DUAL OBLIGATIONS IN CLINICAL FORENSIC MEDICINE

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Declaration

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Summary

This thesis discusses ethical dilemmas faced by district surgeons in South Africa. District surgeons render clinical forensic services, which means that they deal mainly with detainees and victims of crime. The main functions of district surgeons are the collection of forensic evidence from patients and the care of detainees. So the focus is to assist in the administration of justice rather than improvement of patient wellbeing.

The district surgeon may therefore find himself in a situation where patients' interests are in conflict with those of law enforcement agencies. Being a medical practitioner in clinical forensic medicine, the district surgeon has an obligation to assist in the administration of justice, as opposed to the traditional obligation to care for patients and put patient's interests first. This allegiance to both administration of justice as well as patient wellbeing lead to an ethical dilemma of dual loyalties. A dual obligations presents an ethical dilemma for the district surgeon, especially if they are in conflict and mutually exclusive. I discuss the detention and subsequent death of Steve Biko to illustrate how dual obligations can lead to serious human rights violations and even death.

Dual obligations are however not limited to detainees and police custody settings, and I demonstrate this by discussing three other scenarios commonly encountered by district surgeons.

There is a lack clear guidance for district surgeons who are faced with a conflict of obligations. I explore several ethical theories including consequentialism, deontology and virtue ethics, in search of an ethical framework suitable for resolving conflicts in clinical forensic medicine. I therefore argue that a duty based ethical framework is central to clinical forensic medicine and the resolution of loyalty conflicts. I recommend the resolution of conflicts by using an approach developed by Benjamin (2006). This approach involves weighing -up the different duties in conflict, applying philosophical reasoning and then amelioration. By adopting a structured and well-reasoned ethical framework, district surgeons will be able to deal with conflicts of obligations better.

Opsomming

Hierdie tesis bespreek etiese dilemmas wat in die gesig gestaar word deur distriksgeneeshere in Suid-Afrika. Distriksgeneeshere lewer kliniese forensiese dienste, wat beteken dat hulle handel hoofsaaklik oor die gevangenes en slagoffers van misdaad. Die belangrikste funksies van distriksgeneeshere is die insameling van forensiese getuienis van pasiënte, en die sorg van gevangenes. Met hierdie benadering is die fokus om te help met die administratiewe doeleindes van geregtigheid, eerder as die verbetering van die pasiënt se welstand.

Die distriksgeneesheer kan hom dus in 'n situasie vind waarby die pasiënte se belange in konflik is met dié van wetstoepassingsagentskappe. As 'n geneesheer in kliniese forensiese geneeskunde, het die distriksgeneesheer 'n verpligting om te help met die administrasie van geregtigheid, in teenstelling met die tradisionele verpligting om te sorg vir hul pasiënte, en hul welstand eerste te plaas. Hierdie getrouheid gaan gepaard met beide regspleging, sowel as die welstand van die pasiënt, wat kan lei tot 'n etiese dilemma van dubbele lojaliteit. Dubbele verpligtinge bied 'n etiese dilemma vir die distriksgeneesheer, veral as hulle in konflik en wedersyds uitsluitend is. Ek bespreek die aanhouding en die daaropvolgende dood van Steve Biko om te illustreer hoe dubbele verpligtinge kan lei tot ernstige skending van menseregte en selfs die dood.

Dubbele verpligtinge is egter nie beperk tot die gevangenes en polisie-aanhouding instellings nie, en ek demonstreer dit deur die bespreking van drie ander “scenario's” wat oor die algemeen eervaar word deur distriksgeneeshere.

Daar is 'n gebrek aan duidelike riglyne vir distriksgeneeshere wat 'n botsing van verpligtinge in die gesig staar. Ek verken verskeie etiese teorieë insluitende konsekwensialisme, deontologie en deugde-etiek, op soek na 'n etiese raamwerk geskik vir die oplossing van konflikte in kliniese geregtelike geneeskunde. Ek argumenteer dus dat 'n pligsgebaseerde etiese raamwerk sentraal is tot kliniese forensiese geneeskunde, en die resolusie van lojaliteit konflikte. Ek beveel die oplossing van konflikte deur die gebruik van 'n benadering wat ontwikkel is deur Benjamin (2006). Hierdie benadering behels 'n gewigsoorweging tussen die verskillende pligte in konflik, die toepassing van filosofiese redenasie en verbetering.

Deur die aanneming van 'n gestruktureerde en beredeneerde etiese raamwerk, sal distriksgeneeshere dus in staat wees om konflikte van verpligtinge beter te hanteer.

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I. INTRODUCTION

Medicine traditionally has been practiced mainly for the purpose of benefiting patients, typically relieving suffering. This is proclaimed in a number of fundamental professional codes and oaths, notably the Hippocratic Oath. The relationship between physicians and their patients is generally seen as fiduciary in nature, i.e. a kind of relationship "where one person places complete confidence in another in regard to a particular transaction" (Free online dictionary 2013). The purpose of the practice of medicine as a profession is still primarily understood as meant to serve only the needs of patients.

However, due to realisation that medical knowledge and skill can be used for other non-therapeutic purposes, the role of physicians has expanded to serve a variety of other social purposes. These social ends typically involve taking third party interests into consideration, alongside the interests of patients. Third party interests may be those of employers in occupational health medicine, administration of justice in forensic psychiatry and forensic medicine, as well as managed healthcare organisations in managed health care systems. These expanded roles of medicine force physicians to meet the needs of parties outside the traditional doctor-patient relationship. This has led to claims that doctors are being dishonest by serving more than one master.

Clinical forensic medicine is a branch of medicine where medical knowledge is applied to legal processes for purposes of the administration of justice. It has come to be accepted that forensic medicine is a broader field encompassing both forensic pathology and clinical forensic medicine. The difference between forensic pathology and clinical forensic medicine is that the former is concerned with the examination of the dead, whereas the latter is concerned with the examination of living people.

Most of the evaluations in clinical forensic medicine are directed at assisting the court in administering justice. Examples include determination of fitness to drive, fitness to give statements, fitness to stand trial or examinations for obtaining evidence, e.g. obtaining blood samples for Deoxyribonucleic Acid (DNA) evidence from rape victims and murder suspects. These tasks are not fundamentally directed at the improvement of patients' wellbeing, but rather aimed at serving socially

sanctioned ends. In clinical forensic medicine, that end is the advancement of justice. The physician in clinical forensic medicine is clearly serving purposes other than patients' well-being.

The additional duties for the doctor in clinical forensic medicine have led to divided loyalties by the doctor between the patient and other third parties. Sometimes these duties cannot always be simultaneously served as they may stand in conflict. The doctor finds himself in situations where he has to choose which obligation he has to fulfil and which to neglect. An example in clinical medicine is that of a patient with an Ebola virus, a highly contagious and deadly infection. He is to be treated in isolation to protect the public by preventing further spread of the deadly virus. This can be done with his consent, and for the benefit of both the patient as well as the whole of society. So the doctor here can satisfy his duties to both the patient and to the public. There is therefore no conflict between the two obligations in this instance. However, should the patient refuse to be treated, the obligation to respect the patient's wishes and hence respect the patient's autonomy will clash with the obligation to protect the public. So the doctor may have to choose between serving society's interest, i.e. to admit and confine the patient against his wishes, or acceding to patient's demands for freedom at a huge risk to the public. In deciding whether to confine and treat the patient with an Ebola viral infection against his will, or release him into the public, the doctor will have to consider the consequences of both actions. On utilitarian grounds, the doctor is most likely to choose to neglect the patient's desire to be released into the society and opt to protect the public instead. The doctor may argue that this will have the best outcome for greatest number of people. From a deontological perspective, the doctor's duty to respect patient autonomy will require the release of the patient, even if this will lead to his death. This action will expose the public to risk of harm, and the doctor will have to consider another duty to protect third parties from harm.

This is an example of dual obligations which are in conflict. These conflicts are, however, not always easy to resolve by appealing to a single principle or moral theory, and may at times even remain unresolved.

Clinical forensic medicine is a practice of obtaining evidence from patients for use in criminal proceedings. The services include obtaining samples from detainees,

assessment of fitness to plead of suspects, examinations for concealed substances or objects and care of detainees and prisoners. An article by an anonymous author published in the *Lancet* referred to clinical forensic medicine as "three-faced practice" and the author correctly warns that "this potentially conflicting combination of roles leads to serious ethical dilemmas" (Anonymous 1993 p.1246).

In South Africa these services are generally provided by district surgeons[1]. These are medical practitioners appointed for the purpose of rendering medico-legal services. However, due to the need to serve more than one master, dual obligation situations arise commonly in the field. The Truth and Reconciliation Commission (TRC) stated in its final report that "of all the health professionals in South Africa, district surgeons working under the apartheid government had one of the most difficult jobs in terms of upholding medical standards and human rights" (TRC Report 1998 p.111).

No other case illustrates this better than the arrest, detention and subsequent death of Steve Biko, which I will discuss briefly in chapter two, where I will also show that although the district surgeons system was changed in 1998, doctors in clinical forensic medicine are still faced with dual obligations arising from the forensic nature of their work, as opposed to pressure from employers and the State due to political reasons. Failure to identify these conflicts may result in the:

(i) Erosion of trust between society and the forensic medicine field. This will spill over and discredit the whole criminal justice system.
(ii) Violation of rights of detainees.
(iii) Death resulting from failure to protect detainees where necessary.

Should the new generation of clinical forensic medicine doctors fail to recognise and correctly manage conflicts of obligations, it will imply that an opportunity to learn from apartheid mistakes and TRC outcomes would have been wasted.

Therefore, overlooking dual obligation situations or failure to identify these situations is as morally blameworthy as is failure to correctly resolve such conflicts.

[1] District surgeons are medical practitioners of any gender, including female practitioners. However, in this paper I refer to district surgeons as he/him for simplicity.

In chapter two of this paper, I explore the field of clinical forensic medicine as well as the role of district surgeons. I highlight some atrocities mentioned in the TRC's damning report regarding the conduct of some district surgeons. I also discuss the changes that accompanied the dawn of the constitutional era in post-apartheid South Africa. I highlight the consequences of failing to manage dual loyalties by discussing the case of Steve Biko's death.

In chapter three, I discuss possible ethical frameworks for approaching dual loyalty conflicts in clinical forensic medicine. This includes traditional ethical theories such as utilitarianism, virtue ethics and 'principlism' as they relate to the obligations of district surgeons. I later argue for a duty based framework as the most appropriate in dealing with dual loyalty dilemmas.

Then in chapter four, I will outline the dilemmas commonly confronted in clinical forensic medicine by using three case scenarios.

I will also outline the differences between specific obligations for district surgeons as opposed to those of physicians.

In the last chapter, I suggest an approach for dealing with dual obligation conflicts, and I argue for obligations that should be regarded as central and specific to clinical forensic medicine. I end by revisiting the case vignettes and resolve the dilemmas by applying the approach suggested earlier in the chapter.

II. THE NATURE AND SCOPE OF CLINICAL FORENSIC MEDICINE

CLINICAL FORENSIC MEDICINE DEFINED

Clinical forensic medicine is a branch of medicine where medical knowledge is combined with legal processes for the purpose of the administration of justice. These legal processes include investigations of crimes like rape, driving under influence of alcohol and child abuse. The professionals in clinical forensic medicine may be involved at any stage of the legal process. This may include examination immediately after a crime has been committed (e.g. examination of a rape victim), examination before detention (e.g. a fitness to be detained examination), before giving evidence (e.g. fitness to plead) or after conviction (e.g. examination of sentenced prisoners). Whatever the setting, the subjects in clinical forensic medicine are living beings (compare with forensic pathology where medico legal investigations are conducted on the dead – e.g. autopsy to ascertain the cause of death). Dealing with living subjects implies that the district surgeon has to take into consideration the human rights of his subjects. However, some of the rights of citizens are limited once a person is in police custody, e.g. the right to freedom of movement. The district surgeon ought to be aware of all his obligations in these situations.

The term forensic is defined in the Free Online Dictionary as “pertaining to courts law” This term originates from Latin ‘*forensis*’ meaning forum or court of law. Likewise, clinical forensic medicine is practiced by medical practitioners who have to present evidence during court proceedings and write medico-legal reports. This branch of medicine does not include forensic pathology, forensic nursing and forensic psychiatry, which are well established separate disciplines.

Clinical forensic medicine practitioners are often referred to as police surgeons in the United Kingdom, and commonly known as district surgeons in South Africa. The role of clinical forensic medical examiners (district surgeons) is mainly the determination of a fact for use in court, collection of samples for further analysis at forensic laboratories or giving expert opinion in courts of law.

For simplicity and consistency, I will refer in this paper to medical doctors doing clinical forensic medicine work as district surgeons.

Clinical forensic medicine is “a medical field which may relate to legal, judicial and police systems” (Payne-James 2005 p.1).The value contribution of clinical forensic medicine to a societal good is its input in the fair adjudication of disputes and solving of crimes. It is this justice orientated role that sets clinical forensic medicine apart from other clinical specialties of medicines. There are several settings in which clinical forensic medicine may operate. These, however, vary greatly in scope and duties across different jurisdictions. Some of these duties as listed by Payne-James (2005 p.2) include the following:

(i) Determine status of
- Fitness to be detained
- Fitness to plead /be interviewed
- Fitness to be transferred
- Fitness to drive

(ii) Collect evidence
- From rape victims
- From suspects (DNA)
- Intimate body searches (for drugs and weapons)
- Documentation of injuries

(iii) Render medical care
- To detainees in custody
- To rape victims

(iv) Give expert opinion
- Expert in court /tribunal
- Criminal and civil court.

The primary duties in clinical forensic medicine are mainly non-therapeutic. The focus is on evidence collection rather than relieving suffering. However, in some settings, medical care of detainees and victims may overlap with forensic examinations.

Regardless of the setting, the duties of a district surgeon include either the drafting of a medico-legal report, recording and documenting such findings and/or interpreting these findings for purposes of legal proceedings.

Clinical forensic medical assessments ought to be carried out in an objective, fair and impartial manner. Often, two or more parties are involved in a dispute and have competing interests. On the one side, the suspect may desire not to have incriminating evidence or information revealed to the police by the district surgeon, whilst on the other hand, the police and /or prosecution may desire to obtain evidence or information that will prove a certain allegation. To this end, the police may attempt to secure evidence in a manner that undermines the suspect's rights. A district surgeon must not favour any of these sides during his work, and ought to conduct his or her duties in an objective and fair manner. However, district surgeons have been misunderstood by many in society as performing duties that merely serve the interests of law enforcement agencies and prison authorities. The use of the terms like 'police surgeon' in the United Kingdom (UK) does not do the image of these district surgeons much good either.

THE ROLE OF DISTRICT SURGEONS

Internationally, there is great variation of the skill requirement, knowledge, scope, employment arrangements and duties of district surgeons. Perhaps the most publicised clinical forensic medical examiner system is the UK's police surgeon system. Cooke (1978) argues that the realisation that crime was becoming sophisticated implied that there was a growing need for dedicated medical practitioners with intellectual abilities, training and requisite integrity to assist in fighting crime.

Most of these police surgeons are general practitioners with an interest in clinical forensic medicine or law. The police surgeon "provides a form of continuing care" (Cooke 1978, p.26). Initially they interact with a detainee/accused pre–court. This is immediately following an offence. At this early stage, they may be requested to obtain blood samples from the suspect who is arrested for driving under the influence of drugs and/or alcohol. Secondly, they interact with the accused in court during trial. Here they are asked by the magistrate or judge to assess the accused's fitness to stand trial or are requested by the defence advocate to examine an

accused alleging torture or assault. Thirdly, after the conviction, the police surgeon is called to determine the prisoner's fitness to be kept in custody. Finally, once in custody the police surgeon is again called to attend to the medical needs of the prisoner. This may be minor medical ailments, and/or complaints of ill-treatment by prison officials. Even after the prisoner's release on parole, the police surgeon is still involved by way of monitoring compliance with parole conditions and rehabilitation e.g. screening for substance abuse. Whenever a police surgeon interacts with an accused or detainee, at whatever point in the continuing care or at any point of the criminal –justice system, there is a fundamental duty for "sagacious and unbiased factual expression" (Cooke 1978 p.7). I will argue in this paper that respect for persons is a fundamental principle for practitioners in clinical forensic medicine from which other obligations can be derived.

In the South African context, the role of the police surgeon has been the responsibility of the district surgeon until recently.

THE DISTRICT SURGEON – A GLOBAL PERSPECTIVE

The Department of Health is responsible for the provision of clinical forensic medical services in South Africa. The services include care of prisoners in correctional facilities, as well as obtaining evidence from living subjects who may be in detention, under arrest or are victims of crimes such as rape. The medical practitioners appointed by the Department of Health to perform these duties were referred to as district surgeons until recently. With changes within the Department of Health, there has been suggestions to use other terms like 'clinical forensic medical examiner – (CFME)' when referring to district surgeons[2]. However, most people know these CFME as district surgeons and the term district surgeon is still dominant in South Africa to date. I therefore use the term district surgeon throughout this paper.

Compared to police surgeons in the United Kingdom, or forensic physicians in Europe, there are a number of similarities in scope, duties, requisite skills and background. In South Africa as well as other areas in Europe and USA, there exists no post-graduate training requirement for appointment into these posts. The result is

[2] The term CFME was suggested in draft Clinical forensic medicine regulations, regulation No: 33655(amendment to National Health Act) gazetted in October 2010, and was later dropped when the draft regulations were signed into law on the 2nd March 2012.

that most district surgeons have no specific training. They are general practitioners with an interest or inclination towards the field. They are employed to perform clinical forensic medical duties mainly on a part-time basis. This is also the case with the police surgeons in the UK. In South Africa as well as the rest of the world, district surgeons traditionally earned their skills through what Cooke (1978) refers to as self-instruction. This is the accumulation of experience as well as learning from colleagues.

However, there are differences between these district surgeons across the different countries. For example, police surgeons in some metropolitan areas in the UK serviced medical needs of police officers and their families. This obviously resulted in a much closer relationship between the police officials and police surgeon. This included “mutual respect and goodwill” (Cooke 1978 p.7), which are good values and ought not to be frowned upon per se, except where they influence the police surgeon’s objectivity when performing his duties. However, what made the South African district surgeons’ relationship with police extremely problematic was the political environment under which they practiced. Racial discrimination administered by the apartheid government divided the country broadly along racial lines. The apartheid system was an oppressive and undemocratic rule by a minority white government in South Africa prior to the first democratic elections where all races had the opportunity to vote. Many district surgeons became trapped in the political climate of the day, much so that their decisions on the treatment of detainees and suspects became tainted by racial prejudice. The district surgeon system was “riddled with racial prejudice, as well as unsympathetic, judgmental and untrained staff” (Jewkes 2008 p. 3).

