MORAL RELEVANCE OF OATHS,

DECLARATIONS

AND CODES IN

MODERN MEDICINE

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Abstract

Oaths, declarations and codes are seen as moral guides to which physicians can subscribe in the daily practice of medicine. Due to events since the Second World War, the World Medical Association was prompted to change the Hippocratic Oath to establish the Declaration of Geneva. In this thesis I ask the question: Are oaths, declarations and codes still morally relevant in addressing the realities of medicine, given the pluralistic belief systems of physicians from a variety of cultural backgrounds? Furthermore I address the following question: Do oaths, declarations and codes have any moral relevance, or are they just documents of a symbolic nature? In answering the central moral question; should the medical profession move away from oaths, declarations and codes and establish a new medical professionalism where more emphasis is placed on virtues, the characteristics and differences of the aforementioned documents are discussed. The consequences of the changes to the Declaration of Geneva are explored on a symbolic as well as a practical level. It seems as if the changes had little effect on the moral behaviour of physicians after 1948. If one evaluates the pledges of the Declaration of Geneva, one can come to the conclusion that it is mostly very difficult to expect of physicians to adhere to these pledges fully and that this document is more of symbolic significance. In conclusion I argue for establishing a new medical professionalism where the emphasis is more on virtues of the individual physician and continued medical education in this regard, at the undergraduate as well as the postgraduate level.

Abstrak

Ede, deklarasies en kodes kan gesien word as dokumente wat as ‘n morele kompas gebruik kan word in die daaglikse beoefening van medisyne deur geneeshere. As gevolg van die gebeure tydens die Tweede Wereld Oorlog, het die Wereld Mediese Vereniging besluit om die Hippokratiese Eed aan te pas en te verander om die Geneefse Deklarasie daar te stel. In hierdie tesis vra ek die volgende vraag: Is ede, deklarasies en kodes nog steeds moreel relevant om die realiteit van medisyne in die moderne wereld aan te spreek, gegewe die pleuralistiese en multikulturele omgewing waarbinne die moderne geneesheer hom/haarself bevind? Ek probeer ook die volgende vraag beantwoord: Het bogenoemde dokumente nog steeds enige morele relevansie of is hulle waarde slegs simbolies van aard? In my poging om die sentrale morele vraag; behoort die mediese professie weg te beweeg van ede, deklarasies en kodes na die daarstelling van ‘n nuwe mediese professionalisme met die klem op deugde, te beantwoord, bespreek ek die verskille van genoemde dokumente. Die gevolge van die verandering na die Geneefse Deklarasie word bespreek op ‘n simboliese sowel as ‘n praktiese vlak. Dit wil voorkom asof die veranderinge nie veel effek gehad het op die gedrag van geneeshere na 1948 nie. As ‘n mens die onderskeie verklarings van die Geneefse Deklarasie evalueer, kom ‘n mens tot die gevolgtrekking dat dit uiters moeilik blyk wees om van geneeshere te verwag om ten volle aan hierdie vereistes te voldoen. Dit wil voorkom asof hierdie dokument meer simbolies van aard is. Ek sluit die tesis af met ‘n motivering vir die daarstelling van ‘n nuwe mediese professionalisme waar die klem geplaas word op die deugde van die geneesheer as individu. Ek voer ook die argument dat persoonlike deugde van die geneesheer as sulks verder ontwikkel en ondersteun moet word deur voortgesette mediese opleiding op voorgraads sowel as nagraadse vlak.

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CHAPTER ONE

Introduction

Since Hippocratic times medicine has always been a moral enterprise. It has been conducted in accordance with a definite set of beliefs about what is right and wrong moral behaviour when physicians interact with their patients. These beliefs can be seen as statements of moral principles as set out initially in the Hippocratic Oath dating from approximately 400 BCE. Most of these moral principles entrenched in this ancient Greek document are still held sacred today. Since 1948, in the wake of the Second World War and the well documented atrocities committed by the Nazi physicians as well as Unit 731 of the Imperial Japanese Army, the Hippocratic Oath has been challenged and questioned by physicians and sadly even violated by others. This fractured the image of the traditional idea of medicine as seen since Hippocratic times. These events prompted the World Medical Association to revise and amend the Hippocratic Oath in 1948 to establish the Declaration of Geneva to act as a moral guide to which physicians could prescribe in the daily practice of medicine.

1.1 Statement of the problem

Until 1948 the physician was seen as a benevolent all-knowing authoritarian figure who always decided what was in the best interest of his patients. This concept was well - accepted and served society well in simpler times. With the evolution of medicine as well as society's easier access to information via a variety of sources like the printed media, social media and the internet, the once simple relationship between patient and physician changed irrevocably: from an authoritarian to a more social – cooperative relationship, where the patient's autonomy is recognized and respected. These changes have brought a host of new questions of values and constantly changing morality. Patients demand to be involved in the act of decision- making regarding their own health. Apart from patient autonomy and the rights of patients that enjoy

prevalence, more external factors also complicate the once more simple relationship between physician and patient e.g. health insurance, administrators, governmental legislation and limited resources.

In a world where one deals with pluralistic societies and moral fragmentation, the following questions can be asked by members of society:

- Do the moral principles entrenched in oaths, declarations and codes still constitute a shared core of moral values held by all physicians of different religious beliefs and cultural backgrounds, or even absence of any belief system?
- Is it possible to define a common set of moral principles to which all physicians can subscribe?
- Has the oath and subsequent declarations and codes become inadequate to address the realities of modern medicine, where radical changes at the scientific and technological level, and change at the social, political and economic levels could never been foreseen in 1948, let alone in Ancient Greek times?

Therefore one can argue from a societal perspective that the central moral question should be: Are oaths, declarations and codes still morally relevant in addressing the realities of modern medicine, given the pluralistic belief systems of physicians from a variety of cultural back grounds?

The ever changing clinical relationship between physician and patient has led to the involvement of the physician in decision making processes far beyond clinical practice, which often leads to conflicting responsibilities due to the multitude of stakeholders involved. Healthcare has evolved to such an extent that it has become multi-disciplinary and multi-agency in service delivery to the patient where different role players have a varied impact on the quality thereof. Medical insurance companies are prescriptive regarding the quality of health care delivery driven by funding constraints. Different health care practitioners are more accessible to patients creating a system of organized

chaos, where the primary care physician is no longer in control of the patient's health. This results in a situation where different opinions have different outcomes, not always in the patient's best interest.

Furthermore patients have access to more medical information via the Internet, social media as well as the printed media, encouraging them to take greater charge of their own health. The information gathered in such an informal setting is not always trustworthy or empirically sound, leading to more confusion than anything else, to the detriment of the patient, for example the current Vaccination Debate in the United States of America.[1] Scientific research and the availability of new technological possibilities can land the physician in very difficult predicaments. All of these changes make for greater complexity in everyday clinical practice.

Regardless of the aforementioned new complexities, at the center of morality in the medical sphere, is the relationship between patient and physician, according to Pellegrino (2006: 65). He argues that a physician cannot fully heal and arrive at a mutually satisfactory decision unless the patient has an understanding of alternatives in keeping with his/her own moral values and beliefs without expecting the physician to sacrifice his/her own moral values. Even more so, he states that in today's pluralistic society, universal agreement on moral issues between physicians and patients is no longer possible, let alone between physicians themselves.

According to the Medical Ethics Manual of the World Medical Association (2009), the two main moral duties and responsibilities that a patient has towards his/her patient are firstly to always act in the best interest of one's patient, and secondly to do no harm. One could argue against the background of the aforementioned, some significant issues for physicians themselves may come to the fore:

[1] Self informed parents are wary of vaccinating their children as per internationally recognized vaccination protocols. The main concern is the belief that increased number of vaccines received is to blame for the rise in children with autism spectrum disorders.

- Have traditional oaths, declarations and codes kept pace with the constant developments and change in medical science?
- Are certain concepts and definitions as entrenched in the more traditional oaths and declarations still relevant in modern times e.g. the concept of life?
- Do traditional oaths, declarations and codes recognize the tension between the physician's moral responsibility towards his/her patient and legal accountability?
- Has the physician's position changed from an individual of moral significance to one of merely instrumental utility?
- Keeping these pressing issues in mind, have oaths, declarations and codes become pointless anachronisms or can it still be seen as an invaluable moral guide?

Not only members of society but physicians themselves are asking these aforementioned questions regarding the validity and applicability of oaths, declarations and codes in modern times. These pressing concerns beg the question; do oaths, declarations and codes still have any moral relevance or are they just documents of a symbolic nature?

Therefore one can argue from societal as well as the medical fraternity's perspective that the central moral question is: Should the medical profession move away from oaths, declarations and codes and establish a new medical professionalism where more emphasis is placed on virtues?

In the next section I will explore professionalism in the medical realm in more detail.

1.2 Medicine as a profession

Medicine as a profession is unique in a sense that it is built on a very intimate relationship between patient and physician. The nature of the relationship is one of inequality that is built on vulnerability and on a promise. This

relationship involves virtues such as compassion and trust, as well as appropriate scientific knowledge and the subsequent appropriate application of this knowledge. According to Pellegrino (2006: 67), the word profession comes from the Latin word *profiteri*, which means to declare aloud. Physicians declare 'aloud' when they ask a patient, 'How can I help you?' In this question lies the essence of the ultimate promise that a physician made by swearing to an oath or making a declaration.

To act professionally has two implications. Firstly it implies that the physician has the necessary knowledge to help the patient, i.e. that he/she is competent. Secondly, it implies that the physician will use his/her knowledge and competence to serve the best interest of the patient. The best interest of the patient implies that the patient's interpretation and understanding of 'the good life' will be protected and that he/she will be informed accordingly. Furthermore, it also implies that the patient also has the opportunity to make the value choices that will fit into his/her value system. In such a relationship one has two individuals involved one the patient due to his/her vulnerability due to illness and the physician who promises to help and care.

1.3 Chapter outline

In this dissertation I will endeavour to answer the central moral question: Should the medical profession move away from oaths, declarations and codes to establish a new medical professionalism where more emphasis is placed on virtues? In Chapter One, I will explore some background and discuss the statement of the problem, by highlighting pressing issues and defining the central moral question. Furthermore I will discuss important concepts relevant to this dissertation. In Chapter Two I will discuss oaths, declarations and codes by looking at their characteristics, making a comparison between these three documents and highlighting their differences. I will also look at the purpose of these three documents and explore the duties and obligations entrenched in oaths, declarations and codes. In Chapter Three I will explore the historical origin of the Hippocratic Oath, how the Hippocratic Oath was changed to form the Declaration of Geneva, as well as the current state of

oaths, declarations and codes. In Chapter Four I will look at the consequences of changing the Hippocratic Oath, concentrating on the symbolic and practical consequences. I will also try and answer the question as to whether these changes had the desired effect on the medical profession. In Chapter Five I will ask the question if declarations are still relevant, using the Declaration of Geneva as a case study. In Chapter Six I will argue for a move away from oaths, declarations and codes to a newer medical professionalism based on virtues.

1.4 Important concepts

In the next section I will discuss important concepts that are used throughout this thesis. I will discuss the following concepts:

- Morality
- Ethics
- Duty

1.4.1 Morality

According to Moodley (2011: 3) morality is a matter of doing the right thing. It is a reflection of actual human practices in the world that are informed by the values and norms within a particular society. It refers to the value dimension of human decision making and behaviour.

Beauchamp and Childress (2009: 2) are of the opinion that morality refers to norms about right and wrong human conduct that are widely shared in such a way that it forms a stable social agreement within a particular society. Morality is, therefore a social institution and can include many standards of conduct including moral principles, rules, rights and virtues. These standards are not the same for all societies and can differ from society to society. It can even differ within a particular society and/or community. Individuals within a society can have different moral standards, but still adhere to the broader moral belief system of the particular society. Beauchamp and Childress (2009: 6) make a

distinction between a universal morality that holds for everyone and a specific morality consisting of values and norms that bind only members of special groups, such as physicians, nursing staff and public office officials.

Beauchamp and Childress (2009: 4) also argue for the existence of a common morality. Common morality is the set of norms shared by all persons committed to morality. This common morality is applicable to all persons in all places and one can rightly judge all human conduct by its standards. It contains norms that can be seen as standards of action (rules or obligations) and moral traits or virtues that are universally recognized and admired as traits of character in moral behaviour. Examples of these standards of action are: do not kill, do not cause pain or suffering to others, prevent evil or harm from occurring, tell the truth, keep your promises, do not steal, do not punish the innocent and obey the law. Examples of moral character traits or virtues are: non-malevolence, honesty, integrity, conscientiousness, trustworthiness, fidelity, gratitude, truthfulness, and kindness.

Beauchamp and Childress summarize their position on common morality as follows (2009: 4-5):

> "Common morality is a product of human experience and history and is a universally shared product. Common morality is found in all cultures.
>
> We accept moral pluralism. The common morality is not relative to cultures or individuals because it transcends both.
>
> The common morality comprises moral beliefs (what all morally committed persons believe), not standards prior to moral belief.
>
> Explications of the common morality are historical products and every theory of the common morality has a history of development by the authors of the theory".

Accepted moral standards have changed over the years; what was morally unacceptable behaviour in the past can be acceptable now. Morality changes as society changes. However, certain moral norms stay the same although societal changes do take place. These societal changes lead to changes in the scope of application of these moral norms, usually by an increase in scope according to Beauchamp and Childress (2009: 390).

1.4.2 Ethics

According to the World Medical Association, ethics is the outcome of the study of morality, a careful and systematic reflection on and analysis of moral decisions and behaviour, whether past, present or future (Williams 2009: 9). According to Moodley (2011: 3), one can make the distinction between morality and ethics as follows: Morality is a matter of doing the right thing, whereas ethics is a matter of knowing what the right thing is to do. Therefore, ethics is a reflection upon what one ought to do in a particular situation.

Different philosophers have formulated different ethical theories over the centuries to give substance to and to try and understand ethics and the reasoning behind different ethical viewpoints. Van Niekerk (cited in Moodley 2011: 19) explains that in order to reach a moral decision when confronted with a moral dilemma, one must look at the concerns that need to be brought into play in the attempt to get to a satisfactory answer. Drawing on these different ethical theories helps one to come to a possible plausible answer. An ethical theory can be described as a conceptual framework in terms of which norms for action are formulated, as well as certain rules in terms of which those norms for action are to be applied.

Beauchamp and Childress formulate ethical theory as follows: “Ethical theory is commonly used to refer to each of the following: 1. abstract moral reflection and argument, 2. systematic presentation of the basic components of ethics, 3. an integrated body of moral principles, and 4. a systematic justification of moral principles”.(2009: 333).

From the late eighteenth century to the twentieth century the main objective of an ethical theory was to locate and justify general moral norms as a system. A newer take on ethical theory since the late twentieth century is to reflect critically on actual and proposed moral norms and practices.

A further distinction can also be made between different ethical theories. The following ethical theories will be discussed in this document:

a) Deontology

Deontology proposes that one has certain moral duties. Actions following from these duties are morally right, while actions which do not follow these duties are morally wrong. Immanuel Kant was the most prominent proponent of this theory, most famously with his Categorical Imperative which states 'Act only according to that maxim by which you can at the same time will that it should become a universal law' (Rachels and Rachels 2010: 128).

Kant argued that morality is grounded in reason. He was of the opinion that human beings have rational powers that motivate them morally, that resist tempting desire, and that allow humans to prescribe moral rules to themselves (Beauchamp and Childress 2009: 344). Kant argued that each individual should accept moral principles willingly, therefore becoming the lawgiver unto himself. The principle of autonomy, he contended, is the sole principle of morality. A person's dignity comes from being morally autonomous.

b) Utilitarianism

According to Rachels and Rachels (2010: 109) classical Utilitarianism, developed by Jeremy Bentham and John Stuart Mill, consists of three propositions:

> "Actions are to be judged right or wrong solely by the virtue of their consequences; nothing else matters.
>
> In assessing consequences, the only thing that matters is the amount of happiness or unhappiness that is created; everything else is irrelevant.

> Each person's happiness counts the same. Thus, right actions are those that produce the greatest balance of happiness over unhappiness, with each person's happiness counted as equally important".

c) Virtue Ethics

Virtue ethics has its origin in Aristotle's *Nichomacean Ethics* (ca. 325 BCE) when he asked 'What is the good of man?' According to Aristotle a virtue is a trait of character manifested in habitual action, where the trait of character is commendable. Therefore, moral virtues are traits of character, manifested in habitual action that is good for anyone to have (Rachels and Rachels 2010: 160). According to Moodley (2011: 29) virtue ethics is the moral status that is conferred on acts because of the character traits of the individual himself, therefore it is the character and the virtuousness of the character of the individual which confers moral status on what the individual eventually decides to do. To act rightly is to act with virtue. Virtue ethics requires of one to be less concerned with ethical rules as is the case in deontology, or consequences of an act, as is the case in utilitarianism. Rather what matters morally is the quality of the character of the individual.

