Forum

The problem of dual loyalty – through African eyes

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All health professionals, no matter what their background, will experience problems of dual loyalty. As long as relationships between the health professional and parties other than the patient exist, there will be potential for problems of dual loyalty. Our challenge as health professionals is to place our patients first and negotiate the many ethical challenges this duty presents. How can we negotiate these challenges on the African continent?

Introduction to the winning entry of the University of Witwatersrand's Medical Protection Society Bioethics Competition

I write to briefly introduce Kyle Wilson's article entitled 'The problem of dual loyalty – through African eyes'. The goal of the introduction is threefold. Firstly to introduce the winning entry in the first University of Witwatersrand's Medical Protection Society Bioethics Competition – and by qualifying it as the first competition the implication is that there will be more. Secondly to make other universities aware of the possibility of holding similar competitions in a similar collaboration. Thirdly, and most importantly, to congratulate the editorial team of the *Journal of Bioethics and Law* on publishing the article in the journal.

The main reason the editorial team should be congratulated is for going against the natural tendency, when considering publishing an article like this, to have it submitted to the full review process which doubtless would have changed it substantially.

On reading the article, remember it has not been fully reviewed and extensively rewritten. This is the raw talent of a young undergraduate student (Kyle in fact has a degree in physiotherapy). He has not been trained in philosophy and is not an expert on communitarianism or African culture or ethics. What is appealing is how he is willing to view the complex issues of dual loyalty from the communitarian angle rather from that of individualism.

Undoubtedly exception can be taken to many of his arguments and he approaches a complex problem with a broad brush, but rather than criticise take note that the goal of the competition was not to create professional philosophers but to encourage undergraduate health care students to think and write about an ethical issue. Before criticising him for any misunderstanding you feel he has of African culture, remember Steve Biko's words, 'One of the most difficult things to do these days is to talk with authority on anything to do with African culture.'[1]

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1. Biko S. Paper given at a conference called by IDAMASA (Interdenominational Association of African Ministers of religion) and ASSECA (Association for the Educational and Cultural Development of the African People) at the Ecumenical Lay training Centre, Edendale, Natal, 1971.

The bioethics field, despite the phenomenon of globalisation, is dominated by Anglo-American thought and ideas.[1] With a history of colonisation by Western countries, these thoughts and ideas have shaped the modernisation of the African continent. While modernisation is not a bad thing, the Western models used may not necessarily be suitable for the African system. As an illustration think of an African marriage compared with traditional Western marriage. Preparations before the African wedding involve extensive negotiations between the respective extended families in order to agree on payment, *lobola*, with the actual wedding being a grand community celebration. A Western marriage involves very little pre-wedding negotiation, mainly being between the bride and groom, with an intimate wedding involving a painstakingly formulated guest list of close family and friends. The key difference can be found in the respective understanding of 'family'. Africa's family systems are large and extensive and linked with other family systems, in contrast to the Western model, where family seldom extends beyond the boundary of the family home.

The fathers of modern ethics – citizens of the Western world – all shared two important premises in their moral theories, the first being that ethical truth can be found through rationality, and the second that the individual is central to the moral concern.[2] The individual is therefore the reference point for deciding, through a rational process, the 'goodness' or 'badness' of an action. Examples of this individualist focus can be found scattered all through the South African health care system, from teaching of the patient-centred approach at medical school level to the rights of patients as described in the Patients' Rights Charter of the South African Department of Health.

As mentioned above, Western thought places the individual central to the moral concern, individualism. How is it then that African understanding differs from that of the West? In my simplified explanation of the difference, an African family is larger, more extensive and linked to other families. South Africa's former president Nelson Mandela described an encounter with an African family by saying: 'A traveller through a country would stop at a village and he didn't have to ask for food or for water. Once he stops, the people give him food, entertain him.'[3]

The South African Nobel laureate, Desmond Tutu (in 1999) described a member of the family as: 'open and available to others, willing to be vulnerable, affirming of others, do not feel threatened that others are able and good, for they have a proper self-assurance that comes from knowing that they belong in a greater whole'.[3]

African eyes

'Umuntu ngumuntu ngabantu' is the Zulu explanation of this concept. Translated it means 'a person is a person because of others', and is commonly known as *Ubuntu*. This is African communitarianism. In communitarian ethics, the importance of the society in shaping the individual is emphasised. The question asked by communitarians is 'Which policies would promote the kind of community in which we want to live?'[2] Various forms of communitarianism exist, differing only in the weighting of importance placed either on the community or on the individual. Radical communitarianism places the value on the community as the sources of an individual's humanity, while moderate communitarianism sees a more equal weighting of value between the community and the value of its constituent members.[4]

