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THE "OUGHT" VERSUS THE "IS"
THE SOURCES USED BY DOCTORS FOR DECISION-MAKING IN MEDICAL QUANDARIES

Tracy Catherine Jacovides

A Thesis submitted to the Faculty of Health Sciences, University of the Witwatersrand, in fulfilment of the requirements for the degree of Doctor of Philosophy (Bioethics and Health Law)

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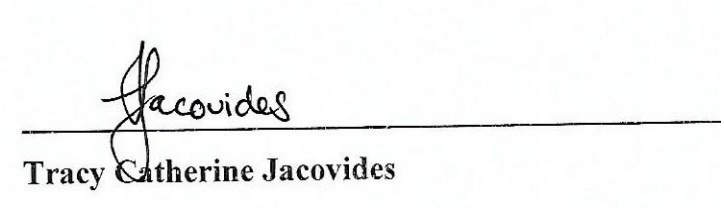
Johannesburg, September 2021

DECLARATION

I, Tracy Catherine Jacovides, declare that this Thesis is my own, unaided work. It is being submitted for the Degree of PhD – Doctor of Philosophy (Bioethics and Health Law) at the University of Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.



Tracy Catherine Jacovides

September 2021

DEDICATION

This work is dedicated to my husband Andreas- my constant, and the wind beneath my wings. It only takes one person to believe in you and keep you inspired, to achieve your dreams.

To my children, Vicky, Nick, Gareth, and Katy. We can look forward to long Sunday lunches and tough running trails again.

Finally, to my late father, who from an early age instilled the mantra “ain’t no mountain high enough”. Although he did not get to see the final product, he was there at the beginning and is always at my side.

ABSTRACT

Doctors make moral and ethical decisions every day in medical practice. These are decisions that require normatively reasoned deliberation to determine the 'right' action or what 'ought' to be done. Ethical theories, professional guidelines and law purportedly guide these decisions. In diverse, pluralistic, liberal democracies the application of 'universal' ethical principles is expected.

This study sought to examine the normative sources that medical doctors refer to when confronted with moral and ethical quandaries in the clinical context. In Phase I, an analytical tool, the Ethics Tetrad, based on the Wesleyan Quadrilateral, was developed to facilitate the analysis of data collected from interviews obtained from doctors in Phase II.

The data collected in Phase II was analysed according to the dilemmas, the resolutions, and the justifications. It was further analysed according to thematic content analysis. Finally, the normative sources were identified and discussed.

The study concluded that doctors experience normative uncertainty and justify their decisions in resolving moral and ethical quandaries in medical practice on the basis of the "patient's" best interest, and on the traditional values of the 'Golden Rule' and 'first do no harm'. There was little reference to ethical theory, professional guidelines, or the law. The law was used defensively rather than normatively. There also appeared to be minimal awareness of the professional guidelines as provided by the HPCSA medical ethical guidance booklets.

A consequence of normative uncertainty was moral distress; and this has implications for the practice of medicine. To ameliorate the moral distress experienced, regular debriefing and discussion groups, both inter and intra healthcare professionals, would help bring awareness and resolution of the problem.

Finally, it was concluded that the teaching of ethics to medical doctors, should be specialised to a clinical ethics, rather than an umbrella bioethics. Further, a system needs to be implemented to ensure that doctors are adequately trained on the topics covered in the HPCSA guidance booklets and that this training should form part of the licensing standards that are required for doctors to practise medicine in South Africa. A mobile application of

these guidance booklets would also provide easy access for reference when needed in ethical quandaries.

ACKNOWLEDGEMENTS

This work would be incomplete without acknowledging my two advisors.

Professor Ames Dhai was a wise and guiding force, despite what was for her, a very trying 2020- the year of Covid-19.
[Professor Ames Dhai. PhD; MBChB; FCOG; LLM; PG Dip. Res. Ethics. (Former Head: Steve Biko Centre for Bioethics, University of Witwatersrand)].

Dr Anthony Egan, eloquent, very thought-provoking, and controversial. Need I say more? Anthony, the discussions and debates over coffee and cake have not ended just because this work has.
[Dr Anthony Egan: BA Hons MA (UCT); MDiv STL (Weston); PhD (Witwatersrand) (Part-time Lecturer, Steve Biko Centre for Bioethics, University of the Witwatersrand)].

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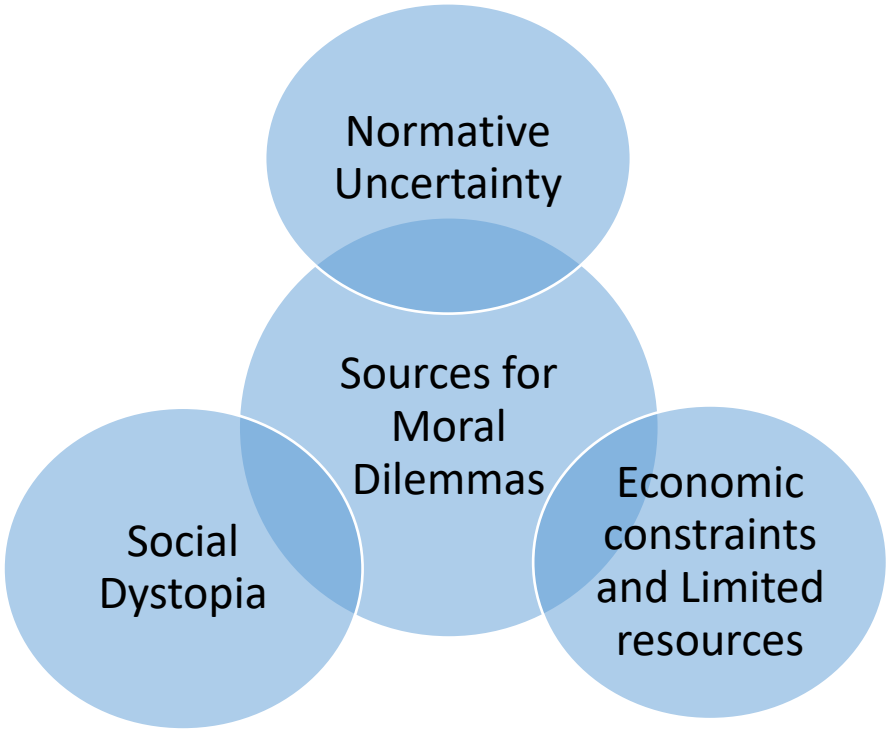

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LIST OF ABBREVIATIONS

ACLS	Advanced Cardiac Life Support
AIDS	Acquired Immuno-Deficiency Syndrome
ARV	Anti-retroviral
BCE	Before Common Era
CE	Common Era
CHBH	Chris Hani Baragwanath Hospital
CMAH	Charlotte Maxeke Academic Hospital
DNR	Do Not Resuscitate
DSM-V	Diagnostic and Statistical Manual of Mental Disorders-5
GCP	Good Clinical Practice
HCT	HIV Counselling and Testing
HIV	Human Immuno-Deficiency Virus
HPCSA	Health Professionals Council of South Africa
HR	Human Resources
ICH-GCP	International Conference on Harmonisation- Good Clinical Practice
ICU	Intensive Care Unit
KZN	Kwa-Zulu Natal
MEDUNSA	Medical University of South Africa
MDR	Multi-drug resistant
MPS	Medical Protection Society
MVA	Manual Vacuum Aspiration
NHA	National Health Act
PCI	Percutaneous Cardiac Intervention
PEP	Post exposure prophylaxis
SAMA	South African Medical Association
SAPS	South African Police Services
SOA	Sexual Offences and Related Matters Act
TCA	Thematic Content Analysis
TOP	Termination of Pregnancy
RVD	Retroviral Disease
WITS	Witwatersrand
WMA	World Medical Association
UNESCO	United Nations Educational, Scientific and Cultural Organization

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CHAPTER 1

1.1 Introduction

Doctors, in everyday medical practice, make decisions about the action to be taken in the care of their patients. While some decisions are of a scientific or technical nature, many are moral or ethical decisions consequent to questions of values, rights, and responsibilities in the clinical doctor-patient relationship (Kennedy, 1981). These are questions where appropriate deliberation is necessary to determine the "right" thing to do or what "ought" to be done. Ethical theories, law, or professional guidelines purportedly guide these actions and decisions. Some decisions may be easier to address than others because there is a reasoned universal agreement on the process to address a particular clinical moral or ethical dilemma (Williams, 2015). Others are more complicated because there is no universal consensus; there is a conflict between the doctor's personal and professional moral expectations; or new moral and ethical insights in response to the continual evolution and technological advances of medical science, are required (Jonsen, 1998; Wildes, 2002). Generally, there is an agreement that the added "problems" of biomedical technological advances and the increasing difficulty in the provision of healthcare to people have caused an increase in the number of conflicting ethical situations (Falco-Pegueroles, Lluch-Canut, Roldan-Merino & Goberna-Tricas, 2015). At the same time, these "problems" may also create personal moral conflict for the medical doctor.

Contemporary liberal democracies are made up of many cultural, religious, and philosophical traditions (Turner, 2004). Consequently, secularism, a product of and response to the many moral and religious differences (Turner, 2004; Taylor, 2007), as well as the pluralistic nature of modern society, has come to dominate current "Western" medical ethics. As a result, tension may develop between the plurality of religions and cultures, on the part of both patient and doctor, and the core values of ethical guidelines and expectations. Arguably, "Western" medical ethics, assumes that secularism is universally appealing, but the universalism that comes with secularism may contribute to conflict in moral and ethical dilemmas.

The terms moral and ethical are often used interchangeably. For the purposes of this research, and because I am dealing with personal and professional dilemmas, moral and ethical are two distinct terms and are not synonymous. Moral refers to personal character and the individual agent's principles and values that determine a right or wrong action. Ethics on the other hand refers instead to a social construct, that is, the rules or guidelines provided by an external source, for example, a professional or religious body, that provide codes of conduct for that

profession or that religion. These codes are adopted by members of that profession or religion (Gert, 2008).

Ethical or moral conflict not only affects professional moral integrity, but also has implications for personal moral integrity (Falco-Pegueroles et al., 2015). Questions arise around how physicians determine what they "ought" to do; how they "ought" to act and how this "ought" is rationalised and justified[1]. Further, how do doctors deal with a professional ethical "ought" that defies their morality? Is the rationale and justification for moral decision-making absolute for every decision, or is it dynamic or case-based? What considerations are factored into the decisions? In making these decisions, medical doctors are 'ultimately responsible for making their own ethical decisions' and for their implementation (Williams, 2015, p. 27). Ultimately, the big question is how the decisions are deliberated and justified.

1.2 Background Literature Analysis and Critique

It is premised that medical doctors make decisions both rationally and ethically in moral dilemmas; that moral theory forms the basis for the decisions; and that professional guidelines aid in the decision-making. Ideally, several normative sources are used to guide what "ought" to be done, but arguably, these "quandary" decisions are not solely decided or influenced by the various normative sources. External or non-rational factors such as context, intuitions, perceptions, relationships, emotions, and a personal morality also play a role in moral and ethical deliberation (Rogerson, Gottlieb, Handelsman, Knapp, & Younggren, 2011; Ten Have & Lelie, 1998).

The following literature review examines the normative theory and normative sources in bioethics. Potential influences, such as the roles of conscience and intuition, in moral and ethical decision-making are also explored.

1.2.1. Ethics, bioethics, and theory

Ethics is a branch of philosophy, sometimes referred to as moral philosophy (Moodley, 2017, p.2). Broadly, ethics is a term used to convey different perspectives, understandings, and examinations of the moral life (Beauchamp & Childress, 2013). Ethics and ethical behaviour have been an integral part of medicine since the time of Hippocrates (5th century BCE), who

[1] The 'is' and the 'ought' used in this research is not to be confused with the "is/ought" fallacy described in philosophy or with Hume's "is/ought problem" (Hume's guillotine). It is to be understood in the simplest sense, that is, the way things 'ought' to be and the way they are in reality ('is').

is regarded as the founder of medical ethics. Historical research into this era reports that Hippocrates' position was in fact a minority position. Even in ancient times there was ethical pluralism (Miles, 2004). Ethics provides a set of standards for how we ought to act in different situations. It is about moral choices: what we choose to do intentionally, our acts, omissions, and our failures to act (Devettere, 2009; Rosen, 2003). Ethics is pursued not as a development of rules to guide actions but rather as an explication of the good and the just (Svenaeus, 2018). Thus, ethics is also about justifying why we should act in a "good" way. Although ethics is about decisions, choices, and actions, not every choice is ethically significant. Arguably, the judgements and actions of concern in ethics are those that produce significant good or bad in the world (Devettere, 2009). Complex ethical choices are the acts and omissions that lead to conflict or controversy in ethics (Devettere, 2009).

The World Medical Association (WMA) describes ethics as the study of morality (Williams, 2015). In other words, it is the careful and systematic deliberation and analysing of moral behaviour and morality where morality refers to the value dimension of human decision-making and action. Ethics determines the "good" of an action: what an action "ought" to be in a particular situation. Morality is about putting the "ought" into action: "doing" the right thing. Ethics is not only about being aware of the intention of action but more importantly, questioning whether the action is the "right" thing to do.

Bioethics, as a field of philosophical inquiry, emerged in the 1960s and 1970s in response to the ethical implications of scientific and technological advances in medicine and medical research (Muller, 1994; Jonsen, 1998). Bioethics encompasses all ethics related to medical and biological practice and research. In response to a contemporary, secular, pluralistic society, particularist perspectives such as those prescribed in theology were considered inappropriate. The concerns of the collective whole, rather than of individual groups, had to be addressed (Wildes, 1994). To address these concerns, a universal bioethics, incorporating medical ethics, had to be formulated.

The emergence of bioethics stimulated inquiry into principles of right or wrong when applied to medical practice and within the clinical context (Muller, 1994). Callahan (1999) differentiates medical or clinical ethics from bioethics. For Callahan (1999), bioethics is dominated by medicine, law, and philosophy, albeit with discernible biases such as its heavily American origins. Clinical or medical ethics, on the other hand, aims at analysing moral problems and dilemmas of clinical practice and discerning the virtues appropriate for the

caring of patients (Callahan,1999). Thus, medical ethics is the specific discipline that knows how to implement and apply a well-defined set of theories and principles to a variety of [bio]medical problems that arise in the practice of healthcare and doctor-patient interaction (Ten Have & Lelie, 1998; Hoffmaster,1994). (This research is specifically concerned with medical or clinical ethics).

Social scientists have long criticised contemporary bioethics for its Western, mainly Anglo-American, origins (Fox & Swazey, 1990; Callahan, 1999; Muller, 1994; Turner, 2004). Arguably, because there is no universal consensus on a theory of right or wrong, bioethics and more specifically, medical ethics should be more than theory (Iltis, 2000). Medical ethics is not a science (Devettere, 2009). It is the study of the real-world implications and consequences of the judgements we make. Medical ethics is about the right choices, decisions, and actions in the clinical and professional context; the consideration of other influencing variables; and resolving cases in a justifiable way.

The goal and role of medical ethics is also about practical decision-making (Iltis, 2000). There is no universally agreed upon background moral theory, and as a result, reliance on moral theory would often make it impossible to justify moral and ethical "quandary" decisions to the relevant parties (Iltis, 2000).

Richardson (2018) also argues that bioethics is not about theory but about guiding actions. Bioethics, including medical ethics, prescribes rules for behaviour, and attempts to determine a set of principles and practices to meet the competing ethical challenges of a pluralistic democratic order. However, what is construed as ethical or unethical, reasonable or unreasonable, is dependent on a variety of normative commitments and background understandings of social reality (Bosk, 2010). Medical ethics should then propose a set of general principles, acts, and rights that guide physicians in ethically difficult situations to determine what they ought to do.

The morality of medicine is argued to be internal to medicine (Pellegrino, 2001). The vocation and values that brought the individual to the profession, the desire to do good and to help others, are practised within the profession. Ten Have and Lelie (1998) argue that modern medical ethics no longer focuses on the internal morality of medicine. According to them, the internal morality of medicine is secondary to the external morality of medicine. In other words, the morality of medicine lies in factors outside of medicine: societal and cultural

norms and values, as well as legal prescriptions, determine the "ought". Further, they argue that the primary role of medical ethics is to monitor, regulate, and control medical practice within this framework of social and cultural values (Ten Have & Lelie, 1998). However, because medical ethics is normative, it should not be confused with other determinants or prescriptions for moral decisions such as the law or religion (De Vries, Turner, Orfali, & Bosk, 2007).

According to the above descriptions, then, medical ethics is the matter of *knowing* what one *ought* to do in a clinical ethical dilemma, and morality is the matter of *doing* what one *ought* to do in that same situation. This raises the question of whether *knowing* and *doing* are always congruent. If one is learned and trained in ethics, does this lead to ethical behaviour? One may *know* what one ought to do in an ethical conflict, but one may not always *do* what one ought to do.

Devettere (2009) argues that in 'Western' culture, the major ethical theories fall into two groups. The first is theories of moralities of obligation based on law. The second is theories of the morality of behaviour- the good of the person performing the action. Currently, ethical theories and principles centred on obligation and duty, thus founded on moral principles, dominate medical ethics. These theories are normative and propose the application of principles, rules, and rights to particular situations in determining obligatory acts (Devettere, 2009, p.7 and 11).

1.2.2 Normative theory and normative ethics

Normative ethics is the study of ethical action. It is that branch of philosophical ethics that investigates and prescribes how one ought to act, morally speaking. Kagan (1998; p.2) proposes that normative ethics involves substantive proposals that concern how one ought to act, live, or what kind of person one ought to be, morally speaking. It examines the rightness or wrongness of an action. Normative ethics also seeks to justify the answers that are produced (Sulmasy & Sugarman, 2010). Medical ethics is normative because it sets down the norms for acting "right" and by implication for practising medicine, in the "right" way.

Several normative theories are used in the field of bioethics, for example, consequentialism and its subset utilitarianism, and Kantian deontology. Equally, several taxonomies categorise the various normative ethical theories (Arras, 2016; Marcum, 2008). One taxonomy divides normative theories into general and practical categories, where "general normative ethics

attempts to formulate and defend basic principles and virtues governing the moral life", as described in virtue ethics as an example (Beauchamp & Walters, 1999; Beauchamp & Childress, 2001 in Marcum, 2008, p.211). Practical normative ethics addresses the application and development of rules and guidelines to be used in daily medical practice (Beauchamp & Walters (1999).

Arras (2016) describes normative ethical theory as the most obvious example of bioethical theoretical work. It is a level of moral discourse, higher than the common sense or practices which prevail in the quotidian. This moral discourse is used to satisfactorily justify an individual's judgements or decisions as "right" or "wrong", especially where there is conflict or controversy (Arras, 2016). The theory leads to normative justification for action rather than explanation. What sets normative ethical theory apart from common sense and standard practice is the consideration of not only moral obligations, but importantly, also the consequences of the action.

Typical examples of normative ethical theory, such as utilitarianism, Kantian style deontology, and Rawlsian theories of justice (Arras, 2016), are higher-level theories which are not practical in the field of medical ethics, because moral and ethical decision-making in the clinical context is an immediate task. Consequently, the theories are better suited to policymakers, academic ethicists, and philosophers. Ethical decision-making in clinical quandaries is phenomenological, "in the moment", and does not enjoy the luxury of the prolonged deliberation, pontification, and academic debate that the higher moral theories entail.

Under normal circumstances, common sense and standard practice prevail when we judge our actions and decisions. Where there is conflict, controversy, or disagreement, we need to appeal to higher levels of moral discourse to justify our actions. We also have to consider moral obligations and consequences. Aside from prescribing the standard and scope of moral obligations and ethically permissible behaviour and policy, normative ethics also prescribes the kind of people we ought to be. For this reason and because this research is concerned with the conduct and agency of medical doctors in ethical and moral quandaries in the clinical context, I have used David Solomon's (2004) categorisation of normative ethics. This categorisation is based on the three key features of human action: agency, act, and consequences.

Agency is defined as having the will and capacity for intentional action. This will and capacity enable the making of an intentioned, reasoned moral judgement (Beauchamp & Childress, 2013, p.102). The character of the moral agent shapes the intentions and motives of any act and the consequences thereof (Solomon, 2004). For Solomon, these three features determine the following categories of theory: virtue, deontological, and consequentialist. Virtue theories deal with the agent and character of the person leading to the moral judgement; deontological theories deal with the judgements of action, and consequentialism deals with the consequences of that judgement.

The following literature review will briefly introduce virtue ethics, deontology, and consequentialist theory. Further, the "common morality" theories will discuss the aspect of universal ethical principles, and "Anti-theory" will elaborate on the 'is' in this research.

1.2.2.1 Virtue ethics

Virtue ethics is concerned with the quality of moral agency and the kind of person one wants to be. Virtue ethics 'holds that the character of the moral agent, the virtue [that] they have, is of fundamental importance to ethical conduct' (Jansen, 2000, p.262). Virtue ethics does not centre on the adherence to moral rules or values in particular contexts, nor is it concerned with the consequences of one's actions. Instead, it focuses on the kind of person one aspires to be. It concerns the virtues and traits the moral agent would have. In the medical sphere, virtue ethics involves the virtues of the doctor or the nurse and the kind of person or healthcare professional they would want to be. These virtues would include empathy, fairness, a commitment to the patient's good, courage, honesty, and technical skill (Pellegrino, 1993).

Pellegrino (2002b) argues that virtue ethics is a necessary complement to any other theory of ethics because of the "ineradicability" of the moral agent in the moral life. He argues further that the moral life of an agent should reflect all the principles, duties, and roles of ethics. Possible critiques of virtue ethics are that they are relative, limited, and have the potential for a conflict of virtues. Virtues are relative to the culture or ethical system that an agent subscribes to. One person's understanding of "good" may not be another's understanding of the same thing (Gray, 2019).

Also, some virtues are limited in application since they do not apply to all situations or every context. The role of virtues in modern medicine is secondary to roles and duties (Jansen, 2000). As a result, virtues are likely to be 'inadequate for medical practice and for resolving

medical dilemmas' (Reeves, 2002, p.960). Finally, in that situation where virtues conflict, both virtues may be appropriate and right, but it may be unclear which one should take precedence.

1.2.2.2 Deontological ethics

Deontological ethics is a duty-based ethical theory. It deals with choices, decisions, and actions regarding what is morally required, permitted, or forbidden. It is a moral theory that guides the actions we choose.

The source for deontological theories lies in rational law (Marcum, 2008). According to Marcum (2008, p.212), 'doing the right thing or avoiding the wrong thing is to perform one's duty or obligation by following an absolute rule'. This maxim applies regardless of the effects of actions on one's well-being or the effects our actions may have on the welfare of others. A person is doing good if they are doing a morally right action. Deontological ethics is different from virtue ethics because it centres on the act and what one ought to do, rather than the agent or kind of person one should aspire to be, as in virtue ethics.

Deontological ethics is non-consequentialist. It does not consider the consequences of actions. Instead, it considers whether an action is good or bad; right or wrong. The reason for the action, that is, the reason for the duty, defines its moral worth, rather than the agent's desire to achieve an end or goal.

Deontological ethics also recognises the worth and equality of all human beings. It helps to provide certainty where there is indecision, as it is preferable to do the right or good thing. However, it is a limiting theory, because it is not always advisable not to consider the implications and consequences of an action. Not all good or right actions result in good outcomes. This theory is also absolutist, and there is no middle ground. This lack of flexibility makes it challenging to use when one is faced with conflicting duties.

In his version of duty-based ethics, Kantian ethics, Immanuel Kant argued for the "Categorical Imperative". Kant argued that it was possible to develop a consistent moral system by using reason. For him, every rational person could reason for themselves what was right or wrong, without religious, cultural, or societal influences or thought for consequences. The "Categorical Imperative" was for Kant the supreme principle of morality. It is a rule or moral law that is true in all circumstances and directs one to act in certain ways regardless of

the goals one wants to achieve or what one's ends may be (Swindal & Spurgin, 2010). Kant's "Categorical Imperative" is absolute or unconditional for all agents, because the validity of a claim does not depend on any ulterior motive or end.

According to Johnson and Cureton (2019, p.1), Kant characterised the "Categorical Imperative" as an:

> 'objective, rationally necessary and unconditional principle that we must always follow despite any natural desires or inclinations that we may have to the contrary'

There are two most important aspects to Kant's categorical imperative: namely, the universalisability, and the end-in-itself formulations (Swindal & Spurgin, 2010). The universalisability formulation directs one to act according to the maxim that one can will that act to become a universal law. Maxims are principles of volition or guides to action (Swindal & Spurgin, 2010). A universal law is a law that applies to all rational agents. When one is determining an action, one must decide on the maxim and then let reason judge whether one can will the maxim to be a law for all rational agents to follow: a universal law. For Kant, personal preferences are not the issue. Instead, it is whether one's reason can will the universalisability of a judgement (Swindal & Spurgin, 2010)

The end-in-itself formulation prescribes moral rules as universal, and these rules should also recognise all human beings as free and equal members of a shared moral community. As a result, people should be treated with respect, always as an end, not as a means to an end, nor a means to achieve a desire, for example, by deceiving or coercing another person to gain something personally.

A weakness with duty-based ethics, especially Kantian ethics, is that it assumes universal moral rules. Other possible criticisms of deontological ethics are that it is very rule-bound or legalistic in its application (Beauchamp & Childress, 2013). It also under-emphasises relationships because it places a higher value on rules rather than persons (Beauchamp & Childress, 2013; Swindal & Spurgin, 2010).

Further, within this theory, there is no room for an accurate understanding of the facts of the case; no consideration for context, influencing factors or the alternatives and consequences of the decision. The theory also does not provide for conflicting obligations. Finally, it focuses

on the act rather than on the agent, giving only duty-based actions, and not outcomes of the actions, any moral worth (Beauchamp & Childress, 2013).

1.2.2.3 Consequentialism

Theories that hold actions as being right or wrong according to the balance of their consequences, either good or bad, are known as consequentialist theories (Beauchamp & Childress, 2013). The right action in a circumstance is that act which produces the best result according to that theory's account of value (Beauchamp & Childress, 2013).

This study will focus on utilitarianism, which holds the value of well-being either as pleasure, happiness, and welfare (as examples) as being important. The principle important to utilitarianism is the principle of utility. If only undesirable results can be achieved, this principle states that the maximal positive value over disvalue (or the least possible disvalue) should always be produced (Beauchamp & Childress, 2013). In other words, the value that provides the least harm overrules the other. The moral rightness of an action is produced by doing the greatest good for the most considerable number or by achieving the maximal balance of good consequences over harmful consequences. Thus, utilitarian theory determines which actions are right or good by referring to the consequences of the action rather than any moral features the action may have (De Grazia & Beauchamp. 2010). Essentially, it sees "good" as outcome based.

There are two schools of utilitarian thought: act utilitarianism and rule utilitarianism. The difference between the two schools lies in their attitudes towards the rules of universal morality. Act utilitarianism holds that an action is morally right if it produces the greatest good for the highest number of people. Rule utilitarianism maintains the moral correctness of an action is dependent on the correctness of the rules that allow for the attainment of the greatest good. Further, morality is beneficence-based and is seen in terms of promoting welfare (Beauchamp & Childress, 2013).

A problem with consequentialist theory is that there is no definition or universal consensus on the source of moral authority. An additional weakness in the method is that there may be no agreement on who or what determines the greatest happiness.

1.2.2.4 Common morality theory

Common morality theories are interested in the ultimate source of moral principles, rules, and ideals. A common morality is a morality that is shared by all people of goodwill. It is not merely a morality in contrast to other moralities (Beauchamp & Childress, 2013). It is a morality that is normative for everyone, everywhere, at any given time, and the standards apply to all judgements (Arras, 2016), and claims that all humans, in all places "see" certain moral requirements (Veatch, 2003). The core premise of a common morality is that all morally committed humans have a primitive, pre-theoretical awareness of certain moral norms (Veatch, 2003).

Further, all people, everywhere, at any time, share the primary objectives of morality. These objectives are: to relieve suffering; prevent premature death; and to obviate the foreseeable consequences of limited resources, hostility, or conflict (Arras, 2016). The moral authority for common morality is established historically and logically through the success of norms that alleviate the cause for human suffering. These norms are universally binding.

Common morality theories are pluralist because they include moral rules, principles, values, and ideals that are used to address many diverse consequentialist and deontological ethical concerns dealing with universal issues such as deception or killing (Arras, 2016). Arras (2016) describes two current, rival common morality theories, namely those of Beauchamp and Childress (2009), and Bernard Gert (2006). This research will focus on the "Common Morality Theory", known as the "Four Principles Approach", developed by Beauchamp and Childress (2009) because it is currently most influential, most frequently cited and, most familiar to many medical doctors (Garcia & Monlezun, 2015; De Grazia, 2003).

The term "Common Morality", as used by Beauchamp and Childress (2009), is used to distinguish the "universal" common morality from the particular moralities that are the result of societal, cultural, historical, or professional influences. Beauchamp and Childress' "Common Morality" is a 'pre-theoretic moral point of view that transcends local customs and attitudes' (Beauchamp & Childress, 2001, p.403).

The leading theory in the field of bioethics is principlism (Garcia & Monlezun, 2015). The promotion of certain principles given below is extremely attractive in the United States, according to Callahan (1999), and is becoming increasingly popular in other countries (Callahan,1999). The "Common Morality" is the source for the four bioethical principles of

autonomy, beneficence, non-maleficence, and justice (Beauchamp & Childress, 2009). These core principles are referred to by Beauchamp and Childress as universal norms and originate in commonly shared beliefs rather than the reason of deontology or in other high moral theory. This universality makes them accessible to and understandable by all people.
A problem with principlism is the assumption that the principles are universal. Devising universal principles ignores the intricacies of individual moral lives and social contexts (Callahan, 1999).

The four-principles common morality theory is also criticised for its potential for reductionism in the application (Callahan, 1999). In other words, one could reduce a dilemma to complying with the four principles, without holistic thought, deliberation, or reflective equilibrium for any other variable or consequence. While it appears to be a clear method for applying ethics and involves relative theoretical simplicity, it remains reductionist, because the four principles are thought to be sufficient to deal with ethical demands and quandaries (Callahan, 1999). Callahan (1999) argues further that the reductionist drive of principlism has had some negative effects. One of them has been to make ethical analysis appear easier than it is, which might explain its attraction to physicians looking for simplicity. Another effect has been obviating the deliberation of old and important ethical questions (Callahan, 1999) and the practice of looking at precedents.

De Grazia (2003) challenges the principles for being notoriously subject to conflict. He argues that while Beauchamp and Childress offer a solution to resolve a principle conflict, that is, that one should balance the principles and make the principles more specific (De Grazia, 2003), the moral reasoning in their model does not always move "downward" from more general to more specific norms. Further, he posits that this theory lacks coherence. Coherence is defined by De Grazia (2003, p.221) as being 'for the purposes of ethical theory and evaluation… the holistic embodiment of theoretical virtues, the characteristics one expects of any good theory'. It is about consistency and integrity. Because the common morality may be inconsistent, application of the method of reflective equilibrium may make the theory more acceptable, considering that in cases of conflict, reflection on concrete cases is used to revise or reject a more general norm.

The principles are also *prima facie* and thus are not absolute. They can be challenged by other ethical considerations. Thus, whenever the principles conflict, they have to be balanced

against each other to determine which one prevails in a particular situation. However, the principle of respect for autonomy is the main force in principlism (Callahan, 1999).

Also, current bioethical universalisms are Westernised (mainly American) and do not recognise the social and cultural differences that exist within and between societies and social groups (Engelhardt, 2012; Fox & Swazey, 2010; Turner, 2003) challenges the common morality hypothesis on the basis that it is not empirically supported cross-culturally. In order to justify any claims of a "Common Morality," Turner requires evidence that such a morality exists universally and consistently across all cultures. He argues that scant anthropological or historical evidence exists to support a theory of universal common morality (Beauchamp, 2003). Questions are raised around the inherency of the common morality and whether it is a product of moral socialisation. Further, where there is a moral conflict, what is construed as ethical or unethical is dependent upon several normative commitments and background understandings of social reality (Turner, 2004).

Bioethicists prescribe normative analysis but pay little attention to the diverse audiences that their arguments reach or how distinctive interpretive communities propose different criteria for evaluating normative claims. Thus, the four principles may not be universally applicable or meaningful and may be interpreted or perceived differently by different audiences or communities. Norms, values, and interpretations are not identical for all contexts nor all people. An example of this would be the principle of respect for autonomy or self-determination, which is the main force behind principlism (Callahan, 1999). In Western societies, this principle applies to the patient as an individual. In some non-Western or traditional societies, individual autonomy refers to the individual as part of a collective. It is not personal freedom or independence. The community or certain members of the group assist or need to be consulted in critical decision-making. Concepts of autonomy and self-determination are different in these contexts when compared to Western practice (Al-Saadoon & Al-Adawi, 2019; Guerrier, Sicard, & Brey, 2012; Gray, 2019). In pluralistic societies, understandings of moral obligation, reason, science, religion, and medicine are not individual or singular. The existence of a plurality of moral traditions means that moral matters are addressed, defined, defended, and evaluated from a diverse array of interpretive perspectives.

In contrast to common morality, particular moralities (or particularism) contain moral norms that are not shared by all cultures, groups, and individuals (Beauchamp & Childress, 2013). These moral norms are unique to particular cultures, societies, groups, or even individuals and

are distinguished by the specificity of their concrete, content-rich and non-universal norms (Beauchamp, 2003; Beauchamp & Childress, 2013). These particular moralities are not justified if they violate the prevailing moral standards or norms (Beauchamp & Childress, 2013; Gray, 2019).

1.2.2.5 Anti-theory

Since moral theory arguably universalises ethical dilemmas, processes that may be local or specific to certain people, whether patients or doctors, may be overlooked when resolving moral questions (De Vries, 2011; Gray, 2019). Hoffmaster (1990) proposes that ethical reasoning should focus on social practices [and context] rather than on the application of abstract moral theory. Not everyone shares the same concept of morality, nor are all contexts identical. Thus, a tension develops between the "ought" and the "is"- focusing on what one ought to be doing normatively rather than factoring in the reality, uniqueness, and influencing factors of different and individual contexts and cases.

Anti-theory is a position that opposes normative ethical theory (Clarke, 1987). It is critical of theory as the appropriate approach to ethics (Adorno, 2011). This stance is a response to the dissatisfaction with the weighted role given to notions of duty and obligation in some contemporary accounts of morality. Anti-theory objects to the reduction of morality to compliance with a set of abstract rules. It calls for a more realistic, comprehensive vision of morality, and for the consideration of diversity (Gray, 2019) and conflicting ethical perspectives (Genuis & Lipp, 2013).

Anti-theory is critiqued for not recognising that ethics cannot be explained or justified without appealing to concepts, rules, and abstraction. Little (2001, in Adorno, 2011, p.42) argues that the objections made by anti-theorists are often 'objections to an impoverished moral theory, not to moral theory *per se*'. This objection implies that more depth is needed in moral theory. Ideally, an ethical approach is required that considers the deliberations and extraneous variables that present in daily moral quandaries in the clinical context and is able to bridge them with rational moral theory. Examples of anti-theory practices are casuistry and moral and ethical intuition.

Casuistry became unpopular as a moral or ethical approach in the 17th century, but was revived in 1988 by Jonsen and Toulmin, as a 'neo-casuistry' (Garcia & Monlezun, 2015). The term, casuistry, here refers to this neo-casuistry: it uses inductive reasoning rather than the

top-down approach of high and mid-level theories (Beauchamp & Childress, 2013, p.398; Garcia & Monlezun, 2016). Casuists reject moral theory and general principles (Turner, 2004). Iltis (2000), describes casuistry as the ethical analysis of cases, using paradigm cases to determine how and when to apply moral rules to particular situations. In its modern form, casuistry is an 'applied ethics approach'. The theory uses case comparison and analogy or case-based reasoning to achieve ethical convergence from the pluralistic stakeholders in the form of expert opinions in paradigm cases (Garcia & Monlezun, 2015).

Casuistry also claims that familiarisation of the facts of particular situations, as well as the historical facts of similar cases, make for the right moral judgements. While not disregarding absolute or foundational theories and principles, casuists maintain that theories containing rigid universal principles are limiting and unnecessary. According to casuists, moral beliefs, reasoning, and decisions are possible without referring to ethical principles or moral philosophy (Beauchamp & Childress, 2013).

There are three essential steps to casuistic reasoning. The first is gaining insight into, or having an understanding of, the subjects under consideration, where the case is contextualised; highlighting the aspects of the moral dilemma; and the evaluation or balancing of the principles involved. Secondly, there is case comparison, where cases are compared to previous paradigm cases and analogical reasoning is used to compare the similarities and dissimilarities of the present case with the paradigm case (Jonsen, 2010; Garcia & Monlezun, 2016). Finally, the moral judgement is agreed on through inductive reasoning and moral intuition, with consideration for the historical and sociocultural context of the past paradigm precedent and the present context sociocultural influences of the present case (Garcia & Monlezun, 2015).

Historically, casuistry was castigated because arguably, it led to moral relativism and laxity. It was also criticised for its failure to base case reasoning on a solid foundation. Casuistry can also become problematic when a case is used, without unique consideration, deliberation, and use of conscience, as a general precedent for new cases (Jonsen & Toulmin,1988). As a result, the individual components and "uniqueness" of each case are not considered in judging the case on its merit. It is also uncertain how a particular case is determined to be paradigmatic, and which aspects of the case are morally relevant.

1.2.3 Phenomenology and phenomenological bioethics

Phenomenology is a philosophical tradition more than 100 years old. It explores and answers philosophical questions by analysing "lived experiences" (Svenaeus, 2018, p.1). Phenomenology became part of bioethics through the philosophy of medicine and the medical humanities. According to Braude (2013), Richard Zaner was the pioneer behind the application of phenomenology in the medical realm: Zaner found medicine, because of its relationship with biological and social life, a field for phenomenological reflection. The starting point for phenomenology is not in the scientific realm but in the meaning structures of the quotidian (Svenaeus, 2018). According to Svenaeus (2018), there are three different understandings of phenomenology in medicine: as the "thick" descriptions of experiences and situations of importance; as a lesser-known descriptive research programme in philosophy, that incorporates theory and concepts; and as a qualitative research method, where the researcher aims to give voice in an unbiased way to the experiences of research subjects. Phenomenology can contribute to applied ethics by providing careful and adequate descriptions of the context in which the principles are to be applied.

Phenomenological bioethics is that part of the phenomenology of medicine and clinical practice that deals with ethical and moral dilemmas that arise in the clinical context when dealing with the sick or dealing with medical-technological quandaries involving human bodies and their parts (Svenaeus, 2018). Phenomenological medical ethics studies the lived experiences of moral quandaries that are to be determined by the application of *prima facie* principles that have their roots in ethical theories.

No phenomenon occurs in isolation. Phenomena are always embedded- temporally and spatially- in a context that makes it possible for the experience to be significant (Svenaeus, 2018). As described previously (p.6), medical ethics is not a science (Devettere, 2009) and as such is hermeneutically variable and open to interpretation. Devettere (2009) argues further that it is also the study of the implications and consequences of the choices, decisions, and actions in the professional context. Medical ethics also studies the influence of external variables and is about justifying the decision made. In this regard, phenomenology can also play a role in reflective equilibrium where moral intuitions are taken into account (Arras, 2007).

Traditional phenomenological moral theories may have different emphases, but they are all united in questioning what "ought" to be done (normative principles) and what "is" done (the situation if and where principles are applied in moral and ethical deliberation).

In principle-based medical ethics, the central notions are phrased as *prima facie* principles that are applied in morally problematic situations in order to reach a moral decision (Beauchamp & Childress, 2013). In the context of medical ethical practice, investigations of the lived experiences of persons involved in morally problematic situations are necessary in order to understand how the main principles of medical ethics will apply.

In the process of applying ethical principles, there is a mutual process of elucidation and interpretation. In the process of balancing the understanding of the case, and the principles to be applied to it, phenomenology can take on a more important role than merely providing the details of the case. Phenomenology may be regarded as an attempt to set up medical ethics by way of alternative principles, or in a manner that is not understood as a procedure for the application of principles in the first place (Welie, 1999).

In applied ethics, phenomenology can provide careful and full descriptions of the context in which principles are to be applied (Svenaeus, 2018). Phenomenology can be used either to inform the application of principles or to criticise the contemporary setup of bioethics and offer alternative approaches. Phenomenological bioethics can be carried out as an integrated part of a critical outside perspective on principle-based ethics. It can also be used either to inform an application of ethical principles by way of describing the lived experiences of moral dilemmas, or to critique the current setup of bioethics and offer an alternative approach (Svenaeus, 2018) .

1.2.4 Moral and ethical decision-making in the professional context

Bioethicists, within the philosophical and normative tradition, have recognised and accepted diversity within modern society. As a result, they have formulated principles held to be "universalistic": to protect patients; to enable the doctor to act in the "best interests" of the patient; to protect patient rights, and to prevent ethical conflict. However, these formulations are one-sided as they have failed to address the plurality and diversity of the cultures, religions, and traditions of the decision-makers (Pellegrino, 2001).

Currently, medical ethics, as a subset of bioethics, is dominated by ethical theories centred on obligation and duty based on moral principle. However, moral and ethical decisions in the clinical context are often made "in the moment". They are not decisions made in vacuums.

These decisions are made in the lived clinical encounter with the patient. They do not allow for extensive deliberation, debate with colleagues and peers or, as may happen in some institutions, review by an ethics committee. Equally, those making the decisions are expected to draw on the "oughts" of moral theory and apply them to the "is" of the situation they are confronted with (De Vries, 2011). At the same time, medical doctors are also held accountable for the decisions they make in these moral and ethical dilemmas.

Medical ethical decision-making involves more than the evaluation of options and the enactment of choices in response to one's understanding of a moral quandary (Hunt & Carnavale, 2011). Medical doctors working in pluralist, secular societies are involved with people of differing beliefs and value systems. The values people hold may share similarities, but they may also conflict. Individuals regularly face value conflicts in the different aspects of daily life, for example, in the spheres of religion and science or politics, which intersect within their personalities, social lives, and professions.

Medical moral and ethical decisions are complicated even further when decisions are made and influenced at various levels, namely, the individual or personal level, the professional or institutional level, and finally, at the public or social level. How is it determined which level takes precedence?

Making a value judgement or deliberating an ethical or moral dilemma in the clinical context requires the person making the judgement to acknowledge a value or moral conflict. There is an added difficulty in the professional clinical sphere, where personal and professional values may conflict. For the medical doctor, personal morals or values may directly influence the treatment of patients, either because of a difference in values between the doctor and patient or because there is a conflict between the doctor's personal and professional values. An important consideration is whether medical doctors should act following their values or adapt their behaviour in keeping with the particular moralities of their profession (Dhai, McQuoid-Mason & Knapp van Bogaert, 2011).

The World Medical Association (WMA) Medical Ethics Manual (3rd edition) states there are two different ways of approaching moral quandaries: the rational and the non-rational (Williams, 2015). Non-rational does not mean irrational. It is distinguished from rational because it is a process that is contextual and considerate of social relationships rather than "systemic and reflective reasoning" (Williams, 2015, p.27).

Non-rational decision-making is a moral experience that is about more than laws, principles, and ethical guidelines; it is also about processes (societal, interpersonal, and personal) that realise values in ordinary living (Kleinman, 1999). Non-rational approaches are not always reasoned normatively and consequently may not always include an "ought" (Williams, 2015). These approaches include the following processes: obedience (adhering to or following instructions or rules without question or critique); imitation (where one follows the examples set by mentors, peers, or role models); feelings or desires (subjective); intuition; and finally, habit (good or bad) (Williams, 2015).

Rational decision-making, on the other hand, involves the use of traditional ethical theories, principles, and professional guidelines (Williams, 2015). While medical ethics recognises and accepts the prevalence of the use of non-rational approaches in decision-making and behaviour and does not disregard these approaches, it remains primarily concerned with rational methods and the normative justification of a resolution.

Overberg (1998) advocates a "discerning" approach to moral decision-making. This approach combines the value and wisdom of law [and ethical principles] with the uniqueness of concrete situations; it is rooted in reality, and thereby avoids relativism. Overberg (1998) argues that by recognising and accepting the significance of a case, one prevents blind adherence to the law [and ethical principles].

To make a moral decision, one should examine the total reality of the dilemma, that is, the context, the intention, implications, and consequences of the action for all involved. One should also consider the potential for the decision ultimately becoming generalisable. Further, when values conflict, they often cannot be resolved without extensive consultation with peers, colleagues, and experts. Finally, the effect of cultural influences on the judgement and wisdom of past experiences as embodied in law [and ethical principles] should be considered.

Moral and ethical conflict appears to be an obstacle to successful quandary resolution. To this end, it would be useful to understand what a moral or ethical dilemma is.

1.2.5 Moral matters, moral experience, moral dilemmas, and moral distress

'Moral matters are rooted in a person's moral ontology' (Hunt & Carnavale, 2011, p.659). In other words, the moral beliefs and convictions that one possesses are inherent and implicit. The moral life of a person is shaped by historical, cultural, and social processes, in addition to the moral experiences of local networks, neighbourhoods, and communities (Hunt & Carnavale, 2011).

Pellegrino (2001) describes medical doctors as having both a personal and professional morality. Personal morality may have its origins in sources external to medicine. This morality may describe the moral character of the person before becoming a medical doctor and appropriating a professional morality. The result is a duality of moralities: a morality intrinsic to the nature of the person, and a morality fundamental to the professional. In the professional space, professional morality is expected to take priority. Sometimes though, the context of the ethical dilemma or the strength of the influences of personal morality may produce dissonance between the values of the medical doctor, the expectations of the patient, and professional normative prescriptions.

The moral experience is a personally interpreted lived encounter, or a set of lived encounters (Hunt & Carnavale, 2011). It encompasses every person's sense of values that they deem important, being realised or thwarted in everyday life (Hunt & Carnavale, 2011) These encounters would fall on the spectrum of being right-wrong; good-bad; or just-unjust.

Moral and ethical conflict can occur both within a person or between people. In the clinical context, this conflict can occur within the doctor, where there is tension between personal values; between personal and professional values; or between professional values. It can also occur between physicians and their patients, colleagues, or others in the clinical or professional space, or institutional or organisational structures. In these situations, the desire or obligation to "do good", or enact what one "ought" to do, becomes central to the ethical conflict. The ethical conflict has negative consequences for professional moral integrity as well as for personal moral integrity and ethical well-being (Falco-Pegueroles et al., 2015). The preservation of personal integrity is imperative for the well-being of the doctor and the care of patients. Breaching personal integrity has implications for both the doctor and for the

practice of medicine, as manifested for example, in cases of moral distress or moral disengagement.

In his seminal study conducted on nurses caring for individuals or groups, the philosopher Andrew Jameton (1984) described three types of ethical conflict: moral uncertainty, moral dilemma, and moral distress.

Moral uncertainty occurs when an individual intuits a conflict of ethical values or principles but is unable to identify the values or ethical principles involved, thus preventing appropriate moral or ethical decision-making (Falco-Pegueroles, et al., 2015).

A moral dilemma occurs when two ethical principles are involved in the making of a decision, each of which offers a different course of action, both good but only one acceptable. In this case, either of the principles may be morally correct '*a priori* but at different extremes of morality, thereby making it difficult to choose between the two' (Falco-Pegueroles et al., 2015, p.2). Thus, the moral dilemma is a complicated circumstance involving a conflict of values. Ultimately, the solution to this conflict is to sacrifice one of the values (Falco-Pegueroles, et al., 2015).

Jameton (1984, p.6) describes the phenomenon of moral distress as '[arising] when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action'. Thus, moral distress is when there is difficulty acting according to one's morality due to an external barrier. Perni (2017), adapting Jameton (1984), elaborates moral distress as occurring when a clinician makes a moral judgement about a case in which [they] are involved, and an external constraint makes it difficult or impossible to act on the judgement, resulting in 'painful feelings and/or psychological disequilibrium'. Thus, the agent is conscious of the values and ethical principles involved in the situation; can identify the action best suited to the situation; but is unable to act because something or someone external prevents the agent from doing so. Essentially, the agent is unable to translate the moral decision or preferred "good" option into moral action (Falco-Pegueroles, et al., 2015). (Moral distress is elaborated on in Section 1.2.6)

Moral disengagement is an adverse effect of moral distress (Perni, 2017). Moral disengagement occurs when agents remove or distance themselves from accepted ethical standards of behaviour and engage in new unethical behaviours. The new behaviours are

justified on the basis of some perceived extenuating circumstance (Knoll, Lord, Petersen, & Weigelt, 2016).

Similar to the ideal state described in virtue ethics, the morally perfect state exists where there is an absence of ethical or moral conflict, leading to ethical well-being. It is a positive state, where the agent displays congruence between thought and moral action. In this state, the professional and personal values, principles, and ethical responsibilities are assumed. The agent feels morally respected and recognised by others and is involved in the making of decisions. This ethical well-being is different from the experience of an absence of conflict due to moral indifference (Jameton, 1984).

Moral indifference describes the absence of conflict as a result of a lack of responsibility and sensitivity. It implies the lack of inclination or a disinclination to questions of an ethical nature. When applied to the clinical context, moral indifference suggests a failure to assume the ethical responsibilities of the profession, resulting in a passive state that calls into question the moral integrity of the individual and threatens the obligation to protect the vulnerable patient (Jameton, 1984).

1.2.6. Moral distress

As described above, for Jameton (1984; 1993) moral distress is a constraint of moral agency, where agency, as the ability to think, act and be accountable for actions taken, is hindered by external (institutional) or internal (personal) factors. More recently, Thomas and McCullogh (2015, p.102) describe moral distress as 'the judgement that one is not able, to differing degrees, to act on one's moral knowledge about what one ought to do'. They do not specify a constraint, merely indicating that individuals, for whatever reason, are impeded from acting on their moral knowledge in a situation that requires normative action.
Sometimes, moral distress involves a judgement where one has violated a core value commitment, failed to fulfil an important moral obligation, or, in some other way, fallen short, morally or ethically, consequent to the constraint (Carse & Rushton, 2017).
Carina Fourie (2015, p.92) contributes to Jameton's definition of the phenomenon by adding the manifestation of moral distress as:

> '... a psychological response to morally challenging situations such as those of moral constraint or moral conflict, or both'.

She specifies the distress as consequent not only to a moral constraint, but also to moral conflict, or both moral constraint and moral conflict. As more research has been conducted on the moral distress phenomenon, Fourie (2017) argues that because Jameton limits his definition to a moral certainty and a constraint (*moral constraint distress*), his definition is too narrow and should be broadened to include other morally challenging situations. These would include situations of not only moral conflict and moral dilemmas, but also moral uncertainty, which she terms *moral uncertainty distress* (Fourie, 2017).

There are two phases to moral distress; initial moral distress and reactive moral distress (Jameton, 1993, p. 544; Wilkinson, 1988). Initial distress occurs when individuals are prevented from doing what they perceive as the right thing to do, by institutional obstacles or interpersonal value conflict. It is expressed with feelings of frustration, anger, and anxiety (Jameton, 1984, p.544).

Reactive distress occurs when moral agents do not respond or act on their initial experience of distress. Reactive distress is experienced as powerlessness, guilt, self-criticism, or low self-esteem or with symptoms of sleeplessness, loss of sleep, or nightmares (McCarthy & Deady, 2008).

Thus, from both the initial and expanded definitions, it can be deduced that the defining elements of moral distress are :

- There is moral knowledge; one knows the right thing to do and therefore there is moral certainty.
- A constraint or impediment prevents the perceived appropriate action. The constraint may be the result of internal or external factors.
- There are two phases of distress: the initial distress which happens at the moment of the experience; and the reactive distress, which occurs later in response to the initial experience. The distress manifests psychologically or emotionally.
- Moral distress compromises the agent's moral integrity, violates one's core values, or threatens one's identity (Campbell, Ulrich, & Grady, 2016; Fourie, 2015).
- It is a morally undesirable or challenging situation.

While some authors support Jameton's definition of moral distress with the two criteria of moral judgement and action constraint (McCarthy & Monteverde, 2018), current literature largely critiques Jameton's concept of moral distress as being too narrow, too vague, and too

similar to other concepts such as conscience (Jameton, 2017). While the moral component and emotional and psychological response are acknowledged, the narrowness is seen in Jameton's criterion of "constraint". For example, it ignores a "moral intuition", where an agent may intuit or sense a moral wrong, but then may have uncertainty about "how, when, why or which" rule, law, or principle to apply to the problem.

1.2.7 The process for moral and ethical decision-making

Moral and ethical decision-making should be considerate of principles, ideas, emotions, values, beliefs, and context. However, the "ought" of human conduct is dependent on three factors: consciousness, wilfulness, and accountability (Fagothey, 1959). Consequently, ethical and moral deliberation should be the foundation of any adequate decision-making methodology. Although moral and ethical quandary decisions should be made reasonably, i.e., guided rationally by normative sources, the role of non-rational factors, such as intuition, conscience, and context, also needs to be considered. In the clinical context, this consideration is especially true of the doctor's interaction with the patient. In this context, decisions may be influenced intrinsically by factors such as personal feelings, values, and beliefs, and extrinsically by factors such as context, patient and the patient's family expectations, financial constraints, and available resources.

Several guides to the process for moral decision-making exist in the literature, for example, the seminal 'Four Box' or 'Four Topic' method described by Jonsen, Siegler and Winslade (2015). While others have also been described, the methods share the following common features: identification of the moral or ethical problem; gathering of the facts; determination of the implications and consequences of the desired action; checking for biases (religious, cultural); and then the ethical or moral justification for the decision.

To discuss this in more detail, I draw on Moodley (2017) because she describes her process specifically for decision-making in ethical *dilemmas*. Moodley's (2017) stepwise process elaborates on several considerations in each stage of the deliberation proces. The first step involves the recognition and articulation of a moral dilemma. Beauchamp and Childress (2013) describe this as 'circumstances in which moral obligations demand or appear to demand that a person adopt each of two or more alternative actions' without being able to perform all the required alternatives (Moodley, 2017, p. 184).

The second step requires the establishment of all the facts pertinent to the case, specifically, scientific and medical information; legal positions that may influence outcomes; and finally, ethical questions. Normatively, Moodley uses the Four Principles approach described by Beauchamp and Childress (2013).

To address the second step *medically*, Moodley uses a "four-quadrant approach" adapted from the curriculum in medical ethics, courtesy of Dr Eugene Bereza, family physician/clinical ethicist, Department of Family Medicine, McGill University, Canada. This approach allocates a quadrant to each of the following: clinical indications; patient preferences; quality of life; and contextual features.

Step Three requires an analysis of the information obtained. Step Four asks for the formulation of potential solutions and recommendations. Finally, Step Five involves the implementation of policies and guidelines to guide future dilemmas.

Arguably, there are at least four obstacles to moral and ethical decision-making in clinical practice. These are time constraints; the lived decision-making process; potential ethical or moral conflict; and non-rational influences such as conscience, intuition, and context. Sufficient time is necessary to deliberate appropriately in order to make a decision; but to take excessive time over the decision is not always practical in the clinical context. In the real-life clinical encounter, where one is faced with a patient requiring a "now" decision, there is no time to refer to or reflect on moral or ethical theory. The decision-making process should ideally follow a practised, reasoned, logical method that allows for organised thought, reflection, and conclusion.

The respective roles of conscience, intuition, emotion, and context in decision-making are factors that may also contribute to internal conflict.

i) The role of conscience

The literal meaning of the word conscience, derived from Greek and Latin etymology, is "with knowledge" (Genuis & Lipp, 2013, p.2). The act of conscience in medicine is controversial because there is no consensus on what conscience is (Lawrence & Curlin, 2007). According to the Abrahamic traditions, conscience is divinely constructed, and we act according to what we believe (Lawrence & Curlin 2007). However, in the secular world moral law is not divine, and the sources for moral law differ among the secular traditions,

meaning that moral obligations are constructed rather than discovered (Lawrence & Curlin 2007).

Conscience is described broadly by Callahan (1991) and Sulmasy (2008) as a psychological activity that is personal and self-conscious, and that integrates reason, emotion and will in self-committed decisions about right and wrong, good and bad. The most succinct description of conscience, according to Birchley (2012) in Genuis and Lipp (2013, p.2), is that it 'involves a moral decision-making faculty, influenced by a rational perception of the observable world which is both reflective and reflexive'. Reflective refers to the scrutiny of past, present, and future decisions. The reflexive aspect is enacted instantly in the form of internal discomfort or dissonance when one has to choose an action or decision that does not agree with one's values (Genuis & Lipp, 2013). This is very similar to the previously described moral distress.

Traditionally conscience has been used to explain our inherent inclination to act morally. It originates in the commitment to be moral and the ability to determine whether a deliberated act would violate that commitment (Sulmasy, 2008). Conscience concerns an individual's own moral beliefs, be they spiritual, philosophical, or cultural (Pellegrino, 2002b; Genuis & Lipp, 2013). A person's conscience 'establishes a felt need or disposition to act in accordance with knowledge or belief, giving him a sense of internal failure, frustration or guilt, when through some fault of his own, he fails to do so' (Fuss, 1973; Sulmasy, 2008; Wicclair, 2011, p.65).

The preservation of moral integrity necessitates any conscientious person acting in accord with the dictates of their conscience (Pellegrino, 2002b). The physician's conscience is formed, in both professional and personal capacities, by convictions about wrong or right acts (Pellegrino, 2002b). The potential for professional conflict of conscience occurs in two aspects of the physician's daily work: firstly, concerning the ethical appropriateness of actions and duties implicated in the doctor-patient relationship; and secondly, in the moral obligation to practise scientifically sound, humane, and contemporary medicine (Pellegrino, 2002b). Fuss (1973) describes conscience in the healthcare setting as being rooted in a fundamental responsibility to consider all situations within a framework of ethical obligation. Further, this responsibility should lead to judgements and reasoning about actions and behaviours that would characterise a moral life.

Conscience is not infallible and can direct the individual incorrectly, resulting in errors of judgement. Historically, most moral philosophers conclude that an erring conscience is binding. If the conscience is derived from the fundamental moral commitment to choose the right and the good, one is obligated to inform the conscience appropriately in order to do the right and good (Overberg, 1998). One is only culpable in those cases in which one has failed to inform the conscience, resulting in an errant decision (Overberg, 1998).

Factors that may affect and influence conscience are extremes of emotion; irrational reasoning or poor judgement; ignorance of important facts or the appropriate moral rules; or one's self-identifying moral commitments (Overberg, 1998).

Genuis and Lipp (2013) argue that to perceive conscience as a mystical intuition based on emotions, feelings, and preferences, is reductionist. Instead, conscience should be understood as a representation of the decision-making capacity of the human mind. This representation is based on the desire to live a virtuous life that represents good for oneself and others (Sulmasy, 2008).

Genuis and Lipp (2013) also propose that along with diminishing respect for the wisdom of both individual conscience and personal ethical conviction, doctors are also coming under increasing pressure from sources external to clinical healthcare (law, politics, bioethicists, institutions and third-party payers) to act unquestioningly following peer standards and professional governance. Thus, while acting in good conscience based on ethical or moral conviction may represent personal moral integrity to the physician, this may be seen as unprofessional by others because it does not comply with professional prescriptions or the dictates of those in authority (Genuis & Lipp, 2013). Most people consider themselves moral agents and would want to do the right thing. They have concerns about what they ought to do and feel guilty when they feel they may have done the wrong thing or acted against conscience.

To suggest that there is anything more important to moral life than conscience, whatever the source, is almost impossible (Sulmasy, 2008). We should, therefore, act according to our most deeply held moral beliefs as something that comes to us intuitively.

ii) The role of intuition

Conscience is commonly understood as an intuitive moral sense that determines whether an action is right or wrong (Sulmasy, 2008). However, intuitions are not acts of conscience, but rather, of moral knowledge (Sulmasy, 2008). Arguably, most moral judgements are made unconsciously and through an automatic, intuitive process (Gazzanigga, 2006, p.172).

Intuition is defined as the 'ability to know or understand something immediately without conscious reasoning or being taught' (Oxford Everyday Dictionary, 2005).

Personal experiences make us aware as human beings that we have immediate and instinctive emotional reactions to different situations. Sometimes, behaviours, observations, or actions, can just "feel" right or wrong. The absence of scrutiny or justification for these feelings does not negate the 'intractably personal nature of a moral conviction', which is taken by many to be a sure sign of their validity (Scott, 2011, p.5). Fricker (1995) suggests moral intuitions are the result of previous moral experiences and are consequent to the lessons learned from these past experiences, social conditioning, and moral upbringing.

Some argue that moral intuitions may be subjective, relative, and ethically biased (Scott, 2011). They cannot be relied upon, no matter how convincing they are to us. They are irrational feelings and may be nothing but the products of 'prejudice, selfishness or cultural conditioning' (Rachels, 2012, p.10).

Shaw (2001), on the other hand, contends that at the very least, even where these intuitions are not right, they are consistent with a widespread view of what is right. Scott (2011) argues that more weight should be given to intuitive judgements and challenges the supremacy of normative theories. Accordingly, this weight would also avoid the reduction of the various elements that create ethical dilemmas to fit within "cumbersome" normative frameworks, ethical theories, and principles (Cowley, 2005).

In every quandary situation, there are two fundamental factors: the reality of the situation accompanied by a sense of right or wrong, good or bad; and the fact that our actions shape us, who we are, and who we become (Overberg, 1998). Thus, if we reason or intuit that an action is not good or will not have a favourable outcome, will cause harm, or is not in the best interest of another, we should, as reasonable or rational persons, intervene or act appropriately (Overberg, 1998).