1.4.3 Duty

Oaths, declarations and codes are all documents that are deontological in nature, as will be discussed more extensively in Chapter Two. These documents require that the physician bind himself to certain kinds of duties and obligations. In the physician-patient relationship, the physician has moral duties and obligations towards the vulnerable patient. In this section I will discuss the concept duty.

A moral duty is commonly accepted to mean a duty arising out of considerations of right and wrong. According to Sampol (2009:1) the term moral duty is used in a situation in which a person has no choice but to carry out or abstain from carrying out a particular action requiring that one should act in accordance with a predetermined set of moral values.

Furthermore Sampol (2009: 1) identifies two schools of thought regarding moral duties: a deontological tradition – Deontology, and a teleological tradition – Utilitarianism, as previously discussed.

According to these two perspectives individuals must fulfill duties derived from a set of moral values. From a Utilitarian perspective the fulfillment of the duty will bring about maximum benefit to the most people, whereas from a Deontological perspective, the fulfillment is demanded by our nature as moral agents.

Fishkin (1986: 73) is of the opinion that moral human actions can be classified into three groups. In the first group one finds actions that are subjected to the dictates of moral norms, and are therefore the moral requirement. In the second group one finds actions that surpass aforementioned moral requirement - therefore actions that go beyond moral duty. The third group comprises of actions that lack moral relevance - actions of moral indifference. The inclusion of a certain action in any of these groups will depend on the moral conception accepted. Different societies have different sets of basic moral values. Therefore one has to keep in mind that in open societies the moral relevance of actions has to be justified according to the basic moral values of a particular society.

Duties can be classified as having a positive or a negative character according to Kant depending on how they are fulfilled. If a duty requires an action it is regarded as a positive duty and if a duty requires an omission, it is regarded as a negative duty.

Sampol is of the opinion that moral duties can be general or special. General duties are those duties that can benefit anyone, whereas special duties benefit people who have a special relationship with the person that has an obligation to fulfill the duty. Special duties demand an effort, a sacrifice on the part of the individual who has the obligation to do the duty. Moral duties that physicians have towards their patients are classified as special duties due to the unique relationship between physician and patient (2009: 3).

1.5 Conclusion

To conclude this chapter, the Hippocratic Oath needed to change post 1948 for reasons discussed previously, and in response to demands from society and physicians alike. It also seems as if the Declaration of Geneva and Codes of Conduct are not sufficient anymore to address the needs of physicians as well as society in modern medicine. This is evident in the fact that there is not a universal oath, declaration or code that is used universally by all physicians worldwide, not to mention the constant need to amend the Declaration of Geneva by the World Medical Association. According to Crawshaw and Link (1996: 452) medical graduates swear to various oaths, from the original Hippocratic Oath to lesser known oaths, to using prayers as 'oaths', to making the Declaration of Geneva, on graduation. In some cases the undergraduates write their own oaths or declarations and in some cases physicians graduate without swearing to an oath or making a declaration. This state of affairs provides motivation for the questions I raised in formulating the central moral question of this thesis earlier in this chapter.

In the following chapters I will explore the current state of the Hippocratic Oath, Declaration of Geneva and Codes, using the Ethical Guidelines of the Health Professions Council of South Africa as an example of a code. I will investigate whether these aforementioned documents still have any moral relevance, or whether the medical profession should move away from oaths, declarations and codes to a newer medical professionalism which can be acceptable to all physicians universally.

In the next chapter I will discuss oaths, declarations and codes, looking at their respective definitions, characteristics and differences. I will also look at the purpose of oaths, declarations and codes and explore the obligations and duties entrenched in these documents.

CHAPTER TWO

Oaths, Declarations and Codes

2.1 Why oaths, declarations and codes in Medicine?

Oaths, declarations and codes act as moral guides for physicians in their daily clinical practice. Loewy (2007: 2) argues that swearing to an oath on graduation from medical school can be useful to impress the gravity of the event even more. The same can be said of a declaration, being a statement of intent of dedication to the humanitarian goal of medicine. What adds to the gravity of the situation is the knowledge that not keeping the oath will have certain consequences. According to the Hippocratic Oath these consequences can be positive or negative. Keeping the oath will lead to enjoyment of the physician's life and art and the respect of humanity as well as colleagues, but not keeping the oath may lead to the reverse (Addendum A). In essence, the oath is a declaration of intention, a public promise of faithfulness and loyalty sworn on the physician's honour. Declarations seem to be more vague, without mention of sanction or punishment on failing to adhere to the principles in the declaration. Ethical codes differ from oaths and declarations, due to the fact that they can be used to hold physicians legally and morally accountable for unethical behaviour. As medicine is a moral enterprise as discussed previously, oaths, declarations and codes are important instruments to emphasize the moral component of the profession.

In the following paragraphs I will discuss the definitions and characteristics of oaths, declarations and codes, as well as the similarities and differences between these documents.

2.2 Definitions of oaths, declarations and codes

2.2.1. What is an oath?

An oath is commonly understood to mean according to the Concise Oxford Dictionary (1950, s.v. 'oath'), "a solemn or formal appeal to God (or a deity or something that is held in reverence or regard), in witness of the truth of a statement, or the binding character of a promise or undertaking; … a statement or promise corroborated by such an appeal, or the form of the words in which such a statement or promise is made". An oath can be seen as either a statement of fact with certain intent. The wording of the oath relates to something considered sacred as a statement of truth. "The essence of a divine oath is an invocation of divine agency to be a guarantor of the oath taker's own honesty and integrity in the matter under question. By implication, this invokes divine displeasure if the oath taker fails in their sworn duties" (Oath, 2011). Therefore it implies greater care than usual in the act of fulfilling one's duty. An example of an oath is the Hippocratic Oath.

2.2.2 What is a declaration?

A declaration is a formal or explicit statement or announcement/proclamation. Such a statement can be oral or written and it is usually a statement of intent by the person making the declaration. In the context of medicine, it is a formal statement by a physician regarding his/her dedication to the humanitarian goal of the practice of medicine. The Declaration of Geneva is an example of such a declaration.

2.2.3 What is a code?

According to the Concise Oxford Dictionary (1950, s.v. 'code'), a code is a "systematic collection of statutes, body of laws so arranged as to avoid inconsistency and overlapping". "A code of conduct is a set of rules outlining the social norms and rules and responsibilities of, or proper practices for, an individual, party or organization" (Code of conduct, 2015). An example of such a code of conduct is the Ethical Guidelines of the Health Professions Council of South Africa by which physicians registered with the Council should adhere to. This code of conduct consists of values, norms and standards that guide the professional behaviour of health care practitioners. Adhering to the ethical guidelines should promote moral behaviour contributing to the welfare and respecting the rights of all health care practitioners as well as patients.

Historically, the assurance of professional conduct was wholly undertaken by private professional bodies, the sole legal authority for which was of a contractual nature with the purpose of guidance of their members as well protecting the public by regulating their members acting under statutory power appointed by the government.

2.3 Comparison of oaths, declarations and codes

Before one can discuss the difference between oaths, declarations and codes, one needs to look at the characteristics of the aforementioned.

2.3.1 Characteristics of oaths, declarations and codes

Oaths and declarations are performative utterances with a moral weight which burdens the individual swearing to the oath or making the declaration. It implies certain lifelong moral obligations and duties that are self-imposed and that the individual willingly undertakes to comply with. Codes are prescriptive documents containing the same obligations and duties as in oaths and declarations, but are imposed by a specific regulatory body. In order to register with such a regulatory body, it is compulsory to adhere to these duties and obligations as outlined. Oaths, declarations and codes can be seen as deontological in nature, since they bind the individual to certain kinds of special duties and obligations.

Although oaths, declarations and codes are based on similar moral values and norms and share similarities, they also differ in certain aspects. In the following section I have used and adapted the framework of Sulmasy (1999: 331 – 334) to demonstrate these similarities and differences between oaths, declarations and codes.

2.3.1.1 Moral Weight

Oaths, declarations and codes bear a great moral weight, as it is not merely a promise to do something, or a reflection of one's intentions. It never applies to trivial things. It binds the swearer or individual making the declaration on a deeper moral level to commit oneself to certain virtues and/or become a

virtuous human being. It intertwines the uttered words and persona of the individual when swearing or making a declaration. It risks the honour and the being of the individual. The relationship between the physician and the patient as well as the society to whom the commitment is being made is emphasized.

2.3.1.2 Public Context

An oath is usually sworn to or a declaration is made in public. This public character of oaths and declarations means that it may be witnessed by the public, colleagues and even a professional body. The individual is not only faithful to an oath or a declaration but also to the subjects of the oath/declaration, in this case the patients, broader society and to a lesser extent humanity. Such a promise of fidelity by the individual to the subjects of the oath/declaration includes all possible future patients and individuals with whom the physician may come into contact with during the course of his/her professional career thereby including broader society. Codes also have a public context to it, as the regulatory board has a duty and obligation towards the general public to protect them against medical professionals who do not adhere to the ethical guidelines as included in the code.

2.3.1.3 Validation

Although an oath should be sworn to in public, the witnesses cannot validate the oath. An oath is validated by something externally, through some transcendent appeal, either to a deity or something deity like which is held in similar reverence and regard. Therefore an oath is sworn to and not self–generated like a promise. A declaration is also made in public with witnesses but validation is of no concern as declarations are made in the first person. Validation depends on the academic institution where the degree is conferred and on the virtuousness of the individual making the declaration. Codes on the other hand are documents that are validated by the specific regulatory body of the profession and compulsory for registration and licensing to practice medicine.

2.3.1.4 Commitment to Virtues

The commitment the physician makes between him/her and a patient has certain implications. The physician makes a commitment to be a certain kind of person in dealing with the other, and to act in a certain kind of way. This evolving interpersonal relationship is mainly built on the virtues fidelity and trust. Therefore the physician is obliged to be faithful to the subject of the oath, declaration and code, the patient.

2.3.1.5 Consequences

The aforementioned validation invites or can prescribe consequences, if one fails to adhere to the oath, declaration or code. In the oath and code consequences for failing to adhere to the principles as required are mentioned explicitly, whereas in the declaration, no mention is made of any consequences.

2.3.1.6 General Scope

The scope of an oath and a declaration is broad and generally vague in character in what is sworn to, or promised. Codes are far more specific mainly due to the prescriptive nature of the document. Oaths and declarations are aspirational in nature requiring a certain virtuousness of the physician grounded in a motivational dimension to improve the quality of human life and making a positive contribution to society. Codes are more preventative in nature, negative in character, consisting of rules and often in the form of prohibitions.

2.3.1.7 Time Frame

The time frame to which oaths and declarations apply is usually extended, even a lifetime commitment. Adherence to codes is dependent on the time period of registration with the particular regulatory body and the subsequent issue of a license to practice medicine. As soon the physician’s registration expire and he/she does not practice anymore, a physician is not required anymore to adhere to the particular code.

2.3.1.8 Circumstances

A physician swearing to an oath or making a declaration is not dependent on change in circumstances, whatever the circumstances may be. Oaths and declarations and the physicians adhering to them are always bound to the moral binding power which holds under all circumstances. Codes however are dependent on change in circumstances as discussed previously.

2.3.1.9 Personal Relationships

Oaths, declarations and codes address a variety of interpersonal relationships; first and foremost the personal relationship between the physician and patient; secondly, the relationship between the patient, physician and the family members of the patient; thirdly the relationship between the physician and his colleagues and lastly, the relationship between the physician and society.

2.3.2 Main differences between the Hippocratic Oath, Declaration of Geneva and the Ethical Guidelines of the HPCSA

If one compares the Hippocratic Oath, the Declaration of Geneva and the Ethical Guidelines of the HPCSA as examples of oaths, declarations and codes, the following differences are evident:[2]

1. The Hippocratic Oath is sworn to Greek gods, Apollo, Asclepius, Hygieia and Panacea. Declarations are made in the first person by the person making the declaration. Ethical guidelines are available in booklet form on registration with the HPCSA.[3]

2. In the Hippocratic Oath dealing with patients and the complexity of illness is seen as an art form, implying that clinical evaluation of a patient as a whole is important. The Declaration refers to medicine as a profession and a human

[2] The original version of the Hippocratic Oath – Addendum A

[3] Undergraduate students are registered with the HPCSA whilst completing their undergraduate studies. Once their student intern year is completed and they have complied with all the statutory regulations, they are registered as interns. Once they have completed their internship, they are then listed on the main register of the council as medical practitioners. The ethical guidelines are available to them from a variety of sources, but it remains their own responsibility to acquaint themselves with the content of these guidelines.

science. The Ethical guidelines deal with maintaining of good professional practice, based on directives that follow certain core values and standards.

3. The Hippocratic Oath addresses non adherence or violation of the oath and consequences thereof. In the Declaration there is no reference to punishment or sanction of a physician if he/she violates the principles, values and norms mentioned. The ethical guidelines of the code are presented as a list of core values and standards that are ethically required of a professional to maintain good professional practice. There is no mention of sanctions in the Ethical Guidelines of the HPCSA , if these requirements are not met.

3. Abortion and euthanasia are addressed specifically by the Hippocratic Oath, but in the Declaration as well as in the guidelines the generic principle of non-maleficence is used. No specific reference is made to abortion or euthanasia. By omitting specific conditions like the aforementioned, declarations and codes become more vague and non-specific and leave the content of these documents open for a variety of interpretations.

4. The Hippocratic Oath addresses respect for patients and improper conduct towards patients specifically, whilst the Declaration and guidelines require respect for persons and their intrinsic worth and dignity on a much larger scale including societies and humanity as a whole.

Due to societal changes in the post Second World War society and the rise of the Human Rights Movement as previously discussed, two new pledges were added to the Declaration of Geneva:[4]

> "I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient". These issues are also addressed in the ethical

[4] Declaration of Geneva – Addendum B

guidelines of the HPCSA under the headings “Tolerance”, “Justice” and “Community”.

“I will maintain the utmost respect for human life; I will not use my medical knowledge to violate human rights and civil liberties, even under threat”. The ethical guidelines address this under the headings “Respect for persons”, “Human rights” and “Best interest or Well-being”.

To summarise, in the previous sections I have discussed the definitions and characteristics of oaths, declarations and codes respectively. I then compared these documents, using the Hippocratic Oath, the Declaration of Geneva, and the Ethical Guidelines of the HPCSA as examples, highlighting the differences as well as the similarities. In the next sections I will explore the purpose of oaths, declarations and codes.

2.4 What is the purpose of oaths and declarations?

Swearing to an oath or making a declaration, is an integral and shared aspect of professionalization in the medical profession. Simply put, the oath and the declaration’s main purpose is to guide the physician regarding the profession’s moral values and principles and subsequently the physician’s professional behaviour. Oaths and declarations represent a set of moral and ethical precepts, common to and binding on all physicians (Kao and Parsi 2004: 886). By swearing to an oath or making a declaration, the physician makes a public commitment to be of service to humanity in sickness and in health. The physician undertakes to be faithful to this commitment to care for whoever seeks his/her advice and care, thereby creating an expectation of altruism and the complete obliteration of self-interest. The physician makes a public profession to his commitment to humanity. Swearing to an oath or making a declaration is a way in which the medical profession validates the individual by certifying the skills and the character of the person taking the oath or making a declaration, and welcomes the newly graduate into the

moral community of the medical profession, with its moral obligations and requirements (Sulmasy 1999: 341).

Morrow (1981: 1) observes that all societies are held together by a complex web of obligations and responsibilities that people engage in with another. Modern society functions within a framework of formal and informal understandings, agreements, plans, written and oral contracts and formal vows. Examples of these, include formal contracts in business, sales contracts, testimony as a witness in court, marriage ceremonies etc. The oath seems to be the most solemn of all the aforementioned examples by calling upon a divine power. Oaths and declarations are a way of connecting to the absolute. The Hippocratic Oath and the Declaration of Geneva reminds physicians of their moral obligations and duties, emphasizing the human context of their calling.

Morrow (1981: 2) argues that an oath has a crucial ceremonial function in a free society. An oath is an act of will, intelligence and intent that can make a society coherent. Oaths and declarations give moral meaning to the practice of medicine. According to Hurwitz and Richardson (1997: 1672) “the main intention of a medical oath seems to be to declare the core values of the profession and to engender and strengthen the necessary resolve in doctors to exemplify professional integrity, including traditional moral virtues such as compassion and honesty. Oaths also provide moral orientation through rule-like precepts and prohibitions, from which generalities the practitioner is left to infer or extrapolate to the specifics of everyday practice”. This is also applicable to declarations. In swearing to an oath or making a declaration, one commits a moral act, by professing one’s moral commitment to the profession and the moral obligations and requirements of the medical profession.

An oath can be seen as a deliberate moral performance as argued by Sulmasy (1999: 340). This moral act requires one to profess publicly to become a professional. By uttering the words “I swear…” or “I declare…”, emphasis is being placed on the moral force that comes with the oath. The oath and/or a declaration governs all interactions, not only with patients, but

also with society as a whole, when the physician pledges “I will lead my life” and “I will consecrate myself” within an ongoing time frame. Oaths and declarations are written in absolute terms without any exceptions. The oath and a declaration has an ongoing binding character which is very clearly written and should also be understood in these absolute terms, where the welfare and the best interest of the patient remains the ultimate goal.

