2010.

63. Singh JA. American physicians and dual loyalty obligations in the" war on terror". BMC medical ethics. 2003;4(1):4.

64. London L. Dual loyalties and the ethical and human rights obligations of occupational health professionals. American journal of industrial medicine. 2005;47(4):322-32.

65. Baron IZ. The problem of dual loyalty. Canadian Journal of Political Science/Revue Canadienne de science politique. 2009;42(4):1025-44.

66. Williams JR. Dual loyalties: How to resolve ethical conflict. South African Journal of Bioethics and Law. 2009;2(1).

67. Rodwin MA. Medicine Money And Morals – Physicians' Conflicts of Interest. New York: Oxford University Press, 1993.

68. Wilson K. The problem of dual loyalty-through African eyes. South African Journal of Bioethics and Law. 2009;2(1):4-7.

69. Physicians for Human Rights. Dual loyalties: the challenges of providing professional healthcare to immigration detainees. 2011. Available: https://s3.amazonaws.com/PHR_Reports/2011_DualLoyalties_Final_3_24_2011_opt.pdf. [Accessed 10.12.2018]

70. Karim SA, Karim QA, editors. HIV/Aids in South Africa. Cambridge University Press; 2010.

71. Von Mollendorff: No going back. News24. 10 March 2003. Available from: https://www.news24.com/SouthAfrica/News/Von-Mollendorff-No-going-back-20030310 [Accessed 10.12.2018]

72. Hills SL. Dual Loyalty Conflict: the Ethical Ramifications of Medical Professionals' Participation in Torture.

73. Ienaga S. The glorification of war in Japanese education. International Security. 1993;18(3):113-33.

74. Waller J. Becoming evil: How ordinary people commit genocide and mass killing. Oxford: Oxford University Press; 2002.

75. White RM. Unraveling the Tuskegee study of untreated syphilis. Archives of Internal Medicine. 2000;160(5):585-98.

76. Gould C, Folb P, Folb PI. Project Coast: Apartheid's chemical and biological warfare programme. United Nations Publications UNIDIR; 2002.

77. Clark PA. Medical ethics at Guantanamo Bay and Abu Ghraib: the problem of dual loyalty. The Journal of Law, Medicine & Ethics. 2006; 34(3):570-80.

78. Ferlito BA, Dhai A. The Life Esidimeni tragedy: A human-rights perspective. South African Journal of Bioethics and Law. 2017;10(2):52-4.

79. Dhai A. The Life Esidimeni tragedy: Moral pathology and an ethical crisis. South African Medical Journal. 2018;108(5):382-5.

80. Bloche, M. Gregg MD. Clinical loyalties and the social purposes of medicine. JAMA. 1999; 281(3): 268-274

81. South Africa. 2002. Mental Healthcare Act No.17 of 2002. Available from: https://www.gov.za/files/a17-02.pdf (accessed 08 June 2018).

82. Lukhozi SM. Dual Obligations in Clinical Forensic Medicine. Masters dissertation: Stellenbosch University. Available: http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.911.5472&rep=rep1&type=pdf [Accessed 05.11.2018]

83. Free Online Dictionary. 2001. Forensic. [Online]. Available: https://www.thefreedictionary.com/forensic [Accessed 10.10. 2018].

84. South Africa. 2003. National Health Act No.61 of 2003. Available: https://www.up.ac.za/media/shared/12/ZP_Files/health-act.zp122778.pdf [Accessed 10.10. 2018].

85. South Africa. Amendment to National Health Act. Regulations Regarding the Rendering of Clinical Forensic Medicine Services No: 33655. Available: http://www.health.gov.za/index.php/2014-03-17-09-09-38/legislation/joomla-split-

menu/category/84-2012r?download=240:regulations-regarding-the-rendering-of-clinical-forensic-medicine-services-r176-2012 [Accessed 10.10. 2018].

86. Cooke, R.H. 1978. A practical guide to clinical forensic medicine. In: Burges, SH. The new police surgeon. Benham, London: Hutchinson.