The absence of formal training and a common forensic medicine ethic amongst district surgeons implied that ethical dilemmas, especially loyalty conflicts, were resolved in an arbitrary manner or inadequately resolved. This was often to the detriment of the vulnerable detainee, who in most cases happened to be a black person, often a political prisoner. This was more so where the district surgeon in charge happened to be a white person who strongly identified himself with the apartheid government’s course and was himself a racist. He would perceive the vulnerable black prisoner or suspect as a threat to ‘the Nation’.

The lack of field specific ethical guidance and non-specificity of the basic medical ethical principles to the field of clinical forensic medicine left the detainees' well-being and care, including treatment and justice at the mercy of the district surgeon in attendance. If the district surgeon was racist and white, the treatment a black detainee would get, especially if he was a political prisoner, is a kind of treatment which is similar to that would be rendered by an enemy. Medicine had become "as tainted by apartheid as had any other sphere of interaction of people in South Africa" (McLean, Jenkins 2003 p. 84).

This is clearly demonstrated by the detention and subsequent death of Steve Biko, a Black Consciousness Movement leader in South Africa. The district surgeons who attended to him whilst in custody "had become habituated in wrong attitudes and practices" (McLean, Jenkins 2003 p. 87). They demonstrated total failure to recognize and act in accordance with their ethical obligations.

I will expand more on this failure to recognise dual loyalty situations by discussing the clinical forensic medicine aspects of Steve Biko's death. At each and every turn during Steve Biko's detention, the district surgeons either overlooked an obligation, or incorrectly managed a conflict of loyalties. Amongst other things, the Steve Biko case highlights the importance of ethical guidelines for clinical forensic medicine, which are currently non-existent in South Africa.

LESSONS FROM THE DETENTION AND DEATH OF STEVE BIKO

According to the TRC report (1998), Steve Biko was born 18 December 1946 in the Eastern Cape, South Africa. He was a medical student at Natal University, but he had to terminate his studies for political reasons. He was politically active mainly as a leader of the Black Consciousness Movement. The apartheid regime saw him as an enemy and threat, and he was arrested on 18 August 1977. Whilst in police custody, Steve Biko was repeatedly interrogated, at times for extended hours. It was during these interrogation sessions that he sustained serious injuries, most likely due to being assaulted by police officials. Despite the visible external injuries and apparently obvious symptoms of a head injury, the district surgeons who attended him several times either did not perform their duties diligently or failed to recognise their obligations. This resulted in his death under police custody. Where one duty

was in conflict with other obligations, they failed to identify and correctly manage these conflicts.

The numerous actions and non-actions by the district surgeons cannot be justified using any of the general ethical frameworks. I analyse specific actions or non-actions by the district surgeons who attended Steve Biko. In each action or non-action, I apply one of the basic ethical frameworks to explain the existing duties which were either not identified or conflicts that were incorrectly resolved. I therefore argue that this failure to identify a duty or incorrectly resolving the conflict of these duties is morally impermissible. The specific behaviour of the district surgeons I plan to explore further relates to:

(i) Steve Biko being examined in cuffs and shackles on the floor, chained to wall.

The TRC report (1998) details how a district surgeon examined Biko in a prison cell. He was in leg irons and handcuffed, despite his clinical condition showing a very ill Biko. He remained on the floor, on a piece of mat chained to the wall even after a clinical examination by the district surgeon. His hands and ankles, as well as feet were swollen and had cuts. These injuries are consistent with the unnecessarily excessive physical restraining used on Biko.

(ii) Steve Biko being left to lie naked on urine-wet mat

The sight of a patient on his own urine or even wet diaper is stimulus enough for most doctors to question nursing staff about the care a patient is receiving. Steve Biko remained in such conditions after being seen by the district surgeon, according to the TRC report (1998). The nursing care of a prisoner is not a direct responsibility of the district surgeon. However, where such care is required, the doctor should prescribe or facilitate adequate care. For example, a doctor can advise nursing team to move a patient periodically to an area with sunshine. It is in the fiduciary nature of the role of medical practitioners that we have come to expect these actions, even though they may have already been prescribing good medication to patients. What are the obligations of district surgeons when a detainee is kept under inhumane conditions?

(iii)Steve Biko being transported on the back of a van and a mat used as a stretcher

A critically ill Biko was transported from Port Elizabeth to a facility in Pretoria. It is common in South Africa that patients are transferred from one province to another for specialized care. Though these journeys are often long, the transfer is arranged so as to minimise chances of adverse effects. Precautions include well equipped ambulances and appropriate personnel, often a professional nurse who accompanies the patient. The doctors from both facilities liaise telephonically and also by using referral documents.

Biko was, however, transported in the back of a Land Rover van in a critical condition (head injury). The transfer was without any of the above equipment, personnel or documentation.

On arrival at the Pretoria facility, a police official gave a verbal brief to the receiving doctor. This transfer was authorised by district surgeon.

(iv) Biko being given a drip and vitamins

On arrival at the Pretoria facility, Steve Biko was seen by a district surgeon, who was given a background that Biko is “a detainee who is on a hunger strike and also faking illness” (TRC report 1998 p.113)

The district surgeon prescribed a drip and multivitamins. The doctor here accepted the diagnosis given to him by the police and treated the patient according to that information. Intravenous rehydration and vitamin supplementation may be of benefit to a detainee who is on a hunger strike, if otherwise healthy. The district surgeon here may argue that he acted to promote good and at the same time not violating the detainee’s supposed determination not to consume any food.

DIFFICULTIES IN JUSTIFYING THE ABOVE CONDUCTS OF THE DISTRICT SURGEONS

It is impossible to justify the above actions by using any ethical framework of reasoning.

(i) An attempt to appeal to tradition and practice standards

The practice of medicine has traditionally been about more than healing the sick and the wounded. Knight *et al* (1995) state that the doctor-patient relationship is traditionally seen as fiduciary in nature. This is a relationship based on trust. The patient is reliant on the doctor for his well-being. The doctor's duty is to act in such a way as to promote the well-being of patients. Included in this is the need for the doctor to ensure the patient's psychological well-being. The inhumane chaining to the wall of Biko, who was already weakened from assault and torture, should have prompted the district surgeon to request less degrading conditions of detention for the patient. He was so weak that he could not possibly escape from custody even if left alone with doors open. The doctor ought to have advocated for release of pressure from leg irons and handcuffs, which were causing pain and injuries to Biko's wrists and ankles. This also could have included a request for a bed or couch, at least a mattress to also assist with the clinical examination.
To treat the injuries caused by excessive physical restraints would involve releasing the force used for restraining someone.

However, the doctor also has a duty to assist police officials in solving crimes and this extends to keeping detainees in a secure facility. The doctor should therefore not frustrate the efforts of the police by directly or indirectly enabling prisoners to escape from custody. At first inspection, it appears as though there is a conflict of duties that the district surgeons were facing:

(i) Duty to act in the best interest of the detainee by reducing force used in physically restraining Biko, vs.
(ii) Duty to assist police including keeping of prisoners in detention.

However, a closer inspection will show that the duty to the patient can easily be satisfied without compromising safety and security of society. Keeping a weak person in a cell, guarded, handcuffed, shackled and chained to a wall is excessive restraint. The district surgeon could have appealed to patient's interests and well-being considerations in negotiating for use of lesser physically restraining methods. The district surgeon failed to identify this duty or ignored it deliberately, or he might have incorrectly given priority to security considerations over the patient's well-being,

and hence his actions and/or non-actions were morally impermissible, as they were inconsistent with the general tradition of medical ethics.

(ii) An attempt at virtue–based appeals also fails

The make-up of a good doctor and thus good actions are not always captured by analysing the nature of their actions. Virtue ethics is "primarily concerned with character than conduct" (Darwall 2005 p.34). There are character traits desirable for a person doing clinical forensic medical work like a district surgeon. These include honesty, fairness, justice and respect. These character traits are especially crucial for a district surgeon who deals with very vulnerable individuals.

Upon seeing a detainee in conditions described above, a virtuous district surgeon will automatically enquire into these conditions. He may also insist that the detainee be clothed appropriately and kept in a clean space. According to the TRC report (1998), the district surgeon involved in this scenario did not express discomfort at the horrific conditions under which Biko was kept. The character of the district surgeon allowed him to permit such conditions to persist. It seems that key virtuous character traits were lacking from these district surgeons, or else they deliberately chose to act out of character. They therefore cannot be said to be acting as virtuous agents if these traits are periodically and not habitually exhibited, since they also failed to exhibit such character traits when dealing with Biko. There is also no identifiable duty that could cause a conflict with an action such as requesting a bed for a patient. The district surgeon's actions were morally reprehensible from a virtue ethics perspective.

(iii) Attempts to justify actions by appealing to duty based theories - Deontology

The police obtained authorisation to transfer Biko between the two facilities from a district surgeon. This was following a clinical forensic medical assessment, which includes fitness to be released from custody, fitness to be detained or transported. The main objective of these fitness examinations is to protect detainees from harm. The obligation 'not to do harm' is expressed in many oaths and medical codes, notably the Hippocratic Oath. It is therefore imperative 'not to put the detainee at risk of harm'. It is the duty of a district surgeon which can be said to be a 'perfect duty' in Kantain terminology. This means that this duty applies to all aspects of clinical

forensic medicine, including during evidence collection. It applies at all times without exception. One example of a rule in the collection of evidence is that clinical forensic evidence need not be obtained at all cost, especially where this exposes detainees to a risk of harm or death. This duty was violated by the district surgeon, who by authorising improper transportation of Biko exposed him to significant harm. This district surgeon's maxim that 'one can expose others to harm if he wants to' is non-universalizable. Imagine if such a maxim were to be adopted by an air traffic controller. He could therefore authorise departures and landings that risk crashes and expose passengers to risk of death. People wouldn't use aeroplanes in such situations. Hence the district surgeon failed to act according to his duty by acting on a maxim that himself would not wish it to be universal law.

Those sympathetic to the district surgeon's action will argue that he acted in accordance with another duty. They may claim that the district surgeon acted on a maxim that one must co-operate with police. This therefore allows the police to perform their tasks without disturbance. They argue that the district surgeon acted out of this latter duty for fear of frustrating police work. The opposite of this will be universalizing a maxim of not co-operating with the police. If people are allowed to disobey police demands, it will lead to an uncooperative society that frustrates the police in their work, and thus general disregard for the rule of law.

However, the problem with this argument is that it presupposes that the duty not to put detainees at risk is in conflict with a duty to co-operate with police. They fail to recognise that both duties can be fulfilled simultaneously. Such a failure to identify duties is morally impermissible, whether the failure was deliberate or not. Biko could easily have been transported in an ambulance as opposed to a van, accompanied by nursing personnel, with proper documentation under police guard, without exposing him to unnecessary harm or disregarding police requests.

(iv) Appeal to 'principlism'

Medical ethics has a number of guiding principles which are often easily applied to practical situations. These principles are "respect for autonomy, non-maleficence, beneficence and justice. The basic idea is that "moral problems can be best approached by applying one or more of these basic moral principles" (Van Niekerk

2013 p. 37). These principles, according to Beauchamp and Childress (2013) should be weighed until coherent.

Dealing with the detained Biko, the receiving doctor at the Pretoria facility acted in a manner that did not inflict harm. So the principle of nonmaleficence was upheld by giving a drip and multivitamins, those who defend the doctor's actions will so argue.

However, there is some discomfort with the appropriateness of this treatment, given the condition of the detainee, who in fact died the following day. The district surgeon did not inflict harm, but failed to recognise another duty, that is the duty to prevent harm. Fulfilling this would involve identifying the head injury and treating it accordingly.

Defenders of the district surgeon's actions also maintain that he acted morally since he accepted what he was told by the police and acted according to the information at his disposal. However, this position forgets that the work of a district surgeon is forensic in nature. This means it is based on a 'quest for the truth'. Taking what a police officer tells you about a detainee's condition without verifying it with a thorough examination is a failure to perform clinical forensic duties. This in turn disadvantages the detainee, who can't put across his version of the truth. Clinical forensic medicine is also about the uncovering of truth through evidence collection and interpretation of findings.

The district surgeon thus failed to recognise this fundamental duty in clinical forensic medicine. He instead focused narrowly on superficial conception of non-maleficence. He failed to bring his judgement into coherence with all other relevant factors. This is why the prescription of a vitamin injection and a drip for Biko does not sit well with a lot of people even though the action itself is not prohibited. Following reflection, such a superficial application of 'principlism' lacks coherence and stability, i.e. it is not in equilibrium and hence morally reprehensible.

By following Steve Biko from Port Elizabeth to Pretoria, through different district surgeons, I have demonstrated a number of ethical obligations that arise in clinical forensic medical practice. I have also identified situations where there was conflict of loyalties and demonstrated the instances where there was either: failure to identify

an obligation and act accordingly; or simply a failure to correctly resolve the dual loyalty situations.

The actions of the district surgeons cannot be supported by any argument based on the fundamental ethical framework including medical tradition, ethical theory, and mid-level biomedical principles. It is therefore no wonder why district surgeons received such a serious rebuke at the Truth and Reconciliation Commission. Such ethical violations by district surgeons were common occurrence before 1994 in South Africa.

CLINICAL FORENSIC MEDICINE IN –APARTHEID SOUTH AFRICA

The Truth and Reconciliation Commission (TRC) conducted hearings on a wide range of violations that occurred during the apartheid era. The Department of Health's role in the atrocities came from many fronts, one being the forensic medical services in South Africa. In its report, the TRC acknowledged difficulties and challenges faced by district surgeons.

This was due to the fact that "primary function of district surgeons is not the provision of health care" (TRC report 1998 p.111), and hence they are exposed to dual obligation situations as illustrated by the district surgeons who attended to Steve Biko. It was established that "the most common offence was failure to carry out their duties within internationally accepted guidelines of medical ethics" (TRC report 1998 p.113). Amongst the violations listed in the report were failure to treat patients with respect and dignity, failure to examine patients thoroughly, inaccurate documentation, and violation of patients' privacy. All these violations were committed in the Steve Biko case.

As a result, the district surgeon system was changed, and their duties are now carried out by staff of the forensic medical services directorate. This directorate is under the Department of Health. The practitioners are still general practitioners, some full time and others part time. There is no qualification specific for appointments into the positions of a district surgeon, as was also the case with district surgeons during the apartheid era. However, there are still ethical violations by the new district surgeons, but these are not as atrocious when compared to those violations committed by the previous district surgeons. These ethical violations may

no longer be as a result of racial prejudice and influence by the state or pressure from the employer. I will argue that they are violations mainly due to failure to recognise obligations specific to clinical forensic medicine, and this eventually results in unethical practices, through improperly resolved dual loyalty conflicts. I will discuss in detail these situations in chapter four below by using case vignettes.

The reduction in ethical violations following the disbandment of the pre-apartheid district surgeon system is not as a result of better trained district surgeons who are able to recognise their obligations and can resolve dual loyalty conflicts. It is mainly a reflection of the changes in whole of society following the ending of the apartheid system, and hence the impact of the introduction of a Constitution of the Republic of South Africa (1993).

The Constitution of South Africa introduced into the country a legal obligation and a culture of respect for human rights. Chapter two of the Constitution of the Republic of South Africa contains a Bill of Rights. Citizens have many rights guaranteed in this constitution (The Constitution 1993). Especially important to the district surgeon are the rights to human dignity, equality before the law, privacy and security of person. The Bill of Rights further lists certain rights applicable specifically to detainees. These include the right to appear in court as soon as possible, a right to fair trial and a right to be detained under conditions consistent with human dignity, including medical treatment (The Constitution 1993 Chapter 2). The manner in which evidence is obtained by district surgeons must not violate the Bill of Rights.

The above rights have direct bearing on the manner in which district surgeons treat detainees and prisoners. This new culture of respect for human rights contributed to a shift in the mind set of district surgeons, who also made submission to the Truth and Reconciliation Commission. They claimed that they were not aware that they can disregard police instructions if those requests were unethical and cruel.

Gross ethical violations may have lessened with changes that took place post -1994 in South Africa. However, even in an environment completely different from apartheid South Africa, district surgeons continue to face ethical dilemmas, especially dual obligation conflicts. There is therefore a need to prepare the district surgeons for these kinds of situations. These dual obligation conflicts are, however, not restricted to clinical forensic medical practice.

Take for an example a casualty officer who receives a patient from a paramedic with a history of having crashed onto a wall whilst driving home from meeting with friends at a local bar. He complains of pains on the chest and right ankle. He is clinically stable and conscious, but smells of alcohol.

The doctor has a primary obligation to safeguard the well-being of the patient. However, section 37subsection(2)(b) of the Criminal Procedure Act 51 of 1977 places an additional duty on the treating doctor to go beyond mere treatment of injuries, and take samples for blood alcohol if these may be of value in later criminal proceedings. Sec 37 (2) (b) states that "if any registered medical practitioner attached to any hospital is on reasonable grounds of the opinion that the contents of the blood of any person admitted to such hospital for medical attention or treatment may be relevant at any later criminal proceedings, such medical practitioner may take a blood sample of such person or cause such sample to be taken".

This therefore introduces a dual loyalty dilemma for the casualty officer, whose primary loyalty should be to his patient.

However, the legal obligation as stated in this Act is not categorical (the wording states that *may* and not *must*) and it therefore allows the casualty officer to apply his mind to the situation. Often he will focus only on his primary obligation, that is to treat his patient, without violating the provisions of section 37 (2) (b) stated above. So in this instance, the doctor will ignore the provisions which do not make it obligatory, but merely allows him to obtain blood sample if he deems it necessary. The doctor realises his duty to be loyal to his patient's interests. However, there is also an expectation as a member of society to contribute towards the betterment of society, by bringing drunk driver to face the relevant legal sanctions. The doctor's loyalty to his patient is in conflict with his loyalty to the society. The doctor prioritises his fiduciary obligations to the patient at the expense of society's interests.

Clinical forensic medicine is a challenging specialty, and district surgeons continue to face ethical dilemmas despite changes brought about by constitutional democracy in South Africa. The Steve Biko case demonstrates the numerous ethical violations that a district surgeon ought to be aware of when dealing with detained persons.