2.5 What is the purpose of Codes?

Richardson and Hurwitz (1997: 1672) contend that “medical codes on the other hand seek to clarify the means by which such moral ends can be achieved, by offering guidance for everyday practice, outlining applicability in exemplary cases together with grounds for identifying exceptions”. Codes can act as a supplementary field of moral guidance to physicians when affirmed by means of an oath or a declaration.

Hick (1998: 150) asks the question, ‘Codes and Morals: is there a missing link?’ Does a code carry the same moral weight as an oath/declaration or is a code only a tool to clarify the means by which moral ends can be achieved as argued by Richardson and Hurwitz?

Ethical codes as well as Ethics are necessary ingredients of our morality (Hick 1998: 150). Codes can be incredibly vague and cannot inform one about actual decisions, but it gives opportunities for interpretation making it a viable document. Codes have to be evaluated and interpreted primarily in the light of their moral content and only after that in their legal form. Levinas argues that the meaningful ethical core of codes, consisting of moral values and norms, should be linked back to one’s own moral framework and life experience. Ethical judgments should stem from one’s own moral life-world and should be interpreted accordingly (Hick 1998: 151)

Hick (1998: 151) comes to the conclusion that a link between codes and morality does not exist in a static logical foundation, but in a dynamically ‘living’ continuum. The meaning of codes can be discovered, interpreted and

understood by a process of constant inquiry into the moral meaning of one's own reality.

Jay Katz recognized the contingent status of ethical codes upon day – to – day moral practice (1996: 1662).

> "Do not place too much reliance on codes of ethics. That would be dangerous. Codes are deceptive documents to which all of us probably could subscribe in principle, but if you study them carefully, you will find that they are painfully vague. They do not inform us well about actual decisions. Codes analogous to a legal statute, requires opportunities for interpretation; only then could it be a viable document."

From the aforementioned arguments presented one may come to the conclusion that oaths, declarations and ethical codes are interdependent. Just as an oath and declaration cannot predict or guarantee moral behaviour by a physician, codes derived from oaths and declarations can guide the physician towards more moral and ethical behaviour in the daily practice of medicine. Codes can be seen as an instrument through which medical councils can hold a physician legally and morally accountable for ethical transgressions using adopted ethical guidelines.

According to Limentani (1999: 396) the general ethical character of medical practice can be set by concepts, moral values and principles found in codes. "The implications for establishing ethical codes lie in recognizing their potential value in describing the ethical environment and ethical attitudes that are shared by health care workers". Unfortunately it is of little use in helping to solve moral dilemmas and explaining individual ethical judgments. Codes cannot give clear definitive answers to many of the ethical problems encountered in the course of everyday medical practice. Codes tend to offer general solutions to individual problems.

In the following two examples one can see the duties and commitments, as deduced from the Hippocratic Oath as well as the Declaration of Geneva, required of physicians registered with the General Medical Council of the

United Kingdom and the Health Professions Council of South Africa respectively.

In the United Kingdom the General Medical Council (GMC) is the statutory body appointed by the government to supervise the conduct of the medical profession. According to Preston (2009: 2) a booklet called 'Good Medical Practice' is sent out to all physicians registered with the council. This booklet discusses the duties expected from a physician registered with the council as deduced from the moral principles found in the Hippocratic Oath as well as the Declaration of Geneva. These duties can be summarized as follow:

> "Patients must be able to trust physicians with their lives and health. To justify that trust one must show respect for human life and one must commit to the following:

1. Make the care of your patient your first concern.
2. Protect and promote the health of patients and the public.
3. Provide a good standard of practice and care:
   - Keep your professional knowledge and skills up to date.
   - Recognize and work within the limits of your competence.
   - Work with colleagues in the ways that best serve patients' interests.
4. Treat patients as individuals and respect their dignity:
   - Treat patients politely and considerately.
   - Respect patients' right to confidentiality.
5. Work in partnership with patients:
   - Listen to patients and respond to their concerns and preferences.
   - Give patients the information they want or need in a way they can understand.
   - Respect patient's right to reach decisions with you about their treatment and care.
   - Support patients in caring for themselves to improve and maintain their health.
6. Be honest and open and act with integrity:

- Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk.
- Never discriminate unfairly against patients or colleagues.
- Never abuse your patient's trust in you or the public's trust in the profession.

7. You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions" (Preston: 2009).

In South Africa the Health Professions Council of South Africa (HPCSA) published the following Ethical Guidelines as core ethical values and standards for good medical practice, to be followed by physicians registered to practice medicine in South Africa once again deduced from the moral principles as found in the Hippocratic Oath as well as the Declaration of Geneva.

- "Respect for persons: Healthcare practitioners should respect patients as persons, and acknowledge their intrinsic worth, dignity and sense of value.
- Best interests or well-being: Non-maleficence: Healthcare practitioners should not harm or act against the best interests of patients, even when the interests of the latter conflict with their own self-interest.
- Best interests or well-being: Beneficence: Healthcare practitioners should act in the best interests of patients even when the interests of the latter conflict with their own self-interest.
- Human rights: Healthcare practitioners should recognize the human rights of all individuals.
- Autonomy: Healthcare practitioners should honour the right of patients to self-determination or to make their own informed choices, and to live their lives by their own beliefs, values and preferences.

- Integrity: Healthcare practitioners should incorporate these core ethical values and standards as the foundation for their character and practice responsible healthcare professionals.
- Truthfulness: Healthcare practitioners should regard the truth and truthfulness as the basis of trust in their professional relationships with patients.
- Confidentiality: Healthcare practitioners should treat personal or private information as confidential in professional relationships with patients – unless overriding reasons confer a moral or legal right to disclosure.
- Compassion: Healthcare practitioners should be sensitive to, and empathize with, the individual and social needs of their patients and seek to create mechanisms for providing comfort and support where appropriate and possible.
- Tolerance: Healthcare practitioners should respect the rights of people to have different ethical beliefs as these may arise from deeply held personal, religious or cultural convictions.
- Justice: Healthcare practitioners should treat all individuals and groups in an impartial, fair and just manner.
- Professional competence and self-improvement: Healthcare practitioners should continually endeavor to attain the highest level of knowledge and skills required within their area of practice.
- Community: Healthcare practitioners should strive to contribute to the betterment of society in accordance with their professional abilities and standing in the community" (HPCSA 2008: Booklet 1: 2-3).

From both above-mentioned documents, one can see that they are very similar in content and that most of the moral principles of the Hippocratic Oath as well as the Declaration of Geneva are included in these working documents. If one analyzes these documents, one can to agree with Miles

that the most important commitments that are required from a physician according to Miles (2002: 46) are as follow:

> "Patient confidentiality.
> Quality of care and reduction of error.
> Improving access to care.
> Fair distribution of finite resources.
> Scientific knowledge.
> Maintaining trust by managing and disclosing conflicts of interests.
> Maintaining professional competence.
> Honesty with patients.
> Fulfilling professional duties for the oversight of the profession and as needed to improve the quality of healthcare.
> Avoiding financial and sexual exploitation of patients".

Miles (2002: 46) are of the opinion that in fulfilling these commitments three ethical principles come to the fore:

1. The primacy of patient welfare.
2. Patient autonomy.
3. Social justice.

If one fails to adhere to these principles, it would be very difficult to fulfill the aforementioned commitments.

Codes of conduct or ethical guidelines are of a prescriptive nature and "increasingly formatted as assertions to physicians by institutions, rather than by physicians". These documents are grounded in law and/or professional associations. One can ask the question as aptly asked by Miles, "whether the proffered statement is grounded in tradition, deduced from the 'internal morality' of the practice of medicine, or imposed on physicians by society?" (2002: 47).

Such codes can be seen as authoritarian in nature, allowing the author to unilaterally bound the scope of medical practice mainly as it stems from an external locus of authority such as a statutory body.

This assertive authoritarian voice is bureaucratic. It does not the address the moral integrity and the internal morality of the physician as well as medicine as a profession per se as one would find in the Hippocratic Oath or the Declaration of Geneva. One can argue that the act of adhering to ethical guidelines or a code of conduct helps to internalize it to influence moral behaviour on the part of the physician, but a physician can very easily function within the boundaries of these codes without being a morally conscious individual or a person of virtuous character. In my opinion it can lead to a situation of 'check-list' ethics which can be detrimental to the profession as a whole by not addressing the moral values and virtues as demanded by oaths and declarations.

2.6 What obligations and duties are entrenched in oaths, declarations and codes?

According to Kao and Parsi (2004: 885), oaths are deontological in nature. An oath requires that the swearer bind to certain kinds of duties and obligations. The same can be said of declarations and codes. In the physician–patient relationship one has to do with two individuals that interact as moral agents. Within the relationship the physician has moral duties and obligations towards the patient who is in a vulnerable position due to his/her illness.

Gillon (1985: 1194) observes that the World Medical Association's International Code of Medical Ethics requires that a physician should adhere to the Declaration of Geneva. Furthermore he emphasizes the following requirements as entrenched in the Declaration:

"The highest professional standards.
Clinical decisions uninfluenced by profit margins.
Honesty with patients as well as colleagues.
Exposure of incompetent and immoral colleagues.
Physicians shall owe patients complete loyalty and all the resources available.
Confidentiality should be preserved in life as well as in death".

Loewy (2007: 7) is of the opinion that a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals and most importantly to the self. He emphasizes the following cardinal duties and obligations a physician pledges to:

> "Promoting good health, caring for the sick as well as alleviating pain and suffering.
>
> A realization that although harm is inevitable, it must be outweighed by benefit.
>
> Treating patients with integrity, honesty, humility, compassion and respect.
>
> Equal treatment of all, no discrimination in his/her judgment.
>
> To oppose policies that are in breach of human rights, and to work towards an equal distribution of healthcare resources.
>
> Patient care and research will have equal standing.
>
> Promises made are made freely and without coercion".

Oaths, declarations and codes in modern day use encompass mostly the same certain principles, core values and virtues required that guide the behaviour of physicians in modern medical practice. The most important principles included in these aforementioned documents are respect for patient autonomy, non–maleficence, beneficence and justice. Required virtues include humility, honesty as well as compassion. Core values of importance are confidentiality, informed consent and non–prejudice.

Whereas physicians who swear to an oath or make a declaration subscribe to an ethos of a certain standard of moral behaviour, values, norms and moral duties, an ethical code of conduct (ethical guidelines) is purely a prescriptive document outlining the moral duties, obligations and responsibilities expected of a physician. Therefore, the locus of authority of an oath and a declaration is internal, where the physician either swear to a higher power (deity) or make a declaration in the first person that he/she undertakes to honour his/her duties, obligations and promises to adhere to certain moral values and to be of virtuous character.

Codes of conduct on the other hand function from an external locus of authority where certain duties and obligations are prescribed to a physician by an external source with a certain legal authority. All physicians licensed to practice are required by law to adhere to the ethical guidelines of the medical council which makes it legally enforceable. Adherence to ethical guidelines however do not guarantee ethical or moral behaviour of any physician. One can therefore argue that there will be a constant tension between the ethos of oaths and declaration on the one hand and ethical codes comprising of ethical guidelines on the other hand.

To summarise, in this chapter I discussed the definitions and characteristics of oaths, declarations and codes. Furthermore I explored the main differences between these documents using the Hippocratic Oath, Declaration of Geneva as well as the Ethical Guidelines of the HPCSA to highlight these differences. I then focused on the main duties, ethical values and standards as deduced from these documents by the GMC and the HPCSA respectively. I also explored the obligations and duties entrenched in these aforementioned documents as pointed out by a variety of authors.

In the view of the aforementioned, one can come to the conclusion that oaths, declarations and codes are interdependent and cannot function individually on their own. Although these documents are similar in some aspects, codes (ethical guidelines) are needed for enforcement of the aforementioned duties and obligations required from a physician. None of these documents - not swearing to an oath, making a declaration or adhering to ethical guidelines can guarantee ethical behaviour from a physician. They can merely act as moral guides in the daily practice of medicine.

Due to the interdependent nature of these documents, there will always be a constant tension between the ethos of oaths and declarations on the one hand and ethical codes consisting of ethical guidelines on the other. Despite the identified ethical principles, requirements and duties and obligations mentioned, one is confronted with an increase in medical malpractice cases due to unethical behaviour, not only in South Africa but also internationally.

One may ask, do physicians still serve their moral conscience and adhere to the aforementioned moral principles and values or are these ethical prescriptions ignored in favour or monetary gains? Given the above, one should ask the central moral question once again. Should the medical profession move away from oaths, declarations and codes to establish a new medical professionalism placing more emphasis on virtues?

In the next chapter I will explore the origin of the Hippocratic Oath and the reasons for changing the Hippocratic Oath to the Declaration of Geneva. I will also discuss how the Hippocratic Oath was changed and the reasoning behind the changes. Furthermore I will discuss the current state of oaths, declarations and codes and the use of these documents in medical schools.

CHAPTER THREE

Historical Context

3.1 Origin of the Hippocratic Oath

The Hippocratic Oath for physicians is an ancient Greek document dating to approximately 400 BCE. At the time it was only titled 'The Oath'. There seems to be no evidence that this was the only oath that was used at the time and it is speculated that this may be the only survivor of dozens of similar oaths that were used during ancient times. Historians also argue about the context in which the Oath was used. It appears that this document was used for swearing in a person at the beginning of his medical apprenticeship and cannot be seen as a legal code or a sacred scripture. There is no evidence that links the oath to Hippocrates, or that he was ever aware of the existence of such a document. It was only in the first century that Scribonius Largus referred to Hippocrates as the founder of the 'calling of medicine' and it is only for the past five hundred years that the oath gained influence more widely and was accepted as the moral basis for the practicing of medicine.(Miles 2004: 3). According to Graham (2000: 2841) it was as recently as 1804 that graduates or medical students started swearing by the Hippocratic Oath. Even as the twentieth century began it was not widely used.

In this chapter I will explore the origin of the Hippocratic Oath as well as the reasons for changing it to the Declaration of Geneva. Furthermore I will elaborate on how the Hippocratic Oath was changed to form the new Declaration of Geneva to address the demands of modern medicine as well as those of society. Lastly I will look at the current state of oaths and declarations.

Hurwitz and Richardson (1997: 1671) observe that "problems and controversies surround the textual authenticity and the meaning of the

Hippocratic Oath". For example it is not clear how much the original oath influenced medical practice in ancient Greece. From the little that is known about medical practice in Ancient Greece, it seems that some of the Oath's prohibitions were completely ignored and that surgery, abortion and tolerance of infanticide were the order of the day.

It seems as if in the succeeding centuries clauses were omitted, added and changed to suit the demands of the times and that the Oath in its original form was rarely administered.

3.2 Reasons for changes to the Hippocratic Oath

As society changed, and newer technologies were introduced in the medical world, the Oath had to change in order to keep up with the demands of this changing environment. It became evident that the Hippocratic Oath was no longer suitable for modern times and could be interpreted in a variety of ways.

Sherman (2006: 609) is of the opinion that despite the Hippocratic Oath and the recognition that it enjoyed amongst physicians during the first half of the twentieth century, it was of no significance to many medical practitioners during the Second World War. During the Second World War experiments were conducted on civilians and prisoners of war by the physicians and nursing staff employed by the Nazi regime as well as the infamous Unit 731 of the Imperial Japanese Army. Examples of these experiments were "high–altitude experiments, freezing experiments, malaria experiments, sulfanilamide experiments, bone, muscle and nerve regeneration and bone transplant experiments, sea water experiments, jaundice and spotted fever experiments, sterilization experiments, experiments with poison and incendiary bombs" (Sherman 2007: 610). In these experiments the physicians and nursing staff ignored their basic duties and obligations towards their 'patients' as prescribed by the Hippocratic Oath (to act in the best interest of one's patient and to do no harm). These atrocities prompted the United States of America to establish the Military Tribunal I on 25 October 1946 for the trial

of twenty-three Nazi physicians, charging them with war crimes and crimes against humanity.

Similar charges were brought against some of the wartime leaders in Japan by means of the Tokyo War Tribunal. Only fourteen of them were convicted and hanged for war crimes. The United States Authorities were more interested in the findings of the research done by Unit 731 regarding biological warfare. The result was that the staff of Unit 731 was granted immunity from prosecution in exchange for information on their findings for America's own biological warfare programme. The Soviet Union prosecuted a dozen members of the unit and sentenced them to labour camps. Thousands of individual cases were adjudicated by the Tokyo War Tribunal and the Military Tribunal of the United States of America. Despite these tribunals there has never been a public examination of Japan's wartime conduct and the issue has remained largely unsolved (World War II/Facts Summary Information, 2015).

According to Sherman (2007: 614), euphemistic and scientific language played a critical role in the medicalization of killing in the aforementioned instances. Killing, 'life unworthy of life' was a matter of euthanasia.[5] This example of euphemistic language helped to promote the myth of special treatment as therapeutic. Thereby physicians could distance themselves morally and insulate their moral conscience.