The apparent discrepancy between normative theories and moral intuitions may be explained by accepting that our common morality functions within the real world (Elliot, 1992), is a lived experience, and does not function within a theoretical vacuum. Arguably, the resolution of real ethical problems should not be solely dependent on normative sources. To ignore or fear moral intuitions would be to overlook the valuable social perspectives they may provide to the ethical deliberations in progress.

The problem with intuition or act intuition as a theory of ethics is that intuitions differ in ways that cannot be explained, nor challenged (Sulmasy, 2008). Sulmasy (2008) argues that if intuition has a role in moral decision-making, it would be at that level of moral knowledge, known as *synderesis.* Synderesis may be innate and may occur when one absorbs the most basic and primary principles of moral action through social conditioning, and these are then habitually imprinted on the mental or intellectual faculty (Sulmasy, 2008).

Synderesis or more correctly, synteresis, is a term used by academic theologians to describe the habitual knowledge of universal practical principles of moral action (Sulmasy, 2008). Synteresis is different to conscience in that conscience is the 'dictate' or edict of practical reason and decides whether an action is right or wrong. Synteresis is the decree of 'sane reason' where an action is decided by the primary general principles of moral action. An example of a first principle of moral action is "evil must be avoided, good done" (Catholic.Encyclopedia. newadvent.com, 2020).

Intuition is also described as the first step in moral and ethical deliberation. Intuition alerts the agent that there is an event which ought to be evaluated morally and ethically.

iii) Emotion

Traditionally, clinical decision-making has been thought of as a purely rational and cognitive process (Kozlowski, Hutchinson, Hurley, & Sutherland, 2017). Emotion, loosely defined as a mental state, was not thought to influence clinical decision-making. However, recent research has shown that it does influence a physician's clinical decision-making (Kozlowski, et al., 2017). If emotion does play a role in clinical decision-making, then emotion would most likely also play a role in moral decision-making in the clinical context.

Beauchamp and Childress (2013, p.35) argue that the use of the word *care* in descriptions such as healthcare or medical care implies that caring is a prominent feature in the practice of medicine. It is a virtue, and forms part of an aspect of virtue ethics called *ethics of care*, where *caring* refers to an emotional commitment to act on behalf of another and *caring for* is expressed in those actions (Beauchamp & Childress, 2013, p.35).

Beauchamp and Childress (2013, p.35) elaborate further that healthcare professionals' trustworthiness, quality of care, and sensitivity in patient care, are vital to their professional moral lives. Compassion is one of the five focal virtues important in healthcare (Beauchamp & Childress, 2013, p.37). The others are discernment, trustworthiness, integrity, and conscientiousness.

This literature review focuses on the virtue of compassion because it is an emotion. As described by Beauchamp and Childress (2013, p. 37) 'the virtue of compassion combines an attitude of active regard for another's welfare with an imaginative awareness and emotional response of sympathy, tenderness, and discomfort at another's misfortune and suffering'. It is expressed in acts of beneficence and aims at relieving the suffering and misery of others.

Arguably, physicians who lack the appropriate display of compassion in their behaviour towards their patients (emotional disengagement), not only fail to provide what their patients need most, but also have a moral weakness (Beauchamp & Childress, 2013, p.38). However, appropriate, rational judgment in moral and ethical decision-making in the clinical context may be clouded by compassion.

Thus, compassion (emotion) can either enhance the professional caring relationship or it can have a negative effect, where it can blind reason and prevent rational, 'impartial reflection' (Beauchamp & Childress, 2013, p.39). However, Callahan (1988) argues that emotions are important in ethical and moral decision-making in that they promote and inform ethical deliberation. The antidote to too much compassion is some emotional detachment. However, ideally a balance has to be found between emotional engagement and emotional detachment to enable clear, rational decision-making.

iv) Context

For social scientists, moral decision-making is contextual. For medical doctors, moral dilemmas and consequent decisions occur in the clinical setting and are contextual, moral and

ethical. The clinical encounter is defined by Svenaus (2018, p.15) as: ‘an ethical event to the extent that a suffering person presents her ailments, and the healthcare professional is under obligation to help’.

This definition describes only the clinical encounter between the doctor and patient, and with it the doctor’s obligation or duty to help. However, this particular ethical event encompasses much more than a professional medical consultation. Svenaus (2018); Pellegrino and Thomasma (1993) posit that further to the obligation or duty to help, empathy is a central and necessary skill along with other virtues. However, this definition is not mindful of other variables that may influence any moral or ethical decisions that may have to be made in that interaction, such as cultural, economic, or social factors.

Ethical dilemmas in the clinical context need to be analysed from the perspective of the encounter with the patient, and not merely as a set of moral choice situations in which medical doctors merely inform patients, respect their desires or deliver medical services in just and fair ways (Welie, 1999 in Svenaus, 2018, p.55).

Empirical research is necessary to assess what processes or methods medical practitioners use in resolving moral and ethical dilemmas in the clinical context.

1.2.8 Context in medical ethical decision-making

Bioethics and its claims are dynamic and dependent on the circumstances and era where the claims are made (Turner, 2004). Context is the term used to describe each ethical dilemma as unique with its characteristics and non-generalisable facts.

When making a moral decision, only an understanding of the reality of the situation and its particular circumstances, including the intentions and consequences, can produce a moral resolution (Overberg, 1998). The context of a medical moral dilemma requires specific practical clinical experience which enables the medical practitioner to act accordingly. Experience in actual clinical practice, in the first-person perspective, not hypothetical situations, enables practitioners to address the problems they encounter (Jonsen & Toulmin, 1988). As a result, any attempt at resolution should be appropriately focused on the specific case being dealt with at the time. An understanding of all aspects of the medical situation increases the possibility of positive solutions to medical ethical quandaries. The positive solution would encompass personal and professional accountability.

Each patient, their expectations, and what they bring to the clinical space, as well as each doctor, their morality and what they deliver, is unique, and that is why each patient's context is unique. Factors which may influence clinical context are the patient's economic resources or particular medical prognoses.

1.2.9 The role of empirical research in bioethics

'What is the role of empirical ethics research in bedside care?' is the question asked by Alexander Kon (2009). In other words, how does the "is" inform the "ought"? Historically, one of the strongest criticisms of medical ethics, by the social sciences, is the paucity of empirical research to substantiate the normative claims.

The empirical turn in bioethics research methodology occurred consequent to the concern for the practical context of moral problems. Traditionally, research in bioethics was conducted using philosophical-normative analysis. This philosophical-normative analysis prevailed until the so-called "empirical turn" in bioethics (Borry, Schotsman, & Dierickx, 2005), when empirical research was incorporated. Three hypotheses explain this "turn": first, dissatisfaction with the dominant interpretation and method of applied ethics; second, the engagement in empirical research by clinical ethicists due to their integration in the clinical setting; and finally, the influence of the evidence-based paradigm on the practice of bioethics (Borry et al., 2005).

This "turn" has its methodological origin in the social sciences. It has as its objective, the gathering of qualitative and quantitative data about ethical issues (De Vries et al., 2007), and uses a "bottom-up" approach to "ethics in action" (Borry et al., 2005).

Salloch, Schidmann, and Vollmann (2012), identify two typical shortcomings in medical ethics research concerning a link between normative questions and empirical data. The first shortcoming is the 'complete lack of normative analysis' and the second is a missing account for the relationship between "is" and "ought" statements.

A further problem identified with empirical research in medical ethics is the relationship between empirical data and normative analysis. Brody (1993) argues that empirical work in medical ethics can be valuable in identifying ethical issues but will offer no valuable contribution if it does not correctly or entirely conceptualise the ethical issue at hand. This argument suggests that to conduct empirical research into medical ethics, one needs to be

familiar with moral and ethical theory, or else collaborate with those who are practised in the discipline (Arnold & Forrow, 1993). Empirical research is meant to bridge the gap between descriptive and normative ethics.

Medical ethics is dynamic, continually evolving in response to changes in medical technology and pharmaceutical advances. As a result, empirical research is necessary to move forward with the developing sciences in a well informed and consequently, well-reasoned action.

Kon (2009), describes empirical research informing bioethics at four levels: the exploratory level; the ideal versus the reality level; the improving care level; and the changing ethical norms level. This research is concerned with all these levels.

I would argue that empirical research, especially qualitative research, is necessary for medical ethics. The methods they provide are suited for exploring and understanding the values, perspectives and contextual circumstances that are concerns in contemporary medical ethics (Taylor, Hull, & Kass, 2010). These methods provide better understandings of the kinds of experiences, beliefs and attitudes that permeate clinical practice, especially in a diverse, pluralistic world. The new knowledge gained enriches the content of modern medical ethics in a dynamic, evolving sphere. The implications and consequences of this new knowledge would add to a necessary evolution of medical ethics in response to the identification of new issues in medical practice in modern, liberal democracies and diverse values, rather than only in response to medical and scientific technological advances.

1.2.10 The Wesleyan Quadrilateral

The Wesleyan Quadrilateral was a term first used by Albert Outler to describe the four-element method first developed by John Wesley, an 18th-century Anglican priest who served as a theological mentor to "the People called Methodists" (Outler, 1985). In this method, John Wesley used four sources of authority, Scripture, Tradition, Reason, and Experience, when deliberating on matters theological or doctrinal (Outler, 1985). These four sources are accepted as the bases for moral wisdom and knowledge in the Christian understanding. For Wesley, Scripture referred to the Christian Bible, a written text to be referenced. Wesley gave Scripture primacy, regarding it as the supreme norm, though interfaced with tradition, reason and Christian experience as dynamic and interactive aids (Outler, 1985). Tradition, for Wesley, referred to the adopted practices of the primitive church, in keeping with prescriptions in the text of the Bible.

Scripture and Tradition were not enough for Wesley, without critical Reason. Reason, or the ability to rationalise, was a gift from God. Outler (1985) describes Wesley's unique genius as being instrumental in adding experience to the traditional Anglican triad of Scripture, Tradition and Reason. By doing this, Wesley took faith from one of theory to an "existential one" (Outler, 1985). Experience does not refer to past or personal history, but rather to a divine revelation. Humans experience the reality of God when the other three sources are in place.

The Wesleyan Quadrilateral is examined extensively in Chapter 2. The rationale for the choice of the Wesleyan framework is elaborated on in section 2.6.

1.3 Research Questions

The overall research question for this thesis is:
When faced with moral and ethical dilemmas in the clinical context, how do medical doctors act, and what normative sources do they use as justification for their actions?

Medical ethical and moral decisions are not made unconsciously, without deliberation, or in a vacuum. They are guided by or grounded in some means, rational or non-rational. The question is: how much of this means is rational, and how much non-rational?

The sub-questions addressed in my thesis are:
Where does the moral self of the medical doctor come from? What normative sources do medical doctors use to justify their moral agency? In other words, what "is" the deliberative process clinicians use when making decisions in moral and ethical dilemmas in the professional context? Do doctors make decisions as they "ought" to, or is the reality different to the normative prescription? What drives the moral agency of the physician? Further, how are ethical and moral decisions in the clinical context justified? What are the consequences of the deliberative process?

1.4 Rationale

Healthcare and medical ethics are currently dominated by normative theories centred on obligation and duty, backed up by laws and guidelines. These theories make moral principles the focus of medical ethics and propose broad guiding principles, rules and laws that physicians are expected to apply to moral quandaries. The theories do not explicitly consider factors intrinsic to medical doctors such as their beliefs, cultures, and habits, nor how these

may affect quandary decision-making. Further, although there are legal and professional prescriptions that purport to guide moral decision-making in the professional context, it is not clear whether South African medical practitioners are compliant with these prescriptions and if not, how the non-compliance is justified.

Medical ethics is about values and normative theory and requires the application of these values, theories and principles to quotidian clinical practice. As such, the personal values and moralities that doctors bring to the clinical space should not be confused with professional, ethical determinants or prescriptions for moral decisions. Nevertheless, arguably, medical ethical decision-making is an intricate and difficult process, more than the mere application of theory, norms, and values. In addition, it requires the use of reason (as expressed in medical science and in law), emotion and understanding to appropriately evaluate a decision, arrive at a just resolution, and ethically justify that action or decision (Hawkins, 2002 in Geisler, 2006). It is not an explanation for the path followed, but rather involves a moral, normative justification for the outcome.

The rationale for this study is that moral dilemmas do not occur in vacuums or according to textbook prescriptions where a "sterile" environment allows for a rigid, top-down application of moral theory and ethical principles. The clinical encounter is a real-life situation. Theories do not explicitly consider factors intrinsic to all physicians: their beliefs, cultures, habits, or feelings, and how these may influence their ethical decision-making. The "human element" of the decision-maker is not considered in normative prescriptions. Further, in the South African situation, the application of a Western ethos is not universally applicable, especially in the context of multicultural diversity and the multiplicity of religious practices. The traditional Western paradigm is limited in assisting doctors in making decisions when faced with dilemmas in a pluralistic, secular society.

Finally, as described by Devettere (2009), ethics is not simply about reality or the positions people hold as moral; it is about the norms that enable us to justify which positions are morally and ethically good, and which positions are morally and ethically bad.
No in-depth normative and empirical work has been done as yet on how, in situations of moral conflict, medical doctors deal with questions that contend with personal belief, conscience, moralities, and values, and how their approach to the "ought" in medical ethical dilemmas are shaped.

1.5 Hypothesis

Despite medical ethical training, professional guidelines, and the law, moral theory is not the sole means physicians use to make moral judgements. Moral theory alone would often make it unfeasible to justify decisions to the involved parties, because there is no universal consensus on a background theory or process for moral or ethical deliberation in the clinical context. Moral judgements are informed by much more than medical ethical insights received during medical and professional training. Moral judgements are a complex mixture of rule-following, traditional influence (including cultural beliefs, and religious, moral reasoning), as well as, for better or worse, emotion and instinct. Thus, medical doctors in the clinical setting will, more often than not, use an eclectic approach incorporating all or some of the above factors when making professional judgements.

1.6 Aim

The aim is to evaluate what medical doctors ought to do when faced with ethical dilemmas, against what they do in reality, and to investigate the normative sources they use to guide and justify their decisions.

1.7 Study Objectives

1. To develop an adaptation of the Wesleyan Quadrilateral as a normative framework to facilitate moral and ethical deliberation and meta-analysis in quandaries in medical practice.
2. To normatively justify the multi-layered approach based on the normative framework developed in the first objective.
3. To describe the moral and ethical conflicts experienced by doctors in everyday medical practice.
4. To determine what normative sources medical doctors use to facilitate decisions when confronted with a moral or ethical dilemma in the clinical context.
5. To ascertain whether doctors use and comply with professional, ethical guidelines, codes, and principles to assist and guide decision-making in clinical moral and ethical quandaries.
6. To normatively evaluate how physicians make their decisions against the proposed ideal of adopting a multi-layered approach in the designed normative framework.

1.8 Research Design

This design includes both normative and descriptive inquiry. The study was divided into two phases for two reasons. The first reason was to review the literature to describe the normative frameworks that medical practitioners ought to employ in moral and ethical quandaries in clinical practice. This literature review also provided the necessary foundation required to formulate an adapted "Wesleyan Quadrilateral". The second reason was that empirical research was necessary to validate and test the hypothesis and the analytical tool that I have developed.

In the first phase, a normative investigation of the literature was conducted, and a framework for ethical and moral deliberation was developed, based on the four elements of Outler's "Wesleyan Quadrilateral". The tool I have developed was used in the second phase of the study to facilitate the analysis of responses and results obtained in this phase. It also helped to unpick the moral reasoning behind the doctor's decision. The tool was also used to defend the argument, that while moral and ethical dilemmas in the clinical context may be resolved normatively, ultimately the resolution is multi-layered.

Medical ethics is normative, and for this reason, a normative inquiry was essential. Normative ethics questions and answers the "ought" action in medical ethical or moral dilemmas. It attempts to guide medical professionals towards the kind of person they ought to be and also seeks to justify the answers they produce in response to ethical and moral questions (Sulmasy & Sugarman, 2010).

The value of empirical research is dependent on scientific methods and experimental rigour. Further, by revealing dissonance, one can instigate change. Empirical work informs concepts of appropriate action, usually by revealing knowledge gaps or unwanted or unintended consequences. Data obtained can be used to base an argument to change an ethical norm or perspective.

Muller (1994) argues that to understand the reality of moral and ethical decision-making, it is essential to examine the actual behaviour of people in morally and ethically challenging situations and, the reasons or justifications they give for that behaviour. Empirical research is necessary to enable and substantiate answers to normative questions or issues in daily medical practice. The second phase was conducted as a qualitative, exploratory, descriptive study, using a phenomenological approach to explore the lived experiences and resolutions taken by

medical doctors when confronted with ethical or moral dilemmas in the clinical context. This phase is discussed in section 1.9 (ii) and extensively in Chapter 4.

1.9 Research Methodology

i) Phase I:

A Normative Defence of a Modified "Wesleyan Quadrilateral" as a Framework for how Doctors Ought to Make Moral Decisions

Phase I was conducted as a normative enquiry that investigated what normative sources ought to be used when resolving medical ethical and moral questions. Medical ethical theory and professional guidelines prescribe what doctors ought to do when faced with a moral dilemma. Another normative source external to the practice of medicine, but that is also prescriptive in medical conduct, is the law. This phase set out to determine the extent and value of these and any "new" sources.

Quandary ethics deals with tangible, objective, human situations of moral doubt, uncertainty, or conflict; so, this study sought to develop a four-element framework, based on the format of the Wesleyan Quadrilateral. In these morally or ethically uncertain situations, Curran (2011) argues that the four sources of morality - knowledge, reason, science, and human experience - predominate.

To this end, the mentioned tool was developed to analyse the normative means used in clinical moral decision-making. This tool is a modification or adaptation of the original Wesleyan framework and similarly has four sources of authority that medical doctors could use to guide and justify their resolutions of moral and ethical quandaries in the clinical context. An explanation of this framework is given in Chapter 3.

Phase I of the research was initiated by an extensive review of the literature examining normative and non-normative sources for medical moral and ethical decision-making in the clinical context. The literature review (Chapter 2) was conducted to identify the four possible sources of authority for moral and ethical decision-making in the clinical context. It included the investigation of rational and non-rational means that doctors may rely on when trying to resolve moral and ethical conflicts.

Several pertinent national laws, for example, the Bill of Rights (Chapter 2 of the South African Constitution, 1996), and the National Health Act, 2003 (Act 61 of 2003), were examined. The Health Professions Council of South Africa (HPCSA) guidelines were reviewed as well as some international professional codes and guidelines.

Following the literature review, the modified "quadrilateral" was developed. The modification was used as a normative framework to enable the analysis of the data collected in Phase II. In the same way that the Wesleyan Quadrilateral used four tenets to facilitate theological deliberation, so the adapted "framework" identified four sources of authority to enable medical moral and ethical decision-making in the clinical context. The Wesleyan Quadrilateral was chosen as an exemplar for the adaptation because it helps to integrate theory into practice, and also prevents an over-reliance on just one source of authority. The Quadrilateral and the justification for a similar model in medical ethics are discussed in Chapter 2, section 2.6.

The newly developed framework, titled the "Ethics Tetrad", concisely sums up a complicated multi-sourced theory of medical ethics. It was also used to critically examine the responses obtained from the doctors interviewed in Phase II.
This phase utilised the resources available at the University of the Witwatersrand, including the Humanities and Law libraries, Google Scholar, and the library at the Jesuit Institute in Johannesburg, South Africa.

ii) <u>Phase II</u>:
Qualitative research to establish how medical doctors resolve moral and ethical dilemmas in the clinical context, followed by a normative analysis of the ideal versus reality.

Phase II was conducted as a qualitative, exploratory, descriptive study. Qualitative methods help to explain why individual experiences, beliefs, or attitudes exist (Cresswell, 1998, p.17-18). The qualitative method allows in-depth descriptions and explorations of phenomena about which little is known (Taylor, et al., 2010). It provides a platform for understanding values, personal perspectives, experiences, and context. For this reason, and because it has its roots in philosophy, a phenomenological approach was used to explore the lived, "in the moment", experiences and moral resolutions made by medical doctors when confronted with ethical and moral dilemmas in the clinical context.

Phenomenological research supports the re-examination of a "taken for granted" experience. The examination and analysis of this experience allow for the identification of its essence and meaning (Pellegrino, 2001; Churchill, 1977; Thomasma, 1980). Further, the "internal" morality of medicine is grounded in the phenomena of medicine - in the actual clinical context and experience between physician and patient. It is not abstract or remote. This decision was motivated by Dreyfus and Dreyfus (1991), who claim that if -

> 'one returned to the phenomenon and tried to give a description of ethical experience, one might find that phenomenology has a great deal to contribute to ethical debate, particularly since the focus of discussion has shifted from interest in meta-ethical issues to a debate between those who demand a detached critical morality based on principles that tell us what is *right* and those who defend an ethics based on an involvement in a tradition that defines what is *good.'*

This inquiry focused on the decision-maker, the medical doctor. It did not interrogate how doctors thought they ought to act in their lived clinical encounters, but rather how they acted in reality. Arguably, in daily medical practice, where there is a medical moral or ethical dilemma, that dilemma is embedded in the clinical context. Moral theories and principles fail to consider the reality of clinical work, interaction with patients, and the lived experiences of physicians.

Based on my hypothesis that doctors use a multi-faceted approach to resolve medical ethical and moral quandaries, this phase explored the extent to which clinical practice reflects the premise that physicians faced with professional dilemmas "actually" do what they "ought" to do.

The phenomenological approach relies on interviews with participants familiar with the phenomenon under study (Taylor et al., 2010). The research was conducted by interviewing individual medical doctors in either public or private practice. This phase began with a premise regarding ethical norms in the medical context and then sought to assess the extent to which clinical practice reflected the ideal.

1.9.1 Population and sampling

The population considered in this study was medical doctors working in either private or state practice. For this study, I used purposive sampling for theoretical reasons: that it would best represent the population about which I wished to draw conclusions from, and further, that this

sample would reflect and describe the phenomenon under study. The size of the sample was set at twenty participants. (In phenomenological studies 2-10 participants are considered adequate to reach data saturation (Groenewald, 2004). See section 4.3.2.

The research sample included family doctors and medical practitioners in private practice, as well as specialists working in both the private and public sectors. The diversity of specialities was important to determine whether there were different or specialist specific insights, approaches or guidelines that enabled ethical and moral decision-making in the medical space. (It was revealed for example, that the discipline of psychiatry has specific guidelines to aid their doctors in ethical and moral decision-making in the clinical context). Private and public sector doctors were also selected because I was interested in whether institutional guidelines might influence the moral decision-making.

The research data were collected from a purposive sample of medical doctors in the Midrand and Johannesburg areas.

Midrand is an area situated halfway between Johannesburg in the south and Pretoria in the north. The area includes the suburbs of Halfway House, Halfway Gardens, Vorna Valley, Noordwyk, Kyalami, Waterfall, Tembisa, Ivory Park, Ebony Park, and Rabie Ridge. The main suburb is Halfway House. Central Halfway House accommodates a large shopping mall, the Magistrates courts, a major conference centre, a police station, a fire station, a small airport (Grand Central), and a large taxi hub. Located around this area are several general and family medical practices. There are several state nurse-run primary health care clinics in the area as well. The nearest private hospitals are Carstenhof, Waterfall, and Midstream. The nearest and only state hospital is Tembisa Hospital.

For logistical reasons, private practitioners working in the Midrand area were selected. This researcher gave a presentation at the Midrand Medical Centre. Following the presentation, volunteers were invited to participate in the research. Other doctors in Midrand, who did not attend the presentation, were approached by the researcher, given the background on the aims and objectives of the study, and were invited to participate. There was no pressure or coercion to take part. The interviewees were informed that they could withdraw at any time. I assured participants that there was no risk or benefit to their participation, other than to contribute to the research.

This part of the sample constituted eleven general practitioners, one psychiatrist, one gynaecologist, and two specialist physicians.

Doctors working in the public sector were recruited from the Charlotte Maxeke Academic Hospital (CMAH) and Chris Hani Baragwanath Hospital (CHBH). These are academic hospitals linked to the Faculty of Health Sciences, University of Witwatersrand, Johannesburg. Both hospitals form part of the Wits Medical School. Doctors rotate through these hospitals as part of their medical training.

The Head of the School of Clinical Medicine, where the specialist departments are located, was approached for permission to conduct interviews with the doctors working in those departments. The various Heads of Departments were then approached for permission to conduct interviews with their staff. Permission was granted to conduct my research in the following departments: Clinical Medicine; Gynaecology and Obstetrics; Neurosciences; and Psychiatry. No responses, despite repeated requests, were received from other departments, including the departments of Paediatrics, and General Surgery.

To recruit interested volunteers, I was able to present my research proposal at one weekly department meeting in the Department of Clinical Medicine at CMAH. Another presentation was made at one weekly department meeting in the Gynaecology and Obstetrics Department at CHBH. At the end of both presentations, the audience was invited to participate in the research. Contact details were obtained from volunteers, and appointments were arranged at a time and place most convenient for each volunteer.
From this sector, three gynaecologists, a registrar in the Department of Nuclear Medicine, and a consultant from the Department of Public Health, who worked emergency room sessions, were recruited.

1.9.2 Data collection

After obtaining informed consent, data were collected via in-depth, semi-structured individual interviews with medical doctors. This consent included consent to be interviewed and audio-recorded.

The participants were also given a participant information sheet to retain. This sheet described the purpose of the research and also provided the contact details of this researcher's supervisors and the University, should the participant have had any concerns.

The interview schedule (Appendix V) was formulated based on findings in Phase I. A journal or "interview field guide" was used to record participant demographics. The information gathered included the date of participants' qualification; the medical school that they attended; and whether medical ethics was taught as part of the curriculum at that medical school. Non-verbal notes, for example, gestures or facial expressions were also recorded (these gestures and facial expressions were useful in the transcription of the recordings because they added meaning and context).

Four pilot interviews were used to assess the efficacy of the initial interview schedule. The pilot interviews gave perspective on the expected duration of the interviews (the shortest was twenty minutes and the longest 58 minutes); as well as the adequacy of the interview schedule. Amendments were made to the initial interview schedule, as it did not fully explore the aims and objectives of the study. The amendment was used in the twenty interviews used for analysis in this research.

1.9.3 Data analysis

Initially, the analysis of the data was guided by the research objectives. The modified quadrilateral, developed in Phase I, was used as an analytical tool in determining which normative source the participants relied on when deciding a moral dilemma in the clinical context.

Data analyses also followed the three necessary steps described by Taylor et al. (2010). These steps are immersion, data reduction and, finally, synthesis.

i) Immersion

Immersion is necessary to enable the planning and completion of the remaining steps in data analysis. Immersion involves the routine review of the data to identify what additional data are needed, which also helps to determine when the saturation point is achieved. The interview field guide was an aid to this. Data were reviewed as they were collected, enabling identification of the need for additional data as well as the saturation point.

All interviews were listened to before transcription to ascertain audio-quality and clarity. Following this, the interviews were transcribed. The transcriptions were then listened to again to confirm the correctness and accuracy of the transcriptions.

After transcribing the initial interviews, I reviewed the data, looking out for data gaps. The transcripts were then referred back to the participants to verify and validate that the transcriptions were a true reflection of their thoughts and feelings as captured during the interview. Another reason for this step was to ensure reliability. The participants were asked to make written changes on the transcripts if they felt such changes were needed, or if they were unhappy with the interpretation. Alternatively, they were invited to participate in a follow-up interview to clarify any misunderstandings or interpretations and to fill in gaps in the data already collected. These changes, follow-up interviews, and transcriptions were all used in the final analysis.

ii) Data reduction

The process of data reduction required the data obtained from the interview transcripts to be divided into more manageable units (Miles and Huberman, 1994, in Taylor et al., 2010). In this way, the interview transcripts were reduced to smaller units according to the different topics raised in interviews. Initially, the data were broken down into the three key research objectives, that is, a description of the dilemma, the resolution, and the justification for the resolution. These units were labelled and coded according to the modified quadrilateral, or the insights that emerged from the data. All coding was done manually following the transcriptions.

Following analysis according to the research objectives, the data were further analysed according to the Ethics Tetrad.

iii) Synthesis

Once the data were reduced and coded, the researcher explored themes and patterns in order to reshape and synthesise the data into a more coherent whole. Conclusions generated during the process were tested within the data set by re-examing the data in search of instances that may have contradicted the conclusion.

According to Taylor et al. (2010), the final product of data synthesis is determined by the qualitative approach taken, the phenomenon under study, or both. This approach influences the level of interpretation by the researcher. The data were synthesised using both the phenomenological approach and the description of the social and psychological process of quandary decision-making described by the participants. As a result, the narrative product

included several quotations and interpretations to try to demonstrate this researcher's reasoning, analysis, and conclusions. This is discussed further in Chapter 4.

1.9.4 Trustworthiness

Trustworthiness in qualitative research is often questioned because the concepts of reliability and validity cannot be measured in the same way as quantitative work (Shenton, 2004). In response, the use of four criteria is proposed, namely, credibility; transferability; dependability and confirmability (Guba, 1981).

1.9.4.1 Credibility

Credibility is concerned with establishing confidence in the integrity of the research. To this end and to ensure credibility, the following were described and implemented: the qualifications and experience of the researcher; the adoption of appropriate well recognised research methods; triangulation using different methods, participants and sites; tactics to ensure honesty in participants; debriefing sessions between researcher and supervisors; peer scrutiny of the project; use of reflective commentary; member checks of data collected; and interpretations and theories formed.

i) The qualifications and experience of the researcher

This researcher had experience interviewing volunteers as part of an Honours research report. In this research, four pilot interviews were conducted and the interview schedule was amended. The early interviews required in-depth follow-up to gather the necessary data. The later interviews were an improvement, and even though follow-up was needed to close data gaps, this was not extensive.

ii) The adoption of appropriate well recognised research methods

This study was conducted in two phases, a normative study and a descriptive inquiry. Phase I was conducted as a normative inquiry that investigated the normative sources medical doctors ought to use when confronted with an ethical or moral dilemma in the clinical context. This phase also interrogated the normative sources, if any, that medical doctors may use to justify their decisions. This phase provided a thick description of the phenomenon under scrutiny. It also examined previous research to frame the findings in Phase II.

Phase I aimed to develop an analytical tool to analyse the sources doctors use when making their decisions. This phase was facilitated by an extensive review and analysis of literature as described in Chapter 3.

The literature review and analysis in this phase enabled the development of the analytical quadrilateral that was to be used to analyse the moral reasoning behind the doctors' decisions in data collected in Phase II.

Phase II was conducted according to an empirical, qualitative research design. A phenomenological approach was used to capture the lived, "in the moment" experiences and moral resolutions made by medical doctors when confronted with moral or ethical dilemmas in the clinical context.

iii) Tactics to ensure honesty in participants

Ensuring honesty was a bit of an obstacle. The researcher had the sense that a number of the participants initially had the perception that they were being judged or examined to see whether they "practised ethically". This was also an obstacle to recruitment. To overcome this perception, for those participants who had consented and were willing to continue, the researcher began each interview with an unrecorded "introduction" where the participant was assured that the interview was not a "check" or examination. Rather, that there was no right or wrong answer; that the interviewer was not in a position to judge, never having been in the same position; that each moral dilemma was unique and that there are many ways to address moral and ethical dilemmas. The aim of the research was to explore those many ways and methods. The participants were also assured that if they wished to end their participation, they could withdraw at any time and would suffer no consequences as a result.

Following transcription, each transcript was given to the participant concerned to verify and validate that it was a true reflection of the interview and what they had said. If not, they were asked to correct the transcript where appropriate, or were offered a follow-up interview. This step was also a protection against misinterpretation in the final analysis.

iv) Peer debriefing

Regular meetings were held with the researcher's supervisors to discuss emerging themes, findings, and methods.

v) Member checks

Testing of the credibility of data is performed using member checks. In this research, member checking was conducted by asking the participants to check the transcripts of their interviews and validate the transcripts as accurate representations of what they had meant. The participants were allowed to change discrepancies or have a follow-up interview where they could clarify or elaborate on any data collected.

Regular meetings were also held with the researcher's supervisors to discuss findings and compare analyses. This is discussed in Chapter 4.

vi) Triangulation

Triangulation is a rigorous approach to compensate for weakness in the study methodology. It increases the validity and credibility of research findings. Combining theories, methods or observers can help to ensure that fundamental biases of a single observer are overcome (Hastings, 2010). Triangulation is achieved by using more than one method to collect data, having multiple sources of data or, using multiple approaches to analyse data (Hastings, 2010). This research used three methods to analyse the data. The first was an analysis according to the research objectives. The second was a thematic content analysis and the final method was an analysis using the Ethics Tetrad as an analytical tool.

vii) Participants and Sites

This study drew participants from three different types of sites: CHBH, CMAH and various private practices in Midrand.

1.9.4.2 Transferability

Transferability is ensured by the provision of background data to establish the context of the study and a detailed description of the phenomenon in question to allow comparisons to be made (Guba, 1981). The individual doing the research should ensure that in-depth information about the fieldwork in context is provided to allow the reader to make the transfer and allow other researchers to make comparisons with their own work (Kelly, 2008). Thus, thick descriptions of the methodology and results with direct quotations from the participant interviews are provided. I compared and critiqued the results according to current literature (Krefting, 1991; Polit & Beck, 2010). A detailed description of the demographic information of the participants, as well as the sampling methods, ensured transferability (Burns & Grove, 2009).

The phenomena studied in qualitative research are closely linked to the context and time in which the research is conducted. In other words, social and behavioural events are context-bound (Guba, 1981). This raises the question whether data are transferrable from one context to another. The literature recommends that one uses thick descriptions of both data and context (Guba, 1981). Thick descriptions place real-life events and phenomena into perspective. If these thick descriptions demonstrate essential similarities, then it reasonable to suppose that the tentative findings in context A are likely to hold in context B.

The thick descriptions are presented in Chapter 5, under each individual discussion and analysis.

Another method used to confirm transferability is that of purposive sampling. This sampling method is intended to maximise the range of information uncovered. The respondents in this study were the product of purposive sampling.

1.9.4.3 Dependability

To ensure the dependability or stability of the data, an "audit trail" was established. The audit trail took the form of the recorded interviews and the interview transcripts. The researcher also kept an interviewer's journal which described the context and process of the interviews.

1.9.4.4 Confirmability

Confirmability was achieved by keeping a reflexive journal in which introspections were recorded. Through this diary, the researcher maintained objectivity and tried to ensure that the findings were based entirely on the data collected from the participants and were not influenced by any personal biases, interests, or motivations.

This candidate's supervisors also checked the transcripts for confirmability that data existed to support her interpretations and that these interpretations were consistent with the data.

1.10 Research Ethics Approval

Research Ethics approval (Clearance certificate number M170703) was obtained on 28 July 2017 (Appendix I). This approval included the original interview schedule (Appendix II), the participant information sheet (Appendix III), and the informed consent form for interviewing and audio-recording (Appendix IV). The amended interview schedule approval is found in Appendix V.

1.11 Ethics

The researcher obtained consent to be interviewed and audio-recorded from all participants before their interviews. All participants who consented to be interviewed were provided with the ethics approved information sheet, which included the information on audio-recording. This consent form assured participant confidentiality and elaborated that there were no risks or benefits to participation in the research. All participants signed a separate consent form for the audio-recordings to be made and subsequently stored.

Participants were assured that all data collected would be kept confidential and that transcripts and recordings would be stored by the researcher, in a lock-up cupboard, in her office at the Midrand Medical Centre. This storage would be for two years after any publication resulting from the research or for a six-year period if there were no publications.

CHAPTER 2

THE WESLEYAN QUADRILATERAL

2.1 Introduction

This chapter explains the "Quadrilateral" and the Wesleyan method. It lays the foundation for my rationale for the use of the "Wesleyan Quadrilateral" as a model for the four-element framework that was designed for medical ethics thought, analyses, and decision-making. The original "Wesleyan Quadrilateral" was similarly a method for theological deliberation, analysis, and decision-making. The concept developed from the contributions of mid-20th century Methodists working in different phases of the ecumenical movement (Campbell, 1991). It originated from an approach described by John Wesley, an 18th-century Anglican priest who led an evangelical revival in England that led to Methodism. Wesley used four sources of knowledge or authority to help understand and communicate the truth of Scripture and enable decision- making in theological practice. At that time, in the Anglican tradition the Christian triad of Scripture, Tradition, and Reason was used to address the needs of the time (Porter, 2004). This is apparently an error on Outler's part. The 'Anglican Triad' is a 19th century invention of Francis Paget (1851-1911), who attributes the threefold appeal to Richard Hooker (1554-1600) (Morris-Chapman, 2018, p.2.1), Wesley added Experience to the triad, making up the so-called Quadrilateral. Wesley was not the first to add experience into his method. According to Morris-Chapman (2018), the philosopher John Locke did this half a century before Wesley (Morris-Chapman, 2018). While Wesley did not use the term "Wesleyan Quadrilateral" (this has been ascribed to Outler, 1985, as explained below), these four complementary and hierarchically arranged sources of knowledge, Scripture, Tradition, Reason, and Experience, have become known, since Outler, as the Wesleyan Quadrilateral.

2.2 Historical Perspective

In the 1980s, Albert Outler, thinking that it fairly summarised Wesley's methodology, used the term "Wesleyan Quadrilateral" to describe the fourfold approach that John Wesley (1703-1791 CE) used when reflecting on theological matters. To regenerate spirituality in England, John Wesley was instrumental in the formation of the Methodist Movement and denomination (Felton, 1997). England in the 1700s was experiencing the Enlightenment and the scientific revolution. As a theologian living during this period, Wesley was witness to the effects that reason had in overriding and challenging the Scriptures and Christian beliefs. These effects resulted in the growth of scepticism about Christian doctrines (Urrutia, 2005).

Wesley was concerned with the practical relevance and application of theology. To preserve orthodox Protestant beliefs and spirituality, he developed a system of theology that challenged the authority and efficacy of reason as argued by the Enlightenment philosophers of the time (Urrutia, 2005). To this end, he used four hierarchical, unequal but interrelated sources of authority to facilitate a system of theological deliberation. These sources are Scripture, Tradition, Reason, and Experience. The framework challenged Enlightenment thought by contesting the ultimate authority of reason. It has since come to represent a modern attempt to summarise the fourfold set of guidelines used in theological methodology (Thorsen, 1990, p.21).

For Wesley, Scripture referred to the Christian Bible and was the first written text to be referred to, interpreted, and deliberated upon, to validate or justify a decision in religious practice. Historically, Scripture has been regarded as the foundational source for Christian theology (Porter, 2004).

Scripture, as the primary source of authority, has been threatened throughout the history of the Church (Porter, 2004). In pre-Reformation times, the Catholic church placed a higher emphasis on tradition, namely the statements of church fathers, creeds, councils, and popes. These were elevated to an equal if not a higher source of authority than the Scriptures (Pelikan, 1984 in Porter, 2004). This appeal to tradition had two effects: it led to a sense of the incompleteness of the Scriptures; and it denied the Scriptures to the 'common' or lay people (Abraham, n.d.).

Following the Reformation, 18th-century Protestant Deists and theological liberals moved away from these traditional positions. Instead, they advocated Reason (seen as empiricism and rationalism) as the preferred source of authority, using it to override knowledge revealed by the Scriptures (McGrath, 1986 in Porter, 2004; Hey & Roux, 2012). Secular philosophy rejected the Bible as a source of authority, claiming instead that the conclusions reached using logical analysis (reason) were superior to the claims of revelation. This resulted in the implication that all knowledge should be dependent upon reason alone (Thorsen, 1990).

In the 19th and early 20th centuries, liberal Protestant theologians, revivalists, and Pentecostals determined religious experience as the primary source for theologising (Hey & Roux, 2012; Murphy, 1996). Post-liberal theology, in the late 20th century, returned to the text offered in Scripture, but with a 'philosophy of language that disembowelled the authority of Scripture'

(Porter, 2004). Throughout these times, evangelical theology consistently held onto Scripture as the sole and supreme source of authority, an approach known as "*Sola Scriptura*" (Latin; Scripture only), and rarely referred to other sources of secular or "extra-Biblical" knowledge (Marsden, 1980 in Porter, 2004; Cosby, 2002).

The Wesleyan theological method, on the other hand, gives Scripture primacy as a source of knowledge rather than exclusivity. It remains the supreme source of authority but as a "*Prima Scriptura*" (Latin: Scripture first) for theological revelation. For Wesley, this primacy does not ignore the enlightening, complementary, and supportive roles that tradition, reason, and experience can offer. Currently, the Quadrilateral remains a useful method for theological deliberation, provided the user understands and bears in mind that Wesley did not apply equal authority to each of the four elements (Cosby, 2002). Scripture for him remained supreme.

In the 'Doctrinal Guidelines in the United Methodist Church', released in 1972, Experience and Reason were assigned contemporary meanings, where "experience" now refers to 'specifically religious experience *and* our general experience of the world', and "reason" is taken to mean "rational analysis" (Campbell, 1991). This statement of religious authority gained acceptance as a tool for theological analysis and the starting point for the recovery of the Wesleyan theological tradition in a modern ecumenical context (Campbell, 1991).

2.2.1 Scripture

In Christianity, the Biblical canon of Scripture is the highest and most relevant source of authority and knowledge for theological doctrine, and for understanding God, His works, and His relation to His works (Porter, 2004; Crawford, 2017). For Christians, the Old and New Testaments contain the texts that most accurately reveal the message of God (Hey & Roux, 2012). The Testaments also preserve the traditions, values, and cultures that are valued by Christians as foundational to their faith (Hey & Roux, 2012). Scripture as the primary source of knowledge determines doctrinal categories, their content, and restrictions (Porter, 2004). Scripture is also regulatory in that its supreme authority regulates the lesser influences of tradition, reason, and experience.

The Bible was central to Wesley's theology because, for him, it was divinely inspired and consequently infallible. It was also the authority for determining Christian belief and practice (Maddox, 1994 in Cosby, 2002). Wesley, in keeping with the Reformation approach of S*ola Scriptura* still followed by Protestant evangelical theology in his time, relied heavily upon

Scripture to guide his discussions of reason and the Christian faith (Urrutia, 2005). However, while Wesley held Scripture as the primary and regulatory source for concerns of faith and practice, he interpreted the Protestant *Sola Scriptura* to mean the principal rather than the exclusive Christian authority (Maddox, 1994 in Cosby, 2002) – the *Prima Scriptura* approach.

Wesley had no difficulty integrating Biblical teachings with the modern science of the time and did not discount appeals to sources of knowledge outside of Scripture to clarify, explicate or confirm the teachings in Scripture (Porter, 2004; Cosby, 2002). Wesley was eclectic, fostered theological tolerance, and was open to reason. Scripture was sufficient in itself as a source of knowledge, but Wesley also contended that Scripture itself speaks of sources outside that would assist theology more completely in relevance, completeness, and understanding (Cosby, 2002). Wesley appealed to Scripture as both a source and a norm (Urrutia, 2005). He contended that it plays a foundational role in efforts to formulate positions on issues of ethics, morality, and daily life (Cosby, 2002).

However, while Scripture is written to be readily interpreted, it cannot be fully or most accurately interpreted, historically, or in any succeeding age and each new cultural context, without other supplementary sources of knowledge (Hey & Roux, 2012; Crawford, 2017; Whidden, 1997). Thus, where the Bible remains primal in theological practice and reflection, the Wesleyan method is open to the employment of other tools of modern scholarship. Scripture, as *Prima Scriptura* and not *Sola Scriptura*, in its primary and regulatory role would be more easily understood and interpreted with the application of the tools of tradition, reason, and experience (Porter, 2004; Crawford, 2017; Whidden, 1997).

Thorsen (2008) argues that no-one uses Scripture exclusively in theological deliberation and analysis. Rather, there is constant interaction and interdependence between the study of church history and relevant experience while using critical thinking (reason) in the process (Thorsen, 2008).

2.2.2. Tradition

Tradition refers to the passing down of customs, statements, and beliefs from one generation to another, especially by word of mouth or by practice (Oxford Everyday Dictionary, 2005). Wesley identified Tradition as ‘Christian antiquity’ or the ‘religion of the whole church in the purest ages’, which for him was the church of the first three or four centuries CE as well as

the English Reformation (Cosby, 2002; Porter, 2004). Early Christianity (especially in the New Testament period) was held as the exemplar of true faith (Campbell, 2010). Further, Whidden (1997) proposes that Tradition can be seen as the collective wisdom of Christian communities of all ages and societies.

Within the Wesleyan method, Tradition refers to the accumulated and adapted practices and beliefs of the Church. These are in keeping with prescriptions in the text of the Bible and the historical, consensual, doctrinal formulations of Christians. Tradition brings to theology the ancient teachings and lives of the early fathers of the church (Porter, 2004). Wesley saw the church fathers of Christian antiquity as the most 'authentic commentators on Scripture' because they were closest to the original writings of the Scripture and for him, must have been empowered by the Holy Spirit (Porter, 2004).

People do not receive their understandings of God and His ways in a vacuum or from a single source, but within particular social and historical contexts that involve interaction with the communities in which they live and the traditions they follow. Crawford (2017) argues that the source for theological thinking [and preaching] most important after Scripture is the 'orthodox tradition of Christian antiquity'. This is especially true of the ecumenical creeds, because it supplies content to Christian beliefs and practices and the form the Christian faith takes. To have knowledge of Christian Tradition and its history, helps people interpret, understand, appreciate, and realise the truth of Scripture in their life (Thorsen, 2008, p.7 in Crawford, 2017). Thus, knowledge of Tradition provides insight into the truth revealed by Scripture. As one learns the traditions, one can understand and realise how interpretations of the Word have been applied historically (Crawford, 2017).

Later in life, Wesley became aware that the primitive church was fallible and that there were problems in both doctrine and Christian life from almost the inception of the Church (Maddox 1994, p.43 in Cosby, 2002). Wesley felt that an appeal to church tradition might help to explain doctrine that was not clear or to confirm interpretations. Still, he argued that the teachings of Christian antiquity were not inspired in the same way as the Bible, were thus capable of error, and consequently were not as supreme in their authority as the Scriptures.

While always constrained by the primacy and regulatory authority of Scripture, he finally concluded that appeals to tradition could clarify or explain Scripture's general principles and particular understandings of doctrine which might appear unclear or need reviewing.

Tradition, in this view, is about the hermeneutics of Scripture. It may be understood as a record of interpretations of Scripture and doctrinal formulations of Christians that have been consensual throughout the church history.

Time and context in hermeneutics are everything. Interpretations change within temporal, cultural, and situational contexts since people do not receive understandings from a single source, but also within social interactions with others, as well as within particular social and historical contexts. These contexts also influence values, perspectives, and approaches to understanding and interpretation (Hey & Roux, 2012). Biblical texts should be interpreted within the conceptual frameworks in which the original authors lived, and contemporary readers live (Thorsen, 1990, p. 150 in Hey & Roux, 2012). Tradition can serve to reconcile current doctrinal interpretations or conclusions with those in the historical tradition (Porter, 2004; Hey & Roux, 2012).

Tradition plays three roles in the Wesleyan methodology, in the sense that it provides explication, confirmation, and clarification (Porter, 2004).

In the first case, in its explicatory role, it can be used interpretively, providing understandings where doctrine may be vague or unclear (Porter, 2004). Secondly, it provides confirmation where contemporary doctrinal conclusions symphonise with the historically orthodox traditions (Porter, 2004). Thirdly, the application of tradition as a source of authority has a positive aspect in that it helps address historical and cultural bias (Porter, 2004). It does this by alerting us to a less historically or contextually biased understanding of text and doctrine, thereby providing clarity. Porter (2004) argues that cultural [and historical] context plays a role in influencing perspectives on text or theory. For this reason, other interpretations from other times and places can help us uncover our ‘contextual blind spots and historical idiosyncrasies’ (Porter, 2004).

2.2.3 Reason

Reason at the time of the Enlightenment called for a rationalist approach to traditional learning and knowledge as favoured by the philosophers of the time (Campbell, 2010). The concept of reason or the ability to rationalise is, for Wesley, a gift from God that was given at the time of creation (Crump, 2012). Wesley believed that people are created in God’s image, and that reason is part of this divine reflection (Cosby, 2002). Wesley advocated the use of reason in theology since reason provides to theology the intellectual ability to come to

justified beliefs about aspects of theology, especially where there is conflict or disagreement (Porter, 2004). He appreciated both the value of reason and its limitations.

Wesley argued that to renounce reason was to abandon religion, that religion and reason belong together, and that all irrational religion was false religion (Thorsen, 1990, p.169 in Porter, 2004). However, Wesley felt that reason alone leads to a limited understanding of God. For him, the Scriptures provided detailed knowledge of God. At its best, human reason was limited because man was not able to understand everything and at its worst, reason could lead man away from the truth (Cosby, 2002). Cosby (2002) goes on to argue that although human reason is limited, it is a precious ability that humans should learn to use effectively in order to live responsibly. While Wesley acknowledged the limitations of reason, he maintained that right reason and interpretation would always provide consistency. Further, Wesley also felt that humans have a God-given ability to perceive a reality that transcends the boundaries of enculturation (Cosby, 2002).

According to Porter (2004), reason, which requires critical analysis, plays at least three 'ministerial roles' in theological reflection. In the first role, reason provides clarity, where it clarifies and effectively organises terms and thoughts. In the second role, reason provides the logical norms involved in real forms of reasoning. Finally, reason can be used to rationally confirm and defend one's conclusions in theological deliberation (Porter, 2004).

Crawford (2017) argues that there are two kinds of reason within the Wesleyan Quadrilateral: a background of knowledge and the discipline of reading broadly, and the process of thinking or deliberation. Firstly, Wesley was extremely well-read in a variety of subjects in order to understand the workings of the world and creation. For Wesley, the discipline of reading and better informing oneself helps one to understand and experience the world more thoroughly. Today, resources drawn upon in the reasoning process include the sciences, philosophy, social sciences, and cultural factors (Gilbraith, 2016; Mann, 2017). Science, based upon observation and experiment is purely reasonable, and its truth is perfectly available to all rational minds 'in some kind of absolutist and objective way' (Mann, 2017).

Secondly, reason is a process of organising thoughts and thinking through something. Wesley was familiar with logic, which he studied and taught at Oxford, but did not limit reason to the rationality that comes from making logical arguments (Crawford, 2017). For him, reason was also a mediating construct that helps one make decisions about what is useful or helpful and

what is not. Further, reason as a mediator helps one to discover the Word of God by understanding the role of tradition in Scripture and how Scripture works in itself (Crawford, 2017).

2.2.4 Experience

The fourth tenet of the Wesleyan Quadrilateral is experience. Experience, in the context of the Wesleyan Quadrilateral, does not refer to past or personal history but rather to a phenomenon that comes through a personal relationship with God (Crump, 2012). The role of experience is to provide reception of the biblical revelation into the heart through the faith that one has (Outler, 1985). Experience offers a subjective dimension to the Word of God, and it balances the tendency towards an overly rationalistic religion. Scripture, Reason, and Tradition provide safeguards to interpretations of religious experience, but Experience provides the validation and context for the other three sources. Humans experience the reality of God when the other three sources are in place. According to Porter (2004), experience can confirm what Scripture teaches, providing an assurance of Christian beliefs and a means of gaining empirical knowledge relevant to the canon of Scripture.

Thorsen (2008) argues that Wesley was open to what could be learnt through relevant experience, whether it included personal, social, or scientific experience. The more contemporary interpretation of experience in the Wesleyan Quadrilateral includes our general experience of the world as well specifically religious experience (Campbell, 1991). This general experience would consist of both the personal and the collective and can be a shared occurrence (Whidden, 1997). Therefore, Experience in the Quadrilateral can be understood as that event that occurs when a decision or conclusion is reached, which concurs with Scripture, following the analysis, deliberation, and interpretation of Scripture, through Reason and Tradition.

2.3 The Wesleyan Method Explained

The Wesleyan Quadrilateral, as a methodology, is an aid to theological deliberation and analysis. However, this term coined by Albert Outler (1985) for Wesley's four sources of knowing, was actually a misnomer. Outler (1985) had meant the term "Wesleyan Quadrilateral" as a collective, but it was a misnomer in that it implied that the four sources were equally weighted when deliberating a quandary. The four doctrinal norms were intended to be used in a "step-wise" fashion, with Scripture being the pre-eminent source of direction (Campbell, 1991). Therefore, the term "Wesleyan Quadrilateral" has been criticised for its

implication that the four elements are equally weighted in theological deliberation. However, Thorsen (2008) argues that the term is useful when discussing Wesley's practices, values and beliefs, while at the same time affirming his emphasis on the primacy of scriptural authority.

Wesley was aware that Scripture alone would rarely settle any controverted aspect of doctrine on its own, so he appealed to the Christian *tradition* of the 'primitive church' as a complement to Scripture's meaning (Outler, 1985). Wesley also recognised that Scripture and tradition were insufficient sources, and consequently, critical reason was an essential addition to the other two tenets (Outler, 1985). Wesley insisted on logical reasoning or "cohesion" as an "authorised referee" on any point of contention (Outler, 1985). The fourth source for Wesley was that of experience, specifically the Christian experience of the assurance of redemption. Scripture was the pre-eminent norm interfaced with the other three sources in the interpretation of the Word of God in Scripture. Thus, Scripture establishes the parameters for the proper exercise of reason. Further, it provides the standard for measuring logic and experience.

Although Scripture is the primary source of authority, other sources are needed to understand the message of God delivered in the Scriptures entirely. To interpret and understand the Scriptures and to provide insight into God's truth, a variety of sources complementary to Scripture need to be used. The insights of tradition, reason, and experience work together to bear upon and enrich Scripture and not overshadow it (Crawford, 2017).

Crawford (2017) explains that enabling interpretation of the Scriptures in the search for truth in them, Scripture, requires that the reader "play" with the other three tenets in various degrees in a way that provides some enlightenment in the Word of God. The Wesleyan Quadrilateral does not offer a formula for the extent to which the other three sources are to be used, and it is up to the reader to "play" with them to find the truth (Crawford, 2017). This deficiency may result in the reader using more of one element than another, but always reverting to Scripture as supreme. Thorsen elaborates that within the Quadrilateral, 'tradition, with proper discernment, reinforces the truth of scripture, as do reason and experience' (Thorsen, 2005, p.38 in Crawford, 2017).

According to Thorsen (1990; 2008), within the Wesleyan method there should be constant interaction and interdependence between the study of Christian church history, tradition and relevant experience, enhanced by the use of critical thinking in the analytical process.

Thorsen (1990), to illustrate the hierarchical and stepwise process of the Wesleyan Quadrilateral, describes it as a three-sided pyramid (Figure 1) with Scripture as the foundation upon which the others rest. This depiction provides a more accurate description of the hierarchical method than Outler's apparently equally weighted 'Wesleyan Quadrilateral' (Figure 2).

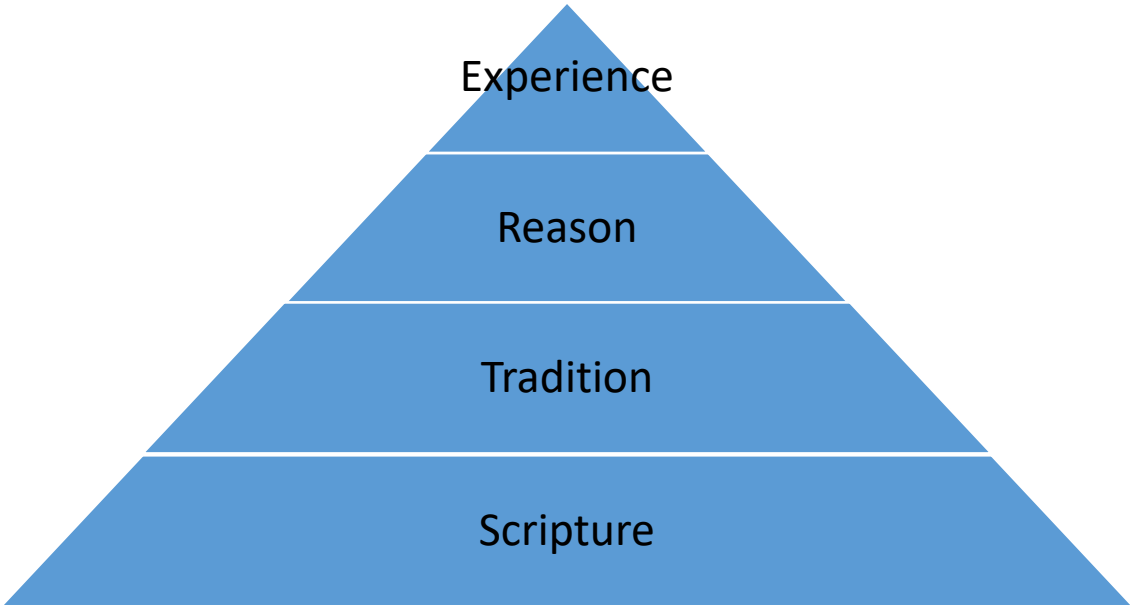


Figure 1. Thorsen's Pyramid

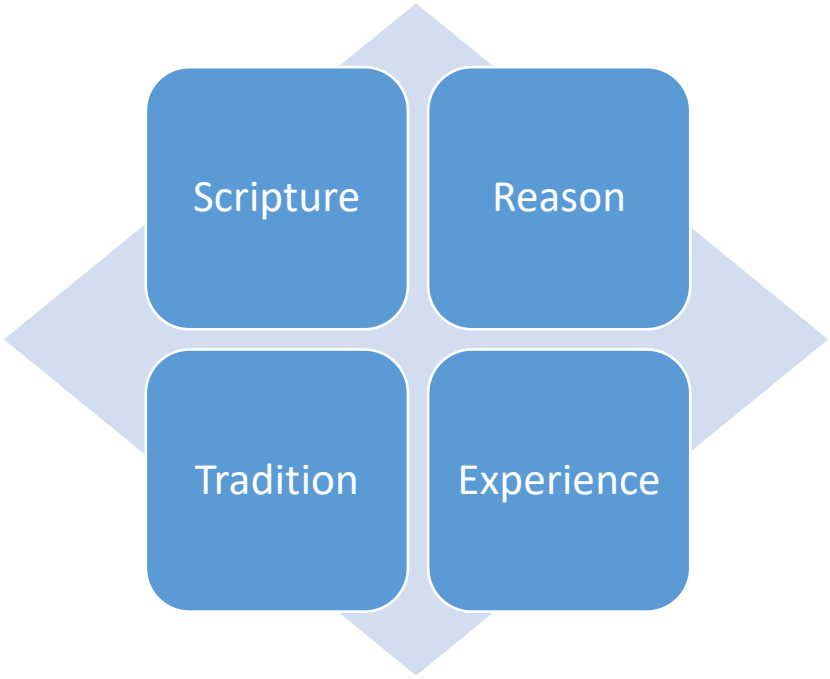


Figure 2. Outler's Wesleyan Quadrilateral

2.4 Weaknesses and Strengths of the Wesleyan Quadrilateral

There are several critiques of the Wesleyan Quadrilateral method. Some of these critiques addressed here include the contention between a *Sola Scriptura* versus a *Prima Scriptura* (Whidden, 1997); that the method is epistemologically and hermeneutically limited (Stovell, 2015; Cosby, 2002); that it offers only a methodology for theological reflection and not a basis for the affirmation of the substance of historical, doctrinal claims (Abraham, 2002 in Campbell, 2010); it does not provide a formula for the extent to which tradition, reason and experience are to be used (Crawford, 2017); and finally, that the method dilutes the authority of Scripture (Osei-Bonsu & Samson, n.d).

The strengths of the Quadrilateral can be briefly stated: it provides a logical method and framework for theological deliberation and analysis.

Weaknesses of the Quadrilateral

2.4.1 Sola Scriptura vs Prima Scriptura

Some Protestant tradition argues that the sole source for decision-making in theological, moral quandaries should be the Bible (*Sola Scriptura*). Wesley's interpretation of this Protestant tradition was that Scripture should be the first or primary source (*Prima Scriptura*),

but not the only source. He argued that the other three sources were complementary and provided clarity and strength to the outcome (Cosby, 2002). Because it is the first source does not mean it should exclude the other three sources.

"Prima Scriptura reflects the conservative Protestant concern for the *normative* finality of biblical authority, but it realistically acknowledges that other factors (such as tradition, reason, and experience) play powerfully *formative* roles in interpretive and doctrinal development" (Whidden, 1997). Thus, the Scriptures are used as a "canon" and by working through the contributions that tradition, reason, and experience give, one is ultimately led to an answer.

Whidden (1997) argues that the problem with *Sola Scriptura* is that it is too fundamentalist and focuses on the perceived inerrancy of the Bible. The *Sola Scriptura* traditions also ignore the influences of historical and contemporary 'formative' church leaders over the interpretations of Scripture. Whidden (1997) goes so far as to question the claim of Scripture as a sole ultimate authority if key formative figures are Church mentors that bring their own interpretations from different contexts and eras.

The implications of *Prima Scriptura* instead of *Sola Scriptura* are: an honest self-criticism or reflexivity; a greater focus on the message of Scripture, rather than the medium of the Bible; and the inclusion of personal and collective experience. Whidden (1997) describes this as more productive for theological formation. Use of Tradition, Experience and Reason in "dynamic conjunction" with Scripture keeps religious thinking open and unlimited (Whidden, 1997). According to Paul Basset (1983) cited in Whidden (1997):

> 'It is the specific task of Scripture, within the Quadrilateral, to serve as the foundation for "norming" the other norms, by the inspiration of the Spirit.'