The actions of the district surgeons who attended to Steve Biko cannot be justified by any way of reasoning possible. They instead claimed they were ignorant of their ethical obligations. In the next chapter, I explore ethical theories in search for a framework that will provide a basis for the district surgeons' ethical guidelines.

III. POSSIBLE APPROACHES TO DILEMMAS IN CLINICAL FORENSIC MEDICINE

INTRODUCTION

District surgeons should act ethically during the conduct of their duties. This is especially important since their work involves dealing with vulnerable individuals at the hands of power yielding law enforcement agencies. Where should guidance for this ethical practice for district surgeons derive from? “Is the source that grounds medical ethics internal or external to medicine?” (Beauchamp 2001 p.606)

In this chapter, I explore both internal and external sources of medical morality applicable to clinical forensic medicine. I also explore ethical frameworks and highlight the multiplicity of obligations resulting from the nature of clinical forensic medicine.

Clinical forensic medicine is concerned with the application of medical knowledge to the adjudication of legal disputes. The practice of clinical forensic medicine often involves examinations or assessments of subjects, often a detainee, as well as the supply of medico-legal reports to legal practitioners, court or police. The implication is therefore that there exists some form of an expectation from both sides of the dispute, i.e. the side of the detainee and the side of the law enforcement agencies. Often these two sides’ interests stand in stark opposition to one another.

First I discuss the possibility of obtaining guidance from clinical forensic medical tradition, and then secondly I explore fundamental ethical theories. This includes an exploration of consequentialism, mid-level principles and then virtue ethics. I then argue that a duty based theory is better suited to provide an ethical framework for clinical forensic medicine.

TRADITIONAL PRACTICES IN CLINICAL FORENSIC MEDICINE

The practice of medicine has a long rich history, with a tradition based on the doctor–patient relationship. Medical ethics derives from this tradition, which is focused on serving the patient. Almost every medical ethics or code for professional conduct appeals to this overarching aim of medicine, that is; not to harm patients and act for

their benefit. The Hippocratic Oath, (North, 2004) for an example, in all its versions appeals to a sort of '*primum non nocere*' and benefiting of your patient's principles. An early version of the Hippocratic oath states "I will follow that system of regimen which, according to my ability and judgement, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous" (North 2004 p.1). Another modern version approved by the American Medical Association states that "into whatsoever house you shall enter, it shall be for the good of the sick to the utmost of your power" (North 2004 p.3). This tradition has been expressed in a number of codes of ethics to date. It implies that doctors ought to act for the sole benefit of their patient. The World Medical Association (WMA) code of ethics states that a "physician shall owe his/her patients complete loyalty" (WMA 2006 p.2).

The fiduciary nature of the doctor-patient relationship is based on trust. A fiduciary relationship in law, as discussed previously, is between someone who is entrusted with power or property to be used for the benefit of another. It is therefore "dependent on trustees not to further their own interest" (Rodwin 1995 p.242). In medicine, a doctor trusts that the patient will open up to him/her, and in return the patient trusts that the doctor will respect and use the information for his/her benefit.

The values that the physician should seek to promote are therefore entrenched in the tradition of medicine. As a result, the duties of a physician can be derived from the rich tradition of practice of medicine, such as relieving suffering.

Clinical forensic medicine is a discipline that is not based on the traditional doctor – patient relationship. It is a field not primarily focused on the well-being of patients. It is mainly concerned with "the application of medical knowledge to the adjudication of legal disputes, both criminal and civil" (Payne-James 2005 p.5). Hence the traditional medical ethics based on trust and fiduciary nature of doctor –patient interaction is not central in clinical forensic medicine. Clinical forensic medicine's main objective is the administration of justice. However, clinical forensic medicine is a very young field, which began finding its distinct identity during the past few decades. It therefore lacks a tradition that can be referred to as a basis for practice and guidance unlike general medicine. This, coupled with the lack of uniformity internationally in the scope and skills required for the practice of clinical forensic medicine, means that there is a lack of a well-established clinical forensic medicine tradition to appeal to.

The standard of medical care of detainees in police custody “is variable, and there are no international standards of practice or training” (Payne-James 2005 p.9). The district surgeons committed numerous violations during apartheid South Africa. By so doing they acted unethically but did not break away from any well recognized clinical forensic medical tradition. They did not belong to any association locally and internationally which had a distinct ethical code, other than the code of ethics applicable to the general medical profession. Whilst overlooking the international medical ethics codes such as Geneva Convention, they relied heavily on individual morality, which was biased along racial lines. This meant therefore that there was a lack of uniformity in the way a district surgeon would treat detainees, as individual moralities vary greatly. The ill-treatment that Steve Biko endured is representative of one extreme end of a continuum, which on the opposite end consists of individual district surgeons who not only treated detainees humanely, but actively fought for the rights of detainees. A case in point is district surgeon Dr Wendy Orr. According to the TRC report, district surgeon Dr Wendy Orr, sought a court interdict to restrain police from assaulting detainees. Dr Orr told the court that she felt “morally and professionally bound to seek legal intervention.” (TRC Report 1998 p.117)

The actions of Dr Orr stand in stark contrast to those of the district surgeons who treated Steve Biko. There is also a lot of variations in-between these two extremes. It seems district surgeons lack a unifying code of ethics and rely on individual morality, which is too arbitrary.

Even if there existed a code of ethics for district surgeons and police surgeons derived from the unique goals of clinical forensic medicine, mere adherence to such internal morality does not mean that there would be no ethical violations and loyalty conflicts. It is also important to remember that “an internal medical morality notoriously may not be adequately comprehensive, coherent or even morally acceptable. Traditional and professional standards are no guarantee of even minimal moral adequacy” (Beauchamp 2001 p.605).

So even if clinical forensic medicine can try to appeal to the short tradition championed by police surgeons via the establishment of the Association of Police

Surgeons (APS)[3] in 1952, in the UK, such a morality will not be self-justifying. There is therefore a need to explore ethical theories in order to form the basis of such a justification.

In a simplified representation of human action by Solomon (2004), the following is depicted as a broad outline of components of human actions:

P →→→→ A →→→→ C +++++++

This represents "an agent (P) is performing an action (A) which leads to consequences (C)" (Solomon 1995 p.814). I will explore guidance from ethical theory by looking at each of the above components. In the next section, I discuss the dominant ethical theories that can provide guidance for district surgeons in identifying their obligations.

CONSEQUENTIALIST THEORIES

Utilitarianism

Consequentialism is an ethical theory which judges actions by the greatest good in the outcomes they produce. Utilitarianism subscribes to the principle of results as well as the principle of utility.

There are a number of very prominent philosophers who contributed to the development of utilitarianism. The most prominent of these according to Greetham (2001) includes the English philosophers Jeremy Bentham, John Stuart Mill, and George E. Moore. The first two developed a classical form of utilitarianism. They argued that pleasure should be promoted for the greatest number of persons. Pain is the opposite of pleasure and hence must be reduced.

Greetham (2001) argues that Bentham J (1748 – 1832) recognised any form of pleasure as worthwhile, whereas Mill JS (1806 – 1873) differentiated sophisticated pleasures from simple one. The conception of pleasure as being more than a sensation, but to include other sophisticated forms like happiness, partially replied to the pigsty philosophy objection. This objection basically rejected the promotion of every kind of pleasure; including, as an extreme example, a pig deriving pleasure from dancing in dirty mud.

[3] The Association of Forensic Physicians, formerly the Association of Police Surgeons, remains the leading professional body of forensic physicians worldwide, with more 1000 members (Payne-James 2005 p.8).

Hedonistic utilitarians view pleasure as the sole good (and pain at the opposite end). Ideal utilitarianism on the other hand, championed by Moore GE (1875 – 1958) argue for a pluralistic conception of good to include more than mere pleasures. However, no matter what the conception of good is, utilitarians agree that actions ought to promote the greatest good for the greatest number of persons.

This means that an agent's actions ought to promote the greatest human welfare for the greatest number. In this theory then, every person counts for one and equally. There is no special consideration for certain classes of persons or special relations. Physicians, nurses and more especially district surgeons are sometimes confronted with the question 'what is the morally right thing to do'. The answers are not obvious in many situations. This sets in motion a normative enquiry into what a moral agent ought to do.

For utilitarianism, the outcomes of an act are the basis of a judgment into the rightness or wrongness thereof. The characters of the agent as well as the nature of the action are therefore not significant. The aim of a moral agent is to act in a manner that maximises good outcomes over negative ones.

Utilitarianism can further be divided into rule and act utilitarianism. Rule utilitarianism requires that rules producing the greatest good should be followed. These are rules that are more generally applicable to a variety of situations. On the other hand, act utilitarianism will demand a more specific analysis of each and every situation.

The consequentialist theory of right may be summarised in the following formulation: An action is permissible if and only if it results in the promotion of good over evil for the majority, where everyone counts for one.

How can utilitarianism be adopted as a framework for the ethical guidance of the district surgeons? The district surgeon deals with a detainee who is accused of a certain crime against a person or a number of persons. This automatically disadvantages the detainee whose interests at times are in direct conflict with that of the whole community. It is unlikely that a utilitarian calculus will ever yield an outcome that will benefit a detainee.

Apart from challenges with such a calculus in clinical forensic medicine, the utilitarian district surgeon must still decide what 'good' means? Is it going to be pleasure (hedonistic) or holistic good (non-hedonistic ideal utilitarianism)?

What should good consequences for clinical forensic medicine entail?

Solomon (1995) explains that the utilitarian theory also draws distinctions between intrinsically good things and extrinsically good things. Intrinsically good things are things that are good in themselves. Examples include pleasure, happiness and knowledge. On the other hand, instrumentally good things are desirable for the good things they are capable of producing. Examples of instrumentally good things are things like money and patience.

For a district surgeon, the fair adjudication of disputes and hence ultimately crime reduction are goods to be promoted over injustices. Fair adjudication of disputes, fair procurement of evidence and impartial presentation of facts are instrumental goods to strive for in the field of clinical forensic medicine. These are instrumental goods since they promote justice, contribute to the fight against crime and promote the safety and well-being of citizens. Reduction of crime is good in and on itself. A safer environment forms the basis for individual self-actualization. The district surgeon ought to contribute to the reduction of crime.

What if, in certain instances, the reduction of crime might be better served by fabricating evidence, so as to make it easier for the court to convict an accused person? In other words, remove one criminal by whatever means possible for a safer society. Or maybe reduce crime by torturing one suspect who will yield answers that lead to the arrest of several more dangerous criminals and make the world a better place for many people. Ought a district surgeon to assist in these actions that will lead to the reduction and even elimination of crime? Utilitarianism seems to suggest that weakening the accused's case by overlooking a minor piece of evidence and hence assist in putting a criminal behind bars is morally permissible. The district surgeon may find himself in an uncomfortable position by having to promote some predefined good through wrong actions, such as fabrication of evidence, as the ends justify the means in this moral theory.

So when confronted with a dilemma, a utilitarian district surgeon is to consider all possible outcomes in that particular situation, and compare alternative actions. By 'balancing' all possible outcomes for all involved, the district surgeon will be able to arrive at an action guide. This is, however, very time consuming and the result can also be unpredictable in each and every case. In clinical forensic medicine, it will amount to non-standardized treatment of subjects who otherwise may be facing similar situations. Treating detainees in similar situations differently for no valid reason may violate basic principles of justice.

This theory is ill-suited for clinical forensic medicine, because of its overemphasis on good for the majority at all costs. This means that a person's well-being will always be overridden by the majority. So violating others' basic human rights is permissible if net results will bring about maximum utility. The implication here is that utilitarianism "is incompatible with the ideal of justice" (Rachels and Rachels 2010 p.112). Such a situation cannot be promoted in clinical forensic medicine where the individuals' rights and justice are the ultimate good that every district surgeon ought to strive for.

VIRTUE ETHICS

Utilitarianism seems to fail to adequately give description of a 'good' district surgeon and/or 'good' medicine. Take for example a doctor who visits a very sick detainee (patient) in custody. Instead of actively intervening in an attempt to improve the prognosis of the patient, this doctor simply sits next to the patient. He chats to the patient about social and political issues, family background and the patient's interests. During the 30 minute chat, the district surgeon will occasionally hold the patient's hand. As he leaves the holding cell, the doctor taps patient on the shoulder and smiles. The patient may be left with a feeling of 'yeah! This is a good doctor'. But what makes this district surgeon good? The fundamental ethical theories would attempt to enquire into consequences of the doctor's actions, or appeal to some duty that the doctor is supposed to have carried out. These frameworks cannot adequately explain why the actions of the doctor are praiseworthy. There is also nothing in the utilitarian account that would even suggest an obligation to chat to this patient. What the district surgeon displayed is valued by the detainee. It is in the kind of person he is, not because he is duty bound nor because it maximizes some good. As seen on the schematic representation of human actions by Solomon (1995 p.814):

P →→→→ A →→→→ C +++++++

where an agent (P) performing an action (A) which lead to consequences (C). Utilitarianism considers the basis of morality to be its consequences (C), whereas the deontological approach considers moral judgment to be based on intrinsically action (A). Both these approaches overlook agent (P) in the moral judgment of actions. And as can be seen from the example of the chatting doctor above,

something about his character makes him a good doctor. This in turn makes his actions good. This is the basis of virtue ethics.

Virtue ethics attends to the agent (P) as opposed to just the nature of the actions or mere consequences. This suddenly brings to the fore another aspect of ethical enquiry which can be relied upon by a district surgeon facing a dilemma.

Virtue in this case simply means excellence, as argued by Oakely (1998). A simple conception is that “moral virtues are praiseworthy character traits that lead people to act well” (Hauerwas 1995 p.2552). Virtues are “traits valued by society and affect our judgement” (Greetham 2005 p.330).

There is no permanent universal list of virtues for all mankind. Each community specifies their own list, which may vary over time. For example, in religion “the theological virtues of faith, hope, charity and obedience have a central place” (Pence 2005 p. 253). There are also character traits which are undesirable. These are the opposite of virtues, and they are referred to as vices. Examples include pride, wrath, lust, envy etc. Greetham, (2001) quotes Aristotle describing virtue as a mean between two vices. For example, prudence is a virtue that is central to clinical forensic medicine. For every assessment and medico-legal report, caution and vigilance ought to be exercised when giving an opinion, taking into consideration the possible ramifications of erroneous judgement.

A prudent district surgeon should employ tact and wisdom whenever faced with a request from court or law enforcement officers. An example is a request to assess whether a detainee is faking an illness in order to evade prosecution. However, some symptoms cannot be confirmed by clinical examination. These include symptoms such as headache, dizziness and chest pain. The district surgeon should exercise foresight by careful clinical examination and application of general wisdom to discern the likelihood that the detainee is faking an illness. And if the district surgeon is unsure, the most ethically right thing to do should be to err on the side of caution.

Prudence in this instance is virtue. Deficiency in prudence leads to a district surgeon who is careless and reckless. Faced with a similar situation, this district surgeon will be very quick to disregard other factors at play and opine that the detainee is faking illness even if not entirely sure. This can have undesirable consequences and subsequent miscarriage of justice. Such recklessness (a lack of prudence) is a vice and should be avoided in the practice of clinical forensic medicine. On the other

hand, too much caution may lead a district surgeon to a situation where he is fearful to give an opinion against a detainee who is in fact faking illness. This can result in many detainees taking chances and eventually getting away with injustices. This kind of fearfulness (excessive prudence) is undesirable and can paralyse the district surgeon. The district surgeon ought to find the balance of the two extremes, which is virtuous. This example brings to the fore what Slote (2010) refers to as the multi-track nature of virtue, in that virtue is not merely the possession and exhibition of certain character traits, but also the to exhibit 'practical wisdom' by way of "situational appreciation" (Slote 2010 p.1). This practical wisdom enables a district surgeon to correctly appreciate the gravity of the dilemma he is facing, and is acquired mainly by experience. This is an extremely important quality to possess when dealing with dual loyalty conflicts.

So virtue ethics claims that "the morally right thing to do is what a good person will do in that situation" (Schiavo 2007 p.35). This approach seems to give a better account of the actions of the compassionate medical professional. He is simply a good person. He is a virtuous person. He possesses virtues that make him a good doctor. Our character "comes from like activities" (Greetham 2001 p. 331), meaning our actions lead to our characters.

Character "indicates the stability that is necessary so that various virtues are acquired in a lasting way" (Pence 2005 p.251). So character is not mere possession of virtues, but is also the ability to reliably act in that manner. But do virtuous actions towards a detainee imply that the doctor is virtuous? Slote (2010) disagrees and argues instead that occasional good actions do not make one a virtuous person.

To possess a virtue is "to be a certain sort of person with a certain complex mindset. The most significant aspect of this mindset is the wholehearted acceptance of a certain range of considerations as reasons for action" (Slote 2010 p.2).

So being virtuous is more than acting in a particular manner.

The virtuous person does good things for their own sake and his own fulfilment. He looks at a good life as that of 'human excellence and flourishing' (Greetham 2001 p.331). No other external motivations are necessary.

However, implications of the above are that virtuous characteristics may be defined differently by different societies and over time, as some critics have repeatedly argued. So, for a community of district surgeons, there should also be a set of virtues that will make one a virtuous practitioner. The professionals in clinical forensic

medicine should therefore develop certain virtues to guide them in order to act morally. For example, technical competence is required as a minimum to practice in the field of forensic science. This is a virtue intrinsic to forensic sciences.

Are there virtues which can be said to be intrinsic to clinical forensic medicine? Such a list should at least include honesty, justice, impartiality and compassion. Any list of virtue for a community cannot be exhaustive and absolute, since they are not to be displayed by all physicians at all times. However, we expect a "virtuous physician to exhibit these virtues when they are required and that he will be so habitually disposed to do so that we can depend upon it" (Hauerwas, 1995 p.2553).

The requirement to develop a way in which virtues can be possessed also implies that one does not possess these virtues by mere birth right. One has to work to develop these virtues. So irrespective of political landscape, a district surgeon should be able to develop and cultivate desirable virtues through training and experience.

A formulation of theory of right action in terms of virtue ethics will be as follows: An action is morally right if and only if it is performed by a perfectly virtuous agent. So in clinical forensic medicine, to act morally would entail possessing virtues that are desirable for physicians in this field of practice.