Ubuntu is also a religious concept, the root word *'ntu'* meaning God or Supreme Being, *'abantu'* the people of God and *'ubuntu'* the practice of being Godly (R Ngara, personal communication, 21 February 2009). The belief is that ancestors exist among the living as spirits. These ancestors are one's link to the divine and a source of wisdom and guidance. The ancestors are respected because of the honourable lives they lived and the wisdom that they possess. A member of a community would therefore strive to live an exemplary life valuing 'peace, harmony, stability, solidarity, mutual reciprocity and sympathy'[4] in order to become a venerable ancestor.[5]

In a traditional African setting, can a Western bioethics mindset be used to rationalise actions? While there is overlap between the individualist and the communitarian quest for 'goodness', the focus is slightly different. A utilitarian approach (an example of Western thought) defines good actions as those that maximise the common good of all individuals, whereas in communitarianism, good actions are those that create a good community.[2] This difference is subtle but crucial. The importance of community is ignored in an individualistic approach and the interests of the individual are placed first. As a result, the African continent is incorrectly understood and described as wild, uncivilised, barbarous. The challenge is to view the continent through the eyes of the Africans who live here, and realise that the problems Africa faces might best be solved by remembering the communities that make up the continent as well as the millions of individual black, white, Indian and oriental faces.

I do not see the need to create an entirely new set of principles or approaches to be used to analyse the African 'situation'. The four principles used in bioethics practice do not conflict with the *Ubuntu* principles. In fact, values held by members of *Ubuntu*, 'peace, harmony, stability, solidarity, mutual reciprocity and sympathy',[4] complement autonomy, beneficence, non-maleficence and justice. In a traditional African setting, however, they need to be approached from an *Ubuntu* perspective, placing more emphasis on the community but at the same time not forgetting the individuals that make up the community – remember that in *Ubuntu*, the community and the individual are inseparable.

Dual loyalty

Conflicts of interest are problems faced by all health professionals, no matter what their background. Rodwin[6] divides conflicts of interest into two groups: *(i)* conflicts between a health professional's personal interests and the interests of the patient; and *(ii)* conflicts that divide a health professional's loyalty between two or more patients or between a patient and a third party.

Rodwin's second type of conflict of interest can also be called a problem of dual loyalty. Dual loyalty, as defined by the International Dual Loyalty Group, is 'the clinical role conflict between professional duties to a patient and the interests of a third party'.[7] Therefore, in order for a dual loyalty problem to exist, we need a health professional, his or her patient, and a third party to whom the health professional has an obligation. The critical part of dual loyalty problems is that the obligations to the patient and the obligations to the third party must be divergent. In other words, the obligations to the parties do not have a common goal, which is putting the interests of the patient first. If they were parallel obligations the health professional, patient and third party would be heading towards a common goal.

An example of such a scenario, where obligations diverge, would be the 2008 clash between the KwaZulu Department of Health and medical staff from a KwaZulu-Natal hospital on the provision of antiretroviral treatment to HIV-positive mothers to prevent the spread of the virus to their newborn babies,[8] the divergent obligations here being the health professional's duty to provide the best care to his patient and simultaneously his duty to the Department of Health, as an employee, to follow departmental protocol.

Patient or third party

How would problems of dual loyalty be viewed through *Ubuntu* eyes? The most important factor when considering this question is the scope of the patient in an *Ubuntu* setting. In *Ubuntu*, the scope of 'patient' extends beyond the body of the sick person presenting with illness. This is because that patient's humanity is inextricably bound to the community and his or her suffering and sickness extends into the community. We can see an African example of this with the current HIV/AIDS pandemic, the moribund patient surrounded by AIDS orphans, child-headed households and loss of that community's human capital. HIV/AIDS is not confined to the patient. The health professional, being part of the community, shares the same interwoven existence.

If the scope of the 'patient' extends to include the community, who then is a third party in *Ubuntu*? This would not be a party from within the community. A party from within the community would want to act in a way that promotes the values of that community, the values of *Ubuntu*. A third party then would be a party whose values were not that of *Ubuntu*. The third party would exist outside of the community and not share an interwoven existence. Examples could be governments, other distant communities not sharing similar values, corporations, and any party whose existence is independent to that of the index community. This definition of the third party illustrates a potential downfall of radical communitarianism in that there is potential for the index community to become prejudiced towards their community at the expense of others.

Dual loyalty through African eyes

Let us examine a few examples of dual loyalty problems. I shall present the examples as found in the literature and explore them from an African, *Ubuntu* point of view. Bloche[9] has divided these dual loyalty problems into three categories: *(i)* pursuit of public health aims, occurring when public health aims conflict with individual patient interests; *(ii)* furtherance of non-health-related social ends, where a health professional's clinical skill is towards non-medical ends; and *(iii)* ascription of rights, responsibility and opportunity based on health status, where health professionals act as gatekeepers to health care.