2.4.2 The Quadrilateral is epistemologically and hermeneutically limited

Jon Stovell (2015) argues that the Quadrilateral is limited since epistemologically, there is no unmediated access to any of the four elements. Scripture cannot just be accessed, only our interpretations of Scripture can be accessed, and the same applies to tradition. He argues that our experiences cannot be accessed because they are already interpreted by the time they are accessed. Finally, reason is not directly accessible because what we access is always our interpretation of what is reasonable and how to reason. This critique highlights the fact that the four sources are not equal and should not be used "unweighted".

Probably the biggest critique of the Quadrilateral would be the matter of hermeneutics in each one of the tenets. Hermeneutics refers to ways of interpretation and can be either literal or philosophical. It is almost always dependent on the interpreter, context and experience (Urrutia, 2005). Understandings of God and interpretations of Scripture and traditions are received within particular social and historical contexts, and in interaction with their communities and their traditions (Hey & Roux, 2012). Every Christian group has its own historically situated standards for determining what is authoritative for doctrine and practice. Sound interpretations of text should follow the intended meanings of the writer, within the original context. The role of the reader's traditions and community in influencing the way the text is read should also be recognised (Hey & Roux, 2012). Further, interpretations can vary greatly depending on traditions, systems of reasoning, or other viewpoints (Hey & Roux, 2012).

However, while everyone interprets Scripture from their own viewpoint, experience, study, and reason, the strength of the four-element approach is that it encourages a balance between the four sources or tenets of the Quadrilateral, but at the same time, it diminishes the tendency for an over-reliance on any one of them.

2.4.3 The quadrilateral is a methodology, not doctrinal affirmation

The method is also criticised on the premise that the Wesleyan Quadrilateral only offers a methodology for theological reflection and not a basis for the affirmation of historical, doctrinal claims. Campbell (2010) argues that this critique is ignorant of the context of "Outler's misnomer". He defends the Quadrilateral on the basis that it was meant to function as a guideline for the Church as new issues became apparent that had not been dealt with historically or in traditional formulations of doctrine (Campbell, 2010). It was not meant to replace the central doctrines affirmed by the United Methodist Church (Campbell, 2010). It was intended to provide enlightenment and insight as society and the Church evolved, and new issues arose that needed reflection and policy.

2.4.4 The formula for the use of each authority

There is no formula for the extent to which each authority is to be used in theological deliberation, analysis, and decision-making. Instead, there should be a play amongst the four sources until a reasonable conclusion is reached. Ultimately, Scripture has supremacy, and any deliberation should revert to Scripture for confirmation.

The framework of the Wesleyan Quadrilateral is that it is a conversation among the four religious sources with Scripture setting the criteria and guidelines. It is not a matter of using the resource that seems the most helpful or of playing one resource against another, but instead, conferring among them until agreement is found. This consensus would arise when each of the three complementary sources was used rightly and rationally in symphony with Scripture (Maddox, 1997).

2.4.5 The dilution of the authority of scripture

According to Gulley (2003, in Osei-Bonsu and Samson, n.d.), the Quadrilateral demoted Scripture from its position of supremacy and made it equal to the other lesser, human sources of tradition, reason, and experience, making it a 'witness' to revelation rather than the only source. This criticism is based on 'abuse' of the Quadrilateral by those who take it literally and attempt to consider each of the four sources dialectically, granting each of the sources relative autonomy (Osei-Bonsu and Samson, n.d.). Wesley did not intend this interpretation of his method, but it became the 'misguided' use in terms of Outler's metaphor. However, it can equally be argued that it was the Enlightenment concept of Reason and not the Quadrilateral that lowered or diluted the authority of Scripture, because it forced people to confront what they thought Scripture revealed.

Strength of the Quadrilateral

Thorsen (2008) argues that the strength of the Wesleyan Quadrilateral lies in the way it helps Christians realise more readily the complementary rather than the contradictory relationship between Scripture, Tradition, Reason, and Experience.

He claims that because we live in a postmodernist age, which rejects modernism and, questions the ability of each individual to be objective in their search for the truth using philosophical and scientific investigation (Thorsen, 2008). Modernism advocated the use of reason and rationalism in the search for the truth. Thorsen, on the other hand, posits that in a post-modern world, knowledge is connected to the socio-cultural context in which learning occurs. The Quadrilateral acknowledges the experiential dimension of knowledge and the complexity with which Christians formulate their beliefs, values, and practices, and accepts the socio-cultural context of learning with the addition of experience.

From the hermeneutic perspective, while it may be argued that we interpret Scripture from our own viewpoint, experience, and reason, the strength of the four-source approach is that it

encourages the balance between these valued Christian sources and at the same time, limits the tendency for an over-reliance on just one source (Hey & Roux, 2012). Hey and Roux (2012) argue further that the Wesleyan method also supports a sense of continuity with previously held religious belief and understanding (tradition), while opening it up to new understandings and interpretations.

2.5 Additional Use of the Wesleyan Quadrilateral in Contemporary Times

In addition to the work of theology and theological deliberation, the Wesleyan Quadrilateral is used evangelically as a basis for preaching and sharing the Word of God (Crawford, 2017). Importantly for this research, it is also used as a method for teaching theology and reasoning (Cosby, 2002; Hey & Roux, 2012; Felton, 1997; Thorsen, 2008). Cosby (2002) proposes that the method is useful for overcoming a 'pluralist impasse', that is, the hostility and challenges encountered by those teaching Biblical studies face from the plurality and diversity of students that come together to study theology. Cosby (2002) argues that the Wesleyan Quadrilateral bridges the gap between left- and right-wing extreme perspectives while relying heavily on tradition, reason and experience. The Quadrilateral also promotes interaction with the spiritual, moral and ethical concerns expressed in biblical texts. His objective for the use of the Quadrilateral is to provide contemporary relevance to education. Further, using it is important for character formation. It also avoids relativism in that it critiques traditions to determine what beliefs need to be modified while at the same time, building a greater respect for other traditions.

Thorsen argues that the Quadrilateral also promotes interaction with the spiritual, moral and ethical concerns expressed in the biblical texts (Cosby, 2002). Further, he proposes that if only 'historical-critical or literary information without considering contemporary relevance is taught, we bore students and fail in our duties as educators' (Cosby, 2002, p.71). In other words, we do not inspire those we teach if we merely dispense information but do not teach the method or application for that information.

Cosby (2002) describes the "middle-way" of Wesley's method where the Bible is maintained as the centre of reflection on theology and practice, while at the same time employing the tools of modern scholarship. Cosby (2002) argues that Scripture, for Wesley, plays a foundational role in efforts to create stances on ethics, morality and daily life issues. In recognising different cultural perspectives and interpretations, Cosby (2002) uses the Wesleyan Quadrilateral to teach students to identify the ambiguities of interpretation and

application and to deliberate and reflect more critically. He balances the views of Scripture, Tradition, Reason and Experience. He argues that the implementation of the model also avoids extremes, good or bad, of reason and is specific to contemporary relevance (Cosby, 2003).

Thorsen (2008), explains that in a post-modern world, the use of the Wesleyan method is useful because of its theoretical and practical capability in dealing with life's difficulties. He argues further that Wesleyan Quadrilateral can be helpful to Christians in teaching any subject, whether the arts, humanities or science (Thorsen, 2008). For him, Wesley provides a dynamic, interdependent understanding of authority. The Wesleyan Quadrilateral also provides for more complex and relevant ways of discovering, integrating, applying and teaching truth (Thorsen, 2008).

Theology students often struggle with the challenge of integrating the faith and traditions that were part of their sociocultural upbringing with critical and diverse perspectives required in tertiary education (Hey & Roux, 2012). Intellectual, social and faith development requires a well-developed dialogue between one's perspective and the perspectives of others. Hey and Roux (2012) in teaching theology, sought to establish a robust framework that promoted the development of academic critical thinking skills which at the same time, supported the integration of theory and practice. They argue that the Quadrilateral provides this framework usefully, because it integrates different perspectives, sources of authority and ways of gaining knowledge, while simultaneously developing the critical skills needed to analyse information and make academic progress. It also assists with putting learning into practice when integrated with a praxis cycle (the praxis cycle is not discussed here). For them, the Wesleyan Quadrilateral is a:

> '…useful aid to tertiary Christian education, facilitating the integration of students from a variety of backgrounds, promoting interaction with the spiritual, moral and ethical concerns expressed in the biblical texts, and encouraging reflection on the roles of Christian communities' (Hey & Roux, 2012, p.195).

For Hey and Roux (2012), the strength of the Quadrilateral is that it encourages a balance between the four elements that Christians most value while limiting any tendency for an over-reliance on one source since 'a single source of authority cannot support a sound theology' (Grenz and Franke, 2001:51, in Hey and Roux, 2012).

Skills in hermeneutics and discerning the power of language are important tools for not only interpreting the past but also for present sources of knowing. The idea that a single source of authority can support a sound ethics is ill-conceived.

Consideration of historical contexts can enhance historical knowledge. It can also enhance understanding of the ways in which those sources of knowledge have been understood and valued in particular historical contexts and also of how they have evolved. Considering historical contexts also helps one to appreciate how contemporary tensions between different ways of knowing arise and how they might be resolved.

No tradition can be solely dependent on biblical texts, since biblical texts must be interpreted within the conceptual frameworks and contexts in which biblical authors lived and contemporary readers live (Osborne, 2006, p.6).

In practice, Scripture is not used exclusively in theology. Ideally there is constant interaction and interdependence between the study of church history and relevant experience with critical thinking. The Quadrilateral acknowledges the experiential dimension of knowledge in a post-modernist society where knowledge is bound up with the socio-cultural context in which learning occurs.

2.6 Justification and Defence for a "Wesleyan Quadrilateral" in Medical Ethics

Making decisions in moral and ethical dilemmas can be difficult for medical doctors. It is premised that physicians are morally and ethically informed, and make their decisions normatively using professional ethical guidelines, codes or the law. Medical doctors are taught medical ethics and bioethics as undergraduates. In furthering and maintaining their awareness of medical ethics, doctors are also expected to collect a prescribed number of "ethics points" as part of continuing professional development and education once they have graduated. However, there is a difference between "knowing" and "doing". Physicians may be given the "toolset", but do they know how to apply medical ethical principles in clinical practice?

There is growing awareness in contemporary medical ethics of the existence of the plurality of cultural, religious and philosophical traditions in modern societies, as well as the plurality of the normative frameworks, their particular moral reasoning and potential for moral or ethical conflict that these bring with them. Despite the awareness of all this, professional and

ethical guidelines prescribe “ethical” action regardless of the doctor’s personal subscription to a particular set of religious beliefs or cultural values.

The rationale for my choice of the Wesleyan Quadrilateral as an exemplar for a method in medical moral and ethical decision-making is that it uncomplicated, uncluttered and not cumbersome. It relies on personal morality, normative tradition, experience, both personal and peer, and reason. Finally, it seeks confirmation in Canon, which is not only about the law (which may sometimes be unethical or morally wrong) but provides confirmation for the ‘right’ decision where there is moral conflict. In this way it also helps to prevent personal bias or cultural leanings. Decisions in moral and ethical quandaries in the clinical context cannot be absolutist and the use of the four authorities obviates this. The adapted Wesleyan Quadrilateral would assist in overcoming the absolutist and pluralistic obstacles to moral and ethical decision-making by providing a logical framework to guide the process.

The ethical position is always placed within a code of general rules and principles. It is generally held that ethical principles or moral rules are exhaustive of ethics and that a commitment to some codes accepted as authoritative, is all that is required for a moral understanding (Churchill, 1977).

Williams (2015) argues that medical ethical decisions are made rationally or non-rationally. Rational decision-making involves the use of traditional ethical theories, principles and professional guidelines (Williams, 2015). While moral decisions should certainly be considerate of principles, ideas, emotions, values and beliefs, deliberation should be the foundation of any adequate decision-making methodology (Overberg, 1998). Ultimately, moral decisions should be reasonable and prudent. Thus, a reasonable and prudent method should be utilised to reach decisions.

Arguably, moral decisions cannot be made completely rationally, since they are influenced by feelings, values and beliefs. Non-rational decision-making is a moral experience that is about more than laws, principles and ethical guidelines, but also about processes (societal, interpersonal and personal) that realise values in ordinary living (Kleinman, 1999). Non-rational approaches are not always reasoned normatively. Moral and ethical deliberation and decision-making is thus multifactorial and requires knowledge and consideration of all the specifics of the case at hand.

Pellegrino (2001) describes medical doctors as having both a personal and professional morality. Personal morality may have its origins in sources external to medicine. It may describe the moral character of the medical doctor before becoming a clinician and appropriating a professional morality. The result is a duality: morality intrinsic to the character of the person and morality essential to the professional. In the professional space, professional morality is expected to take primacy. Sometimes the context of the clinical ethical dilemma and the strength of the influences of personal morality may produce dissonance between the values of the doctor, the expectations of the patient and professional normative prescriptions.

Medical practitioners are taught ethics, but do they know how to apply ethics? They may be ethics theorists but are they practitioners of ethics? The question underlying this research is how physicians resolve moral and ethical dilemmas in the clinical space, and what normative sources, if any, are drawn upon to justify their ultimate decisions and actions.

Applied medical ethics is the discipline where a pre-determined, well-defined set of theories and principles are applied to a variety of medical quandaries that occur in the clinical context. Medical ethics is, however, more than the application of moral theories and principles. The healthcare environment is also more than the domain of the application of these theories (Ten Have & Lelie, 1998). Moral theories and principles are necessarily abstract and therefore fail to consider the sometimes-idiosyncratic reality of clinical work and the actual experiences of the medical doctor. Medical doctors have, accordingly, criticised applied medical ethics for being too dogmatic and theoretical, and have also criticised ethicists for being alienated from clinical reality (Ten Have & Lelie, 1998).

Applied medical ethics is critiqued even further by Ten Have and Lelie (1998) for the lack of attention given to particular settings, and for its failure to integrate theory with the lived reality of clinical practice.

However, applied medical ethics can clarify complicated moral quandaries by analysing various ethical dimensions with the help of an analytic framework

> ‘What is the point of knowing good if you do not teach people to be good and do good? The highest purpose of Christian doctrine was providing practical guidance for Christian life in the world’ (Maddox, 1997, p.126).

Mann (2017) argues that Scripture, Tradition, Reason and Experience, the four sources in the Wesleyan method, work together to bring us to the truth or the correct decision. In the same way, the establishment of a framework based on the four elements to analyse and facilitate decision-making in moral and ethical dilemmas in the clinical context, would be helpful.

In agreement with Crawford (2017), I understand the Wesleyan Quadrilateral, as a logic or way of thinking in the practice of theology. I believe that a similar method can be applied to medical ethical and moral decision-making in clinical practice. In the clinical space, to arrive at any scientific or ethical conclusions, one should follow some principles or methodology. In the work of medical ethics, a four-element ethical framework based on the four sources of the Wesleyan Quadrilateral and modified for use in clinical bioethics would provide a structured approach to ethical and moral decision-making. Arguably, a modified "quadrilateral" specific to clinical ethics could apply logic to ethical and moral dilemma resolution in the clinical space. Instead of merely following or applying principles, one could refer to known law and ethics and professional guidelines and then use the other three elements to arrive at a justifiable conclusion. Alternatively, one could begin with one of the three lesser elements and then revert back to the primary source for confirmation and justification for the decision made. The four-element framework could aid in integrating medical ethics theory with medical practice.

Currently, medical ethics maxims, guidelines and law are the *Sola Scriptura* of clinical practice. They prescribe the "ought" of all moral quandaries. They are, however, inconsiderate of context (temporal and spatial), personal moralities, physician reason and autonomy, and other factors which may be brought to bear on decision-making in the clinical setting. Moral quandaries in medical practice do not occur in vacuums. To this end, a different approach to moral and ethical decision-making should be considered rather than the rigid, prescriptive, inerrant "ought" currently in use. Just as no-one uses Scripture exclusively in the Wesleyan Quadrilateral (Thorsen, 2008), so normative theory and principles should not be used exclusively. A framework that utilised other sources of knowledge would enrich moral and ethical decision-making.

Quandary ethics, just like the complexities of life in theology, emanates from the pluralism of ideas that come from diverse secular heterogeneous societies. These problems are the result of the different interpretations made by humans and are dependent on the interpreters, contexts and eras of all these interpretations. As with the Wesleyan Quadrilateral, the Tetrad can

provide a way out of the "pluralistic impasse" through the judicious use of the methodology provided.

The Wesleyan Quadrilateral begins and ends with Scripture as the primary source. It is also a normative authority. The primary source of authority in the Ethics Tetrad, under the heading of Canon, would encompass professional ethical guidelines; "universal" ethical principles and codes; and national and international health law. These normative sources would be the primary source of authority, a *prima auctoritas* (Latin: the first authority), for ethical and moral thinking and analysis in the clinical space. As a consequence, it should dominate the normative thought and approach to moral and ethical dilemmas in clinical practice (quandary ethics).

This placing would not make professional guidelines, codes, maxims and law inerrant or negligible; but it would rather facilitate a process of deliberation that would encompass the parameters and influencing factors that come to bear in the phenomenology of moral and ethical decision-making in clinical practice. As a *prima auctoritas,* Canon would provide a normative finality for ethical knowledge and justification. At the same time, it would acknowledge the role the other three sources for deliberation have to play in interpretation and further ethical and moral development.

The adapted medical ethical Quadrilateral, just as the Wesleyan Quadrilateral does for theology, would bring in other supplementary sources to aid interpretation and facilitate deliberation in the practice of moral and ethical decision-making. Although Canon is primary, it still needs interpretation. The normative sources prescribed for moral and ethical dilemmas in clinical practice also require analysis. By bringing in the other three elements to facilitate and aid interpretation and thinking, our understanding is enriched. Quandary ethics deals with real human situations, and it is these situations where the human sources of moral wisdom and knowledge, especially reason, philosophy, science and human experience should play a role (Curran, 2011). Thus, in the practice of medical ethics, the sources of tradition, reason and experience would be supplementary in the modified bioethics quadrilateral. As in the Wesleyan methodology, these three sources are not meant to confute or contradict the primary source, but are there to add new knowledge, rationality, logic and understanding.
Following Canon, the second important source of authority would be Tradition. Tradition would give content and form to the primacy of Canon. The element of Tradition would include historical bioethical theory, moral philosophy, medical, religious and cultural

traditions and casuistry. Tradition would also serve as a precedent for future dilemmas, which, even though they may not be exactly the same problem, may be analogous to present-day challenges. Also, by alerting the agent to less historically or contextually biased understandings of text and doctrine, tradition would help to address historical and cultural bias by providing clarity.

Reason, as in the Wesleyan Quadrilateral, would be the third element. Reason would be applied as in the method of Wesley, in two ways. Firstly, where the "interpreter" would be well informed and well-read so that reasoning "blindly" is avoided. Secondly, where the interpreter applies a logical system of rational thinking and uses reason as a mediator. Porter (2004) argued that in theology, reason, which requires critical analysis, plays three roles: the provision of clarity (where it clarified and organised terms and thought); the provision of logic and finally, where it can be used to rationally confirm and defend one's conclusion in deliberation. I argue that in exactly the same way, in medical ethics, reason could play the same roles. Further, reason would also assist in the integration of science, ethics and practice.

The final source would be that of Experience. The difference between the Wesleyan Quadrilateral and the bioethics Tetrad would be that Experience, in the latter, would encompass clinical, ethical, and moral experience, personal and collective. "Collective" experience here refers to that of peers, and the knowledge of consequences of previous experience.

Just as in the Wesleyan Method, there is no formula for the extent to which each authority is to be used in deliberation in medical ethical and moral quandaries. Instead, there should be a play amongst the four sources until a reasonable conclusion is reached. Ultimately, Canon should have supremacy and deliberation using the other three sources, should revert to Canon for confirmation and justification.

While it can easily be argued that as with neo-casuistry, it would make more sense to prioritise the precepts of tradition (referring to historical precedents as paradigms), reason and experience over Canon in medical moral and ethical decision-making, I argue that the advantage of having Canon as the final justification, is that in a diverse pluralistic world, the "standardised" professional ethical guidelines, law and principles that Canon has to offer would alleviate personal bias and particularism on the part of the decision-maker.

CHAPTER 3

PHASE I: THE DEVELOPMENT OF THE ADAPTED WESLEYAN QUADRILATERAL

3.1 Introduction

Arguably, very often in daily medical practice, where there is a medical or ethical dilemma, that dilemma is embedded in the clinical context and all its variables. It is generally premised that doctors resolve these conflicts by referring to professional and ethical guidelines as well as the law. Ultimately, it is the physician who, considering all variables and consequences, has the duty to act ethically.

The decisions are usually "immediate" and "in the moment". They are not decisions that are made in a vacuum. Rather, one would expect the physician to make these decisions only after adequate deliberation of the quandary, using a careful decision-making process with a sound normative foundation. Often, however, this is not the case, and decisions are made quickly and instinctively from habits developed over a lifetime (Crump, 2012). Hastily made decisions based on what seems the best way at that moment, without assessment of consequences for others or the long term, are short-sighted, limited and fail normatively. The method used to make moral and ethical decisions is important, has significant consequences and should be justifiable normatively. Codes, guidelines, and principles are taught, but there is no real established method for applying this knowledge. Further, various processes for moral decision-making are also described in the literature (Moodley, 2017; Overberg, 1998). However, there is no formal process for integrating theory and practice or that reflects on the justification for the final decision (Crump, 2012).

Phase I of this research began with an extensive review of the literature, which examined normative and non-normative sources for moral and ethical decision-making in the clinical context. This process was enabled by reviewing current and past medical ethical literature, as described in section 1.9.

The literature review highlighted the concept of four authoritative sources that may be used to facilitate the resolution of medical ethical and moral dilemmas. These four precepts provide the foundation for an analytic tool, loosely based on the Wesleyan Quadrilateral. The modified quadrilateral developed a framework incorporating the four sources medical doctors

ought to refer to when making ethical and moral decisions in the clinical context. These sources are, Canon, Tradition, Reason and Experience. The adapted "Wesleyan Quadrilateral" which for the purposes of this research is called the Ethics Tetrad, uses the idea of the four sources as in the original quadrilateral except for the source of Scripture. In the Tetrad, the authority of Scripture is replaced with the authority of Canon. While no one precept is more important than another, the precept of Canon takes primacy and is the source to start from and revert to, for normative confirmation. The Ethics Tetrad also enabled the analysis of medical doctors' responses obtained in Phase II.

The four sources are justified by Callahan's (1999) argument, that in addition to using formal theories to analyse ethical issues, to reason ethically requires three skills: knowledge of the traditions of ethics (religious and secular); a social perceptiveness; and self-knowledge (Callahan , 1999). Social perceptiveness refers to the capacity to understand our own culture and the way it has shaped our values and norms. This is the basis for the tenet of Experience. Self-knowledge is defined by our ability to introspect, to understand our own biases, moral weaknesses and inability to resist self-deceit (Callahan , 1999). Self-knowledge is the basis for Reason.

Finally, the addition of law and human rights to the source of Canon was essential. Medical ethics is closely related to the law, and in recent times, medical ethics has been greatly influenced by developments in human rights.

The following four tenets were therefore proposed as the normative sources for facilitating a reasoned decision in moral and ethical dilemmas in the clinical context. These tenets, with elaboration, are Canon (incorporating law; professional codes and guidelines; and current medical ethical theory and principles); Tradition (including societal values; medical tradition; religion and cultural traditions and normative theory); Reason (scientific and medical; moral reasoning; justice and fairness and critical analysis) and finally Experience (conscience, intuition, context, medical experience, personal experience, peer experience).

The four sources form an integrated framework for ethical deliberation for moral and ethical judgements in medical ethical and moral quandaries. Further, they provide the foundation for the discerning philosophical approach described by Overberg (1998) in, section 1.2.7 to assist with conflicts in moral decision-making. This framework combines the value and wisdom of

law, medical ethics and professional guidelines with the unique and individual aspects of concrete ethical cases by way of using tradition, reason and experience.

3.2 The Ethics Tetrad

As described previously, the Wesleyan Quadrilateral was chosen as an exemplar for the Ethics Tetrad because it provides a normative framework for ethical and moral decision-making. It is not a normative theory, but rather a valuable tool for the integration of normative theory, professional guidelines, and the law with everyday medical practice. I decided to formulate the tool as a tetrad (Figure 3) rather than a quadrilateral because the Tetrad, as I have designed it, demonstrates the primacy of Canon whereas, as in the Wesleyan Quadrilateral, a quadrilateral would wrongly imply that all four sources are equal. In the Tetrad, Canon is the *prima auctoritas* and is the both the starting and endpoint for normative justification in medical moral and ethical quandaries.

The tool helped enable the analysis of medical doctors' responses obtained in Phase II. It is also hoped that this framework can be used as a tool in teaching medical ethics methods for ethical and moral deliberation and enabling appropriate justification for decisions reached. The simple Ethics Tetrad is illustrated in Figure 3.

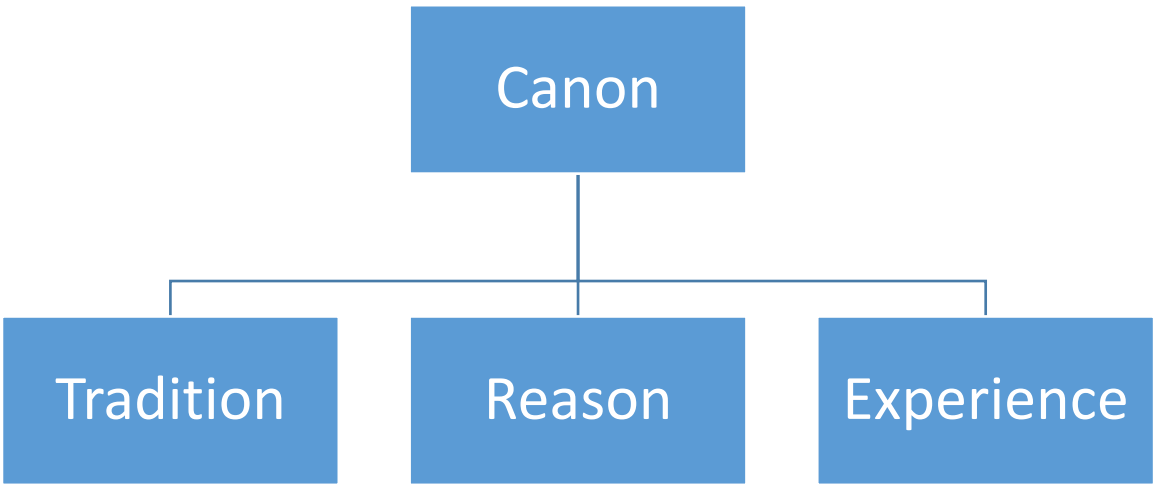


Figure 3. The Simple Ethics Tetrad

The Ethics Tetrad, as illustrated above, demonstrates the primacy of Canon but not to the exclusion of the other three tenets. The other three are to be considered in varying degrees,

(sometimes one tenet may have more to offer than another), and worked through, ultimately referring back to the first source. Any one of the three supplementary sources can be used more than another, but ultimately confirmation for the decision should be justified by Canon. Canon, referring to current ethics guidelines, codes and principles, human rights and law, takes primacy. On a lower but equal level, the three sources of tradition, reason and experience are presented. Tradition would refer to normative theory, as well as cultural, religious, and societal traditions. Reason refers to the ability to rationalise and deliberation of rational and non-rational factors as well as the implications and consequences of one's actions. It also includes scientific reason. Experience would include individual experience and influencing factors based on this experience, such as conscience and intuition, and history. It would also include the experience of peers, colleagues, and mentors.

3.2.1 Canon

The primary normative authority for the Tetrad is Canon. Canon is defined as "an accepted principle or rule; a criterion or standard of judgement; a body of principles, rules, standards or norms" (Oxford Everyday Dictionary, 2005). Canon in the Tetrad is used as a collective term to incorporate ethics principles; South African, international, and institutional ethics guidelines; national law, international conventions, and declaration; and common law. Canon may be legally constituted, rule-bound or a subscription to an international convention. It is thus recognised as those rules or principles that overarch "lesser" rules, norms, or values, since these canons are designed to govern and protect society as a whole.

Other than technical or scientific decisions to be made in the care of patients, Foster and Miola (2015) posit that the type of decisions that doctors make when faced with quandaries are either legal, ethical and/or moral. Legal decisions are those where the decision is mandated or prescribed by law; "ethical" decisions are those prescribed and regulated by the medical profession itself; and moral decisions are those determined by the conscience of the medical doctor (Foster & Miola, 2015).

Ethical decision-making in the clinical context is complex and often involves more than the many members of the healthcare team, but also the patient and their family. There exist other influences such as ethics committees, healthcare administrators, medical aids and the government, each with their own normative or legal prescription about what "ought" to be done. While not actively involved in the ethical decision-making process, these bodies do exert an influence on the practitioner involved in the ethical quandary. Arguably, knowledge

of the law and human rights obligates one to act within the law as well as to act morally and ethically (Callahan, 1999); however, the current decision-making processes open to legal and professional guidelines may serve to limit the options available to the doctor in a dilemma.

In South Africa, ethics application in the law relating to the health context may be found in the Constitution of the Republic of South Africa (Act 108 of 1996), certain Acts of Parliament, for example, the National Health Act, 2003 (Act 61 of 2003) and various regulatory and policy documents. However, the complexity of ethical issues is reflected in the complexity of legal issues when it comes to resolving conflicts of conscience in secular and pluralistic societies (Wicclair M. , 2000). Once the ethical issues are expressed in law, the contention may be reduced to instruments and procedures that cannot resolve fundamental moral tensions (Pellegrino, 2002a), and in some cases may even exacerbate them.

Law and professional guidelines are sources to be referred to in order to ensure that decisions made in moral and ethical dilemmas are both legal and ethical. To rely solely on the law is reductionist because it reduces the dilemma to a "the law says so, so it must be right" situation- the so called is/ought fallacy. This reductionism also places the law above any moral reasoning. The law is normally the dictate of those in power and may not always be right, moral or ethical. It also does not demand any moral deliberation on whether a decision is good, nor does it consider any of the ethical or moral implications or consequences of a judgement. Arguably though, the law and ethics are inter-related, so some reasoning or deliberation is appropriate to arrive at a normative justification. Canon should be the first source of knowledge to refer and revert to in a moral quandary, but moral and ethical decision-making should not be reduced to mere text or theory.

Wesley used Scripture as both a source and a norm (Urratia, 2005), arguing that it was foundational to the formulation of positions on moral and ethical issues as well as issues of the quotidian (Cosby, 2002).

While several considerations are important in ethical healthcare, the five key issues, especially in the clinical interaction, can be deemed to be the following: how medical treatment and services are provided (i.e. with beneficence, non-maleficence and justice as well as compassion, caring, empathy and trust); patient privacy; patient information confidentiality; the right of the patient to self-determination; and informed consent by the patient (autonomy) (Oosthuizen & Verschoor, 2008). For the purposes of this literature

review, these five issues will be the focus in the exploration of ethical principles, guidelines and codes, the law, human rights and key ethical principles.

The tenet of 'Canon' encompasses the current written ethical guidelines as recorded by medical professional bodies, national and international. It also incorporates applicable national and international law and human rights declarations.

3.2.1.1 Professional ethical principles, guidelines, and codes

Professional ethical codes provide guidelines for healthcare professionals on how to act in quandary situations. The codes also enable them to make the required ethical interventions according to universally accepted principles. These professional guidelines include international guidelines and conventions; those prescribed by the HPCSA; and the 'canonical guide to morality and bioethics' (Engelhardt, 2012):- the four principles of Beauchamp and Childress (Beauchamp & Childress, 2013). (Despite the contention that there is no common understanding of their content or meaning (Engelhardt, 2012), the four principles – which I discuss later in this section - are accepted as the universal bioethical principles based on a common morality).

Codes of ethics are the moral and ethical principles that govern the practice of members of a profession. Codes of ethics for medical doctors are drawn up by international and national regulating bodies of the medical profession. South African medical doctors rely on ethical guidelines as provided by the HPCSA, international codes, declarations and universal ethical principles as guidance to medical practice.

i) Health Professions Council of South Africa guidelines

The HPCSA, a statutory body established by the Health Professions Act 56 of 1974, established a series of 17 booklets that prescribe guidelines for good practice in the healthcare professions (HPSA, Booklet 1, p. 9). While ethical guidelines are not usually legal documents and do not carry the weight of the law unless they have been incorporated into statutes or regulations (McQuoid-Mason & Dada, 2011), the HPCSA ethical guidelines are a response to the Health Professions Act, and therefore have quasi-legal standing. Adherence to the provisions of ethical guidelines depends upon the morality and motivation of the individual medical doctor (Dhai & Etheredge, 2011). However, subscribing to ethical guidelines will ensure accordance with regulatory authorities and the law, where these provisions are incorporated into regulations and the law (Dhai & Etheredge, 2011). They may

also help to resolve complicated medical dilemmas in a morally justifiable manner. While all the HPCSA's booklets are important to contemporary medical practice in South Africa, the section below describes those guidelines that may be relevant to this research.

- *Booklet 1-General Ethical Guidelines for the Healthcare Professions* details general ethical guidelines and describes core ethical values and standards for good clinical practice. Section 3 of *Booklet 1* provides advice on resolving ethical dilemmas. Essentially, a process of ethical reasoning is described, which proceeds in four steps. These are the formulation of the problem; gathering information; considering options; and finally, making a moral assessment. The moral assessment includes evaluation of the consequences of various options, the most important values, duties and rights, the "Golden Rule" and finally, consideration of the patient's "wants". The Golden Rule is that rule dictating that healthcare practitioners themselves asks how they would want to be treated under similar circumstances.

  This booklet further elaborates on medical professionals' duties and obligations, specifically, their respective duties to patient, colleagues and self. The booklet also prescribes the recognition and respect of the human rights of all individuals.

- *Booklet 2-Ethical and Professional Rules of the HPCSA as Promulgated in Government Gazette R717/2006* explores the ethical and professional rules of the HPCSA as promulgated. This booklet covers various aspects of clinical practice such as supersession, fees, exploitation and issuing of prescriptions.

- *Booklet 3- National Patients' Rights Charter* describes patients' rights and responsibilities.

- *Booklet 4- Seeking patients' informed consent: The ethical considerations* provides guidelines on obtaining informed consent from patients. According to this booklet (Section 2.2), the right to informed consent flows from the South African Constitution, the National Health Act, various other statutes and common law.

- Confidentiality and the protection and provision of patient information are discussed in *Booklet 5*. In section 1.2, the National Health Act (Act No. 61 of 2003) is cited and prescribes that patient information and confidentiality can only be disclosed if the patient consents or the healthcare practitioner can justify the disclosure.

- *Booklet 6- Guidelines for the management of HIV infections or AIDS.* This booklet provides guidelines specific to the treatment and management of HIV infection and AIDS. It describes the responsibilities of healthcare practitioners to HIV positive patients; deals with matters of confidentiality; and covers HIV testing of patients and healthcare practitioners. Advice is also provided on how to deal with knowledge of the HIV status of patients in the healthcare environment. Section 9 provides particularly important guidance on partner disclosure.

- *Booklet 7- Guidelines for the withholding and withdrawing of treatment.* Guidance is provided in this potentially distressing area of medical practice. It provides 'an ethical framework of good practise (*sic*) for healthcare practitioners in circumstances where they are faced with deciding on whether to withhold or withdraw life-prolonging treatment' (Section 1.2). These guidelines also recommend that healthcare practitioners observe the World Medical Association Declaration on Terminal Illness. This Declaration is provided in the booklet as an annexure.

- *Booklet 8- Guidelines on Reproductive Health Management.* This booklet addresses many women's health issues, including violence against women, contraception, sterilisation, termination of pregnancy and the collection of cord blood.

- *Booklet 17- Ethical Guidelines on Palliative Care* provides advice and guidelines on the provision and goals of palliative care, with special consideration for the four principles approach as described by Beauchamp and Childress (2013) and discussed in (IV) below.

ii) South African Medical Association (SAMA) guidelines

The South African Medical Association guides members on a variety of ethical issues. The guidelines address ethical questions and are available to members of the Association on their website. The SAMA is not a statutory body, and HPCSA rulings supersede their guidelines. Also, while their guidelines apply to members of SAMA, they are not binding on non-members.

iii) International guidelines

There are many international codes, declarations and guidelines that are meant to guide medical professionals on principles of the patient's right to self-determination (autonomy and informed consent) and right to physical integrity, privacy, and confidentiality.

The World Medical Association (WMA) is considered the global representative body for physicians (Dhai & Etheredge, 2011). Although the WMA is prominent in creating ethical codes for good medical practice, it is the responsibility of the medical associations from individual countries to adapt and formulate the WMA guidelines specifically for their own countries.

The WMA Medical Ethics Manual (2015), admittedly a basic introduction to medical ethics (Williams, 2015), describes the principal features of medical ethics and the duties and obligations of the medical doctor in the interplay between physician and patient, physician and society, and physician and colleagues. Further, it provides ethical guidelines for medical research. The manual provides case studies for ethical reflection and questions of values, rights and responsibilities.

The WMA prescribes ethical guidelines through many of its formulated declarations. For example, the WMA Declaration of Geneva: International Code of Medical Ethics (2017) details the ethical duties and obligations of physicians towards their patients, which are: acting in the patient's best interest; respecting patient confidentiality; and the provision of emergency care as a humanitarian duty (WMA, 2017).

The WMA also has Declarations that deal with the rights of the patient; the rights of the child to healthcare; therapeutic abortion; professional autonomy; and the conduct of medical research. The guidelines are accessible through the WMA website.

The United Nations Educational, Scientific and Cultural Organization (UNESCO) also has a declaration on the aims and scope of bioethical practice: the Universal Declaration on Bioethics and Human Rights. The scope of the Declaration addresses ethical issues related to medicine as applied to human beings, with consideration for their social, legal and environmental dimensions. Several articles address issues applicable to the practice of medicine, for example, human dignity and human rights (Article 3); benefit and harm (Article 4); autonomy and consent (Articles 5, 6 and 7). Advice is also given on the

application of the principles of the declaration, for example, Article 18 - Decision-making and addressing bioethical issues, provides for professionalism on the part of practitioners.

iv) Key ethical principles

The key ethical principles central to bioethics today, described by Beauchamp and Childress (2013), are derived from the common morality. Beauchamp and Childress (2013) argue that this is not merely a list of four principles, but a guide to how principles link to and guide practice. The four principles are: respect for patient autonomy, beneficence, non-maleficence and justice. Sometimes ethical principles may conflict, and a balance of principles is necessary. In these instances, the principle that provides the least harm to the patient may be the one that takes primacy. There is also scope to appeal to the law in these situations, for example, in the case of so-called 'therapeutic privilege' (Moodley, 2017, p.66). As an example, the National Health Act No.61 of 2003, Chapter 2 section 6, provides for 'therapeutic privilege' and describes an exception to the duty of full disclosure to a patient, where that disclosure would not be in the best interests of the patient.

Respect for autonomy refers to the right of patients to make decisions on healthcare themselves. This right is not afforded to those who are immature, incapacitated, ignorant, coerced or exploited (Moodley, 2017). Telling the truth; respect for the privacy of others; the protection of confidential information; obtaining informed consent for intervention; and assisting others, when appealed to, in making important decisions – these are all *prima facie* duties justified by the principle of respect for autonomy. Sometimes, as in some traditional communities, individual decision-making and individual autonomy are not culturally acceptable. In these situations, family or community consultations may be necessary, and this should be equally respected.

3.2.1.2 Human rights

The United Nations Charter of 1945 was established to protect human rights after World War II. The initial objectives of this Charter included providing a means of defending the individual from abuses of power committed by organs of state. Further, the Charter aimed at promoting opportunities for people to thrive; and laid the foundation for the International Bill of Rights, which was introduced to protect people from suffering and deprivation (McQuoid-Mason & Dhai, 2011(b)). The International Bill of Rights is the culmination of the United Nations International Covenant on Civil and Political Rights (1966), the International

Covenant on Economic, Social and Cultural Rights (1966) and the Universal Declaration of Human Rights (1948) (McQuoid-Mason & Dhai, 2011(b)).

Civil and political rights, known as "first generation" rights, protect against interference or oppression from the state. They include the right not to be subjected to medical or scientific experimentation without consent; the right to freedom from torture; and the right to freedom from slavery (McQuoid-Mason & Dhai, 2011(b)) economic and social rights represent claims on the state for the provision of basic services.

Rights have two distinctive features; the first is that every right has a correlative duty. The second is that rights have unusual moral strength, meaning that the right can supersede other moral considerations (Benatar, 2005). Rights may be legal or moral. Moral rights include those that fall within the realm of bioethics (Benatar, 2005).

One human right, albeit an economic and social right, is the right to access healthcare (McQuoid-Mason & Dhai, 2011(b)). The denial of access to healthcare has consequences that deny the potential for the individual to develop optimally (McQuoid-Mason & Dhai, 2011(b)). McQuoid-Mason and Dhai (2011(b)) use a bioethical framework, incorporating the four previously mentioned principles of autonomy, beneficence, non-maleficence and justice to reflect on the aspects of human rights conventions that affect health.

These four principles and their connection to human rights are addressed in the International Bill of Rights; the African Charter; the Bill of Rights in the South African Constitution (Chapter 2); and the Patients' Rights Charter. Also, in South Africa in terms of Section 36 of the Constitution, every right may be limited in terms of the law of general application where that limitation is reasonable and justifiable in an open and democratic society (McQuoid-Mason & Dhai, 2011(b)).

3.2.1.3 Law

'Good law should be based on good ethics' (Pellegrino, 2001). In other words, the law and what it claims to protect should be justifiable and carry moral weight (Miola, 2015). Law is defined as a rule of human action prescribed by authority (French, 1893). Law is often thought to be normative because it regulates the rightness and wrongness of man's actions in society, with 'external acts and positive legality' (Fagothey, 1959). Thus, it is a normative

social practice that purports to guide behaviour. Ethics is concerned with acts of will and deliberation in right or wrong action.

In many countries, ethics may be incorporated into the law. Medical law and medical ethics may seem closely related because many countries have laws that specify ethical conduct for physicians when dealing with issues in patient care and research, but they are not the same, nor are they coextensive (Williams, 2015; Benatar, 2005). The law can be morally defective, and moral rights may be excluded or only partially included in the law (Benatar, 2005). Consequently, legal rights and the law are inadequate in addressing moral dilemmas or rectifying the moral defects of medical practice (Benatar, 2005). The law might not always be moral in that it may permit actions that are contrary to the medical doctor's value system, or it may be harmful it that in necessitates actions that may be harmful or require unethical behaviour from the doctor, for example, the medical torture of prisoners.

Williams (2015) argues that the reasons for the differences between the two are that ethics often prescribes higher standards of behaviour than the law. Further, ethics prescriptions are universal, whereas law differs from country to country. While physicians have always been subject to the general laws of the land, the law is also not always ethical, and sometimes ethics may require physicians to disobey laws that require unethical behaviour (Williams, 2015). Respect for the law is the foundation for a just and safe society. Medical practice and medical professionals form part of society and while compliance with the law is essential to the profession, it is insufficient without ethics and morality to effect a good profession. The promulgation of legislation in South Africa post-1994, led to ethical principles such as patient confidentiality and the right to informed consent becoming statutory requirements (Oosthuizen & Verschoor, 2008).

"Legal" decisions are decisions where the doctor does not have a choice in the process because the law determines a course of action (Foster & Miola, 2015). Such a legal determination may occur where the law decides that the decision to be made should be that of the patient, rather than the physician. This prescription may lead to moral or ethical conflict for the latter, especially where personal or professional ethical principles may conflict with the law. Legal compliance is important but is meaningless if it is not ethical. If legal prescriptions do not comply with ethical prescriptions and morality then I argue, legal decisions can be regarded as morally wrong.

Doctors may find themselves in conflict with the law and ethics in two ways. The first is where legal obligations appear to conflict with personal beliefs about the ethical acceptability of a certain course of action, for example, providing a "lawful" treatment they believe to be unethical. The second is where the ethical responsibility towards a patient conflicts with the law, that is, where the law requires action at odds with the more important ethical duty to the patient, for example, mandatory reporting as against the respect for confidentiality (Jackson, 2015).

As previously mentioned, Oosthuizen and Verschoor (2008) propose that medical law plays an important role in legislative and judicial control over the practice of medicine. Addressing the five issues identified above by Oosthuizen and Verschoor (2008), the following pieces of South African legislation, in addition to the country's Constitution, are of importance in this regard: National Health Act 61 of 2003; Mental Health Care Act 17 of 2002; and the Promotion of Access to Information Act 2 of 2000. Non-compliance with the statutory requirements of these legislations is a statutory offence (Oosthuizen & Verschoor, 2008). The third type of decision described by Foster and Miola (2015), in addition to legal and "ethical" decisions - the moral decision attributed to conscience – will be discussed in this interrogation of the literature under Experience (Section 3.2.4 below).

Canon, as *prima auctoritas,* in its principle and regulatory role in the Ethics Tetrad, just as with the *prima scriptura* in the Wesleyan Quadrilateral, cannot be fully or readily interpreted without the application of tradition, reason and experience, and so these supplementary sources are added.

3.2.2. Tradition

Turner (2004, p.206) argues that what most theological ethicists and moral philosophers neglect is:

> "The degree to which distinctive cultural, religious, ethnic and healing traditions play key roles in structuring many disagreements where medicine and morality intertwine''

Use of the overarching universal principles commonly exercised in contemporary medical ethics 'minimises the role of social, cultural, and contextual factors, in shaping moral precepts, attitudes, and behaviour' (Fox & Swazey, 2010, p.278). It is for these reasons that the tenet of Tradition is important hermeneutically.

It is generally held that in more traditional societies, a greater agreement on ethics as well as social pressure (reinforced by law where appropriate) encourages doctors to behave in certain ways rather than others (Churchill, 1977; Thomasma, 1980; Iltis, 2000). Religion and culture, each with its own values, beliefs, and traditions, have and continue to play a role in medical moral and ethical decision-making (Thomasma, 1980), despite the "universalisms" of modern secular medical ethics.

When addressing moral matters, Callahan (1999) suggests that in addition to an understanding of the medical or clinical context, healthcare workers follow one of two moral pathways, the religious or the secular. In a pluralistic, diverse society, it is expected that the secular path will be deemed more appropriate. However, the influence of religious, cultural and social traditions' role in personal morality cannot be discounted. In pluralistic societies, understandings of moral obligation, reason, science, religion, and medicine are not uniform (Muir Grey, 1999; Sweder, 1991). The plurality of moral traditions means that there are diverse ways in which moral matters are addressed, defined, evaluated, and defended. (Turner, 2004).

Medical ethics has also been guided by the values and traditions of individual societies and cultures. In these societies and cultures, acts and decisions have been seen as right or wrong, as determined by that society and culture at a specific time. Thus, religious, secular and societal values, principles, norms and traditions shape the concept of rightful and wrongful behaviour; the moral or immoral; the ethical or unethical. These concepts apply to both the collective and the individual.

Reiterating Callahan (1999), good ethical awareness requires the cultivation of three skills. The first is knowledge of the traditions of ethics, religious and secular. In addition to this knowledge, one should be informed about the formal theories and strategies that have historically been used to analyse ethical issues. Historical reflection can also help medical practitioners to recognise the steps needed to avoid repetition of the mistakes of past historical periods (Hey & Roux, 2012).

The second skill is social perceptiveness. Social perceptiveness is the capacity to understand our own culture and the way it has guided us with particular values and patterns of thought and behaviour. The third skill is self-knowledge. Self- knowledge is discussed under Experience in section 3.2.4.1.

3.2.2.1 Religious tradition

Historically, religion has been a powerful force in shaping ethical attitudes. The practice of caring for the sick was originally rooted in the worldly concerns of various religions (Williams, 2015). As part of "good" acts, the religious took it upon themselves to nurse and try to heal those that were ill and unable to take care of themselves. As a consequence, the acts of caring for patients reflected the ethos and ethic of the prevailing religion in society at a particular time. Over the centuries, religious deliberation and tradition have addressed medical ethical problems (Iltis, 2000). According to Callahan (1999), the social and medical ethos within which medical ethics [bioethics] emerged in the previous century was constituted in part by the theological and religious questions related to quandaries in the practice of medicine. However, Callahan elaborates that since the 1970s, bioethics has evolved secularly and has moved away from the traditions of religion and medicine, to an ethics shaped by philosophical and legal concepts. This is evident when one examines healthcare policies, legal, ethical, or professional, which ignore formal religion, theological doctrine or church tradition (Marty, 1990).

Iltis (2000) argues that even though religious traditions contribute substantive moral theories that can give guidance on particular and diverse moral questions, these theories cannot help to resolve dilemmas in the current pluralist and secular public forum. However, while these religious traditions may not be so relevant to the ethics of current clinical practice, they may still be relevant to individual medical doctors, patients, and policymakers (Wildes, 2002). Some religions or denominations may even have bioethical guidelines, specific to the faith, to assist followers in medical moral and ethical decision-making, for example, Jewish guidelines, Islamic guidelines, and Catholic guidelines.

Pellegrino (2002a) claims that while the modern secular society presents serious conflicts of conscience for all physicians, the religious physician is particularly conflicted. Pellegrino further contends that conflicts of belief affect a clinician's conscience more than any other issue of professional life or behaviour with patients. These conflicts centre on the value placed on human life itself, its purpose, quality, and fate (Pellegrino, 2002a).

Contemporary bioethics, being more secularised, ignores many physicians' religiosity or traditional non-Western value systems. It does not address how the physician should deal with a conflict of personal moral integrity grounded in either religion or other value systems in the decision to be made.

Contemporary, dominant secular culture demands that the medical profession and its ethics should be built around basic secular commitments to very particular views of liberty, equality, human dignity, and social justice (Engelhardt Jr, 2015). However, while the bioethical precept of universalism does not allow religion to be an important consideration in moral decision-making, it does give it limited moral legitimacy. The influence of religious tradition on the medical doctors' ethical deliberation is an important consideration for checking for bias or prejudice. Further, to refuse to provide medical treatments or interventions based on religion, denies the authority and choices of dominant secular culture, impedes the provision of legally established health care services and violates human rights (Engelhardt Jr, 2015).

3.2.2.2 Medical tradition

Among the most influential sources of medical ethics are traditions, defined as concepts, practices and norms that have long guided conduct in the professional context. The Hippocratic Oath is an example of one such tradition (De Grazia & Beauchamp, 2010). These traditions are not enough to deal with contemporary problems arising from medical technological advances, research, practice, moral pluralism, and health policy (Jonsen, 1998). Reliable moral judgements can only be made when there is an understanding of a particular situation and an appreciation of the record of relevantly similar situations (De Grazia & Beauchamp, 2010).

An example of a medical tradition is casuistry. Casuistry can be traced back to the early Christians and Rabbinic Judaism (Jonsen & Toulmin,1988). Casuistry is the ethical analysis of cases, using previous paradigm cases to determine how and when to apply moral rules to particular cases. It has been used in religious thought, moral teachings, and the legal system. Although in contemporary bioethics, there is no universal consensus on any background theory or moral authority (Iltis, 2000), attempts have been made to understand the methods casuists use and ground these methods more solidly within moral reasoning (Jonsen, 2010).

Another example is the oft quoted *primum non nocere* (first, do no harm) attributed to Hippocrates although the origin is uncertain. The Hippocratic Oath in fact includes the promise to "abstain from harm" which is the basis for the contemporary principle of non-maleficence. *Primum non nocere* prescribes that sometimes it is better not to act or to do little rather than cause more harm.

3.2.2.3 Cultural and societal traditions

Culture is a learned behaviour among members of a group and may be passed down from generation to generation (Berlinger & Berlinger, 2017). This learned behaviour includes ways of perceiving and thinking and consequently, the adoption of values and norms. The values individuals hold may share similarities

but may also conflict. Individuals constantly face value conflicts between different aspects of their daily lives, for example, in the spheres of science, religion and culture. These value conflicts intersect within their personalities, social lives and professions (Weber (1919) as cited in Dhai, McQuoid- Mason & Knapp van Bogaert, 2011).

Making a value judgement requires thought about one's values, especially when faced with ethical conflict. Personal and professional value judgements may differ and may not always agree. In the clinical context, personal value judgements may directly influence how patients are treated as a result of a value conflict between the doctor as a professional and the patient who has different values. An important consideration is whether medical doctors should act following their personal values or adapt their behaviour in keeping with the values of the profession (Dhai, McQuoid-Mason et al., 2011).

3.2.2.4 Normative theories

The role of normative theory was discussed in Chapter 1.

3.2.3 Reason

Just as Reason in the Wesleyan Quadrilateral is described as a process of thinking, based on knowledge and informing oneself, so reason in the Ethics Tetrad is applied in the same way. Reason is necessary to provide clarity by organising thoughts and terms effectively, to process logical norms, and to confirm and defend the conclusions reached in ethical and moral quandary resolution. For Hey and Roux (2012), the development of reasoning skills is a considerable aid to thinking. Reason as a source of knowledge dominates in Western societies. Reason can be used to rationally confirm and defend one's conclusions and justifications in moral and ethical quandaries in the clinical context.

The Ethics Tetrad acknowledges the strengths and limits of reason and the way it fits with the other sources.

3.2.3.1 Moral reasoning

Medical doctors are ultimately responsible for making their own moral and ethical decisions, and for their implementation, in clinical practice. As previously described, these decisions can be approached non-rationally or rationally. The rational approach involves the systematic, reflective use of reason (Williams, 2015).

Moral reasoning refers to the processes involved in how an agent thinks about right and wrong and how agents acquire and apply moral rules and guidelines. An important aspect of moral reasoning involves knowing when a response to a dilemma is emotional, partly intuitive or completely rational. Moral reasoning is rational and involves concerns with welfare, justice and rights (Turiel, 2015). It is the agent's first-person practical reasoning about what ought to be done; the agent can be expected to have the motivation to prioritise moral and ethical values. Moral reasoning involves processes that describe how we recognise moral dilemmas, cope with moral conflicts and arrive at judgements (Richardson, 2018). It also provides opportunities for gaining insight into what we ought to do and how we reason about what we ought to do (Richardson, 2018).

Moral reasoning in the practice of medicine involves working through ethical principles, theories and guidelines and identifying the ones most relevant to the situation or case at hand, in order to arrive at the right judgement.

Decision-making processes are described in section 1.2.6.

3.2.3.2 Medical and scientific reasoning

Medical practice is not merely the application of medical science and making use of medical technologies and therapies. Medical practice is a particular form of understanding disease, patients and duty. It is about treating and managing patients according to current medical standards, morally and ethically; about doing good and avoiding harm. Medical and scientific reasoning includes a clinical acumen which is based on experience and insight.

Medical knowledge includes applied biology: the scientific explanation of what is happening to the diseased or problematic body; and the appropriate treatment of these ailments. Medical insight, by contrast, includes the consideration of the patient's needs and expectations over and above the application of medical science and technology (Williams, 2015).

Today, medical practice is guided by standardised treatment guidelines that sometimes take out the "thinking" from treating patients appropriately or as needed. Further, medical practice is regulated by healthcare policies and third-party funders. As a result, medical doctors are influenced by economic constraints and budget considerations and cannot always treat or manage patients the way they would like. A major part of medical reasoning is concentrated on how to manage and treat patients ethically within the constraints of limited resources.

3.2.3.3 Context

Churchill (1977) claims that while most of medical ethics thought has developed under the assumption that ethical reasoning appeals to the physician as a person, ethical reasoning cannot be appealing without special consideration of other variables that influence medical decisions, for example, clinical context. Bioethics and bioethical scholarship involve more than the evaluation of options and enactment of choices in response to one's perception of a moral quandary (Hunt & Carnavale, 2011). Medical doctors are more than isolated moral thinkers, and a greater recognition and allowance for context and social relationships in ethical and moral decision-making should be encouraged (Hoffmaster, 1994; Hunt & Carnavale, 2011).

A physician may be mindful of underlying moral theory, ethical principles and professional guidelines, but when rationally deliberating an ethical or moral dilemma in clinical practice, the specifics of the case also need to be considered in context. Thomasma (1980) argues that understanding the medical context increases the chances of finding helpful solutions to medical dilemmas, as well as the professional and personal accountability for making ethical decisions.

Bioethics and its claims are dynamic, dependent on the era and circumstances where its claims are made (Turner, 2004). Context is the term used to describe each ethical dilemma as unique with its circumstances and non-generalisable facts. Medical ethics practice and scholarship involve more than the evaluation of options and the enactment of choices in response to one's understanding of a moral quandary (Hunt & Carnavale,2011). Moral dilemmas do not occur in "textbook" scenarios, in a vacuum or in isolation. Thus, greater recognition and accountability for context and social relationships in ethical inquiry should be encouraged.

The context of a moral dilemma requires specific practical clinical experience which enables the medical practitioner to act accordingly. Moral and ethical conflicts arise out of lived experience in actual practice and not from third-person perspectives of hypothetical situations (Jonsen & Toulmin, 1988). As a result, any attempt at resolution should be appropriately focused on the specific case being dealt with at the time. Ethical dilemmas should be resolved by experience as well as by the limited norms of medical practice expressed by medical philosophy, patient values and clinical context (Thomasma, 1980). It is the duty of the decision-makers, the medical doctors, to ensure that they are informed and reflective, and where they are inexperienced, to consult 'experts' or experienced peers (Williams, 2005).

Context in the Tetrad refers to the medical and social (cultural, religious, societal and economic) aspects of the dilemma as a whole: what is important to the patient and what is not; as well as the experience of the medical doctor facilitating the decision. An understanding of all aspects of the medical situation increases the possibility of positive solutions to medical dilemmas, including professional and personal accountability (Thomasma, 1980). Each patient is unique with their expectations and what they bring to the clinical space; each doctor is also unique with their morality and what they wish to deliver; and that is why each context is so different. Context refers to the well-informed medical doctor acting in the interest of a well-informed (by that physician) patient. Other factors which may influence contexts are economic resources and particular medical prognoses.

Context is also discussed in Chapter 1, section 1.2.7.

3.2.4 Experience

Experience *per se* is unique to the individual. Consequently, experiences cannot be generalised as common to all people. The moral dimension is first and foremost 'experienced' (Ten Have & Lelie, 1998). The initial response to a moral or ethical dilemma is "what ought to be done?". This question initiates the beginning of a moral or ethical inquiry into the right action to be taken. This sequence is no different in the clinical context. Moral experience is humanity's way of understanding in moral terms, and ethics is the interpretation and explanation for this understanding (Ten Have & Lelie, 1998).

Experience teaches us that some actions can cause harm and be destructive, while other actions can produce happiness and be good (Overberg, 1998). Personal experience also

teaches us and makes us aware that sometimes we have immediate and instinctive emotional reactions to various situations, and that some actions can "feel" right or wrong.
This literature review includes an exploration of experience, both medical and personal. Included under the tenet of Experience are the aspects of conscience and intuition.

3.2.4.1 Personal experience

The basis for ethical decision-making should be a subjective assessment and should include a perceptive understanding of the ethical values that guide one's decisions. The internal values that have been formed and practised over the doctor's life are crucial in guiding medical ethical and moral decision-making. Medical doctors should be cognisant of their own individual values, the origin of these values and how these values affect their decision-making (Sulmasy, 2008). This is known as self-knowledge. Inherent in this process is the acknowledgement of those deeply held values that guide their consciences; those that represent habitual patterns from socialisation; and those which are merely personal preferences (Sulmasy, 2008). To prepare for situations of ethical conflict or moral dilemmas, physicians need to understand their own moral and ethical compass. This process aids in critically assessing whether reservations or oppositions to a medical course of action are justified and can potentially allow for revision and justification (Sulmasy, 2008).

Further, the more experienced one is at a specific moral practice - in this research, medical practice - the more specific moral wisdom one holds. The specific moral wisdom facilitates a more thorough moral reasoning (Van Thiel & Van Delden, 2010).

Habit is a very efficient method for moral judgements because one does not need to repeat the deliberative process each time a moral or ethical issue arises that is similar to another one experienced previously (Williams, 2015). The negative side to this is that sometimes situations that appear similar may require different judgements. Further, some habits can be bad or good, and become entrenched, whether right or wrong.

3.2.4.2 Medical experience

Medical experience refers to the experience one has in practising the profession. It stands to reason that a medical doctor who has been practising for several years has more experience in dealing with medical cases and clinical quandaries that one who has just qualified. With experience comes confidence as well. The more experienced the doctor, the more familiar

they may be with clinical methods as well as the law and ethical guidelines generally, which changes their approach to clinical quandaries.

However, medical experience does not only refer to the temporal aspect of clinical practice. It also refers to medical training and professional socialisation. The institution from where a doctor graduates and who their mentors and teachers were and are, also play a role in the experience of medicine. These factors may influence the physician's approach, not only to the practice of medicine, but also to the related ethical practice.

Williams (2005) describes non-rational approaches to ethical dilemmas as obedience and imitation. Obedience as an ethical method consists of following the rules or orders of those in authority, whether or not one agrees with the instruction. Junior doctors may lack the confidence or experience to question those in authority. The problem with this approach is that this unquestioning attitude may become entrenched, and the questionable action may become accepted.

Imitation is similar to obedience in that one's judgement about right or wrong is subordinated to another person, usually a role model (Williams, 2005). Thus, one follows the example set by the role model. Williams (2005) argues that this has probably been the most common way of learning clinical practice and medical ethics for aspiring physicians. In this way of learning the role models are senior consultants, and moral learning is via observation and imitation of the values displayed (Williams, 2005).