The virtue theory will be useful in the development of an ethical framework for clinical forensic medicine. For a start, actions like those of district surgeon Wendy Orr may be better explained by appealing to this theory, as Van Niekerk (2011) argues, virtue ethics is able to account for moral motivation. This fills the gap left by deontological and utilitarian approaches and will assist the district surgeon to justify his actions as being merely virtuous as opposed to being linked to a certain political agenda or a certain set of rules.

Secondly, the theory's emphasis on personal flourishing and fulfilment has benefits for those practitioners working under pressure from political forces. Even though their actions are frowned upon by colleagues and employers, they are left with a feeling of self-respect and triumph. For a change, the physician's success can be defined in terms of personal fulfilment and a sense of well-being.

But in clinical forensic medicine, there is a need for uniformity and consistency in the way different district surgeons handle certain ethical dilemmas. So an ethical framework for clinical forensic medicine must be able to produce clear action guides for the district surgeon. The treatment of detainees should not depend solely on the character of a district surgeon. This is because there is no easy way of ensuring that

district surgeons have the desired characters. A routine job interview will not be able to address this challenge. Otherwise the appointment of district surgeons would have to go to great lengths scrutinizing the characters of potential district surgeons, an impossible task when taking into consideration the multifaceted nature of the concept of virtue. Some may suggest a solution that allows district surgeons some time to cultivate the relevant virtues since virtues are not necessarily acquired at birth. So, how about allowing district surgeons time to acquire experience and become virtuous agents?

Such a suggestion is noble, however, virtue requires far much more than time or experience. A lot of damage may result from actions by district surgeons who may purport to be slowly cultivating the relevant virtues. Many detainees may suffer irreparable harm as a result of such unethical conduct.

Therefore, virtue ethics is not ideal as a basis for a clinical forensic medicine framework. It can however be relied upon to supplement another basic framework. Later in this thesis, I argue for the supplementary role that practical wisdom can play in the resolution of dual loyalty conflicts in clinical forensic medicine.

Much of clinical medicine relies on the four principles of bioethics to deal with dilemma in clinical practice. Is this approach sufficient for clinical forensic medicine dilemmas? I explore this approach in the next section.

MID-LEVEL PRINCIPLES

The Four- Principled approach to Bioethics (Beauchamp and Childress)

A district surgeon facing a dilemma may appeal to any number of ethical theories in order to make a decision. However, ethical theories are often stated in very abstract formulations and may be too broad for direct application to everyday practical dilemmas. These ethical theories are an “attempt to systematize and justify a set of principles that applies comprehensively to all of the moral issues that people are confronted with” (Ainslie 2002 p.2100). These principles are more accessible for health professionals to apply in practice than abstract moral theories. One such principles based approach is the four principle approach championed by TL Beauchamp and JF Childress. They argue that four principles “provide the proper justificatory framework for bioethics” (Ainslie 2002 p.2100). This approach was mockingly referred to as ‘principlism’ by critics, a term “that has since been

embraced by its defenders" (Ainslie 2002 p.2100). Henceforth, I refer to the four-principled approach to bioethics by Beauchamp and Childress as 'principlism'. According to 'principlism', there are four core principles identifiable in bioethics which can be used as rules of conduct. These principles are:

(i) Respect for autonomy
(ii) Non-maleficence
(iii) Beneficence
(iv) Justice

These principles are biomedical in orientation (as opposed to forensic or legal).

- Respect for Autonomy:

Respect for autonomy is one of the four biomedical principles identified alongside non-maleficence, beneficence, justice. Beauchamp and Childress (2013) define autonomy simply as free, unlimited self-rule. However, the authors also point out from the onset that all four principles are equal and *prima facie*. Respect for autonomy must not be taken to be above the three other principles. Beauchamp and Childress (2013) argue that respect for autonomy is self- determination, which is most commonly expressed via informed consent rule. In clinical forensic medicine, most subjects are either under arrest or convicted criminals. This severely limits their rights to self-determination. Take for example; a detainee may not refuse a medical examination requested by a law enforcing officer investigating a crime. Section 65 (9) of The National Road Traffic Act (1996) provides that "no person shall refuse that a specimen of blood, or a specimen of breath, be taken of him or her". Legally, there is no need to obtain consent from a suspect facing a drunken driving charge. According to section 37 of the Criminal Procedure Act (1977), provision is made for blood samples to be taken even if a suspect refuses, including by use of minimum force if necessary. However, more important in clinical forensic medicine is the much broader concept of 'respect for persons' as opposed to the principle of respect for autonomy.

- Beneficence

The authors define beneficence as "all forms of action intended to benefit other persons" (Beauchamp and Childress 2013 p.203). Beneficence means doing good to others. Beauchamp and Childress (2013) identify a number of rules or obligations derived from the principle of beneficence. These are expressed as positive

obligations and include protecting and defending the rights of others, as well as preventing harm from occurring to others and removing conditions that will cause harm to others. These impose a duty on the district surgeon to at least protect vulnerable detainees. This principle can be said to be still relevant in most clinical forensic medicine settings.

- Nonmaleficence

The non-maleficence principle relates to another much celebrated rule in the tradition of medicine, i.e. the rule 'of not doing harm'. This is often expressed as a prohibition, often stated as 'do not inflict harm'. Harm is simply defined as 'setting back some party's interests' (Beauchamp and Childress 2013 p.153). However, nonmaleficence also involves an obligation "not to impose risk of harm" (Beauchamp and Childress 2013 p. 154). This means therefore that a district surgeon should balance all duties when deciding whether a detainee is faking an illness, ensuring that he does not expose such a detainee to risk of harm.

- Justice

Beauchamp and Childress (2013) explore the concept of justice by outlining the formal and material principles of justice. However, distributive justice is not as relevant to the district surgeon as is the language of equal human rights.
Beauchamp and Childress (2013) argue that the four principles are *prima facie* binding. This means that in a situation where there is no conflict between several principles, whichever relevant principle is binding. However, these principles are also not absolute in that they can be overridden by other principles where there is a conflict. The principles are not ranked in any lexical order, so no principle is prioritised over another. A number of scholars have attempted to position respect for autonomy above all others, claiming autonomy is more equal than others, a view rejected by Beauchamp and Childress (2013).
In practice, the suggested approach in applying 'principlism' is to use one or more of the principles in any given situation. The principles often provide warrants for more specific rules, which specify more concretely the type of prohibited or permitted action. Principles give rise to rules which must be applied to real situations. Arras (2007) describes the following steps, namely identification, justification, specification and then balancing.
Arras (2007) explains that the relevant principles are identified, and then specified, a process involving restricting the range and scope of the principle. Specification also

reduces the conflict between several principles. But at times there persist a number of principles which appear to be in conflict. According to Arras (2007), a process of balancing takes place. This is when conflicting principle are weighed up against each other. Any principle can be overridden since none of the principles are absolute. Balancing principles takes into consideration *inter alia* necessity to uphold the principle, and the infringement of a principle will be a last resort. The principle/s that prevails therefore is justified if there is coherence. So to establish coherence, "the judgment should be connected and supported by relevant principles, values, ideas and previous cases" (Levi 1996 p.14). The aim is to bring the judgement into equilibrium with all relevant factors. The belief is that coherence is justified if all factors in the mix are in equilibrium. So, such a reflective equilibrium should be as wide as possible. This means that it scrutinizes judgments from all possible angles. Arras (2007) argues that all components in the reflection mix can be pruned and modified for the sake of achieving maximum coherence. Arras (2007) sees this wide reflective equilibrium methodology is non-foundationalist. This means that any other component in the mix can be pruned and fine-tuned. So a formulation of statement of right action will state that 'an act is right if and only if it has features that according to relevant principles establishes rightness, and can be shown to be in equilibrium after reflection'.

Medical ethics is based on the traditional doctor-patient relationship, so is 'principlism'. The application of the four principles in a forensic setting is limited. For example, there are several derivative rules from each of these primary principles. These rules serve as more direct and specific action guides. Beneficence and nonmaleficence remain forceful in clinical forensic medicine to a much greater extent than respect for autonomy and distributive justice.

'Principlism' is a non-abstract method and can assist district surgeons identify their obligations in simple situations. However, it may not be sufficient as a sole action guide in clinical forensic medicine, which is not based on a goal of improving patients' welfare. A more universal and non-therapeutically orientated method of action guidance is therefore required as a framework for clinical forensic medicine.

DEONTOLOGY

(Duty based approaches)

I now turn to another foundational ethical theory in bioethics, namely deontology. As outlined previously, a simplified representation of human action by Solomon (1995), the following is depicted as a gross outline of components of human actions:

P →→→→ A →→→→ C +++++++

This represents an agent (P) performing an action (A) which leads to consequences (C). Utilitarianism judges the wrongness and rightness of actions by referring to C (the consequences). In the case of a deontological approach, the moral judgment of the wrongness and rightness of conduct is based on the intrinsic value of the action (A) itself. No appeal to consequences of the action is taken into consideration.

Deontology is derived from a Greek word "*deon*" meaning duty. German philosopher Emmanuel Kant (1724-1804) is among the most influential deontologists, and argues that duties derive from reason and freedom. Humans are "free beings and can act using reason" (Solomon 1995 p.816). There are "some moral laws that all rational beings had to obey simply because they are rational beings and hence duty bound to do so" (BBC 2001). A person is duty bound to perform or not to perform certain actions. Moral rules dictate how people should act. These duties can either be perfect or imperfect. Perfect duties are absolute, hence binding at all times on all agents. According to Schiavo (2010), *prima facie* duties on the other hand are those duties that have presumptive force, but can be overridden.

The duties in deontology are formulated as severe restrictions. This means that one is duty bound not to violate these restrictions. The restriction from violating duties is referred to as a deontological constraint. So in a deontological framework, one has acted wrongly when one has intentionally violated a deontological constraint. Intention in this last sentence implies that the agent has to be a free agent, with ability to make choices without any undue influence. So the agent must intend to violate a deontological constraint, and not merely foresee the possibility of such a violation.

Deontological constraints are very specific. The constraints are narrowly framed and directed in terms of both agent and action. To illustrate this narrow formulation, I employ the example used by Davis (2005, p. 208);

- Firstly that, a deontological constraint will be stated as “do not lie” as opposed to ‘tell the truth’.
- Secondly, the deontological constraints are specific to the agent by stating that ‘you must not steal” as opposed to a more general “stealing is not allowed” prohibition.
- Thirdly, the deontological constraints are absolute. This means that they are to be followed irrespective of how grave the consequences will be.

There are several questions arising from the above description of deontological approach;

i. Where do duties in deontology derive from?
ii. Where or who provides the list of duties? Or how is an agent to know his/her duty in a particular situation? Or more practically, how is a district surgeon going to determine the course of action to be followed or which duty to fulfil?

This brings us to the different types of deontological approaches. As stated by Schiavo (2010), deontological approaches derive their duties and hence constraints from religion, tradition, common sense or any other fundamental principle. Morality according to Kant is derived from rationality. This means also that, according to Davis (2005), all moral laws are rationally supported. So a moral agent ought to act rationally. “Reason results in objective laws” (Greetham, 2001, p.303). An example of a fundamental objective law and supreme principle of duty is the Categorical Imperative. The categorical imperative is absolute and hence non-negotiable. This can be contrasted with hypothetical imperatives, which “are conditional and non-binding” (Davis 2005 p.208). So an agent has a duty to act out of universalizable maxims. The fundamental principle of morality — “the categorical imperative — is none other than the law of an autonomous will” (Johnson 2013 p.1). The two common formulations of the categorical imperative are stated by Johnson (2013) as:

- act only in accordance with that maxim through which you can at the same time will that it become a universal law;
- never act in such a way that we treat humanity, whether in ourselves or in others, as a means only but always as an end in itself.

This means that rules must be universalizable (it can be general law whilst still applicable logically) and agents must treat people properly (with respect and as ends in themselves)

So for Kant, the fundamental supreme principle that we ought to adopt is a maxim that that must serve all rational agents from all walks. If a maxim cannot serve all rational agents, it is to be rejected. Morality "begins with the rejection of a maxim which cannot serve all" (Davis 2005 p.215). This rejection of non-universalizable maxims is a categorical imperative.

As an action guide for the district surgeon, the categorical imperative can be stated as follows: A district surgeon acts morally if and only if he/she acts out of a maxim that he at the same time will that it be universal law. So for example, suppose a physician charges patients for services not rendered, he would be acting on a maxim that it is right to make people pay for services or goods not received. He must therefore imagine a situation where drycleaners, car mechanics and banks charge people for services not rendered. If he finds that situation undesirable, then he does not want everyone to adopt that maxim, and hence he ought not to charge for services not rendered. Simply put, the categorical imperative dictates that in order to act right, one must hold the right principles.

So detainees as rational agents ought to be allowed to act freely and be respected. The strength of this approach is in its formula of ends. This captures the relevance of deontology to clinical forensic medicine, which is that district surgeons have a duty to treat agents equally and with respect. This, as noted by many scholars, provides a basis for human rights - it ensures that due regard is given to the interests of a single person even when those are at odds with the interests of a larger group. The district surgeon is obligated to treat the individual detainee with respect and as an end in himself. This duty generates corresponding rights that are owed to each and every detainee, irrespective of consequences to larger societal interests. Therefore, the district surgeon has a number of obligations flowing from these rights, often expressed in various declarations as human rights.

Prior to 1994, district surgeons in South Africa would have to refer to international codes, for example World Medical Association's declaration of Tokyo (WMA, 1975) as the culture of respect for human rights was foreign during the reign of the apartheid regime.

However, since 1993, a Bill of Rights is now entrenched in chapter 2 of the Constitution of The Republic of South Africa (henceforth referred to as 'The Constitution 1993')

HUMAN RIGHTS AND DUTY

The Constitution (1993) guarantees everyone human rights as outlined in chapter 2, which is referred to as The Bill of Rights. These rights are, however, subject to a limitation clause (The Constitution 1993 sec. 36). The Constitution (1993) states that "the Bill of Rights binds a natural or a juristic person if, and to the extent that, it is applicable, taking into account the nature of the right and the nature of any duty imposed by the right" (The Constitution 1993 sec 8(2)). It places a duty on relevant persons to "respect, protect, promote and fulfil the rights in the Bill of Rights" (The Constitution, 1993, section 7(2)).

District surgeons have a duty to ensure that the relevant detainee's rights are not violated. The most relevant rights for the district surgeon are those rights related to equality before the law and human dignity, as well as those specified in section 35 of the Bill of Rights. Section 35 of the Constitution (1993) deals with the rights of arrested, detained and accused person. Some *prima facie* duties for district surgeons can be derived directly from the rights to adequate medical treatment and humane conditions of detention. The right to fair trial goes to the heart of clinical forensic medicine, with duties to ensure independent and impartial representation of evidence and facts derivable from this right. However, a multiplicity of legal rights exists in any given situation, and may at times be in direct conflict with each other. Though section 36 of the Constitution allows for limitation of certain rights in given situations, this can only be done in accordance with specified law. So the district surgeon cannot on his own weigh competing rights should a situation of conflict of rights arise.

The practice of clinical forensic medicine is intricately linked to law and vulnerable detained persons and victims of crime, and hence a duty based, particularly rights based theoretical framework provides a better theoretical framework than consequentialist approaches.

IV. ETHICAL DILEMMAS IN CLINICAL FORENSIC MEDICINE

MANIFESTATIONS OF DUAL OBLIGATIONS IN CLINICAL FORENSIC MEDICINE

In any clinical forensic medicine consultation, there are a number of duties and obligations to be considered simultaneously. Clinical forensic medicine is full of dual loyalty dilemmas since it is a discipline dealing with two or more interested parties at a time. These parties often have competing interests and may therefore have demands that are in stark conflict to one another. Typically the parties involved in clinical forensic medicine involve detainees, police, prison warders, victims of crimes, society and the courts. Dual loyalty tensions may arise where there is a conflict of obligations between any of the above parties. Generally, the following are some of the manifestations of dual loyalty conflicts in clinical forensic medicine:

(i) Police vs. detainee obligations
(ii) Detainee vs. society obligations
(iii) Victim vs. suspect obligations
(iv) Minor vs. parents obligations
(v) Court vs. victim obligations

Although the above are the most common manifestations of dual obligations encountered by district on a daily basis, there is a form of conflict involving employer vs. detainee obligations. This particular dual loyalty dilemma would be more prevalent where a district surgeon is employed by correctional services' departments to render medical care to prisoners. The employer vs. detainee conflicts may be due to interference by employers or security officials in the work of a district surgeon. The district surgeons who attended Steve Biko "adopted a subservient attitude to the security police when advising of the care and management of their patient, they were under no clear intimidatory pressure" (McLean, Jenkins 2003 p.83). Highlighting the challenges that physicians face whilst working in prisons, McKinney (2008) says that "the prison officials' attitude that accompanies the goals of discipline and security may be among the most serious challenges the prison physician faces. Correctional officers and other prison officials may be inflexible" (McKinney 2008 p.117). The

interference may be more overt, taking the form of security officials instructing a district surgeon on how to deal with a particular detainee. This can involve pressure to falsify reports or overlook signs of ill-treatment such as torture. The district surgeon may therefore have to choose between carrying out the instructions of employers, or acting objectively and impartially. Failure to carry out orders may lead to sanctions like victimization and even dismissal. However, giving in to pressures from employers and prison officials may result in the violation of detainee's human rights, and in severe cases like Steve Biko, even leading to death. A district surgeon who finds himself faced with this dilemma ought to consider his obligations to all the parties involved. This will therefore allow him to weigh all obligations and decide whether there is a conflict. If so, he is therefore to resolve the conflict correctly.

In South Africa, district surgeons are employed by the Department of Health. There are, however, still some healthcare professionals employed by correctional services departments to render care to prisoners. These are mainly nurses and are responsible for delivery of primary health care services to inmates. Though employed by prisons and correctional service departments, the dual loyalty challenges are lessened by the environment they work under. They are supported by a number of legislations that enable them to defy unethical instructions, like the Bill of Rights and whistle blowing regulations and transparency laws. They also have several watchdogs to whom they can report undue influences, notably the Public protector, Human Rights Commissions and Prison inspectors. Healthcare providers can use these and other agencies when pressured by prison officials to falsify reports or act in any manner that exposes detainees to risk of harm. All these were not available during apartheid South Africa, so these kinds of dual loyalty dilemmas were really difficult to deal with.

I therefore will not be discussing employer or prison official related dual obligations any further. Below I explore the commonest manifestation of dual loyalty that district surgeons deal with in South Africa today by discussing the following three case vignettes.