87. McLean GR, Jenkins T. The Steve Biko affair: a case study in medical ethics. Developing World Bioethics. 2003 May;3(1):77-95.

88. Steve Biko Biography. Available at: https://www.biography.com/people/steve-biko-38884 [Accessed 10.10.2018].

89. Truth and Reconciliation Commission (TRC) Report. 1998. Volume 4(5). Cape Town: Juta Press.

90. Baldwin-Ragaven L, De Gruchy J, London L. An Ambulance of the Wrong Colour: Health Professionals, Human Rights and Ethics in South Africa. Cape Town, South Africa: University of Cape Town Press; 1999:91-101, 148-162.

91. Lee N. Johannesburg Spotlight on South African Medical profession. The Lancet. 1997 Jul 5;350(9070):39.

92. Susser M, Cherry VP. Health and healthcare under apartheid. Journal of Public Health Policy. 1982 Dec 1;3(4):455-75.

93. Williams JR. Ethics and human rights in South African medicine. Canadian Medical Association Journal. 2000 Apr 18;162(8):1167-70.

94. Medical Association of South Africa. Submission to the Truth and Reconciliation Commission; 1997 June 17; Cape Town, South Africa. p. 3.

95. Jenkins T. Ethical issues in the medical care of prisoners and detainees. S Afr J of Contin Med Educ 1987;75:40-9.

96. Price M. Healthcare as an instrument of apartheid policy in South Africa. Health Policy Plan 1986;1(2):158-70.

97. American Association for the Advancement of Science. Apartheid medicine: health and human rights in South Africa. Washington, DC: AAAS. 1990.

98. World Medical Association. Declaration of Tokyo-Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment. Available at: http://www.cirp.org/library/ethics/tokyo/ [Accessed 10.10.2018].

99. Dhai A. The Life Esidimeni tragedy: Moral pathology and an ethical crisis. South African Medical Journal. 2018;108(5):382-5.

100. Claassens MM. Responsibility in healthcare (Doctoral dissertation, Stellenbosch: University of Stellenbosch). Website and date of access

101. Von Mollendorff T. Daring to care: a doctor's persecution in Mpumalanga. The virus, vitamins and vegetables: The South African HIV/AIDS mystery. Auckland Park: Jacana Media. 2009.

102. Baleta A. South African doctor sacked for giving antiretrovirals to rape survivors. Lancet. 2002;359:954.

103. Altenroxel L. 2002. Doctor on the carpet for sticking to oath. The Star Newspaper. Available: http://www.grip.org.za/news/doctor.htm [Accessed 10.10.2018].

104. Altenroxel L. Activists gunning for Mpuma health MEC. IOL. 28. November 2002. Available: https://www.iol.co.za/news/south-africa/activists-gunning-for-mpuma-health-mec-97951 [Accessed 10.10.2018].

105. Landman W. Respect doctors' ethical obligations. Indian Journal of Medical Ethics. 2002:6(2). Available: http://ijme.in/articles/respect-doctors-ethical-obligations/?galley=html [Accessed 10.10.2018].

106. Donna KV, Dhai A, van Bogaert LJ, Howarth G, Hanekom D, Ogunbanjo G. The state attitude to antiretroviral treatment- The doctor's duty to speak out. South African medical journal. 2002 Apr;92(4):272.

107. South Africa. The Protected Disclosures Act 26 of 2000. Available: www.justice.gov.za/legislation/acts/2000-026.pdf [Accessed 10.10.2018].

108. Pitt C. News24. 13 September 2018. Tower Hospital psychiatrist opts not to appeal Health Ombudsman's decision. Available: https://www.news24.com/SouthAfrica/News/tower-hospital-psychiatrist-opts-not-to-appeal-health-ombudsmans-decision-20180913 [Accessed 15.10.2018].

109. Maphanga C. News24. 23 August 2018. Tower Psychiatric Hospital is no Life Esidimeni - health ombudsman. Available: https://www.news24.com/SouthAfrica/News/tower-psychiatric-hospital-is-no-life-esidimeni-health-ombudsman-20180823 [Accessed 15.10.2018].