Professional socialisation is another aspect of the medical experience. Professional socialisation can relay certain facets of a professional culture, such as beliefs about what it means to be a responsible and caring physician and which codes of ethics to abide by (Vaidyanathan, 2015). Professional socialisation shapes junior doctors' values and behaviour through modes of socialisation, informal and tacit, at different structural and organisational levels (Vaidyanathan, 2015). In medicine, there is a danger that this socialisation can contribute to an "ethical erosion" (Vaidyanathan, 2015) ,where that socialisation has been influenced by 'negative' values for example, poor mentoring, moral disengagement of mentors, or even avarice.

3.2.4.3 Peer experience

In the making of a decision in a medical ethical quandary, it may be helpful for the medical doctor to know what other doctors would do in the same situation.

Sometimes lack of experience or the extraordinary circumstances of a case require the medical doctor to seek opinion or assistance when deliberating a medical moral dilemma. The medical and moral experience of others can benefit and enrich ethical reasoning and moral experience (Van Thiel & Van Delden, 2010). Van Thiel and Van Delden reference the moral intuitions that arise from specific moral practices. I apply their references to experience here, specifically to peer experience because the same argument applies. People who work in particular fields with a moral dimension, such as medical practice, have experiences or a "specific moral wisdom" that are generally not found outside of that practice (Van Thiel & Van Delden, 2010). Van Thiel and Van Delden define this specific moral wisdom as an 'expert-level knowledge and judgements in the fundamental pragmatics of life'. This specific knowledge and experience require the ability to combine knowledge, reflection and life-experience with emotional, social and ethical capacities (Edmondson and Pearce, 2007, p. 233).

Arguably, people who have an extensive amount of relevant experiences are more likely to have gained more moral wisdom than those with less experience. Thus, moral reasoning and beliefs can be deepened when one considers the experiences held by more seasoned agents in addition to one's own initial reactions to a given case (Van Thiel & Van Delden, 2010).

3.2.4.4 Conscience

Human conscience involves a moral decision-making faculty. This faculty is convinced by a rational perception of the world as it is experienced in its entirety (Sulmasy, 2008). When deliberating a moral dilemma or quandary, one is aware of conscience because acting by conscience involves will and judgement, where the will is confirmation that one ought to act morally, and judgement pertains to the specific act (Sulmasy, 2008). Conscience itself is not the standard for an appeal to moral standards; it is rather a consciousness that is the result of standards applied to behaviour (Childress, 1979). Consequently, it plays a role in determining right or wrong behaviour, implications, consequences and outcomes of behaviour.

Before the end of the Middle Ages, conscience came to encompass four basic functions: judicial, legislative, sanctioning and lastly, motivational, where we are encouraged to achieve

higher moral standards. Conscience is also described as having reflective and reflexive functions (Overberg, 1998). The reflective function of conscience examines past, present and future decisions. The reflexive function provides instant feedback in the form of discomfort or unease when one is compelled to choose a decision or action that may be problematic or immoral.

The notion of conscience carries with it the obligation, to oneself and to those that one serves, to form one's conscience correctly. This obligation entails working to inform one's conscience concerning the adoption of moral principles and by assimilation of accurate knowledge of the details necessary to decide a case correctly (Overberg, 1998). Sulmasy (2008) describes two interrelated parts of conscience: (1) a commitment to morality itself and (2) the ability to determine whether a deliberated act would violate that commitment. Fuss (1973) describes conscience in the healthcare setting as originating in a fundamental responsibility to consider all situations within a framework of ethical obligation. Fuss argues that this responsibility should lead to judgements and reasoning about actions and behaviours that would characterise a moral life.

The role of conscience in medicine is controversial because there is an absence of consensus about what conscience is (Lawrence et al., 2007). Laurence et al. (2007) posit that in the Abrahamic traditions, conscience is divinely constructed and that we act according to what we believe. Conversely, moral law is not divine in the secular world, and the sources for moral law differ among the secular traditions. Lawrence et al. (2007) propose that moral obligations are constructed rather than discovered. Whatever the source for conscience, divine or other, Sulmasy (2008) argues that to suggest there is anything more important to moral life than conscience is almost impossible; we should, therefore, act according to our most deeply held moral beliefs as something that comes to us intuitively.

The Declaration of Lisbon on the Rights of the Patient (2005) prescribes '…the physician should always act according to his/her conscience and always in the best interest of the patient'. This statement in itself provides possible tension for the physician, where the best interest of the patient may conflict with the physician's conscience.

'Convictions about right or wrong conduct, both as a professional and as a person, form the physician's conscience' (Pellegrino, 2002b, p.223). Medical doctors in the course of their work as healers, must 'form their consciences in two inseparable dimensions of their lives- the

professional and the personal'. Pellegrino (2002b) posits that professional conscience plays a role in two spheres of doctors' daily work. The first is the ethical appropriateness of their actions regarding the moral duties implicated in the physician-patient relationship. The second is the moral obligation to practise "good" scientifically sound, humane and contemporary medicine (Pellegrino, 2002b).

The preservation of moral integrity would necessitate a conscientious person acting in accord with the dictates of their conscience (Pellegrino, 2002b). In a pluralistic, secular world, with the added realities of financial restraints, cultural differences and moral disagreements, this may lead the conscientious person to come into conflict with others' moral values and those of a society. Conscience issues also arise in situations of direct ethical collision. In these situations, a medical doctor may be asked or expected to participate in an action the doctor may deem to be ethically wrong. The act of conscience may be accompanied by emotions which may influence decisions. However, conscience itself is not an emotion, and it is one's moral duty to unite personal powers of reason, emotion and will into an integrated moral whole based upon one's most fundamental moral principles and identity (Sulmasy, 2008). The practice of medicine has evolved from one of altruism and the desire to alleviate the suffering of others to a practice of duty and obligation, often dictated by medical funders, hospital policies or the law. As a result, Genuis and Lipp (2013) argue that along with diminishing respect for the wisdom of both individual conscience and personal ethical conviction, increasing pressure from sources external to clinical healthcare (law, politics, bioethicists and institutions) is being exerted on medical doctors to act unquestioningly following peer standards and professional governance. Thus while acting in good conscience according to an ethical or moral conviction may represent personal moral integrity to the individual doctor, this action may be perceived as "unprofessional" by others because it does not conform with professional normative prescriptions (Genuis & Lipp, 2013) or with the dictates of those in authority.

Disputes about the proper role of conscience in the practice of medicine may be revealed in the unexamined and unspoken theological and philosophical differences found in pluralistic and secular societies. While no one person can tell another what is moral, most people consider themselves moral agents and would want to do the right thing. They would have concerns about what they ought to do and feel guilty when they feel they may have done the wrong thing or acted against conscience.

Where one's conscience dictates that an action is right or wrong, one should, as a conscientious person, act in accord with it (Pellegrino, 2002b). There are three dimensions to conscience: the general sense of value; the determination of the right course of action; and the actual judgement made by conscience (O'Connell, 1997).

The general sense of value is where we have the inner debate with ourselves and where we are made aware that we should do good and avoid evil. The determination of the right course of action requires that we inform our conscience by searching through various sources, political, social, economic or religious, and then weighing the competing values and meanings. Actual judgement refers to the action decided upon following the above deliberation. However, the action we decide upon can be wrong because we do not acknowledge our feelings, fail to inform conscience adequately or miss the truth (O'Connell, 1997).

3.2.4.5 Intuition

Arguably, most moral judgements are made unconsciously and through an intuitive autonomic process and are thus automatic responses to conflicts or dilemmas (Gazzaniga, 2006, p. 172; Musschenga, 2008, p. 132; Haidt, 2001). Intuitions are usually sudden and not deliberated. Intuitive acts include perception, imagination and memory (Braude, 2013). Moral intuitions are preliminary interpretations that give an agent a sense of judgement about a case (Haidt 2001, p. 818). A moral intuition is usually the first step that moral deliberation is required and may result in a sudden and ill-conceived reaction in terms of a right or wrong action (Van Thiel & Van Delden, 2009). It is that unexplained response to an event that requires moral action.

Haidt (2001) elaborates that more deliberate conscious reasoning follows the intuitive response to a problem and tends to be a rationalisation for the intuitive response rather than for the moral judgement. So, although the agent may offer reasons for reaching a moral judgement, those are not the real reasons for the moral judgement; rather, the initial intuition is the reason.

Moral intuitions are non-rational approaches to moral decision-making and are usually the result of an emotional activity (Singer, 2005). These intuitions are the result of social conditioning and may be shaped by our parents, teachers and others. Arguably, they may also be innate, where one "just knows" or "just feels" that an action is wrong or right.

Reflective equilibrium proposes that moral intuitions are justifiable if one can justify that intuition with a moral theory. In reflective equilibrium, moral intuitions should also be evaluated with respect to the characteristics of the agent, and the intuitions of agents other than the actor also need to be evaluated (Van Thiel & Van Delden, 2009).

The way reflective equilibrium works is as follows: where there is no inherently plausible theory that justifies our initial moral judgement, we should modify the theory or the judgement until there is an equilibrium between the two. There are however criteria for good reasoning before acting on an intuition. These are described by Van Thiel and Van Delden (2009) as transparency, openness of mind and reasonableness.

Intuition is also discussed in Section 1.2.6

3.3 Discussion and Analysis

Following the literature review in Phase I, a tool was formulated as a normative framework for moral and ethical deliberation and analysis. This tool provided a framework that was used to examine the responses received from physicians in interviews that questioned which normative sources they used as justification for decisions made in moral and ethical dilemmas in the clinical context.

To understand individual moral functioning, one has to consider the moral agency of the decision-maker and how that person's choices are made. These choices may be made by balancing reasoning and the acceptance or rejection of moral argument intrinsic to the moral agent, with consideration for philosophical and rational moral justification extrinsic to the agent (Callahan, 1999).

It is not enough to have elaborate ethical guidelines or sophisticated moral theories if the individual medical doctor is not compliant with those ethical guidelines or theories. This position could be interpreted in two ways: either the current professional ethical guidelines, moral theories and the law are not considerate of moral and ethical tensions in the clinical context; or an individual medical doctor does not value or is ignorant of professional ethical and legal prescription, or, at worst, is amoral.

Grenz and Francke (2001, p. 51) argue that sound theology cannot be supported by a single source of authority. Equally, a single source of authority cannot support sound medical ethics

or moral and ethical decision-making in the clinical context. The strength of the Ethics Tetrad is that it encourages balancing the four elements and in doing so, limits an over-reliance on one source.

Jonsen and Toulmin (1989) posit that there are two ways of examining ethical issues in moral cases: either in terms of principles, rules or with a focus on the specifics of the case. The tool or normative framework that I have formulated, provides a means to integrate the two ways. In everyday medical practice, medical doctors and even ethicists tend not to use principles or normative theories as their basis for moral reasoning, but use practical decision-making instead (Jonsen, 2010). Jonsen goes on to argue that this is because social practices are shaped by more than traditional understandings and ways. Embedded in human practices, in his view, are normative features that dictate how people using these practices behave and ought to behave. Thus, while medical ethicists may have an interest in ethical theory and principles, when it comes down to a medical moral or ethical quandary facing them as consultants in clinical medicine, they unintentionally or unconsciously use precedent or paradigm as bases to guide and inform their decisions (Jonsen, 2010).

The Ethics Tetrad is an attempt to integrate both methods by examining ethical issues in terms of principles, rules as well as with a focus on the specifics of a case. The Tetrad also provides a framework for examining ethical issues rationally and incorporating the agent's lived personal experience.

This tool was used to determine how moral and ethical conflict in the clinical context is resolved. Also, the tool gave insight into the first-person application of normative guidelines to moral quandaries in medical practice. It did this by analysing the data obtained in interviews to ascertain which sources are better used by medical healthcare practitioners in real-life situations, not merely analysing the data as part of hypothetical ethical problem-solving. The Ethics Tetrad is illustrated below. It is this tool that will be used to analyse the participants' responses in the interviews.

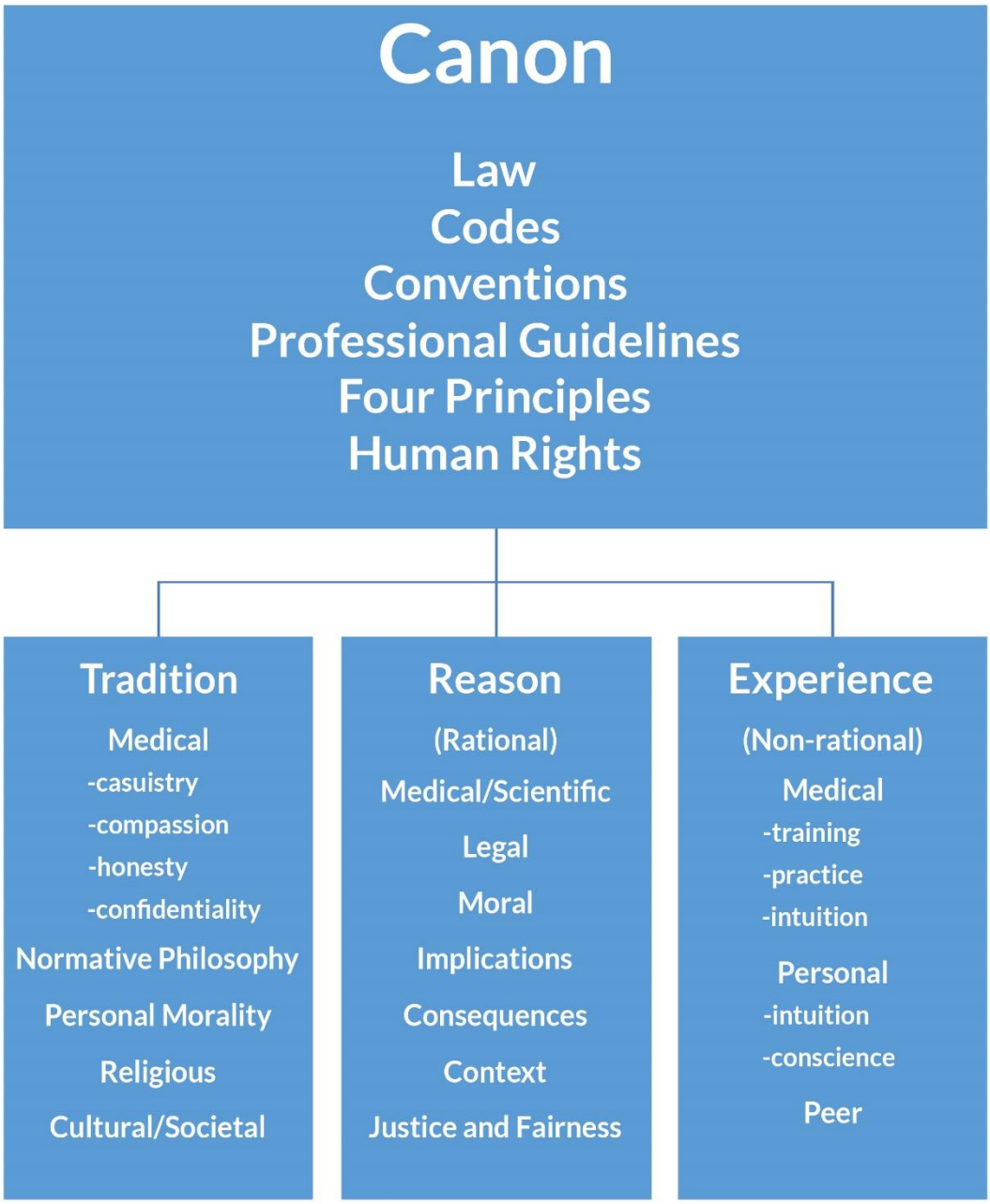


Figure 4. The Expanded Ethics Tetrad- An Analytical Tool

CHAPTER 4

PHASE II: QUALITATIVE RESEARCH TO ESTABLISH HOW MEDICAL DOCTORS RESOLVE MORAL AND ETHICAL DILEMMAS IN THE CLINICAL CONTEXT, FOLLOWED BY A NORMATIVE ANALYSIS OF THE IDEAL VERSUS REALITY

4.1 Introduction

In this chapter, I focus on the qualitative research methodology used in the study. I begin with a description of the rationale and purpose of an empirical part of the study. Next, I discuss the paradigmatic perspectives, the methodology, quality criteria and the ethical considerations referred to in Chapter 1.

4.2 Rationale and Purpose

As discussed in Chapter 1, moral and ethical dilemmas in the clinical context do not occur in vacuums. Further, the resolution of these quandaries is purportedly guided by bioethical principles, institutional guidelines and in some cases the law. This would suggest that medical moral and ethical decision-making is rigid, prescriptive, and inconsiderate of variables such as context, personal morality, physician agency or patient autonomy.

Making decisions in moral and ethical dilemmas in everyday medical practice can be difficult for medical doctors. The process of quandary resolution in the clinical context is experiential and personal. Questions, therefore, arise around the usefulness of inflexible, prescriptive theory, guidelines, and principles and whether they are even considered when the doctor is confronted with a clinical moral or ethical dilemma. Social scientists argue that in the reality of everyday medical practice, what happens often contrasts with the “ought” prescriptions of bioethics (De Vries et al., 2007).

Muller (1994) argues that to understand the reality of moral and ethical decision-making, it is essential to examine the actual behaviour of people in morally or ethically challenging situations, as well as the reasons or justifications they give for their behaviour. Further to this, I would argue that an exploration of the deliberative process and normative values motivating the final action is also essential.

My purpose in this phase was to explore the actual working and process of ethical and moral deliberation in challenging quandaries. I also sought to determine the normative justifications provided for the resolutions in these cases. This was an exploratory study. Exploratory studies tend to be associated with new or underexplored areas of research (Singh, 2007).

To my knowledge, there is no existing research on how medical doctors resolve moral and ethical dilemmas in the clinical context, nor on how they go about resolving each dilemma, or on how the final decision is justified.

4.3 Methodology

4.3.1 Research design

Phase II was conducted as a qualitative, descriptive, exploratory study. Exploratory studies are emergent, explore the research phenomenon, and focus on gaining a better understanding of the phenomenon (Singh, 2007). Further, they allow the exploration of the lived experiences of research participants, enabling a more in-depth understanding (Dudovskiy, 2018). The disadvantages of exploratory studies, described in the literature, are that the data and the data interpretations can be subject to researcher bias. Smaller sample sizes may also not accurately reflect the views of the communities or individuals interviewed or under study (Dudovkiy, 2018). To avoid bias, the quality assessment criteria explained in section 1.9.3 and 1.9.4 were adopted.

This study used a descriptive phenomenological approach. Phenomenology aims to discover the common features of phenomena as they are experienced (Shosha, 2012). Participants' explanations of a phenomenon (which in this research was the experience of ethical or moral decision-making in the clinical context) are embedded in their specific, personal experience of the phenomenon, including the meaning they ascribe to it.

In this research, participants were asked to describe a moral or ethical dilemma they had experienced in clinical practice and then to explain the deliberative process for resolution as well as the justification for the action. The participants were not given a vignette or an example to resolve specifically, because I wanted to capture the "lived" experience of the first-person perspective. A vignette or an example of a case would have resulted in a problem-solving exercise rather than the lived reality; in other words, a third-person perspective. For the phenomenologist, the experience must be studied by recognising its form and content for the person having the experience (Svenaeus, 2018). According to Svenaeus (2018), the

difference between the first-person and the third-person perspective is important because the first-person perspective makes it possible to understand how human experience is meaningful and material simultaneously, when the experience belongs to that person. Consequently, the interviewees had to draw on their experiences of quandary resolution in the medical space, allowing for a deeper understanding from their perspective.

Phenomenological research is both inductive and descriptive (Bloor & Wood, 2006: Flood, 2010). In descriptive phenomenological research, empirical materials are collected and analysed mainly through interviews and recordings of the research participants' experience of relevant phenomena (Balls, 2009; Svanaeus, 2018). Two to ten participants are sufficient for a descriptive phenomenological study because, according to Groenewald (2004), the emphasis is on the quality and depth of the data rather than the quantity. This study enrolled twenty participants to give more scope to the analysis, because of the importance of the research question and of achieving data saturation.

Descriptive phenomenology, in keeping with traditional scientific rules of research, requires the researcher to preserve objectivity. In order to achieve this, "bracketing" is recommended (Balls, 2009). Bracketing requires the researcher to declare and shed preconceptions, assumptions, and personal biases relating to the research phenomena so that the data and results can be explored objectively (Balls, 2009; Shosha, 2012). Bracketing also prescribes taking steps to ensure that findings are the result of the participants' descriptions instead of the researcher's own presumptions and expectations (Tufford & Newman, 2012).

It can be difficult for the researcher to bracket off personal experiences and preconceived ideas (Cresswell & Poth, 2018). In order to overcome this, and to ensure that the data were not interpreted according to assumptions or preconceived ideas, I followed Creswell's recommendations (2013) and stated and acknowledged my assumptions, which are based on personal experience. This is dealt with in Section 4.3.4.1. In addition, I had a regular debriefing and member-check session with my two supervisors to confirm and ensure that my interpretations were not the result of personal assumptions.

4.3.2 Participants

The population and sample enrolled for this study are described in Chapter 1, section 1.9.1. This research made use of purposive sampling of doctors in private practice in the Midrand area. Doctors working in the public sector at CMAH and CHBH were also purposively

sampled. One of the advantages of purposive sampling is that the sampling criteria align with the study. Further, purposively sampled participants provide insights appropriate to the research (Acharya, Prakash, Saxena & Nigam, 2013).

Purposive sampling is limited by the researcher's subjectivity and bias in selection of participants, because the researcher may make assumptions about the participants (Etikan, Musa & Alkassim, 2016). Further, the findings of research conducted using purposive sampling cannot be generalised outside of participants who are similar to the sample (Acharya et al., 2013). To overcome this, I invited different doctors to participate in the study, following presentations that I had given. I did not approach potential participants directly. Further, I included requests for demographic details such as medical school attended, graduation dates, ethics teaching as an undergraduate, private or public sector practitioner and whether the participant was a specialist or a general practitioner. These data are demonstrated in Table 5.1.

Purposive sampling aims at data saturation, or "data adequacy" (Morse, 1995, p.147; Van Rijnsoever, 2017). This is reaching the point where no new or relevant information is evident or emergent. Generally, in a phenomenological study, two to ten participants are enough to reach data saturation (Groenewald, 2004). In this study, as reported in Chapter 5, the participants had similar experiences of and explanations for the phenomenon under study. Thus, twenty participants were deemed adequate to achieve data saturation in this study. One participant (020) withdrew consent for his data to be used in the final analysis as he felt that he might be identifiable by his contribution. This request was respected.

4.3.3 Data collection

Data were collected from the research participants via audio-recorded semi-structured interviews. Interviews took place at a time and place most suitable for the participant. These appointments were pre-arranged once the participants expressed interest in being interviewed. Most interviews took place in each doctor's consulting rooms at lunchtime. Two interviews were conducted in the hospital coffee shops at the interviewee's request. As described in Chapter 1, all participants signed consent forms to be interviewed and audio recorded.

The interviews opened with an unrecorded short introduction describing the purpose of the study. To ensure honesty from the participants, they were assured that this was not an examination, inspection, or a "check" that they practised ethically; that the interviewer was

not judging their responses; and that honesty was vital to ensure that the research reflected the reality in contemporary medical practice.

To help the interviewees relax, they were invited to describe where and when they graduated, what their special area of interest was and were given some time to think of a recent moral dilemma in quotidian medical practice. Recording started when they were ready.

The interviewees started off each interview with a description of a moral or ethical dilemma that they had recently encountered. Most of the participants had a very clear and recent dilemma or case that they wanted to discuss. A few were not sure what to talk about, and some probing was necessary. The interviews followed the Interview Schedule (Appendix V). Throughout the interview, notes were taken on the interview schedule and in a "field guide". While interviewing, the researcher tried to record the participant's feelings towards the responses in order to acknowledge and avoid potential bias.

The interviews were recorded using an iPhone 10 or an iPhone XR. The audio files were uploaded to the researcher's laptop as m4 files for transcription. The audio files were then deleted from the phone and saved in a secure folder on the laptop. The audio files were assigned random case numbers to ensure some anonymity. All potential identifiers were redacted, deleted or edited to ensure the interviewees could not be identified.

All data were reviewed by the researcher as they were collected to identify what additional data were needed. Where possible, participants were invited to take part in a follow-up interview.

The purpose of the study was not to judge the decisions or justifications given for the decisions as right or wrong; good or bad; but rather to establish what sources were used to guide the decisions. This purpose was made clear during the informed consent process as well as at the start of each interview (The discussions that follow each case description are not intended to criticise the participants' handling of the cases but rather to highlight the role Canon, that is, the law, ethics and professional guidelines should play in moral and ethical decision-making. Having said that, we are dealing with the real world and lived realities in these interviews. What matters is how one deals morally and ethically with the situation one is faced with and, whether one can move past it and onto the next one. One should bear in mind,

in these discussions that where theories are clean and simple, real situations rarely are (Also see page 46, (iii)).
As explained in Section 4.3.2, the sample was a mixed group of private and public healthcare practitioners, and their practice of medicine varied from general to speciality practice. This variety represented primary as well as tertiary healthcare settings, and as a result, a spectrum of different dilemmas that occur in the healthcare context.

Following an informed consent process, interviews were conducted in-person and were recorded. In all the interviews, a set interview schedule was used, opening with a question asking the participants to describe a recent moral dilemma. They were asked to describe how they went about resolving the issue and how they justified their decision.

Some interviews were easier than others, where a participant was willing to talk and explain their dilemma. Others were more difficult and guarded, and I got the feeling that either the participant wanted to "be ethical" or that they were concerned they were being judged. I attempted to overcome this by talking around the subject for a bit, citing some personal experience, or bringing up examples of ethical dilemmas. This helped to open the interviews.

Almost all the participants spoke about more than one dilemma as the interview progressed. The initial dilemma introduced was the dilemma used in the main analysis. This was justified on the basis that each participant would first describe a case that had made the greatest impression on them.

4.3.4 Data analysis

4.3.4.1 Assumptions

Before my analysis, I made the following assumptions:
i) that participants answered the questions honestly and transparently
ii) that participants fitted the criteria for inclusion in the study
iii) that the dilemmas the participants described, resolved and justified were real and true
iv) that the participants were interested in my research

4.3.4.2 Analysis

The process for the interviews was what was described above. The interviews were recorded and transcribed verbatim. The transcriptions formed the data collected. For the analysis of

these data, I analysed each interview individually according to the research objectives. The data were then analysed as a data set, both deductively according to preconceived themes and inductively, identifying new emerging themes. The data were analysed according to thematic content analysis. Content that was not relevant to the research questions was not analysed.

Thematic content analysis (TCA) is a descriptive presentation of qualitative data (Anderson, 2007). A satisfactory TCA portrays the thematic content of transcribed interviews by identifying common themes in the transcripts provided for analysis. TCA examines the data to identify a recurring phrase, word or concept, which is then assigned a code. Once these codes are identified across the data set, the researcher sorts the codes into patterns and themes (Guest, MacQueen & Namey, 2012). This research used the six-step guide described by Braun and Clarke (2006) for conducting thematic data analysis.

The six steps are:

i) Familiarity with the data

To familiarise myself with the data, I listened to the individual audio-recordings several times before transcription. Transcribing the data also helped me to become familiar with them. Following the transcriptions, I listened to the interviews again, and matched the audio-recordings against the transcriptions. This was to ensure accuracy and to pick up any innuendos that may have been missed. The data were read through several times before coding. I kept a memo book to record notes and thoughts on ideas that emerged while familiarising myself with the data. All descriptions relevant to my research objectives were highlighted.

ii) Generating initial codes

A code is a word or phrase that summarises pieces of data that answer the research question (Silverman, 2014). In qualitative research, there is usually a large amount of data, so researchers only code data relevant to the research question (Cresswell, 2014).

This step involved coding the data according to the research question and objectives, as described in Chapter 1, section 1.9.3

Coding was performed manually using highlighters and mapping techniques. Following Creswell (2014), I examined my data and assigned an open code to each piece of data that responded to my research question and research objectives.

iii) Searching for themes

A theme is a significant piece of data that relates to the research question (and in this case, the research objectives) and represents a recurring response within the data set (Braun & Clarke, 2006). I grouped similar open codes into groups related to possible themes.

iv) Reviewing themes

This involves working through the themes to see which had sufficient data to support them, thereby generating a thematic map. After creating code groups, I examined the data for codes which had the thickest evidence to support possible themes. These possible themes were presented to my supervisors to review.

v) Defining and naming themes

In this step, the themes were analysed and refined to create clear definitions that explained their contribution to the research (Braun & Clarke, 2006). After presenting my potential themes to my supervisors, I used their feedback and my discretion to define and name themes. The themes are discussed in the analysis in Chapter 6.

vi) Producing the report

In this step, the final themes were written up and discussed to produce a report on the findings. This analysis and discussion are detailed in Chapter 6.

The Tetrad developed in Phase II was used as an analytical tool in determining which normative source the participant relied on when deciding a moral or ethical quandary in the clinical encounter.

4.4 Quality Criteria

The five quality criteria used in qualitative research are credibility, dependability, transferability, conformability and authenticity (Creswell & Poth, 2018).

4.4.1 Credibility

In qualitative research, credibility refers to the veracity of the findings. To enhance credibility in this study, a well-established research design (phenomenological) was used. Further, the research question was aligned with appropriate methods, the research design, research methods and background theory. In addition, member-check meetings were held with my supervisors and discussed. (Credibility is discussed at length in section 1.9.4.1).

4.4.2 Dependability

Dependability is defined as the degree to which the findings of the study can be repeated by others (Lincoln & Guba, 1985). Established credibility can also increase dependability (Niewenhuis, 2016). Dependability is discussed in section 1.9.4.3.

4.4.3 Transferability

Transferability rejects generalisability as an aim of research and refers to the ability of the research findings to align with individuals in different contexts (Nieuwenhuis, 2016). Transferability is discussed in section 1.9.4.2.

4.4.4 Confirmability

Confirmability describes the researcher's ability to remain neutral and allow the participants to guide the research findings (Nieuwenhuis, 2016). To heighten confirmability, I admitted my assumptions before and after analysis.

4.4.5 Authenticity

The authenticity of a study can be understood as the reliability of the researcher's data sources - in other words, the extent to which the participants were able to represent themselves realistically (Yin, 2016). To present an authentic account of the knowledge my participants communicated, I have included extracts from all the interviews I conducted and used direct quotes from the transcript.

4.5 Ethical Considerations

As described in section 1.10, Research Ethics Approval (M170703) was obtained on 28 July 2017 (Appendix I). This approval included the interview schedule, the patient information sheet and the informed consent forms for interviewing and audio-recording (Appendices II, III and IV).

Further, I had to respect the principles of confidentiality, beneficence, and self-determination for each participant. To this end, personal identifiers were removed, medical practices were not named, and participants were free to withdraw consent at any time during the interview and analysis. The participants were also able to review their own transcripts to verify and validate that the transcripts reflected their true responses.

CHAPTER 5

RESULTS, ANALYSIS, AND INTERPRETATION OF INDIVIDUAL INTERVIEWS ACCORDING TO RESEARCH OBJECTIVES

5.1 Introduction

In real-life moral and ethical medical dilemmas, it is assumed that physicians make their decisions guided by normative sources: moral, religious, and societal norms and traditions, as well as reason and experience. Medical or clinical ethics is taught using hypothetical or standardised cases, which require analysis from a third-person perspective, and can be formulaic. This approach utilises an ethics "fit to case" or "cookie-cutter" methodology that ignores variables that may be pertinent in real-life situations. Factors that may affect deliberation of dilemmas in the clinical context, such as time constraints, emotions, interpersonal relations, or legal and ethical uncertainty, may influence how the decision-making takes place. For this reason, this study asked doctors, from the first-person perspective, to describe real cases that they had experienced and explain how they made their decisions. The analyses were conducted once data collection was complete.

Following confirmation of the accuracy of the transcription from the recordings, by the researcher and the participant, it was analysed according to the research objectives. To reiterate, the objectives for Phase II were:

- To describe the moral or ethical dilemmas or conflicts experienced by doctors in everyday medical practice
- To determine what normative sources, if any, medical doctors use to facilitate decisions when confronted with a moral or ethical dilemma in clinical practice
- To ascertain whether practitioners use and comply with professional or ethical guidelines, codes, and principles to assist and guide moral or ethical decision-making in clinical quandaries
- To normatively evaluate how doctors make their decisions against the proposed ideal of adopting a multi-layered approach in the designed normative framework, the Ethics Tetrad was used (This stage is in response to the research question and is analysed and discussed separately in Chapter 7).

To analyse the first three objectives, the data were divided and themed into three sections, namely, moral dilemma, resolution, and justification. I then described the dilemma, the resolution and justification drawing on quotations from the participants' transcripts. I followed each participant's descriptions with an analysis and discussion drawing on the applicable South African law and professional guidelines as well as ethical principles and values. This process informed the "is", what actually happens, and the "ought", what is normatively expected.

The Ethics Tetrad, as an analytical tool, was used to facilitate the normative analysis in the fourth objective, according to the four sources of authority determined in Chapter 3. This is analysed and discussed separately in Chapter 7.

Most of the participants were unable to verbalise their dilemma into "ethics speak". For example, the use of terminology such as "dual loyalty"; "double effect" or "Golden Rule" was not spoken but implied and explained. These descriptions were coded according to the ethics definitions. Thus, where a participant described a duty to the practice or hospital where they were working, as well as a duty to the patient, although they did not describe this as a "dual loyalty", it was coded and then described with this term.

A summary table is provided in section 5.2, Table 5.2, which gives a breakdown of the types of dilemmas, the resolution, and the justification for each resolution.

Table 5.1 Participant Demographics

Number	Private/ Public Sector	Medical School	Graduation year	Ethics training	Specialist	General Practitioner
001	Both	KZN	1981	No	Physician in Midrand	NA
002	Private	KZN	1978	Yes	NA	Yes, in Midrand
003	Both	Wits	2010	Yes	Orthopaedic Registrar	Locum in Midrand
004	Private	Stellenbosch	2011	Yes	NA	Yes, in Midrand

Number	Private/ Public Sector	Medical School	Graduation year	Ethics training	Specialist	General Practitioner
005	Private	Wits	2011	Yes	NA	Yes, in Midrand
007	Public	West Africa/Wits	2015	Some	Gynae/Obs	NA
008	Public	Wits	2010	Some	Gynae/Obs	NA
010	Private	Wits/MEDUNSA	2000	Some	Psychiatrist	NA
011	Private	Wits	2010	Some	NA	Yes, in Midrand
012	Private	Wits	1984	Yes	NA	Yes, in Midrand
014	Private	Wits	2010	Some	NA	Yes, in Midrand
016	Private	Wits	2015	Yes	NA	Yes, in Midrand
017	Public	MEDUNSA	1986	Yes	ER officer	NA
018	Public	West Africa/Wits	2018	Some	Nuclear Medicine	NA
019	Private	Wits	1986	Some	Cardiologist	NA
020	Private	Wits	1987	Yes	Gynae/Obs	NA
021	Private	Wits	2010	Yes	NA	Yes, in Midrand
022	Private	Stellenbosch	2011	Yes	NA	Yes, in Midrand
023	Private	MEDUNSA (Limpopo)	2014	Yes	Gynae/Obs	NA
024	Public	Wits	2018	Yes	Gynae/Obs	NA

Where ethics training is described in the above table as “some”, this is defined as no formal ethics training at an undergraduate or postgraduate level. Ethics awareness for these participants was either the result of ethics lectures for continuing professional development or participation in some clinical research trials. The participants from West Africa had no formal training but had attended some ethics lectures in their departments of speciality.

The research sample in this study was limited to physicians working in the Midrand area, CMAH and CHBH.

5. 2 Analysis of the Interviews According to Research Objectives

As described in the literature review in Chapter 1, Andrew Jameton (1984, p.6) described moral dilemmas as occurring when two or more ethical principles or values involved in the making of a decision in moral or ethical quandaries, conflict. Either principle or value may apply in such a situation for good reason, but one has to be sacrificed for the sake of the other. Beauchamp and Childress (2013, p. 11) elaborate that 'moral dilemmas are circumstances in which moral obligations demand or appear to demand that a person adopt each of two (or more) alternative but incompatible actions, such that the person cannot perform all the required actions'.

As an "ice-breaker", participant demographics were collected. To initiate the interview, where some participants were reticent, they were asked to define what they thought constituted a moral or ethical dilemma in clinical practice.

The following are examples of the responses to the questions, "What do you understand by a moral dilemma? For you, what does a moral dilemma or moral conflict mean?"
In the ensuing quotation, the participant expresses a personal morality that extends to the professional. She describes a moral dilemma as knowing the difference between right and wrong but does not describe a conflict between two or more ethical principles or moral values.

> "I think it comes down to your understanding, or my understanding of right and wrong, you know? Like I think everyone has an innate ability to distinguish between right and wrong…And you know when…yes you have it in a clinical setting, but it is actually everyday – dealing with people, dealing with family, and if, I think, one knows when one is not being morally sound you know. If, and I always look at it in terms of myself- would I want someone to do that to me, would I want someone to do that to my friends and family, or even anybody." (Participant 003).

Participant 012 offered:

> "First of all, a dilemma is when you have to choose between two actions, so a moral dilemma would be a choice between right or wrong actions. But what may be right for one person, might be wrong for another so that makes the dilemma, for example, in a relationship an abortion may be the wrong thing for a person but the right thing for the other."

The next quotation personalises ethical considerations but makes no mention of professional principles:

> "So obviously, a moral dilemma would be something that goes against my ethical considerations or my ethical – the principles that I follow." (Participant 004).

Participant 023 gave an elaborate 'textbook' description of the ethical dilemma:

> "An ethical dilemma is when, you know, like with every profession, there are certain rules and regulations that govern a profession and certain rules that govern how the practice or whatever profession has to be conducted, and if a person is going to do the right thing. You have to observe certain ethical obligations that are expected of you either as a nurse or a doctor or as a dentist. Certain things you can do, and certain things you cannot do. At the same time, moral values that can be at loggerheads with maybe what your ethical obligations are, to save lives, to do no harm etcetera." (Participant 23).

Generally, the descriptions of moral dilemma were diverse and did not fulfil the criteria of the phenomenon as defined by Jameton (1984) and, Beauchamp and Childress (2013). There was, however, a sense of right or wrong action, whether it was based on personal morality, a professional morality or both.

> "Okay, so it's the do's and don'ts especially related to the 'do no harm' concept and to patient autonomy, where you have to balance everything out and remove your personal beliefs at times in order to assist the patient and their expectations." (Participant 005).

Some participants found it easier to describe the conflict of principles in their lived encounter rather than giving a definition:

> "So, you are stuck in-between having you know, these ethical dilemmas of do you now invade the person's confidentiality and privacy, or do you leave them in the dark and not let them know what's going on." (Participant 016).

While some participants were able to define a moral dilemma, most of the descriptions provided were descriptions of moral uncertainty. Moral uncertainty is defined by Jameton (1984, p.6) as arising "when one is not sure whether there is a moral dilemma or not, or if it is just assumed that there is, one is unsure what principles or values apply in the ethical conflict".

> "Okay, so I think a moral dilemma is when you encounter a medical condition where the intervention that you have to give sort of contradicts your morals" (Participant 007)

> "So, it was kind of like, I didn't know if it was right, ethically right for me to be doing blood tests like that without consenting…" (Participant 21).

> "I think if we say ethical dilemma, it would either be something that might be against my moral beliefs but still making sure the patient gets the best treatment. I also think, how can I say, so there's a lot of things where things might not be ethical. So let's say a patient has the right to privacy, has the right to decide what happens. However, their decision can have a big influence on the people they live with. But I know that the patient doesn't allow me to actually protect them, or the immediate family, or the immediate contacts, let me put it like that, because of the fact that the patient has the right on whether we disclose information or not. So I think that would be an ethical dilemma." (Participant 022).

Most of the dilemmas or moral uncertainties are best described in the context of the interviews.

The following descriptions, analyses and discussion also expand on the literature review in Chapter 1, particularly with reference to the relevant law and professional ethical guidelines.

5.2.1 Participant 001

5.2.1.1 Description of the dilemma

Participant 001 is a senior specialist physician who works in private and public practice. The example he cited is one that he encountered in private practice. He described a situation where he, assuming he was acting in the best interest of his terminal patient, and her family, was accused of euthanasia:

> "My intention was to try and avoid the family members from seeing their loved one dying a so-called gruesome death…so I intended to give a drug called Cyclimorph in small doses so as to appease the air hunger that the patient was experiencing…So I explained to the family, firstly from the poor prognosis and secondly, that I wanted to avoid them from seeing a traumatic scene because inevitably, the patient was going to die…There was one sibling who was troublesome…she surprisingly felt that I was trying to practice euthanasia."

The accusation of euthanasia created a situation of uncertainty which made this physician question his actions, retract his proposed treatment and seek legal opinion:

> "I had to pull back and inform the other three siblings that I would consult with the [hospital] attorney…And so I sought the advice of the attorney, and the attorney concurred with me that this was not euthanasia, this was giving small doses of a drug to appease the air hunger and avoid a gruesome death."

The participant demonstrated the uncertainty around his intended actions:

> "It struck me for the first time, that indeed they may have a point, maybe it is in a way, euthanasia."
>
> "One didn't want to be seen to be hastening someone's death."

Despite his many years of medical experience, he also demonstrated concern about possibly breaking the law:

> "What made me pull back was that for the first time I realised that if I had been taken up in a court of law, the charge against me would have been, this doctor practised euthanasia, and it's against the law in South Africa."

The following two statements also illustrate that his actions had never been questioned before and that he perceived that he had always done the best for his patient:

> "I was worried about breaking the law, although, with years of experience, I never experienced this with other groups."
>
> "It struck me for the first time…maybe it is in a way, euthanasia…so yes, I felt I might be breaking the law…"

This physician did express some paternalism, in that his decisions and management had not been questioned previously:

> "I have had these situations in the past, and I have never had people query my intentions or integrity", inferring that he knows that his actions are for the best for the patient.
>
> "There was one sibling who was troublesome. She was a schoolteacher with post-graduate qualifications etcetera, and she surprisingly felt that I was trying to practise euthanasia."

He cited ethical concerns about the consequences of his treatment:

> "Secondly, I also felt that I was treading on thin, you know ethical lines, because it is very difficult to be in a situation where you may potentially cause discord in the

family…implications in terms of insurance pay-outs and property bequeathed to siblings in a will etcetera, I felt that I might be drawn unwittingly into those sagas."

Ultimately, his dilemma was described as:

"So yes, it was ethical, it was legal, and it is also obviously a moral dilemma because one does not want to be seen as hastening somebody's death."

5.2.1.2 Resolution

The dilemma was resolved by seeking legal advice. The main issue for the physician was not that he might be acting unethically, but rather that he might be breaking the law. Once he had confirmation that he was not in breach of the law, he was at ease:

"The only time I didn't sleep well was when the sibling…said to me I may be in breach of ethics or the rules, and I didn't sleep well for a night or two, but once I had clarification from the attorney, I felt good…"

Although the participant, in this case, sought legal advice to help resolve his dilemma, when asked if he relied on any other influences, such as religion, his moral and ethical decision-making appeared to be guided predominantly by scientific reasoning and experience:

"I would like to think I am totally scientific in that respect…I am a person that follows evidence-based medicine."

On being questioned if he approached each case differently or was consistent in his approach to all cases (in other words, case-based reasoning guided by medical guidelines or protocols) he responded:

"We follow a generic set of rules, but one has to individualise…" [where the prognosis is better] one might be more aggressive…you wouldn't readily, in that situation, talk about comforting the patient at all, you will aggressively go and try and reverse the process."

He bases his way of reasoning on his experiences as an undergraduate and post-graduate, and admits that he has relatively little or no ethics training:

Researcher: "…is it your experience that helps you determine what is in your patients' best interests?"

Participant 001: "Yes. It is multifactorial. The first factor and this is surprising, it may come as a surprise, is my experience. The reason why I say this is, in the past, I have had

> situations like this arise where family members had watched their loved ones die a needlessly gruesome death…and I learned from experience that those stressful last few moments…often lead to a psychological disorder [for family members] in the ensuing years and I felt that this experience has led me to be a little more circumspect, a little more introspective and hence now become proactive in trying to prevent these ungainly experiences from affecting surviving family members."
>
> "Secondly, I have to say, that my undergraduate training certainly, and I must also add in the postgraduate training that I had, did not adequately prepare me for these situations and I think one of the reasons why it didn't, besides it not being given importance in the syllabus, it is because of the training institutions I came from…it was medicine that I practised as an undergraduate and a postgraduate was so gross that it made me an expert physician in the actual physical sense of disease healing but not in healing of the soul, so to speak."

For this participant, professional guidelines for guidance, for example, the HPCSA guidelines, did not seem to be an option for referral to when confronted with dilemmas. For him, the HPCSA guidelines were only to be referred to when there were complaints from patients about professional practice. When asked if he referred to the HPCSA guidelines, he responded:

> "We refer to the HPCSA guidelines mostly when we get complaints from patients that have gone straight to the HPCSA, and when we receive a letter saying we have transgressed certain rules etcetera. It is only in those cases that we go and open up the rule book…we make reference but only when we are in trouble…"

This implies a lack of awareness of the true purpose and benefit of the HPCSA guidelines.

5.2.1.3 Justification

The decision made in the management of the patient was justified by this doctor on the grounds that it fulfilled legal requirements. His main concern was that he might be in breach of the law. Even though he intended to ease the patient's suffering, his intention had never been questioned as unlawful before.

5.2.1.4 Discussion

In this case, it would seem that the main ethical conflict was the tension between the doctor's intentions and the perception of those intentions by the patient's family. He intended to alleviate suffering, control respiratory distress and allow the family a peaceful death for their parent, but the intention was perceived as hastening the patient's death or euthanasia. This conflict is known as the principle or doctrine of double effect.

The doctrine of double effect refers to a single action that has two effects; one desired and one unwanted (or unintended). One of the central distinctions is between the intentional causation of the unwanted effect and the ability to discern the unwanted effect as a consequence of the action (Gillon, 1986). In this case, the intention or desired effect was to relieve pain and discomfort. The drug to be administered to achieve such an effect would have the unintended and yet inescapable effect of shortening the patient's life. Feinberg and Feinberg (2010, p. 185) argue that as long as the intention behind the administration of the drug is to ameliorate the patient's suffering and discomfort, rather than to hasten death, the administration of the drug is morally justified. The principle of double effect states that the bad effect must not be the means to the good effect. In other words, if one does evil to achieve good, one is not acting morally according to the principle of double effect (Van Den Beld, 1988). Thus, according to Van Den Beld (1988, p. 95) "one must do good for its own sake, even though doing good also brings an evil".

The HPCSA Booklet 7: Guidelines for the withholding and withdrawing of treatment (2016), advises South African doctors that any medical intervention where the healthcare professional's *primary* intention is to end life is contrary to the ethics of healthcare and is illegal. However, according to McQuoid-Mason and Dhai (2011(e)), medical practitioners often express concern and uncertainty about increasing sedation and pain relief that may have the unwanted side effect of an accelerated death. In these cases, the honest intention behind the action is paramount. Where the intention is to relieve suffering and not to hasten death, the treatment would be both legally and ethically acceptable.

Classically, there are four necessary conditions for an act with the principle of double effect to be morally justified (Beauchamp & Childress, 2013; Gillon, 1986). Although controversial (Gillon,1986), when found together, these necessary conditions form sufficient conditions for a morally permissible action:

i) ACT- The nature of the act, where the act should be good in itself, or at least morally neutral, regardless of the consequences.
ii) INTENTION- The agent's intention, where the agent intends solely to produce the good effect. While the bad effect may be known or foreseen, it must not be intended.
iii) JUSTIFICATION- The distinction between means and effects, where the bad effect should not be a means to the good effect, that is, the good effect is not achieved through the bad effect.
iv) PROPORTIONALITY between the good effect and the bad effect, where the good effect outweighs the bad effect, that is, there is sufficient reason to permit the bad effect.

Ultimately, Gillon, (1986) proposes that the general reminder for medical ethics that emerges from the doctrine of double effect is that actions cannot be judged solely in terms of their consequences. The conditions and the intentions under which the actions of double effect are performed are a vital aspect of the moral assessment.

Currently, in South Africa, euthanasia is regulated by the common law which provides that active euthanasia (where a person intentionally or actively causes the death of a terminally ill patient to end their pain and suffering) is unlawful and is murder (*S v Hartmann* 1975(3) SA 532(C) in McQuoid-Mason & Dada, 2011).

The World Medical Association (WMA) Declaration on Terminal Illness (2006) condemns euthanasia and doctor-assisted suicide as unethical and emphasises palliative care. While not law, many of the principles of the Declaration are to be found in the South African Constitution, 1996; the National Health Act, 2003 (Act 21 of 2003); the common law as cited as above; and the ethical rules of the HPCSA.

The question of paternalism (medical paternalism) or inferring that one knows what is best for the patient, was also raised. Historically, doctors relied mostly on their unilateral judgements in what they perceived as their patients' "best interests". Beauchamp and Childress (2013, p.215) define "paternalism" as the 'intentional overriding of one person's preferences or actions by another person, where the person who overrides justifies this action by appeal to the goal of benefitting or of preventing or mitigating harm to the person whose preferences or actions are overridden'.

Although in this particular example, the physician, while not consciously, complied with the requirements set out in the HPCSA Booklet 7, Section 2.4 and 2.5, to include family where and when the patient is incapable of being involved in making a decision, and to act in what he considered to be the patient's best interests, he also made it clear he was not used to having his decisions regarding the medical management of his patient challenged. This suggests a medical paternalism.

The modern practice of medicine recognises patient (or family, where the patient is incapable) autonomy. The principle of respect for patient autonomy implies shared informed decision-making, and that the doctor should not just make decisions for the patient. There should be a consensus.

The problem arises when the unilateral "good" intentions of the doctor conflict with respect for autonomy. In this case, the doctor decided on a course of action and merely informed the family. He did not consult with the family and allow a family decision about the best way forward. He did not involve the family in the decision-making; rather he informed them of the decision he had made. He also made no reference to professional guidelines or ethical principles for guidance.

5.2.2 Participant 002

Participant 002 is a Family Medicine specialist working as a family practitioner in Midrand. He graduated as a doctor in 1978 from what is now the University of Kwa-Zulu Natal. He had a private practice as a general practitioner in Kwa-Zulu Natal before relocating to and opening a private practice in Midrand.

5.2.2.1. Description of the dilemma

This interviewee described a dilemma involving economic constraints or limited resources and treating patients accordingly. He described the conflict between trying to treat a patient appropriately but being constrained either by the patient's limited finances or third-party payer limits.

> "I think the thing I have most experienced in practice is the frustration in trying to do the best for your patient, but you are unable to do it because there's a whole lot of other factors that come in. One of them is your third party, that is the medical schemes. They won't necessarily pay for what you want to do."

"Or if the patient is not on medical aid, and is a cash-paying patient, they cannot afford it. So, you're not able to give the best care that you would like to give for your patient, or what you would like for yourself or members of your family. With the result that, you know, it's problematic, you have to come to some sort of compromise."

5.2.2.2 Resolution

Participant 002 expressed frustration at not being able to do the best he could for his patient because of economic constraints. Frustration is a symptom of moral distress which occurs when one knows the right thing to do in a situation but is unable to proceed with that action because of an institutional or organisational constraint (Jameton, 1984).

Moral distress is not a moral dilemma, because there is no moral or ethical conflict. Moral distress occurs when an agent is compelled to act in a way that he does not feel is right, but constraints force him to.

Ultimately this participant treats and manages his patients according to patient affordability, albeit with difficulty:

"With the result that, you know, it's problematic; you have to come to some sort of compromise."

He expresses dissatisfaction at not fulfilling his obligations:

"So, you are not doing what ideally you should be doing for the patient."

"So, in other words, you'll treat the patients in terms of what the medical schemes, for example, will be prepared to pay, or what the patient can afford and see what happens thereafter."

When asked how he dealt with the dilemma, he expressed resignation and acceptance of the situation. He has to set his feelings aside:

"At the moment, to be honest, it's very difficult to get over it, but you just have to go on."

5.2.2.3 Justification

Justification for moral and ethical decision-making was described as:

"I think it'll be multi-factorial. So, your professionalism will come into it. Also, it is what you think you would do, you know, what you would do if you were in that situation, or members of your family were in that situation."

Thus, medical professionalism and the Golden Rule are the two principles the doctor uses to justify his moral and ethical decision-making.

5.2.2.4 Discussion

The doctor in this interview described a dilemma not uncommon in this era of managed health care: the conflict between the desire to do one's best and provide the best treatment for one's patient and the inability to do so because of economic constraints. He describes the frustration he feels, by not being able to provide the care for a patient that he would have provided for himself or a family member. This frustration is known as "moral distress". (Moral distress is discussed in depth in Chapter 6.)

In South Africa, economic constraints on patients are not limited to third party payers- most South Africans seeking healthcare do not have access to medical aids and either have to attend state clinics or hospitals or pay for private healthcare themselves (See section 6.2.1. (b)).

This interviewee referenced not being able to treat a patient as he would like himself to be treated or would want a family member to be treated: this principle is known as the "Golden Rule". He repeats this later on in the interview:

> "Also, it is about what you think you would do. You know, what you would do if you were in that situation, or members of your family were in that situation."

Darwin (1896, p.106 in Midgely, p.10, 1993) described the Golden Rule as the foundation for morality:

> 'the social instincts- the prime principle of man's moral constitution- with the aid of active intellectual powers and the effects of habit, naturally lead to the Golden Rule, "As ye would that men should do unto you, do ye to them likewise" and this lies at the foundation of morality'.

The Golden Rule has also been described by Swidler (2019, p.279) as "Love your neighbour as you love yourself" or as "putting yourself in someone else's shoes" (Corazzini, et al., 2005, p. 255). According to Swidler (2019), it is arguably the most widely known and affirmed ethical principle worldwide, since it is found in all the major world religions and cultures (Corazzini, et al., 2005). It is also known as the principle of reciprocity, based on the Roman principle of *do ut des*- "I give that you may give" (Swidler, 2019, p.280). Essentially, the Golden Rule guides one to choose to do for others what one would want for oneself.

Singer (1963, in Gould, 1983) argues that the Golden Rule is not a moral rule and should rather be understood as a moral principle. Further, it is not a substitute for a moral theory but is a method for deciding a line of action. Gould (1983) argues further that the Golden Rule is an approach to ethical problems and not a solution.

Corazzini et al. (2005) posit that although the Golden Rule has universal appeal and is a guide to our interactions with others, it can be reductionist and oversimplistic, leading to unintended negative consequences or inappropriate actions. These consequences occur because important factors in the application of the principle, may not be considered despite good intentions. Complicated dilemmas are reduced or simplified by the agent. As a result, agents may proceed from their perspective of how they would like to be treated, and use this as the standard for how they perceive others would want to be treated, especially where the desires or preferences of the one for whom the agent is acting, is not known (Corazzini et al., 2005).

In other words, what agents would like done for themselves, may not be what those the agents are acting for, want for themselves.

Medical professionalism describes the relationship between the doctor and patient, the doctor's relationships with colleagues and other professionals, as well as the relationship with society (Williams, 2015; Swick, 2000). Williams (2009, p.48) defines professionalism in the healthcare context 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 autonomy'.

The practice of medicine today is complicated. It is best expressed as a social "interactivity", not solely dependent on a doctor, but also on interaction with government, researchers and research institutions, "Big Pharma" and political and economic factors. Further, as Williams (2015) explains, the profession is expected to treat diseases and illnesses that are social as well as biological in origin.

The relationship with society can be characterised as a 'social contract', meaning that society grants the profession privileges and in return, the profession uses those privileges firstly for the benefit of society and secondarily for its own benefit.

To maintain professionalism in the practice of medicine in contemporary society raises many difficulties. Doctors have a duty to patients, but equally are expected to play a role in triaging those patients as well as allocating scarce health resources. They are also expected to be compliant with the prescriptions of third-party payers. They are further duty bound to treat patients even where a patient cannot afford such care. In South Africa, this is a particularly difficult issue, as unemployment and poverty are rife, and the public health system is overburdened. Further, professional integrity is easily tainted when the relationship between the doctor and patient is perceived to be purely transactional, with the patient as customer and healthcare as the commodity (McQuoid-Mason & Dhai, 2011(c)).

Some third-party payers limit the clinical autonomy of physicians to decide how their patients should be treated. While these limits may not necessarily compromise the care of the patient, they may not always be in the best interest of the patient, or what the treating physician perceives as the best interest of the patient. Ultimately, medical doctors have a societal relationship of trust, between all concerned, that has to be maintained to retain professionalism.

Finally, the principle of the Golden Rule is a traditional medical value, that also contributes to the maintenance of professionalism and is a recommended consideration in moral and ethical decision-making by the HPCSA (Booklet 1, Section 3, 3.3.4.4).

5.2.3 Participant 003

Participant 003 is a graduate of the University of the Witwatersrand, having graduated in 2011. She is working as a locum in family practice in Midrand.

5.2.3.1 Description of the moral dilemma

This participant described several moral and ethical dilemmas that she has encountered in both private and state practice. The dilemmas carried a common theme related to economic constraints and limited resources. Issues such as dual loyalty and third-party payer deception were also raised. These other issues are discussed following the analysis of the 'key' dilemmas.

The moral and ethical quandary chosen for analysis in this case, was the dilemma the participant spent the most time discussing, and which appeared to be the cause of the most discomfort.

The case was that of a 13- year-old girl who had been sexually abused by a family member and was pregnant. For this participant, the quandary was that the young girl had been sexually abused, needed a termination of pregnancy and extra-ordinary care, but, because of financial constraints, this patient would have to go to a state hospital, where the doctor was not convinced of the quality of care.

> "…anyway, after about an hour of chatting to them it came out that it was him, he had assaulted her and she was now pregnant with the cousin's baby, and the mother…was pushing for the police to be called and she was pushing for the termination on that day and all this kind of thing. But remember, the medical aid won't pay for that."

The doctor felt that the young girl was vulnerable, was concerned that she may experience further harm and prejudice at a state hospital and preferred that she received private care and counselling.

> "So, I would have, so then I spoke to the gynaecologist, because then I thought I'm now going to send this 13-year-old to the state and you know how brutal they are with little girls hey? Before they even know the story, they would be assuming that she's sexually active, she got herself pregnant, now she's lying about it. They always, they would assume that."
>
> "And so, in terms of that, just to keep her protected, to keep her safe."

In this case, the participant's conflict was between protecting the patient, preventing further harm, and compromising her own personal and professional integrity.

To achieve this, this participant was going to "game the system" (Morreim, 1991), that is, deceive the third-party payer in the form of "ambiguous documentation" (Freeman, Rathore, Weinfurt, Schulman, & Sulmasy, 1999, p.2263) to access the denied care.

This doctor collaborated with a gynaecologist in private practice to "mask" the true indication with another one qualifying for admission to hospital and surgery that the medical aid would cover, thereby enabling the young girl to get the desired treatment.

> "And the gynaecologist and I…so I spoke to her and told her, listen, is there no way we can get this through on medical aid. So she also then said, "You know what R.? I agree with you."

"And so I said to her, the only way we can actually get her through on medical aid, is if we tell them, you know, that she's having an abnormal bleed and you know…"

5.2.3.2 Resolution

Ultimately, the resolution of this quandary was facilitated by reason, emotion and empathy, combined with deception. The patient was referred to a private hospital and was treated by a gynaecologist in private practice because the patient diagnosis was changed to enable this treatment under the third-party payer rule.

5.2.3.3 Justification

The resolution was justified based on the contemporary principle of beneficence, where beneficence is described as all forms of action intended to benefit others (Beauchamp & Childress, 2013, p. 203). This principle also includes the *prima facie* rules of the obligation to:

1. Protect and defend the rights of others.
2. Prevent harm from occurring to others.
3. Remove conditions that will cause harm to others
   (Beauchamp & Childress, 2013, p. 204).

The participant also justified her decision with the traditional value of the Golden Rule. (The Golden Rule is discussed in Section 5.1.2.2).

5.2.3.4 Discussion

In this description, a vulnerable young patient presented, who in the opinion of this doctor needed extra-ordinary care that would not be provided in a state institution. The doctor also felt that because of her age and condition, the patient might suffer prejudice at a state institution. Although this patient subscribed to medical aid, private care and treatment for this particular indication were not covered. Further, the family was not in a financial position to pay for this extra-ordinary service.

For the participant, the ethical dilemma was how to reconcile her professional obligation to prevent harm and her professional responsibility as a patient advocate, with her conflicting obligation to a third-party payer (dual loyalty). This was exacerbated by the conflict between the universal and professional value to be truthful along with the need to be transparent with third-party payers on the one hand, and her duty to the patient on the other.

Ultimately, even though this participant felt she was advocating for her patient and acting in her best interests, the dilemma was resolved by deception of the third-party payer. This was not done, however, without thought for possible consequences:

> "…I mean, I'm sure if the medical aid found out we would both be in trouble you know? But what do you do?"

Lying and deception contravene the values of both common and professional morality. These actions are contrary to the principal virtue of truthfulness. Medical doctors have a duty as members of society and as members of the medical profession to uphold these values. However, these are *prima facie* values and as such are not absolute (depending on the normative theory one subscribes to; for example, deontology prescribes that lying is always morally prohibited as it defies the principle of veracity). In extraordinary circumstances these values may be contravened, for example, one may have to lie to save another person's life. In the moral and ethical quagmire described by this participant, she felt she was preventing further harm and acting in the patient's best interests. By using deception, she was acting for the "better" good.