Hurwitz and Richardson (1997: 1671) point out certain incongruities that make it extremely difficult to apply the Hippocratic Oath to modern medical care. Fundamental principles which are still applicable in the modern world are beneficence and non–maleficence towards patients, not to harm and not to seduce patients and to maintain confidentiality and never to gossip. These principles sit uncomfortably with other values included in the Oath which "seek to foster an archaic professional exclusivity" (Hurwitz and Richardson

[5] Euthanasia comes from the Greek word 'eu' which means beautiful. Euthanasia refers to 'therapeutic killing', 'killing as healing and cure', 'killing for the sake of the strong and the healthy' (Sherman 2007: 614).

1997:1671), such as solidarity with teachers and other physicians, as well as the commitment to leave surgery to surgeons. This demonstrates the tensions between the impetus of the original oath and the modern endeavour to ensure good clinical practice.

In the next section I will discuss how the Hippocratic Oath was changed to form the Declaration of Geneva.

3.3 From the Hippocratic Oath to the Declaration of Geneva

The World Medical Association appointed a study committee in 1946 to prepare a document called the 'Charter of Medicine' to specifically address the issues regarding rights of patients and human rights. This was a consequence of the aforementioned details that came to the fore at the Nazi Doctor's Trial at Nuremberg and the revelations of activities of the Imperial Japanese Army's Unit 731 in China during the Second World War (Declaration of Geneva, 2015). It seemed evident that after 1948 the Hippocratic Oath needed to change to reflect the changing values, customs and beliefs associated with the fast changing post war society. These changes also had to reflect changing views with regard to the ethical practice of medicine (Markel 2004: 2026).

These aforementioned events prompted the World Medical Association to update The Hippocratic Oath for twentieth century use to prevent any recurrence of the unethical and immoral conduct exhibited by the physicians in Nazi Germany and Japan and the medical crimes committed. The emphasis was placed more on a physician's dedication to the humanitarian goals of the practice of medicine. The result was the Declaration of Geneva, a formulation of the Hippocratic Oath's moral truths that could be comprehended and acknowledged in a modern world. The Declaration was adopted at the World Medical Association's General Assembly in Geneva in 1948.

As the medical fraternity evolved worldwide, it needed to recognize the fact that physicians, practicing all over the world, reflected the diverse societies in which they were active. Therefore the oath had to recognize the fact that physicians come from different backgrounds and religions and even in some cases, the absence of any religion. Physicians could not be subjected anymore to swear to a god. Therefore divine references had to be omitted.

The study committee also had to take into account that physicians function in a morally fragmented and pluralistic society and as members of such societies, which include a magnitude of religions and beliefs, modern day versions of the oath require that the physician swear upon their own honour. The oath requires a pledge to the physician's own personal conscience (Graham 2000: 2841).

Changes that were made included the removal of references to abortion and euthanasia from the Oath as can be seen in addendum A.

In the Declaration of Geneva, changes were made to address the moral responsibility of the physician and the following two pledges were added (Addendum B):

- "I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient".

- "I will not use my knowledge to violate human rights and civil liberties, even under threat".

These changes were made when it was quite evident that moral responsibility was of no concern to the Nazi physicians and the law failed miserably to protect vulnerable and victimized groups. Moral responsibility must step in, in the absence of laws or when laws fail.

The Declaration of Geneva has since been accepted in various forms and has been revised several times since 1948. The first amendment was in 1968, the second amendment in 1983 and the third amendment was in 1994. Editorial revisions took place in 2005 and 2006 (World Medical Association 2006). With each amendment the Declaration became more vague and generalized.

In the next section I will discuss the current state of oaths and declarations.

3.4 Current State of the Oath and Declarations

In 1948 the General Assembly of the World Medical Association adopted the Declaration of Geneva, which was a revision of the Hippocratic Oath to incorporate the changes as discussed previously. This declaration was seen to address mainly respect for human life, as well as a commitment not to use medical knowledge in a way that is contrary to the laws of humanity (Declaration of Geneva, 2015).

Since 1948 society has changed significantly with the establishment of the civil rights movement, the women's rights movement as well as the patient's rights movement. Court cases in the United States of America (Roe v. Wade 1973, Karen Ann Quinlan 1976)[6] brought concepts like informed consent and the autonomy of the patient to the fore, which had a major influence on the physician patient relationship. In the 1970's the Patient's Bill of Rights was adopted by the American Hospital Association.

According to Gordon (2012: 5) a greater demand for bioethics was grounded in reaction to some negative events. These negative events included the

[6] Roe v. Wade (1973) The Supreme Court case that held that the Constitution protected a woman's right to an abortion prior to the viability of the fetus; thus, government regulation of abortions must meet strict scrutiny in judicial review https://www.law.cornell.edu/wex/roe_v_wade_1973 [Accessed: 12. 03. 2015]
Karen Ann Quinlan (1976) After severe brain injury due to anoxic brain damage, she was kept alive by extraordinary means, being artificially ventilated. In 1976 the New Jersey Supreme Court ruled in the family's favour to take her off the ventilator. She continued to breathe unaided and she was in a permanent vegetative state until her death due to natural causes in 1985 http://en.wikipedia.org/wiki/Karen_Ann_Quinlan [Accessed: 01. 05. 2015]

previous mentioned research on humans by the Nazis but also the Tuskegee Syphilis Study (1932 – 1972) in the United States of America.[7] Developments in the medical field as well as particular innovations such as gene technology and cloning demanded better ethical guidance and a newer approach to moral problems to deal with these complex and novel problems of the twenty-first century. Influential books such as *Morals and Medicine: The Moral Problems of the Patient's Right to Know the Truth, Contraception, Artificial Insemination, Sterilization and Euthanasia* (Fletcher 1954) and Ramsey's ground breaking book, *The Patient as Person: Explorations in Medical Ethics* (1970) argued that there was an urgent need for newer thinking about complex moral issues in medicine seemingly not addressed by the Declaration of Geneva. All these events prompted and facilitated the creation of a new academic discipline known as bioethics to address complex issues and moral dilemmas for which the Declaration of Geneva was not sufficient.

Oaths as well as declarations such as the Declaration of Geneva were questioned regarding their relevance and applicability in the current health care environment where the physician–patient relationship was changing fast with a decrease in physician paternalism and an increase in patient autonomy. Advancements in technology in daily medical care and increased access to these newer technologies by physicians and patients also had a major influence on the relationship between physician, patients and the society at large. All these changes prompted some medical schools to formulate their own oaths, to be more relevant to modern society.

According to Meffert (2009: 411) most graduating students will take some form of oath on graduation. The nature of these oaths has changed over the years as society itself has changed. Morality has changed over time and what was acceptable in the past is often not relevant anymore in a certain given

[7] The Tuskegee syphilis experiment was an infamous clinical study by the U.S. Public Health Service to study the natural progression of untreated syphilis in rural African-American men in Alabama. They were told that they were receiving free health care from the U.S. government. This study was controversial, primarily because researchers knowingly failed to treat patients appropriately after the 1940's validation of penicillin as an effective cure for the disease they were studying https://en.wikipedia.org/wiki/Tuskegee_syphylis_experiment [Accessed: 11. 07.2015]

circumstance. New social issues in the 1950's and 1960's prompted a re-evaluation of what a physician was expected to be and what rules of professionalism a new physician should adhere to. Change was evident on different levels, including societal, all levels in the medical fraternity, as well as in the interaction between physicians and patients, society and governmental institutions. The content of and the issues addressed in oaths and declarations also changed to address these changes. It seems that despite all these changes, the contents of the oaths and the declarations remained reflective of the values and norms of the medical profession.

Sritharan *et al* (2001: 1441) argue that "oaths are neither a universal endeavor nor a legal obligation and they cannot guarantee morality" or a required work ethic. In 1992 a British Medical Association working committee found that an affirmation may strengthen a physician's resolve to behave with integrity in certain circumstances. Oaths seem to encourage self-importance and fuel paternalism some critics claim and therefore it can be seen as anachronistic. Some critics see swearing to an oath as a bid for respectability, while others view it as swearing allegiance to an introverted self-serving club. Declarations are deemed more acceptable to medical students as it focuses on the intent of the prospective physicians to help the patients in their care as well as the community at large. (Sritharan *et al* 2001: 1442).

In the Declaration of Geneva certain principles of ethics, virtues required from the individual as well as core working values expected in the practice of modern medicine are included. Other important aspects addressed in the declaration are accountability and continued professional development.

According to Loudon (1994: 952), oath taking is still popular in a large number of medical schools internationally. Crawshaw (1994: 952) states that about 98% of medical schools in the United States of America use some form of medical oath. In his research conducted in 1989 he observed a remarkable development where the Hippocratic Oath was being displaced by other medical oaths and covenants, probably because the Hippocratic oath ignores certain current relevant ethical issues. A wide variety of oaths and

declarations exist and are administered in a wide variety of ways including the Declaration of Geneva, the classic Hippocratic Oath, a modified Hippocratic Oath, the prayer of Maimonides, a covenant and an unknown Oath. Some medical schools used a combination of oaths and a prayer. In some medical schools no oath is taken or declaration made.

It seems as if medical schools prefer to introduce their own versions of the Hippocratic Oath to the graduating medical students. Lowes (1995: 197) found during his research that various oaths were drafted by the students themselves and that the oath has been subject to liberal and creative rewriting over the years leading to a whole array of conflicting and confusing oaths. This situation reflects pluralism with a touch of political correctness which characterizes the medical profession and society at large these days.

According to Lowes (1995: 200) some medical schools give their medical graduates a choice of oaths from which they can choose, and other medical schools even encourage medical students to write their own oaths, in order to set a professional moral compass in their own words. Edward M. Hundert of the Harvard School of Medicine is of the opinion that the process of developing the oath is more important than the particular formulation. The core values do not change that much, but the students can choose which core values they want to emphasize (Lowes 1995: 200).

Hurwitz and Richardson (1997: 1672) mention that the process of oath taking differs from medical school to medical school. Some schools ask for the graduandi's signature, some read the oath out loud and others others require the students to recite it together during the graduation ceremony. The question of how voluntary such oath taking is has not been well documented.

As previously discussed oaths and declarations are deontological in nature as they bind the swearer to certain kinds of duties and obligations (Kao and Parsi 2004: 883). These newer oaths and declarations as written by the students or adapted by the universities have been so diluted that they have very little if

any impact on the behaviour of the physician as the students choose which duties and obligations are revalent.

The lack of a universal oath/declaration that is used by everybody has far reaching implications for the medical profession according to Kao and Parsi (2004: 886). Firstly the emergence of such 'boutique' oaths can lead to fragmentation and confusion about ethical values inherent to the medical profession and therefore dilute the value of a professionally binding oath. Secondly, the fact that several medical schools offer a set of oaths/declarations to their students every year from which they can choose creates a situation where students from the same medical school take different oaths/declarations every year. This custom sends a message to the students that oaths/declarations can be seen as flexible documents that can be shaped to suit the prospective physician's needs. Another concern that was raised, was the fact that the chosen oath/declaration is selected by the majority of the class, but what happens to the students that did not choose the particular oath/declaration?

To conclude, although it seems from the literature that the tradition of oath taking and/or making a declaration is still followed in the large majority of medical schools, the content of these documents vary in substance and different issues are addressed in these different documents. It is only in a minority of medical schools that the Declaration of Geneva is being used and in some medical schools they still even use the Hippocratic Oath in its original form. Most medical schools use the Declaration of Geneva as a guideline to formulate their own oaths/declarations and these documents can change from year to year and are seen as flexible documents. There seem to be no universal oath or declaration that is being used by all prospective physicians internationally.

The efforts of the World Medical Association to create a universal declaration to be used by all physicians internationally, initially by formulating the original Declaration of Geneva and subsequently by amending the original on a regular basis to address newer issues and the concerns of physicians and

society as mentioned in Chapter One were unsuccessful. This is aptly illustrated by the fact that there are so many different versions of oaths and declarations being used. This state of affairs brings one once again to ask the central moral question: Should the medical profession move away from oaths, declarations and codes and establish a new medical professionalism where more emphasis is placed on virtues in the light of the shortcomings of oaths and declarations as discussed?

In the next chapter I will discuss the consequences of the changes to the Hippocratic Oath by looking at the symbolic and the practical consequences, highlighting concepts like power of myth and empty currency. I will try and answer the question as to whether the declaration is inherently empty. I will also explore the lack of enforceability and the problem with uniformity. Furthermore I will discuss the need for ethical guidelines and to conclude I will try and answer the question as to whether the changes to the Hippocratic Oath had the desired effect.

CHAPTER FOUR

Consequences of changes to the Hippocratic Oath

The Second World War effectively ended European Colonialism. The war was also a catalyst for changes on many fronts including the rise of the civil rights movement in the United States of America and liberation movements across Africa and Latin America. These social changes started the process of officially ending sanctioned segregation, discrimination in employment and other social ills such as prejudice, discrimination and social injustice. In contrast in South Africa a new conservative government was elected in 1948 leading to even stricter racial policies than what had existed before under the name segregation.

These aforementioned social changes had a substantial influence on the daily clinical practice of medicine. Therefore the call to change the Hippocratic Oath to the Declaration of Geneva and Ethical Codes in Medicine gained prominence to reflect these social changes.

But did these changes have the desired effect on physicians in clinical medicine, or were they merely symbolic? According to Ms Romany Sutherland (2015) of the South African Medico-Legal Society there has been a significant increase of medical malpractice cases over the last twenty years in South Africa. Unfortunately eighty five percent these cases are settled out of court. In these settlement documents, a non-disclosure clause is usually included and prohibits the plaintiff to report such medical negligence to the HPCSA. These circumstances make it extremely difficult to access reliable statistics in this regard. However, the report " A profession under siege?" by Landman and Mouton (2001) also provides confirming evidence of large scale unethical practice of medicine in South Africa. Examples of unethical behavior includes: observation of professional misconduct by a colleague,

supplementation of income by over-servicing of patients and private arrangements with private clinics and hospitals, cash payments that are not declared for income tax purposes as well as increased charges to medical aids by unnecessary consultations with patients according to Landman and Mouton (2001: 2). Possible reasons for this unethical behavior identified by Landman and Mouton includes mostly financial reasons, be it low medical aid remuneration and/or patients unable to pay for their consultations. Unnecessary government intervention, managed care as well as the fear of litigation are other reasons mentioned in the report. These examples of ongoing, and perhaps even increasing unethical behaviour in the practice of medicine suggests that the changes to the Hippocratic Oath have not necessarily had the desired effect.

In this chapter I will highlight and discuss these consequences under the respective headings of symbolic and practical consequences by making use of relevant examples. I will discuss symbolic consequences making use of the following concepts: Firstly, in the section 'Power of Myth', I will explore the physician-patient relationship and more particularly the expectation and trust of the patient. In this section I will try and answer the question if this trust placed in the physician is purely mythical. Secondly, in the section, 'Empty Currency' I will look at the role of economic factors in clinical medicine and ask the question if economic standing takes precedence over the moral duties and obligations required from the physician in the Declaration of Geneva. In this section I will also explore the role of external role players like medical insurance companies. In my discussion of the practical consequences, I will look at the following issues: Firstly the issue of enforceability and the lack thereof in the Declaration of Geneva. Secondly I will address the issue of lack of uniformity in the use of the Declaration of Geneva among different medical schools. Thirdly I will look at the need for ethical guidelines and ask the pivotal question if the moral weight of oaths and declarations has declined to such an extent that they have little if any impact on the moral bahaviour of physicians. To conclude this chapter I will discuss if the changes to the Hippocratic Oath had the desired effect, by using the example of Dr Wouter Basson.

4.1 Symbolic Consequences

Were these changes to the Hippocratic Oath merely symbolic? To try and answer this question, I will explore the concepts as mentioned in the chapter outline in the previous paragraph.

Seeing that there is no consensus amongst medical professionals over one universally accepted oath or declaration as noted in Chapter Three, has such a document any moral meaning anymore or is it just a symbolic gesture grounded in tradition? Although it seems that the core moral values of oaths and declarations are still relevant in modern day healthcare, do physicians still abide by the pledges and does it ensure quality of patient care, or has it become a meaningless exercise in a pluralistic healthcare system where the physician patient relationship has taken the back seat subservient to economic influences via the government and medical insurance companies?

In the next section I will explore the physician-patient relationship and the expectations of the patient within this relationship by using the concept of the power of myth.

4.1.1 Power of myth

In this section I will explore the reasonable expectation from a patient that a physician will act in his/her best interest and alleviate suffering. Furthermore I will ask the question if this expectation is grounded in misplaced trust and is just a myth?

Any patient on a first clinical encounter with a physician has no direct knowledge or experience that could possibly warrant the initial act of trust in the attending physician, despite the physician's claims of competence and trustworthiness (Zaner 2000: 267). Any patient because of his/her vulnerable position due to illness has no choice but to enter into a structurally

asymmetrical relationship with a physician, reinforced by institutions, such as the hospital and the medical profession (Zaner 2000: 267). This raises the question, is the patient's initial trust warranted, or is this apparent trust just a myth or even merely based on a myth? In this section I will explore the power of myth regarding the physician–patient relationship and the reasonable expectation from the patient that the treating physician will act in his/her best interest as required by the Declaration of Geneva and the Ethical Guidelines of the HPCSA.