Bloche gives the example of vaccinations as an example of a dual loyalty problem in pursuit of public health aims. It could be argued, using the bioethics principles and an individualist point of view, that compulsory vaccination ignores the individual's autonomy with the aim of protecting the health of the greater community. From an *Ubuntu* point of view, protecting the community would be in the interests of the patient being vaccinated, so there would not be any problem of dual loyalty. Another example is the quarantining of extensively drug-resistant (XDR) tuberculosis-infected patients in medical facilities until they can no longer infect others. Again from an individualist point of view this violates patient autonomy, but from an *Ubuntu* point of view is in the interests of creating a healthy community. Another example Bloche presents is the case of research on human subjects. These subjects, Bloche suggests, bear the medical risks of the experimental procedure for future patients. If the experiments were in line with creating a good community this would not present a problem from an *Ubuntu* point of view, but if the experiments benefited another remote community, they would be exploitative of the index community.

The case of Steve Biko, Black Consciousness Movement leader in the 1970s, is an example of Bloche's second category, where the health professional's loyalties are stretched between the patient and the 'furtherance of non-health-related social ends'. Steve Biko was detained in a Port Elizabeth prison and regularly interrogated in the security police headquarters. During one of these interrogations he received a head injury. The medical treatment of their head-injured patient by attending doctors Lang and Tucker, later described by the supreme court as 'callous, lacking any element of compassion, care or humanity',[10] resulted in Biko's death 6 days later in a jail cell. These doctors had a *prima facie* duty to their patient, which was conceded to the racist norms widely followed in South Africa during the apartheid era. Clearly the actions of these doctors did not show the values, 'peace, harmony, stability, solidarity, mutual reciprocity and sympathy',[4] valued by *Ubuntu*, and from a Western point of view all four bioethics principles where completely ignored. This case illustrates the potential downfall of radical communitarianism, which is the risk of communities becoming racist owing to complete insulation from other communities. Could doctors Lang and Tucker have been acting in the best interests of their community?

Another example of using clinical skill to further non-health-related social ends would be the case in which an aggressive psychiatric patient is sedated against his will. This is common practice in psychiatric units, and there is provision for it in section 32 of the Mental Health Care Act (No. 17 of 2002). Patient autonomy in this case is overridden to protect the patient, and the terrified family, from that patient inflicting serious harm. This would be in line with *Ubuntu* thinking, as the interests of the community are considered.

Bloche's[9] example of a dual loyalty conflict, where the patient's opportunity and rights may be limited by their health status, is the case of managed care. In these situations, through financial incentives and disincentives, the clinical practice and decision making of the professional may be influenced by the organisation implementing managed care. According to the Health Professions Council of South Africa, incentives should only be used when they promote quality and cost-effective care.[11] A situation in which this could occur is where a health professional is offered an incentive to keep health costs below a certain level and penalised for 'overspending'. In this situation the patient would potentially receive a sub-standard level of care. From an *Ubuntu* perspective this could be acceptable if keeping health costs at that level was in the best interests of the patient and the answer to the question 'Is limiting access to this intervention in line with creating a community that we would like to live in?' was 'yes'. If the answer was 'no', limiting access to care should not be accepted. From an individualist point of view limiting a patient's access to care in order to meet a target is not acceptable.

In the above examples the key difference between Western and *Ubuntu* points of view is the importance of community. When dealing with dual loyalty problems in an African community, health professionals need to extend their understanding of the patient beyond the ill person to that person's family and community. There are a few approaches suggested by various authors – the Human Rights approach of the International Dual Loyalty Working Group,[7] the Clinical Loyalties approach of Bloche,[9] and the traditional bioethics principled approach[2] – for dealing with problems of dual loyalty. The challenge in Africa is to apply them from an African perspective. I would suggest that the following points be borne in mind when applying the suggested guidelines:

1. In an African community the patient extends beyond the sick person presenting with illness. The implications of this are that the health professional's clinical loyalty extends into the community.
2. To an African community, a third party is a party that does not share the common interests of that community.
3. In an African community, by doing their duty in an exemplary fashion health professionals are behaving in a godly manner. They are behaving in a manner worthy of becoming a respected ancestor.
4. We need to be aware of the dangers of radical communitarianism when deciding who is part of the community, and who is not.

To conclude, I believe that there is a need to approach the various dilemmas faced on the African continent from an African perspective. This does not necessarily mean redesigning the many useful tools created by Western minds, merely adapting them to an African setting. When it comes to dual loyalty, a problem arises when the loyalties of the health professional result in a compromise of their duty to place their patients' interests first. In an African setting, under an *Ubuntu* beliefs system, the patient extends beyond just the ill person and includes the community. The third party is one who does not share the common interests of the patient. *Ubuntu* is also a religious concept where actions that promote a type of community worth living in would place one in a position of becoming an ancestor worthy of respect. When facing problems of dual loyalty in an African setting, health professionals should try and interpret the problem from the point of view of the community, in order to best resolve it.

'Umuntu ngumuntu ngabantu.'

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