David Wendler (2010) describes twenty-seven exceptions to the principle that physicians should always act in the best interests of their patients. One of these exceptions is lying or stealing for patients - including lying to or deceiving third-party payers. The reason he gives is that lying for patients compromises the moral integrity of health professionals. However, not acting in a patient's best interests because of a moral or ethical judgement would also compromise that professional's moral integrity. Compromised moral integrity can also lead to moral distress. The problem, in this case, is that the doctor had judged that the patient, in light of her vulnerability, needed to be protected, and in ideal circumstances would have been able to act accordingly. She felt she was advocating for the patient:

> "So, in terms of that, just to keep her protected, to keep her safe."

However, in this case, the doctor's agency was constrained by third-party payer limitations. Sometimes medical doctors have to lie to third-party payers in order to grant their patients treatment that they would not otherwise have access to (Tavaglione & Hurst, 2012). This strategy is commonly known as "gaming the system" (Morreim, 1991). Physicians game the system when they "break healthcare rules and regulations regarding access to care and/or reimbursement" to gain the treatments they consider the patient needs (Regis, 2004, p.19). Therefore, doctors game the system when they lie to or deceive third-party payers for the sake

of their patients. In doing so, priority is given to traditional medical ethical duties rather than the rules of reimbursement (Tavaglione & Hurst, 2012). While medical doctors have a *prima facie* duty not to lie and to be truthful, Tavaglione and Hurst (2012) argue that there is one particular clinical context where gaming the system may be justifiable. This context would be where the third-party payer sets treatment limits that do not concur with the physician's judgement concerning what would be the best care for the patient (Tavaglione & Hurst, 2012). Pellegrino (1986, p.31) argues that when the system harms the patient, then the question of the physician's primary agency arises. So where the physician is primarily the 'patient's advocate, agent and minister' then he must guard the patient's interest against the system, even though this action may harm her own self-interest (Pellegrino, 1986, p.31).

Tavaglione and Hurst (2012) argue that doctors are justified in putting their patient's best interests first, and if medically necessary, the doctor has a professional duty to game the system. Equally, they also have a duty to be truthful and honest. W.D. Ross (in Beauchamp & Childress, 2013, p.15) distinguishes between *prima facie* obligations and *actual* obligations, where the *prima facie* obligation must be fulfilled unless it conflicts with an equal or stronger obligation. As such, the "greatest balance" of right over wrong must be found (Beauchamp & Childress, 2013, p.15). In this case, it would seem that the principle or obligation of beneficence was prioritised over the duty not to lie or deceive. Beauchamp and Childress (2013, p.151) refer to the duty to prevent evil or harm as one of the principles of beneficence.

Booklet 1 of the HPCSA guidelines, section 5.1.1. prescribes that healthcare professionals should always regard concern for the best interests or well-being of their patients as their primary professional duty. Further, section 5.1.9 advises that medical doctors should respond appropriately to protect patients from any risk or harm. However, section 4.6.1 of the same booklet indicates that the truth and truthfulness is part of the natural duties of HCPs.

Crucial to this debate on the acceptability of deception of third-party payers is what Tavaglione and Hurst (2012, p.8) call the 'idealistic fallacy' where 'real-life morality cannot mechanically be derived from ideal theory'.In other words, the behaviour of agents in non-ideal conditions is judged as bad or wrong, based on normative criteria drawn from an ideal theory. Ideal theory, in its prescription that there is no need for deception or for any wrong act, assumes sociopolitical contexts within which background institutions are perfectly just, and that those individual agents living in these contexts are compliant with the requirements of justice (Tavaglione & Hurst, 2012). However, in an unjust society like South Africa, with

the historic and contemporary economic and healthcare disparity, where economically vulnerable patients either cannot pay or are dependent on medical aid rules, the system is not ideal. Those patients will suffer further insult and injury because they cannot be properly taken care of. This argument does not condone "gaming the system" or give weight to lying and deceiving in order to obtain appropriate treatment for patients (there are almost always alternatives like patient advocacy); but it proposes rather that in less than ideal situations and extraordinary circumstances, where there is no reasonable alternative in the best interest of the patient, sometimes it is justifiable to game the system. Arguably, the deception of third-party payers does not portray a problem with physicians, but rather a problem with the restrictive environment they work in (Tavaglione & Hurst, 2012).

The acts of deception and lying to third-party payers are not without consequences. Firstly, as previously discussed, there is a compromising of both personal and professional moral integrity.

Secondly, lying and deception can become a habit. Each time an agent lies or deceives, they reinforce the habit of lying and in so doing, undermine the virtues of honesty and truthfulness. Gaming the system without prudent and contextual deliberation can inure the agent to the wrongness of the act. Sade (2012,p. 18) argues

> "lying is a misrepresentation of reality that not only harms others by denying them the truth to make decisions rationally…but much more importantly in Aristotelian terms, lying harms the liar by undermining his character and leading him away from, rather than toward, a flourishing life."

Sissela Bok (1999, xix) in her seminal work on lying, noted:

> "The most serious miscalculation most people make when weighing lies is to evaluate the costs and benefits of a particular lie in an isolated case, and then to favour lies if the benefits seem to outweigh the costs. In so doing, they risk blinding themselves to the effect that such lying can have on their integrity and self-respect, and to the jeopardy in which they place others."

Further, dishonest behaviour can lead to moral disengagement which in turn can lead to more bad behaviour, dishonest practices and leniency in other moral codes (Shu, Giro and Bazerman, 2011). Moral disengagement occurs where an agent changes from ethical behaviours to unethical behaviours and then justifies the new behaviour by citing extenuating

circumstances (Knoll, Lord, Petersen, & Weigelt, 2016). Agents find ways to convinces themselves that the unethical behaviour is justified, for example,"everyone else is doing it". This can also have consequences for professional reputation should disciplinary action be taken.

The legal aspect of the deception of third-party payers is that the act is essentially fraudulent. The intentional and unlawful misrepresentation of facts which prejudices or is calculated to prejudice another person, constitutes fraud (McQuoid-Mason & Dada, 2011). The Council for Medical Schemes (CMS) (Businesstech, 2019) describes medical aid fraud as:

> "Knowingly submitting, or causing to be submitted, false claims or an intentional misrepresentation of the facts in order to access payment of a benefit to which one would otherwise not be entitled".

While this definition does not explicitly mention falsifying the patient record so that the patient may benefit, ultimately, in a private healthcare setting, even though the patient benefits medically, the physician is guarding against any financial loss. The claim for reimbursement may be "ambiguous" but the physician, usually, will still be paid for the service rendered. So unless the doctor acts *pro bono* there is no financial cost to the doctor. Ultimately though, there is a cost to the patient. Fraud and abuse have consequences and implications for the medical aid industry as well as for the members subscribing to the medical aids. As a result of fraudulent claims, medical aids are forced to increase their premiums and reduce benefits to members. Subscribers are consequently forced to pay more or "downgrade" their memberships, neither of which improves access to healthcare in non-ideal circumstances; and so the cycle continues.

In South Africa, doctors who commit fraud by intentionally and unlawfully falsifying medical records are criminally charged and disciplined in terms of the regulations under the Health Professions Act, 1978 (Act 56 of 1978). The National Health Act also makes it an offence for a person to commit fraud.

Other consequences to gaming the system are threefold: harms to the patient; harms to other patients; or harms to society at large. Harms to the patient may result from the falsification of the patient records leading to a false medical history which may have future implications for that person's healthcare. Harms to other patients could happen in two ways: gaming the system may prioritise one patient's needs over another; or it may prioritise "privileged"

patients who are defying the ‘equal opportunities for the same need’ principle of justice over those who are not “privileged” (Regis, 2004).

The direct harmful consequence to society is that the resource system as a whole is either undermined or is depleted. An indirect consequence is that statistical data used to improve or manage services become distorted, thus preventing the development of new and improved health policies (Regis, 2004). Also, gaming the system may be easier than actually challenging or advocating for a change in the system. Advocacy takes time, is emotionally draining and does not provide an immediate “in the moment” solution, whereas gaming the system is not time-consuming and provides “instant gratification”. Finally, gaming the system represents a lack of responsibility for the social consequences of one’s actions (Tavaglione & Hurst, 2012).

The tension between duty to the patient and a contractual obligation to third-party payers raises the problem of dual loyalty as well. Dual loyalty is defined by McQuoid-Mason and Dhai (2011(c), p.66) as:

> ‘simultaneous obligations, express or implied, to a patient or a third party resulting in a clinical role conflict between professional duties to the patient and the interests of the third party.’

In these situations, it is ethically challenging to act in the best interest of the patient despite the pressures or restrictions of third-party payers. The interests of these payers argue that rules against deception or for patient priority are not “categorical imperatives.” To overcome this challenge, Beauchamp and Childress (2013, p. 18) advocate the specification of the principles in order to know what can or cannot be done. In other words, where there two moral rules, values, duties, obligations or principles that come into conflict with one another, the second rule ought to be specified in order to handle the conflict with the first rule ((Beauchamp, 2003). That is, one should specify which rule or principle is more right and which is more wrong in that circumstance. A statement regarding an exception or condition within the second rule should be specified that allows for that rule to be used.

Finally, it is possible that the decisions made by this participant were clouded by emotion, namely empathy. Traditionally, ethical and clinical decision-making have been viewed as a rational and cognitive process, but this view ignores human virtues like empathy and

compassion. Baron-Cohen (2012, p. 12) defines empathy as a double-minded focus of attention and as :

> " our ability to identify what someone else is thinking or feeling, and to respond to their thoughts and feelings with an appropriate emotion."

Participant 003 recognised her patient's need and responded to that need, even though personal integrity was sacrificed. In clinical practice, the successful treatment of patients depends on effective patient-physician interactions. Empathy is an example of one such interaction, because it is an emotional experience occurring between the doctor as an observer, and the patient as a subject, and is based on visual and auditory cues, which the doctor as observer identifies and transiently experiences (Hirsch, 2007) and then,in turn,responds to. Kozlowski et al. (2017), posit that even though emotion is excluded from theoretical models of clinical decision-making, there is enough evidence to suggest that in reality it plays a role . I propose that the same argument can be applied to moral and ethical decision:-making: emotion, in this case empathy, is an influencing factor.

5.2.4 Participant 004

Participant 004 is a graduate of Stellenbosch University. She has spent time in General Practice in Western Europe. After returning to South Africa, she worked as a Casualty officer in Midrand before entering private general practice. She is currently also working part-time on a Master's degree in Public Health.

5.2.4.1 Description of the first dilemma-the medical certificate

This doctor described several dilemmas. For the sake of variety in the overall analyses and because there is a common theme, two of these dilemmas that occur frequently in daily medical practice were selected to be discussed. Both these quandaries reference patients who deceive doctors.

The first dilemma was that of a patient who requested the doctor to extend his period of sick leave without any medical justification. To put it in context, this dilemma occurred during the COVID-19 pandemic lockdown which dictated some extra-ordinary protocols in medical practice, notably the requisite periods of quarantine or isolation, depending on the patient history. In this case, a patient, potentially exposed to the virus, came to be tested. This process required an isolation period until the results became available.

> "So, it was a patient that, he came in with suspected COVID exposure due to work, and I sent him for a test, which he, he never actually went for, but he took the time off work that I gave him off. And he came back three or four days later, saying oh he needs the sick note to be extended but he never went for the tests that I sent him for. But his employers did some other test at work and they wanted him to take some more time off until he has those test results. And then I told him well, I don't have any proof that he actually went for it and if they [the employers] want him to have more time off, then they need to give him the time off because I don't have any proof of that. And I told him that I can write on the note that he informed me that he was sent by his employers to have the test done, and he also didn't want that. He wanted me to make up something and then …so."

She explains why she was mistrustful:

> "Because he wouldn't allow me to write that his employer advised him to take off until the results are available, which is the story he gave me."

What made this situation a dilemma for the doctor was that the patient expected the doctor to be complicit in the lie:

> "Because he wanted me to lie on the sick note".
>
> "He wanted me to make up something…"

For this doctor, "falsifying" a sick note would compromise her personal and professional integrity as well as have legal implications:

> "It was personal and professional because I could get into trouble for being dishonest on…it's a legal document at the end of the day. The employer can investigate and then… And then they could report me to the HPCSA for fraudulent sick notes."

5.2.4.1 a) Discussion

Medical certificates are legal documents in that they are required to be compliant with statutory and professional requirements. They are certifications of illness relating to absence from work, enabling the employee to qualify for statutory sick leave and payment. Medical practitioners often come under pressure from patients to issue medical certificates even when not indicated. The three most common concerns for medical doctors around issuing medical certificates or "sick notes" are:

- How to deal with a patient who is demanding a medical or sickness certificate that the doctor is not comfortable providing
- When the medical doctor is contacted by an employer and asked to verify the veracity of the medical certificate
- When a complaint is made to the medical professional body by an employer, about the veracity or accuracy of the certificate provided by the physician

The dilemma above encompasses the first and third concerns. This medical doctor was not comfortable providing the medical certificate to her patient, and she was concerned about being reported to the HPCSA.

Sara Bird (2006) argues that employees as patients have a responsibility to provide legitimate reasons for requesting a medical certificate in a way that enables the medical practitioner to make an accurate assessment that the request is valid. Equally, medical practitioners have a responsibility to obtain and note sufficient accurate information, through the patient history and physical examination, to issue the certificate for work absenteeism consequent to poor health. The medical certificate should state that the employee was incapacitated due to illness or injury and the exact period of sick leave (HPCSA, Booklet 2, Rule 16(1) (h)). Without the patient's consent, a description of the injury or disease diagnosis is not a requirement (the Basic Conditions of Employment Act (1997) does not require any diagnosis). To address concerns around issuing medical certificates, medical doctors ought to familiarise themselves with professional ethical requirements and the law.

The HPCSA's Booklet 2, Ethical and Professional Rules of the Health Professions Council of South Africa, prescribes the requirements for issuing a certificate of illness under section 16. According to rules 16(1)(e) to 16(1)(g), a medical certificate should only be issued based on a proper medical examination and diagnosis, and not merely on the observation of a patient. Further, a medical certificate may only be issued if the patient is truly medically unfit to perform their duties, and may not be issued for routine visits, examinations or tests. The exception, in this case, was that the COVID-19 protocol required patients awaiting test results to isolate themselves at home until the results become available. This does not justify an extension when the patient did not attend the testing in the first instance.

Where a patient requests an extension of the originally allocated sick leave, the medical doctor should insist on conducting a follow-up consultation and examination with the patient,

and then only on merit, issue an additional medical certificate (Verwey, 2015). Verwey (2015) notes that a medical practitioner may not extend the initial period of sick leave and issue an additional certificate without having consulted with and examined the patient. In the dilemma described here, the employee requested the medical certificate because, while not ill or injured, he had to have time away from the workplace post-testing, for his health and the health and safety of the others in the workplace. However, the patient did not go for the viral testing when this doctor sent him, yet still took the time off work. He came in to ask for a sick leave extension allegedly because his employers had conducted tests and wanted him to take more time off.

> "…but he never went for the tests that I sent him for, but his employers did some other test at work and they wanted him to take some more time off until he has those results."

The participant told the patient that if the employer wanted him to have the time off work, they should give him the time off work and a medical certificate should not be necessary, especially during the pandemic:

> "…if they want him to have time off then they need to give him the time off because I don't have proof of that [the employer-conducted tests]."

Without proof of the tests conducted by the employer, the medical practitioner was justified in not issuing an extension to the medical certificate.

As discussed above, the medical certificate is a legal document as it may be used as evidence in disciplinary hearings and has implications for employer productivity and employee earnings. According to section 29(1) of the Basic Conditions of Employment Act (Act No 75 of 1997), an employee is obliged to provide a legitimate medical certificate if the employee is absent from work for more than two consecutive days or on more than two occasions during an eight-week period. Importantly, according to the Basic Conditions of Employment Act (1997):

An employer is not required to pay an employee in terms of section 22 if the employee has been absent from work for more than two consecutive days or on more than two occasions during an eight-week period and, on request by the employer, does not produce a medical certificate stating that the employee was unable to work for the duration of the employee's absence on account of sickness or injury.

The employer has the right to investigate the validity of an employee's medical certificate and confirm the dates that the employee was booked off (Verwey, 2015). Should the medical certificate produced by the employee in such circumstances be proven as fraudulent or invalid, this would have consequences for the medical practitioner who issued and signed the certificate. Where a medical doctor cannot show clinical evidence of the condition with which the employee claims to have suffered - or in this case that he 'complied' with the COVID-19 testing and isolation protocol - it is recommended that the doctor should consider providing a letter of support to justify the issuing the medical certificate (Bird, 2006). In this particular dilemma, the patient did not want the doctor to provide elaboration on the extended medical certificate.

The implications and consequences of issuing fraudulent sick notes, other than the threats to personal and professional integrity, are disciplinary action by the professional bodies and even criminal charges. According to the South African Medical Association (SAMA), employers who suspect fraud on the part of the medical practitioner have to approach the medical practitioner and may report the matter to the relevant SAMA branch's ethics committee (South African Medical Association, 2012). The practitioner may also be reported to the HPCSA for professional misconduct.

5.2.4.2 The second dilemma- the drug-seeking patient

Medical doctors are often placed in the unenviable position of having to determine whether a patient has a genuine need for analgesia, that is, that there is a legitimate medical indication for prescription painkillers, or whether the patient is feigning or exaggerating symptoms to deceive the doctor in order to obtain these medications to satisfy an addiction, use recreationally or in some cases even sell to others. But what of the case where there is both a legitimate medical indication and an addiction? The participant describes one such case that she encountered when she was working in Casualty:

> "I had a… when I was a consult up in Casualty, I had a patient come in like looking for a Pethidine prescription…she came in with a whole soppy story which is like 90% of the stuff she told me is true, but she is … an addict. So, she has cancer and nothing else works for her and this is the only thing that works for her, and it was a Sunday, and she couldn't get her GP and…you could see she was sick…"
>
> "…and I felt like I would like to help her but obviously, I don't want to enable her, and Casualty is not the place you would come…"

5.2.4.2 a) Discussion

What made this situation a dilemma was that the doctor had a choice; either administer the Pethidine to relieve the patient's pain (doing immediate good for the patient but perpetuating harm), or not provide the Pethidine and cause the patient to suffer (good for the doctor but causing harm to the patient). However, if the patient is an addict and this Pethidine is given ostensibly to 'alleviate' pain but instead ameliorates her craving, then the doctor may be enabling the patient and causing harm, in the belief she is doing good. This may also have legal consequences for the doctor, either from a medical negligence or a medical malpractice perspective.

The participant was reluctant to submit to the patient's request for the Pethidine because she suspected the patient of "doctor-shopping" for her addiction– she presented to a Casualty and apparently could not get hold of her general practitioner. "Doctor-shopping" is broadly defined as 'attempting to obtain prescription medication from many different doctors, or the exaggeration or even complete feigning, of symptoms in order to acquire a prescription for which there is no legitimate medical need' (Sanders, Eassey, Stogner, & Miller, 2016). Identifying a patient who may be doctor-shopping is a difficult task. It may be made even more difficult when the patient is a known terminal patient and addict.

Medical doctors generally assume that patients come to see them because they have a problem that requires treatment. Within this consultation, according to Burgoon, Callister and Hunsaker (1994), doctors usually interact with the patient according to a 'truth bias'. A truth bias is a presumption that the patient's presentations of themselves are true, complete and accurate. However, in this case, the physician was reluctant to accede to the patient's requests because she feared being deceived.

Deception and the fear of deception have consequences for the patient. When a patient successfully deceives a doctor, the patient may be overtreated or, when a doctor fears being deceived, the patient may be undertreated.

There may be several reasons for a terminal patient seeking prescription drugs outside of their pain management regime. The first is that the patient is a true addict, where addiction is defined as "the compulsive use of a substance resulting in physical, psychological, or social harm to the user and continued use despite the harm" (Passik & Portenoy,1998, in Kirsh and Passik, 2006, p. 426). However, according to the Cancer Pain Working Group, addiction is

rare in palliative care when opioids are prescribed at the appropriate doses to relieve pain and the patient is compliant with the recommended regime (Cancer Pain Working Group, 2015). Secondly, drug-seeking behaviour such as requests for additional prescriptions or increased doses may be due to "pseudo-addiction". Pseudo-addiction is an iatrogenic syndrome where patients may use deception when distressed and this distress may be mistaken as signs of addiction (Kirsch & Passik, 2006). However, the deception occurs in an attempt to obtain pain relief and is thought to resolve when the pain is controlled (Cancer Pain Working Group, 2015). The possibility of pseudo-addiction should be considered if the patient is reporting distress associated with unrelieved pain.

The doctor-patient relationship is a relationship of trust. Just as doctors have a duty to be honest and truthful in their relationships with patients, so patients should be honest and truthful in their relationship with the doctor. Compassionate care is dependent on reciprocal communication and dynamics between the patient and the physician. The Model Policy for the Use of Controlled Substances for the Treatment of Pain used by the Federation of State Medical Boards of the United States states that "a physician-patient relationship must exist and the prescribing [of opioids] should be based on the diagnosis and documentation of unrelieved pain" (Jung & Reidenburg, 2007, p. 435).

But what does the medical doctor do when one fears deception but also knows that a patient may need pain relief? Ideally, when more than one doctor is treating a patient, the one prescribing the controlled substances should keep other doctors involved in that patient's care informed about the pain management regimen and any other medical issues (Jung & Reidenburg, 2007). One could argue that this is almost impossible when a patient is doctor-shopping or seeking prescriptions from multiple sources, but an accurate history is essential. Further, it would only take a phone call to the patient's primary oncology doctor to confirm the need for administration of the requested analgesic.

5.2.4.3 Resolution

The first dilemma was resolved according to the law and guidelines. The doctor did not want to be reported for unprofessional conduct. The extended sick note was not given.

> "It's a legal document at the end of the day. The employer can investigate and then… they could report me to the HPCSA for fraudulent sick notes."

In the second dilemma, the participant resolved the dilemma by consulting a senior physician.

"…but then I consulted my senior on-call and well I took the guidance given from them."

She would have justified giving the pain relief on medical reasons because:

"Well, that I, I verified that she actually does have cancer, so she…she is in pain"

"Even though I knew that she is an addict and she'll probably go somewhere else, but I ended up not doing it because I got instructions from higher up not to."

However, she did have some misgivings. The resolution of this dilemma also led to some moral distress:

"Well, I felt sorry for her because I kind of had empathy to her situation and…her desperation."

"If it was up to me, I probably would have given her like one shot on the day."

When asked about the effects of her decision, for example, did she have regrets or did her conscience affect her, she replied:

"There wasn't time to regret it, it was busy that day…I kind, a little bit, because I felt I should have because she probably just went somewhere else and she, they probably gave her what she wanted and more, which might not have been the best thing for her."

5.2.4.4 Justification

This participant generally tries to resolve her clinical moral dilemmas according to reason and if she cannot, she discusses the problem with colleagues:

"Well, I would, if I can't figure it out on my own I would obviously discuss it with a colleague…and just get their opinion as well, of what they think I should do in that situation."

When asked if there was ever reference to professional guidelines or the HPCSA guidelines:

"Not in South Africa, but in Ireland, because of the whole litigation thing we actually consulted MPS [Medical Protection Society] a lot for …you phone them, and they give you advice."

So, the law is foremost for this doctor when making decisions. When asked if she would describe her process as legal rather than ethical, she responded as follows:

Researcher: "So it's acting legally, not ethically?"

Participant: “Ja, probably, ja, that makes sense. Well, considering all the pillars of ethics. You have to weigh them all up, but ja” (although she was vague on the ethics).”

Each dilemma is resolved on a case-based system, balancing ethical principles:

“I try to balance all the different elements…like the beneficence and non-beneficence and all of those ethical stuff because I’m actually just doing a Masters in Public Health so I just did an ethics module so, I try and balance the different elements and obviously each one I take an individual approach.”

“So, you won’t have the same formula for each patient. Ja, but I try to stay within the law as much as possible.”

5.2.4.5 General discussion

Lies occur commonly in the doctor-patient relationship (Palmieri & Stern, 2009), whether it is “whole truth withholding” as when the doctor downplays the severity of a patient’s diagnosis, or when the doctor withholds an undesirable prognosis. In the same way that patients expect honesty from their doctors, so doctors expect honesty from patients. Accurate diagnoses and compassionate care are dependent on effective bidirectional communication between the patient and the doctor (Palmieri & Stern, 2009). Lies in the doctor-patient relationship can serve as obstacles to effective medical care and have a significant impact on treatment and patient safety. People lie for a variety of reasons, and Palmieri and Stern (2009) propose that one reason is for secondary gain. In this participant’s two dilemmas, this would be, respectively, to achieve a fraudulent sick note and to obtain medication.

Lies in the doctor-patient relationship can have both immediate and far-reaching consequences. Immediate consequences are where, as already discussed the patient is either over or under-treated. Also, once the deception is discovered, trust is violated in the relationship. Within the field of medicine, where the patient has come to the doctor for help but resorted to deception to get that help, the doctor may be tempted to retaliate against the patient by withholding treatment or denying the request, as happened in these cases.

Ultimately, trust is essential in the doctor-patient relationship, and doctors ought to take the lead, nurture the relationship by being honest themselves and gain the patient's confidence, so that patient’s do not have to deceive to gain their objectives.

5.2.5 Participant 005

Interviewee 005 is a graduate of the University of the Witwatersrand. She graduated in 2011 and has worked in private practice for five years. For the last four years, she has worked in general practice in Midrand. She described the following dilemma.

5.2.5.1 Description of the dilemma

The participant was consulted on a Sunday morning, by a young female patient requesting post-exposure prophylaxis following an alleged rape. At the time she was the only doctor on duty. The patient did not want to be examined and did not wish to report the rape. She also did not want anyone, including family, to know about the incident.

> "So, her request was, I don't want to report it. I don't want to be examined. I just want post-exposure medication and blood tests."
>
> "[the patient had said] I don't want to report it…but I had to take time to counsel her, set her down, give the full story. And even then, after I explained that yes, she's got that right not to report it to the police, but she still ideally needs to be examined. Full examination, looking for evidence, and still from that side, she still refused. So I…considering that you're refusing all of this out, I will give you medical treatment."

This doctor was conflicted between complying with the principles of patient autonomy and confidentiality, the medico-legal requirements regarding rape (medical examination and documentation), and her fear of the legal repercussions. She was also constrained from acting in what she thought was a legally appropriate manner, by the duty to respect the patient's autonomy. The situation was complicated by the potential for the patient wanting to report the rape at a later stage, as there would be no medical examination or forensic evidence to substantiate the claim. The doctor felt she would be held responsible for the lack of evidence and an examination report. The doctor also feared the legal repercussions of "not doing enough". She did consider documentation to protect herself.

> "…I will give you medical treatment. But you also need to sign a disclaimer of sorts that you refused. One, for me to report it to authority; two, that you yourself refuse to report it, and three, also for refusing a physical examination because medico-legally that's a big thing. A year from now she could decide she wants to press charges…it will come back to me, to the doctor who saw her."

5.2.5.2 Resolution

The dilemma was resolved by respecting the patient's wishes (respect for autonomy) and her right to confidentiality. There was also the legal aspect:

> "Medico-legal, ja and the patient confidentiality part as well. I mean she kept repeating; 'I don't want anyone else knowing, I don't want anyone else knowing."
>
> "So, I ended up going according to her request, and obviously the little extra that I did was then just the medico-legal aspect. So just according to patient wishes, not belief. Patient wishes, ja."

The law was not a consideration initially:

> "The law part only came after because I saw her initially and gave her some time to just rest in the rooms, and I saw other patients. When I got back, that's when I was a little bit more clear-headed …I thought ah legal stuff, medico-legal stuff."

The Golden Rule came into play in her deliberation:

> "I started thinking okay, now let me look at it from her point of view. Let me try and be in her shoes, her, maybe her mindset in terms of what she wants from us, not what I want from her, as a doctor. So I ended up going according to her request."

5.2.5.3 Justification

When asked how she justified her decision, she responded:

> "It was more me, my intuition…What I felt was right at that point…"

She acted intuitively, doing what she thought was right for the patient.

When asked where her professional moral sense came from, she cited the principle of:

> "First do no harm."

Her actions troubled her, and she was concerned that she had not done enough for her patient. She also displayed some moral distress in that she lost sleep over the incident. Ultimately, she was 80 per cent sure she had acted appropriately but:

> "the 20 percent I truly lost sleep over it."
>
> "I just feel like I didn't do enough for them."

5.2.5.4 Discussion

This dilemma raises several issues: the medical doctor who is inexperienced in dealing with sexual violence and uncertain of the correct process; the rape survivor who does not want to be examined; the right to post-exposure prophylaxis (PEP); and the legal obligation of the medical practitioner in such cases.

The HPCSA Guidelines, Booklet 8, section 4, Violence against women, while not specifically referencing rape, prescribes that violence against women is not condoned and consequently, healthcare practitioners treating women are ethically obligated to, at point 4.1:

> 'Inform themselves about the manifestations of violence and recognise cases. Documentation must consider the need for confidentiality to avoid harmful consequences for the woman, and this may need separate, non-identifiable compilation of data.
>
> i. Treat the physical and psychological results of the violence…'

The rape survivor, in this case, did not want to be examined despite the doctor informing her of the reasons for an examination and the consequences of not undergoing one. The principle of respect for autonomy relates to respecting the individual choices and decisions made by patients. This principle also takes into consideration self-determination and respecting confidentiality in the doctor-patient space. The issue of whether respecting patient autonomy is in the patient's best interest does arise, but in this case the patient was advised of implications and consequences and made an informed choice, although it may have been clouded by the trauma.

David McQuoid-Mason (2016) reports that doctors who, in cases of rape, do not record the necessary medico-legal evidence correctly, provide rape survivors who lay criminal charges against alleged offenders little chance of success in obtaining justice. The challenge in this case with the rape survivor was that the medical doctor had to respect the autonomy of the patient, provide as much medical management as the patient would allow and further, try to persuade the patient to collect forensic evidence.

Usually, when a rape survivor reports to the police, the SAPS will request an examination via a South African Police Service 308 form, and the survivor will be taken to a district surgeon or health examiner appointed by the Department of Health, to be examined and to have evidence collected. The examination results are recorded by the medical examiner on a J88 form. During this consultation, the survivor is also tested for HIV and provided with PEP.

(This process is constrained by a time limit of 72 hours, which is the limit for the successful prevention of HIV infection (McQuoid-Mason, 2016)).

But what of the patient, as in this case, who refuses an examination and does not want to report the incident to the police? Where a rape survivor does not want to report the assault to the police, she may be examined by a private or state-employed doctor and the SAPS 308 and J88 forms do not apply. However, McQuoid-Mason (2016) recommends that in such a case, because the survivor may change her mind and wish to report the assault, the medical doctor should record the examination following annexure C of the national instruction stipulated by the Criminal Law (Sexual Offences and Related Matters) Amendment (Act No.32 of 2007) (SOA), Section 2. The patient should be examined, and any evidence should be collected and preserved just as if the examination had been in conducted at the request of the police (McQuoid-Mason, 2016).

In the above dilemma, the patient refused any examination. The doctor had to accept the patient's account, respect autonomy, and treat her accordingly, providing counselling and PEP. The patient should also have been tested for HIV. In this case, detailed documentation by the examining doctor should help in the eventuality of the patient changing her mind.
In terms of the SOA Act, free PEP and medical advice are also available to victims who decide not to report the matter to the police- provided they have reported the alleged sexual offence as prescribed to a designated public health establishment (McQuoid-Mason, 2009). The patient in this case did not receive free PEP as she did not report to a designated establishment. She was given a prescription for PEP.

Ultimately, because of procedural, ethical and legal uncertainty, this participant used the law as her reference point. Uncertainty, as a constraint, led to moral distress.

5.2.6 Participant 007

Participant 007 is a West African doctor specialising in gynaecology and obstetrics in South Africa. The need for further medical specialisation, not available in his home country, brought him to South Africa. He is currently working at CHBH as a registrar in the department.
He also described several dilemmas involving limited resources, mainly in his own country, which he attributed to poor leadership. He found resources in South Africa not as limited as in his homeland, although there he did work in a rural setting. The dilemma I used in this analysis is the first one he described when he started working at CHBH. He displayed signs of

moral distress as the interview progressed (related to incidents that he described in his homeland) and was asked if he wished to withdraw participation. This was declined.

5.2.6.1 Description of the dilemma

He described an incident when he was still relatively new to the department at CHBH;

> "I have been in Bara for I think four months and there is one instance where there was a patient who presented for a TOP actually and I had to do a sonar for the patient and then my intern can go ahead and administer the Cytotec. But once I was done with the sonar, she came to inform me that she was not comfortable administering the Cytotec and she asked if I was comfortable doing that. I wasn't comfortable either …"

He described a conflict between performing a procedure for a patient and his religious beliefs:
Researcher:

> "Okay, so you weren't comfortable because of religious beliefs or traditional beliefs, cultural…?"
>
> Interviewee: "Religious."

5.2.6.2 Resolution

The dilemma was resolved by asking another intern to do the procedure:

> "So, I asked that maybe we, we speak to another intern who is ready to do it, and we got somebody else what was prepared to do it."

5.2.6.3 Justification

This participant realises that his personal beliefs cannot interfere with a patient's rights and he has a responsibility. He has a plan in place for procedures he is not comfortable with:

> "Okay so as much as I would not want to do a TOP, I also feel that if a patient needs a TOP, then it must be done."
>
> "So, in all my practice, I make sure there is somebody else who is there to …there is somebody else who will do the TOP. There is no way I will turn the patient away. Because I don't want to do it, it's my responsibility to make sure there is somebody else."

He justifies his decisions by his professional duty and 'responsibility' (obligation). He did not mention the law or ethical guidelines, but recognised that patients have a right before his own:

> "Because I don't want to do it, it's my responsibility to make sure there is somebody else [to do it]."

5.2.6.4 Discussion

Dilemmas that arise in gynaecology and obstetrics are often influenced by personal values, culture and tradition conflicting with professional duties and obligations, patient rights and the law. Termination of pregnancy (TOP) is one such example of reproductive health being affected by these factors. It is not an easy decision to make and very often both the women who make the decisions and the healthcare practitioners they seek assistance from, grapple with the decision.

McQuoid-Mason and Dhai (2011(d)) argue the reason for controversy in these decisions revolves around the question of deciding when life begins and the moral status that is assigned to the embryo or foetus.

For some life begins at conception and is assigned full moral status. For others, the embryo and foetus have no moral status. And then there is a group in between who assign moral status according to gestational age (McQuoid-Mason & Dhai, 2011(d)).

The dilemma in this case not only raises the problem of women's right to reproductive choices and ownership of their bodies, but also the issue of conscientious objection in medicine, where conscientious objection refers to the right to refuse to participate in certain activities based on conscience, belief or religion.

The HPCSA guidelines, Booklet 1, section 5, rule 5.1.5 and 5.1.6 advise that healthcare professionals should ensure that their personal beliefs do not prejudice their patients' healthcare and further if they feel that their beliefs may affect the treatment they provide, this should be explained to the patient and the patient should be informed of their right to see another healthcare practitioner.

In South Africa, a medically induced termination of pregnancy (also called an abortion), is provided for by the Choice on Termination of Pregnancy Act, 1996 (Act 92 of 1996). Doctors and registered midwives may carry out a termination of pregnancy during the first 12 weeks of gestation provided that the necessary training to do this procedure has been completed. After 12 weeks of gestation, only medical doctors may perform the procedure (section 2 (2) of the above Act).

Concerning the conscientious objection to the procedure by a doctor, the Constitution of the Republic of South Africa, 1996 (section 15 read with section 27(3)), provides that a doctor may refuse to participate in a termination of pregnancy on the grounds of conscience, religion or belief - except in emergencies. Thus, where a woman's life is in peril or where she may suffer serious bodily harm if the termination is not performed, a doctor may not refuse to participate for reasons of conscience, religion, or belief. Doctors should also not dissuade, hinder, obstruct, or prevent a woman from seeking a legal termination of pregnancy. Preventing a legal termination of pregnancy is a criminal act (section 10(1) (c) of the Choice Act as interpreted by McQuoid-Mason, 2011, p. 7). Doctors who wish to exercise their right to freedom of conscience, do not have to participate in healthcare services that they conscientiously object to, if it is not an emergency; but they are still legally obliged to refer a patient seeking a termination of pregnancy to a doctor (or midwife depending on the gestational age) or agency willing to do the procedure (Choice of Termination of Pregnancy Act, 1996 (Act 92of 1996)s 10(1)(c)).

The HPCSA guidelines, Booklet 8, *General Ethical Guidelines for Reproductive Health,* section 8, advises that respect for autonomy means that healthcare professionals should not be expected to perform abortions against their personal convictions and that their careers should not be prejudiced as a result. Point 8.5 prescribes that such practitioners are, however, obliged to refer the patient to a colleague who is not opposed to the procedure.
While this participant did not actively cite the law or professional guidelines, there was a sense of responsibility and obligation towards the patient. He recognised the patient's right to the procedure and acknowledged that while he was not happy to act, he would ensure that there was someone who would.

5.2.7 Participant 008

Participant 008 graduated in 2010 from the University of the Free State. This doctor worked as a locum general practitioner in Midrand. She is currently specialising in Obstetrics and Gynaecology.

5.2.7.1 Description of the dilemma

The quandary described in this case involved a child in a State hospital, who needed a surgical repair of her vagina and perineum following a rape. The mother of the child was required to stay with the child in the State hospital. The child's surgery kept on being postponed because, in this particular department, Caesarean sections were being given priority. At the same time,

the mother of the child was distressed because she had left other children at home with the potential rapist. The participant explained:

> "Just one of the first ones that come to mind is when I was doing my community service at L. We had a, a child who had been raped and we needed to get her to theatre to do some suturing…like repairing the vagina and the perineum but we could not get her into theatre because there is a lot of emergency theatres that take precedence. But now you have also got a child in a very unfamiliar environment and the mother was staying with her as they insisted that the parents stay with them in the hospital and the mother, one evening when I went to see her, so we kept booking it and then cancelling it because the Caesars would take precedence. And obviously, it's not an emergency procedure so no-one wants to do it at night and the mother asked me when I went to see the little one, obviously, when is it going to be done because she needs to get home. And I told her you have no other issues at the moment, you really just need to be here for this child and she said no because someone at home had perpetrated this act and she had left the rest of the children at home so she needed to get home to look after the children because she didn't trust for them to stay there…So she was now, we keep her there to be with her child but on the other hand there are children at home who are potentially staying with a rapist. And then it becomes very difficult, you know, you try and push for this child to now have her surgery so that she can get home."

5.2.7.2 Resolution

This dilemma was resolved using deception:

> "So, you start thinking of you know, am I going to tell the anaesthetist that this is now going septic so that they push it onto the emergency list, you know. So trying to, because during the day, no one you know, this kid is put to the back every time on the list and eventually we decided we, screw it let's do it…let's take her to theatre…and we will get into trouble with the anaesthetists and we will just say we are not prepared to wait anymore…'

She was aware of the reason for and the consequences of the decision she made:

> "So, you have got to answer for what went wrong …where and [it's those consequences] of those decisions you are making but on the other hand are you keeping the baby in the ward where she doesn't know anyone and the mother away from the house where other children could be potentially hurt."

5.2.7.3 Justification

The doctor justified her decision based on the Golden Rule (discussed in section 5.1.2.4).

> "If I was in this position what would I want somebody to do for me?"

She also cited conscience as a contributing factor:

> "Yes, mostly conscience."

5.2.7.4 Discussion

The above description describes a situation of triage, limited resources, and ignorance of the social circumstances and lived realities of the majority of South African patients. Awareness of the patient's social circumstances only became evident when the mother questioned the doctor and she realised delaying treatment, while not medically urgent, had potentially harmful implications for others.

Further, the doctor in this case was unable to prioritise her patient because of departmental policy on Caesarean sections:

> "…but our head of department was not happy with that because you are making his Caesars wait and it is very important in our setup, the maternal mortality and morbidity meetings."

The dilemma for this doctor was that delaying the treatment was not in the best interests of the patient (and her family) and that limited resources - not enough doctors, not enough theatres, and not enough time -, was delaying the treatment. Further, there was the matter of triaging or allocation of treatment based on need. Because the procedure was not an emergency, no one was willing to treat it as urgent or to do the surgery at night. It was not a priority. The greater concern for the department was the potential for maternal deaths as a result of delayed Caesarean sections. It would seem that very little consideration was given to the vulnerability of the patient; her age, her physical and psychological trauma, and the consequences; or her social circumstances, especially those that led to the assault.

Triage is a French term meaning "sorting", "picking" or "choosing" (Beauchamp & Childress, 2013, p. 291). In healthcare, triage is a process where criteria are developed and used to determine prioritisation for treatment. Triage decisions are usually made by appealing to medical utility; other variables, such as vulnerability, are not considered. In this case, the resources were allocated to the Caesarean sections based on need and to prevent maternal

mortality and morbidity. Equally, however, just consideration should have been given to the vulnerability of the child in this situation, and to what was in the best interests of that child. South Africa has extremely high rates of both physical and sexual abuse of children (Richter & Dawes, 2008), but lacks the resources to treat and manage the consequences of the abuse. Children are among the most vulnerable members of a society and consequently, need special attention. Section 28 of the Bill of Rights (Chapter 2 of the South African Constitution 1996) specifies children's rights. Section 28(1)(d) prescribes that "Every child has the right to be protected from maltreatment, neglect, abuse or degradation". The role of the health professional is to recognise abuse or potential abuse and then act appropriately. Healthcare professionals should also advocate for their paediatric patients where healthcare is not as appropriate as it should be due to a certain circumstance.

Section 28(1)(c) of the Bill of Rights states: "Every child has the right to basic nutrition, shelter, basic health care services and social services". Further, section 28(2) of the Bill of Rights states: "A child's best interests are of paramount importance in every matter concerning the child". The Declaration of Ottawa on the Rights of the Child to Healthcare (1998) prescribes that the healthcare of a child should include the physical, mental, psychological and emotional wellbeing of the child and that doctors should always act in the best interest of the child. The Declaration of Ottawa is not law in South Africa but many of its principles are to be found in the Constitution 1996; the Children's Act (Act 38 of 2005); the Children's Amendment Act, 2007(Act 41 of 2007); the common law; and the ethical rules of the HPCSA. Failure by a doctor to comply with the ethical principles on the Declaration of Ottawa may result in legal action for breaching a provision of the aforesaid laws, and a breach of the ethical rules of the HPCSA (McQuoid-Mason & Dada, 2011).

Thus, the best interests of the child should be the principal factor in the healthcare rights and actual healthcare of the child. However, as Kling and Kruger (2017) argue, there are problems with the concepts of "basic healthcare services" and "best interests". Does basic healthcare mean primary healthcare or essential healthcare? Without clarification, this concept is difficult to apply. Regarding the "best interests" principle, in healthcare "best interests" does not refer to the best treatment, especially where there are limited resources. Instead, it is taken to mean "the best treatment available in a given healthcare context" (Kling & Kruger, 2017, p. 217). The "best interests" decision affects individual children where treatment decisions, that is, determining, if, what, how and when to treat. Low-risk treatment with substantial benefit is generally held to be in a person's best interest and is a quality-of-life criterion (Kling &

Kruger, 2017). Importantly, for this case, drawing on Kling and Kruger (2017), factors that had to be considered when deliberating the best interest of the child were, among others, the implications of treating or not treating, and the risks from delayed treatment or denying treatment. Further, the physical, emotional, social, cultural and psychological needs of the child also needed to be assessed.

As described in this case, there were social implications and consequences of the delayed treatment. The conflict in this dilemma here was between the principles of beneficence (best interests of the patient) and social justice (limited resources).

Finally, on the point of 'conscience". The Random House Dictionary of the English Language defines conscience as: "the inner sense of what is right or wrong in one's conduct or motives, impelling one towards the right action". Sidney Callahan (1991, p.17) defines conscience as an 'integrated, self-committed, conscious activity oriented to moral values and moral standards of the right and good'. From this doctor's actions, we get a sense that she realised that she should be doing "right" in the best interests of her patient.

The Declaration of the Rights of the Patient (1995) prescribes that "the physician should always act according to his/her conscience and always in the best interest of the patient". Thus, if one reasons that an action or decision is not good or will not have a favourable outcome, and is not in the best interests of the patient, it would seem that a reasonable or rational person would act or intervene appropriately.

5.2.8 Participant 010

Participant 10 is a psychiatrist in private practice. This psychiatrist is a graduate of the University of the Witwatersrand. Her specialist training was split between MEDUNSA and the Wits College of Psychiatry, where she completed her national examination.
This participant described different types of dilemmas common to psychiatry, for example, malingering, confidentiality, and litigation. She is not influenced or "dictated to" by her religion or the patient's race, although there are legal prescriptions that she has to respect.

> "I'm not dictated by religion, neither am I dictated by the person's race, but I'm very respectful of what the patient would want of me, and I would try to accommodate the patient. There are certain rules in terms of how we are dictated by the medical law society, and that has to be respected."

5.2.8.1 Description of the dilemma

> "Well, one would be malingering. Ethical dilemma would be in terms of a patient wanting longer leave more often than not. A lot of patients, you know they are unhappy in their work environment and constantly ask me for longer leave."

The ethical dilemma would be giving the longer leave when it is not deserved and compromising professional integrity:

> "And, I mean, I feel it would be detrimental to my degree, my qualifications, to give the patient longer leave."

5.2.8.2 Resolution

The psychiatrist explains that with malingerers she is transparent and honest:

> "With malingering, I am fairly direct."

She explains that she establishes a relationship with her patients at the very first consultation so that there is an understanding of expectations:

> "I am very straightforward. I tell them this is what I think and this is how I'm unable to help because when I do sit with patients, I always ask them what is their expectations of me. I start off like that, and if they list things that's not in keeping with what I believe is correct, I would verbalise it to them."

To help the malingerers in their situation, she explains how she intends to resolve it:

> "So, I would tell them how many weeks I would give them, and thereafter, write a letter to HR informing them of the dilemma the patient is experiencing and recommend what can be done to assist the patient. And that sense, you know, I would assist."

5.2.8.3 Justification

Justification for the psychiatrist's decisions and actions is multi-factorial. She uses psychiatric professional guidelines, the law, and the principle of non-maleficence:

> "There are certain rules in terms of how we are dictated by the medical law society, and that has to be respected."

She is conscious of litigation:

> "Otherwise, you get sued."
>
> "…and we update our knowledge on litigations on a regular basis."

She does not use social media to communicate because:

"…you just open yourself to litigation."

However, when asked which came first, the best interest of the patient or the law, she responded that more often it was the best interest of the patient.

On the specific dilemma of malingering and extra leave, she also thinks that the extra leave may be detrimental to the patient, implying that she is doing what is best for the patient.

5.2.8.4 Discussion

Malingering presents special challenges to the practising clinician (Malone & Lange, 2007). This is because the traditional doctor-patient encounter assumes the patient is seeking therapeutic assistance rather than intentionally deceiving a doctor for a personal gain, for example, drug-seeking, extended sick leave or for insurance purposes.
Malingering, while not a disease, is defined in the DSM-V (American Psychiatric Association, 2013) as "the intentional production of false symptoms or the gross exaggeration of symptoms that truly exist". The symptoms may be physical or psychological, but have in common the conscious intention to deceive to obtain a known gain or to achieve a certain goal. Key to malingering is the conscious intention to deceive. The deception of doctors by patients was discussed in section 5.2.4.5.

The initial clinical suspicion of malingering is often intuitive, and yet doctors are often reluctant to 'diagnose' a patient as a malingerer for two reasons: there is an apparent lack of objective data to definitively document the clinical impression of the syndrome; and it would be equivalent to accusing the patient of fraud and deceit (Malone & Lange, 2007).

Taking the path of least resistance and giving in to the patient's deception may most likely violate the maxim of "first do no harm" as it could promote or perpetuate a dysfunctional, psycho-social developmental process and long-term negative effects (Malone & Lange, 2007). This sentiment was corroborated by the participant:

"…because a lot of the patients feel they'd like to stay for two months or three months at a time, and I'd flatly refuse. There are some of my colleagues that would continuously give them leave and I just think that would be detrimental to the patient's well-being."

Rather than act negatively in response to the betrayal of trust, Malone and Lange (2007) recommend that the reason for the deception should rather be determined. Again, this is the approach this participant uses in treating her patients:

> "Well, if it's an external factor, it has to be addressed. You can't run away from an external factor… but it's learning to become assertive and asserting yourself and saying, okay I need to improve on this, or we need to communicate."

She does mention that her colleagues do not act in the same way:

> "It's all about communication, and somehow, that isn't being done in this day and age, or maybe this is just what I am experiencing lately in my profession."

This interview raised the issue of a breach of confidentiality, where she described that where a patient had been hospitalised, she would tell the patient that she would write a letter to the Human Resources department, informing them of the patient's dilemma and her recommendations. Under "normal" conditions, a patient's diagnosis can only be revealed with the express consent of the patient. This is discussed in section 5.1.4.

Where that patient is a danger to others or putting others at risk, especially in psychiatry, confidentiality may be breached. Unless the malingerer is a threat to others, in which case they would probably still need to be in care, the patient's diagnosis cannot be disclosed to anyone (McQuoid-Mason & Dhai, 2011, p.88).

5.2.9 Participant 011

Participant 011 graduated from the University of Witwatersrand in 2008. She entered private general practice soon after completing her community service. She has been in private practice for eight years and has a special interest in HIV and AIDS management.

5.2.9.1 Description of the dilemma

The participant did not describe a particular dilemma but spoke more generally of a problem she experiences in private practice but is unsure how to deal with.

> "Kids are very close to my heart, and child abuse for one or that suspicion of child abuse. For us, I mean, sometimes getting concrete evidence takes so long, and you really have to dig some information. And my problem sometimes is that these patients don't get followed up. Say for instance, you've got a situation where this child is being abused, what you'll find is that the parents will go from pillar to post."

So, she describes suspecting child abuse in private practice, but being constrained from acting on her suspicions, either because she does not have definitive proof to make the claim, because there are incomplete medical records or because the parents visit several doctors so there is no continuity of care.

> "They won't just come to this medical centre for treatment. They might come if there is an acute trauma happening now, and then tomorrow, they'll go to the next doctor, and the next doctor."
>
> "And remember we don't have a database where you can go and see, okay, this patient was followed up on this day, and then two months later, you know, there's a cracked humerus or whatever. So, a lot of that we miss in society, I think, because patients tend to doctor-shop, and you miss out on an opportunity to actually pick up what is going on.
>
> "Because remember, they come in, they'll tell you this story, and then, you know, if you ask them questions that they're not too comfortable with, they're not going to come back to see you again. They'll go to the next doctor, you see."

What makes this an ethical and moral quagmire, is the uncertainty around the correct action in confronting the real issue, that is, is the child being abused? Is the parent guilty?

> "Because you can't just assume, you see, you can't just point a finger, but remember, that child is the victim in those instances. But unfortunately, sometimes what happens is like you get to a point where it's like when do you get the social workers involved because once you go down that route, it's almost like that parent, you know, is already guilty."

She speaks about the problem being a difficult one to interrogate. When asked if she saw child abuse often, she responded that she is aware of a few cases in the centre that she works in, but it is not something people talk about. She revealed that in cases where older girls have been abused, they will admit the abuse, but it is not information that is volunteered. When asked how she responds to the abuse of the older girls:

> "It's so difficult. What can you do? You try psychotherapy, you try this and this, because remember, most of, for instance, you see a young girl in this…we see a lot here where they come in and, you know, it's like, you know, they have a bit of an infection, like a urinary tract infection. So, it can just be a urinary tract infection, but you never know, but once you have to dig deeper and ask those uncomfortable questions, you see, sometimes the parents don't want that."

A parent is usually present in the consultation which also makes communication difficult. Sometimes the child lives in a rural area with a grandparent and then on a visit to the parents, the issues are exposed. She cites time constraints as a factor that exacerbates the quandary:

> "I think a lot gets missed through the fact that there's not really full continuity, you see. If they come and follow up and you can dig deeper, because remember, when we see them, it's 15 minutes. It's not enough, ja."

5.2.9.2 Resolution

She resolves her dilemmas by dealing with what is in front of her. She transfers responsibility by referring the patients to social workers or psychologists. That's not to say that they shouldn't be referred to these specialists, but it is almost as though this participant feels helpless or powerless and hopes someone else can sort it out.

5.2.9.3 Justification

This participant was unable to justify her decision-making normatively. She feels that emotion influences her ability to make decisions and that she does not always act ethically. In response to the question of whether she felt she acted ethically she responded that, to be honest, she did not. She went on to explain:

> "Because I feel like sometimes, I get too emotionally drawn into the situation"
> "So, you know, I don't know if it's being a woman, but ja, it's sometimes difficult being unbiased" (talking about judgements she makes).

Later on, in the interview, she cited experience as the basis for her decision-making.
Her personal morality, she elaborates, originates in personal experiences and her religion. Although she is religious, she cites the virtues of tolerance, humility and compassion as being more important than religion.

> "So, for me, I think, you know, being tolerant and having humility and that, compassion. That, for me, is more important than this whole hyper-religious act sometimes people put up."

She appears to be suffering from some burnout or moral distress as she seems very despondent:

> "You know, sometimes in medicine, it's not like you can always get things right the first time. And remember, [sighs] I don't know. I think it's all of it (referring to conscience).

You worry if you've made the right decision, but you also worry about the consequences…"

She does not refer to HPCSA guidelines or the law. In response to a question about this, she answered in the negative:

"Mm-hmm. To be honest with you, I mean, I have an idea of what's happening, but I must say I haven't looked at it in a long time, ja, mm-hmm."

5.2.9.4 Discussion

Child abuse and the mandatory reporting of child abuse is discussed in Section 5.2.23.4. The phenomenon of "doctor-shopping" is discussed here to shed some light on why this happens. Doctor-shopping is a pattern of behaviour that entails patients visiting multiple clinicians. Typically, this behaviour is associated with negative connotations, that is, either to procure prescription drugs illicitly or for a continuing illness (Sansone & Sansone, 2012). In this context, I propose a different indication where "doctor-shopping" is taken to mean parents consulting different doctors for various injuries to their child, to avoid child abuse detection. If a different doctor, hospital, or practice is visited each time the child is physically injured, a trend cannot be detected because the case histories are not continuous. The inability to act on the suspicion of child abuse was the cause of this participant's distress.

The inability to act on her suspicion of child abuse raises the question of why this doctor did not consult the law, guidelines, or colleagues to determine the correct way to deal with these suspicions. By dealing with what is in front of her, or by referring the patient on to psychologists and colleagues, she is not confronting what is causing her distress. She expresses this as:

"I try most days to act appropriately but I get stressed and overwhelmed, and it leads me to getting anxious and that reflects on how I manage stressful situations- I can get agitated."

"Because I feel like sometimes, I get too emotionally drawn into the situation."

It is my perception that this participant does not know how to address dilemmas normatively. This may be the result of either lack of training or lack of awareness. She admitted that she had an idea of the guidelines and the law. However, knowledge of the application of normative guidelines is more appropriate in real-life clinical situations than mere theory.

This participant expressed a moral fatigue as a result of moral distress. Corley (1995) describes moral distress as "the painful psychological disequilibrium that results from recognizing the ethically appropriate action, yet not taking it, because of such obstacles as lack of time, supervisory reluctance, an inhibiting medical power structure, institutional policy, or legal considerations". I argue that moral distress in clinical practice is also the result of normative uncertainty.

For this research, I define normative uncertainty as 'occurring when one knows, intuits or feels something is wrong in interaction with a patient, but one is unable to act appropriately because one does not know how to apply normative rules, principles, guidelines or law in response'. I argue that medical doctors as decision-makers can suffer moral distress when they are unsure what moral, ethical or legal action to take. The consequence of not dealing with or confronting the cause of the moral distress is moral fatigue or moral injury. The literature does not offer much on moral fatigue, but there is some literature on moral injury (typically called burnout) (Talbot & Dean, 2018).

The term "moral injury" was initially used to describe soldiers' responses to their actions in battle (Litz, et al., 2009). Talbot and Dean (2018) describe it occurring in medical doctors in response to the third-party payer constraints and limited resources. I use it in the context of moral frustration, where doctors are "injured" by their frustration at the constraints imposed on them.

What is important about the term "moral injury" is what it describes. It is the equivalent of post-traumatic stress disorder in combatants and when experienced by medical doctors, is sometimes called 'burnout' (Talbot & Dean, 2018). It has been described as "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations" or "as a deep soul wound that pierces a person's identity, sense of morality, and relationship to society" (Silver, 2015). This participant was perceived as suffering from moral distress and moral injury, both of which have implications for professional attrition; the ability to function adequately and general apathy towards the work of medicine. Her distress was her perceived helplessness and inability to act for children she suspected were being abused. It also leads to her second-guessing herself and apathy toward "arming" herself with the necessary knowledge. This might be one solution to problem; another tone might be to give this particular participant training in dealing with these types of quandaries.

Another aspect introduced in the interview was the role of emotion in decision-making. Medical ethical decision-making in context, as discussed under section 5.1.3, can arouse emotional responses. Emotions are broadly defined as "distinctly patterned human experiences, that, when consciously felt, produce qualitatively".

Some writers advise that one should reason rationally and impartially, setting irrational thoughts and feelings aside and that reason should always trump emotion (Engelhardt Jr, 1996, p.10; Feinburg in Callahan,1991, p.9). Feinburg also advises that emotion should never be considered as an "ethical criterion".
Callahan (1988), on the other hand, argues that emotion can inform ethical decision-making, provided there is a balance between emotion and reason. She argues further that emotion can alert one to a moral or ethical dilemma and thus provoke the appropriate reaction.

5.2.10 Participant 012

Participant 012 is a graduate of the University of the Witwatersrand. He works in his own practice and has been in general and family practice for 30 years in Midrand. He graduated in 1984.

5.2.10.1 Description of the dilemma

In this dilemma, the family practitioner had been consulted by a diabetic patient with co-morbidities. The patient complained of an infected hallux, which also showed signs of necrosis. The patient was also compromised vascularly. The doctor felt that the treatment for this condition was beyond his scope of practice and that in the patient's best medical interests the patient needed a referral to a specialist vascular surgeon.

> "The problem is his toe got infected and he came to see me because he wasn't happy and he couldn't get an appointment to see a specialist. The toe didn't look very good, and I felt it was beyond my scope to treat this toe. It was septic and needed debridement."

The patient had had a previous digital amputation by a vascular surgeon and the family practitioner wanted to refer the patient back to his care.

> "So, the dilemma here, well, like the issue I had was that I felt this was beyond my scope and I felt that he needed to be referred back to his vascular surgeon who actually knows him and has previously operated on him. But there was a huge disinterest in this patient from the specialist."

The dilemma arose because the surgeon could not see the patient for two weeks because of his workload and the patient did not wish to see another surgeon:

> "Trying to get a second opinion was difficult. The patient felt he would rather see his own doctor because he knows him well, wasn't in the mood to start his story all over again."

The referring doctor felt the toe could still be saved and so he felt the case was urgent, but the referral was hindered by the specialist's disinterest:

> "I felt that somebody with a threatened limb or digit should be seen immediately by the relevant specialist, let alone someone who's known to have a proven problem whose doctor doesn't see him."

The outcome caused some distress:

> "…It put me in a position that I had to treat the patient myself…but there were bones sticking out and I was very uncomfortable with the situation"
>
> "So, the bottom line is he went home with the treatment that I gave him, and it caused me some distress because I was not comfortable with the situation."

The participant tried to explain why this was a dilemma:

> "Well, I think the dilemma is that it is was beyond my scope of work, and in fact, it wasn't my problem. He belonged to another doctor for this particular problem, but it became my problem, and I took on the case where I felt it wasn't within the scope of my ability."

When asked why he took on the "problem", the doctor responded:

> "I think the patient made it my problem. The patient put his trust in me that I would be able to do something for him, which we probably did, but I don't think it's the correct…It could have been better. His outcome certainly would have been better."
>
> "I just think it does constitute a medical emergency, and I don't think the specialist saw it as a medical emergency. Well, he does, but maybe he's overworked and triaging on his side."

It seems that part of the frustration and distress was the inability to communicate with the specialist directly and consequently not being able to impart the gravity of the situation:

> "The problem here is we're dealing with secretaries and receptionists and we can't speak to doctors directly because they're too busy or they have a fobbing off kind of attitude."

This added to the distress and it also raised the subject of managed care, where general practitioners cannot authorise certain procedures or investigation without a specialist motivation:

> "I felt helpless in the situation. I felt I had made a decision, and my decision was that he needed to get specialist care because he would need investigations which could only have been done by the specialists…without those tests being conducted, we still weren't absolutely sure what was wrong with this person, and it was an emergency in the sense that if it was a vascular compromise, any delay would have worsened the situation."

5.2.10.2 Resolution

The dilemma was resolved at the follow-up visit, where the doctor took photographs of the toe for the patient to send to the specialist. The patient had obtained the specialist's cell-phone number because the specialist was going to phone him if he had any cancellations:

> "He called me on Monday and was told no, definitely no cancellations, can't be seen, he wants to come back and see me which creates further distress because I know the situation, I know his toe's going to be no better than it was and I'm going to be back in the same situation…his necrosis had worsened marginally, and the infection was, although a bit better, but the wound, the whole of the ulcer was wider and the bone was sticking out even further. So, this is a problem. It's a problem with these specialists. So, I took pictures of his toe because the patient had the specialist's cell-phone number. He managed to forward the pictures to the surgeon who then realised the severity of the situation and called the patient in the day after that…he was told it had reached a point where it [the toe] couldn't be treated conservatively and he actually, in fact, needed an amputation."