As noted above, a clinical encounter between a patient and a physician can be described as an unequal and asymmetrical relationship. Zaner (2000: 267) is of the opinion that the patient is in an extremely vulnerable position, not only compromised by the very condition that she/he is in but also disadvantaged by this very relationship. The physician on the other hand has the power in the form of skills, knowledge, access to resources, social legitimacy and legal authority.

The illness experience and the subsequent clinical encounter are quite unique. Illness represents an underlying threat of compromise and loss and cuts into the social fabric of the patient's individual life with far reaching effects on the relationships that the patient has. It severely compromises the patient's sense of him/herself and their experience in their own world. The physician's very presence and the utterance of the words, 'How can I help?' implies that he/she possesses some ability to help, heal or even cure, whether or not he/she can in fact do so (Zaner 2000: 267). Is this trust and expectation from the patient to be helped and cared for reasonable, or is it grounded in a myth?

In contrast to the aforementioned, Zaner (2000: 270) also argues that a patient's illness, vulnerability and experience of significant difference to the norm of being healthy, brings him/her to prominence in the physician-patient relationship and invokes a strong moral cognizance. This very exposure of the patient's vulnerability in the face of illness is morally commanding and compelling. Therefore one can argue that the patient's vulnerability can also

be seen as potent and powerful in the aforementioned asymmetrical relationship between physician and patient.

Therefore at the core of the clinical encounter lies the physician-patient relationship, be it between the powerful physician and the vulnerable patient, or as the patient being in a morally commanding position invoking a strong, compelling moral cognizance from the physician as discussed before. This relationship, unequal as it may be, forms the basis of the Hippocratic Oath, and even more so the Declaration of Geneva and the Ethical Codes. By swearing to, making a declaration or adhering to these aforementioned documents, a physician pledges to help all sick and vulnerable people without prejudice. By following the virtue of philanthropy amongst others, the physician accepts fundamental moral responsibilities and duties, not only to the vulnerable patient but also to him/herself. Oaths, declarations and codes incorporate a special blend of virtues that govern this special relationship, for example justice, disciplined self- restraint and courage, and demand an urgency to cause no harm and to provide benefit. It invokes a moral vision focused on the physician-patient relationship. Therefore one can assume that the changes made to the Hippocratic Oath to emphasize this moral vision should encourage physicians to be diligent in meeting the reasonable expectations of patients to act in their best interests and to respect the unconditional trust placed in them.

One is compelled to ask: Did the aforementioned changes to the documents in question reverberate in clinical medicine post 1948? I can use numerous examples to illustrate the power of myth in the clinical setting where a patient does not actively choose to place his/her trust in the chosen physician. Examples of such clinical settings include where a patient is assessed in an emergency room by an unknown physician, or where a patient is being referred by his primary care physician to a specialist for specialist treatment. In the latter example the patient has to trust his/her physician's judgment that the specialist will be competent in dealing with the specific disease and will act in his/her best interest. One example that illustrates this is the case of Steve Biko, a South African anti-apartheid activist's torture and subsequent

death and the role of the attending physicians in this tragedy (How Steve Biko died, 2012). In my opinion this case demonstrates the power of myth quite clearly. Although Biko, like any other patient, one could assume, placed his trust in the attending physician to act in his best interest and to alleviate suffering, quite the opposite happened, where the physicians were partly responsible for the deterioration of his condition resulting in his death. It seems as if Biko's trust in the attending physicians was completely misplaced.

> *On 18 August 1977, Biko was arrested at a police roadblock under the Terrorism Act No 83 of 1967 near Port Elizabeth in South Africa. He was interrogated and tortured resulting in a brain haemorrhage. According to reports, Biko suffered at least three brain lesions caused by the application of excessive force to his head whilst in custody. These injuries were sustained between the night of 6 September and 7 September 1977. The district surgeon, Dr. Lang was called to examine Biko and despite the fact that the patient was in a daze, suppressed consciousness, and presented with a badly swollen face, hands and feet, he concluded that there was nothing clinically wrong with the patient. When a more senior colleague of Lang's, Benjamin Tucker was called in and recommended that Biko should be taken to a hospital, the police strongly objected, and Tucker subordinated the moral values and norms in the Hippocratic Oath and the Declaration of Geneva to the wishes of the police. Lang, although fully aware of the seriousness of Biko's condition, recommended that he be driven 700 kilometers to the prison hospital in Pretoria. On 11 September 1977, Biko was driven more than twelve hours from Port Elizabeth to Pretoria - naked, manacled and unconscious in the back of a van. On arrival in Pretoria a newly qualified physician administered an intravenous infusion. This physician was given no other information about the patient other than that he was refusing to eat. On 12 September 1977 Biko died of complications resulting from a brain injury* (How Steve Biko died, 2012)

I specifically chose the example of an inmate in a prison setting for the following reasons. In the prison setting the patient is extremely vulnerable,

even more so than in a normal clinical setting, therefore the extreme asymmetrical relationship between patient and physician as previously discussed. Furthermore, one could assume that physicians working in a prison setting might be part of a discriminatory system, but a moral physician should deal with patients without prejudice and in a non-judgmental way as required by the Declaration of Geneva. Biko, himself a former medical student, had a reasonable expectation, like any other patient, of the attending physicians to act in his best interests and to adhere to the principles of non-maleficence, beneficence, non-discrimination and justice, which they clearly did not do. Although the attending physicians probably had the clinical expertise to help the patient, they did not, succumbing to external pressure from the police as well as the South African government and ignoring their moral duty and responsibility as required by the Hippocratic Oath as well as the Declaration of Geneva. This case aptly illustrates, that although the Hippocratic Oath was changed to address mainly humanitarian concerns, as previously discussed, these changes had seemingly little effect in the practical environment of clinical medicine in this particular case.

In the next section I will look at the roles of the multitude of external role players and economic benefit to the physician as well as these external role players by making use of the concept of empty currency. I will try and answer the question as to whether the moral norms and values required became subservient to economic benefit to the physician and the external role players. Despite the fact that the changes to the Hippocratic Oath included non-discriminatory pledges, emphasizing the economic/social standing of the patient, it seems as if this requirement was merely a symbolic gesture, as I will demonstrate with a case study from personal experience.

4.1.2 Empty currency

Healthcare is increasingly seen as a business, with the physician as the businessman, and the “coin of commerce serves increasingly as the common currency of medical discourse” according to Gunderman (1998: 1). One observes an increase in physicians specializing and even super specializing in a particular field partly because of the monetary incentive. In this section I

will discuss some of the economic forces that play a role, and the increasing importance of commerce in modern medicine. Furthermore I will try and answer the question as to whether the moral values and norms as required by the Declaration of Geneva as well as the Ethical Guidelines of the HPCSA have become less important in comparison to the economic benefit to the physicians as well as numerous external role players.

Since 2011, patients have become healthcare consumers and physicians are subject to the South African Consumer Protection Act, published in 2009 and effective from April 2011 in South Africa (Republic of South Africa 2008). In addition to this development, healthcare has become an economic enterprise with the introduction of Managed Health Care where reimbursement moves away from the fee for service model to the capitation fee model. In the latter model physicians are reimbursed a fixed fee per patient seen, regardless of the costs involved in attending to the patient.

Against the above-mentioned background one can ask: Has the internal morality of medicine with its duties and obligations entrenched in the oath and declarations become obsolete in modern healthcare and were the changes to the Hippocratic Oath of a mere symbolic nature? What is the objective of medicine? One has to consider two options in trying to answer this question. Is medicine about maximizing the income of physicians and/or healthcare organizations and “do patients and their suffering exist in some fundamental sense for the benefit of the physician, hospital or stockholder? Or do physicians and the entire medical enterprise of which they are part exist for the benefit of the patients and the relief of human suffering” as Gunderman (1998: 8) rightfully observes.

As early as ancient Greek times, Socrates already pointed out this phenomenon in *The Republic*: A “physician who ceases to seek the health of his patient and begins to regard patients as opportunities for self-enrichment has ceased to be a physician and has become a mere moneymaker” (Gunderman 1998: 3).

In oaths, declarations and codes, sworn to and taken by physicians internationally, service to humanity is paramount. To serve the best interests of the patients is one of the pivotal moral norms entrenched. In reality patients still have a rather naïve trust in their physician that he/she will do what is best for them as patients and will have their best interests at heart. Gunderman (1998: 4) points out that patients still believe that they will be treated as innately worthy human beings to be studied and cared for, for their own sake. Is this trust, anchored in historical and societal beliefs misplaced and do physicians still adhere to the core moral values of oaths, declarations and codes or have the moral values and norms in these documents become obsolete in the current economic climate of modern medicine where cost containing and remuneration apparently takes precedence over patient welfare?

The following case study demonstrates the monetary influence on patient care very well.

Mr H, a 59 year old man is seen by Dr S late afternoon presenting with extreme tiredness, short of breath, cold, clammy and sweaty. He gives the history of a gastro-intestinal bleed for the past forty eight hours. Dr S makes the diagnosis of a gastric bleed and informs the patient that he needs to be admitted to a hospital urgently to be stabilized and treated. Mr H does not have medical insurance, and upon enquiry, the nearest private hospital insists on an upfront payment of R30 000. Mr H only has access to R20 000. He is refused admission and he is referred to the nearest government hospital (Author's own observation, 30 May 2015, Melkbosstrand).

Although a good standard of medical care is promised in the Human Bill of Rights of the South African Constitution (Republic of South Africa, 2003), the sad reality is that, due to a variety of factors, the probability of Mr H passing away from his gastric bleed is higher than him being saved.

In reality no patient may be turned away from a private hospital or surgery, due to a lack of funds. The patient should be stabilized medically and only

once stabilized the patient can be transferred to a subsidized medical facility (government hospital) where he can be treated. Unfortunately this recommended procedure does not happen as frequently as it should, giving economic factors far more importance than proper patient care.

This example is unfortunately one of many, a daily occurrence in South Africa where economic factors take precedence over the moral values and norms to which physicians are supposed to adhere. Further examples in clinical practice where economic factors play a predominant role include: medical practices where medical aids are not accepted and cash or credit card payment is required after the consultation and charging three to four times the accepted medical aid tariff. The latter practice is quite common among specialist practices. According to the HPCSA the patient should be informed prior to the consultation of the increased tariff and be in agreement. In an anaethesist practice this requirement is not always met and the patient do not always have a choice. In emergency cases the anaethesist will only meet the patient in theatre, with hardly any time to discuss fee structures.

There should be a critical distinction between organizing medicine so as to maximize profit of physicians and/or shareholders in private healthcare, and organizing a system of professional and institutional incentives so structured to promote a higher moral vision of what is best in medicine and ultimately for the patient.

To summarise, it seems as if economic standing takes precedence over moral duties and obligations as required from a physician, contravening the non-discriminatory pledges of the Declaration of Geneva, as well as those of the Ethical Guidelines of the HPCSA if one looks at the aforementioned examples.

4.1.3 Are oaths, declarations and codes inherently empty in the daily practice of medicine?

Underlying structural changes in healthcare, including increased incentives for physicians and patients alike to contain costs have had a ripple effect in the

healthcare system. Greater incentives to restrain costs have prompted the forming of new organizations and have attracted a multitude of different role players involved in the care of patients. This changed scenario makes it increasingly difficult for physicians to adhere to the core values of an oath or declaration. Due to the fact that the physician is not the sole authority anymore regarding patient care, it seems as if monetary factors insisted on by external role players, are the driving force in patient care, and that the moral values and obligations that are required from a physician in oaths, declarations and codes are subservient to these economic factors.

This greater political pluralism with the introduction of National Health Insurance schemes by governments across the globe and the ever expanding prescriptive role of government and the private medical aid sector, has reduced and shifted the power away from the physician to always act in the best interest of his/her patient and to alleviate suffering effectively. Physicians who did not want to conform to the new system were ostracized from medical societies, including denial of medical malpractice insurance, denying patient referral and hospital admission privileges as well as other benefits according to Laugesen and Rice (2003: 291). It seems as if less internal consensus in the medical profession and diminished trust in physicians have successfully added to the strained physician patient relationship. All these external forces including underlying structural changes in the healthcare system have changed the quality of interaction between physician and patient permanently.

Although numerous examples exist where patient care is being dominated by external forces, I will mention two examples that occur daily in clinical medicine in South Africa. Medical aid schemes dictate the treatment and quality of care daily leaving the physician successfully out of the equation. Practical examples include only paying for medication on their respective approved lists, irrespective of what the patient needs to successfully treat his or her condition and the process of getting authorization prior to certain examinations being conducted, or hospital admissions or surgical interventions carried out. These decisions for approval are made by administrators, who have never examined or even seen the patient, based on

information given by the attending physician. It is clear from this example that patient care is not physician driven anymore and is subservient to the demands of the medical aid scheme. It becomes increasingly difficult for the physician to adhere to the required moral values and norms in this economically driven climate in patient care.

A further example of this trend is evident in the introduction of an information technology application by one of the biggest medical aid schemes in South Africa where the requirements of confidentiality and informed consent in the Ethical Guidelines of the HPCSA are contravened. This application is called HealthID where the patient gives blanket consent to the physician to access the patient's medical history, electronic health records, benefit information and to writing online prescriptions (Discovery App, 2013). The objective of this application is supposedly one of cost saving to the patient.

There are, however a multitude of ethical transgressions with this system. The patient gives a once off blanket consent to whoever has access to this application, including administrative staff. This blanket consent is a direct violation of the pledge dealing with confidentiality of the Declaration of Geneva as well as the Ethical Guidelines of the HPCSA. In clinical practice there is no such entity as blanket consent. Informed consent should be obtained from the patient before any intervention, be it medical or administrative. The physician can access the patient's benefit information as well as the approved medicine list and is expected to prescribe only the medication on the approved list, but not necessarily the best medication available for the patient's condition. Once again this could be viewed as a violation of the pledge in the Declaration of Geneva dealing with discrimination. A generic sample of available medications may not be suitable for all patients and their respective illnesses. Electronic record keeping and electronic prescriptions are in use in clinical medicine in South Africa, but have not yet been approved by the HPCSA, making this practice unlawful. All entries into the patient record must be signed or initialed by the attending physician otherwise it has no legal standing in a court of law. Engaging in an unlawful practice means that respect for the patient is not prioritized. All

prescriptions should be signed by the attending physician, as a prescription is a legal document, which is not the case with electronic prescriptions. Furthermore the attending physician gets a financial incentive from the medical insurance company to use this system, and an increased consultation fee.

Although it initially seems as if this system is designed to benefit the patient, it seems evident that it is a cost driven exercise whereby the medical insurance company and the physician benefit. One can assume that because of the cost incentive, more time may be spent with the patient belonging to this particular medical aid scheme, compromising the quality of care of other patients not belonging to this particular medical aid due to the fact that less time is available to them. Thereby the non-discriminatory pledge of the Declaration of Geneva is not adhered to where it specifically states that the social standing of the patient should bear no influence on the physician. Systems such as these may play a role in a physician in private practice only accepting patients from this particular medical insurance company in his practice due to the financial incentive. Although the Hippocratic Oath was changed to place more emphasis on the physician's dedication to the humanitarian goals of the practice of medicine, it seems as if these novel goals are often ignored in favour of an economically driven system.

To summarise, although the core moral values are still relevant to an extent, it seems as if the already strained physician-patient relationship is further weakened due to existing external forces such as the multitude of role players and financial incentives offered by various role players. Patients have no control over their confidential information being shared on a variety of levels. In the aforementioned example it is quite evident that the physician as well as the medical insurance company benefit from this arrangement and that the quality of care of the patient can suffer tremendously. Although the changes to the Hippocratic Oath as previously discussed, were aimed at improving the patient's rights, honouring the humanitarian goals of medicine, as well as emphasizing the moral duties and obligations of the physician, it seems as if these changes have little relevance as demonstrated by the aforementioned

examples where economic benefit receives precedence over proper patient care as required by the Declaration of the Geneva as well as the Ethical Guidelines of the HPCSA.

4.2 Practical consequences

With the changes to the Hippocratic Oath as previously discussed, certain practical consequences also ensued. These problematic consequences will be discussed in the following section.

4.2.1 Enforcement

In the Hippocratic Oath the issue of enforcement is addressed by the pledge,

'If I fulfill this Oath and do not violate it, may it be granted to me that I enjoy life and art, being honoured with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot' (Addendum A).

According to Meffert (2009: 413) the Hippocratic Oath does not state if a physician violates any of the moral standards in the Oath that one may not be a physician anymore nor does it address steps that may be taken regarding corrective action. It provides no definite promise of punishment of corrective guidance for corrective instruction. In the Declaration of Geneva - initially in 1948 as well as in subsequent revisions - no mention is made of any enforcement actions or even a possibility of punishment for not adhering to the moral obligations and duties required of a physician (World Medical Association, 2006). It seems as if the Declaration of Geneva is only a body of moral rules that purport to govern medical practice, but can by no means enforce these moral rules.