CASE VIGNETTE 1 - Dual obligations involving police and detainees

Districts surgeons deal with suspects from arrest, through court trial and after conviction as prisoners or inmates. The examinations may involve obtaining blood and urine samples as well as pubic hairs in sexual offences. A district surgeon is often requested to conduct an intimate examination on detainees. This involves examination of genitals whereby detainees have to undress. This is often the case where body orifices have to be searched for concealed drugs and weapons. Searching body orifices like the anus and vagina is very invasive. Similar intimate examinations are carried out on those who are accused of rape. However, some of these detainees are potentially dangerous criminals who are under very heavy police guard. The police may be so concerned with safety and security that they may not be willing to allow such a high risk detainee out of their sight. They usually adhere to very strict security protocol.

Should a detainee be afforded privacy and at the same time risking that he escape?

Should the district surgeon prioritise the detainee's privacy at all cost?

This case raises issues of safety, privacy and doctor's obligations

If a detainee escapes whilst in their custody, disciplinary proceedings will be instituted against those who were in charge. Hence, there is a reluctance to leave such a detainee to consult and be examined by a district surgeon in private. The concerns for security involve the district surgeon's safety, who may be used as a human shield in attempts to escape. In some instances, medical personnel have been held hostage by a detainee who demands freedom or a ransom. In December 2012, newspapers reported that at a Bloemfontein maximum security prison, "two prisoners held a doctor and a nurse hostage for two days" (Hosken 2013 p.1)

It is not only the safety of medical staff at risk with such detainees, it is also the community that would be exposed to a dangerous criminal should he manage to escape. He may commit further crimes whilst on the loose. It is therefore understandable for the police to insist on guarding such detainees during

consultations. At times, police may insist that it is a risk to remove restraining equipment like leg irons, shackles and handcuffs for an examination.

However, as much as the district surgeon understands security concerns raised by the police, he has a duty to treat every detainee with dignity. He also has a responsibility not to frustrate the efforts of the police to prevent harm to society by reducing risk of detainee escaping.

However, conducting an intimate examination of the detainee in full view of the police will violate the detainee's privacy and dignity. On the other hand, chasing the police out of the consulting room may be risky. The district surgeon therefore has an obligation, firstly to recognise the conflict between these duties and secondly, attempt to resolve the conflict correctly. How should the district surgeon act in such a situations?

CASE VIGNETTE 2 - Conflicts involving detainee and society's interests

Another common dilemma district surgeons face is conflicts involving detainee and society's loyalties.

> The district surgeon often gets called to obtain blood samples from a suspect arrested for driving under the influence of alcohol. The normal procedure involves laying criminal charges at a police station, and then taking a suspect to a district surgeon for blood samples. These are sent to the laboratory for alcohol content analysis. The police request a sample by way of completing a request form referred to as form SAP 308(a). This form grants permission for the district surgeon to examine a suspect for evidence of drunkenness including taking blood samples. This form is not a consent form, but may be equated to a form of a search warrant. The detainee is not required to give consent for the blood sampling in these circumstances. "No person shall refuse that a specimen of blood, or a specimen of breath, be taken of him or her" (NATIONAL ROAD TRAFFIC ACT, 1996).

Should the district surgeon take a blood sample from a suspect who is refusing to voluntarily give a sample?

Is it ethically permissible for a district surgeon to take a blood sample from a suspect who is being physically restrained by the use of force?

In South Africa, no consent is required for blood sampling of suspects, and suspects may not refuse to give a sample. In other countries, notably the United Kingdom, a suspect is required to give consent before a blood sample is taken from him/her. He also has a right to exercise his autonomy and can refuse to give a blood sample even if under arrest. In South Africa however, a suspect is merely informed that he is to give a blood sample, or that a blood sample will be taken from him. The respect for the suspect's autonomy is therefore severely compromised under these conditions. The district surgeon has to decide whether he has an ethical duty to solicit consent from the suspect before taking a blood sample from him. However, the law allows him to take a sample for blood alcohol without seeking consent.

In most instances, the district surgeon finds a middle path between taking blood samples without consent, and affording the suspect some opportunity to exercise his autonomy.

This is done usually by getting the suspect to assent to the procedure. The district surgeon therefore manages to obtain blood samples without expressed consent, and at the same time not against expressed refusal of the suspect.

Critics will argue that by relying on the assent of the suspect, the district surgeon is being dishonest since the environment is coercive and hostile. Hence, obtaining expressed consent is the only way to ensure the suspect's autonomy is respected. The above criticism is valid, but it overlooks the fact that autonomy is limited once someone is under arrest. Though the suspect retains most of his rights enshrined in the constitution, the rights to freedom of movement, freedom of choice and freedom of association are extensively limited. Even though it is not unlawful to obtain a blood sample from a suspect without his expressed consent in South Africa, the question remains whether it is ethical to do so. The district surgeon will have to recognise the duties to the suspect and those to society for the administration of justice. Having recognised the obligations, he is to identify the conflict between these duties and manage it correctly. So he must decide whether to insist on obtaining expressed consent from the suspect, or expedite the administration of justice by taking the blood samples without consent. The two obligations stand in direct conflict with one another.

It can be argued that as much as the district surgeon ought to respect the autonomy of persons, he also has a duty to respect laws of the country. The laws, including the constitution, limit the autonomy of detainees. It is therefore morally permissible to balance the conflicting obligations by relying on the suspect's assent for blood sampling. On the other hand, aiming for the expressed consent of suspect should be viewed as a moral ideal.

The challenge of dealing with drivers who are under the influence of alcohol is that their behaviour can be quite irrational and unpredictable. Often a suspect who is arrested for drinking and driving tends to be uncooperative and aggressive. Some suspects can be so violent that they even aggressively refuse to give a blood sample for blood alcohol level determination. They therefore physically resist any attempt to draw blood from them and fight with the police officers. In other countries such as the United Kingdom, refusing to give a blood sample is taken as an admission of guilt. However, in South Africa aggressive refusal to give a blood sample causes a lot of challenges to the law enforcement officers as well as the district surgeon. The law in South Africa allows police officers to use minimal force to restrain uncooperative

suspects. This often manifests in practice with police officers on the scene calling for further backup in order to assist in restraining the suspect. The arrival of many more police officers is often sufficient to intimidate the suspect into cooperating and hence give a blood sample. However, some suspects continue to put up a fight and aggressively refuse to give a blood sample. Several police officers will try to physically restrain the suspect, who may end up on the floor, with each police officer grabbing a limb, one sitting on the suspect's chest, and another with his boot firmly on the neck of the suspect. This can be a very violent struggle, ending with a defeated suspect lying on the floor, maybe in an undignified position, half naked or even having passed urine on himself. The district surgeon is therefore invited to go ahead and take a blood sample from the suspect who is held firmly.

The district surgeon should carefully analyse the situation and ask himself- what are my obligations to the suspects and what are my obligations to society (police are here to serve interests of society, i.e. taking dangerous drunk drivers off the roads and laying criminal charges where necessary. This situation is no longer the same as taking a blood sample from a non-consenting suspect. It now amounts to obtaining blood sample evidence in a manner that violates basic human rights and is therefore degrading and inconsistent with the constitution.

The Declaration of Tokyo (1975) states that "The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment. The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment is used or threatened" (WMA, 1975).

The district surgeon therefore ought to recognise the duty placed by the above declaration, and should at least object to taking blood samples from the suspect under these conditions.

Critics will argue that the district surgeon also has a duty to society and the administration of justice. We cannot allow a drunk driver who put innocent lives at risk to get away just because he refuses to give blood samples. This will have undesirable consequences to road safety and justifiability of traffic rules.

A simple reply to this criticism is that we need to look for alternative ways of bringing the violent drunk driver to face legal consequences of his actions. A conviction for drunk driving can be achieved by using more humane ways of evidence collection. In

this case of an aggressive suspect, a clinical observation is sufficient to diagnose alcohol intoxication, and hence a conviction on an alternative charge of driving under the influence of alcohol will be achieved, as opposed to a charge of driving with a blood alcohol level in excess of the legal limit. This does not require violence and sacrifice of human dignity.

Human dignity is not the only problem with restraining of violently aggressive suspects. An aggressive suspect, who is under the influence of an intoxicating substance, may die following violent behaviour and physical restraint. This is called excited delirium or agitated delirium. Excited delirium is associated with “sudden unexpected death of individuals suffering from extreme agitation immediately after being physically restrained” (Stratton et al 2001 p.201). This condition is associated with several risk factors including alcohol intoxication, use of stimulants and physical restraint. The above risk factors should serve as a warning sign as no one can predict this condition. It is therefore important for district surgeons to fulfil their obligation of preventing harm (death of a suspect) by diffusing tense situations that may lead to aggression and the excessive use of physical restraint.

Not all dual loyalty conflicts in clinical forensic medicine involve the police. In some instances, parents and minor’s interests stand in stark contrast with a complex mix of obligations and conflicts as the next case demonstrates.

CASE VIGNETTE 3 - Minor and parent's conflict of obligations – Sexually active minors

It is common for a teenage girl to be reported missing at a local police station by her mother. A search is initiated but not trace of the girl until a teenage school mate informs the parents that the girl often leaves the school in company of another young man.

Before they can establish who this young man is, the girl re-appears two days later. When asked by her parents, she admits to have spent the past two days with her boyfriend. She admits to have slept in the boyfriend's room, but denies any form of sexual intercourse. She tells them the boyfriend is 18 years old. The mother is furious, rushes back to the police station to lay a charge of abduction and statutory rape. The girl denies sexual activity and the police advice that she be taken for a medical examination at the district surgeon's office.

She, however, insists that she does not want to be examined. Her mother is adamant that she must be examined.

The district surgeon tells her that he needs to know exactly what happened. He urges her to be free and open as he will do all he can to keep their communication confidential, unless absolutely necessary to divulge information. He also tells her of the advantages of having a medical examination. Advantages include appropriate medical treatment, clearing her name, reassuring and mending relationship with her parents.

The girl finally agrees to undergo a medical examination, including gynaecological examination. She completes an informed consent form and signs it.

She confides to the district surgeon that she is in love with an 18 year old male. She also tells the district surgeon that she had sex with her boyfriend during the past two days, but claims she used a condom. She also tells him that her parents don't know about the sex, and pleads with him not to tell them.

The district surgeon conducts a clinical examination in the absence of the parents. The examination findings are normal. There are no findings confirming previous sexual intercourse. The examination does not however rule out previous sexual activity. Simply put, the examination cannot confirm nor dispute virginity.

The district surgeon is now faced with a dilemma in case vignette 3[4].
Does he give the parents and the police all the information, including breaching confidentiality in respect of confession about sexual intercourse?
Or, should he keep confidential what was revealed to him in confidence by the girl?
Or should he have refused to examine 13 year old out of respect for autonomy and lack of consent?
This dilemma raises several questions about a number of ethical obligations for the district surgeon, namely confidentiality and trust between the girl and the district surgeon, as well as veracity, objectivity and promise keeping.
Though it is clear that the sex was consensual, meaning that the girl was not forced into sexual intercourse, the boyfriend however had consensual sexual intercourse with an under aged girl, something prohibited by the law. The boyfriend committed a crime of "statutory rape", as prescribed in section 15/16 of the Sexual Offences Act 32 (2007). Statutory rape is distinguished from rape, which is more of a violent crime and carries a heavier sentence.
The girl is vulnerable to HIV and falling pregnant as a result of this sexual encounter. Informed consent is required before an examination can be carried out. This is even more important since the examination or procedure is not entirely therapeutic. It is a forensic examination to establish evidence of sexual intercourse. Even though she refused an examination initially, she can be overruled by parents, but this is more theoretical than practical since the examination requires her assent and co-operation.
However, the real dilemma for the district surgeon arises not from whether to conduct an examination or not. It is only after concluding the examination that the doctor is faced with a difficult situation. Does the district surgeon tell the parents and the police what the findings are, leaving out information provided to him by the girl in confidence? Or does he tell them that the girl confessed to him that she had sexual intercourse with an older boyfriend? But the girl can deny in police statements having told the district surgeon that, and he also doesn't have any clinical evidence to these claims.

[4] This is a modification of a case I previously discussed in an essay submitted to the Department of Philosophy. The scenario is very common and poses a huge challenge to professionals dealing with minors who are sexually activity.

The district surgeon should consider his obligations to parents, court and the child. These include truth telling, objectivity, confidentiality, privacy and trust within the doctor – patient relationship.

Duty to maintain confidentiality

The girl didn`t confesses to having been involved in sexual activity to police. She also didn`t even confesses to her parents. However, after talking to the district surgeon, she opened up and told him everything. This included a confession that she indeed was involved in sexual intercourse twice. She also cannot stand the idea of having the boyfriend arrested, since she claims the boyfriend is a hard worker who provides for his mother and his two siblings. The arrest of the boyfriend will lead to him losing his job.

The girl clearly didn`t want her parents to know about this. The clinical examination on other hand is equivocal.

The district surgeon is faced with a conflict of duties, i.e. truth telling vs. confidentiality. Does he reveal to the police and parents what the girl told him in confidence?

The girl confided to the doctor in the hope that this information will neither be revealed to police nor her parents. She did this with the expectation that the doctor will be in better position to advice and treat her properly. Telling the police and parents the truth will be a blow to her. Though he has an obligation of maintaining confidentiality, lying to the police and the girl's parents is also undesirable. Telling a lie and claim that everything shows she never had sex will definitely please the girl and her parents. However, it will also amount to unethical conduct which will be difficult to justify. Not telling the truth to her parents will falsely reassure the girl's parents. They will think their daughter's ways require no intervention. They will not have to deal with the problems of a sexually of active teenager. The parents will be relieved that what they feared the most was not confirmed. This option on the surface seems to benefit everyone involved.

However, the lie will have long-term undesirable consequences. For example, the false reassurance implies that the parents will not take corrective action against the girl. She is likely to continue her sexual activity with her boyfriend. She will have an impression that she can get away with such behaviour in the future. This will ultimately expose her to more diseases and also unwanted teenage pregnancies. The boyfriend will likely not stop dating under aged girls. He won't be stopped from

exploiting young girls as police won't confront him. More young girls will be exposed to unprotected sexual intercourse. The benefit of lying seems to be temporary and in the long-term, these undesirable consequences do matter. The district surgeon's obligation of confidentiality does not justify telling a lie.

The medical profession is expected to be honest in its interaction with patients and families, "the virtues of honesty, truthfulness and candour are among deservedly praised character traits of healthcare profession" (Beauchamp, Childress 2013 p.302). The reason the girl's parents allowed time for the district surgeon and their daughter to consult privately is because of the expectations that the consultation outcome will be revealed by the district surgeon later. However, for the district surgeon, truthfulness is not the only value to uphold, and hence it is prima facie and not absolute. The district surgeon will have to weigh the benefits and risks of telling the whole truth. He will also have to balance this against other competing ethical values and obligations.

Obligation to be truthful and objective:

The district surgeon can truthfully say that the examination was normal, but that he was told by the girl that she did have sex with her boyfriend. He can further state also that this is consistent with his normal findings on medical examination since the sexual intercourse was consensual. This will be the complete unadulterated truth. But this may have shocking and undesirable consequences for both the girl and her parents. Full disclosure will confirm to the parents that their daughter is a liar and is sexually active at a young age. This will destroy the idea that their girl is an obedient angel who is in need of tender care and nurturing. They will be so disappointed and may withdraw certain privileges as a form of punishment. For the girl, she would have disappointed her parents and her relationship with them shaken. It also means an abrupt end to the affair with her boyfriend, who is likely to be charged with statutory rape. The police will have to open a case, obtain statements from her and have her going to court to testify. This will be disruptive to her school work. Being honest will destroy trust between the girl and her parents. She may also react by being rebellious, abusing illicit drugs or by attempting suicide. Hence, fulfilling the duty to the parents by telling the truth is likely to cause more harm to both parties. It is therefore desirable to balance the competing interest of all the parties involved.

Respect for autonomy:

The district surgeon has another option, to not examine the girl and claim he respects the young person`s right to refuse. Hence, no medical examination due to the absence of consent.

Those who support this option charge that the child must be left alone since she initially refused medical examination. She shouldn't have been convinced in the first place, as that undermined her autonomy.

Refusing to examine the girl on the basis of lack of consent and respect for autonomy however, will leave the family in more distress. There would be no closure and parents might be more aggressive towards the girl for refusing an examination. The parents are likely to move to another doctor in search for one who can convince the girl to be examined. This will have an overall negative effect to the family unit and the administration of justice. Meanwhile, the girl's risky behaviour may continue if she sees that she can get away with refusing an examination.

It is obvious that the consequences of overlooking any of the obligations are dire. There is a need to therefore carefully balance the conflicting obligations.

Values in conflict and their justification in vignette 3

Truth telling demands that the doctor reveals information to parents, whilst obligations of maintaining confidentiality forbid him from telling them about what the girl told him. The clinical examination is equivocal and can be reproduced by any other clinician by a mere re-examination. However, the conversation and confession are based on trust. They might not be reproducible as the next examiner might not be able to establish trust and rapport as the district surgeon managed in this instance. So revealing the clinical findings cannot be said to be of the same confidential cloth as the verbal confession by the girl to the district surgeon.

Though the consequences of either action are variable, it's obviously not possible to satisfy both obligations in full.

It is either the district surgeon violates the rules of confidentiality and tells the truth, or he abandons demands of veracity by claiming to be honouring his duty of maintaining confidential what is deemed to be sensitive information.

The above case vignettes demonstrate the many obligations that are at play in any given scenario. The district surgeon must take into consideration the interest of many parties. These may come into conflict and the district surgeon ought to be able to decide which of the many obligations to fulfil and which to overlook.

An ethic for clinical forensic medicine should be duty based as discussed in the previous chapter. However, district surgeons ought to know their core obligations, and how these differ from those of the traditional medical ethics.
The above three cases will be revisited in the final chapter. I will apply my recommended approach to each case in order to illustrate how this approach can assist in the resolution of similar ethical dilemmas within this context.

OBLIGATIONS FOR PHYSICIANS

The development of medical ethics reflects the changes in the practice of medicine. Early in the development of medicine, there was no common ethic when the practice of medicine was dominated by a heterogeneous group including magicians, priests, exorcists etc. However, as the group of physicians differentiated themselves from other non-physician healers, societies or associations began forming. The earliest such grouping is the Hippocratic physicians. They swore to a Hippocratic Oath that, in the words of MacDougall & Langley (2001) represents the interplay of trans-generational knowledge transfer as well as the Greek reverence for knowledge and concern for reputation. Outside Greece, similar groupings began to emerge in other parts of the world including India and China. These groupings swore to their own oaths, which were often canonical as explained by MacDougall and Langley (2001). The various oaths promoted several values. For example, the “Hippocratic oath took an altruistic stance, whereas Hindu principles promoted honesty, generosity and hospitality” (MacDougall Langley 2001 p.10).