The doctor was not happy with the resolution because he felt without the delay there could have been a better outcome for the patient:

> "So, I feel that had I been seen sooner, earlier, and the problem is, he's already got a missing toe…his ability to walk will be very difficult."

5.2.10.3 Justification

Justification for the resolution of this dilemma was in the interests of the best outcome for the patient:

> "The basis of my decision-making is you want the best outcome for the patient. We, you want the best outcome that we are medically capable of doing. So, if we don't act efficiently for that outcome, we are causing harm purely because of our negligence. In my opinion, it constitutes negligence."

In response to the question of whether he thought there may have been negligence:

> "I don't think I was negligent. I think I acted, I believe, correctly, ethically, which was not necessarily the best interest of the patient, for the best treatment possible for the patient because there was more treatment than I could offer that could be done. But I couldn't go beyond what I was capable of doing. He needed more than what I was capable of doing on a more urgent basis."

This participant seemed very aware of acting for the patient and the condition, rather than making decisions for the patient. The basis for this was his medical experience, medical reasoning and awareness of implications and consequences of acting or not acting for a patient:

> "By referring the patient, I was acting in the best interest of the condition…Well it's not better for, it's what the condition requires. It's like saying I'm only half treating something he could get more treatment for."
>
> "I'm saying I'm making the best decision for the patient for the condition he has. I know that he can get more than what I can offer him."

5.2.10.4 Discussion

This interview raised two issues; the first is of medical doctors practising within their scope of practice, and the second is that of limited resources, which in this case was the availability of specialists for referrals. The second issue, a consequence of the first problem, acts as a constraint to one doing one's best for one's patient and as a result, leads to moral distress and even a crisis of conscience.

This participant was particularly aware of the relationship of trust that the patient had with his specialist. He also knew that because the patient could not get an appointment with the specialist, the patient had come to him in the hope that he, as the family practitioner, might be

able to do something more for him, whether it was influencing the surgeon to give him an earlier appointment or at the very least, providing suitable treatment.

i) Acting within the scope of practice

The HPCSA guidelines Booklet 2, (2016), Ethical and Professional Rules of the Health Professions Council of South Africa, Rule 21 prescribes that a practitioner shall perform, except in an emergency, only a professional act-

a) for which he or she is adequately educated, trained and sufficiently experienced; and

b) under proper conditions and in appropriate surroundings.

Thus, a medical practitioner is expected to exercise the degree of care and skill of a reasonable practitioner in their field. Here, the medical doctor was a general practitioner, who is not expected to have the same degree of skill in a particular field as a specialist. Greater care and skill are required where more complicated procedures are involved. In this dilemma, the patient required surgical debridement under anaesthetic- an intervention that a general practitioner could not perform, not only because he does not have the required skill set, but also because he does not have the appropriate environment to conduct the intervention. As a result, the doctor might have been guilty of professional negligence if he undertook to perform the procedure.

Professional negligence is defined by McQuoid-Mason and Dada (2011) as occurring where ‘a patient is harmed because a doctor has failed to exercise the degree of skill and care of a reasonably competent doctor in his branch of the profession’. Except in emergencies, or where ‘no specialist is available’ (McQuoid-Mason, 2011, p. 93), doctors should not attempt procedures outside their scope of practice. The problem here is what constitutes an emergency? Emergency medical treatment refers to situations where medical treatment is required because a person’s life or health is in danger as a result of disease, injury or ill health (McQuoid-Mason & Dada, 2011, p. 178). Even if the threatened toe was considered an emergency or needed urgent attention, it was not an immediate risk to the patient’s life. Also, there was a specialist available- he just was not accessible. Further, this doctor provided the best care he could, performing a debridement, although not aggressive, and prescribing antibiotics for the infection.

This dilemma also raises issues of professionalism as well as the potential for litigation for malpractice. The Health Professions Act,1974 (Act 56 of 1974) provides for the imposition of penalties where doctors may be found guilty of professional negligence.
Further, as the doctor disclosed, the patient also needed further investigations which he could not motivate for because of medical aid constraints, which only allow for specialist motivations.

ii) Limited resources and managed care

The second part of this dilemma involved the experiences of difficulty in referring patients to specialists, the limited number of specialists available and also, the reduced autonomy of the doctor working in primary healthcare.
There is not much literature available on medical specialists in South Africa being a scarce resource. I think this "scarce resource" may be a misperception. I argue the real problem lies in the availability of the specialists. This is most likely the result of the hours that they choose to work and/or poor time planning, or that the wrong patients are being referred, thereby taking up the time that could be dedicated to more "deserving" cases. When I say the wrong patients are referred, they are often "self-referring" patients or patients who could be managed by a primary healthcare physician, but that physician is either not confident in his ability or would rather pass the responsibility of the patient's management to a specialist. Some patients also expect to be referred either because they are not confident that their primary healthcare physician can manage their condition or because the patients want the "more authoritative" opinion of a specialist.

I propose that as a solution to the shortage, the diagnosis and management plan can be formulated by the specialist, and the general practitioner can monitor the patient and refer back to the specialist when there is a complication or deterioration.
This participant also brought up the poor communication that frequently occurs between general practitioners and specialists. O'Malley and Reschovsky (2011) argue that to co-ordinate healthcare and to improve patient outcomes and physician satisfaction, effective communication between primary care physicians and specialists regarding patient referrals and consultations is essential. In the situation described in this dilemma, the participant describes the difficulty in being able to speak to a specialist personally because access is only through a receptionist or secretary. Very often the front staff do not understand the diagnosis, urgency or importance of the need to speak to the specialist:

"The problem here is we're dealing with secretaries and receptionists and we can't talk to doctors directly because they're too busy and they have a fobbing of kind of attitude."

5.2.11 Participant 014

Participant 014, a graduate of the University of the Witwatersrand in 2011, worked as a general practitioner for five years in family practice in central Halfway House before starting her own practice in a nearby suburb of Midrand.

5.2.11.1 Description of the dilemma

The primary dilemma for this participant was that of patient-centred economic constraint, where patients who cannot afford private medical care ask to be treated under the name of a relative who is on a medical aid:

"Ja, no, we face it every day, as I say, especially with the medical aids. People who aren't on medical aids, who cannot afford private treatment. And so, they will come to you and ask you to claim under their, maybe sister's or cousin's name. But personally, what I do, I refuse, I don't do it. I send them to the public hospital".

"It makes me feel bad because you know how they're going to be treated at the public hospital, but on the other hand, it's not an ethical thing to do. You cannot claim, you know, under someone else's name."

5.2.11.2 Resolution

Generally, this participant refuses to accede to the patient's expectations. There are times, though, when she breaks this principle when she is influenced by a patient's need:

"There are, however, times when I did do it when you see that the patient is really really, really desperate and you really feel sorry."

She feels "bad" on one hand, but then on the other, feels that she has done the right thing:

"Ja, you really do feel bad…But then, on the other hand, you have that feeling that I've helped someone."

When asked why she has acted in this way, her answer reflected not only a personal morality but also resentment for the control third-party payers have:

"It's the conscience, more empathy, and I think another thing that also drives us like us doctors to do such things is the way medical aids treat healthcare professionals. So, they dictate to us what to do. They're giving us a really hard time. So, you get to the point

where you don't feel for them anymore, you know. You say, argh, let me just do it anyway, ja."

The doctor justifies her actions and explains her problems with medical aids, namely the constraints on her professional autonomy and medical judgement:

"Number one, it's a refusal of medication. You'd believe that this medication is suitable for this patient, and then the medical aid will say to you, no, don't give this, give that. But you say to them, but I want to give this patient this, and they will not pay for it, and this poor patient has to either pay the co-payment or pay for the medication themselves."

"So, in that regard, you end up doing things like this just to… not really get back at the medical aids, but you are really cross with the medical aids because of the way they're treating us. So sometimes, we break ethics when it comes to medical aid because of that."

"…because you feel targeted as a medical doctor. You don't even think about the patient, like they're targeting the patient, no. You feel like they are targeting the doctors, they are undermining our profession."

This "getting back" at the medical aids is limited, though, because when it comes to patients on lower-tier medical aids, she complies with the rules, even performing procedures that are not covered, at no cost to the patient:

"To be honest, I do it for free."

5.2.11.3 Justification

Even though she is "anti" economic constraints, especially on the part of the third-party payers, she cites ethics and early socialisation as justification for her actions:

"Because of the ethics, because of what I was told in medical school, because of the oath I took in medical school…I put the patient first, ja, ja."

So, it would seem her target is to do her best for the patient at corporate third-party payer cost, but where the patient has to contribute, she acts at her own expense:

When asked about the source of her morality she agreed some of it was learned at medical school, but also:

"…the way you were brought up as well, your personality as well plays a role, ja. The way I was brought up."

5.2.11.4 Discussion

Participant 014's dilemma again raises the issue of patient-centred economic constraints in everyday medical practice. Again, as in interview 004, it is difficult to address the expectations that some patients may have, in wanting the doctor to collaborate with them dishonestly.

In this discussion, the patient expects the treating doctor to collude in third-party payer deception to obtain treatment. Again, there are several implications for this type of action. As discussed under participant 003, third-party payer deception has consequences; for the doctor, for the patient; for the third-party and for society as a whole.

First, it is fraudulent behaviour on the part of the doctor. It also has two implications: for the patient who is not a member of the medical aid and for the member of the medical aid that the non-member is using for the claim. Not only are the actions fraudulent, but the medical history of the member may be corrupted by the medical history of the non-member, which may lead to medical management problems and confusion in the future.

Again, this dilemma also raises concern regarding access to healthcare. The patient deception in this case may be the result of either economic constraint, where the patient cannot afford private care, or the result of delayed or perceived poor-quality care in State institutions. There may be the perception that private healthcare is "better". In private, there are no delays or queues to see a doctor nor is there a possibility that treatment will not be provided. If one is claiming from a third-party payer, prescriptions will also be paid for and there is an assurance that there will not be a shortage of medicines.

In the interview, the doctor also raised the controversy that medical aids dictate to doctors how to treat patients. There was a perception and underlying resentment that physician autonomy was being denied by the medical aids:

> "and I think another thing that also drives us like us doctors to do such things is the way medical aids treat healthcare professionals. So, they dictate to us what to do. They're giving us a really hard time. So, you get to the point where you don't even feel for them anymore, you know."

5.2.12 Participant 016

Participant 016 is a graduate of the University of the Witwatersrand. She graduated in 2015. She worked in Stellenbosch for two years and has been practising as a locum in Midrand for the last two years.

5.2.12.1 Description of the dilemma

At the time of this dilemma, this participant was working in a neonatal/ paediatric ward in a state hospital. The interviewee described the conflict between patient confidentiality, limited resources and her duty as a doctor as the source for her dilemma:

> "Let's say patient confidentiality, so that's a very big dilemma, where, in State, it's always [a problem]. I mean divulging a person's results when the person next door is listening and there is nothing you can do because the beds are so close together. Or, in my context having to counsel moms in paeds and their babies are in the same sort of bassinet area. So for me, it's, you sort of had to grow a thick skin because this is personal information. This is a child. This is a patient but if I have to move through every single mom to try to explain everything in a private space then it takes too much time and we don't have that time. So often you scream across mothers to give diagnoses and results. And you have to sit back and question whether do you even want to speak to them because you don't want to put them in that situation but they have to know. So you are stuck in-between having you know, these ethical dilemmas of do you now evade the patient's confidentiality and privacy, or do you leave them in the dark and not let them know what's going on. So often there were times where I would try to get the mom to come and sit as close as possible or go up to them, but the mom's sitting next door, you can't tell them all to stand up and leave. So, that for me was one of the big ones."

The dilemma for this patient was breaching confidentiality while simultaneously trying to inform the mother of her baby's condition. She was unable to give the privacy and respect that the mother deserved because of overcrowded conditions, lack of space, time constraints and insufficient doctors to deal with the patient load.

> "I think every circumstance was different. I mean in very serious situations, for example, an HIV positive mom who, by some [means], despite taking ARV's, managed to still pass on the HIV to the little, I mean in those circumstances you have to tell the mom and that for me, was one of the worst, because, yes you need to then further counsel but if I then take the mom out of that situation, there is no room for me to try and counsel her.

But do I let her sit in the dark, now I want her to try to breastfeed her child, or not understand why the child still continuously getting sick…"

5.2.12.2 Resolution

The dilemma was resolved by choosing the value of informing the patient over the value of patient confidentiality. The workload and limited resources were a big constraint to acting ethically. The issue of not informing the patients was a big problem.

"I tried for the first two weeks to try to counsel moms as privately as possible so that they have, you know some form of confidentiality but then it just became, it became not feasible. I was seeing five patients and my colleagues were seeing twenty patients. So, in the end, you couldn't."

She expressed frustration at having to compromise her values:

"And the worst part is you start to get frustrated because of the system because then you are battling your own ethics, but you have to keep the patient informed but you have so much work to do that in the end ethics is literally thrown out of the window."

She elaborates on how she adjusted her values:

"I mean most of the times I would just keep it to the as bare minimum as possible in terms of giving a broad aspect of what was going on, which is impossible in the medical aspect. So, I mean, all the moms, all the babies were sick. So you sort of think to yourself, okay fine, I just, I need to let the mom know how serious this is. So I mean, they also then became, had this camaraderie amongst them because they're all moms with the sick babies and they would all want to know something because many of my colleagues would then revert to not telling them but then after day three of having a doctor come in, see your baby and not say anything to you, you start to then collect your own sort of information around you and that for me is a lot more dangerous than sort of understanding what is going on. So, I keep it to the basic principles and trying not to divulge too much. And if the mom had questions, then I'd try and say, okay, try to find me afterwards when the moms leave because during feeding time is the ideal time to try and counsel, or try to tell them what's going on. I mean you are trying to see sixty babies and there's two of you. And that's sixty moms, that's 120 people you have to interact within a small space of time excluding bloods, excluding procedures. So, in the end, you don't have time. You just don't have time."

Her explanation highlights several unaddressed issues that either contribute to dilemmas or that are the result of social injustice. For example, the question of patient's rights. Patients have a right to information and mothers have the right to information regarding their babies' condition. For a patient or parent to have to glean information from other patients or from what one overhears, is not the ethically or morally correct manner to keep a patient appropriately informed and not confused or misinformed. Further, do patients know they have rights, including the right to information? Also, how does a patient exercise autonomy without being informed? There still seems to be a paternalistic way of handling problems. Admittedly, overcrowding, time constraints and limited staff do contribute to the brusque handling of transferral of necessary information to patients. However, this raises the question of what is the point of ethics or teaching ethics if it is disregarded and we continue to treat patients unethically?

The participant in this situation resolved the dilemma by "growing a thick skin" and "remove[ing] yourself from the situation".

> "In the state context, you sort of have to remove yourself from that and just sort of doing what has to be done."

She explains that as a student, one already becomes morally disengaged:

> "You grow a thick skin. I mean as a student you sort of, already as a student, you're shown that patients are not really seen as patients. They're more of illnesses. You know. The lymphoma in bed 2. The pulmonary, the MDR in bed 6. Or in ward…You never get to grasp the patient as a whole. The patient as a patient. Already as a student, I mean that's how you are taught."

5.2.12.3 Justification

She justified her approach to the dilemma based on her duty as a doctor:

> "It was based on my duty as a doctor to keep the patient informed. Yes, it was to the patient's benefit, but I mean privacy you can argue is confidentiality, is the patient autonomy" and defends the breach of confidentiality, continuing "…it's a very blurred line in that respect because then on the complete polar opposite then, not saying anything to them, what does that then violate of their ethical rights?"

The Golden Rule is subtly referred to:

"There was the, for me, privacy is a very big thing. Confidentiality for me personally, as a human, I mean, you wouldn't want somebody divulging your information in front of all these mothers."

5.2.12.4 Discussion

Confidentiality is described by McQuoid-Mason and Dada (2011, p.88) as 'the duty imposed on healthcare professionals to ensure that all information concerning a patient is not disclosed without the consent of the patient or under the conditions prescribed by law'. It is a core ethical value and should be incorporated into the practice of responsible medical practitioners. McQuoid-Mason and Dhai (2011(a), p. 86) propose that value of confidentiality should be seen as the need to keep sensitive personal patient information within proper bounds and that patients have the right to expect that this information will not be disclosed to others.

In the medical spaces, the principles of autonomy, respect for persons and trust provide the sources for confidentiality (McQuoid-Mason & Dhai, 2011(a)). According to the principle of autonomy, personal information is the property of the individual and should not be made known to anyone without that individual's consent. Respect for persons requires that information disclosed in confidence should be respected and upheld. Finally, because the doctor-patient relationship is a relationship of trust, it would be a breach of this trust to not uphold confidentiality. Without trust in this relationship, patients would not disclose information that would be beneficial in the healing process. Thus, without the individual's consent, confidentiality must not be breached either verbally or in writing.

The principle of confidentiality is not only a professional requirement but also a legal requirement. The Constitution of the Republic of South Africa, 1996 states that everyone has the right to privacy, which includes the right not to have the privacy of their communications infringed (s14). McQuoid-Mason and Dhai (2011(a), p.86) argue, however, that although privacy and confidentiality are closely linked, there are differences. For them, privacy relates to aspects of a person's being into which no one else should intrude. So, while patients may share information with their doctors there are some aspects of their privacy that they may have to forgo, for example, where there is a chaperone or a student present in a physical examination.

Confidentiality involves a relationship and confidential information should be treated with utmost care to prevent unauthorised people from obtaining the information and also to

facilitate the sharing of sensitive information necessary to help the patient (McQuoid-Mason & Dhai, 2011(a)). Breaching confidentiality always involves harm, either breaking trust in the doctor-patient relationship or hurting the individual whose confidentiality was breached in other ways, for example, social stigmatisation.

In participant 016's case, for whatever reason, whether lack of space or privacy, time constraints or a limited number of doctors, this practitioner felt that breaching her patients' confidentiality was the lesser of two harms. She felt that her patients had the right to information about their babies, condition, treatment, and prognosis. Arguably, there was a duty to maintain confidentiality but without privacy - already relinquished in overcrowded conditions in the hospital- she had to breach this to keep the patient informed. While confidentiality has its source in autonomy, so too does the right to information and self-determination. In this case, one duty had to be sacrificed for the other.

McQuoid-Mason and Dhai (2011(a), p. 88) argue that where a breach of confidentiality is necessary and justifiable, the harm to the patient should be kept to a minimum. Thus, one should ask oneself whether the benefits of breaching the confidentiality outweigh the harms and whether it is ethically appropriate.

In South Africa, the National Health Act, 2003(Act 61 of 2003) provides that all information concerning a patient, that is, health status, treatment and hospitalisation should be kept confidential. However, what does one do in a situation that does not provide the conditions necessary to ensure this compliance?

McQuoid-Mason and Dada (2011) caution that doctors should realise that inappropriate or inadvertent disclosure of information can occur in clinical settings and should take steps to prevent this.

Although not a law, the National Patients' Rights Charter provides that information concerning a patient's health, including information concerning treatment, may only be disclosed with informed consent except when required in terms of any law or an order of the court.

5.2.13 Participant 017

Participant 017 is a graduate of MEDUNSA. She works full-time for the Centre for Rural Studies and lectures students at the University of the Witwatersrand. She still does clinical work as a sessional overtime doctor at a public and a private healthcare institution, where she deals mainly with patients in Casualty. She was interviewed at CMAH.

5.2.13.1 Description of the dilemma

This physician described dilemmas that were the consequence of personal values and judgements that conflicted with professional duties and obligations, especially in the emergency room:

> "Some of the conflicts, affect conflicts, in the sense that you have your own personal issues. I'll give you an example; having to treat a car hijacker that is delivered to the ER unit by an ambulance, and everyone knows that this man has been injured from a car-hijack shooting. It's an internal personal conflict because if you have been hijacked before, or if you have had a near-hijack, or even if you haven't for that matter, you have issues against hijackers because you don't know when you will be hijacked."
>
> "So, you would have your own personal conflict on 'do I want to be involved in helping this person live, or do I not want to help him live?' And you don't have options being an ER practitioner. Your immediate response is to help everyone live. But as you are working on that person, deep down internally you do have another fine conflict on 'how far do I want to go? How much sacrifice of my time and convenience do I want to involve in trying to help this person live?''

For her the issue is that the patient is an alleged criminal and although she has a duty as a doctor to treat the patient, she feels she is:

> "…preserve[ing] the number of hijackers out there."

For her, this is a challenging situation, and she explains:

> "That one kind of situation is for me personally, is the most challenging one because I would never refuse to give emergency treatment to anyone. That's now the ethical standards I adhere to as an emergency medical practitioner. I choose to know that, apart from the rules from the system, on a personal basis, I am not God to decide who lives and who dies. But I would still remain with the deeper conflict on how much sacrifice of my…time and space and convenience would I put into saving his life?"

5.2.13.2 Resolution

Although this participant has personal conflicts or misgivings about treating those who have broken the law, she complies with the law as required. She seems to have a good understanding of the law and what she has to do, as she also referenced the law above ethical guidelines the other quandaries she described. Quandaries are resolved using context, reason and the law.

5.2.13.3 Justification

This participant relies heavily on the law to justify her decisions. She holds onto personal moral values but in the professional space complies with legal prescriptions.

5.2.13.4 Discussion

The participant describes a dilemma where she is obligated by professional duty to provide emergency care to potential criminals. She resents providing the care because her personal feelings dictate that criminals are not worthy of her commitment or obligation. There may be a history of her being a victim of crime. While she does not directly admit this, it is implied, and this prejudice may be an influencing factor in her approach to treating criminals:

> "The person is a criminal and the person is the kind of criminal that would kill you yourself one day because you drive a car, you've been hijacked. You've had near hijacks and you are a potential for another hijack at any other time."

When deciding to treat the patient, she declares that she does so based on ethical principles ("…ethical standards I adhere to as an emergency medical practitioner"), personal values ('I am not God who to decide who lives') and the law. This healthcare professional cites the law as having her "hands tied" and that she cannot choose who she would like to treat or refuse to treat:

> "Because the law says you can't refuse a patient emergency treatment."

She explains:

> "And with emergency treatment, you can refuse a patient treatment if you are going to be transferring this patient to another practitioner, but with emergency treatment, there is no time to transfer to another practitioner. Therefore, technically even though the law says I have the right to refuse to be involved in someone's treatment, the law says you have a right to refuse to be involved in someone's treatment if you are going to be transferring the patient to the next practitioner. But with the emergency unit, there is no next

practitioner to suit the emergency situation. So technically, the law in that situation has our hands tied."

Legally, private practitioners can accept or refuse to treat patients provided the reason is not based on unconstitutional grounds, for example, unfair discrimination on racial or religious grounds (McQuoid-Mason & Dhai, 2011 (c), p.62). Emergency medical treatment refers to the administration of necessary medical treatment where a person's life or health is in imperilment as a result of disease, trauma, or ill-health (McQuoid-Mason & Dada, 2011, p. 178).

In South Africa, ethically, the professional and ethical guidelines of the HPCSA require physicians to provide emergency medical treatment to those whose lives are at risk should they not receive the required assistance. Ethically, the obligation to provide emergency medical care applies even if this may conflict with the healthcare practitioners' religious or other beliefs (McQuoid-Mason & Dada, 2011, p. 178). Doctors may not refuse to provide emergency medical treatment except when it is against the wishes of the patient or where the doctor's life may be endangered in the provision of such treatment. An unjustified failure to render emergency medical treatment may be considered improper or disgraceful conduct and may lead to disciplinary action by the HPCSA.

The HPCSA Booklet 1, General Ethical Guidelines for the Healthcare Professions, under Duties to Patients prescribes in the following extracts from Section 5 that healthcare practitioners should:

5.1.1 Always regard concern for the best interests or well-being of their patient as their primary professional duty.

5.1.3 be mindful that they are in a position of power over their patients and avoid abusing their position.

5.1.5 Make sure that their personal beliefs do not prejudice their patients' healthcare. Beliefs that might prejudice care relate to patients' race, culture, ethnicity, social status, lifestyle, perceived economic worth, age, gender, disability, communicable disease status, sexual orientation, religious or spiritual beliefs, or any condition of vulnerability.

5.1.7 Not refuse or delay treatment because they believe that patients' actions have contributed to their condition, or because they - the healthcare practitioners - may be putting their own health at risk.

5.1.13 In emergency situations, provide healthcare within the limits of their practice and according to their education and/or training, experience and competency under proper conditions and in appropriate surroundings. If unable to do so, refer the patient to a colleague or an institution where the required care can be provided.

5.2.5 Guard against the human rights violations of patients, and not allow, participate in or condone any actions that lead to violations of the rights of patients.

In section 5.7.1 the guidelines recommend that healthcare practitioners should:
5.7.1 Promote access to healthcare. If they are unable to provide a service, they should refer the patient to another healthcare practitioner or to a health care facility where the required service can be obtained, provided that in an emergency situation, practitioners shall be obliged to provide care in order to stabilize the patient and then to arrange for an appropriate referral to another practitioner or facility (Section 5 of the National Health Act).

Booklet 3, the National Patient's Rights Charter, section 2.3 Access to Healthcare, reads in part:
Everyone has the right to healthcare services that include-
a) receiving timely emergency care at any healthcare facility that is open, regardless of one's ability to pay.

HPCSA Guidelines Booklet 7, Guidelines for the Withholding and Withdrawing of Treatment, Section 6, reads in part:
6.1 In an acute life-threatening emergency where any delay might prejudice the outcome and where it is impossible to obtain all relevant information, or hold any consultations required-or where there is uncertainty about the diagnosis or the likelihood of recovery, healthcare practitioners should start treatment which may be of some benefit to the patient until a clearer assessment can be made.

Legally, the duty to provide emergency medical treatment is provided for in the Constitution of the Republic of South Africa (1996) (s 27(3)). According to the Constitution, nobody may

be refused emergency medical treatment. This prescription applies to visitors to South Africa, non-South African residents and illegal immigrants, not only South African citizens (McQuoid-Mason & Dada, 2011, p.178). If a patient is harmed consequent to the failure to provide emergency medical treatment, legal action may be taken. Further, if a patient dies as a result of such negligence, the doctor may be charged with culpable homicide (McQuoid-Mason & Dada, 2011, p.179).

The National Health Act, 2003 (Act 61 of 2003), section 5, states that no healthcare provider, healthcare worker or health establishment may refuse a person emergency medical treatment. Thus, it is clear that healthcare users have the right to emergency medical treatment and that all healthcare practitioners and personnel have the duty to provide emergency medical treatment.

5.2.14 Participant 018

Interview 018 is a graduate of a West African University. He is a specialist in Nuclear Medicine, having obtained his MMed in Nuclear Medicine in 2018. He is currently completing his residency programme at CMAH.

5.2.14.1 Description of the dilemma

The participant described a conflict that he experiences while treating patients according to medical protocols or guidelines when he knows that the patient cannot afford to return for the recommended follow-up visits for up or down-titrations as prescribed by the guidelines. He chooses to adhere to the clinical guidelines because he is wary of litigation should he deviate. Referring to medical practice in South Africa, compared to his home country, he says:

> "In this situation [South Africa] I have more professional consideration. Even when certain things might not even be in the best interest of the patient."

When he refers to 'professional consideration' he is talking about medical treatment standard procedures, protocols or guidelines:

> "There are certain things which are more professional, that is the professional requirement, but the application and given the situation, they might not be in the best interest of the patient."

The medical treatment guidelines and protocol are evidence-based but at the same time a patient might not be able to return for the follow-up visits as required, because of personal economic constraints:

> "But then there are certain situations when maybe you want to give certain things and even beyond, and then based on the situation of the patient, it may be transportation and all that you know. People come from different places and that more frequent coming is difficult for the patient. Cost and all that things. And it requires that if the patient will be able to come would definitely not be within that [window], but then it is wrong for you to write medications more to cover the period, which might actually assist the patient."

He would prefer to prescribe a treatment level of medication to cover a period that would enable the patient to make hospital visits when they could rather than more frequently as prescribed by the guidelines. This extended treatment is not evidence-based, so:

> "you think okay, you just have to come, even at the cost of the patient missing [the visit] and not benefiting."

He describes a diminished professional autonomy:

> "It's just the guidelines. There is this one that is one of the best available evidence that you can have to justify judgement…you have to treat them like humans also, but the guideline says you can review, you should review the patient then prescribe. You can override the guideline based on your clinical acumen as a doctor…[but in that situation] the [scientific] support is not as strong as the guidelines, but you can use that and prescribe more medication."

Because an extended prescription period is not evidence-based, he prefers to stick to the treatment guideline to avoid litigation:

> "Now I will refuse to do it even when I am almost certain that this patient would not be able to come for that follow-up and I know the consequences of that patient not getting the treatment. But I will choose what is in defence of the profession to avoid litigation. I just insist on, even a, just because the guidelines say so, even though I can do otherwise because it is even more helpful to the patient."

He implies that if he had a choice, he would not follow the guidelines, even though the guidelines prescribe something, he feels one has to consider other factors and adjust treatment

accordingly. Because he is fearful of litigation, he prefers to stick to the treatment guidelines despite the patient not benefitting:

> "where there is a lot of litigation, defensive medicine, you are also likely to go for what is professionally right, but personally, if you empathetically each and every situation you assess the patient you know it's not the best thing…"

His main concern is that where he does not comply with treatment guidelines, depending on the patient's level of education, he should "self-protect."

5.2.14.2 Resolution

The dilemma was resolved by the doctor determining in this case, that he had to "self-protect" and follow the treatment guidelines, even though, by following the guidelines there was every chance that the patient would not be able to make a review visit and would default on treatment because he would not have enough treatment to sustain him until the next visit. Although he recognised that what he was doing was not in the patient's best interest, he reasoned he was protecting himself by adhering rigidly to the guidelines. This is called "defensive medicine".

5.2.14.3 Justification

In this case, the doctor used medical and scientific reasoning and, awareness of liability to facilitate his decision. Second opinions were not sought because "seniors" also self-protect and prefer not to give advice:

> "But for the senior ones, they might think okay, maybe you have issues, and then I will discuss. It might be perceived as giving advice. Also, the senior is self-protecting myself, they self-protect themselves, they don't want to listen to my problem."

Peers may feel complicit in any wrongdoing should litigation arise.

Williams (2015) describes a type of non-rational decision-making called imitation. Imitation subordinates decision-making about right and wrong to a role model. Morality consists in following the example of the role model. Williams (2015) argues that this may be the most common way of learning medical ethics for aspiring physicians, where the role models are senior consultants. The mode of moral learning is via observation and assimilation of the values portrayed (Williams, 2015). In this case, because the seniors are "self-protecting" this may be perceived as the appropriate way to act.

No reference to any normative justification/ source/ authority was expressed other than compliance with the law.

5.2.14.4 Discussion

The conflict in this interview was between the desire to comply with the medical treatment guidelines and protocols as prescribed and backed by evidence-based medicine on the one hand but knowing on the other hand that the patient would not be able to fulfil the treatment guidelines because of personal economic constraints. In other words, professional duty to avoid litigation versus duty to the patient. The patients are afforded access to appropriate healthcare, but because of poverty, destitution, or poor working conditions, they are unable to return for the required follow-up visits. The options are to prescribe a certain level of the intervention for an extended time until the patient can return, or to stick to the guideline prescriptions and risk patient attrition or default. The conflict is complicated, according to the doctor, because the more educated or informed the patient is, the more likely it is that the doctor's failure to stick to the guidelines could result in litigation should things go "wrong".

Defensive medicine occurs when physicians deviate from sound medical practice due to fear of liability claims and lawsuits (Baungaard, et al., 2020). The primary aim of defensive medicine is self-protection from liability rather than affording primacy to the patient's well-being (Ogunbanjo & Knapp van Bogaert, 2014). In other words, it is the practice of diagnostic or therapeutic measures conducted as a safeguard against litigation rather than to ensure the health of the patient (Ogunbanjo & Knapp van Bogaert, 2014). There are two components to defensive medicine: a medical action; and an underlying motive for acting defensively (Baungaard et al., 2020). Defensive medicine has been associated with overtreatment; over-prescription and over-diagnosing (Baungaard et al., 2020).

There are two main forms of behaviour in defensive medicine: 1) Positive defensive medicine (also called active or assurance defensive medicine) and 2) Negative defensive medicine (also called passive or avoidance defensive medicine) (Baungaard et al., 2020; Ogunbanjo & Knapp van Bogaert, 2014). Positive defensive medicine involves physicians ordering extra or medically unjustified diagnostic tests, procedures or visits in an attempt to cover all possible areas from which a claim of medical negligence could arise (Ogunbanjo & Knapp van Bogaert, 2014). It also involves providing the patient with extra services which have little or no medical value. Negative defensive medicine is the avoidance of high-risk procedures or patients and the unnecessary referral of patients to other doctors or institutions.

The diminished autonomy mentioned above also diminishes one's purpose as a doctor, which for most doctors is to save lives or make people better.

One of the biggest problems with a diminished autonomy and defensive medicine is that acting defensively (and with limited autonomy) may over-ride the clinical judgement of medical doctors (Hauser, Commons, Bursztajn, & Gutheil, 1991). Equally, doctors may lose enthusiasm for attending to the needs of the patient because of the perceived lack of autonomy in the doctor-patient relationship:

> "… [your purpose becomes] a kind of mechanical thing between you and the patient, instead of really being fully thinking of the patient rather than the condition or the situation. Because ideally, this is even where the doctors, a lot of us are enlightened to what the practice of medicine should be, unfortunately. And then it is the patient, not just that particular, you know, condition the patient presents to you, because sometimes you neglect other things, just concentrating on one thing- the professional requirement. We don't see the bigger picture on what our role should be…"

Ogunbanjo and Knapp (2014) argue that the biggest negative result of the fear of litigation is an alteration in the doctor's attitude towards the patient. They explain that this is because the focus of the clinical interaction shifts from the patient's well-being to one of legal self-protection for the doctor. The patient is seen as a risky legal case rather than a patient in need of care. Rather than this, it is proposed that doctors should remain as ethical as possible in patient interactions, by explaining all care options and when in doubt, obtain a second opinion from a colleague.

Medical doctors belong to the healthcare profession. The medical profession is '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 autonomy' (Williams, 2009, p. 48). However, medical professional autonomy can be limited by various political, social, and economic factors affecting healthcare and institutional policies. Professional autonomy can also be limited by medical treatment protocols which take the "thinking" out of the practice of medicine. Further, non-adherence to treatment protocols may bring the potential for litigation.

In contemporary times, professional autonomy has given way to professional accountability (McQuoid-Mason & Dhai, 2011(c), p. 60). Accountability relates to how doctors exercise the

responsibility afforded them, where responsibility denotes a duty to perform a certain function satisfactorily.

The Declaration of Madrid on Professional Autonomy and Self-Regulation (2005) outlines an ethical code for self-regulation and professional autonomy for doctors (McQuoid-Mason & Dada, 2011). While the Declaration of Madrid is not the law in South Africa, many of its principles are to be found in the Constitution, (Act 108 of 1996); the National Health Act,2003 (Act 61 of 2003); the common law; and the ethical rules of the HPCSA (Booklet 1).

The Declaration states that doctors have, amongst others, the right to i) exercise their professional judgement unhindered by others; ii) autonomy that is consistent with quality patient care that should not be compromised; iii) engage in a system of self-regulation that ensures that physician autonomy is maintained ethically; iv) offer the most effective intervention to patients.

However, the erosion of trust in the medical profession; treatment guidelines and protocols; and an emphasis on litigation as a tool where doctors have not acted appropriately, has led to an increase in the practice of "defensive medicine".

5.2.15 Participant 019

Participant 019 is a cardiologist working in private practice at a clinic in Midrand. He graduated from the University of Witwatersrand in 1986. He specialised in internal medicine in 1991, following which he specialised in cardiology. He spoke of a general dilemma common in his field, specifically in the ICU setting. These dilemmas involve end-of life-decision-making.

5.2.15.1 Description of the dilemma

> "In general, the most important dilemma we have in cardiology, in ICU, is patients with end-stage cardiac failure, where absolutely nothing can be done. We have done the medical therapy, we have done the mechanical therapy, and it's the end of the road, and the only thing we can do is transplantation. The patients are usually elderly, seventy-five, eighty, nowadays even ninety. And you have to resolve the issue, what you should do. And I can tell you what I do."

He confirmed that the decisions were end-of-life decisions:

"It's an end-of-life decision and it's in the elderly. People usually over seventy-five, most of them in their eighties and nineties…"

5.2.15.2 Resolution

He describes the process he uses in making the decision:

"How I make my decision. I gather all the information, get a second opinion, we are three cardiologists at this hospital so it's easy to get a second opinion from a second cardiologist. And then I approach the family and I tell them this is what I think, this is what the second opinion thinks, and I will tell them what the options are from a medical point of view. And if there are no options, I will tell them the maximum treatment. I document everything and the family has to make the decision".

Sometimes the process is complicated by factors outside of his control, for example, where a family is not available to make the decision:

"Sometimes it's complicated by family. Especially the white families. I find they don't look after the elderly. The children are all overseas, in America…Australia and the elderly mother or father is here on their own, left with a caregiver. What kind of person leaves their parent alone? I ask you. And then you have to phone overseas and then the one who has to make the decision is the caregiver or some second cousin…"

When asked about the importance of documenting everything, which he specifically mentioned:

"It's a medico-legal issue. You cannot take a chance. Especially with end-of-life. With anything. If you don't document or get second opinions, people will sue. If I admit someone to ICU and on a chest X-ray there is a tiny spot or if there is a mildly abnormal kidney function test and I don't get a second opinion, I am open to being sued. You won't believe it…even if I know there isn't anything…I have to cover myself."

When asked about the reasonable person in the same situation theory as a defence he promptly responded:

"What is a reasonable man? If I have had a good night's sleep and three hot meals and not overworked, I may be reasonable. But you can argue, I can tell you with two hours sleep and running around they will argue I am not reasonable. I was in theatre this morning at four o'clock doing emergency PCI and then I start my day, in ICU, in the

wards, then consulting, then emergencies…there is no argument. So, you get second opinions and you document."

Asked if he ever referred to the HPCSA guidelines for assistance in his end-of-life decisions:

"To be honest with you…the HPCSA is a total waste of time. They are not interested. When you phone them, they tell you you must do what you think is right."

5.2.15.3 Justification

This participant bases all his ethical and moral decisions on the law. Documentation and recording everything are crucial in defence of the decisions he makes:

"It's a medico-legal issue. You cannot take a chance. Especially with end-of-life. With anything. If you don't document or get second opinions, people will sue".

"I have to cover myself."

5.2.15.4 Discussion

This interview highlighted the awareness that doctors have of potential litigation. Every decision made is made bearing in mind that it has to comply with the law and be documented. The doctor in this interview also brought attention to the fact that doctors working long hours may not be seen as "reasonable" in a court of law. For this reason, to ensure their medical or clinical decisions in the care of patients are valid, they seek second or even third opinions. This is a further step in protecting the doctor from litigation.

Traditionally, medical records are the source of the patient's medical information. These records are crucial to ensuring safe and effective medical care. Poor record-keeping can influence patient management and continuity of care, which may affect that patient's healthcare. Medical records are also medico-legal documents. Poor quality health records are not only a major cause of iatrogenic injuries, but they also make it difficult to defend a clinical negligence claim or an HPCSA disciplinary inquiry (MPS, 2014, p. 4). Health records may also be used to inform expert medical opinions in cases of medico-legal litigation. For these reasons, good medical record keeping is of the utmost importance.

The National Health Act, 2003, obliges healthcare organisations to create and maintain health records for every user of that organisation. The HPCSA guidelines, (Booklet 9, Guidelines on the Keeping of Patient Records), define a health record as "any relevant record made by a healthcare practitioner at the time of or after a consultation and/or examination or the

application of health management". Essential components of health records are the hand-written notes made by the HCP or at his direction, notes made by other HCP's involved in the health management of the patient, the results of all investigations, referrals to and follow-up letters from other doctors or specialists, and death certificates and post-mortem results.

In an increasingly litigious society, record-keeping practices in South Africa should comply with both HPCSA guidelines and MPS recommendations. Healthcare records and documentation are crucial to demonstrate decision-making and treatment processes as well as a patient's response to treatment. In issues, as sensitive as end-of-life decisions, and especially where that patient may not have the mental capacity to make the decision, an accurate record of discussions, second opinions, informed consent and proxy consents, should all be recorded comprehensively, contemporaneously, accurately and be signed by the physician leading the management of that patient.

This participant's dilemma also raised the issue of end-of life decision-making, notably in those cases where patients cannot make the decision for themselves.

The HPCSA Booklet 7 (*Guidelines for the Withholding and Withdrawing of Treatment),* introduction, point 1.3, guides that the HCP may "alleviate the suffering of a terminally-ill patient by withholding treatment…*provided* there is consultation with another healthcare practitioner who is an expert in the field, and where available discussions with the closest relatives."

The frustration for Participant 019 was that very often, the closest relatives are not available or accessible. The conflict in this case arose either because the patient did not have an advance directive and/or because the option of a discussion with close family was not possible. It seemed that for this doctor, not being able to discuss the issue with family and despite second opinions with colleagues, going ahead with withholding treatment made him uncomfortable.

The HPCSA Booklet 7 describes in section 8.2 the processes for making decisions for patients. (Reaching consensus and the decision-making processes were discussed under participant 001 in section 5.1.1.4)

Documentation of the decisions is a procedure that this participant was very aware of, if only to defend himself should there be litigation. He did not find the HPCSA at all helpful when they were consulted telephonically. However, the HPCSA Booklet 7, section 11, provides guidance on recording decisions and recommends:

> 11.1 Healthcare practitioners must ensure that decisions are properly documented, including the relevant clinical findings; details of discussions with the patient, health care team or others involved in decision-making; and details of treatment or other significant factors which may affect future care.
>
> 11.2 Healthcare practitioners should record the information at the time of the events described or soon thereafter. The record should be legible, clear, accurate and unambiguous.

Documentation has been discussed in this case study as a defence against litigation. However, it should be remembered that accurate record-keeping and documentation is not only to demonstrate that treatment or an intervention occurred in compliance with professional guidelines and the law. Record-keeping by healthcare professionals is also essential to enable the continuity and coordination of the management and treatment of the patient's condition and their progress. The record-keeping ought to be managed as needed in the best interest of the patient and not merely as a defence against litigation by the doctor.

5.2.17 Participant 021

Interview 021 is a graduate of Witwatersrand University. She graduated in 2014. She was working between Helen Joseph Hospital and doing locums in private practice. She is now in full-time private practice in Midrand.

5.2.17.1 Description of the moral dilemma

In this case, the doctor was asked by an HIV positive mother, to test her two children for HIV. The mother wanted the information for her own peace of mind. Her children were not aware of her HIV status and she did not want to disclose her status to them.

The conflict for this doctor was between understanding that an HIV positive mother would want to know the HIV status of her children and doing the tests without their specific consent. The mother had not disclosed her status to her children but was worried about transmitting the

virus to her children. Further, the mother did not want the children to know that they were being tested for HIV, so informed consent was not obtained, and pre- and post-test counselling was not provided.

> "…she's actually RVD reactive, but her children don't know. So she is always like, worried about the risk of transmitting the disease to her kids. So she wanted blood tests for them as well…she wanted the HIV status to be done, but the children didn't know, she hasn't disclosed to them. So it was kind of like, I didn't know if it was right, ethically right, for me to be doing blood tests like that without consenting…"
>
> "They were not aware…And she was like, she hasn't disclosed to them, but she is just worried in daily activities and she doesn't want to make her children sick or transmit the disease to them."

5.2.17.2 Resolution

The doctor complied with the mother's wishes and conducted the tests as part of a general check-up. The children were not aware of the testing, nor were they consulted. The doctor reasoned that the mother had good intentions and that it was for the benefit of the children:

> "So, what did I do? So, in terms of the blood test, I did a full medical work-up for her and her children, and I included the HIV tests."
>
> "Well, like I thought about it, and I thought the mom had a good intention. She was just worried about her child…her children obviously. For whatever reason, she doesn't want to disclose to her family because there's a lot of stigma still associated around it. Yeah, so like from her point of view, I could see that she just was, she was looking out for them because she doesn't want them to get sick. So, it was for the benefit of the children just to, so she knows their status."

It was not clear what the mother intended to do with the knowledge.

5.2.17.3 Justification

When asked how she approached the dilemma, the participant said:

> "So, it was difficult in that sense because she hasn't disclosed anything to her children even though she is looking out for their well-being. And I guess it was for the benefit of them but yeah, I mean, that was a, it was definitely an ethical dilemma for me. And I don't know if I went about it the right way."

There were some vague references to some ethical principles and guidelines, but overall there was no use of or referral to professional guidelines, despite undergraduate training in bioethics:

> "…I think there was like, yeah, that bioethics, that book we had, um, I think just like the internals, the principles of like, for the greater good of people and justice and all of that because, they are those like, principles…And I guess that's always helpful when you are trying to think of like, the greater good of the community, rather than what benefits."

Ultimately, she justified her actions as being in the best interests of the children:

> "…And I guess it was for the benefit of them…"

5.2.17.4 Discussion

Van Rooyen, Strode, and Slack (2016) describe HIV testing in children as a complicated process that creates conflicts for parents, caregivers, the children, and for the medical doctor who works with them. While an earlier diagnosis of HIV infection in children is beneficial in that it enables more effective care and a decreased mortality, some processes need to be fulfilled to effect such testing (Van Rooyen et al., 2016).

Four key norms regulate HIV counselling and testing in children. These norms are found in the Children's Act 38 of 2005. The National HIV Counselling and Testing Policy Guidelines and the 2012 Implemenation Guidelines provide further legal, ethical and counselling guidance for testing children and adolescents (Van Rooyen et al., 2016).

The four key norms described in the Children's Act 28 of 2005, sections (s) 130-133 are:
i) Limitation of HIV testing to defined circumstances
ii) Obtaining informed consent
iii) Ensuring pre- and post-test counselling
iv) Confidentiality
The four norms are discussed individually.

i) Limitation of HIV testing to defined circumstances

Children may only be tested for HIV if it is in their best interests (Children's Act: No.38 of 2005). Arguably most HIV testing, as in this case study, will be in the child's best interests, as it will enable early intervention and treatment if necessary. However, with HIV testing, the child's "best interests" have to be demonstrated (Van Rooyen et al., 2016). This means that

the medical doctor taking charge of the test should assess whether the testing will promote the child's physical, moral, emotional and spiritual welfare. This should, however, be seen as a flexible standard to be applied with appropriate deliberation of the individual circumstances of the child (Strode, van Rooyen, & Makusha, 2013).

In this case, where the mother is HIV positive, even though she has not disclosed her status, she is concerned about transmitting the disease to her children, HIV testing would be appropriate. If she has transmitted the disease it would enable early treatment and prevention strategies. However, there are conditions to the testing:- first and foremost, the condition of informed consent. The Children's Act provides that, other than in exceptional circumstances, HIV testing in children is only lawful if it is in the best interest of the child and is undertaken with informed consent (Strode, van Rooyen, & Makusha, 2013).

ii) Informed consent

The Children's Act, 2005 (Act 38 of 2005) provides that consent for an HIV test on a child may be given by the child itself if the following conditions are met: a) that the test is in the best interests of the child; b) the child is 12 years of age or older, or under the age of 12 years and of sufficient maturity to understand the benefits, risks and social implications of such a test (McQuoid-Mason & Dada, 2011).

The Children's Act also provides that in cases where children under the age of 12 years, but not of sufficient maturity to understand the risks, benefits and social implications of the test, consent may be provided on their behalf, by a parent, guardian or care-giver.

However, while HIV testing may be initiated by a medical doctor or parent, the child, if 12 years old or older, must freely give consent, and the reasons that they wish to know their status should be explored. The condition for those under 12 years are described above; however, the child should still be informed of the reason for the test. Where children are not legally competent to consent to an HIV test, doctors should ensure that consent is obtained from the required person as described in the Children's Act, 2005 (Act 38 of 2005). Further requirements for informed consent can be found in the National Health Act, 2003 (Act 61 of 2003) (ss 6-8) (McQuoid-Mason & Dada, 2011).

The HPCSA Ethical Guidelines for Good Practice with regard to HIV, Booklet 11, section 4.3 prescribes that it is:

"ethically and legally mandatory, to get informed consent before a health care practitioner tests a patient for HIV- by law this always applies except in a medical emergency, or in the case of a child, where a parent or guardian is required to give consent."

No mention is made of the special provisions in the Children's Act or HCT guidelines when testing children.

Section 6.3 of the booklet prescribes:
"In order to obtain an informed consent, the patient should be given information regarding the purpose of the laboratory test; what advantages or disadvantages testing may hold for him or her as a patient; why the healthcare practitioner wants the information; what influence the result of such a test will have on his or her treatment, and how his or her medical protocol will be altered by this information. The psychosocial impact of a positive test result should also be addressed."

Section 5.4 " the decision to divulge information relating to the HIV status of a patient must always be done in consultation with the patient."

Again, there is no mention of special conditions for children for providing informed consent, or provisions for ensuring confidentiality.

There appears to be a gap in the HPCSA guidelines regarding a Children's Ethics. Children are empowered at certain ages to participate in decisions for themselves regarding healthcare. This empowerment raises several complexities and uncertainties for healthcare providers unfamiliar with the law. I recommend an additional HPCSA guideline booklet to address this and the special circumstances and provisions around the Children's Act and decisions around, amongst others, medical care, HIV testing, access to contraceptives, termination of pregnancy, surgery, circumcision and even health research.

iii) Counselling

Pre- and post-test counselling with HIV testing is a mandatory requirement in the Children's Act. This means that HIV testing without counselling is unlawful unless the child waives its right to service (Strode, van Rooyen, & Makusha, 2013).

Both the Children's Act and the National HIV Counselling and Testing (HCT) Policy Guidelines prescribe that HIV testing of children must be accompanied by proper pre- and post-test counselling by an appropriately trained person. Where the child's parent or caregiver is aware of the testing, this person should be involved in the counselling (Van Rooyen, Strode, & Slack, 2016). Post-test counselling informs and prepares the child (and parents where applicable) about the implications of the test outcomes and for referral for treatment, care and psychosocial services as needed (Van Rooyen, Strode, & Slack, 2016).

iv) Confidentiality

The Children's Act (s133) and the National HCT Policy Guidelines maintain that children who are capable of consent can decide who should know their HIV status (Van Rooyen, Strode, & Slack, 2016), and this disclosure should only be with their consent.

The Children's Act, 2005 (Act 38 of 2005) supplies the special provisions regarding the confidentiality of the HIV status of children. Essentially, no person may disclose the positive HIV status of a child without the consent of that child or an authorised person. Exceptions to this provision are when a) it is within the powers and duties of the person making the disclosure in terms of the Act or any other law; b) when necessary for carrying out the provisions of the Act; c) for the purpose of legal proceedings; or d) in terms of an order of the court (McQuoid-Mason & Dada, 2011).

The National HCT Policy recommends disclosure of a child's HIV positive status to at least one other person as being beneficial for psychosocial support and intervention adherence.

In this case, the participant appeared to make her decision non-rationally, based on emotion (empathy), an understanding of the mother's situation and a vague belief that it might be for the benefit of the children.

> " …I could see that she was looking out for them because she doesn't want them to get sick. So it was for the benefit of the children just to, so she knows their status."
>
> " I understood where she was coming from because she was just looking out for the well-being of her children."

Conscience also came into the process:

> "…but I think it was sort of just my conscience and how I felt because I understood from her, she was just looking out for the well-being and the benefit of her children."

Despite some awareness of ethical requirements, the context was an influencing factor in the decision-making process:

> " Well, I definitely know it's this doctor-patient confidentiality, and I know that there's consent when you are testing children for medical procedures and surgical procedures and that's probably what you need to follow. And I think our mom would, she would have understood that. But I don't know, that day I just felt, I just felt like she was there and her children look well, and she was well and she just wanted like a full medical workup in terms of her, and a full medical workup in terms of her children, in spite of that to also include the HIV."

When asked if she was acting in the mother's best interest or the children's best interest, she replied:

> " I think it's sort of in her best interest because she is obviously concerned…that's why she was to come to see a doctor. I don't think it's in the best interest of the children, because it's not ethical testing like that without consent and pre-test counselling and post-test counselling. So in the best interest of the mom and why she wanted it. But not for the children."

Arguably, HIV testing in children should be performed where it is in their best interests. However, this approach cannot only be about the child's best interests. Ethics is breached when there is no consideration for informed consent, counselling and confidentiality. This doctor was not aware what the consequences of those results might have been for those children and their mother, had they been positive. I would argue, that it would also be important to find out what the mother intended to do with the knowledge of those results.

5.2.18 Participant 022

Participant 022 is a graduate of the University of Stellenbosch. She graduated in 2011 and worked at Tygerberg Hospital for three years. She is currently working in a large general practice in Halfway House in Midrand.

5.2.18.1 Description of the dilemma

This general practitioner found the problem of limited resources and economic constraints to be the cause of ethical quandaries in the clinical space.

"Well, we've had a lot of patients who do require further investigations, but things like their medical aids don't really allow them to have that. And also, because there are financial constraints [which] also kind of prevent you from giving the best care"

"So, it kind of feels like you want to do the best for your patient, but you are between the patient and the system, and it doesn't mean they allow you to do that."

The dilemmas are not only the result of limits set by medical aids but also the result of patient expectations or patient participation in their care:

"But then also the patients, if they have medical aid and they want certain things done, and they can't be done, they also refuse to go to the public sector to have it done."

5.2.18.2 Resolution

This participant works around the financial constraints to determine how to treat the patient. She finds it frustrating because she is unable to treat patients as she has decided they should be treated. Sometimes, she may change a diagnosis to access the investigation or hospitalisation needed:

"It makes me very frustrated because I know what the patient needs, but I actually can't give it properly to them."

"Then I'm going to speak to the surgeon on call and see if we can't go through the hospital plan."

5.2.18.3 Justification

This participant justifies her decisions as being in the patient's best interest. Her actions are based on medical reasoning and medical guidelines which she uses to enable the best outcome for her patient. She refers to law, ethics guidelines, clinical guidelines, and patient expectations:

"The courses like ACLS, there is always an ethics part. And in that whichever scenario they discuss, so there is always what is the gold standard? Whether it's in the country or the medical gold standard? What does the law say? And all of that influences as well what you're allowed to do and what you're not allowed to do"

"And I think it's also about what people are expecting of you as a doctor. Sometimes they kind of expect more than you can actually deliver. And you need to kind of put that frame of reference or just adjust that frame of reference."

5.2.18.4 Discussion

This interview with this participant highlighted the differences in the dilemmas faced by medical practitioners servicing different income groups. The dilemmas or the application of ethical principles may be different depending on the class the medical doctor is servicing. Limited resources and economic constraints have been discussed elsewhere in this chapter, under sections 5.1.2; 5.1.14 and 5.1.18. This participant did not raise anything new other than that medical reasoning and clinical guidelines influence her decision-making, where ultimately her goal is to treat the patient as best she can within those constraints.

5.2.19 Participant 023

Interview 023 is a graduate of Medunsa (Limpopo University). Graduated in 2014. She worked as a nursing sister for years before going to medical school to study medicine. She currently works as a general practitioner in private practice in Midrand.

5.2.19.1 Description of the dilemma

The doctor was consulted by a mother and her 7-year-old daughter. The daughter was complaining of burning and painful micturition and vaginal discharge. The treating doctor suspected child abuse and discovered that the mother's boyfriend was sexually abusing the child. The doctor had a duty to treat the child and to report the boyfriend for the sexual abuse. The mother had not reported the sexual abuse of the child because she and her daughter were financially dependent on the boyfriend, without whom they would be on the streets. The mother was unemployed and was protecting her boyfriend.

5.2.19.2 Resolution

The resolution of ethical dilemmas is multi-factorial for this participant:

> "I sort of use every angle, but for me, the first and the main thing for me is the patient in front of me- what is in the best interest of this patient for me? Then the law, then the experience, then my nursing, then maybe my moral values will come into play because I'm a Christian by faith."
>
> "first and foremost is what is in the best interest of the child. And then from experience, I've realised that most of the time, if I'm not sure that I am right, what I always do is consult or call my consultant on-call…I will sound out some of the things to find out we are still legally within the law."

5.2.19.3 Justification

For this participant, the decision is primarily guided by what is in the best interest of the patient, and the Hippocratic Oath: "I think my Hippocratic Oath is first and foremost to above all do no harm". The participant also is aware of legal obligations but is not very clear on the law. There is a reliance on personal experience and peer experience as well. Finally, religious values also play a role:

> "…I've tried all my life, to live a Christian life that is honest before God. And do the right things all the time…"

Moral reasoning seems to play a major role. The participant is very aware of the implications and consequences of her decisions.

5.2.19.4 Discussion

The primary duty of the medical doctor is to act in the patient's best interest and to avoid harm (Dhai & Etheredge, 2011). In this case the priority was in the best interests of the child: "first and foremost is what is in the best interest of the child".

According to the HPCSA *Booklet 1, General Ethical Guidelines for the Healthcare Professions,* Sections 2.3.2, Non-maleficence, and 2.3.2, Beneficence, [medical doctors] should not harm or act against the best interests of patients, even when the interests of the latter conflict with their own self-interest.

The doctor felt immediately that the child needed to be managed and treated medically. Secondly, she had an obligation to report the abuse, despite the mother's refusal:

> "She didn't want to report, and I had an obligation to report it to the police. So, we phoned the Atteridgeville Police Station to report that we have a child who we think is abused."

Child abuse refers to the maltreatment of children which results in harm or the potential risk of harm to a child. This harm may be of a physical, emotional or sexual nature (McQuoid-Mason & Dada, 2011). The Children's Amendment Act, 2007 (Act 41 of 2007) (section 110) and the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007(Act 32 of 2007) (section 54) impose duties on medical practitioners and others to report certain instances of child abuse and sexual offences against children. The Children's Amendment Act imposes a mandatory duty on medical practitioners, amongst others to report child abuse and neglect. The provisions of the Sexual Offences Act (s 54) impose a mandatory duty on anyone

who has knowledge of sexual offences against children, to immediately report such information to the police.

These laws imply that doctors have a legal obligation to report child abuse to the appropriate authorities (McQuoid-Mason & Dada, 2011). While the doctor in the interview appeared informed of her legal obligation, she was not informed of the implications of the law in its entirety:

> "Because, remember, with some of the laws-sometimes I find doctors that I worked with, that they were not keen to report because it's a, it's an allegation, it's a child. Until it's tested in the Courts of Law and somebody proves it right or wrong, it may very well be a questionable, or something that is questionable, or an allegation rather than a fact, or a transgression that has been committed."

However, later in the interview, she states that "the law covers you if you are doing it in the best interest of the child."

According to McQuoid-Mason and Dada (2011), no legal proceedings can be instituted against doctors who act in good faith and report the abuse to the appropriate authorities in terms of the Children's Amendment Act and the Criminal Law (Sexual Offences and Related Matters) Amendment Act - even if it is found that the child is not being abused. Doctors who fail to report child abuse to the appropriate authorities are guilty of breaching the Children's Act and may be prosecuted (section 305(1)(c)). This is according to the legal principle of *Bona fides,* which is essentially acting in good faith. Doctors who comply with their legal obligations to report certain practices in terms of the legislation are protected if they acted in good faith (McQuoid-Mason & Dada, 2011).

Resolution of the dilemma was a multi-disciplinary effort, but the ethical obligation was resolved by the obligation to report.

5.2.20 Participant 024

Participant 024 is a graduate of the University of the Witwatersrand. She graduated in 2018. She was working in Obstetrics and Gynaecology at the CHBH and is currently working in that speciality at the Rahima Moosa Hospital.

5.2.20.1 Description of the dilemma

This doctor has encountered many teenage pregnancies in her term in Obstetrics and Gynaecology and she finds this very distressing, especially where the new mothers are still children themselves. Her conflict is between the lived social realities that she encounters every day and the failure of the state to deliver on what is promised in the Constitution and various Acts concerning, especially, reproductive health.

She described a case of a thirteen-year-old girl who had delivered a baby and was about to be discharged. While this was not an ethical dilemma as per the accepted definitions, she had a feeling that something was wrong with the situation. There was a thirteen-year-old girl who had probably been sexually assaulted; fell pregnant; had given birth and was being discharged back to the same social circumstances that had led her to the situation in the first place.

> "So, there have been a number of teenage pregnancies and young. The one that stands out the most for me was a 13-year-old who fell pregnant. I was doing the discharges …and this one had, I called her…how old are you?'
>
> "She's thirteen years old. And she was with a baby who wouldn't stop crying and normally, you know moms will pacify…so then I put two and two together and I was like oh the baby is having a baby. She doesn't know what to do and the rest of it."

This doctor recognised that the patient needed some counselling, took her aside and asked what happened:

> "She was raped by her brother's employee. So she fell pregnant. So I asked her, was this reported, did mom do anything about it? So mom was very reluctant in the beginning but then I think with pressure mom reported it."

When asked what made the situation a dilemma the response was:

> "So, for me the dilemma was okay, this is a child who now has a child, whose mom was clearly not supportive…this is still a child, technically she's thirteen, she's still a child- how do I discharge two children home to the care of a mom who couldn't take care of her own child. And when her child's rights were infringed upon in a criminal way, delayed it so long."

This doctor's frustration and distress seemed to be centred on social injustice:

> "But the thought that came to my mind, what could we have done better? How do we as a system address this? She's not the only kid. There are others in the ward who are 14, 15,

who have fallen pregnant…As I'm sure you are aware in obs and gynae in this province we have massive delays with regards to getting TOP's and to getting the morning after pills and the rest of it."

She elaborates on nurses and colleagues that refuse to perform TOP's:

"And more than that, there are sisters who just refuse."