One can argue that the moral rules set out in the Declaration of Geneva address the individual moral conscience of each physician making the

Declaration, and rely heavily on each physician's individual moral convictions and virtues. Oaths and declarations only indicate a commitment to firm moral parameters and the affirmation of these moral parameters by swearing to an oath or making a declaration may strengthen a physician's resolve to behave with moral integrity (Hurwitz and Richardson 1997: 1672). There is however no guarantee that taking an oath or making a declaration or even adhering to a set of Ethical Guidelines as set out in a code will have any effect on a physician's competence regarding the moral practice of medicine in the long term.

In an oath one swears to some kind of deity and this exposes the swearer to some consequences if not keeping the oath. Breaching of the oath would invoke the wrath of the deity as aptly demonstrated in the Hippocratic Oath. The original Declaration of Geneva in 1948, subsequent revisions of this Declaration and other modern declarations/oaths that followed have been so diluted that they have very little impact on physician's behaviours, if any. The lack of enforceable sanctions make them almost toothless in their impact. Neither the Hippocratic Oath nor the Declaration of Geneva is legally enforceable, therefore the authority of these documents is virtually nonexistent. The only possible enforcement mechanism that could follow from an oath or declaration is potential censure by other physicians suggesting the idea of a self-regulating profession (Baker 1993). Due to this lack of enforceable sanctions, medical boards like the HPCSA and their Ethical Guidelines are the only recourse when addressing improper conduct of a physician. Although there is no mention of punishment in the Ethical Guidelines of the HPCSA, a physician's misconduct can be reported to the HPCSA according to the HPCSA's website dealing with Professional Conduct and Ethics pertaining to complaints (HPCSA 2013). If there are grounds for the complaint, the board will appoint a Professional Conduct Committee which will hold a professional conduct enquiry. If the physician is found to be guilty of professional misconduct, he/she can be subject to the following penalties:

- "A caution or a reprimand or both.
- A fine.

- Suspension for a specific period from practicing his/her profession.
- Removal of his/her name from the relevant register.
- A compulsory period of professional service.
- Payment of the costs of the proceedings"(HPCSA 2013).

Swearing to an oath or making a declaration by prospective physicians seems to be more of a symbolic gesture, not only for physicians but also for society to affirm the inherent moral duties and core values entrenched in the medical profession.

4.2.2 Uniformity

As noted in previous paragraphs, prior to the Second World War the oath that was mainly used by physicians of the time was the Hippocratic Oath. After 1948 with the change to the Declaration of Geneva, several oaths and declarations surfaced and were used in different medical schools across the world. Some medical schools even chose to abolish the oath taking ceremony all together. With the subsequent revisions of the Declaration of Geneva by the World Medical Association it opened the door for 'boutique' oaths written by medical students themselves. According to Gruenbaum and Jotkowitz (2009: 103), it is quite evident from the literature that there is no universal declaration or oath that is being used by all medical students across the world. It seems as if medical schools use the Hippocratic Oath and the Declaration of Geneva as guidelines to compile their own documents to use at an oath taking ceremony. This document can change from year to year, and students even have the opportunity to choose from a variety of documents to use as an oath or a declaration, according to Crawshaw and Link (1996: 452) This practice has evolved mainly due to the fact that we find ourselves in a morally fragmented world with different moral visions in different societies. It has been argued by Kao and Parsi (2004: 886) that this situation has led to fragmentation and confusion about the core ethical values of the medical profession and therefore has diluted the value of a professionally binding oath or declaration. This can send mixed messages to students regarding the apparent flexibility of such a document. This state of affairs demonstrates very

effectively the lack of consensus within the medical fraternity regarding the core moral values and standards required of a morally sound physician.

4.2.3 Need for ethical guidelines

The need for ethical guidelines emerged due to the following reasons: firstly the lack of consensus amongst physicians on a universal oath/declaration, secondly the lack of moral cohesion in a social environment of moral pluralism and moral fragmentation and thirdly the lack of enforcement/authority of oaths and declarations. Criticisms that are raised against newer oaths and declarations include that they are too vague and provide very little guidance regarding ethical behaviour in specific circumstances. There is no mention of possible consequences if a physician does not adhere to the values and principles included in the oath/declaration. This has resulted in a situation where discipline and censure is left to professional organizations and medical councils.

By law all physicians must be a member of the medical council of their respective countries in order to be licensed and to practice medicine. Such a council is established by the government to ensure that the general public's interests are addressed and protected in their interaction with healthcare professionals. This implies that ethical guidelines as prescribed by the medical council are the only enforceable authority to which the physicians have to subscribe. The medical council, via an ethical code of conduct in which the ethical guidelines are set out, has the legal authority to hold physicians accountable for their actions towards patients. Whereas the oath and/or declaration have an internal locus of authority, ethical guidelines have an external locus of authority, which has to be obeyed by all physicians who are members of the council. This need for enforceable ethical guidelines demonstrates the sad state of affairs where one can no longer assume that taking an oath or making a declaration guarantees ethical behaviour of a physician in the long term. This raises the question: has the moral weight of oaths and declarations declined so dramatically that they have little if any impact on the ethical and moral behaviour on physicians post 1948?

4.3 Did the changes to the Hippocratic Oath have the desired effect?

Was the objective of the changes to the Hippocratic oath to create a new more applicable universal oath to be used by all physicians worldwide to deal with modern healthcare dilemmas driven by structural changes and newer technologies available and prevent recurrence of atrocities like during the second world war, or was it merely a symbolic gesture on the part of the World Medical Association? With all the different newer oaths and revisions of the Declaration of Geneva it is quite clear that the apparent objective to create a new universally more acceptable oath/declaration has not yet been successfully met.

Apart from the previously discussed atrocities committed by the Nazi physicians as well as the Japanese physicians, one finds similar cases in South Africa during the Apartheid era of how these idealistic changes to the Hippocratic Oath had little influence over the ethical behaviour of physicians practicing medicine. One particular example has been prominent portraying the lack of enforceability of the Declaration of Geneva and the evidence that making such a declaration upon graduating had no effect on the future ethical and moral behaviour of a physician.

Dr Wouter Basson headed the apartheid government's chemical and biological warfare programme, Project Coast, during the apartheid years from 1981 until 1992. Basson co-ordinated the production of large quantities of illegal psychoactive drugs, equipped mortars with teargas and provided military operatives with disorienting substances to facilitate illegal kidnappings according to the article, 'How long do we have to wait for Dr Death to be punished?' (Malan, 2014). Basson was also involved in the manufacturing of cyanide capsules available to South African soldiers so that they could commit suicide to avoid revealing sensitive information under torture from the enemy. Allegations were also made that Basson was also involved in developing an anti–fertility vaccine for black women, a so called ethnic weapon to reduce the number of childbirths from black women.

Basson was one of the witnesses at the Truth and Reconcilliation Commission's hearings on the chemical and biological weapons warfare programme. In 2000, forty medical professionals laid a complaint of unethical behaviour against him with the Health Professionals Council of South Africa. In December 2013, thirteen years later, he was found guilty. The HPCSA ruled that he was medically unethical when he was head of Project Coast. According to the HPCSA the medical ethical principle of 'do no harm' was violated in each instance, using the Ethical Guidelines as published by the HPCSA. Although Basson was guilty, he has still not been sentenced and continues to practice medicine at his private cardiology practice in Cape Town, South Africa.

It took the HPCSA more than a decade to find Basson guilty of professional misconduct and unethical behaviour as a medical professional and he has yet to be sentenced. Taking this seemingly straightforward example into account, it seems as if the HPCSA lacks the ability to properly 'police' as well as the will to enforce accepted ethical standards in the medical profession. The general consensus is that South Africa needs a better mechanism to prosecute unethical medical behaviour by which medical professionals can be held accountable as members of society.

If the HPCSA decides not to give Basson the most severe penalty - being struck off the medical practitioners register permanently - it could have far reaching effects. Such a precedent set could give the opportunity to other medical professionals charged with violations of ethical rules by their respective medical councils, to cite this case. It could mean that US physicians who may be complicit in torturing detainees in Guantanamo Bay, as found by The American Taskforce on Preserving Medical Professionalism in National Security Detention Centers in their report, would not be punished fittingly if they were ever charged. The report stated that medical professionals in the US military and intelligence services 'designed and participated in cruel, inhumane and degrading treatment and torture of detainees' (US military doctors designed torture methods for detainees, 2013).

This case demonstrates clearly that ethical guidelines prescribed by the medical council (HPCSA) were used to discipline Basson and to a lesser extent, the moral rules, values and moral duties as set out in the Declaration of Geneva in which it clearly states the following relevant pledges:

- *"I solemnly pledge myself to consecrate my life to the service of humanity.*

- *I will practice my profession with conscience and dignity.*

- *I will maintain by all means in my power, the honour and the noble traditions of the medical profession.*

- *I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient.*

- *I will maintain the utmost respect for human life; I will not use my medical knowledge to violate human rights and civil liberties, even under threat"* (Addendum B).

Dr. Basson violated each one of these pledges spectacularly. Due to the lack of enforceability of the Declaration of Geneva as discussed earlier, ethical guidelines were used in the disciplinary hearings. This case demonstrates that due to the lack of enforceable measures in the Declaration of Geneva, the Ethical Guidelines of the HPCSA were used as a much needed tool to address the ethical transgressions of Basson.

To conclude, in this chapter I considered the consequences of changing the Hippocratic Oath to the Declaration of the Geneva and the need for ethical guidelines. I explored the symbolic as well as the practical consequences

respectively and addressed the concepts of power of myth, empty currency and asked the question if the Declaration of Geneva is indeed inherently empty. Furthermore I looked at the lack of enforceability as well as the lack of uniformity universally. I also addressed the need for ethical guidelines as oaths and declarations cannot guarantee ethical behaviour from physicians in the long term. Finally I used the case study of Dr Basson to demonstrate the great need for ethical guidelines to address unethical behaviour amongst physicians.

I came to the conclusion that it seems that the well-intentioned changes to the Hippocratic Oath are in practice merely symbolic, as it has been shown to have little influence on the moral behaviour of some physicians as demonstrated by the presented case studies. The humanitarian goals set by changing the Hippocratic Oath, seems to be an ideal to which the medical profession constantly has to strive. In reality, these goals seem to not be easily attainable. I also recognized the constant tension between the moral values and standards, required by the Declaration of Geneva and the more practical requirements of Ethical Guidelines and the interdependent relationship between these two documents especially where enforcement is concerned. Having discussed the consequences, it raises the following question: despite the changes to the Hippocratic Oath, are declarations and ethical guidelines still valid and applicable in modern medicine, or should a newer medical professionalism be established where more emphasis is placed on virtues?

In the next chapter I will use the Declaration of Geneva as a case study and evaluate it against the central moral question as formulated in Chapter One.

CHAPTER FIVE

Are Declarations still relevant, with special reference to the Declaration of Geneva?

As previously discussed medical practice all over the world can be seen as a moral enterprise built on the special relationship between the physician and the patient. This special relationship can be seen as the cornerstone of medicine as required by the Declaration of Geneva. This declaration requires from all physicians to promise that the "health of my patient" will be their first consideration. This requirement is also emphasized in the International Code of Medical Ethics, "A physician shall owe his/her patients complete loyalty and all the scientific resources available to him/her" (2009: 36).

In Chapter One I formulated the central moral question of this thesis: Should the medical profession move away from oaths, declarations and codes and establish a new medical professionalism where more emphasis is placed on virtues? To unpack this problem, I asked the following questions: Have traditional oaths, declarations and codes kept pace with the constant developments and change in medical science? Are certain concepts and definitions as entrenched in the more traditional oaths and declarations still relevant in modern times e.g. the concept of life? Do traditional oaths declarations and codes recognize the tension between the physician's moral responsibility towards his/her patient and legal accountability? Lastly, have oaths, declarations and codes become pointless anachronisms or can they still be seen as invaluable moral guides?

In this chapter I will try and answer the aforementioned questions by analyzing and discussing the different pledges of the Declaration of Geneva and highlighting certain issues and concepts in these different pledges.

5.1. Analysis of the core values, concepts and issues as seen in the Declaration of Geneva

To understand the full implications of the Declaration, one needs to analyze the values, duties, obligations and responsibilities as required in the Declaration.

Declaration of Geneva

"At the time of being admitted as a member to the medical profession
I solemnly pledge to consecrate my life to the service of humanity;
I will give to my teachers the respect and gratitude that is their due;
I will practice my profession with conscience and dignity;
The health of my patient will be my first consideration;
I will respect the secrets that are confided in me, even after the patient has died;
I will maintain by all means in my power, the honour and the noble traditions of the medical profession;
My colleagues will be my sisters and brothers;
I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;
I will maintain the utmost respect for human life;
I will not use my medical knowledge to violate human rights and civil liberties, even under threat;
I make these promises solemnly, freely and upon my honour." (WMA, 2006)

5.1.1 *"I solemnly pledge myself to consecrate my life to the service of humanity".*

Important issues that come to the fore in this pledge are humanity, the role of society, dual loyalty as well as the values entrenched in this pledge.

a) Humanity

The essence of this pledge is that all medical professionals will have to serve the interests of their patients to the best of their ability and place the patient's interest above their own. This concept dates from the time of Hippocrates, when medicine was defined as a profession, where this promise was made publically as is still the case today with the Declaration of Geneva.

Humanity can be defined as all human beings alive, incorporating individuals, groups, communities, societies and nations. Does this mean that physicians have a duty and moral obligation to everyone, or only his patients or people under his care? It can be argued that a physician pledges to serve the best interests of all *individuals* with whom he/she deals on a professional level, and to treat them with dignity, thereby respecting the individual's right to autonomy, competent treatment and compassion as required and not necessarily to serve the interests of society as a whole. Keeping this in mind, one is obliged to ask the questions: Is this argument valid and how far does the physician's moral duty and obligation stretch?

This pledge to consecrate my life to humanity clearly states that the physician has to sacrifice his *life* and not only his professional life to the service of humanity. It transgresses all boundaries and all levels, irrespective of the situation. This situation might be on a one-to-one level in the consulting rooms, or in a war situation, or on an institutional level where decisions regarding healthcare issues have to be made. This pledge includes all possible scenarios and is not only limited to the one-on-one physician-patient relationship as previously discussed.

Physicians today have various relationships within society and the traditional authoritarian individual approach to the physician-patient relationship has been replaced with a more inclusive social co-operative approach. Within this social co-operative approach, patient care is influenced by a variety of levels of input from a variety of role players as mentioned in the previous chapter. The value of justice features more prominently, and implies that physicians

are not only responsible for their own patients but also to a certain degree for others as well with regard how their care of their patients influences other members of society. This pledge demands that the physician's moral duty and obligation stretch far beyond his/her daily interaction with patients in a formal setting. This is demonstrated aptly by the World Medical Association's Declaration on the rights of the patient. "Whenever legislation, government action or any other administration or institution denies patients their rights, physicians should pursue appropriate means to assure or to restore them ".

b) Dual Loyalty and Resource Allocation

Physicians' social role is also emphasized with regards to their responsibility with regard to resource allocation. Resource allocation can take various forms from governments dealing with the health budget, to physicians when they have to decide for instance what special investigations need to be done on an individual patient, what medication should be prescribed or what procedure should be carried out. These choices highlight the pertinent issue of dual loyalty, where physicians are not only responsible for the well-being of their patients, but are also accountable to third party role players for example, medical aids, health care administrators, governmental institutions or even family members involved in the care of the patient. This dual loyalty may lead to conflicting obligations, where the best interests of the patient conflict with the interests of society. On the other hand resource allocation and its impact on the wellbeing of individual patients can have a huge impact on communities and society, especially at an economic level. A healthy society functions optimally and can flourish economically. Therefore one can deduce that a physician is not only responsible for his/her own patient, but also for other individuals as well on an indirect level. Decisions about resource allocation can influence the wellbeing of the rest of the community and to a lesser extent the wellbeing of the society by addressing the burden of disease in a responsible manner. The physician's own morality and the socio-political environment in which he/she finds them can play an important role in daily clinical governance and can have a ripple effect upon the well-being of the community in which he/she functions.

c) Values

One can assume that the values relevant in a pledge to serve humanity are dignity, respect for persons and compassion. This implies that the physician has a duty to all human beings to treat them with the dignity and respect that they deserve as human beings. Compassion is intertwined with and based on the respect for the patient's dignity and the patient's respective values and belief system. It also includes the acknowledgment and recognition of the patient's vulnerability due to illness and possible disability, be it temporary or permanent.

d) Evaluation of the pledge

It seems as if it might be extremely difficult to comply with the requirements of this pledge. The pledge requires that the physician's moral duty and obligation are not only applicable to his/her patients but also to society as a whole. However, these obligations may conflict when the needs of the individual patient are not compatible with the needs of society. The issue of dual loyalty comes to the fore especially within the constraints of the allocation of limited resources. This pledge seems to be too vague and too general to give a physician any guidance on how to deal with these conflicting obligations as discussed.