According to MacDougall and Langley (2001), the professionalization of the field of medicine led to the development of codes of ethics in various jurisdictions. These spelt out amongst other things the duties of physicians. Some codes stressed “sympathy and compassion, like Royal College of physician’s John Gregory in 1772. However, the fiduciary duties of physicians were outlined by, Thomas Percival in 1803” (MacDougall, Langley 2001 p.11). The doctor-patient relationship has long since been conceived as fiduciary in nature. This implied that the patients’ interests are to be put first. Different countries had association with their own ethics codes, most drawing largely from the Hippocratic Oath. However, the 1940’s saw more progress towards universal code of ethics for physicians. The World Medical Association was formed in 1947 and had a declaration of Geneva the following year.

This was following the Nuremberg Code in 1945. The obligation of physicians can be derived largely from these codes.

The Physician has a duty to do no harm, act in the best interest of patients and treat patients with respect. These duties of physicians are based on a clinical medicine orientated doctor–patient relationship. All efforts are focused towards welfare of patients, hence doctors “perform fiduciary-like roles and hold themselves out as fiduciaries in their ethical codes” (Rodwin 1995 p.241). Clinical medical practice is however only one of the uses of medical knowledge. Some medical knowledge is used in research, some applied in the development of health care funding strategies. Though medical ethics is historically geared towards clinical medicine, not all practice of medicine involves the diagnosis and treatment of illnesses. Physicians who are performing non-therapeutic roles (e.g. forensic & occupational) have duties to their patients; they also have other primary obligation to parties other than that of patients. For example, occupational health workers have obligations to their employer, who employs them to perform pre-employment examination. This limits the obligations owed to patients by the physician, for instance, the duty to maintain confidentiality is limited because the physician must give relevant information to the employer.

These circumstances “strain the fiduciary metaphor” (Rodwin 1995 p.241) as is applied to clinical medicine. The district surgeon and occupational health physicians cannot always put the interests of the patients ahead of all others. Hence, for clinical forensic medicine, another metaphor is necessary instead of the fiduciary metaphor as applied in medicine. Other scholars argue that district surgeons and occupational health physicians are first and foremost health care providers, thereafter forensic or occupational practitioners. They therefore should not place third party interests ahead of those of patients. They argue that other interests must always be secondary to patient welfare.

However, to restrict the application of medical knowledge to diagnosis and treatment would be harmful to society. There would be no research, no new treatment modalities as well as failure to contribute towards the fighting of crime. Such a situation is therefore undesirable and detrimental to the betterment of society.

Forensic medicine can be viewed as “a kind of medical knowledge which is not so much concerned with the cure of disease, as the detection of error and the conviction of the guilty” (Farr 1814 p.1). This is what forensic medicine is primarily about. Hence, the duty to advance the interests of justice is what forensic medicine is primarily about. The obligation to advance the interests of justice is the core of the practice of clinical forensic medicine. This duty ought not be subjugated to patient’s best interests standard. Instead, the district surgeon ought to realize that his multiplicity of obligations that originate from his role as both a physician and a forensic practitioner. Whereas the duties of physicians are altruistic and fiduciary in nature, they do not adequately accommodate practitioners in clinical forensic medicine, whose main focus is the promotion of justice. Therefore, for each and every case, a district surgeon must keep in mind his duties as a physician and balance these against his obligations as a forensic practitioner. He therefore ought to correctly balance the obligations from both perspectives of his practice. Neither the obligations to advance justice, nor to advocate for the patient is regarded as automatically superior over the other. A careful case by case balancing of all relevant obligations ought to be conducted when faced with an ethical dilemma in clinical forensic medicine. Prioritizing either roles of the district surgeon would be a failure to appreciate the dual nature of the field.

What therefore are the core obligations of a district surgeon?

How should we define a clinical forensic medical ethic? Is there a need for a particular morality for clinical forensic medicine apart from general medical ethics? There are other subspecialties in medicine, for example public health, which have become well established as distinct fields which later developed their own ethical codes outside the traditional medical ethics. Likewise for clinical forensic medicine, a specific ethical framework should be developed.

OBLIGATIONS FOR DISTRICT SURGEONS

The Australian Association of Forensic Physicians’ (AAFP, 2013) ethical guidance states that the forensic physicians are first medical doctors, and are therefore bound by code of ethics that govern medical practice.

These include Geneva Convention, Hippocratic Oath as well as biomedical ethics principles, also known as 'principlism'. These codes and Oath promote *inter alia* beneficence, non-maleficence, respect for human rights and primacy of patients' interests. These are broad codes which are meant to promote and protect the well-being of patients. The various medical specialties are bound by these codes and oaths of medical practice. They can be regarded as a form of common morality of the medical field. They are *prima facie* binding on all physicians irrespective of specialty.

There should be no need to exempt particular specialties from this broad morality. This is so because the codes and the values this broad medical ethic promote form the base of the medical ethics and thus keep the profession as one unit. So a medical practitioner who has information that a patient is about to harm a third party need not seek exemption from the application of the rules of confidentiality. Instead, he should invoke another ethical principle, such as non-maleficence and balance the two principles so as to show that the duty to prevent third party harm outweighs the duty of strict confidentiality. Hence different circumstances will balance different rules and principles differently. There is therefore no need to formulate a particular ethic outside the one already existing and broadly accepted as a general medical ethic. However, clinical forensic medicine ought to construct an ethical framework better suited for the field. It is said "particular moralities present concrete non-universal, and content rich norms which are specific, but these norms are not morally justified if they violate norms in the common morality" (Beauchamp, Childress 2013 p.5). There are numerous rules and norms in the general medical ethics which can be linked to a common morality. However, the field of clinical forensic medicine serves a specific role in society, which gives rise to specific obligations particular morality. The district surgeon ought to be aware of his specific role within medicine, just as a public health specialist recognizes his role beyond that of benefiting individual patients, and instead focusing on the welfare of communities. The role of clinical forensic medicine

is to assist in advancement and administration of justice. Awareness of this role should be what it entails being a forensic physician and it will come through training, education and experience. A physician practicing as a district surgeon who is not aware of this primary role is not competent to perform duties of in clinical forensic medicine. It is from knowing one's role that a physician can have a meaningful

appreciation of his obligations. Beauchamp and Childress (2013) put this eloquently by stating that the obligations that professions attempt to enforce are determined by an accepted role. These obligations comprise the 'ethic of the profession'. A practitioner who lacks awareness of his role is unlikely to diligently fulfill his obligations.

Clinical forensic medicine assists the courts in the administration of justice through application of medical skills and knowledge by evaluations of fitness to plead, collection of evidence, interpretation of physical findings and providing expert opinion in court proceedings. These roles are part of primary performance requirements, and are not typically for the promotion of the well-being of patients settings. They are instead focused on assisting the court, thus introducing another party that the doctor should serve over and above patient interests. This exposes the doctor to a situation where he has to serve two often opposing interests, that of patient and that of society or courts of law. The district surgeon need not abandon background medical ethical principles such as beneficence and nonmaleficence; however he should be aware of his primary role and obligation so as to be able to balance these duties appropriately where a conflict arises.

Several obligations specific to clinical forensic medicine can be derived from the primary role of assisting courts in the administration of justice. The particular morality of clinical forensic medicine should support this role.

DUTIES IN CLINICAL FORENSIC MEDICINE

In articulating duties and ethics for clinical forensic medicine, the profession "cannot subtract or contradict the existing general ethical obligations'' (Appelbaum 1997 p.238). Appelbaum (1997) further argues that a professional ethic must constitute an addition to the corpus of duties already in existence.

However, an addition does not necessarily mean new value derived from outside the profession. It can merely be a different way of specifying the already existing principles, or a prioritization of obligations and values to suit the specialty. So the implication is that the dominant principles should be focused on supporting "the functional roles that the profession performs to society" (Appelbaum 1997 p.236).

But there are many duties spelt out by different codes that physicians ought to fulfill. However, Beauchamp and Childress (2013) differentiate between action guides as those of aspiration (i.e. moral ideas) and those of duty (i.e. rules). Once a society of professionals has identified their specific roles, they can therefore elevate particular morally desirable ideals to become *prima facie* obligatory moral rules. This will not only ensure that their code does not violate common morality, but is also focused on supporting the specific role of the subgroup.

The focus in clinical forensic medicine is assisting in the administration of justice. Hence, duties are also aligned along the goal of advancement of justice as a core function of clinical forensic medicine. Over and above the duties from general medical ethics, I argue for the recognition of additional duties more relevant to clinical forensic medicine. When dealing with patients in clinical forensic medicine, obligations derivable from both clinical and forensic aspects of the discipline ought to be considered in each and every case.

I have demonstrated how multiple obligations come into conflict by the use of case vignettes. These conflicts extend beyond the traditional scope of medical ethics. I have also suggested that a duty based approach will be the best suitable framework for clinical forensic medicine. In the next chapter, I explore further the concept of duties and obligations, and then suggest core obligations in clinical forensic medicine. I conclude the chapter by suggesting a way to resolve dual loyalty conflicts on a case by case basis.

V. DEALING WITH CONFLICT OF OBLIGATIONS

OBLIGATIONS, DUTIES AND LOYALTIES – A CONCEPTUAL ANALYSIS

Duties can be defined as "things we are required to do" (Pelligrino 1994 p.125). Josephson (2011) defines duties as obligations to act in a certain way. Benjamin (1994) argues that duties are actions to which we are obligated. One who has a duty has an obligation to perform or not to perform something. Both duty and obligation are requirements to perform something. Although used interchangeably most of the times, there is a difference between a duty and an obligation. Duty and obligation can be differentiated by defining duty as "that which is owed as opposed to an obligation which refers to that which is binding" (Thepterosaur 2009 p.1). Other differences between duty and obligation can be tabulated as follows according to the conceptual analysis by Thepterosaur (2009 p.1).

DUTY	**OBLIGATION**
Duty is felt	Obligation is imposed
Duties are assumed by individuals	Imposed by superior
Duty is "ought"	Obligation is "must"
Duty can give rise to obligation	Obligation can destroy duty
Duty means respect for one owed	Obligation does not
Autonomy is foundation of duty	Subordination is foundation of obligation
Duty is internal	Obligation is internal
When accomplished it is fulfilling	When executed it is liberating

A discipline like clinical forensic medicine is associated with both duties and obligations for the district surgeon. Chapter 2 (Bill of Rights) of the Constitution of South Africa (1993), guarantees rights to citizens, but more importantly to detainees. These provisions impose an obligation upon the district surgeon to respect, promote and fulfil these rights. There is therefore an obligation imposed by law upon the district surgeon. Upholding human rights however, should not be viewed as a mere legal obligation imposed upon the district surgeon, but should also be felt by the

district surgeon from deep within as a duty, since it is so fundamental to clinical forensic medicine.

It is clear therefore that the district surgeon has a mixture of duties and obligations towards their subjects. The obligation to uphold and respect human rights can lead to a strongly held duty when internalized. It is therefore not surprising that the terms 'duty and obligation' are often used interchangeably. This interrelatedness is demonstrated by Josephson's argument that "duty is an obligation to act in a certain way. When the obligation is based on moral and ethical considerations, it is a moral duty" (Josephson 2001 p.1). It follows therefore that it will be too simplistic to assume that obligations arise from laws, whilst duties from moral intuition. There is often an overlap between the two.

Some authors argue that the distinction is important where there is a conflict of duties or obligations. This distinction is helpful for resolving dual obligation conflicts. They argue that "if a duty arising from a moral principle conflicts with duties imposed by law or undertaken by agreement, the duty based on a moral principle should prevail" (Josephson 2001 p.3). However, this is an oversimplification of dual obligation resolution method.

Even though the distinction between duties and obligations may be relevant, below I propose a different approach for managing conflicts of duties, (legal or moral), as opposed to the linear oversimplified method mentioned above. I will therefore not be using the terms 'duty and obligation' in the strictest sense discussed above. To this end, I will be referring to dual obligations when discussing competing duties, or competing obligations, as well as where duties are in conflict with obligations.

What now of loyalty and dual loyalties? Loyalty can simply be defined as 'allegiance or fidelity or devotion' (Merriam-Webster Online Dictionary). Medical practitioners are expected to be loyal to their patients according to the Hippocratic Oath. Based on the traditional doctor-patient relationship, doctors have been understood as owing complete allegiance to their patients. So the duty of loyalty is one of the most fundamental duties of a medical practitioner. The World Medical Association's code of ethics (WMA, 2006) states that a physician shall owe his/her patients complete loyalty. However, the role of doctors is no longer limited to that of a healer as discussed previously. Perhaps the most telling example is that of doctors in public

health. These doctors have to take the interest of the public into consideration when dealing with patients, disease or policy formulation. The same can be said of occupational health doctors. They are primarily employed to apply their skill and knowledge to a workplace environment, dealing with both employee and employers' interests. The district surgeon also deals with detainee's interests, as well as society's interest in the promotion of justice. There are therefore several instances where doctors have to serve the interests of more than one party. It is under such situations that the doctor owes allegiance to more than one interest group. These multiple roles for doctors are commonly referred to as dual loyalty situations.

The Dual Loyalty Working Group (DLWG) defines dual loyalties as "simultaneous obligations, express or implied, to a patient and to a third party" (DLWG 2002 p.12). Dual loyalty situations are also referred to as 'double agent or double agent situations', which Knight *et al* (1995) defines as being divided between allegiance to the patient and allegiance to some other interest. The district surgeon clearly has dual roles. The first being obligations to patients and detainees as a physician. The second role is an obligation owed to society, namely to promote the administration of justice. Dual loyalties in healthcare are common, and do not necessarily lead to a conflict. Take for example a district surgeon who is attending to a victim of rape. He will have a duty to render medical care, in the form of post exposure prophylaxis against HIV infection as well as emergency contraception. He also has a simultaneous duty to collect forensic evidence and compile a medico-legal report for purposes of criminal proceedings. Often, both these roles can be fulfilled without any conflict of allegiance to either patient or society/court. In these circumstances, the district surgeon can satisfy obligations to both parties with ease. However, the dilemma emerges where there is a conflict between the obligations to the two parties. Henceforth, I will refer to dual loyalties as dual obligations and vice versa.

What is important to realise is that even though the above exposition suggest interchangeable use of the terms dual loyalty, dual obligations and dual agency, it is important to know what is not a dual obligation conflict. So I will differentiate these from another related by different concept, namely a conflict of interests.

A conflict of interests can be defined as "one's obligations to a particular patient or group conflicts with one's personal or self-interests" (Morreim 1995 p.503). So to

differentiate between conflict of interests and a conflict of obligation, one has to view "a conflict of interests as usually a conflict between one's own interests and those of other individuals or group, whereas dual loyalties are conflicts between two external accountabilities that are incompatible" (Williams 2009 p.8). A common example of a conflict of interests, also cited by Williams (2009) is when doctors provide unnecessary services solely for financial gain. They are putting their financial interests ahead of the interests of the patients. This paper however explores dual obligations or a conflict of obligations, and not personal conflicts of interests.

I will now explore a duty based framework for application in clinical forensic medicine.

A DUTY BASED FRAMEWORK FOR CLINICAL FORENSIC MEDICINE

According to Wood (2001), Immanuel Kant (18th century)'s classification of duties into duties to oneself and to others was inspired by Samuel Pufendorf's (17th century) conception of duties.

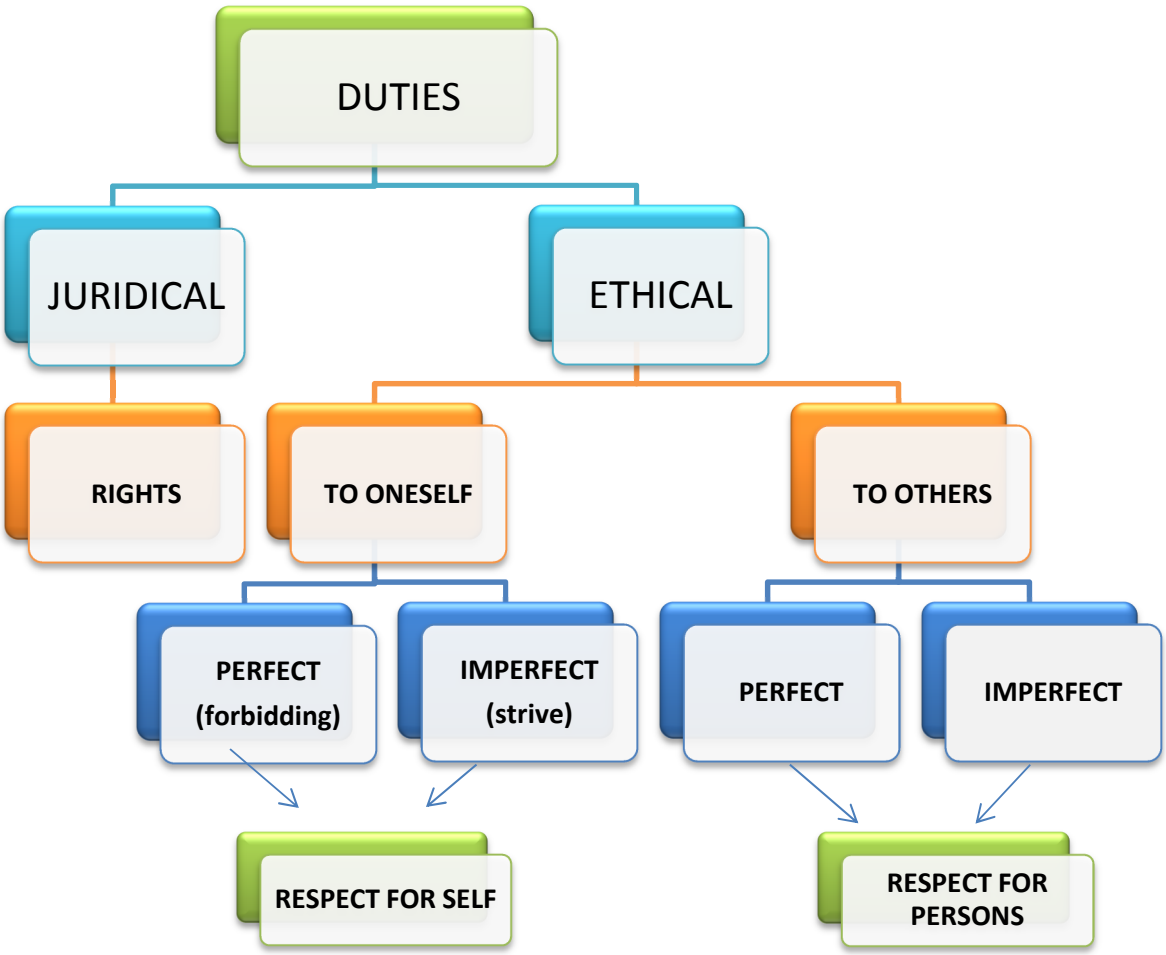
Samuel Pufendorf has a three way classification of duties to:

(i) God,
(ii) To self
(iii) To others.