"So for me the dilemma – it's more like a systematic- how do we deal with particularly teenage pregnancy and then also how are we really dealing with women's, like access to reproductive health. Because there's the law you know, everybody should get a TOP if you want it and you should be able to get contraceptives and all the rest of it. But in practice that's not happening because our nurses often will turn patients away, or they'll say you know I am not performing this procedure."

"Many of my colleagues refuse to do MVA's…they say no, that's an abortion and for me that becomes sticky. Like we've all taken an oath to provide healthcare services. Where do we draw the line between like the rights of the person, your rights and make sure the constitutional rights that are enshrined in our constitution are delivered in the way they should be?"

5.2.20.2 Resolution

This dilemma was resolved with the participant consulting with a social worker and a senior colleague. She was advised accordingly. Ultimately social services took over the management of the case:

"But my dilemma was sending two kids home into a place that probably is not the safest and is not better for me. At that point was it better for me to get social development involved, does the child need to go to a place of safety? And then it was in consultation with the social worker and Prof…who both said no you can discharge her home to her family, the social workers will have to take care of this out in the field."

5.2.20.3 Justification

This participant justified her actions and decisions on her duty to her patient.

"My first call was to her as my patient."

She also felt compelled to prevent further harm:

"How do I discharge two children home to the care of a mom who couldn't take care of her own child."

5.2.20.4 Discussion

The dilemma for this participant was between her duty to her patient and perceived social injustice. She expressed frustration that such incidents occurred and that there were insufficient resources to deal with them. The dilemma raised issues of access to reproductive health, child abuse, limited resources, social justice and duty to the patient.

All these themes have been discussed in the previous sections.

5.3 General Discussion and Conclusion

The analysis according to the research objectives provided rich, thick descriptions of the dilemmas that doctors in routine everyday practice encounter. To obtain the data, the practitioners were asked to describe a moral or ethical dilemma that they had experienced in the clinical context.

For many participants, a response to this question was difficult because most were unable to describe a true moral dilemma according to the definitions provided by Jameton (1984, p.6) and Beauchamp and Childress (2013) as previously defined in Section 5.1. Instead, morally challenging situations of uncertainty were mostly described, where the participants knew or were able to intuit that there was something 'off' or wrong with the situation but were either unable to identify the moral or ethical challenge or were not sure how to go about resolving it or of any recourse they might have. Six participants described events specifically of uncertainty.

The dilemmas were analysed according to themes of uncertainty; limited resources and economic constraints; legal matters; and social issues. Moral distress was the consequence of these morally or ethically challenging events. These themes are confirmed in the thematic content analyses in the next chapter, where they are discussed extensively.
Generally, the dilemmas encountered in the interviews covered situations of limited resources and economic constraints, child abuse, and defensive medicine. Quandaries were resolved using the law, deception, and peer consultation. The most common justification was given as acting in the patient's best interests.

Table 5.2 Summary of moral dilemmas, resolution and justification

NUMBER	MORAL DILEMMA	RESOLUTION	JUSTIFICATION
001	Possible Euthanasia/ Double Effect/Normative uncertainty	Legal advice	Law
002	Best interests/ Patient-centred economic constraints	Compromise according to finances	Golden rule/ professionalism
003	Patient's best interests/ patient-centred economic constraints/ dual loyalty/child rape	Deception of third-party payer	Principle of beneficence (best interest) / Golden Rule
004	Patient deceiving doctor/compromise of personal and professional values	Not complying with patient requests/ advice of peers	Law/ Professional values/Defensive medicine
005	Patient autonomy/legal requirements/defensive medicine/ normative uncertainty	Respect for patient autonomy/ Patient information/ Documentation	Principle of respect for autonomy/ Golden Rule/ Defensive medicine
007	Limited resources/ Patient's best interests	Speak with mentors	Principle of beneficence (best interest)
008	Limited resources/ Patient's best interests	Deception of colleagues	Golden Rule
010	Patient deception /compromise of personal and professional values	Counselling	Law and professional guidelines
011	Moral and ethical uncertainty/continuity of care in child abuse	Not able to resolve/ moral distress	Golden Rule
012	Limited resources/ patient's best interests	Pressure on specialist from doctor and patient	Principle of beneficence (best interest)/ Professional guidelines/ scope of practice
014	Limited resources/ patient centred economic	Deception of third-party payers	Patient first/ Principle of beneficence (patient's

	constraints/patient expectations		best interest)/ defensive medicine
016	Limited resources/ patient confidentiality/ professional obligation	Breach confidentiality to inform the patient as required. Do the best you can	Duty as a doctor to inform the patient. Right to self-determination
017	Duty as emergency room doctor/ personal conflict treating alleged hijacker	Complies with the law/ provides emergency treatment	Law
018	Patient-centred economic constraints/ clinical guidelines	Treats according to clinical guidelines to protect himself	Clinical guidelines/Defensive medicine
019	End-of-life decisions/ defensive medicine	Informs family- family decisions	Defensive medicine
020			
021	HIV testing/ patient's rights	Complied with mother's request	Patient's best interests/Principle of beneficence
022	Patient-centred economic constraints/ best interests	Compromise or deception of third-party payers	Patient's best interests/ Principle of beneficence
023	Child rape/ prevent further harm/ duty to report/ moral distress	Treated and reported	First, do no harm/ prevent further harm/duty as a professional
024	Teenage pregnancy/limited resources/ failure of system/ moral uncertainty	Act according to the advice of seniors	Duty to patient.

CHAPTER 6

THEMATIC CONTENT ANALYSIS

As described in Chapter 4, section 4.3.4, following the analysis according to the research objectives, the data were further analysed according to thematic content analysis. The goal of this analysis was to use the identified themes to address the research by interpreting it and explaining it.

6.1 METHOD

The interviews were analysed both deductively and inductively according to thematic content. Inductively, where the data determined further themes and, deductively, where the data were analysed using the preconceived themes for decision-making as described in the Ethics Tetrad.

Initially, the data were analysed according to the research objectives, that is, the types of dilemmas, the decision-making process and justification. The analyses according to the research question, using the analytic tool, the Ethics Tetrad, are addressed in Chapter 7.

The data in each transcription were coded to describe their content. Key phrases were identified, highlighted, and ascribed different codes. These codes described ideas, feelings or opinions that were expressed in the text. Table 6.1 demonstrates how codes were assigned to Participant 001. The same process was used for each interview.

After the interviews were coded, all the data identified by the codes were collated into groups. This facilitated a concise overview of the important points and common understandings that were recurrent throughout the data. Patterns were identified and themes were created by combining different codes into categories and finally themed.

For example, the following codes were categorised as constraints:

- insufficient time
- lack of space/privacy
- economic constraints
- medical aid limits
- limited doctors available
- limited available nursing staff

This category was finally determined as the sub-theme of Economic and Resource Constraints, under Theme 1- Sources of Moral and Ethical Dilemmas. Throughout the data, this process of identifying, categorising, and creating themes was revised several times before the themes were finalised.

The themes were then defined to produce clarity. The list of codes, categories, sub-themes and the themes emanating from these can be found in Table 6.2.
The themes are discussed in Section 6.2.

Table 6.1 Coding for Participant 001

PHRASE	**CODES**
Meeting with family	Involving family in decision-making
Intention	Intention
Poor prognosis	Influencing factor
Prevent family from seeing a traumatic scene	Protect family/Influencing factor
Trust	Doctor-patient relationship
It occurred to me this may be euthanasia	Uncertainty
Discord in the family	Influencing factor
One sibling was troublesome	Influencing factor
Sought attorney advice	Legal uncertainty/Decision-making tool
Fear	Consequences
Heard nothing	Consequences
Cultural factors	Influencing factors
Indian family-collective decision-making	Influencing factor
Worried about breaking the law	Uncertainty/ Influencing factor
I have had situations like this in the past and have never had people query my intentions	Paternalism
Thin ethical lines	Uncertainty
One does not want to be seen to be hastening somebody's death	Consequences/ Reputation
Court of law; might have practised euthanasia-against the law in South Africa	Legal implications
I had a very deprived form of education when it came to bioethics	Training

PHRASE	CODES
Good intentions/wanted to make the mother comfortable	Best Interest
I learned from experience/ medical training	Experience
Refer to HPCSA guidelines when in trouble/get complaints	HPCSA guidelines
Didn't sleep well until attorney reassured	Consequences

6.2 THEMES

Table 6.2 Summary of Codes, Categories, Subthemes and Themes Identified in Thematic Content Analysis

CODE	CATEGORY	SUB-THEME	THEME
Rape; child abuse; poverty; teenage pregnancy; hijacker	Social Factors	Social Dystopia (Societal Violence)	1. SOURCE OF MORAL AND ETHICAL DILEMMA
Insufficient time; limited space; lack of privacy; medical aid limits; limited health care/resources/ staff/doctors/nurses; access to reproductive health	Constraints	Social Injustice- economic constraints and limited resources	1. SOURCE OF MORAL AND ETHICAL DILEMMA
Legal uncertainty; ethical uncertainty; ignorance of professional guidelines	Uncertainty/ conflict of personal/professional values and the law	Normative uncertainty	1. SOURCE OF MORAL AND ETHICAL DILEMMA
The best outcome for the patient; the best interest of the patient; prognosis; the best interest of the doctor; documentation; over investigation; legal consequences	Intention of the decision-maker	Intentions	2. THE INTENTIONS BEHIND THE MORAL AND ETHICAL DECISIONS

CODE	CATEGORY	SUB-THEME	THEME
Family; culture; poverty; child abuse; personal experience; peer experience; law; personal values; empathy; ethics; ethics of care; training; conscience; intuition; prognoses; mentorship; patient expectations; context; case; Golden Rule; legal uncertainty; ethical uncertainty; defensive medicine; economics; emotion	External considerations to the decision-making	Influencing factors/considerations in decision-making	3. INFLUENCING FACTORS IN MORAL AND ETHICAL DECISION-MAKING
Lawyer; clinical guidelines; law; professional ethical guidelines (HPCSA); personal values; conscience; intuition; personal experience; medical experience; peer experience; do no harm; context; case; seniors; peers	Decision-making tools	Decision-making tools /Ethics Tetrad	4. NORMATIVE AND NON-NORMATIVE SOURCES FOR MORAL AND ETHICAL DECISION-MAKING
Anger; frustration; unsettling; guilt; insomnia; anxiety; constraints; uncertainty; did not do enough; overwhelming	Stress/ Distress	Moral Distress	5. MORAL DISTRESS- A CONSEQUENCE OF MORAL AND ETHICAL DECISION-MAKING

6.2.1 Theme 1. The sources for moral and ethical dilemmas

The sources for moral and ethical dilemmas have been defined as "the root cause in the clinical situation for moral or ethical consternation".

In this research, the sources for dilemmas or conflicts in contemporary everyday medical practice in South Africa seem to originate in conditions of social injustice (inequality; poverty; patient-centred economic constraints; limited resources; health service delivery; access to reproductive health care); social dystopia (rape; child abuse; teenage pregnancy, poverty); or normative uncertainty (uncertainty regarding the law or ethics, or the application thereof).

The individual dilemmas were extensively analysed and discussed in Chapter 5. This section will discuss the sub-themes that contribute to the main theme. Quotations are provided to validate the themes uncovered. While every effort was made to avoid repetition, some of these quotations may be duplicates of those used in Chapter 5.

a) Social dystopia

Although it is not necessary to define a sub-theme, for the sake of clarity, this one of social dystopia may be defined as "those social ills that cause physical and psychological harm to a patient, not a direct cause of disease or pathology".

Violence, mainly sexual in nature was a recurring theme in many of the interviews. Several of the dilemmas described the sexual assault of young girls (see Participants 003, 005, 008, 023 and 024 in Chapter 5) and this caused distress for those doctors reporting the dilemma. The reasons for this distress seemed to be firstly, the vulnerability of the young girls and secondly, that the doctors involved were unsure of the correct ethical or legal way to approach the situation. The participants also had a perception of powerlessness on their part. Those interviewees who had encountered these dilemmas seemed to take the incidents personally, were empathic, attempted to advocate for and wanted to protect their patients. A caveat in this sub-theme is that the participants that reported these dilemmas were all female doctors. It is not known if male doctors would have felt the same distress or responded in the same way, since no male doctor in this data collection reported this type of abuse as a quandary.

This type of dilemma is significant for several reasons:

- Young women and girls are particularly vulnerable to rape (Rape Crisis Cape Town Trust; Women's Legal Centre, 2013). Moreover, healthcare is extremely important for

survivors of sexual violence. Other than a rape survivor's potential exposure to HIV, there are also physical and psychological traumas she may experience. Further, many young girls may not be aware of the risk of pregnancy consequent to rape and may therefore not seek assistance in this regard, until it is too late.

- In 2005, it was reported that some healthcare professionals working in public hospitals did not consider rape to be a serious medical condition (Christofides, Jewkes, Webster, Penn-Kekana, & Abrahams et al, 2005). However, in my research, the participants took the report of rape very seriously. This may have been because most of the cases reported were those of child rape.
- Few healthcare professionals have received training in the holistic management of rape survivors, let alone child rape survivors (Rape Crisis, 2013). This lack of training may be the cause for the dilemma - while a medical doctor may want to act in the best interests of the patient, reduce harm, achieve the best outcome and comply with legal requirements, this may not be possible where the doctor lacks training and is unsure of the correct process.

Child abuse, other than that of a sexual nature, also came up in an interview as a factor causing dilemmas. Again, it seemed that not knowing the correct way to manage the suspected child abuse, medically (other than immediate treatment), ethically or legally was the cause of the dilemma. Further, it was suspected by Participant 011 that patients "doctor - shop" to avoid detection. She felt that a database of suspected cases could help to monitor suspicious cases.

> "And my problem sometimes is that these patients don't get followed up. Say, for instance, you've got a situation where this child is being abused, what you'll find is that the parents would go from pillar to post."
>
> "They won't just come to this medical centre for treatment. They might come if there is an acute trauma happening now, and then tomorrow, they'll go to the next doctor and the next doctor."
>
> "… because we don't have a database where you can go and see, okay, this patient has followed up on this day, and then two months later, you know, there's a cracked humerus or whatever. So a lot of that we miss in society, I think, because patients tend to doctor-shop, and like you said, you miss out on an opportunity to actually pick up what really is going on."

Participant 023 also expressed uncertainty:

> "Sometimes I find doctors that I worked with, that they are not keen to report because it's an allegation, it's a child. Until it's tested in the courts of law and somebody proves it right or wrong, it may very well be questionable, or an allegation rather than a fact, or a transgression that has been committed."

Another angle to the theme of social dysfunction was in the case of Participant 017, who did not want to treat a perpetrator of a crime, in her case, a hijacker, but was ethically and legally obliged to provide emergency care at the least:

> "You have issues against hijackers because you don't know when you will be hijacked."

This highlights the reality that it is not only victims or survivors of crime, but also criminals who have the right to access emergency care and other health care services. The fact of an alleged criminal having the same rights as a non-criminal appeared to be an issue.
Poverty overlaps with social injustice in this theme, as it poses a real threat to social cohesion and development, and increasing violence and crime is attributed to poverty (Govender, 2016). Participant 023 indicated this in her interview:

> "We have got a very violent society."
>
> "And I needed to ensure the law knows because this woman was protecting the boyfriend. She did not report the case. When the sisters spoke to her after we took the child away, we spoke to her and she said no, I cannot report him. For one, he gives us a roof over our head, he buys food for us, he does everything, pays electricity-this woman was not working- and she realised if she reported him then all that surety, all those comforts are gone, she's back on the streets with her child."

However, some participants seemed oblivious to the social realities of patients until these were brought to their attention (See Interview Participant 008):

> "and the mother asked me …when is it going to done because she needs to go home. And I told her you have no other issues at the moment, you really just need to be here for the child and she said no because someone at home had perpetrated this act and she had left the rest of the children at home…so she was now, we keep her there to be with her child but on the other hand there are children at home who are potentially staying with a rapist…" (Participant 008).

b) Social (In)justice, economic constraints, and limited resources

Social justice refers to the fair and equitable distribution of resources in communities or countries. In South Africa, there is enormous inequality and unemployment, and resources are not equally shared, hence the term social injustice.

South Africa has a long history of inequality; economic disparity and unemployment (Govender, 2016). These conditions are consequent to the racially divisive laws and socio-economic exclusion that pervaded the apartheid-era. The consequences of these conditions persist in democratic South Africa, with South Africa described as one of the world's most unequal societies (Govender, 2016). Further, healthcare in South Africa operates on a two-tier system where the wealthy or those who can afford to, have access to "better" private healthcare. There was a sense of frustration that the state had failed in supplying consistent access to healthcare:

> "As I'm sure you are aware, in Obs and Gynae in this province we have massive delays with regards to getting TOP's and to getting the morning after pills and the rest of it…and more than that the sisters just refuse" (Participant 024)
>
> "how do we deal with teenage pregnancy and then also how are we really dealing with women's like… access to reproductive health. Because there's a law about it you know, everybody should get a TOP if you want it and you should be able to get contraceptives and all the rest of it. But in practice that's not happening because our nurses often will turn patients away, or they'll say you know, I'm not performing this procedure." (Participant 024).

Participant 016 expressed frustration at the overcrowded conditions in state facilities, that afforded no privacy. Participant 022 described the reluctance that patients have in complying with a referral to a state hospital. Participant 003 was hesitant to refer a patient to a state hospital because she did not feel that the patient would be treated with dignity.

The economically disadvantaged and unemployed majority of South Africans are forced to seek state-funded medical care, which often entails over-serviced hospitals and clinics, long queues and limited resources. Those who do seek private care, because they cannot wait for public healthcare, are disadvantaged further by what they can afford to pay for, and this in turn may compromise the care they are given.

Accessing state or private healthcare also presents other problems. For example, a poor or indigent patient often cannot afford or does not have the transport money to get to the hospital for follow-up visits. (This example was presented in the dilemma provided by Participant 018). Other patients may have to take time off work to attend the state hospital, which most cannot afford as they may not be paid for that day. Sometimes, it's a choice between feeding a family or using that money for a hospital visit. As a result, this leads to problems of compliance with or defaulting on medical treatment, which in turn presents further problems should the original condition complicate or deteriorate. The result is a bigger economic health burden as costlier healthcare is needed. Participant 023 elaborated on this reality as well:

> "Because like one patient we needed her, she was struggling with bus-fare, transport money, following up at Kalafong. And we thought if she could see a psychologist and be followed up by a social worker at a local clinic maybe she can take all her treatment at the local clinic and relieve herself of the financial burden of having to come to [Kalafong]."
>
> "…based on the situation of the patient, it may be transportation and all that you know, people come from different places and the more frequent coming is difficult for the patient. Cost and all that things." (Participant 018).

Commonly the participants were constrained in the treatment of their patient by either financial constraints or limited resources. Financial constraints presented frequently and were seen as either the result of medical aid limits or of patients being unable to afford the medical care or medication required to treat their condition:

> "We've had a lot of patients who do require further investigations, but things like their medical aids don't really allow them to have that. And also because of that, there's financial constraints also kind of prevent you to give them the best care. But then also patients, if they have medical aid and they want certain things done, and they can't be done, they also refuse to go to the public sector to have that done. So it kind of feels that you want to do the best for your patient, but you are between the patient and system and it doesn't mean they allow you to do that". ("Doesn't allow you to do what needs to be done. The patient's right to choose their care versus what is allowed by the medical aid/own finances." - this was added at a follow-up edit by the participant). (Participant 022).

Caution should be taken in this interpretation. Patients have a right to the treatment available; they do not have the right to expect the extra-ordinary. The law also prescribes that the right

to healthcare is determined by progressive realisation, that is, according to available resources or as the resources become available (South African Constitution,1996, section 27(2)). The right to access health care is a derogable right, meaning it is subject to limitations as defined in section 36 of the Constitution.

Limited resources presented throughout most interviews. These were defined as either being forced to triage patients for investigations or there being not enough staff, time or space to enable the medical doctor to do what they ought to do ethically.

It is generally assumed that doctors enter the profession for altruistic reasons. They want to make a difference in society from a caring perspective and want to help others. However, healthcare comes at a cost, is not unlimited and should be shared fairly. For several participants, the recognition of a patient's need, and then being unable to act according to that need, created conflict and compromised the patient's care or compromised the personal and professional values of the doctor. For the doctor faced with a needy patient, it is difficult to disengage from the immediate clinical situation, calculate financial constraints and limited resources, and then treat accordingly. It is also very distressing when one cannot provide the care one should because of these constraints and other influencing factors such as patient's expectations or empathy:

> "If I had resources, what I would have liked to have done is kept her in hospital for probably a few more days." (Participant 024).

c) Normative uncertainty

Uncertainty, moral, ethical, or legal, created a dilemma for several participants. This theme is defined as "a sense or intuition that moral, ethical or legal action is required in the clinical encounter, but one is not sure of the 'what, how and why'". For this study, drawing on Wurzbach (2015) who comprehensively describes normative uncertainty, normative uncertainty is further defined as an inability to act ethically, morally, or legally, as a result of insufficient factual knowledge; contextual uniqueness; confusion about basic principles, values, guidelines and the law; or uncertainty about the application of principles to a specific situation.

Wurzbach (2015) argues that uncertainty may occur in moral or ethical quandaries because for many of these quandaries, there may be no definite or indisputable answers. This research defined moral, ethical, and legal uncertainty as occurring in those situations where the doctor

was unsure of how they "ought" to proceed because there is no irrefutable answer. This doubt or hesitancy may be the result of a lack of certainty about basic principles, values and law; uncertainty about how to apply principles or the law; the uniqueness of the clinical context and other variables; or the quandary being one that had not been encountered before (therefore there was no precedent or previous experience to model the judgement on).

Where one was uncertain of the right action, one either acted in what was perceived as the "best interest of the patient", or in the case of legal uncertainty, 'covered oneself' to prevent legal repercussions (See Participants 021, 019, 017, 014, 004, 005 in Chapter 5).

A reason for normative uncertainty, especially in the older participants, may be a lack of, or inadequate ethics training. Some participants revealed that they had not received any ethics training as medical students, and that what they did know was the result of CPD requirements for which they had completed online courses. This would also explain uncertainty in the application of ethical principles. Besides, the content of these courses did not deal with the dilemmas experienced in everyday clinical practice.

Younger participants claimed that ethics lectures were boring or were those one could "bunk" (give a miss) or spend doing other course work. The content was not stimulating enough or not memorable or the lack of interest had to do with presentation:

> "I noticed the bioethics and medical ethics – that you go to, but you sort of goof off and you're like, you're there …and you're listening with one ear and then you sort of, ja okay, let me do reading for the next- you're really not there…" (Participant 024)

> "Because it's boring. And I think it's mostly presentation- I don't think the content is boring but I think the presentation is boring." (Participant 024).

> "Um, I think there was like, yeah, that bioethics, that book we had, um, I think just like the internals, the principles of like, for the greater good of people and justice and all that because they are those like principles. They definitely did teach that to us. Yeah." (Participant 021).

> "Yes, I think there was one or two days, which I did not even understand at the time. I think they were, there was an ethics lecture. And I didn't know what it was all about and it didn't hold any meaning to me." (Participant 017).

A further reason for normative uncertainty may be because not enough emphasis is placed on the importance of guidelines and the law, in training or practice:

> "So, you see we have very good laws. We've got a very good constitution, child rights, human rights, everything. Our Health Care Act, our HPCSA, SAMA. Everything is laid down so well. We've got one of the best constitutions in the world, I would like to think. But if there is no-one there to enforce it what good are they?" (Participant 023)
>
> "To be honest with you…the HPCSA is a total waste of time. They are not interested. When you phone them, they tell you, you must do what you think is right." (Participant 019).

Participant 001 reported that he only consulted the HPCSA guidelines when a complaint had been made by a patient. He did not refer to them for guidance in ethical decision-making. This uncertainty also resulted in psychological distress- here loosely termed moral distress. This will be discussed under the theme of moral distress.

Another participant was not even aware of the HPCSA guidelines:

> "Not in terms of HPCSA guidelines. I've never even thought…I never knew they had guidelines." (Participant 004).

An equal vagueness about the guidelines was expressed by Participant 011, who hummed in response to the question of HPCSA, implying an awareness but no use for them.

There also appeared to be some disdain for ethics teaching, as managed healthcare seemed to override professional autonomy. Participant 014 on teaching ethics and patients 'unethical expectations' of doctors:

> "There's no need, there is really no need [to teach ethics]. I think it's just a waste of our time. I don't know, if there was something like, okay, health ethics, as you say, medical ethics, and if there is a medical ethics for the public as well, maybe it'll help."

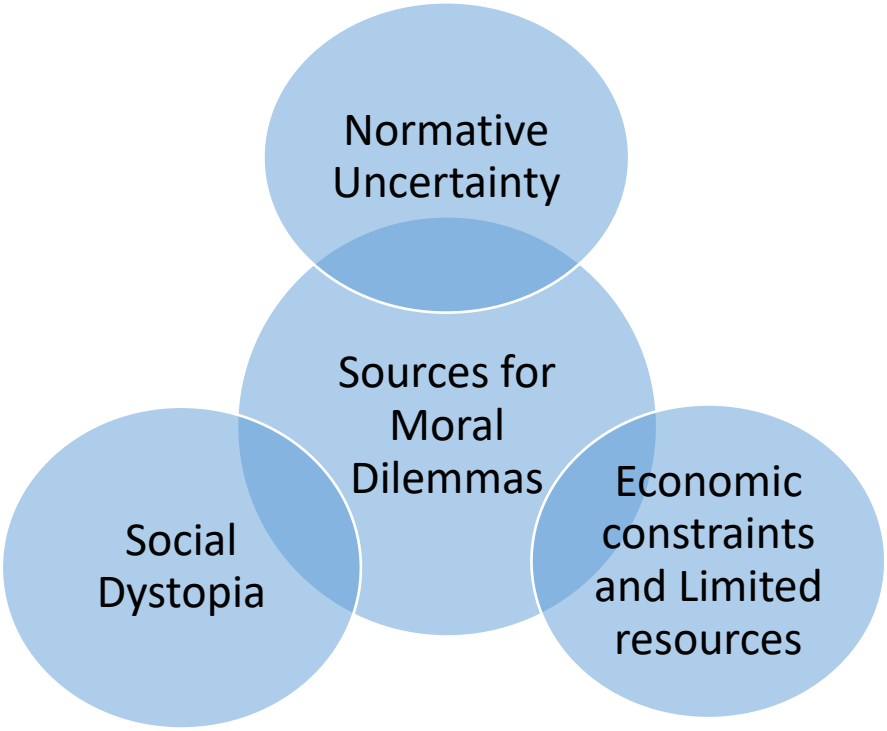
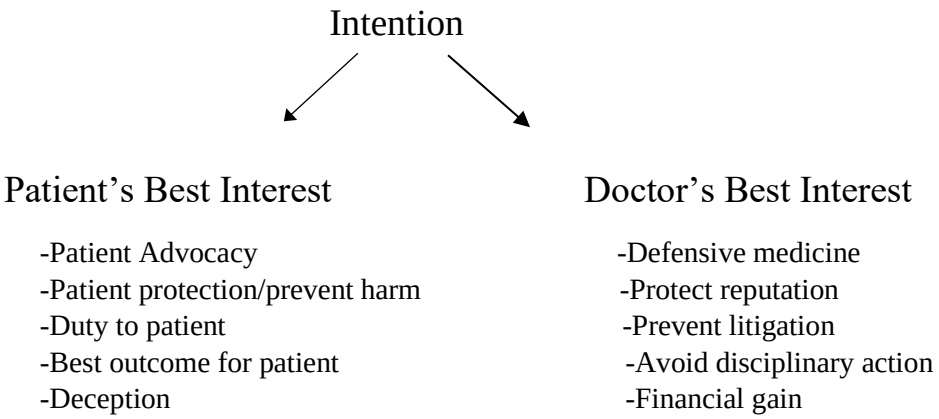


Figure 6.1 The Sources for Moral Dilemmas

6.2.2 Theme 2. Intentions in moral and ethical decision-making

For this research, an intention is defined as "the act or instance of determining an action. It is the end the agent wants to achieve". Central to moral and ethical decision-making in the clinical context is the doctor's intention behind the decision - what they hope to achieve and what motivates them. The intentions identified in this analysis are motivated either by what is seen as best for the patient or what is best for the doctor making the decision.



6.2.2.1 Acting in the patient's best interest

Acting in the patient's best interest is defined as instances where the doctor was doing what he perceived would provide the best outcome for the patient. The decision was made with the patient foremost in mind.

Although Participant 001 may have been doing what was best for the patient according to international guidelines, his statement of intent raises questions about whose best interest he had in mind:

> "So, my intention was to try and avoid the family from seeing their loved one dying a so-called gruesome death."

However, he later states that he intended to make the patient comfortable in the last stages of life and not to implement euthanasia:

> "So, I had to explain to her that was not the intention, the intention was to make their mother comfortable in the last few hours or days."

Participant 016 invoked duty as a doctor:

> "Based on my duty as a doctor to keep the patient informed. It was to the patient's benefit."

Sometimes acting in the best interest of more than one patient can get confused and contradictory, or there may be a dual loyalty:

> "So, in the best interest of the mom and why she wanted it, but not for the children."

Participant 022:

> "You want to do the best for your patient."

Participant 023:

> "first and foremost is what is in the best interest of the child."

Participant 003: Protecting the patient or preventing further harm

> "So, in terms of that, just to keep her safe, to keep her protected."

Participant 012 offers an explanation reflecting his perception of acting in the best interest of a patient to prevent harm:

> "The basis of my decision-making is you want the best outcome for your patient. Well, you want the best outcome that we are medically capable of doing. So if we don't act efficiently for that outcome, we are causing harm purely because of our own negligence. In my opinion, it constitutes negligence."

Sometimes an action can have a dual effect, that is, the decision made may be in the best interest of the patient, for example, preventing further harm. Equally, the same decision may be perceived as serving the best interest of the doctor, ensuring compliance with the law and professional requirement, but not serving the patient's need. Participant 004 described a case of a cancer patient who was also a drug addict that came into Casualty wanting a Pethidine prescription. Because this doctor did not want to enable the patient's addiction, and also following the advice of a senior and in compliance with professional and legal requirements, she denied the patient the Pethidine. However, she also felt sorry for the patient and admitted that another time, without peer advice, she probably would have given the prescription to the patient.

6.2.2.2 Acting in the doctor's best interest

This is where the intended action is deliberated with the doctor foremost in mind, and where the outcome, while it may be to the patient's good, is ultimate to the greater benefit of the doctor.

Acting in the doctor's best interests presented itself in two ways. The first is where the doctor acts defensively from a legal or ethical perspective, either to prevent litigation or to avoid disciplinary action by the professional body. The second is where doctors act in a way that benefits them financially either by exploiting a third-party payer or by doing procedures that they are not morally comfortable with or are not necessary.

The first case, Participant 001, described an incident where the doctor retracted his original intention to enable a comfortable death and protect the patient's family from a traumatic ordeal; instead, he acted to protect himself from the law and a ruined reputation. However, once he had legal clarity he proceeded to act according to his original intention, that is, to act in the patient's and the patient's family's best interests.

> "one does not want to be seen as committing euthanasia." (Participant 001).

Participant 019, on the other hand, approaches ethical situations from a completely legal perspective and makes the decision the responsibility of the family:

> "How I make my decision, I gather all the information, get a second opinion, we three cardiologists at the hospital, so it's easy to get a second opinion from a second cardiologist, and then I approach the family and I tell them this is what I think, this is what the second opinion thinks, and I tell them what the options are from a medical point

of view. And if there are no options. I will tell them the maximum treatment. I document everything and the family has to make the decision."

Fear of litigation is highlighted by Participant 014:

"I would definitely do that because number one to cover myself…yes so we are in a situation as doctors now where we do things to cover ourselves. We're scared to be sued."

Participant 016:

"So, I mean it's always in the back of your head that this patient might come back with a potential lawsuit and how will I be able to rationalise why I made these decisions within the law."

Fear of litigation also emerges in an acknowledgement of practising defensive medicine.

"Ja, ja, because we're really practising defensive medicine today." (Participant 014).

Sometimes acting defensively in terms of the law may not always be in the best interests of the patient. Participant 018:

"Where there is a lot of litigation, defensive medicine, you are also likely to go for what is professionally right, but personally…you know it's not the best thing [for the patient]."

Actions may also be intended to protect both personal and professional integrity, promote legal compliance or to avoid disciplinary action by a professional body:

"It was personal and professional because I could get into trouble for being dishonest on…it's a legal document at the end of the day. The employer can investigate and then…And then they could report me to the HPCSA for fraudulent sick notes." (Participant 004 on issuing false sick certificates).

Medical ethics principles can also conflict with legal obligations. In the case of Participant 005, the doctor had a duty to respect the patient's right to confidentiality and autonomy (which are also legal rights in South Africa), but at the same time was worried about the legal implications of not following the legal requirements for managing a case of rape:

"A year from now she could decide she wants to press charges…It will come back to me as the doctor who saw her."

The participants generally recognised that documentation is very important in protecting themselves:

Participant 005 asked the patient to sign a document that she refused to report her rape incident and the required physical examination:

> "…you also need to sign a disclaimer of sorts that you refused. One for me to report it to the authority, two that you refuse to report it and three also for refusing a physical examination, because medico-legally that's a big thing."

Participant 024 elaborated:

> "But as practitioners, you know everything has to documented because in two- or three-days' time, the patient can turn up and ask for their files and they're going to sue the hospital. So it, ja, the medico-legal stuff -I didn't think I would encounter it this early in my career but it has become a very real part of it. You see the patient; you have to document everything."

Participant 019 also stressed the importance of documentation, especially in end-of-life decisions.

A tangential aspect of acting in the doctor's best interest is that of the doctor's financial benefit. Two participants expressed discontent at third party-payer reimbursements or not being able to charge patients what they thought they deserved:

> "A person who does not have funds, who is having a weave on, nails manicured and done, if it's not really life-saving essential treatment, I would stand firm on payment and I would refuse to give service." (Participant 017).

Sometimes a bill may be "padded" to earn what the doctor expects:

> "Yes, because what medical aid pays the doctors is really shocking. Some consultation fees are really shocking. You get a consultation of like 273, and you've given this patient more or less the same treatment as the one you got almost what you charged for. Normally the rates will go like from 400 to 450, excluding medication in the suburbs but in the townships, you have to include medication…so in that case, then, that's when you end up being unethical, you end up adding like I gave this person a Rocephin, I've given this patient this just to get up to your consultation fee." (Participant 014).

This may also extend to approving procedures that a doctor may normally object to, for example, termination of pregnancy. The following participant objects to TOP's, but is changing her stance to earn more money:

> "In the economy that we're in now, I still believe that I don't want to do it, and unfortunately, for the sake of income, I have to do it, ja, because of the economy we are in now…" (Participant 014).

6.2.3 Theme 3. Influencing factors in moral and ethical decision-making

Further factors that played a role in decision-making in ethical and moral dilemmas were the influence, by manipulation or persuasion, of family and culture; the patient's economic circumstances; law (fear of litigation); emotion (empathy); conscience; intuition; ethics training; mentorship and patient expectations.

In circumstances where the patient was no longer competent, family members played a role in end-of-life decisions (as discussed under Participant 001 and 019 in Chapter 5). Equally, so did culture, in cases where the decision was collective rather than individual and consensus had to be reached.

Family also played a role in influencing a doctor to do more than was required, for example, where an investigation was a limited resource, but, because the family expected the doctor to be in a position to do something, doctors often felt forced to compromise their own values. Such an instance is provided by Participant 003, describing a situation in a state hospital:

> "Okay, so a big consideration is the patient and the family. Because you would sit there, you would know that okay, this is the situation, this is what the patient needs okay. The family is sitting and looking at you and they want to know what the answer is, and then you tell them, you know what this is the situation. However, you know our resources are limited but I will try and see what I can do. And they will beg, and they will cry…and you just do it [falsify an indication and urgency for an investigation]"

> "I know it's illegal, I know that I could get into trouble, I would probably be disciplined and…but you're looking at the person and you're thinking if this man doesn't get this CT this evening, he is going to be dead tomorrow. And then you face the family, and they will ask you 'Doctor how come you couldn't get the CT sorted out?' How do you tell someone 'Oh but there wasn't enough space for that person'?"

Patient expectations often exceeded what the doctor was able to provide, with the result that doctors felt they had to do more:

> "A lot of the time the ethics conflicts with what the patient desires from you …and I can actually tell you there are many doctors who have broken ethical laws so that the patient can be happy, you know." (Participant 003).

Participant 014 described patient expectations in the face of limited resources:

> "We face it every day, especially with the medical aids, people who aren't on medical aids, who cannot afford private treatment. And they will come and ask you to claim under their maybe, sister's or cousin's name." (Participant 014).
>
> "There's that expectation, you know, and they will like emotionally blackmail you as well, and you will end up doing it." (Participant 014).

The patient's economic circumstances also play a role in influencing decisions. Where the patient has medical aid limits or cannot afford the care that the doctor would determine to be in that patient's best interest, the doctor either has to decide to compromise and settle for a lesser treatment or undertreat the patient, or resorts to "gaming the system", where deception is used to achieve an end:

> "I will speak to the surgeon and see if we can't do that through the hospital plan." (Participant 022).

Conscience and emotion have a role to play in influencing decisions as well:

> "…but I think it was sort of just my conscience and how I felt because I understood from her, she was just looking out for the well-being and the benefit of the children." (Participant 021).

Context influences ethical and moral decision-making and may even instigate a breach in ethics:

> "Well, I definitely know it's this doctor-patient confidentiality, and I know there's consent when you are testing children for medical procedures and surgical procedures and that's probably what you need to follow." (Participant 21).

6.2.4 Theme 4. Normative and non-normative sources for moral and ethical decision-making

This research sought to answer the question about the normative sources medical doctors may use when deciding medical and ethical quandaries in the medical workplace. To this end, the Ethics Tetrad was used to allocate the justification in each dilemma to one of four sources of authority: canon, tradition, reason and experience, the first two being normative and the second two, non-normative.

i) Normative sources

While the participants held an idea of legal and ethical principles, it was vague. There was no definite or irrefutable justification citing the law or ethical principles. The participants in this research vaguely justified their decisions according to the law or a traditional ethical value such as the Golden Rule. Justifications were made on vague assumptions of the law and ethical principles.

Although a few participants might refer to professional guidelines or the law, generally, there was no or "low" awareness of the HPCSA guidelines and the role they have to play in medical practice in South Africa:

> "I think it's always best to follow guidelines" (Participant 021). However, context can change the goal of following guidelines as Participant 021 explained when she deviated from the guidelines:
>
> "So in that sense, it always guidelines, and there are always guidelines, but there, in that, I don't want to say that it's like emotion but I understood where she was coming from"
>
> "It will be guided by our, the rules of the HPCSA, for example, some, for example, are the affiliations that I belong to and sometimes by experience from other people." (Participant 023).

When Participant 022 (a doctor in private practice) was asked about professional guidelines, there appeared to be confusion around "professional guidelines". She referred to the "Batho Pele Principles" in relation to patients' rights and also recited the four ethical principles but did not refer to HPCSA guidelines. She also did not seem to have a procedure for ethical decision-making using these sources. This gave the perception of knowing what the guidelines were, but not understanding their purpose:

> "Mm because I know with patients, you need to take into consideration patients' rights. The Batho Pele principles. And then I mean, I always remember the four ethical

principles. So it's autonomy, non-maleficence, beneficence and what's the fourth one, resources. And then just try and figure out between them…where."

The *Batho Pele* principles are eight principles introduced by the public service, so doctors in the public sector are expected to apply them. They do not apply to private practice. The principles are not law but are consistent with the Constitution and the National Health Act. Non-compliance with these principles by doctors in the public sector may result in a breach of a patient's constitutional rights and a contravention of the National Health Act (McQuoid-Mason & Dada, 2011). This could lead to a disciplinary inquiry in terms of the Health Professions Act, 1974 (Act 56 of 1974) and may also result in legal action.

There was also confusion between clinical guidelines and ethical guidelines as was demonstrated by Participant 21.

The ethical principle of beneficence as a normative source and experience as a non-normative source were cited again by Participant 023, and then she refers to the law:

"First and foremost is the best interest of the child and then from experience…and then I will sound out some of the things to find out we are still legally within the law"

"So, ja, I sort of use every angle but for me, the first and the main thing for me is this patient in front of me - what is in the best interest of this patient, for me? Then the law, then the experience, then my nursing, then maybe my moral values will come into play"

"So, for me, it's the rules and regulations. People don't always live by them or apply them…everything looks good on paper but not in practice. What good is it then?"

Referring to familiarity with HPCSA guidelines:

"And to be honest, I am not even familiar with all of the HPCSA guidelines." (Participant 024).

Referring to the HPCSA guidelines was deemed to be cumbersome:

"Because you've got to go to the website and you've got to go and look for them and download the PDF." (Participant 024).

Sometimes the law was considered ambiguous:

"So, like for consenting, every time I see a child that's under the age of 18, even if they have a natural delivery, I always call the mom and like, please come and sign consent in

> case I have to do an emergency C-section… But at the same time, technically they are able to consent themselves with TOP so...It doesn't make sense so as I say, it's almost like I need a refresher in law and ethics now I'm practising…"

The law was frequently cited as a reason for acting in a certain way and I perceived that some participants found it easier to hide behind the law and legal requirements rather than go through a process of deliberative ethical decision-making. This may also be consequent to "stress of conscience" or moral distress, where it is easier to cite the law than to make ethical and moral decisions that lead to anguish as a result of being unable to respond to the dictates of one's personal conscience.

Further, the relationship between medical ethics and medical law is perceived to be filled with tensions between what is "ethical" and what is "legal" in the management of patients and the clinical context. This is especially true when the threat of litigation hovers over every decision. Every action has intentions and consequences, and, more often than not in modern medical practice, those consequences may have legal implications.

What seemed to be unclear to the doctors interviewed in this research, is that, whether practising in the public or private sphere, the HPCSA guidelines are there to provide healthcare professionals with ethical guidance. In addition, this guidance is compliant with South African law.

ii) Non-normative sources

Other than the normative sources, the non-normative sources of reason and experience were referred to as sources for justification in decision-making. An example of medical reasoning:

> "So I think I kind of start with what is my likely diagnosis and why I would like the patient to have further testing…However the patient's medical aid does not cover the [tests], and the patient cannot pay for it themselves and they are not willing to go to the state…then I have a discussion with the patient on what the risks are …and what my constraints as a practitioner are because I can't initiate treatment if I don't have the proper diagnosis. So then we kind of reason, okay, what would it be financially?" (Participant 022).

Peer experience is an important tool in moral and ethical decision-making:

> "I think in most of the times if I have an ethical dilemma as well and I'm not really sure how to handle it, I do ask my peers."
> "I feel like a lot of the times, two heads are better than one, maybe there's something that they consider that I haven't. And if it's someone with a lot of experience, I do ask them, but then it also depends on how the doctors actually treat their patients as well." (Participant 022).

Sometimes the medical management and the ethical management appear muddled - this may be because to manage a patient well medically is also thought to be ethical.
Conscience, emotion and empathy are powerful decision-making tools, as was demonstrated with Participants 003, 005, 011, 012, 021 and 024.

Normative and non-normative sources over and above the thematic content analysis were analysed using the Ethics Tetrad. This is discussed at length in Chapter 7 in response to the research question.

6.2.5 Theme 5. Moral distress- A consequence of moral and ethical decision-making

A theme common to the interviews was that of 'moral distress'. Moral distress is understood broadly as 'anguish or anxiety tied to a sense of imperilled moral integrity' (Carse & Rushton, 2017). Wendy Austin (2012) describes moral distress as a term used by healthcare professionals to express "experiences of frustration and failure in fulfilling their duties and obligations inherent to their fiduciary relationship" with their patients, their patients' families and the public. Moral distress is also known in the literature as "stress of conscience" (Genuis & Lipp, 2013). Genuis and Lipp (2013) describe the experience as occurring when medical doctors are unable to respond adequately to the needs and challenges presented by patients and as the result of a failure to fulfil what one's conscience demands or expects of one. A full examination and critique of moral distress are not within the scope of this research; however, since it was identified as a theme, it is discussed briefly.

In the following analysis and discussion, I review moral distress according to the literature, provide an analysis of the data and discuss the findings in conclusion.

The thematic content analysis identified four constraints that contribute to moral distress, namely, moral and ethical uncertainty; economic constraints and limited resources; legal concerns; and social issues.

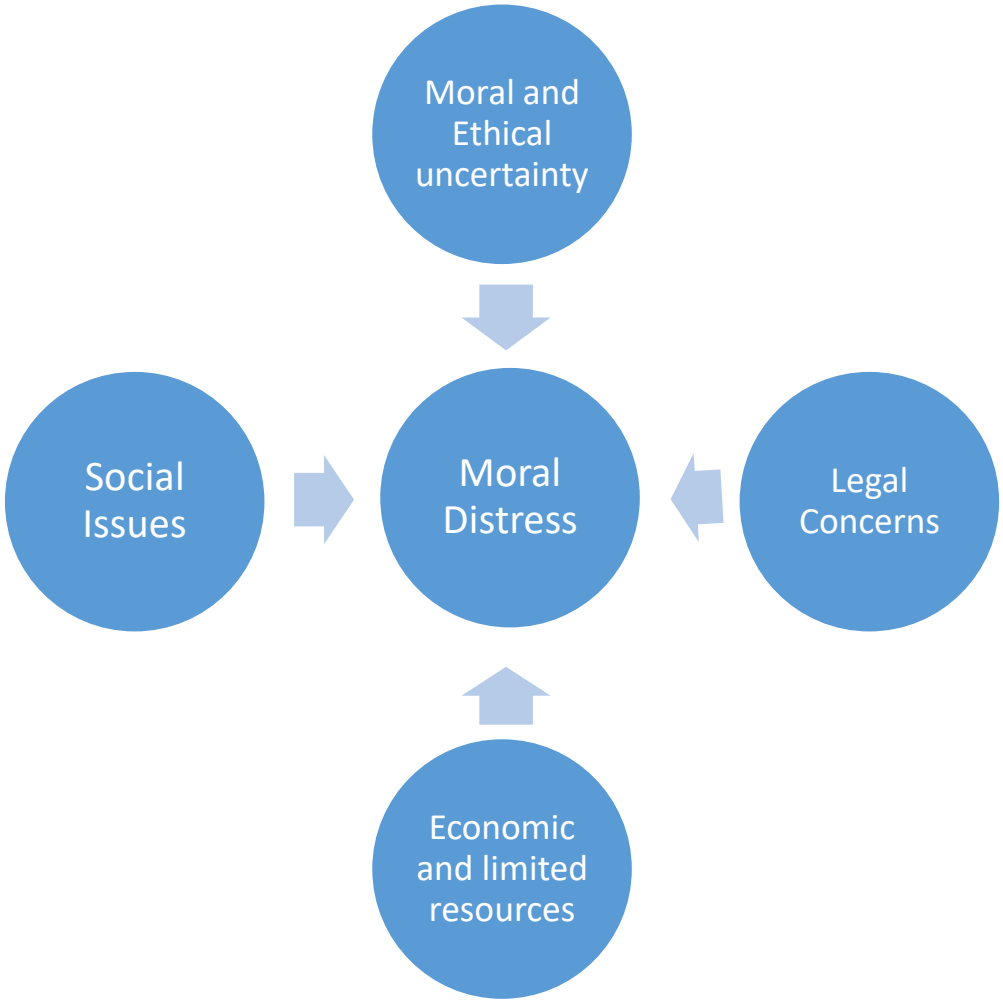


Figure 6.2 Constraints causing Moral Distress

To reiterate, moral distress is traditionally defined as: "[arising] when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton, 1984, p.6). For Jameton, moral distress is a constraint of moral agency, where agency as the ability to think, act and be accountable for actions taken, can be hindered by conflicting values (McCarthy & Monteverde, 2018). Moral distress happens 'in the moment'.

In response to this moral 'inability', the individual feels morally compromised or tainted, and in association with the perceived corruption of the individual's moral integrity and violation of their core values, moral distress occurs (Campbell, Ulrich, & Grady, 2016).
This response may manifest as feelings of frustration, anxiety, self-doubt, helplessness, hurt, anger, shame and guilt (McCarthy & Monteverde, 2018; Campbell et al., 2016). Self-doubt, in

turn, may lead to a lack of confidence in the decisions one makes in the future. There may also be experiences of demoralisation and sleep disturbances.

Most of the participants had great difficulty describing a moral dilemma and instead described morally challenging situations in which they felt frustrated at being unable to act as they thought was morally or ethically appropriate. The distress was expressed using language that described the frustration, anger or despair consequent to the constraints that prevented the doctor's desired agency.

i) Frustration

> "I think the most I have experienced in practice is the frustration in trying to do the best for your patient, but you are unable to do it because there's a whole lot of other factors that come in." (Participant 002).
>
> "And the worst part is you start to get frustrated because of the system because you're then battling your own ethics, but you have to keep the patient informed." (Participant 016).
>
> "My husband often says when I want to offload or just want to de-stress or talk to him, he says 'please no'…because sometimes at the end of the day I just want to de-stress and just tell him about my frustrations or tell him about what I have experienced." (Participant 023).

ii) Sleep Disturbances

> "I truly lost sleep over it." (Participant 005).
>
> "Always, I get sleepless nights sometimes." (Participant 011).

iii) Demoralisation

> "Well so basically you have a situation you think can be solved but because of the lack of resources, you are going to have a morbidity or a mortality. And that is ...very demoralising" (Participant 007)
>
> "I try most days to act appropriately, but I get stressed and overwhelmed and it leads to me getting anxious and that reflects on how I manage stressful situations." (Participant 011).

iv) Anger

> "And you know it makes you so angry because you are not equipped…" (Participant 008).

v) Helplessness and inadequacy

> "So, there are many dilemmas that it's …sometimes it's so overwhelming." (Participant 023).
>
> "So, for me the dilemma was okay, this is a child who now has a child, whose mom was clearly not supportive…and for me the thought that came to mind was okay, this is still a child, technically she's 13, she's still a child- how do I discharge two children home to the care of a mom who couldn't take care of her own child?" (Participant 024).

There are, however, cases of distress that arise from other morally challenging situations, not limited to the constraints mentioned, that result in moral distress. I argue that the criterion of moral certainty is questionable. Crucially, for me, although distress is a psychological and emotional response to the inability to act according to one's moral certainty, it assumes a universal moral knowledge and does not consider that for the person experiencing the distress, the moral knowledge, and values on which their moral judgement is based, may be particularist or may not be irrefutable. I argue that the consequence of moral uncertainty also causes moral distress or stress of conscience. This is because conscience is dictating that an action ought to be performed, but uncertainty does not allow the perceived right action. Further, I argue for the term normative certainty incorporating the legal aspect of moral decision-making, because the law, of late, is playing a larger role in moral and ethical decision-making, which in turn contributes to dilemmas, in that doctors are conscious of the potential for litigation.

In assuming moral certainty, the traditional definition fails to take in the lived experience of the decision-maker and other influencing factors in decision-making. "Life as a moral agent is often complex, and it is often difficult or impossible to know the morally right course of action" (Campbell et al., 2016 p.3). There are often variables, other than normative theories, professional guidelines or ethical principles, that influence moral and ethical decision-making in clinical practice. The criteria specified by Jameton (1984) fail to take into account the following: the distinctive reality of the clinical work and experience of the medical doctors as primary decision-makers in the healthcare team; the consequences of those decisions; or the

ramifications those decisions have for the doctor. Admittedly, Jameton did first describe moral distress amongst nurses unable to act against "unethical" or "morally unsound" doctor's orders, but this denies that doctors, in making a decision or giving those orders, also suffer a stress of conscience or moral distress.

The medical doctor's experience of distress may be consequent to moral conflict, moral dilemma or moral uncertainty and not only constrained action. Doctors as professionals act not only according to their professional standards and codes (professional morality), but as individuals may also be influenced by their conscience or personal standards and virtues (compassion, empathy), and not be free to act according to these values (personal morality). The consequence of continued moral distress is moral fatigue; but this has not been adequately researched, especially in medical practitioners (Genuis & Lipp, 2013). The increased burden of ethical dilemmas and the challenge of making decisions, may lead to avoidance of such encounters, referral of decisions to ethicists (Genuis& Lipp, 2013), or deferring to the law rather than ethical guidelines.

Medical doctors do err ethically; but I contend that this can be related to the following considerations. The practitioner as decision-maker, as the one 'shouldering the burden of the decision', often suffers moral distress as a result of this responsibility. This is not only because they may be constrained ethically, but there may also be a normative uncertainty that contributes to a "normative hangover" for that decision-maker, who feels consumed with guilt, remorse, regret and second-guessing.

Jameton's definition also assumes that the one making a moral judgement has all the relevant facts of the case, thereby enabling a well-founded moral judgement. By this assumption, the constraint or impediment may be that they are inadequately informed; or are uncertain of the applicable principles and values; or a conflict of these values with the law; or uncertainty about how to apply the moral and ethical principles, values, and law; or the effect the potential consequences have on them as decision-makers. As a result, moral judgement can be errant. Consideration has to be given to influencing factors as described in section 6.2.3.

Further, there may be situations where one cannot make a moral or ethical judgement because one is not certain that the situation itself is morally undesirable or requires remedial action. The agent may feel or intuit that there is something wrong morally or ethically with a situation but be unable to identify what is actually wrong, and as a result, is constrained from

acting accordingly. This intuition may result in a “moral unease”, with negative psychological and emotional responses as well.

Finally, moral decision-making is a complex process, that involves more than following and acting according to moral and ethical principles, norms or theory. It should also be considerate of the context; the evolution of said principles, norms or theory; emotion; and consequences. The application of principles and theory in real life is difficult because real-life dilemmas include doubts, uncertainties, inconsistencies, conflicts of conscience and emotion.

6.3 Conclusion

The thematic content analysis identified five important themes in moral and ethical decision-making in the clinical context. To begin with, three sub-themes were identified under the first theme of sources for moral dilemmas. These sub-themes of social dystopia, social injustice and normative uncertainty are realities for the medical doctor in the real world. They do not enable “easy” or “rote” moral and ethical judgements, as they reflect the society in which one has to make the decisions and are in themselves very distressing.

One cannot make a moral or ethical judgement without first identifying what one hopes to achieve with that judgement. This theme identified that doctors in this research acted either in the patients’ best interests or in their own best interests. When they acted in the patient’s best interests, it was usually where they wanted the best outcome, they were able to provide for the patient or what they would have liked for themselves in the same situation.

When acting in their own best interests, it was mostly to “cover” themselves in the case of litigation (defensive medicine). Exceptions based on financial considerations were provided by some participants who felt that they were not compensated adequately by the third party-payers or by the patients themselves.

The third theme of influencing factors in moral and ethical decision-making emphasises that moral and ethical judgements cannot be made in isolation. Every clinical situation and judgement is contextual, each with its variables, and these contribute to the burden of moral distress in the lived experience of the medical doctor.

The fourth theme gave a general overview of the normative and non-normative justifications for the judgements made. This theme provided an idea that either the law, the Golden Rule or

the principle of beneficence, or a combination of these, was used to justify the decision made. The justification was vague and appeared uninformed. Experience was also used as justification for a decision, and in this research, the experience was either personal experience in medicine or privately, a peer's experience or medical experience.

Finally, the fifth theme of moral distress revealed that the doctors in this study did not find it easy to resolve moral dilemmas satisfactorily and that as a consequence, there was some "moral fallout". Factors that contributed to this were normative uncertainty, overwhelming social circumstances and concerns about legal repercussions.

CHAPTER 7

THE NORMATIVE SOURCES USED BY MEDICAL DOCTORS AS JUSTIFICATION FOR THEIR DECISIONS IN MORAL AND ETHICAL DILEMMAS IN THE CLINICAL CONTEXT

7.1 Introduction

The overall research question for this thesis was, how do medical doctors act, and what normative sources do they use as justification for their actions when faced with moral and ethical dilemmas in the clinical context?

As argued previously, medical ethical and moral decisions are not made unconsciously, without deliberation, or in a vacuum. They are guided by or grounded in some means, rational or non-rational. The question is, what are those means, and how much is rational and how much non-rational?

To facilitate the analyses of the multi-layered responses from participants, I used the ethical tool, the Ethics Tetrad, which I had developed in Phase I of this research. The Ethics Tetrad is shown in Illustration 4, page 124.

Each interview was read through and the relevant responses were assigned to the appropriate authority. To strengthen the validity and credibility of each assignation, the participant's response is quoted, or the reader is referred to Chapter 5.

The Ethics Tetrad uses Canon as the first or dominant normative authority to be referred to in the resolution of moral and ethical dilemmas in the clinical context. Further, it is the authority to be used when justifying the decision made. Tradition is also a normative authority but encompasses the values to be found in medical, philosophical, personal morality and cultural and/or religious traditions. Reason is not a normative source but is rather a rational process that directs decision-making. It lays the foundation for normative deliberation and provides the necessary information, before referring to Canon to justify the choice made. Experience is a non-rational source for decision-making. This source encompasses the many factors that influence moral and ethical decision-making. These influences may be from past life experiences, personal and medical; medical training; intuitions; acts of conscience; emotion or even peer experience. They should be recognised as influencing factors and the ultimate

decision should always be referred to Canon for justification. (The Ethics Tetrad used for the analysis is found as Figure 4, page 138).

7.2 Analysis According to the Ethics Tetrad

7.2.1 Participant 001

i) Canon

In the case described, the law was consulted and was the authority that finally provided resolution and justification for the decision made. The justification was that the medical method to be used was interventional and was not hastening the death of the patient. It was not, however, the *prima auctoritas* referred to for guidance in this dilemma. The physician did not refer to ethics or professional guidelines, codes or principles.

He unconsciously followed professional ethics guidelines regarding family inclusion when the patient is incapable of self-decision, that is, that close family must be consulted and a decision taken in what are considered to be the patient's best interests (HPCSA Booklet 7, section 2.4 and 2.5). While he was not aware of the guidelines, in this case, this conduct must have been absorbed or appropriated somewhere in his medical experience, or it may have been intuitive.

ii) Tradition

Traditional normative medical or religious decision-making did not apply in the deliberation process, although it could be argued that this doctor was acting to prevent harm to both the patient and her family.

Influencing factors in his decision were the tradition and culture of the family. He described his dilemma as being:

> "…coloured there by cultural factors, because Indian families tend to be very involved in the decision-making of the death of elders because it is uncommon for Indian families to geographically be separate from their elders. In other words, very few of them live in old age homes and live away etcetera. It is more like a communal setup where, if there are three or four or five siblings, a lot of them partake of in the care of the elderly; you know, sort of intimate fashion as opposed to other communities. So I think this also led to the situation that arose…"

The patient's family was community-centred and made decisions collectively. The consensus among the family was necessary before the doctor could proceed with his decision.

iii) Reason

Medical and scientific reason played a major role in the decision-making process. The patient was in multi-organ failure, on a ventilator and had a poor prognosis. She was also experiencing respiratory discomfort. The doctor intended to ameliorate suffering for the patient and her family.

Once alerted to the potential for breaking the law, the doctor reasoned the implications and consequences, not only for himself but also for the family, that is, concerning insurance pay-outs and bequests to the siblings if there was no consensus on his management.

He had not considered that his medical intervention might be construed as euthanasia. In this case, scientific reasoning and medical experience played a major role. The doctor was aware that the patient was terminal, he intended to appease air hunger, and his action was guided by medical science.

iv) Experience

The physician, in this case, had many years of medical experience and experience with similar cases. Previous experience with such cases made him aware that family watching a family member die a "gruesome" death suffered psychological trauma, and he wanted to spare the family from witnessing their mother suffering. He had, however, never been questioned on medical management or considered his actions as active euthanasia before. He cited experience with family members, in situations like this, as the reason for his choice of management.

This participant had no ethics or bioethics training at university. He had attended a few courses offered by the Medical Protection Society on bioethics and informed consent and the care of the terminally ill patient but did not appear to be able to apply the theory. He referred to the "rule book" only where there was transgression in practice:

> "It is only in those instances we go and open up the rule book and usually in those instances it is more out of a great degree of surprise because, because of my involvement in teaching students etcetera, one feels one is doing the right thing all the time. So when

one is accused of, for want of a better word, “malpractice”, one gets surprised, and one anxiously consults the rule books then, not otherwise.”

v) Justification

This participant uses the law to justify medical moral and ethical decisions. He is legally compliant and practises defensive medicine.

vi) Comments

Canon, as the normative authority was not this participant’s primary source of reference in his decision-making. He acted, in what he perceived was his patient’s best interest, using mainly medical and scientific reasoning and his medical experience. When his actions were questioned, he sought legal opinion. He intended to alleviate suffering, but his decision-making was driven by medical science and experience. Although he acted ethically, in involving the family in the end-of-life decision, ultimately, he had already decided on the action to be taken.

7.2.2 Participant 002

i) Canon

Although this doctor did not cite law or guidelines specifically, he refers to professional requirements and is aware of legal and ethical obligations and duties, for example, when referring to notifying HIV positive patients:

‘…the law does make provision for that in the sense that it is very common in the HIV scene…’

‘It’s our duty as health practitioners to be able to notify the patient…’

Referring to the law and professional guidelines regarding the termination of pregnancy:

‘Whereas even if you as a healthcare provider are not prepared to assist a patient, you should at least refer the patient to someone who can help them, you know.’