5.1.2 *"I will give to my teachers the respect and gratitude that is their due".*

Important issues that can be highlighted with regard to this pledge are firstly the question as to who can be seen as teachers, secondly the dual loyalty of teachers, thirdly, the form that gratitude should take, and finally the accountability of teachers.

a) Who are my teachers?

One can argue that with so many sources of information involved in the education of physicians this pledge has fallen into obscurity. Therefore one is obliged to ask the following question: Who are my teachers?

The concept of teachers can be all-encompassing, therefore including everybody that is involved in the education of the prospective physician. This

can range from professors and lecturers to nursing staff and fellow students, but it also has to include the patients. Patients might not have been actively involved in conveying academic facts to the student, but certainly contributed to the knowledge gathered about human beings and their interaction, as well as their relative experiences of illness and suffering.

With the evolution of medical science, teaching has changed significantly, with a healthy mix of practical and academic exposure on a variety of levels. These levels include personal interaction on a one-to-one basis, classroom instruction, small group activities and self-study via academic literature from a variety of sources. The model of cooperative decision-making where the input of the patient is of more importance than in the past, is now adhered to by most physicians. The purpose of this cooperative decision making model, is to ensure that the patient has access to all possible information regarding his/her illness to make an informed decision in cooperation with the relevant physicians involved, as opposed to the previously accepted authoritarian, paternalistic model.

This pledge is commonly interpreted as referring only to teachers in a formal academic setting, but if this interpretation is indeed what is intended by the pledge, one can question whether this pledge still has any relevance in modern medicine given the aforementioned discussion.

b) Dual Loyalty

In modern times, medicine has become more and more a science instead of an art form intertwined with science, as it was perceived to be earlier during Ancient Greek times. This is mainly due to the rapid discovery of new technologies in the advancement of the health of the patient. The sharing of knowledge has become more formalized and institutionalized in the form of universities and medical schools, where education is not free of charge. These universities are functions of the state, as they are subsidized by the state with the mandate to formally educate the students entering these centres of higher learning. Teachers in the academic sphere therefore have a duty and an obligation to share knowledge in an unbiased manner on a formal

as well as an informal level. The question remains however, as to the degree to which this educational process is prescribed and influenced by the government of the day, and therefore how unbiased it can be, as tertiary institutions cannot function autonomously, separate from their main funder, the government.

Teachers in the medical academic field are usually dually employed, by the university as well as the state. Therefore they have dual loyalties to their student as well as their respective employers. Teachers have an obligation, not only to themselves, but also to their students and their patients, to be diligent in the execution of their daily task and to act as ethically as possible. Not only do they teach, but they act also as role models for their students. Employees of academic hospitals and medical schools also have an obligation to society, from which they draw their patients, and with whom they teach their students. Therefore they have to act in as unbiased a way as possible within this framework of dual loyalties, and always serve the best interest of the patients.

c) Respect and Gratitude

Furthermore this pledge states that the teachers need to be given the respect and gratitude which is their due. As fellow human beings, teachers should be treated with dignity and respect. What form should a former student's gratitude take? Is being grateful for the knowledge shared enough, or should there also be monetary forms of gratitude in a donation towards the university? It can be argued that, as medical education is very expensive in most countries, it can be seen as a fee for service model from a medical student's perspective and that further gratitude can be seen as a choice by the individual and cannot necessarily be demanded, as seems to be suggested by this pledge.

d) Accountability of teachers

As teachers do not only teach in academic medicine but also have the privilege of seeing patients as a physician in a private setting, they are as accountable as any other physician regarding the level of care they provide as

well as competence on a clinical level. With the surge in medico-legal cases, pertaining to medical malpractice, they can also be held responsible for incorrect clinical decisions and the dire consequences that can result. This further complicates this pledge as teachers can be held accountable by their colleagues. Expert witnesses in these cases are usually fellow physicians who have to evaluate the cases and make a judgment on the standard of care and professionalism of the defendant. Does this pledge make provision for such scenarios in cases where students have to hold their former teachers to account?

e) Evaluation of this pledge

If teaching were still done only in a formal academic setting, it would be reasonably acceptable to comply with the demands of this pledge. As I have pointed out in the discussion, teaching takes place in a variety of settings, formal as well as informal. If one looks at the formal education system, teachers are allowed to see private patients. This can lead to new predicaments as discussed. Although it seems initially easy to comply with this pledge, it can become problematic.

5.1.3. "*I will practice my profession with conscience and dignity; the health of my patient will be my first consideration".*

In this section I will discuss some of the virtues required to fulfill this pledge and ask the question if all physicians are of virtuous character. Furthermore I will discuss the duties and obligations that are included under this pledge, and the relationship between these obligations and the role of the patient in promoting his/her own health as well as the role of cultural influences.

a) Virtues

By pledging to practice medicine with conscience and dignity the virtues of compassion, sympathy, empathy and trust amongst others should be adhered to. This implies that physicians should be of a virtuous character and not only possess these characteristics, but also implement them in their daily interaction with their patients. However one needs to ask the following inevitable questions: Firstly, are all physicians of virtuous character and

secondly can virtues be taught? In the next chapter I will explore these questions further.

b) Duties and Obligations

Furthermore the physician pledges to consider the health of his/her patient always. This pledge does not only refer to the physical illness as such, but also that the physician owes the patient professional loyalty and all scientific resources available. By firstly considering the health of the patient, it also implies that the physician should also respect the patient's dignity and own personal values and belief systems, even if it conflicts with their own. By treating the patient with compassion, the physician should acknowledge and respond to the patient's vulnerability in the face of illness. This element of compassion and respect will encourage the establishment of a trust relationship between the physician and the patient. This relationship of trust is of utmost importance in the successful treatment and possible cure of the illness. It also implies that the treating physician should adhere to the ethical principles of beneficence, non–maleficence.

c) Patient Responsibilities

Is the advancement of the patient's health the sole responsibility of the physician, or does the patient also have a responsibility and a duty towards him/herself? As previously mentioned there has been a shift worldwide from a paternalistic authoritarian model to a more inclusive cooperative model of decision-making in the physician–patient relationship, where the autonomy of the patient plays a pivotal role. This more inclusive model also brings responsibilities and duties of the patient to the fore.

Modern society has evolved to such an extent that illnesses are no longer only biological in origin, but also social in origin. Social habits play a very important role in the development of chronic illnesses. Certain lifestyle choices lead to the development of lifestyle illnesses such as the contribution of smoking towards lung cancer and chronic obstructive airways disease, the relationship between promiscuous sexual activity and the development of HIV/AIDS and other sexually transmitted diseases, and the contribution of unhealthy stressful living and diet towards ischaemic heart disease,

hypertension and subsequently myocardial infarction and heart failure. One can argue that the physician pledges to consider the health of his/her patient always first and foremost, but the patient also has a responsibility towards him/herself, as well as society at large to abide by the information and education shared with him/her by the physician regarding healthy living and lifestyle choices. If patients choose to ignore this advice can they claim medical benefits and have access to governmental health resources, stretched and limited as they already are? Does such a patient have a right to all the scientific resources available in these circumstances and what impact does this have on the physician's obligation towards the patient?

d) Social and Cultural Influences

By moving away from the paternalistic authoritarian model of practicing medicine the general assumption was made that most patients have a certain degree of literacy and have the ability to gain insight into their respective illnesses. However is this true of all patients worldwide, or was it only applicable to the post second world war western societies - countries that were involved in the signing of the Declaration of Geneva in 1948? In those countries a certain level of education and literacy was sustained, so physicians had the privilege of dealing with more educated patients. The reality that faces modern healthcare, is that the larger majority of the world population stems from Third World countries where illiteracy is a huge problem. Can one reasonably expect of these patients to make an informed decision, without being biased by cultural and state influences, regarding their own wellbeing? Furthermore, does Western medicine take cultural influences into account in the treatment of life style illnesses?

The pledge to put the health of his/her patient first and foremost implies that the physician can be held accountable for the effective treatment of his/her patient. In less developed countries, cultural influences play an extremely important role, especially in healthcare situations. Physicians should recognize the tension between appropriate treatment according to Western medicine and the influence of cultural beliefs and values. One can then ask if these patients always realize the full implications of their choices regarding

their own healthcare, when their decisions are not always based on medical facts but also on cultural belief systems that have been in place for centuries. In the more accepted social cooperative model of decision-making, the physician's duty is to properly inform, but who takes the ultimate responsibility for the patient's health? It should be a shared responsibility. This pledge is however very vague regarding the extent of the physician's shared responsibility for the patient's health. Can a physician be held accountable, if all authority is being removed and the patient's autonomy must be respected at all times? Does the physician have a right to overrule a patient's decision, when he/she makes a harmful choice regarding their own health?

e) Evaluation of the pledge

To practice medicine with conscience and dignity requires that a physician is of virtuous character. One has to assume that all physicians possess these virtues, but looking at examples discussed in previous chapters, this is seemingly not the case. This pledge requires that the health of the patient will be his/her first consideration, but with the social cooperative model adopted, it is not clear how this pledge should be applied when the physician is no longer regarded to have full authority within the physician-patient relationship.

5.1.4 *"I will respect the secrets that are confided in me, even after the patient has died".*

In this section I will discuss the issue of absolute confidentiality as well as respect, dignity and rights in confidentiality.

a) Confidentiality

Confidentiality dates back to Ancient Greek times and is described by the Hippocratic Oath as follow: "Whatever in connection with my professional practice or not in connection with it I may see or hear in the lives of my patients which ought not be spoken abroad, I will not divulge, reckoning that all such should be kept a secret" (Addendum A). This duty that is being imposed on the physician forms one of the cornerstones of modern medical ethics. Confidentiality is viewed as absolute by the Hippocratic Oath as well as the subsequent Declaration of Geneva.

According to the Medical Ethics Manual of the World Medical Association, the demand for confidentiality is built on three sources (2009: 51). These three sources are autonomy, respect for others and trust. Autonomy pertains to the fact that personal information about the patient belongs to the individual, and should not be made known to others, without his/her explicit consent. Information can only be divulged when one is authorized to do so by the patient or the patient's guardian.

b) Respect, Dignity & Rights

All human beings should be respected and treated with dignity. By preserving their privacy, one shows respect to the particular individual. Care should be taken to determine which necessary personal information should be divulged with the sole purpose of advancing the patient's health. Trust is essential for any physician-patient relationship. The patient needs to trust the physician implicitly to divulge only the necessary information on a need to know basis to other health care professionals.

Most countries have legislation and codes of ethical conduct, by which physicians need to practice medicine and uphold the demand for confidentiality. The World Medical Association's Declaration on the Rights of the Patient summarizes the patient's right to confidentiality as follows:

- "All identifiable information about a patient's health status, medical condition, diagnosis, prognosis and treatment and all other information of a personal kind, must be kept confidential even after death. Exceptionally, the descendants may have a right to access to information that would inform them of their health risks.
- Confidential information can only be disclosed if the patient gives explicit consent or if expressly provided for in the law. Information can be disclosed to other health care providers only on a strictly 'need to know' basis unless the patient has given explicit consent.

- All identifiable patient data must be protected. The protection of the data must be appropriate to the manner of its storage.
- Human substances from which identifiable data can be derived must be likewise protected" (WMA Declaration on the Rights of the Patient, 2005).

c) Breach of Confidentiality

Examples of how the requirement of confidentiality cannot be met in modern medicine are as follow:

- ICD10 coding for billing purposes
- Computerized patient files
- Pathology and Radiology reports
- Confidential interdepartmental patient reports being faxed or e-mailed
- Death Notifications
- Insurance Policies
- Notifiable diseases

Most common breaches of confidentiality are legally required, for example ICD10 coding, whereby diagnoses are required for billing purposes for medical aid or medical insurance companies. This information is more often than not used to determine the patient's risk profile without the patient's explicit consent. Physicians are legally required to adhere to the ICD10 coding policy for reimbursement purposes. The completion of the death notification is another example where disclosure of confidential information is required, without the patient even knowing about it.

d) Evaluation of the pledge

Keeping the aforementioned in mind, this pledge of absolute confidentiality is extremely difficult to uphold. One can argue that absolute confidentiality can only be an ideal to which one could aspire.

5.1.5 *"I will maintain by all means in my power, the honour and the noble traditions of the medical profession; My colleagues will be my sisters and brothers".*

In this section I will discuss the tradition of consultation and the role of technology in the consultation process. Furthermore I will address the disintegration of structure in medicine and the effect thereof on the patient as well as the responsibility and accountability issues that arise as a result.

a) Tradition

Western medicine has a long standing tradition dating as far back as Ancient Greek times. Hippocrates laid the foundation of a rational approach to medicine and he was the first physician to categorize illnesses as acute, chronic, endemic and epidemic. Medicine is seen as a science of art and healing in which the main aim is to restore health, by the prevention and treatment of illnesses, thus alleviating suffering. Although empirical knowledge plays a pivotal role in modern medicine, the actual one-on-one interaction between patient and physician is required to alleviate the suffering brought on by the specific illness. This interaction requires trust and compassion.

b) Consultation

Clinical practice is based on successful interaction between the physician and the patient. Physicians assess a patient through carefully taking a history, followed up by a physical examination. The process of history taking of the patient's symptoms plays a pivotal role in making the correct diagnosis. The clinical examination's sole purpose is to confirm the possibility of the diagnosis already established during the process of history taking. Therefore the initial interaction between patient and physician is of the utmost importance.

All information obtained during the consultation must be documented. After this initial assessment, the physician then decides if there is any clinical indication for special investigations and/or a referral to a specialist physician or other medical practitioners.

c) Technology

Consultation has traditionally been the way in which physicians have engaged with patients over centuries and this is still the case. In recent years medical and scientific research has brought new tests and new diagnostic modalities to the fore. Fortunately these new technologies are more readily available and more accessible for use by the physician for example Ultrasound, CT Scanning and Magnetic Resonance Imaging Scanning etc. These new technologies should be used effectively when clinically indicated for the betterment of the patient. Unfortunately, increased exposure to the internet, social media, and supposedly educational platforms like television shows have led to an overuse and abuse of these technologies by physicians and patients alike, in order to oversimplify the diagnostic process and as an attempt to bypass the proven clinical process. This leads more often than not to misdiagnoses and over expenditure of already limited resources.[8]

The basis of good clinical practice has remained the same and relatively unchanged over centuries. No new research, be it technological or biomedical, can ever replace the personal contact and the relationship of trust that should be the basis of good clinical practice. It should be evident that proven traditional methods and new research should go hand-in-hand and need to grow together. Newer diagnostic modalities should never replace the clinical basis of medicine, although attempts have been made to achieve this. Good solid clinical practice supported by available technology should always be used in a complementary way to achieve the ultimate goal of improving the patient's health.

d) Physician Relationships

Medical tradition requires that physicians treat each other not only as colleagues, but rather as family members. This requirement expects that physicians should respect each other and work cooperatively to maximize

[8] Due to the availability of CT Scans and MRI Scans, patients demand that these examinations should be performed even though there is no clinical indication that such an examination could add to the diagnostic process. On the other hand, clinicians perform these examinations far too easily due to the fact that they do not trust their own clinical skills.

patient care. Within this framework of brotherhood the best interest of the patient must always be the goal, as well as the duty and obligation of every physician. Within the medical profession there has traditionally been a strict hierarchical system, consisting of an external as well as an internal hierarchy. The internal hierarchy exists amongst specialties, within specialties and lastly a hierarchy concerning itself with the care of specific patients where the primary physician traditionally is in charge of the care of the patient when dealing with other healthcare practitioners, for example professional nurses, physiotherapists, occupational therapists and others. These separate hierarchies are determined by the scope of practice of the various levels of the healthcare practitioners, as determined by the various councils overseeing the different healthcare professionals. These strict hierarchical systems have been replaced by a more cooperative approach as discussed previously, where a multi– disciplinary approach is preferred with the best interests of the patient as the ultimate goal. In previous years the primary care physician would be at the centre of the care of the patient, holding the purse strings, figuratively speaking. However this scenario has regressed into a complicated mess where the patient's best interests are not always served. With the progression of medical science, as well as the increased accessibility of the multi–disciplinary team by the public, a lack of communication between the various healthcare professionals and the disintegration of the hierarchical system, patient care seems to suffer. It is no longer the case that one healthcare practitioner acts as the central point of reference. Rather each involved healthcare practitioner treats the patient on his/her own, without taking the treatment process as a whole into account. Patients as well as physicians and other healthcare practitioners are responsible for this mess, in which the patient suffers the most. One of the main reasons for this scenario is economic in nature. The patient uses the healthcare practitioner as a utility and patients are used by the healthcare practitioner as a means to financial gain.

e) Responsibility and Accountability

Although increased accessibility to healthcare and patients increasingly exercising their right to autonomy can be seen as a positive, one can argue

that the negative outweighs the positive if one looks carefully at the bigger picture. The more healthcare practitioners involved in one patient's care the more a loss of control becomes a realistic possibility. The various practitioners involved may have different opinions regarding what is the best possible treatment option for the patient. Such a situation results in a higher demand for better communication between the different practitioners, but the reality is that proper communication is often lacking. More often than not these are conflicting and the result is that patient care suffers and the patient is sent between medical professionals, without receiving a structured approach to his/her care to which the patient is entitled.