110. Mehring S. First do no harm: Medical ethics in international humanitarian law. Leiden: Martinus Nijhoff Publishers, 2014.

111. Loeb Classical Library. 2019. Hippocrates of Cos (1923). 'The Oath', 147: 298–299. Available: https://www.loebclassics.com/view/hippocrates_cos-oath/1923/pb_LCL147.299.xml [Assessed 02.01.2019]

112. University of the Witwatersrand. 2019. The Hippocratic Oath. Available: https://www.wits.ac.za/bioethics/about-us/hippocratic-oath/ [Assessed 02.01.2019]

113. NursingCrib. 2 January 2017. Nightingale's Pledge. Available: https://nursingcrib.com/news-blog/nightingales-pledge/ [Assessed 02.01.2019]

114. University of Johannesburg. 28 January 2016. UJ Nursing Students Pledge to Serve Humanity. Available: https://www.uj.ac.za/newandevents/Pages/UJ-nursing-students-pledge-to-serve-humanity.aspx [Assessed 02.01.2019]

115. Beauchamp TL. *Ethical theory and bioethics*. In: Beauchamp TL, Walters L, eds. Contemporary issues in bioethics. 6th edition. Belmont, CA: Wadsworth, 1999:1–32.

116. Jecker, Nancy S., Jonsen, Albert R., and Pearlman, Robert A.. 2007. *Bioethics: An Introduction to the History, Methods, and Practice*. 2nd edition. Sudbury, Mass.: Jones and Bartlett Publishers.

117. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 7th Edition. Oxford University Press, 2013.

118. Frankena WK. 1963. *Ethics*. 2nd Edition. Englewood Cliffs, NJ: Prentice-Hall

119. Beauchamp TL. *The mettle of moral fundamentalism: A reply to Robert Baker*. Kennedy Institute of Ethics Journal. 1998;8(4):389-401.

120. Rawls J. A theory of justice. Harvard university press; 2009.

121. Dhai A. Understanding ethics with specific reference to health research. In: Health Research Ethics: Norms and Standards for Researchers and Research Ethics Committee Members. Johannesburg: University of the Witwatersrand, 2017:1-13.

122. Rachels J, Rachels S. *The elements of moral philosophy*. 6th Edition. New York: McGraw-Hill, 2010.

123. Gray M. *Philosophy in Medicine: Conceptual and Ethical Issues in Medicine and Psychiatry*. J Med Ethics. 1983;9(3):178. doi:10.1192/S0007125000116320

124. Owen GS, Freyenhagen F, Richardson G, Hotopf M. *Mental capacity and decisional autonomy: an interdisciplinary challenge*. Inquiry. 2009 Feb 1;52(1):79-107. doi: 10.1080/00201740802661502

125. Marrus MR. *The Nuremberg Doctors' trial in historical context*. Bulletin of the History of Medicine. 1999 Apr 1;73(1):106-23.

126. Pogge TW. *World poverty and human rights*. 2nd Edition. Cambridge: Polity, 2008.

127. Sen A. Functionings and Capabilities. In: Inequality Reexamined. Cambridge: MA: Harvard University Press. 1992

128. Farlex Partner Medical Dictionary. 2019. *Utility*. Available: https://medical-dictionary.thefreedictionary.com/utility [Accessed 02.01.2019]

129. Quora. 28 August 2015. *What is social utility?* Available: https://www.quora.com/What-is-social-utility [Accessed 02.01.2019]

130. Clouser KD, Gert B. *A critique of principlism*. The Journal of medicine and philosophy. 1990 1;15(2):219-36.

131. Pera SA. *Ethics in Healthcare*. 3rd Edition. Cape Town: Juta and Company Ltd, 2011.

132. The Australian Commission for Human Rights. 2019. *An Introduction to Human Rights*. Available: https://www.humanrights.gov.au/education/students/get-informed/introduction-human-rights [Accessed 05.01.2019]

133. Dündar S. 2013. *A Comparison of Sensitivity to Human Rights Issues among Students in Turkey.* Human Rights Library: University of Minnesota. Available: http://www1.umn.edu/humanrts/links/hrarticle.pdf [Accessed 05.01.2019]

134. Globalization10. 2017. *Three Generations of Human Rights.* Available: https://www.globalization101.org/three-generations-of-rights/ [Accessed 05.01.2019]

135. UN Preamble. http://www.un.org/en/sections/un-charter/preamble/index.html

136. Cohen J, Ezer T. Human rights in patient care: a theoretical and practical framework. Health Hum Rights. 2013 Dec 7;15(2):7-19.