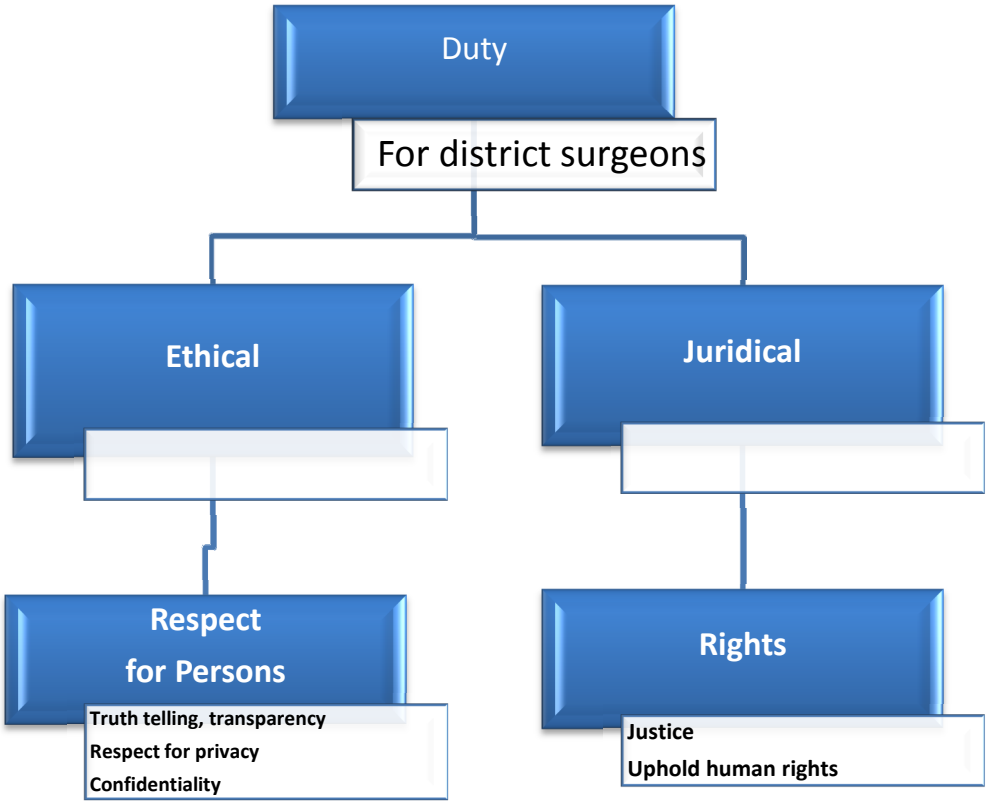
The absence of reference to religion on the Kantian duty conception makes it more attractive for adoption into a medico-legal field like clinical forensic medicine.

According to Kant, there are ethical duties that support a doctrine of rights (Wood, 2001).

Ethical duties are therefore subdivided into duties to oneself and duties to others as per representation below: Adapted from a flow chart by Wood (2001 p.3)



John Locke's conception of duties highlights the correlativity of duties to others and rights (Ling *et al* 2007). The basis for duties and obligation to others in clinical forensic medicine are derivable from the principles of respect for persons and human rights as shown in sketch above. The framework for obligations of district surgeons should be firmly based on these principles. Doctors in clinical forensic medicine should treat subjects with dignity and uphold their human rights. Several action guiding rules are derivable from the principle of respect for persons. Those relevant to clinical forensic medicine will include veracity, respect for privacy and confidentiality. Independence (objectivity) of the practitioner finds expression from the ability to act as an autonomous agent. The duty to uphold human rights is supported by the doctrine of rights. See below a diagram of Kant' division of duties by Wood (2001) as applied to clinical forensic medicine.



This is a demonstration of how central a duty based ethical framework is to clinical forensic medicine. Most rules in clinical forensic medicine can be derived directly from a duty based ethical framework.

RESPECT FOR PERSONS

Respect for persons ought to be the basis of obligations in clinical forensic medicine. This is especially the case since most of the subjects in clinical forensic medicine are vulnerable. They are detainees under arrest or in prison custody. They have some of their rights limited, hence may be easy targets for less than appropriate treatment. Kant's respect for persons principles dictate that rational beings be treated with dignity and is often stated as "to never treat persons merely as means to an end, but always as ends in themselves" (Rachels, Rachels 2010 p.128). Kantian categorical imperative imposes a perfect duty on the practitioner not to treat rational beings only as means to an end. It's a perfect duty, which means that a practitioner may not deviate from this duty irrespective of consequences. The obligation is to treat rational agents as ends in as ends in themselves, including the self and others. The prohibition not to treat self and others as means is absolute and hence obligatory.

Several principles and duties for the district surgeon can be derived from the specification of the principle of respect for persons.

The duty to uphold human rights is extremely important in clinical forensic medicine as most of the subjects are detainees. They are therefore vulnerable to abuse at the hands of law enforcement officials. This situation is exacerbated by the fact that detainees have some of their rights limited by law. The district surgeon ought to be aware of the detainee's rights and thus his duties and obligations. There are several rules for district surgeons that can be derived from further specification of the obligation to respect persons. These include prohibition against exploitation, lack of transparency, invasion of privacy as well as violation of confidentiality.

In the next section, I discuss the specific obligations to be considered by district surgeons. After that, I will explore how these obligations should be managed where they come into conflict with other competing duties.

For purposes of meaningful practice of clinical forensic medicine, I suggest that certain obligations ought to be recognized as core for district surgeons. These core clinical forensic medicine obligations are:

- Truth telling
- Transparency
- Privacy
- Confidentiality
- Independence or Impartiality
- Justice
- Human rights promotion

1) TRUTH TELLING

Clinical forensic medicine applies medical knowledge to legal processes in order to resolve disputes. This is often in the form of medical reports submitted to court, or oral testimony and expert opinion for advancement of justice. According to the Free Online Dictionary (2011), within the various forensic disciplines, the quest for the truth is the uniting theme.

The truth telling can be understood in very general terms to be veracity and authenticity. The documentation and medical reports that a district surgeon presents in court are presumed to be truthful. The medical reports are submitted to court with an accompanying sworn statement of veracity. This statement, often referred to as an affidavit, is a legal requirement that binds the author of the report to not intentionally pervert the course of justice. A similar oath is taken before the district surgeon gives oral evidence in court. Though mainly a legal prerequisite, truth telling is morally obligatory in forensic sciences and clinical forensic medicine. The consequences of not telling the truth at court cannot even be justified by the possible expected, often short sighted self-serving outcomes.

The motivation to falsify court reports may be to serve the interests of a particular party, but this at the same time harms the persons who are seeking justice. The balance of good over evil is unlikely to favor falsifying court reports and giving false oral evidence. The overall effects of distrust in the justice system will overshadow whatever good was meant to come from not telling the truth. Society will rebel and instead of trusting the courts, they will choose to resolve disputes themselves. Even from a non–utilitarian perspective, the district surgeon remains duty–bound to tell the truth in his endeavor to advance the course of justice. The court administers justice and relies on the contribution from many fronts, including district surgeon. From a deontological perspective, the rule not to be truthful in court presentations cannot be universalized. If everyone lies in court, then the purpose of seeking justice through courts will be defeated. The oath to be truthful in court representation will be useless and the very purpose of forensic medicine will be defeated by the contradictions of untruthful district surgeons in legal proceeding. Hence being untruthful in clinical forensic medicine will violate Kantian categorical imperative and basic principles of utility (i.e. promotion of overall good over evil).

Failure of the district surgeon to present truthful evidence can have detrimental consequences to society. At times, dangerous criminals may go unpunished. This might lead to loss of trust in the justice system, and then mob justice. Innocent people may be killed in such circumstances. This has a potential of causing chaos and lawlessness in the society as trust in legal system is being eroded. The district surgeon ought to recognize the obligation to tell the truth when performing his duties. Appelbaum (1997) differentiates between subjective truth telling and objective truth

telling. Subjective truth telling refers to telling the truth to the best of the practitioner's knowledge. Subjective truth is "equivalent to honesty and is the same as giving an opinion assessment that I believe to be true" (Appelbaum 1997 p.240). This standard falls short of the ideal of objective truth telling standard. The objective standard requires the practitioner's opinion and assessment to be based on latest evidence available in the field. His evaluation should accurately reflect this information.

A district surgeon should strive for the objective truth telling standard. A practitioner who gives an opinion that leads to perpetrators of crimes walking free does the same damage to the confidence society has on the justice system whether the practitioner deliberately falsified a medico-legal report or merely gave an erroneous opinion due to ignorance. Specification of the obligation to tell the truth leads to the rule that district surgeons ought to be honest and knowledgeable.

This carries with it a responsibility to keep abreast with the developments within their field. These are referred to in many forensic scientists' codes of ethics as requirements of competence and integrity. To this end, the Digital Forensics Certification Board (DFCB 2008) code of ethics and standards of professional conduct requires practitioners to "continually strive to increase and improve their skills and knowledge and to maintain currency with the advances and standards in their profession". The district surgeon also ought to realise this ethical obligation and fulfil it.

2) TRANSPARENCY

There are several ways in which a district surgeon can violate the principle of 'respect for detainees'. One such violation relates to the non-disclosure of information to the detainee. A detainee ought to be informed by the district surgeon what procedures are to be performed and for what reasons. Failure to give relevant information to detainees in clinical forensic medicine may manifest as deception or therapeutic misconceptions.

- Deception – The district surgeon deals with detainees, who are sometimes tortured and may be in need of sympathy from someone outside the law enforcement and custody officials. He sees a physician as someone who has his best interests at heart. He may be more open and forthcoming with

circumstances of incident and details of the crime alleged. He naturally assumes that a physician has altruistic intentions. However, a district surgeon who deceives a person into believing that the consultation is similar to any other doctor–patient relationship fails to treat the person with respect. He does not inform the detainee that the nature of their interaction is forensic and not purely therapeutic. And also that he may not be able maintain confidentiality as a physician would. In other words, the district surgeon should clearly disclose the aim of his examination, i.e. to inform law enforcement officers and court of a condition. The detainee must therefore clearly be aware that he only has to give the doctor such information that he wouldn't mind if it were divulged to law enforcement agencies. This phenomenon can be likened to the concept of therapeutic misconception in clinical research, also referred to as therapeutic transference.

- Therapeutic transference **-** A doctor, in this instance a district surgeon, passively allows a detainee to believe that their interaction is based on trust. The mere failure to correct this misconception prior to a consultation is deceptive. The obligation is on the district surgeon to ensure that a suspect understands the forensic nature of the consultation as well as the possible loyalty conflicts. It is not only the detainee who is treated with disrespect in these circumstances, i.e. deceived into giving the district surgeon incriminating details. The district surgeon also fails to treat himself with respect by allowing law enforcement agencies to use him as a mean to other ends. The police interrogators who fail to get desired information from the suspect may attempt to use a doctor to get that information out of a detainee. The district surgeon is allowing himself to be used as a means to get incriminating information against the detainee. He is treating himself as a means to an end, i.e. serving the interests of the law enforcement officers. Even though a district surgeon has a duty to assist in the administration of justice, this end is not to be achieved at whatever costs. To violate the human rights of a detainee for purposes of a conviction shows the district surgeon's failure to balance his duty to promote justice against his other duty of promoting human rights. He is therefore treating himself with disrespect. A district surgeon has an obligation not to violate the categorical imperative as formulated in the theory of ends. The detainee merely gives some information

to provide the doctor with background information out of trust. The detainee transferred from a purely clinical setting (doctor-patient relationship) to a forensic setting (evidence collection situation). If the district surgeon does not warn the detainee of this misguided transference of trust, that consultation is deceptive and morally impermissible.

3) **PRIVACY**

Clinical forensic medicine is not purely a clinical practice. It is a practice conducted in association with law enforcement officers or correctional service officers. Arrested persons are taken to courts and clinics by police officers. Prisoners are always accompanied by correctional service officials. Some of the detainees are under heavy police guard. There may be high profile cases, serious crimes or high flight-risk prisoners. It is undesirable to expose a clinician to risk of harm by prisoners or detainees. This can happen if dangerous criminals are left unattended to consult with doctors in private. It is therefore inevitable that a district surgeon will consult with their patient in the presence of non–medical personnel, whose presence serves to protect medical staff and prevent detainee from escaping from custody. However, the principle of respect for persons dictates that personal space and information should be protected. The district surgeon ought to treat detainees with respect. However, unnecessary intrusion into person's being and information is disrespectful and impermissible. So the district surgeon should prevent others from intruding into detainee's personal space and information during a consultation.

In case vignette 3 discussed above, the young girl's parents may want to be present in the consultation room during the examination. It is the obligation of the district surgeon to realise that even though the parents are entitled to information concerning their girl, her privacy ought to be protected.

The district surgeon may ask the girl very private and sensitive questions, for example sexual habits, gynaecological and obstetrical history. The accompanying parents must be at a distant to allow for some privacy during the consultation. Even at the time of a clinical examination, they should be outside the consulting room and the consultation should be discreet.

The district surgeon has an obligation to respect the privacy of detainees by preventing unnecessary intrusion into detainee's personal space and sensitive

information. This also applies where a medical report is generated for purposes of criminal prosecution. Any information that is not material to the case (like HIV status) should be left out of the medical report.

Where the obligation to maintain privacy is in conflict with other equally important duties, the district surgeon ought to resolve the conflict correctly.

4) CONFIDENTIALITY

Clinical forensic medicine examinations are mainly fact-establishing consultations. The confidentiality of the information received from a detainee or discovered is not guaranteed. It is therefore mandatory for the district surgeon to inform the detainee if the information will be passed on to law enforcement agencies. The detainee should have this in mind when deciding whether to divulge something to the district surgeon. Should the detainee give the district surgeon information out of trust, the district surgeon has a duty to respect that information and keep it confidential. Passing on to law enforcement officials information that is not material to the advancement of justice will be treating the detainee with disrespect. Though confidentiality can be severely limited in clinical forensic medicine, proper channels should be followed when breaching this duty, for example, through a court order. An example is the involuntary HIV testing of alleged rape offenders. The Sexual offences act (2007) provides for the testing of suspects in rape cases without their consent and giving their HIV results to victims in these cases. However, even such a test should only be done through a court order.

5) INDEPENDENCE

The South African legal system is adversarial in nature, as opposed to the inquisitorial system in other countries. The South African law of evidence “stems from the English system of adversarial trials before a lay jury as opposed to the Continental inquisitorial trials by professional judges” (Van der Merwe 2009 p.6). In an inquisitorial system, the presiding officer (magistrate/judge) inquires during the proceedings in what appears to be a fact finding exercise. He is an active participant during trial proceedings, asking all parties relevant questions to establish the truth. However, in an adversarial system, the presiding officer is a passive observer. He

listens to both sides with minimal interference and then compares the weight of the evidence presented by both sides.

This means that the verdict in such a legal system is closely related to the strength of the evidence presented by either side. A district surgeon is normally requested to examine detainees for evidence. He may also be called to give an expert opinion in court during trial proceedings. As a professional and a rational agent, the district surgeon ought to act without undue influence. Take for example a detainee who alleges torture at the hands of police officers, and is taken to a district surgeon for examination. The district surgeon will conduct an examination to document and interpret findings so as to ascertain the causes of any injuries. This he must do freely without influence or pressure from employer, police and politicians. The district surgeon should act objectively and impartially during his evidence collection, documentation, interpretation as well as the presentation of evidence in court, irrespective of the sides which the evidence supports. Allowing oneself to be used as a mere means to an end by either side of the dispute is unethical. Hence, objectivity prevents exploitation of the district surgeon to serve partisan needs. It is therefore not surprising to find the requirement of impartiality expressed in a number of forensic associations' codes of ethics. For example, the Australian Association of Forensic Physicians requires that "forensic physicians must acknowledge the importance of impartiality" (AAFP 2013 p.1)

6) JUSTICE AND HUMAN RIGHTS

At the heart of clinical forensic medicine is to assist in the administration of justice. No discussion of a district surgeon will be complete without an exposition of the concept of justice and human rights. Below I briefly discuss justice as it is related to human rights, and then highlight the relationship between duties and rights.

Beauchamp and Childress (2013) argue that common to all theories of justice is a minimal requirement traditionally attributed to Aristotle that: Equals must be treated equally, and unequals must be treated unequally. This is widely accepted by most philosophers. It is however in the details and substance that the concept of justice becomes much contested.

Despite the different meanings given to the concept of justice, fairness and defending of rights find expression in many of these. John Locke (1632 – 1704), an English philosopher, argued that there are certain moral rights that must be protected. His doctrine of natural rights lists liberty, life and property (later to be construed as happiness) as the "rights to be protected absolutely" (Greetham 1995 p.354). On the other hand, American philosopher John Rawls (1921 – 2002) emphasised liberty and equality in his theory of justice. He claimed that "we all have certain basic and equal rights" (Greetham 1995 p.335). Human rights are not merely a legal requirement, but as Raphael (1991) argues, they are stringent moral obligations. They do not come into existence by enactment of positive laws, but they are natural as conceived by John Locke. The utilitarian's conception of rights is narrow and restricted to instances where upholding the rights will promote utility, and is therefore not suitable as basis for human rights.

But what does having a right, whether natural or artificial mean to the holder of that right? A right gives its "holder a justified claim to something and against another party" (Beauchamp, Childress 2013 p.368). This therefore creates an obligation on another party to fulfil a claim. The correlation of rights and obligations is generally accepted, as Beauchamp and Childress (2013) conclude that obligations follow from rights, rather than the converse.