He also cited the concept of medical professionalism as a normative guide in ethical behaviour. Also, he made decisions that he perceived as being in the patient’s best interests. When asked if he complied with unrealistic patient demands, for example, for an unnecessary prescription, despite the possibility of the patient going to another practice for the prescription, he maintained his integrity:

'…you really can't stop the patient from doing that [going elsewhere] …I don't think it's the right thing to do [giving the unnecessary prescription]. And it's not in the patient's best interest anyway.'

ii) Tradition

This participant is not influenced by religion or culture and does not impose his personal values on his patients:

"One of the things I try my very best to do is when I am interacting with patients, I don't let my own beliefs, even if they're religious beliefs or moral values, interfere with the judgement I make."

He does, however, refer to philosophical tradition in the Golden Rule or the rule of reciprocity. Although this rule is cited in various religions, for example in the New Testament of the Christian Bible, it has its origins in ancient Persian culture.

iii) Reason

This participant uses practical reason and context in his approach to each dilemma, for example in the dilemma of financial constraints, he works within what the patient can afford:

"So, in other words, you'll treat the patient in terms of what the medical schemes, for example, will be able to pay, or what the patient can afford."

Although this is his approach, he takes it with difficulty:

"With the result that, you know, it's problematic. You have to come to some sort of compromise."

iv) Experience

The doctor does have previous ethics training and experience. His previous medical experience also plays a role in his decision-making.

v) Justification

The patient's best interests.

vi) Comments

This participant justifies his actions as in his patients' best interest and applies the Golden Rule. He is ethically trained and is very aware of legal, ethical and professional requirements.

Influencing factors such as context and economics play a role in his decisions. Previous medical experience also influences his judgements.

7.2.3 Participant 003

i) Canon

Canon is not the primary authority to be referred to. The participant uses reason to determine her action. She is aware of ethical principles and knows the difference between ethical and unethical actions. However, she does not refer back to these and does not seem to apply them.

> "Look, in a clinical setting you obviously do use a little bit more of your ethics you know as well. I mean I'm sure you know the four laws but like you said, it's not always so easy."
>
> "So if you're faced with something and you will think okay, firstly ethically what is the right thing to do? And a lot of the time the ethics conflicts with what the patient actually desires from you. And I can actually tell you I'm, there's many doctors who have not, who have broken ethical laws so that the patient can be happy you know."

ii) Tradition

The Golden Rule is cited as the reason for and justification for her actions.
She has the virtues of compassion and empathy which guide her actions.

iii) Reason

This participant uses case-based reasoning and contextual influences in her decision-making, for example, patients are treated differently based on economic factors.

iv) Experience

Her medical intuition and practical medical experience play a role in her action. Emotions (empathy) influence her dealing with quandaries and so do patient expectations.

v) Justification

She follows tradition by citing the Golden Rule.

vi) Comments

Although this doctor purports to be aware of ethics principles and some legal requirements, she is guided by the Golden Rule and her desire to do what she perceives as being in the best

interest of her patient. As far as ethics and law are concerned, she is capable of third-party deception and lying to assist her patients:

> "I mean I had to lie a lot of the time on forms to seniors to be able to get a patient to do a test."
>
> "It's very difficult because you know what they deserve, you know what they need, and you have to do it."

7.2.4 Participant 004

i) Canon

The law is referred to in two ways by this doctor.

First she uses the law to defend her actions, so she acts within the law to avoid litigation. Secondly, the law is used to guide her actions, to ensure that she is acting according to the law. She is aware of the disciplinary function of the HPCSA and knows that certain actions can result in disciplinary action. She is not aware that the HPCSA has guidelines.

Currently, this participant is completing a Masters in Public Health and has had a refresher course in ethics, but its course content is not South African. She does not refer to any other canonical source.

In the interview, she confirmed that she acted legally rather than ethically, although she does try to balance the two.

> "I try to stay within the law as much as possible."

There is, however, some confusion regarding the law:

> "But we don't really follow the DNR and the living will and all of those orders." When asked why, she responded:
>
> "Because it's not really legal in South Africa yet, and it's hard to say without having a lawyer or solicitor there."

In another case, she refers to her duty as a doctor:

> "It was my duty as a Casualty doctor to try and reverse everything that I can possibly reverse, and not just terminate without knowing anything about the patient."

ii) Tradition

She cites the preservation of her personal and professional integrity which she refuses to compromise:

> "It was personal and professional because I could get into trouble for being dishonest."
> "So, it reflects me as a professional and my morals."

iii) Reason

This participant invokes medical and scientific reasoning to guide most actions. She gave examples of cases she had encountered in the emergency room where she had to decide on the appropriate action. In response to the question of whether medical guidelines come before ethical and moral guidelines, she confirmed that medical guidelines were given priority.

Case-based reasoning also plays a role:

> "So, if it's a chronically ill person and there's not much you can do, then you're not as active as with someone that you know you can still save."

iv) Experience

She consults experienced peers when she is in doubt or uncertain:

> "…but then I consulted my senior on-call and well took guidance given from them."

Emotion also plays a role. Describing a case where a terminal nine-year-old girl was brought into the emergency room by her parents, and she was advised not to resuscitate by a surgeon:

> "…and when the child came in with like, and had to be resussed, so I told her that I'm sorry but I can't do that. I'm going to do the whole process and only terminate when I feel that I haven't [have?] done everything I could."

v) Comments

This participant acts according to and within the law, although she displays some legal uncertainty. She is unaware of South African professional guidelines. She refers to her *duty* as a doctor.

7.2.5 Participant 005

i) Canon

In the dilemma described by this participant, she cited respect for patient confidentiality and autonomy. She also reasoned that she had to cover herself from a medico-legal perspective, in

case the patient decided to report the assault at a later stage. Documentation was extremely important. She was aware of the legal requirements post-rape but was uncertain of the process. She was aware of what she had to do for the patient and what she had to do to protect herself.

Later in the interview, in another example she spoke about patient autonomy:

> "It's their choice"
>
> "That battle between a choice of being Pro-Choice to…I actually end up going into patient autonomy, ethical guidelines."

She puts the patient first:

> "Get the patient the help they need."

ii) Tradition

She cites the traditional ethical principle of non-maleficence:

> "First, do no harm."

The Golden Rule is also referred to:

> "Let me look at it from her point of view. Let me try and be in her shoes, maybe her mindset in terms of what she wants from us, not what I want from her as the doctor."

iii) Reason

This participant reasoned her way through the dilemma from both a moral and legal perspective. She was also considerate of medico-legal consequences. The reasons for the patient behaviour were also considered and respected.

iv) Experience

This participant had no previous experience with this type of dilemma to rely on. She was alone on that day, so was unable to consult with peers or seniors. Intuition played a role in directing her actions and she did what she thought was right. From a conscience perspective, she was troubled in that she thought she could have done more.

v) Justification

She cited ethical and legal grounds.

vi) Comments

The doctor was uncertain and unprepared for this dilemma. She was aware that it was a medico-legal issue. Ethically, she respected her patient's autonomy and confidentiality. Although she reasoned her way through the dilemma, ultimately, she justified her actions on legal and ethical grounds.

7.2.6 Participant 007

i) Canon

The participant is new to South Africa and as such is unfamiliar with the South African medical law and ethics guidelines. He is aware of universal principles such as 'the patient always comes first'. In the resolution of his dilemma, however, he was aware that even though he objected to a procedure on religious grounds, he still had to ensure that the patient received the treatment needed. This complies with South African law and professional guidelines.

> "We speak to another intern who is ready to do it, and we got somebody else what was prepared to do it."
>
> "Okay, so inasmuch as I would not want to do a TOP, I also feel that if a person needs a TOP it must be done."
>
> "Because I don't want to do it, it's my responsibility to make sure there is somebody else."

He stressed that the patient always comes first.

ii) Tradition

He displayed some compassion in his decision-making. He does refer to the Golden Rule:

> "Well so basically you have a situation that you think can be solved, but because of lack of resources, you are going to have a morbidity or mortality. And that's very demoralizing. So, you can imagine that's somebody's mom or that is somebody's breadwinner on the line."

iii) Reason

Reason did not seem to play a role: he follows procedure, although where unsure, he consults with seniors.

iv) Experience

He consults with seniors when in doubt. He learns from his mentors and this knowledge enables decision-making:

Conscience also plays a role:

> "So, it is a multiple factor, so one, the conscience."

v) Justification

His actions are justified on the principle that the patient comes first, thus invoking Canon. Experience is also invoked in the citing of conscience.

vi) Comments

Although this participant's religion and personal morality may conflict with his duty to perform certain procedures, he does recognise that the patient always comes first and should be managed accordingly. To compensate for his unwillingness to perform certain procedures, he always ensures that there is someone prepared to do the procedure for the patient. If there was no one available, he would do the procedure himself. Conscience is also at play here because he would not allow the patient to go untreated.

7.2.7 Participant 008

i) Canon

Generally, this participant did not seem to have much regard for the law or patient rights. When talking about the management of teenage pregnancies, she stated:

> "If you discuss it with the parents, the child might get beaten. So many times, if they came in, in the early stages of pregnancy, we would just terminate without them knowing."
>
> "We didn't even do informed consent because also, in some of the languages, it's, there is a lot of, there is no words for some of the things we did…You know, but they don't understand that we are now going to terminate…"

In the primary dilemma she described, she failed to consider her patient's rights or vulnerabilities in prioritising her treatment. There was no reference to the law, professional guidelines or ethical principles.

ii) Tradition

Ultimately, when she was made aware of the social reality of this patient and her family, she based her decision on the Golden Rule:

> "If I was in this position, what would I want someone to do for me?"

iii) Reason

Deception was used to help the patient. Context is also an influencing factor. Once she was made aware of social realities in the implications and consequences of delaying treatment, she acted immediately.

iv) Experience

She does refer to medical experience when making decisions as well as conscience.

v) Justification

As justification for the resolution of the primary dilemma, she cited the Golden Rule and conscience.

vi) Comments

Overall, this participant, while not unaware of the law, had an evident disregard for the law and for professional guidelines, as these were not mentioned at all. Medical management of the patient rather than ethical consideration for the 'right' way to treat patients seemed to be her priority:

> "I think, whatever is legal is good, but at some point, you have to say…"

When talking about medical indications and context, she implied that there are factors more important than the law which have to be considered.

7.2.8 Participant 010

i) Canon

This interviewee cited patient autonomy, the law, the best interest of the patient and her specialist professional guidelines as instrumental in guiding her in moral and ethical dilemmas.

> "I'm very respectful of what the patient would want of me, and I try to accommodate the patient. There are certain rules in terms of how we are dictated by the medical law society and that has to be respected."

When asked which took precedence, the best interest of the patient or the law:

"It's more often the best interest of the patient."

ii) Tradition

Tradition is not referred to.

iii) Reason

She uses medical reason to resolve issues and includes the patient in the decision-making:

"I'm very straightforward. I tell them this is what I think and this is how I'm unable to help because when I do sit with patients, I always ask them what is their expectations of me. I start off like that, and if they list certain things that's not in keeping with what I think is correct, I would verbalise it to them."

"Then I give them options. I either tell them the private sector and what costs are involved because there's always cost implications."

She also reasons that an action outside of the law or professional guidelines can be appropriate as long as no harm is done:

"Just so long that it's not going to harm anybody."

iv) Experience

This doctor also bases decisions and actions on experience:

"There are some of my colleagues that would continuously give them leave, and I just think that would be detrimental to the patient's well-being."

"It's all about communication, and somehow, that isn't being done in this day and age or maybe this is just what I am experiencing lately in my profession".

"I think a combination of both [intuition, law and guidelines] and more often than not, my gut is always correct."

"If I am in doubt, I would consult with a colleague."

v) Comments

Participant 010 uses a multi-layered method to resolve ethical issues. This may be because she is very conscious of litigation, which apparently is not unusual in her speciality.

Rules have to be respected or "you get sued".

"So, that also has to be abided by, and that's always at the back of my mind, you know"

"…and we update our knowledge on litigations on a regular basis."

7.2.9 Participant 011

i) Canon

This interviewee, when describing her dilemma and resolution, did not refer to the law, professional guidelines or ethical principles.

ii) Tradition

No reference was made to any traditional normative or philosophical theory, although the participant does display the traditional virtues of compassion and empathy.

iii) Reason

She considers the implications and consequences of her possible decisions and actions. She does not follow up on issues that have caused consternation.

iv) Experience

Medical intuition enables this participant to identify a possible dilemma, but does not facilitate resolution. She expresses emotion and conscience as an influencing factor in decision-making in ethical quandaries.

v) Justification

This participant appears unable to resolve ethical quandaries and seems to pass her concerns onto other healthcare professionals in the team, such as social workers or psychologists.

vi) Comments

This doctor seemed unable to make decisions or resolve ethical quandaries. A concern here is that she is suffering from moral fatigue and consequently avoids situations that require her to make moral or ethical decisions.

It also emerged that this doctor is not familiar with the law or HPCSA guidelines. As a result, she is unable to justify her decisions, and therefore avoids making definitive decisions.

7.2.10 Participant 012

i) Canon

The best outcome for the patient is cited as the reason for this doctor's actions. This would fall under the principle of beneficence and the principle of the patient first, both to be found in professional guidelines. He also noted that not doing the best for a patient causes harm. This

participant was also very conscious of the law regarding acting outside of his scope of practice:

> "The basis of my decision-making is you want the best outcome for the patient"
>
> "If we don't act efficiently for that outcome, we are causing harm."

ii) Tradition

No tradition is referred to.

iii) Reason

Medical and scientific reasoning was used to deliberate the medical indications and the implications of not treating. He also used reason to try to treat until the necessary treatment became available. Legal reasoning was used to determine the implications of acting outside his scope of practice.

> "The toe certainly didn't look very good, and I felt it was beyond my scope to treat this toe."
>
> "I think I acted, I believe correctly, ethically, which was not necessarily the best interest of the patient, for the best treatment possible for the patient was more treatment than I could offer that could be done. But I couldn't go beyond what I was capable of doing. He needed more than I was capable of doing."

iv) Experience

The medical doctor, in this case, had many years of experience medically and was able to determine that his patient had presented with a condition he was unable to treat. He treated as much as possible anyway, but it troubled his conscience and caused some moral distress. Intuition made him aware that the condition required urgent specialist treatment:

> " .. he went home with the treatment I gave him and it caused me some distress because I was not comfortable with the situation."

v) Justification

Despite the patient requiring more treatment than the participant was able to provide, he provided the medical care that he could and kept trying to get specialist attention. He based his decisions on the law and guidelines in that he could not treat outside his scope, but still had to get the patient the treatment he needed.

vi) Comments

The participant put his patient first, but being unable to treat the patient adequately himself, as well as not being able to get a specialist referral, caused him distress.

7.2.11 Participant 014

i) Canon

This participant cited the need to act according to the law, but not where the law guided ethical action, rather where over-investigation or other actions were intended to prevent litigation:

> "So, we are in a situation as doctors now where we do things to cover ourselves. We're scared to be sued."

ii) Tradition

Although the patient cited that she put the patient first (the principle of beneficence under Canon), she also offered that she acts the way she does because of her oath, what she was taught in medical school, and a personal morality:

> "Because of the ethics, because of what was told in medical school, because of the oath I took in medical school."
>
> "…the way you were brought up, your personality as well plays a role. I was brought up to be …religious background."

iii) Reason

The participant uses reason to determine the legal consequences of not acting defensively. She also uses reason to decide whether to overcharge or not charge a patient. Some actions are determined by personal economic outcomes. Although she does not believe in performing terminations of pregnancy, she is prepared to do them for economic reasons:

> "So, in that case then, that's where you end up being unethical. You end up adding, like I gave this person a Rocephin, I've given this patient this, just to get to your consultation fee, ja."
>
> "In the economy that we're in now, I still believe that I don't want to do it, and unfortunately, for the sake of income, I have to do it, ja, because of the economy we are in now."
>
> "I think the economy of our country, it also plays a role on how we treat patients. For example, as I said to you, like the other medical aids will pay you less and others will pay you almost what you charge. So, you end up doing unethical things."

She is very aware of ethical conflict personally:

> "The conscience is talking to you, that you know, you're doing the wrong thing, but then you want the money. So, you do it anyway."

iv) Experience

The interviewee cited conscience and empathy throughout the interview, as influencing factors in her decision-making. She includes her experience with third-party payers:

> "It's the conscience, more empathy, and I think another thing that drives us like now as doctors to do such things is the way medical aids treat healthcare professionals".
>
> "There is, however, times where I did it when you see that the patient is really, really desperate, and you feel sorry".

v) Justification

Although this participant justifies her decisions on the "the patient comes first" principle and cites "covering herself" to avoid litigation, it seemed that her decisions were made mainly in her own best interest, that is, in personal economic gain and the avoidance of legal repercussions.

vi) Comments

This participant did not cite principles, professional guidelines or specific laws. It appeared that for her the practice of medicine was transactional and her decisions were based on personal financial gain.

7.2.12 Participant 016

i) Canon

Although this doctor is well aware of the principles of patient autonomy, confidentiality and the right to medical information, she resolves her issue by violating these principles in the perceived best interest of the patient. She feels she has a duty to patients to keep them informed.

ii) Tradition

No traditional authority is referred to although the participant does respect patient's religious and cultural values. She does cite personal morality:

"So as long as I do stick to my ethical principles, I think they guide me more than the law does."

iii) Reason

This participant reasons medically and legally in deciding on an action. Context also plays a major role:

"I think every circumstance is different."

She is also very aware of the importance of note-keeping as a defence against litigation.

"So, I mean it's always in the back of your head that this patient might come back with a potential lawsuit. And will I be able to rationalise why I made these decisions within the law?"

Context also determines how well she applies ethics in her actions. Private practice enables more ethics application than does the public sector:

Researcher: How is it different for you in private practice?

Interviewee: So you now have a good foundation where you can practise ethics. So you have a lot more time with your patients…[in the public sector] we're so infused with getting through patients. Getting through illnesses that we don't see the patient as a whole."

iv) Experience

Medical ethics training influences how she makes her decisions, although she does find there is a difference between theory and practice:

"So, practical versus theoretical are two different things…so our practical basis is not there. But our theoretical basis is really well informed."

"…But if it's never really enforced in the practical sector, then how will we know when it's necessary and when it isn't."

Researcher: So basically you are guided by your duty to the patient?

Interviewee: Yes.

v) Justification

Moral and ethical decisions in clinical quandaries are justified by this doctor's duty to the patient.

vi) Comments

This participant appeared very aware ethically, although she did not offer reference to any specific professional guidelines or the law. Her first source of authority seemed to be Canon, as she cited important ethical principles specifically, such as confidentiality, patients' right to know, duty as a doctor, and patient's interests.

She is guided by personal morality. Finally, she reasons her decisions, factoring in legal and moral implications and consequences.

7.2.13 Participant 017

i) Canon

This participant complies with legal prescriptions before any other authority. She makes her decisions according to the law, even if it conflicts with her autonomy. She professes to make her decisions based on ethical principles, personal values and the law.

> "The law says you can't refuse a patient emergency treatment."
>
> "I would never refuse to give emergency treatment to anyone. That's now the ethical standards I adhere to as an emergency medical practitioner."

Although she is aware of ethical guidelines, rules and regulations, she places a higher value on her own ethics and morality:

> "Also in the emergency situation, probably it's just technical that it's about the law, I'm prepared to go to the High Court to challenge any law."

ii) Tradition

This participant is religious, and this may affect certain decisions and actions:

> "I decided that as a born-again Christian, I choose not to terminate."
>
> "I had taken a personal decision that I would not terminate any pregnancy again."

No other authority under tradition is referred to.

iii) Reason

Reason is used to consider various aspects of treating a patient particularly when it comes to the law or economics. She feels that the law and guidelines interfere with her autonomy to practise medicine as she would want:

"When I was still younger, I was scared, and I would be forced by the law and the facility guidelines and what the facility manager is forcing me to do. And I would go home unhappy and sad. I'm much older now."

Context, particularly the social circumstances of patients, influences her ability to make moral and ethical decisions in the clinical space.

iv) Experience

Life experience, as well as work experience, have given her the confidence to make decisions based on her moral and ethical values.

v) Justification

While this participant makes decisions in keeping with legal requirements, her personal morality takes precedence.

vi) Comments

The participant was aware of the legal requirements concerning emergency treatment or performing procedures that conflicted with her personal beliefs. Yet there still appeared to be a resentment that she had no autonomy and was expected to comply with professional and legal prescriptions:

"I would not allow anybody's law to violate my own ethical values."

"If it's violating my personal ethical space, sorry, I'll fight you."

7.1.14 Participant 018

i) Canon

The doctor in this case downplays professional guidelines in favour of the law, which he regards defensively:

"But I will choose what is in defence of the profession to avoid litigation."

ii) Tradition

In his own society, he follows the moral and ethical norms prescribed by that society. These are based on religious and cultural values. In South Africa, he has adapted to the society and is very aware of the potential for litigation.

iii) Reason

He reasons scientifically and medically, is aware of clinical guidelines, and prefers to stick to medical management, rather than ethical management, to avoid litigation. He knows that this approach is not in the best interest of the patient but protects himself.

> "Self-protection comes into play."

iv) Experience

Personal experience has taught him to practise defensively. He has had no previous ethics experience or teaching.

Second opinions are not sought from peers or seniors, because they prefer not to advise, also self-protecting, and may feel they could be perceived as complicit should there be litigation.

> "But for the senior ones, they might think okay, maybe you have issues, and then I will discuss. It might be perceived as giving advice. Also the senior is self-protecting myself [himself], they self-protect themselves, they don't want to listen to my problem."

v) Justification

No reference was made to any normative justification, source or authority. His actions are justified by the avoidance of litigation.

vi) Comments

In South Africa, because it is "more litigious", he is inclined to act in his own best interests rather than the patient's. In his homeland, as long as professional requirements do not contravene societal norms and values, he acts according to the societal norms and values. This participant also appeared to be suffering from a crisis of conscience because he was constrained from acting in what he perceived to be the most ethically correct manner.

7.2.15 Participant 019

i) Canon

The law was dominant in any ethical, moral or clinical decision this participant made. He was derisive of the HPCSA, finding them unhelpful.

He was also acting to prevent litigation.

ii) Tradition

No mention was made of any traditional source as an authority in decision-making. He did, however, remark on the different cultures in South Africa and how this complicates the decisions he makes.

iii) Reason

Medical and scientific reasoning leads this participant to the need for end-of-life decision-making. Once the futility of further treatment is established, he follows legal prescriptions.

iv) Experience

Medical experience plays a role in this participant's decision-making; this, while still causing conflict, is an established praxis. He relies on opinions from peers to strengthen his decisions before contacting the patient's family. Finally, he provides the family with a platform to make an informed decision.

v) Justification

This participant is very mindful of the law and legal requirements. He acts according to the law, even though this may also be to protect himself.

7.2 16 Participant 021

i) Canon

The participant was aware of some principles but did not refer to any normative source. She did, however, mention "best interest", although she ascribed this best interest to the mother of the patients and not to the patients themselves. Normative uncertainty presented itself:

> "So, it was kind of like I didn't know if it was right, ethically right for me to be doing blood tests like that without consenting…"

ii) Tradition

There was no reference to any medical, cultural or religious tradition.

iii) Reason

The participant displayed uncertainty ethically. She thought about it and reasoned that the mother's intentions were good. Context played a role in her reasoning:

> "Well, like I thought about it, and I thought the mom had a good intention. She was just worried about her child…her children, obviously."

iv) Experience

Although the participant has had ethics training, she was not able to apply the training to the situation. There was uncertainty. She also did not consult her peers for advice. She refers to emotion influencing her decision:

> "But there is a part of me that I don't want to say that it's like emotion, but like I understood where she was coming from, because she was just looking out for the well-being of her children."

She also refers to conscience:

> " …but I think it was sort of just my conscience and how I felt because I understood from her she was looking out for the well-being and benefit of her children."

v) Justification

The participant's actions were justified as being in the best interests of the children; but without their consent, can they really be seen that way? This participant was acting for the mother.

vi) Comments

Although the doctor advocates following ethical guidelines, in this case, she disregarded the guidelines and principles. She displayed a normative uncertainty and did not consult peers or guidelines to provide clarity. She admits she was influenced by emotion and conscience.

7.2.17 Participant 022

i) Canon

Normative guidelines are not referred to by this participant. She did show that she knows the four ethical principles as well as the Batho Pele principles, but in the interview, these did not play a role in her decision-making. She does try to do the best for her patient despite constraints.

ii) Tradition

No normative tradition is referred to.

iii) Reason

Medical and scientific reasoning and context play a role in her decision-making. She keeps her patients informed and tries to work within their range of affordability. She does change a

diagnosis to obtain an investigation, if necessary. She tries to work within ethical guidelines (none specifically cited) and medical guidelines.

iv) Experience

Experience appears to dominate as a non-rational source for ethical and moral decision-making. She speaks about a 'gut feeling' where something may not be right with a patient – in other words medical intuition - and thinks that may come with experience. Also, when she compares herself as a junior doctor to where she is now, she is more confident in her ability to make decisions. She is willing to consult with peers when unsure about matters.

v) Justification

Although no normative source is cited, this participant justifies her actions on medical science and the best interests of her patients.

vi) Comments

The doctor makes her decisions based mainly on medical and scientific reasoning. She uses clinical guidelines to facilitate most decisions. She does, however, want what is best for her patients and is willing to compromise her integrity to obtain this.

7.2.18 Participant 023

i) Canon

Ethical principles (beneficence and non-maleficence) and the law are normative sources used by this participant to resolve moral and ethical dilemmas experienced in medical practice:

> "First and foremost is the best interest of the child [patient]…Then the law."

Although the law was cited, there appeared to be medico-legal uncertainty.

ii) Tradition

The participant admits that personal moral values play a role. She is Christian by faith:

> "…then maybe my moral values will come into play because I'm a Christian by faith."

She also cited the Hippocratic Oath:

> "I think my Hippocratic Oath is first and foremost, to above all, do no harm."

The Golden Rule is also referred to.

iii) Reason

This doctor uses all-encompassing medical reasoning, which includes medical treatment and management. She is also very aware of the implications and consequences of actions and decisions.

iv) Experience

Her previous experience as a nursing sister and her current experience as a doctor play a role in her actions. She also relies on clinical intuition, peer experience and conscience.

v) Justification

Actions and decisions are based on the patient's best interest and legal prescriptions.

vi) Comments

Although the participant refers to the law, she seems uncertain regarding certain legal principles; for example, she was not aware that she was protected by *bona fides*. She is ethically aware, however. Clinical intuition; medical and personal experience; religion; and emotion are influencing factors in her moral and ethical decision-making. Ethical dilemmas are resolved by prioritising the patient, then consulting the law, followed by experience and then the desire to do good (based on religious values).

7.2.19 Participant 024

i) Canon

The participant does not refer to any normative source for moral and ethical decision-making. She is aware of certain legal documents required when reporting incidents, but normative sources do not seem to guide her ethical actions. She is aware of the requirements for informed consent, the law and the need for documentation and cause for litigation.

ii) Tradition

She refers to a personal morality:

> "So, I was raised in a Catholic household. And I say that because my parents had that as a very strong moral compass that they tried to instil in us…and we went to integrated schools – we never had religion lessons per se. It was more like ethics, so you like encountered all the world religions and did all the ethical stuff…you were forced to think and come out with your own understanding of ethics."
>
> "…but then also the modelling at home was very much a strong ethical you know, basis."

iii) Reason

Moral reasoning is used as well as a reasoning based on justice and fairness. Context plays a role in her decision-making.

iv) Experience

This participant cites age and previous work experience as enabling her to reason and make decisions. She is also reliant on senior and peer experience. She has had previous ethics training.

v) Justification

Moral and ethical decision-making is based on what is best for the patient.

vi) Comments

Participant 024 appeared to be more very socially aware especially regarding social injustices. She felt powerless to assist in situations that required more than medical care. She has had previous ethics training, although she does not appear able to apply this training. She is mindful of the potential for litigation.

7.3 General Discussion

This research set out to determine the sources medical doctors use to guide their decisions in ethical and moral quandaries in the clinical context. The Ethics Tetrad as illustrated in Diagram 4, page 124, was used to analyse the interviews.

The analysis of the data revealed that although there is some awareness of professional guidelines, it is minimal and rarely referred to. One interviewee was not aware of the guidelines at all.

While there is some knowledge of medical law, it is applied contextually and to protect oneself. In other words, the doctors used the law defensively to avoid litigation, even where the action may not have been to the benefit of the patient.

The most common justification given was “in the patient’s best interests’’.

Another common justification for the action taken was that of the traditional “Golden Rule”, where the doctor based their decision on the action taken on what action they would have liked for themselves or one of their family members, were they in the same situation.

Medical and scientific reason also played a dominant role in ethical and moral decision-making. While not a normative justification, reason overruled normative sources, because doctors chose to follow the science or the clinical guidelines, in order to avoid litigation or other legal repercussions.

Personal and peer experience was of value in making ethical and moral decisions. Personal experience was valued, where the doctor was able to use intuition or conscience in deliberation or reflection on the problem at hand.

Overall, there appeared to be an ignorance or uncertainty of professional guidelines, ethical principles and the law. Most participants relied on medical and scientific reasoning to guide the management of their patients. Where there was an ethical or moral issue, they muddled their way through the resolution, citing the patient's best interest.

CHAPTER 8

FINDINGS AND DISCUSSION

8.1 Introduction

This research set out to determine the sources medical doctors use to facilitate the resolution of ethical or moral dilemmas in clinical practice. This was achieved by analysing the collected data following the research objectives and by using thematic content analysis. Finally, the Ethics Tetrad was used to determine the sources of authority that doctors used to resolve their ethical quandaries.

8.2 Findings

The findings in this research are briefly summed up as:

i) Doctors are unable to describe, define or recognise a moral or ethical dilemma in ethics terms

ii) Decisions are justified vaguely on two normative sources

iii) Medical reason is the main source used to resolve a dilemma

iv) Medical doctors do not use a reasoning ethics framework to deliberate decisions

v) Medical ethics demands more than the law

vi) Clinical or medical ethics is not introduced to medical students and doctors in an appropriate way

vii) South African medical doctors are not aware of HPCSA guidelines and how to use them

viii) Medical practitioners suffer from moral distress or stress of conscience

In the following sections, the relevance of each of the findings will be discussed.

8.2.1 Doctors are unable to describe, define or recognise a moral or ethical dilemma in ethics terms

From the data collected in this research, it appeared that doctors were unable to describe, define or recognise a moral or ethical dilemma in the clinical context. While some were able to define it as a situation where something went against their principles, none of them specifically mentioned an actual conflict of personal values with professional principles, or a conflict of professional principles. For most, it was a situation where they were either uncertain how to act or were dealing with a patient they were uncomfortable with; that is, situations of moral discomfort and moral or ethical uncertainty were described.

This uncertainty is significant for three reasons:

i) To resolve a moral or ethical dilemma, normative literature advises that one needs to be able to identify the values or principles in conflict. When one is unable to identify the principles or values in conflict, the decision-maker is left directionless and unable to proceed with the right action or to justify it at resolution.

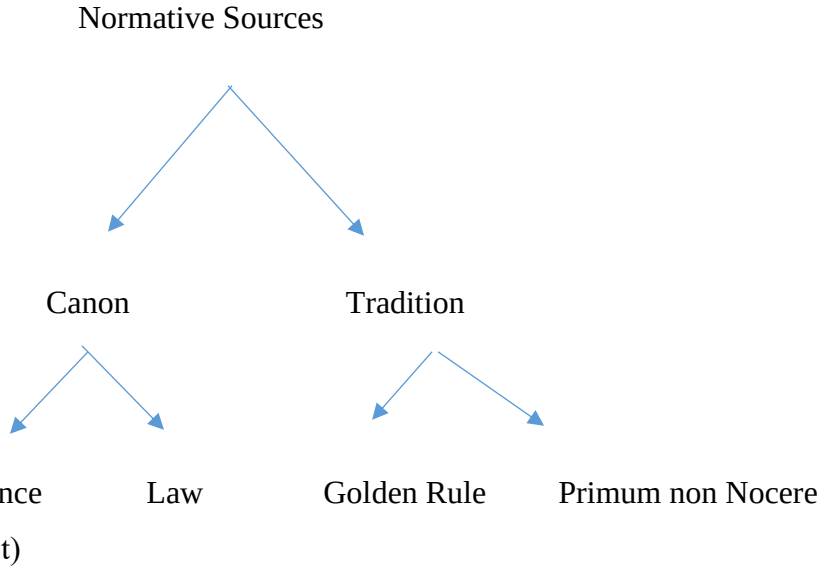
ii). It raises the question of whether doctors are ethically attuned. In other words, are they aware of and accustomed to thinking and acting ethically, or is there a gap in their knowledge? Also, it raises the question of the application of moral and ethical knowledge. If they do have the knowledge, do they know how to apply it? As described before, there is a difference between *knowing* and *praxis.*

iii). Finally, ethical uncertainty has mental consequences. In this research, those consequences were found to be moral distress or stress of conscience.

8.2.2 Decisions are justified vaguely by two normative sources

In this research, the decisions made by the doctors were often justified vaguely by two normative sources, Canon and Tradition.

Justifications for decisions.



The predominant justification given for a decision made or an action taken, was that of acting in the patient's best interest.

This may be argued as fitting in with the principle of beneficence, but it may also be seen as a form of paternalism, depending on the intention and context. Beauchamp and Childress (2013, p.218) differentiate between hard and soft paternalism. In hard paternalism, what the doctor considers to be the best interest of the patient is overriding, and patient behaviour is manipulated to gain the doctor's intended result.

In soft paternalism, the doctor goes along with whatever the patient perceives as their best interests, even if that patient does not fully understand those interests and consequences. However one looks at it, the doctor is ultimately deciding for the patient.

Paternalism raises the issue of *informed* autonomous choices by patients in their medical care, where an autonomous *informed* choice (or consent) occurs only when the patient is informed of all possible choices and consequences and makes their decision accordingly - not where the doctor decides for them. Where the doctor makes the choice for the patient, it can be assumed that the patient has been excluded from the decision and has not made an autonomous choice.

While the view that physicians should always act in the best interests of their patients is widely endorsed and accepted, and although this principle is intended to protect patients' interests, blind adherence to this principle also undermines medical care, increases the potential for an inequitable distribution and fails to guide doctors adequately (Wendler, 2010). Another aspect of this principle, is who determines the patient's best interest? Further, it is not always possible to act in the patient's best interests; for example, in cases of triage or limited resources, the patient's best interests may have to be subordinated to the greater good.

Acting in the best interest of the patient may invoke the principles of beneficence, non-maleficence and respect for autonomy; but using this reason as justification for unethical behaviour, for example, using deception to access a limited resource, does not justify the unethical behaviour.

I would argue that this is also "lazy" ethics and is used as an explanation for moral and ethical decisions and actions, rather than a "pure" justification which would cite "respect for autonomy" or 'not wanting to cause further harm".

Just as the maxim of 'the patient's best interest' is an easy justification, so it is easy to hide behind the law. The participants who cited law as a justification in this research did not cite

any specific law. Rather, they referred vaguely that the law required it or they acted according to the law, even where they were not accurate in their interpretation. This gave the perception that these participants were not fully informed legally.

As previously described, the problem with using the Golden Rule as a justification is that it is essentially a unilateral decision. The action the doctor would have liked for themselves may not be what the patient would like for themselves. Thus, unless the Golden Rule is applied through a collaborative effort or discussion between the doctor and the patient, despite good intentions it suggests paternalism.

8.2.3 Reason is the main source used to resolve and justify moral and ethical dilemmas

This research found that medical doctors predominantly used reason to resolve medical and ethical dilemmas in the clinical context. Although they may not have reasoned normatively, ultimately most decisions were rational and were based on the patient's diagnosis and preferred outcome. There is, however, a difference between clinical decision-making and moral and ethical decision-making in the clinical context.

Clinical decision-making is based on medical and scientific reasoning, and while this reasoning may result in the best medical management for a patient, it may not always be in the best ethical interest of either the doctor or the patient.

When confronted with a dilemma, it was also shown that some doctors use legal reasoning. In other words, they would rationalise which action would result in the least likely legal repercussions. The law itself was not given as a justification as described under Canon in the Ethics Tetrad, but rather legal reasoning formed the justification. In more cases than not, the legal reasoning was defensive.

8.2.4 A normative framework is needed to reason and justify dilemmas

This research found that all in all, doctors in the clinical context do not deliberate dilemmas rationally or systematically. Most ethical decisions were haphazard and followed no structure or process. In some cases, the dilemma was not immediately obvious, meaning the required action was uncertain.

I argue that a structured normative framework, that would enable decision-making combined with recommended decision-making processes as described in section 1.2.7, would do more

than enable a more prudent decision with normative resolution and justification. It would also alleviate the moral distress or stress of conscience that comes with the feeling of not having resolved a dilemma adequately or the perception that one has been constrained from resolving the dilemma satisfactorily, especially where a normative uncertainty is the constraint.

The Ethics Tetrad, as both a teaching and decision-making tool would enable prudent decision-making in moral and ethical decisions because the agent would be informed ethically and morally and would be able to reason rationally incorporating non-rational considerations.

8.2.5 Bioethics is not how clinical ethics should be taught

This is probably a contentious finding, but the participants in this research were derisive of bioethics at the undergraduate and postgraduate levels. The courses offered were criticised for being boring and not relevant. The most likely reason for this is probably because bioethics is an umbrella term used to describe many subfields such as environmental ethics, clinical ethics,and animal ethics. While the history of normative philosophy and traditions is important to the teaching of medical ethics, I would argue that bioethics for healthcare practitioners would be better served if it were taught as medical or clinical ethics. Medicine is a practical, hands-on science and art, and as such, medical or clinical ethics should be taught in order to be applied appropriately.

8.2.6 There is a lack of awareness of HPCSA guidelines and how to use them

The doctors showed a general lack of awareness of HPCSA guidelines and the role they play in providing moral and ethical guidance in clinical practice. This was an unexpected finding, as I thought that the required compulsory registration with the HPCSA for practising doctors, would require those doctors to be familiar with the guidelines and the role the HPCSA has in medical professionalism.

8.2.7 Medical doctors suffer from moral distress or stress of conscience

This finding emerged from the data collected. It was identified as a silent theme in section 6.2.5. While it is not a finding relevant to the research question or research objectives, I find it too significant to ignore. Moral distress or stress of conscience is consequent to normative uncertainty among others, as described in section 6.2.5 and illustration 6.2.

8.3 Discussion of findings and analyses in relation to the study objectives

- Study objective 1. To develop an adaptation of the Wesleyan Quadrilateral as a normative framework to facilitate moral and ethical deliberation and meta-analysis in quandaries in medical practice

The Ethics Tetrad was developed in Phase I of this research and is described extensively in Chapter 3. This Tetrad was used in the meta-analysis of the moral and ethical dilemmas revealed by the participant in their interviews. It would be useful as a normative framework in both the teaching and "practicing" of medical ethics because it relies on the tools that are used and useful in moral and ethical quandary decision-making in clinical practice.
(The Ethics Tetrad was also used to analyse the participants responses in Chapter 7).

- Study objective 2. To normatively justify the multi-layered approach based on the normative framework developed in the first objective

The developed Ethics Tetrad incorporated the normative components of law, professional ethical codes, principles, and guidelines under the authority of Canon. Traditional normative moral theory and values were incorporated under the authority of Tradition.
Reason is the source used to work through these two normative authorities when resolving a dilemma. Reason provides clarity by organising thoughts, processing logical thought and to confirm and defend the conclusions reached in moral and ethical quandaries in the clinical context (See section 3.2.3).
Experience (as discussed in section 3.2.4) teaches us that actions have consequences. There are also different 'types' of experience that influence decision-making, for example, medical training, personal experience, peer experience and conscience. The Ethics Tetrad enables the organisation of experiences and the influence these have on decision-making.
The findings of this study revealed that ethics training the medical doctors in this study "scrambled" when confronted with a moral or ethical dilemma in the clinical context (section 8.2.4). To this end the teaching and practice of the Ethics Tetrad would expand the realm of dilemma resolution and take it beyond the doctor's personal morality, intuition, or traditional moral maxim such as the Golden Rule. While there is nothing wrong with the approach that was used by the medical doctors in this research it did result in moral distress. I argue that this moral distress is the result of uncertainty about the 'right' action in a quandary.

The multi-layered approach developed in the Ethics Tetrad would justify the use of reason (usually the first line of resolution), traditional moral theory, personal and peer experience and would find confirmation in the ethical principles, codes, and guidelines in Canon.
It is my contention that unfortunately, because modern society is litigious, resolutions that are not guided or cannot be defended by professional codes, principles, and guidelines and sometimes, even the law, virtue ethics are sometimes sacrificed. The Ethics Tetrad allows for moral deliberation when one works through the three sources other than Canon but seeks confirmation in Canon.

- Study Objective 3. To describe the moral and ethical conflicts experienced by doctors in everyday medical practice

This was achieved and described extensively in Chapter 5.

- Study Objective 4. To determine what normative sources medical doctors use to facilitate decisions when confronted with a moral or ethical dilemma in the clinical context.

The interviews in Chapter 5 determined these sources and the finding is discussed in section 8.2.2.

- Study Objective 5. To ascertain whether doctors use and comply with professional, ethical guidelines, codes, and principles to assist and guide decision-making in clinical moral and ethical quandaries.

The interviews in Chapter 5 and the analysis according to the Ethics Tetrad in Chapter 7 ascertained this objective. The findings are discussed in section 8.2.2 and 8.2.6.

- Study Objective 6. To normatively evaluate how physicians make their decisions against the proposed ideal of adopting a multi-layered approach in the designed normative framework

The analyses of the interviews in Chapter 5 and the analyses in Chapter 7, using the Ethics Tetrad completed this evaluation. The findings are explained in sections 8.2.2; 8.2.3 and 8.2.4.

CHAPTER 9

CONCLUSION AND RECOMMENDATIONS

9.1 Introduction

In this chapter, I conclude my study. I begin by revisiting my research question. Next, I reflect on the findings and insights gained from this research. I then discuss the limitations of the study. I conclude with recommendations for the resolution of issues that were identified in this research.

9.2 Research Question Revisited

The research question that inspired and guided this research was: When faced with moral and ethical dilemmas in the clinical context, how do medical doctors act, and what normative sources do they use as justification for their actions? Answering this question was facilitated by following the research objectives. Finally, using the analytical tool developed here, the Ethics Tetrad, it was determined which source of authority, if any, medical doctors rely on to resolve moral and ethical quandaries in the clinical context.

Most of the quandaries were resolved by the physician acting either in "the patient's best interests" or according to the law. The traditional values of 'First do no harm' or the Golden Rule were also cited as justification for the action taken.

There was an overall lack of awareness of the purpose or usefulness of the HPCSA guidelines and the value this source has for the resolution of ethical and moral dilemmas. These guidelines have ethical standing and are consistent with South African law. As such, acting following the guidelines ensures acting in accordance with the law, ethically.

9.3 Limitations of the Study

This research provided several useful insights into the resolution of moral and ethical dilemmas in clinical practice. It did, however, have a few limitations:

i) Location of the study

This research was limited to medical practitioners in private practice in the Midrand area and to public service doctors at CMAH and CHBH.

The Midrand medical practices that were approached were either in the Midrand central business district, in so-called township areas or at private hospitals in the Midrand area. These practices serve mainly lower to middle-income populations and as a result, the practices interviewed service either cash-paying patients or patients that rely on medical aids. The two academic hospitals serve the public, that is, those people largely dependent on the state for their healthcare. As a result, the findings in this study, particularly around economic constraints, and limited resources, may be different to findings that could be made in more affluent areas where doctors consult "out of medical aid rates", or where patients can afford 'extra' medical care and treatment.

ii) The Medical Specialty of the Participants

The Gynaecology department at CHBH was receptive to my research, with the result that there is a dominance in the number of gynaecologist participants interviewed. These participants did, however, reveal very useful insights for this research.

The remainder of the participants, except for two physicians and a psychiatrist, were all general practitioners, either in general or family practice, or doing locums in private general practice. (See also page 41).

iii) Gender of the participants

The research sample constituted mainly female participants, with only five participants being male. For some reason, female doctors were more willing to participate. Male doctors were avoidant, either not interested or cited time constraints.

iv) The dilemma that was described

The dilemma that each participant described may have been the dilemma that was most morally or ethically significant for the participant at the time of the interview and may not be representative of moral and ethical dilemmas generally experienced.

9.4 Reflexivity

I come from a background of clinical research. This is an industry heavily regulated by guidelines and codes, for example, ICH-GCP Guidelines etc. These guidelines and codes ensure good, ethical clinical practice in research and are enforced by inspections and audits conducted by the organisation conducting the research, the pharmaceutical company initiating the research, local or international regulatory bodies, or the United States FDA. Clinical

research investigators and staff are all expected to be certified and compliant with good clinical practice (GCP) guidelines. In South Africa, investigator site staff are expected to renew their compliance certificates every two years.

It is well known that pharmaceutical sponsor-driven clinical research is very lucrative for both clinical research organisations and investigators. Despite all the certifications, regulations, inspections and audits, I was exposed to numerous ethical violations and "bending of the rules" by both sponsors and investigators to meet the demands of the industry, which is competitive and largely, economic and profit driven.

It is generally held that medical practice, outside of clinical research, ought also to rely on guidelines for the professional conduct of medicine and in interaction with patients. There should be no difference in the treatment of a clinical research participant and a "normal" patient. And yet, everyday medical practice that should rely on similar guidelines, is unregulated and unmonitored, which is why I raised my research questions. In quotidian medical practice, it is assumed that doctors follow guidelines, ethical principles and the law and practise ethically and morally. Private medical practitioners are audited at random to ensure continuing professional development. Ethics 'refreshers' are part of this continuing professional development. However, despite CPD audits, actual regulatory audits that ensure compliance with the HPCSA guidelines do not take place.

I came into this research with the assumption that medical practitioners are aware of and follow the ethical guidelines prescribed by the HPCSA and international codes and principles. Equally, I held the assumption that clinical research needed regulation because of the possibility of the exploitation of vulnerable populations in clinical research. I learned that most doctors are not aware of or do not use the HPCSA guidelines, act defensively from a legal perspective, and may be normatively uncertain or unaware.

Following my research, I argue that all patients are vulnerable and that all doctors need to be guided ethically, and ought to be subject to regulation to ensure compliance with ethical guidelines. Unfortunately, though, teaching ethics and obtaining CPD points does not ensure ethical practice (as I learned in clinical research).

This research also showed that many doctors suffer from moral distress or stress of conscience and this may lead to moral fatigue. Moral fatigue, in turn, leads to "lazy" ethical deliberation and that many doctors find it easier to hide behind the law.

9.5 Recommendations

i) Bedside clinical ethics teaching

I recommend that for undergraduate healthcare professionals, clinical ethics be taught at the bedside and on ward rounds. This would put ethical dilemmas into perspective and would enable the teaching of medical ethics from a first-person perspective. Currently, medical ethics is taught from a third-person perspective. The third-person perspective excludes extraneous variables and influencing factors that healthcare professionals encounter when confronted with moral and ethical dilemmas in the clinical context.

Having said this, I note that clinical ethics is practiced at three levels. The first two are: i) as the lived experience in interaction with a present patient; and ii) at the third-person level, where one reflects on a past case or interacts with peers in order to determine the appropriate action. Those peers are not in direct contact with the patient and present a "third-person" or "outside" perspective and judgement. The third level is a judgemental one, the level of high theory where judgements are made according to normative theories and ethics philosophy. Clinical ethics teaching should take account of all these levels but should prioritise the first-person level.

Bedside clinical ethics teaching ought to be limited to a number of students at a given time and should not involve discussing the moral conflicts or ethics of a case at the bedside (thus respecting the dignity of the patient). The medical students could be encouraged to note moral and ethical issues or discomforts that would be discussed from the first-person perspective at a post-ward round meeting. The cases could then be analysed and judged using the Ethics Tetrad at the second and third levels of ethics practice. This would instil an ethical awareness and practice at the student level. It would also help to obviate moral distress or crises of conscience because students would be able to vent any moral distress experienced and learn coping mechanisms and problem-solving techniques. It would also encourage familiarity with the professional guidelines and the law as more than just theory.

I recommend that clinicians who are ethicists, that is, trained in clinical ethics, or medical ethicist graduates with experience in the medical field, be appointed to guide this teaching and

mentoring. The reason for this part of the recommendation is that unless one has actually experienced moral and ethical conflicts in patient encounters, one cannot actually understand, prescribe or analyse the "ought".
This recommendation would also ensure appropriate mentoring and would instil the values and virtues pertinent to the medical profession.

ii) Ethics Tetrad

Medical Ethics or Clinical Ethics are subfields of the bioethics spectrum. It is a special type of ethics practised in the clinical space in the first person. Unlike the other subfields of bioethics, medical ethics is an ethics that commonly has to be applied "in the moment" and only exceptional cases, that are not immediate, can be referred to ethics advisors. The moral or ethical decision has to be made by the doctor in interaction with the patient. Patients have expectations from their doctors, and doctors are expected to fulfil these expectations.

To prepare doctors for conflicts and dilemmas in the clinical context, I recommend an undergraduate teaching focus on Medical or Clinical ethics *per se*. To this end, the Ethics Tetrad would be a useful tool in teaching medical ethics. Candidates would be taught to use Canon, as the *prima auctoritas*, as the beginning and end of moral and ethical deliberation. In other words, where tradition, reason and experience are useful sources to enable decisions, the final decision should have justification in Canon.

The Ethics Tetrad would make Canon the primary authority in teaching, where rather than the history of normative authority as applied to bioethics, doctors would be instructed in the relevant national law and professional guidelines, as applied to medical practice. More importantly, they would also be taught to apply the law, guidelines and principles in each case. Practice or habituation makes the process of moral deliberation easier; and the more the praxis is instilled, the easier it will be for doctors to confidently resolve dilemmas or quandaries.

Appropriate knowledge of the health laws and professional guidelines would enable physicians to confidently make decisions without concern for legal repercussions or litigation. As things stand, in this research, it appears that doctors protect themselves at the expense of the patient's best interest.

In the same way that the Wesleyan Quadrilateral is used to teach the deliberation and resolution of theological conundrums, the Ethics Tetrad can be used to teach doctors to deliberate and resolve moral and ethical dilemmas in the clinical space. Doctors ought to be trained that the moment they encounter the presenting patient, they ought to be ethically aware. Ethics does not begin when there is a dilemma or conflict. Every encounter with a patient should be recognised as an ethical encounter. Drawing on Jonsen, Siegler and Winslade (2015), the first stage of the clinical consultation begins with the "medical indications", the patient's problem, the goals of treatment and the patient as human. This process ought to be conducted with ethics in mind from the outset, and not *ad hoc.*

The Tetrad does not ignore the importance of medical, scientific, legal, moral or even case-based reasoning, of experience (personal, medical or peer), or of intuition, in the resolution of ethical and moral dilemmas, but it does provide a foundation for the normative justification for any decision reached or action taken.

iii) Continuing professional development (CPD) and Ethics Regulation

In South Africa, in terms of the Health Professions Act, 1974 (Act 56 of 1974) all practising health-care practitioners must be registered with the Healthcare Professions Council of South Africa. The HPCSA is also responsible for conducting examinations and approving training schools and for recognising local and foreign qualifications.

Medical doctors are required to keep up to date with the routine practice of their profession as well as ethical, legal and other professional responsibilities. According to the Health Professions Act, 1974 (Act 56 of 1974) this ongoing training and education are compulsory. The HPCSA is responsible for the conditions, nature and extent, and the criteria for the recognition of such ongoing training and education.

Medico-legal practice and medical ethics training and education form part of this ongoing training and education. However, the content of the lectures, seminars or online courses may not be relevant for most practising medical doctors. I would recommend that the HPCSA guidelines should form the major part of the course content for healthcare practitioners' continuing professional development. This would ensure that medical doctors are familiar with their own professional guidelines and would know the role of the HPCSA. I also recommend that the relevant health laws are reinforced by becoming part of the required ethics CPD points. I argue, furthermore, that if doctors act, this according to the HPCSA

guidelines and with appropriate familiarity with South African health law and human rights will lessen the practice of some, not all, defensive medicine. At the moment, I feel that doctors feel vulnerable to litigation because they do not know the law or the professional guidelines.

Further, I recommend that just as medical personnel conducting clinical research are subject to regulatory requirements for Good Clinical Practice and Ethics training, so too should practising medical doctors be subject to similar regulation. This would ensure compliance with South African medical professional standards.

iv) HPCSA guidelines for the treatment and management of children

This research revealed a gap in the doctors' knowledge regarding health care ethics in the context of children, acting *bona fides,* and any health law relevant to children, including consent for HIV testing and termination of pregnancy et cetera.

Currently, the HPCSA has produced 17 booklets that provide ethical guidelines for good practice in the healthcare professions. Each booklet is specific to an area of practice, for example, reproductive health management, or the management of people with HIV. There is no booklet guiding healthcare professionals in their management of children. I think such a booklet should be written and made available to guide doctors in dilemmas with children. South Africa is unique in that we have child-headed households, teenage pregnancies, and child-centred violence. Many of the doctors were at a loss, in the dark or uncertain how to proceed when confronted with a dilemma that was child centred. Specific guidelines would help in this regard.

v) An ethics application

In this digital age, where knowledge is easily accessible, I recommend the development of a mobile phone application (app), in the same vein as the current EMGuidelines application, to enable doctors to access ethical or legal guidance when confronted with a moral or ethical dilemma. This would enable them to act decisively and ethically, without guessing or acting as they think they ought.

vi) Regular debriefing

Moral distress or stress of conscience is a common consequence of moral and ethical dilemmas in the clinical space. However, moral distress is not only the consequence of moral

and ethical quandaries, it may also be the consequence of practising medicine in dystopian times and environments. To avoid unacceptable attrition rates in the profession, or moral fatigue or disengagement, I recommend that just as psychologists and psychiatrists have regular debriefing sessions to 'offload' their burdens and troubles, so medical doctors should have access to such a service. The debriefing sessions do not have to be formal therapy sessions, as even informal debriefing with peers and colleagues can give one the space to rationalise one's distress.

vii) Further research

There is very little research on moral distress in medical doctors, especially in South Africa. Traditionally this was research conducted among nurses and gradually expanded into the other paramedical fields. Internationally, there is literature available on moral distress among oncologists, palliative care doctors, intensive care doctors and medical students. In South Africa, I could not find any literature on moral distress among doctors and medical students. There is some literature on moral distress in nurses in South Africa.

I recommend further research in moral distress among doctors of all specialities and among medical students. I argue that early recognition of moral distress would enable the early management of the syndrome and would alleviate the consequences. This research identified some of the contributing causes of moral distress, but I do not believe it is complete. Further research could elaborate on this syndrome and possibly help to manage the contributing factors.

9.6 Conclusion

This study sought to uncover the sources used by medical doctors to resolve moral and ethical dilemmas in the clinical context. The participants in the study demonstrated that they face many challenges in everyday medical practice and normative uncertainty is one of these challenges. The consequence of normative uncertainty is moral distress or as some call it, stress of conscience.

The teaching and application of medical ethics as well as continuing professional development currently fail to deliver when it comes to giving guidance in everyday dilemmas in the clinical context; this contributes to normative uncertainty. There is also low awareness of HPCSA guidelines and health law. Further, medical doctors in this research are also very conscious of litigation and consequently, many practise defensive medicine.

Overall, while medical doctors *ought* to refer to professional guidelines, ethics principles and codes and the law to resolve and justify the resolution of moral and ethical dilemmas in their clinical practice, the reality *is* that actual dilemmas are resolved using medical, scientific or legal reasoning and then justified broadly by 'the patient's best interest', the traditional values of the Golden Rule or *Primum non Nocere* or vaguely by the law or the wish to avoid litigation.

For doctors, 'in the field', the teaching of medical and clinical ethics and how to apply the knowledge should be taught in practice and not from an analytical, third-person perspective. Senior clinicians and mentors in the wards can also contribute to a moral and ethical ethos by setting the example for their students.

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APPENDICES

Appendix I Research Ethics Approval

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG	HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

Office of the Deputy Vice-Chancellor (Research & Post Graduate Affairs)

TO: Ms T Jacovides
School of Clinical Medicine
Steve Biko Centre for Bioethics

E-mail: tracyjacovides@gmail.com

CC: Supervisor: Professor A Dhai & Dr A Egan <Ames.Dhai@wits.ac.za>
and <HREC-Medical.ResearchOffice@wits.ac.za>

FROM: Iain Burns
Human Research Ethics Committee (Medical)
Tel: 011 717 1252

E-mail: Iain.Burns@wits.ac.za

DATE: 16/01/2018

REF: *R14/49*

PROTOCOL NO: **M170703** *(This is your ethics application study reference number. Please quote this reference number in all correspondence relating to this study)*

PROJECT TITLE: *The "ought" versus the "is" - the sources used by doctors for decision-making in medical quandries*

Please find attached the Clearance Certificate for the above project. I hope it goes well and that an article in a recognized publication comes out of it. This will reflect well on your professional standing and contribute to the Government funding of the University.

MSWorks2000/Iain0007/Clearscan.wps

Appendix II Original Interview Schedule

Hello, I am Tracy Jacovides.

Thank you for agreeing to participate in this research project.

As a medical doctor you have been faced with ethical dilemmas in the clinical context.

Tell me about an ethical dilemma that you were recently confronted with.

What made the case an ethical dilemma?

How did you justify your moral judgement/ ethical decision?

Appendix III Participant Information Leaflet



Participant information sheet

Good day, my name is Tracy Jacovides and I am a candidate registered for the degree, PhD in Medical Bioethics and Health Law at the Steve Biko Centre for Bioethics, University of the Witwatersrand.

Background

In everyday medical practice doctors have to make decisions. Some of these decisions are of a scientific or technical nature but most decisions are consequent to dilemmas that is, they are questions of values, rights and responsibilities that determine what the doctor "ought" to do when faced with a medical quandary.

Despite medical ethical training, professional guidelines and law, moral theory is not the sole means doctors use to make moral decisions. Medical doctors in the clinical setting would more often than not conform to an eclectic approach when making a decision in a dilemma. In other words, moral decisions in the professional context are a complex mixture of rule following, cultural and religious beliefs and influences as well as emotion and instinct.

Questions arise around how when the medical doctor determines what he "ought" to do, how the "ought" is rationalised and justified especially when confronted with the tension between his/her personal belief system, cultural affiliation as well as national law, ethical guidelines and professional codes.

Purpose of study

I am conducting research on how medical doctors make decisions when faced with a moral dilemma in the professional context; how the decision is rationalised as well as how the decision is justified. In order to understand and critically examine how moral judgements are made I want to take what doctors do, analyse the processes and formulate a critical moral theory.

There are no risks or benefits to participating in the study. I therefore wish to invite you to participate in my study.

Procedures and conditions

With your permission, data will be collected from you in an in-depth interview which will be audio-recorded (also with your consent). Your participation in this interview is entirely voluntary and you have the right to terminate the interview at any point. If you agree to take part, I shall arrange to interview you at a time and place that is convenient for you. The interview will take approximately one hour. You may withdraw from the study at any time and you may refuse to answer questions that you feel uncomfortable with answering.

Data management

The data collected will be stored and not released. It will be stored in a locked cabinet in the researcher's office at her practice in Midrand.

Confidentiality

With your permission, the interview will be audio-recorded. If you agree to take part in the study, no one other than my supervisors will have access to the interview transcripts. There is a risk that confidentiality may be breached as you may be identified through the nature of the information provided in the interviews. With this in mind, the interviews will be reported with

care. Further, data collected from you will be identified through a numerical system known only to me, the researcher.

The interview schedules and transcripts will be kept for two years following any publication or for five years if no publications emanate from the study. Please be assured that your name and personal details will be kept confidential and separate from the data. No identifying information will be included in the final research report.

Queries regarding the study

Please feel free to ask any questions regarding the study. I shall answer them to the best of my ability. I may be contacted on 082 3758538 or by email tracyjacovides@gmail.com. Alternately, you may contact my supervisors, Professor Ames Dhai on 0117172635; Dr Anthony Egan, on 0729384553; or the Chairperson of the Wits Human Research Ethics Committee (Prof. Peter Cleaton- Jones) on 011 717 2153. If you wish to receive a copy of the results of the study, an abstract will be made available on request.

Appendix IV Informed Consents (for participation and recording)



Informed consent for study participation

- I hereby consent to participate in the research study as described in the Participant information sheet.
- The purpose and procedures of the project have been explained to me.
- I understand that my participation is voluntary and that I may refuse to answer any particular items or withdraw from the study at any time without any negative consequences.
- I understand that my responses will be kept confidential and that all raw data will be kept for two years following any publications or for five years if no publications emanate from the study.

Participant Enrolment Number: __ __ __

Name of Participant	Student: Tracy Jacovides
Date	Date
Signature	Signature

Informed Consent for Digital recording

- I hereby consent to have the interview digitally-recorded.
- I understand that the transcripts from the interview will be kept confidential and will be retained for two years following publications or for five years if no publications emanate from the study.

Participant Enrolment Number: __ __ __

Name of Participant	Student: Tracy Jacovides
Date	Date
Signature	Signature

Appendix V Amended Interview Schedule

In-Depth Interview Schedule

Thank you for agreeing to participate in this research project.

As a medical doctor you have often been faced with ethical dilemmas in the clinical context.

What do you consider to be the definition of a medical dilemma or conflict? How would you describe an ethical dilemma or conflict?

Tell me about an ethical dilemma that you were recently confronted with.

What made the case an ethical dilemma?

How did you resolve the dilemma?

Considering how you resolved or dealt with the dilemma and how ethical prescriptions prescribe how you "ought" to have acted, do you think you acted appropriately?

How did you justify your moral judgement/ethical decision?

How did this decision or action affect you?

Could anything have been done differently?