137. Ventura CA. 2014. *International Law, Mental Health, and Human Rights*. The Center for Civil & Human Rights: Notre Dame. Available: https://humanrights.nd.edu/assets/134859/ [Accessed 05.01.2019]

138. United Nations General Assembly. 10 December 1984. *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. United Nations. Treaty Series, vol. 1465, p. 85. Available: https://treaties.un.org/doc/Publication/UNTS/Volume%201465/volume-1465-I-24841-English.pdf [Accessed 06.01.2019]

139. United Nations General Assembly. 18 December 1979. *Convention on the Elimination of All Forms of Discrimination Against Women*. United Nations. Treaty Series, vol. 1249, p. 13. Available: http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm [Accessed 06.01.2019]

140. United Nations General Assembly. *Convention on the Rights of the Child*. 20 November 1989. United Nations. Treaty Series, vol. 1577, p. 3. Available: https://www.ohchr.org/en/professionalinterest/pages/crc.aspx [Accessed 06.01.2019]

141. United Nations General Assembly. *Convention on the Rights of Persons with Disabilities.* 2006. New York, United Nations. Available: https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html [Accessed 06.01.2019]

142. United Nations General Assembly. *International Convention on the Elimination of All Forms of Racial Discrimination*. 21 December 1965. United Nations. Treaty Series, vol. 660, p. 195. Available: http://www.ohchr.org/Documents/ProfessionalInterest/cerd.pdf [Accessed 06.01.2019]

143. United Nations. *Standard Minimum Rules for the Treatment of Prisoners*. 30 August 1955. Available: https://www.unodc.org/pdf/criminal_justice/UN_Standard_Minimum_Rules_for_the_Treatment_of_Prisoners.pdf. [Accessed 06.01.2019]

144. Diakonia. 2019. International Human Rights Law. Available: https://www.diakonia.se/en/IHL/The-Law/International-Human-Rights-Law/ [Accessed 06.01.2019]

145. Dugard J. International law: A South African Perspective. Kenwyn: Juta and Co., 1994. 16.

146. Reisman WM. *Sovereignty and human rights in contemporary international law*. Amer J Intl Law 1990;84(4):866-876.

147. Pelligrino, E.D. 1994. *Self Interest, Physician duties and medical ethics*. In: Cambell, C & LUSTIG, BA. Theology and Medicine. Duties to Others. Vol (4). Boston, London. Kluwer Academic Publishers

148. Josephson, M. 2011. *Three sources of Moral Obligation*. Available: http://josephsononbusinessethics.com/2011/02/3-sources-moral-obligation/ [Accessed 06.01.2019]

149. Benjamin, M. 1994. *Conflict, compromise, and moral integrity*. In: Cambell, C and Lustig, B.A. Theology and Medicine. Duties to Others. Boston, London. Kluwer Academic Publishers

150. Thepterosaur. 27 June 2009. *The difference between duties and obligations*. http://thepterosaur.com/philosophy/the-difference-between-duty-and-obligation/ [Accessed 07.01.2019]

151. Dickens BM. Legal Approach to Healthcare Ethics and the Four Principles. In: Raanan Gillon, editor. Principles of Healthcare Ethics: John Wiley & Sons Ltd: 1994, 307-311

152. Van der Reyden D. The right to respect for autonomy: *Part 1-What is autonomy all about?.* South African Journal of Occupational Therapy. 2008;38(1):27-31.