However, several duty based theories express obligations to others through the language of rights. A journey through the development of deontology shows, according to Ling *et al* (2011) that, since the 17th century German jurist and philosopher Samuel Pufendorf (1632 – 1694) who claimed that there exists an absolute duty to treat people as equals. Then English philosopher John Locke argued for natural rights that ought to be protected, and his list included rights to liberty and life. Later, the most celebrated deontologist, German philosopher Immanuel Kant (1724 – 1804) provided the most accessible duty based account of rights. As outlined by Wood (2001), Kant divided duties into ethical and juridical, the latter is also referred to as a doctrine of rights.

The correlation between rights and obligations has been clearly established. However, the question that arises for the district surgeon is 'what rights do subjects in clinical forensic medicine have claim to?', and more importantly in this paper is to answer the question 'what obligations for district surgeon flow from these rights?'

The Constitution of South Africa (1993) declares that the Bill of Rights is the cornerstone of democracy in South Africa. It further states that the rights in the Bill of Rights must be respected, promoted, protected and fulfilled. In his interaction with detainees, the district surgeon must keep in mind the detainee's rights to equality before the law, rights to human dignity, freedom and security of person. More importantly though, are the rights specifically guaranteed for detainees, that it is the right to be detained in conditions that are consistent with human dignity, including rights to privacy as well as bodily and psychological integrity. These detainees' rights impose an obligation on the district surgeon to respect, promote, protect and fulfil them. Further specification of the rights to privacy and human dignity imply that the district surgeon must be aware of the environment in which detainees are examined. Minimum intrusion during consultations must be ensured to safeguard detainee's privacy. Prior to the Bill of Rights in South Africa's constitution, the district surgeon could rely on international declarations, for example the Geneva declaration and Declaration of Tokyo. The Geneva declaration, WMA (1948) places an obligation on physicians not to use medical knowledge to violate human rights and civil liberties.

It is important to recognise that even though detainees have their rights curtailed, there remains a host of rights that imposes both positive and negative obligations to the district surgeon, and these obligations ought not be overlooked.

In the above duty based exposition, I have suggested a list of core obligations for the district surgeon which he ought to consider during his interaction with his subjects. I argued that these obligations ought to be recognised, and therefore in the next section I proceed to discuss the conflicts that arise between these obligations, arguing for a method that will assist in the correct resolution of such conflicts.

HOW TO RESOLVE DUAL OBLIGATION CONFLICTS

Prior to 1994, district surgeons in South Africa have been practising under a very difficult political environment. After apartheid, the ethical challenges in clinical forensic medicine persisted. The lack of clearly outlined policies, guidelines and an ethic that is particular to clinical forensic medicine meant that the district surgeons have to rely on the already existing traditional medical ethics. However, this is inadequate in dealing with the quandaries faced by district surgeons. As a result, district surgeons have to address dilemmas by appealing to intuitions, experience and individual moralities. This means that the above ethical dilemmas of dual loyalties will be resolved differently by different district surgeons. This is mainly because intuitions and individual moralities differ vastly. The spectrum extends from that of non-caring district surgeon with a laissez-faire attitude, to those of a very compassionate and astute district surgeon who is obsessed with the respect for human rights of detainees and victims. A typical example can be seen by comparing the actions of district surgeons Drs Tucker and Lang who treated Steve Biko inhumanely. According to the TRC report (1998), their conduct stands in stark contrast to that of other district surgeons who fought for human rights, like Dr Wendy Orr, who refused to be complicit whilst the human rights of detainees were being violated.

A duty based exposition will assist district surgeons identify their specialty's specific obligations as well as recognise a conflict of these duties when they arise. When dealing with a dilemma, Weinstock (2001) suggests a mixed approach that combines both perspectives of practitioner as an evaluator with justice as the primary ethical principle, and also as a clinician who privileges beneficence and nonmaleficence. The district surgeon cannot rely on the fiduciary duties for addressing a dilemma as his role is more than that of a physician as a healer. Over and above being a clinician, his core functions are that of a forensic investigator and evaluator.

A practical approach to resolving dilemmas should recognise these dual roles of a district surgeon. The ranking of obligations in a manner that prioritises loyalty to patients is not suitable for clinical forensic medicine. There are instances where the interests of society and justice overshadow the obligations of a district surgeon to their patients. The converse is also true, and thus as Rodwin (1995) puts it, 'fiduciary

metaphor is strained' when applied to clinical forensic medicine. The list of obligations for district surgeons is extended by third party interests such as police, society and courts. In dealing with a conflict of duties, Ross (1930) recommends that we find the greatest duty. Ross distinguishes prima facie duties from actual duties. Hence, in clinical forensic medicine, the duties to detainees, court and society are prima facie. They are always to be acted upon if not in conflict with other equal or stronger duties. Where there is a conflict, Ross (1930) argues that actual duties will result from the examination of the multiple prima facie duties. So, a district surgeon ought to know all his obligations when dealing with any particular situation. This will allow him to weigh up all duties so as to determine the actual duty. The district surgeons who falter in their management of dual loyalties, like those who treated Steve Biko failed to recognise their duty to uphold human rights as specified in a number of international declarations. This led to a disregard of actual duties since the prima facie duties were not recognised, or at worse were blatantly ignored. The conflict of duties and dual loyalty situations in clinical forensic medicine results from the overlapping roles of the district surgeon. Williams (1981) argues that value conflict is not necessarily pathology; however, the pathology is the philosopher's obsession with eliminating the value conflict. Thus, whilst I suggest a practical approach for the district surgeon, it is important to keep in mind the overall aim of the exercise, which is to manage the conflict and not necessarily to eliminate it.

REJECTION OF SINGLE THEORY APPROACHES

Appeal to moral theory when dealing with dual loyalty conflicts can provide a lot of insight and direction in resolving conflicts of duties. However, single theory approaches are likely to be ineffective in most of the situations. At times, they will result in weird conclusions when applied in practice.

The Kantian idea of perfect duties has no place in the management of dual loyalty conflicts. This is the concept of differentiating perfect from imperfect duties. Perfect duties, as Greetham (2001) puts it, are those that must be acted upon by all agents, in all situations at all times. They are categorical, specific and unconditional. These duties are never supposed to come into conflict with one another. This is obviously not possible in clinical forensic medicine where the possible permutations of dual obligation conflicts are endless. There is therefore no absolute perfect duty that must

always be fulfilled, which can never come into conflict with other duties. The Kantian deontological approach offers no clear guide to resolve a conflict of duties when they clash. For example, a duty in healthcare settings to always maintain confidentiality in doctor-patient relationships may clash with a duty to warn third parties of potential harm. No clear guidance exists to resolve such stand-offs. This is because Kantian duties are absolute and should be fulfilled no matter what.

WD Ross' way of dealing with such a stand-off is to differentiate prima facie duties from actual duties. Prima facie duties are binding until they are outweighed by other prima facie duties, which therefore are referred to as actual duties. Even though less rigid and non-absolutist, this Rossian deontology still has a key question to answer, that is; which prima facie duty will be given priority when there is a conflict of duties? The suggestion is that we "reflect deeply and these will become self-evident" (Greetham 2001 p.321). This, however, does not provide clear guidance for the district surgeon, who will have to rely on intuition for right action. This will also be arbitrary as there is no system of justification and two district surgeons facing a similar dilemma can arrive at different conclusions.

Intuitionism is not helpful either, which relies on "careful perception of situations so as to intuit and find answers" (Benjamin 2006 p.263). However, no amount of intuition will guarantee the correct resolution of conflicts in clinical forensic medicine. It is too arbitrary a framework and its conclusions will vary greatly from district surgeon to district surgeon.

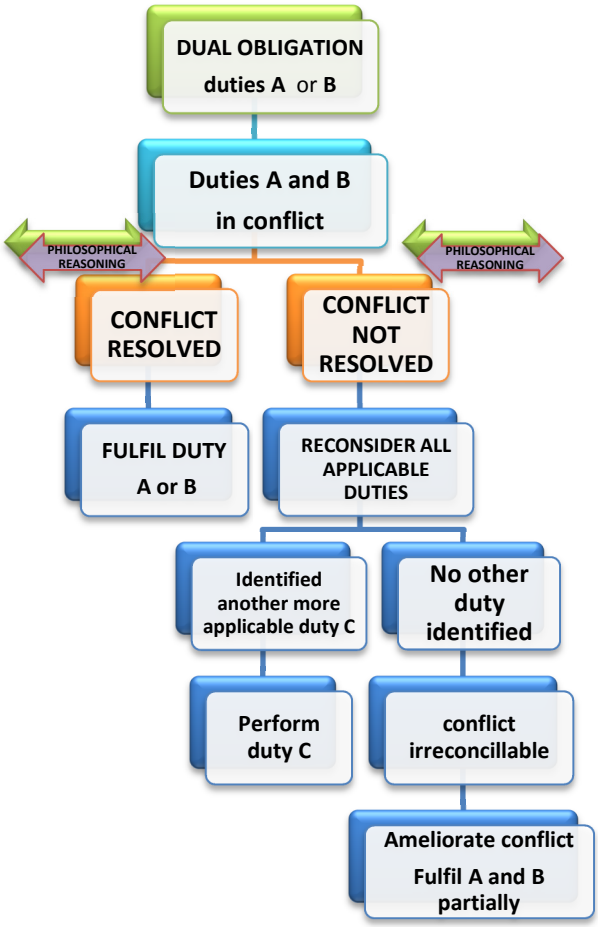
On the other hand, utilitarianism views conflicts as resolvable. However, this is supposed to be done by "direct appeal to utility" (Benjamin 2006 p.261). This is also not suitable for clinical forensic medicine since it ignores the human rights of an individual detainee for the good of the majority. So it means that falsifying a medical report to conceal the torture of a suspect will be permissible if it will result in the expedition of the conviction of a suspect who terrorizes the community.

None of the above moral theories, or any other simplistic moral theory can resolve dual loyalty conflicts in isolation, a sentiment expressed by Benjamin (2006).

A SUGGESTED FRAMEWORK FOR RESOLVING DUAL OBLIGATION CONFLICTS IN CLINICAL FORENSIC MEDICINE

It may now seem pretty obvious to suggest that once having identified duties that are in conflict, one ought to engage in a process of moral reasoning to arrive at the duty that one ought to fulfil. A detailed discussion of the concept of philosophical reasoning is beyond the scope of this paper; suffice to say that the use of logic and weighing up of consequences will often resolve most common and uncomplicated obligation conflicts. For example, whether a district surgeon should take orders from employers, orders that may result in harm to the detainees can be resolved relative easily provided there is moral sensitivity. In South Africa today, the political climate allows most dilemmas to be handled objectively and ethically.

However, there remains a significant number of dual obligation conflicts which cannot be resolved by application of basic moral reasoning. These should therefore be ameliorated (Benjamin 2006 p. 234). This, however, does not mean choosing the most convenient alternative, but involves a process of compromise whilst maintaining coherence of the whole situation. Below I represent in a flow diagram the process to be followed by district surgeons facing these dilemmas, designed from a framework discussed by Benjamin (2006).



Amelioration involves a compromise by fulfilling some aspects of both conflicting duties. Whilst making concessions, it is important not to lose coherence of the situation as a whole. This can be achieved by drawing from the district surgeon's own practical experience and wisdom. Hence this approach will respond to both conflicting duties whilst not fully doing justice to either. I apply this approach to the dilemmas discussed earlier in the three case vignettes.

APPLYING THE APPROACH TO CASE VIGNETTES 1, 2 AND 3

Clearly; in case vignette 1, giving in to the request of the detainee for privacy, whilst turning a blind eye to safety and security concerns is not desirable. The district surgeon has a duty to minimise risk of harm to both detainee as well as the society at large. In standard form, the argument is as follows:

1 The District surgeon ought to minimise harm

2 Giving in to the detainee's demands for privacy may result in harm to third parties

3 Satisfying the police's demands for security may result in harm to the detainee

4 The obligations to police and detainee are in conflict

Therefore, the district surgeon ought to correctly manage this conflict to minimise harm.

The district surgeon cannot resolve the conflict by performing either actions, so he needs to search for another more binding duty, or ameliorate the conflict.

Some may object and argue that it is much easier to simply opt for the action that will cause lesser harm than to attempt to balance the conflict. In this case, violating an alleged criminal's privacy is less serious than risking harming innocent third parties. Hence, the critics argue, a district surgeon should not go against police demands in this case. Instead, he ought to ensure that he and other third parties are not exposed to risk of harm.

The reply to the above objection is twofold. The first reply is that, examining the detainee in full view of police officer will definitely violate his privacy. So the harm to the detainee is guaranteed and will follow directly from the district surgeon's failure to protect dignity of the detainee. Whilst on the other hand, the possible harm to the district surgeon and society does not directly follow from the district surgeon's actions. It is based on presuppositions that the detainee will want to escape and also that having escaped he will indeed commit further crimes. It is not inconceivable that the detainee may escape solely for his freedom and not harm anyone after that.

The second reply to this objection tends to trivialise the privacy concerns of the detainee. This in turn makes a mockery of the Bill of Rights. The rights to dignity and humane, non-degrading treatment are fundamental to the constitution of South Africa. The latter approach goes against the spirit of the constitution and findings of the Constitutional Court in the case relating to capital punishment. The court found in State vs. Makwanyane that the death penalty violated the rights to dignity, humane and non-degrading treatment, and hence outlawed the death penalty. Likewise, the appeal for non-degrading treatment of the detainee in this case ought not to be

trivialized. Hence, the careful balancing of these conflicting obligations is mandatory. Faced with this seemingly irreconcilable dilemma, a prudent district surgeon will fulfil partially both obligations, whilst maintaining coherence of the whole situation.

Therefore, there district surgeon ought to examine the detainee in the presence of police officers, but behind screens or curtains, preferably at earshot length. It is also more humane to release some of the restraining equipment during blood sampling, like requesting for handcuffs to be released whilst leaving the leg irons on. In this way, both the conflicting obligations can be fulfilled without causing significant harm to any of the parties.

However, not all dilemmas require amelioration. For example, in case vignette 2, the duty to obtain evidence to assist with convicting a drunk driver is very likely to cause significant irreversible harm to the detainee.
By carefully weighing the duty to prevent harm to suspects, against the obligation to assist in the administration of justice, a district surgeon ought to prevent harm in this situation. It will therefore be unethical to take a blood sample from a suspect who violently refuses to give a sample and has to be restrained by use of extreme physical force. The duty to assist with the administration of justice can be fulfilled by adopting a safer method of proving alcohol intoxication, which is by observing drunken behaviour and documenting this into medico-legal records.
However, some loyalty conflicts are complex and involve more than two duties in conflict. This is true for case vignette 3.
There is no easy way to resolving the dilemma faced by the district surgeon in case vignette 3. Applying the suggested approach to resolving the conflict clearly shows that there is no way to resolve the dilemma by merely fulfilling one obligation. Maintaining confidentiality will not satisfy the parents and police's expectation for information. Being completely truthful will harm the girl as discussed above. The district surgeon now searches for another duty to fulfil. He identifies the duty to respect the autonomy of the teenager and her right to refuse a medical examination. However, fulfilling this duty by not examining the girl will also have several undesirable consequences. So, amelioration is the district surgeon's next step. This will involve telling the partial truth and hope to satisfy all parties.
I conclude that the district surgeon in case vignette 3 should come out and say that he could not find any clinical evidence of recent sexual activity. This will be truthful

since his examination found no injuries and no abnormalities. The district surgeon's report will therefore satisfy the obligation to be objective and truthful, as any other second opinion will have the same findings on clinical examination. But this option omits a critical confession made by the girl. So though not a lie, such a statement will be incomplete. The district surgeon can consider getting an undertaking from the girl to stop seeing this boyfriend, and hence prevent future harmful consequences. Some of the arguments that the district surgeon should rely on during amelioration are presented below in standard form:

1. District Surgeon ought to minimise harm

2. Full disclosure will result in significant harm

_____

Therefore; District surgeon ought not to disclose fully to parents

Also

1. District surgeon ought to maximise benefit for all
2. ↓Veracity & ↑confidentiality promotes good

_____

Therefore; District surgeon ought to limit disclosure to parents

There are many factors to be considered in dealing with the conflict in case vignette 3. It is possible that different district surgeons will arrive at different conclusions despite using the same approach. This is to be welcomed, as different district surgeons bring along with them variable amounts of experience and practical wisdom. In complex situations like the one above, the conclusion arrived is not universal. It should therefore not be exported to every teenager's case presenting with a similar set of circumstances. Applying the approach on a case by case basis ensures that the context of every dilemma is taken into consideration and allows the district surgeon to use his experience meaningfully.

CONCLUSION

The work of district surgeons is very challenging, partly due to the need to consider the interest of several parties simultaneously. There is a lack of uniform definition, skills and scope of clinical forensic medicine. The conduct of district surgeons when confronted with multiple loyalties daily varies from atrocious to supererogatory and humane. Apart from this lack of uniformity, there is also a lack of a clear ethic to unify this discipline. To this day, district surgeons apply arbitrary methods to deal with conflicts of obligations. District surgeons draw from personal experience, individual morality, and intuitionism when dealing with dual loyalty conflicts. The lack training for district surgeons in ethics makes the situation even worse. As a result, detainees usually are at the mercy of district surgeons' individual moralities.

In this paper, I argued that district surgeons ought to recognise their obligations, and also manage loyalty conflicts correctly when they arise. The obligations central to clinical forensic medicine are not derivable from the traditional doctor-patient relationship. However, a new duty based framework is essential to assist district surgeons recognise their obligations.

I have suggested a list of obligations as core to clinical forensic medicine. This list is largely derived from the specification of the principles of respect and rights. These obligations are to be balanced against all other relevant duties. None of the obligations is given priority over the others. Cases will be decided on their individual merit following a balancing exercise and the application of practical wisdom.

However, even though the guidelines suggested in this paper seem clear and easy to apply, there still needs to be extensive training of district surgeons in ethics, law and forensics. This will contribute to better identification of relevant duties and ability to discern difficult situations. Dealing with sensitive clinical forensic situations requires more than the application of an algorithm. The above approach is not a mechanical application of simple rules, but requires the district surgeon to draw from his own experience. This will ensure that we properly utilise the lessons from history such as the Steve Biko detention and subsequent death in police custody.

If a district surgeon benefits anything from this project, I'm certain that this will include at least some degree of moral sensitivity and the ability for moral judgement.

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