153. United Nations Educational, Scientific and Cultural Organization. *Universal Declaration on Bioethics and Human Rights*. 2006. http://unesdoc.unesco.org/images/0014/001461/146180E.pdf [Accessed 07.01.2019]

154. Government of South Africa. 2000. The Protected Disclosures Act, Act 26 of 2000. Available: http://www.justice.gov.za/legislation/acts/2000-026.pdf [Accessed 07.01.2019]

155. National Department of Health, Republic of South Africa. 2012. National Mental Health Policy Framework and Strategic Plan 2013-2020, Available: https://www.health-e.org.za/wp-content/uploads/2014/10/National-Mental-Health-Policy-Framework-and-Strategic-Plan-2013-2020.pdf [Accessed 07.01.2019]

156. Sakellari E. *Patient's autonomy and informed consent*. ICUS Nurs Web J 2003;(13):1-9.

157. Government of South Africa. 2002. Mental Healthcare Act No.17 of 2002. Available: http://www.gov.za/sites/www.gov.za/files/a17-02.pdf [Accessed 07.01.2019]

158. Morais TC, Monteiro PS. *Concepts of human vulnerability and individual integrity in bioethics*. Revista Bioética. 2017 Aug;25(2):311-9.

159. World Medical Association. Declaration of Helsinki: ethical principles for medical research involving human subjects

160. Bishop L. Ethics background: Principles – respect, justice, nonmaleficence, beneficence. Kennedy Institute of Ethics, Georgetown University. https://www.nwabr.org/sites/default/files/Principles.pdf [Accessed 08.01.2019]

161. The meaning of 'justice' in healthcare. Med Law. 2008 Sep;27(3):535-45.

162. Tarantola D, Camargo K, Gruskin S. Searching for justice and health. Am J Public Health 2015;105(8):1511-1512. doi; 10.2105/AJPH.2015.302760

163. Arras, J.D. 2007. *The way we reason*. In: Steinbock B. The Oxford handbook of Bioethics USA: Oxford University Press

164. Levi BH. *Four approaches to doing ethics*. The Journal of medicine and philosophy. 1996 Feb 1;21(1):7-39.

165. Pictet J. *The fundamental principles of the Red Cross*. International Review of the Red Cross Archive. 1979 Jun;19(210):130-49.

Annexure A: Ethics Waiver

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

Ref: W-CP-180424-2

24 April 2018

TO WHOM IT MAY CONCERN:

Waiver: This certifies that the following research does not require clearance from the Human Research Ethics Committee (Medical).

Investigator:	**Mr Brandon Allister Ferlito (student no 704750)**
Supervisor:	**Prof Ames Dhai**
Faculty:	Health Sciences
School:	Clinical Medicine
Department:	Steve Biko Centre for Bioethics
Project title:	**Dual Loyalty & Human Rights: A Bioethical Analysis of the Situation in South Africa**
Reason:	Literature Review

Professor Clement Penny

Chair: Human Research Ethics Committee (Medical)

Copy – HREC (Medical) Secretariat: Zanele Ndlovu, Rhulani Mkansi,Iain Burns

Research Office Secretariat: Faculty of Health Sciences, Phillip Tobias Building, 3rd Floor, Office 301, 29 Princess of Wales Terrace, Parktown, 2193 Tel +27 (0)11-717-1252 /1234/2656/2700 Private Bag 3, Wits 2050, email: zanele.ndlovu@wits.ac.za Office email: hrec-medical.researchoffice@wits.ac.zaWebsite:

Annexure B: Turnitin Report

704750:BA_Ferlito_704750_TRURNITIN_Final.docx

ORIGINALITY REPORT

15%	9%	5%	8%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	Submitted to University of Stellenbosch, South Africa Student Paper	2%
2	scholar.sun.ac.za Internet Source	2%
3	issuu.com Internet Source	1%
4	physiciansforhumanrights.org Internet Source	1%
5	www.ajol.info Internet Source	1%
6	assets.cambridge.org Internet Source	<1%
7	journalofethics.ama-assn.org Internet Source	<1%
8	www.scielo.org.za Internet Source	<1%
9	www.humanrights.gov.au	