Such a scenario raises another important issue: who is ultimately responsible and accountable for the treatment of the patient and more importantly the standard of care that the patient receives? According to the Declaration of Geneva the physician should be responsible and ultimately accountable for patient care, but this is an almost impossible goal to attain in such an unstructured environment.

Medicine has always been a self-regulating profession. A high standard of behaviour- ethically, morally and professionally - has been established over the years. Disciplinary committees in the various regulatory professional bodies have been responsible for investigating suspicious behaviour and acting on the results of their investigations. The steps taken are not always successful. The only way that these structures can operate successfully is with the loyal support of the members of the medical fraternity.

The relationship between colleagues also implies certain duties and responsibilities. The reporting of unethical behaviour and the incompetency of colleagues is of the utmost importance. By reporting such behaviour, one does not only act in the best interest of the patient, but the integrity of the profession is also safeguarded. The World Medical Association's International Code of Medical Ethics (WMA, 2006) requires the following: "A physician shall report to the appropriate authorities those physicians who practice unethically or incompetently or who engage in fraud and deception".

f) Legal Accountability

During recent years a new discipline has come to the forefront: the medico–legal aspect of medicine. Physicians need to be held accountable for any wrongdoing, and the patients bearing the consequences of these wrongdoings need to be compensated. Professional bodies are not involved in the compensation aspect, and therefore, more and more civil suits against physicians are lodged. More often than not, the regulatory professional body is completely unaware of the legal action, as most of these cases are settled out of court in a pre-trial conference. With a settlement of this nature, a confidentiality clause is included with the condition that the medical negligence is not disclosed to the relevant professional regulatory body.

g) Evaluating the pledge

Although it seems relatively easy to comply with this pledge, the traditional consultation process is not that simple anymore. This is complicated by the disintegration of the structure of medicine as discussed, leading to the fragmentation of responsibility. Due to these factors, patient care suffers resulting in unethical behavior and raising the issue of legal accountability. These aforementioned factors make it increasingly difficult to adhere to this pledge.

5.1.6 *"I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient".*

In this section I will discuss the issue of economic discrimination and the allocation of scarce resources.

a) Human Rights

For centuries human beings were not always treated equally with dignity and respect, as is still the case today in certain parts of the world. Disrespect and unequal treatment of humans used to be quite the norm in societies across

the world, for example discrimination on the basis of race, sexual orientation, slavery and the lack of human rights. It was only in the 20th century that a belief of human rights and equality started to surface with the newly established United Nation's Universal Declaration of Human Rights in 1948 after the Second World War. This states explicitly "all human beings are born free and equal in dignity and rights". Since then numerous organizations were formed to enhance and protect these rights, especially regarding the rights of minority groups for example the rights of women and children as well as gay and lesbian rights.

In South Africa with the establishment of a new democratic dispensation, a new constitution was formulated in 1996, which includes the following statutes in the Bill of Rights.

- Equality: Everyone is equal before the law and has the right to equal protection and benefit of the law.
- Human Dignity: Everyone has inherent dignity, and the right to have their dignity respected and protected.
- Life: Everyone has the right to life.
- Freedom and Security: Everyone has the right to freedom and security of the person which includes the right not to be tortured in any way and not to be treated in a cruel, inhumane or degrading way.
- Integrity: Everyone has the right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction, to security in and control over their body and not to be subjected to medical or scientific experiments without their informed consent (Constitution of the Republic of South Africa: 1996)

b) Equality

Equal rights have been problematic for physicians over the years. Physicians claim that they have the right to refuse to accept a patient except in an emergency. There can be legitimate reasons for such a refusal. Reasons can include not being affordable to the prospective patient, being contracted out of medical aids, not accepting certain medical aids, conflicting personalities or

even personal reasons. One can argue that this phenomenon can be seen as soft discrimination either on economic grounds or any other reason without being held accountable. To honour this pledge one can only rely on the supposed virtuous character of the physician not to discriminate on any grounds, but in the defense of the physician that chooses to discriminate on economic grounds for instance, one can argue that any private medical practice should be run as a business and this gives rise to apparent discrimination. It needs to be emphasized that one should be able to rely on a physician's conscience and virtues to deal respectfully with patients irrespective of their race, social standing or even sexual orientation.

c) Allocation of Resources

The equal treatment of patients also implies that all patients should have equal access to available resources and treatment plans. Is the equal allocation of resources a viable economic option in the current economic climate? Currently a more social approach is being followed regarding the distribution of resources against the backdrop of justice. This social approach demands that physicians also consider the needs of other patients. It implies that physicians are not only responsible for their own patients but also to a certain extent for others as well. When physicians deal with this major issue of allocation of resources they have to decide which approach to justice is preferable taking into account the physician's own morality as well as the socio–political environment in which he finds him/herself. Post 1948 three approaches in the allocation of resources have been favoured namely the Egalitarian approach, the Utilitarian approach and the Restorative approach.[9] Often one finds that a mixture of the three named approaches can be successfully applied.

In South Africa there is a definite movement towards the restorative approach by the government, by which resources are distributed favouring the historically disadvantaged groups. Any choice that needs to be made

[9] Egalitarian approach: resources should be distributed strictly according to need. Utilitarian approach: resources should be distributed according to the principle of maximum benefit for all. Restorative approach: resources should be distributed so as to favour the historically disadvantaged.

regarding access to scarce resources should be based on medical criteria alone and not on any form of discrimination. Different societies require different approaches that suit the needs of the particular society. Choices that face physicians in this respect are based on values, not only their own values but also societal values and these choices can have far reaching effects, not only on the individual patient but also on the community and the larger society.

d) Evaluating the pledge

The reality of modern medicine is that it is as much an economic as well as a moral enterprise. Although seemingly unfair, medicine is a business in modern times. One could argue that a physician does not intentionally discriminate against a patient's economic standing, but has to keep funding in mind for the reasons discussed. Resources are not readily available and should be allocated in a fair manner, but reality dictates that health can be bought. There is a direct link between available funds and access to proper health care. Therefore it is difficult to adhere to this pledge with all patients.

5.1.7 *"I will maintain the utmost respect for human life; I will not use my medical knowledge to violate human rights and civil liberties, even under threat".*

In this section I will discuss the realities of abortion and contraception and the issue of the beginning of life. I will also address quality of life as well as the dual loyalty involving physicians employed by a government/the military.

a) Abortion

This pledge is incredibly vague regarding the concept of life. It does not mention when life starts, therefore leaving it wide open for interpretation. In recent years the beginning of life has been debated quite extensively as there are many different points of view on this matter. One point of view is that one can view a foetus as a human being only after the neurological system has developed, approximately at twelve weeks gestation, in other words, as soon as the foetus has the ability to experience pain. Therefore abortion is legal in certain countries up to twelve weeks gestation. By allowing abortion prior to

twelve weeks, the foetus is not legally recognized as a human person with a right to life and therefore conception is not equated with human personhood as viewed by the legal system in certain countries. Many physicians in these countries perform abortion in state and private institutions. However, if the concept of life in this pledge is to be interpreted as referring to biological human life, abortion is not compatible with this particular pledge. The pledge does not give specific guidance in this regard.

b) Contraception

If one analyzes the pledge further, it brings one to the question of contraception. Some contraception methods do not inhibit the formation of a zygote, but prevents the zygote from being implanted into the mucosa of the uterus. Is the prescription and placing of such devices in line with the pledge to respect human life? It all depends on the different interpretations regarding the start of human life. Some physicians are of the opinion that life starts with conception and the formation of a zygote. Other physicians view the start of life in line with the law as previously discussed. What is the physician's role in this instance and has the Declaration of Geneva kept up with the development of new concepts, such as the definition of 'life'? One can argue that the physician does not only have a responsibility and a duty towards the expectant mother but also to the unborn fetus. This however leads to another question, what is the physician's role towards society regarding population control? The pledge demands that all human life must be respected therefore the role of the physician is unclear regarding family planning, birth control and the subsequent consequences for society.

c) Quality of life

Furthermore this pledge requires that one maintains utmost respect for human life, but how is human life defined? Does the quality of life feature anywhere in this pledge? Does this pledge require from the physician to respect life even if there is no quality of life? Advances through medical technology have enabled physicians to keep patients artificially alive through mechanical ventilation and renal dialysis machines under certain conditions. These practices have unfortunately led to complex ethical dilemmas. The physician's main duty is

alleviation of suffering and to act in the best interest of the patient. One can argue that by ending life support, suffering is alleviated and the best interest of the patient is served, but isn't that the ending of a life? The pledge is unclear as to how one would act in such a complex scenario.

One has to accept that there is a finite limit as to what physicians can do. Physicians should not only respect life *per se* but also place emphasis on the quality of life of the patient or the lack thereof. These decisions about the quality of life of a patient should be carefully considered before any intervention takes place to avoid possible ethical dilemmas, which can be extremely difficult to solve. The physician has a duty and a moral responsibility to use modern technology responsibly, keeping the best interest of the patient always in mind.

d) Human rights and civil liberties

This pledge, "I will not use my medical knowledge to violate human rights and civil liberties, even under threat", was added after the Hippocratic Oath was amended to form the new Declaration of Geneva. This amendment became crucial after the Second World War after the experiments conducted on civilians and prisoners of war became known. These acts were condemned by the International Military Tribunal at Nuremberg as war crimes and crimes against humanity. This added pledge addresses the moral mindset of physicians and healthcare practitioners, not only working in war situations, prisons or other abnormal circumstances, but anyone dealing with a patient who is at risk of torture be it physically or psychologically. It requires that the attending physician needs to distance him/herself from external powers, political or otherwise. Adhering to this pledge can be difficult in situations where the physician is employed by the government or the Military. The physician finds him/herself once again in a situation of dual loyalties, on the one hand to the employer and on the other hand to the patient.

e) Evaluation of this pledge

With this pledge the issue of 'respect for human life' is controversial. Abortion is legal in many countries worldwide and certain contraceptive methods are

also not compatible with the requirements of this pledge, if a strict interpretation of “human life” is used. I also discussed the issue of dual loyalty of physicians working in the government sector with regards to the ‘human rights and civil liberties’. Although one would expect that physicians would act morally in these special circumstances, enough examples exist where this was certainly not the case, as discussed earlier in this thesis.

5.1.8 *“I make these promises solemnly, freely and upon my honour”.*
In this section I will address the issue of informed consent regarding the Declaration of Geneva and the implications thereof.

a) Informed Consent

This pledge implies that the individual that makes the declaration has been properly informed as to what he/she swears to and understands the content as well as the full implications of the declaration. Therefore one can pose the question as to whether medical students are properly educated and duly informed of the full implications of the declaration, or is the reality that most of them see this document for the first time when they are confronted with it at graduation? One cannot expect of any medical student or any physician to make the declaration, without properly informing them of the content and the implications for them as well as for other people involved.

Informed consent implies that the person seeking consent has to inform and explain and make sure that the individual who gives consent understand what is expected, the appropriate duties and obligations as well as the implications that go with giving consent.

Although some medical schools have ethics programs in place, it remains an open question how much time is spent on education regarding the Declaration of Geneva. Some medical schools have no ethics modules. It seems that in many cases, medical students are expected to make a declaration, which they know nothing about. It seems as if the implications of making the declaration are not explained and that they are only confronted with this document in their

final year, when they are about to graduate, or even at the graduation ceremony for the first time.

The Declaration of Geneva is very vague and makes use of general phrasing without addressing specific issues in medicine. It implies conflicting obligations and dual loyalties as described in the aforementioned. The Declaration does not provide any guidance as to handle these conflicting obligations. Therefore it will be very difficult and even impossible in some respects to fully inform and educate prospective physicians regarding the implications of making the Declaration as these implications are not clear from the Declaration itself.

b) Personal Morality

The values included in the declaration should be an integral part of any physician's personal belief system and should be evident in his/her daily interaction with patients. It seems as if newly qualified physicians make a declaration but are completely oblivious as to its contents and its implications. The next question one needs to ask is, are members of the medical fraternity willing to adhere to the values in the declaration and do they understand the implications not only for themselves but also for their patients? Can one reasonably expect physicians to adhere to the declaration if they were not properly educated and informed of the contents of the declaration?

The declaration expects a high degree of personal morality from a physician. Is this morality a given, or is the process of admission to a medical school geared to attract prospective students of a virtuous character and individuals with a moral conscience? In reality it seems that academic excellence is favoured for admission in undergraduate programs in medical schools worldwide and the moral aspect/virtuous character of the applicant is not included in the admission criteria.

c) Evaluation of the pledge

To conclude one can only expect of a physician to abide by the aforementioned pledges if he/she was properly informed and educated

regarding the content and the implications of the Declaration of Geneva. In the next section I will discuss whether the values entrenched in the Declaration of Geneva can be successfully implemented in daily clinical governance.

5.2. Can these values be enforced/implemented in daily clinical governance?

The truth of the matter is, in a complex world in which the physician has to practice medicine, it becomes more and more difficult and at times even impossible to truly adhere to the full implications of the oath/declaration (Loewy 2007: 7). As already mentioned, oaths/declarations are neither a universal endeavor, nor a legal obligation and swearing to an oath or making a declaration cannot guarantee moral and ethical behaviour on the side of the physician. Although it can be difficult to adhere to these moral values entrenched in the Declaration of Geneva, one should be able to apply these values in a practical manner in the daily practice of medicine.

The Declaration of Geneva clearly demands that a physician will not discriminate against any patient on any grounds – social standing, race, colour, creed, sexual orientation etc. but can this demand be met effectively? Economic standing is virtually implicit in social standing in modern society and not every patient has the same access to funding regarding medical treatment. Different patients belong to different medical aids with a variety of benefit plans, giving them access to a scale of benefits, from very little, to unlimited benefits. The physician does not have any say in this matter as it is a contract between the patient and the medical insurance company and the physician has to fit the treatment into this benefit plan/option. To have certain special investigations done, medical aids first have to approve the funding for these investigations. Physicians are not free to treat their patients in the way that their clinical judgment suggests. Therefore it is often nearly impossible to treat the patient and the illness optimally. In South Africa, most patients do not even have a medical insurance plan, so the physician has to be very creative and innovative in addressing the patient's illness in the absence of any

funding. To meet this demand of non-discrimination is virtually impossible in modern medical care in South Africa, as medical care is a costly exercise, not only on a clinical level, but more so when special investigations are indicated to make a proper diagnosis. One also needs to take into account the costs of medicine. If a patient cannot afford certain medications, the physician has to look at cheaper alternatives, which are not always the best for the patient. Physicians find themselves in this unfortunate position, of having to discriminate on a daily basis on the grounds of social standing – implied by financial standing – due to the costs of healthcare and the prescriptive authoritarian management by medical aid insurance as well as government. Physicians no longer have the freedom or the authority to treat their patients in a non–discriminatory manner due to these external factors.

Physicians increasingly function in a managed healthcare system in South Africa, not only in the private sector but also with the imminent introduction of the National Health Insurance Scheme, in the government sector. The physician is merely an employee in the greater scheme of things where his/her clinical judgment and treatment of a patient is being prescribed by healthcare policies, governmental and private (medical insurance companies), pharmaceutical companies as well as the public demand to contain costs in difficult economic climates. For a physician to fully adhere to the moral values of the Declaration is seemingly more and more difficult and even impossible at times. Medicine is not an exact science and can at best be seen as a science of exclusion, where the physician makes a differential diagnosis to exclude possible diagnoses when a patient presents with a complex clinical picture. In most cases physicians have to rely on special investigations to confirm their clinical suspicions. If this complex management system of funding, policies, and insurance companies do not allow certain investigations to be done within the strict framework of rules, physicians often have to lie or coerce patients to lie in order to get certain investigations done, in order to get a proper diagnosis. Only after a definitive diagnosis can effective treatment be commenced. The physician has to lie to act in the best interest of the patient, a nearly daily occurrence in medical practice in South Africa. If one looks at

the following quote from holocaust literature, one can ask, 'have we really evolved as a society, or are we still stuck in systems detrimental to us all?'

> *"…a political, economic, or cultural system insinuates itself between myself and the other. If the other is excluded, it is the system that is doing the excluding, a system in which I participate because I must survive and against which I do not rebel because it cannot be changed…I start to view horror, and my implication in it, as normalcy" (Barnett: 1999).*

Can medicine as a profession still claim to be a self-regulating profession? It seems as if physicians themselves do not want to get involved when they have knowledge of ethical violations. Medical boards and societies are also hesitant in dealing with violations of an ethical nature, but they are more amenable to deal with technical errors of physicians. In the medical malpractice milieu physicians face civil suits where the physician has been negligent in his dealings with the patients. Under South African law patients can mostly only sue for loss of income due to the effects of the negligence of the physician, in other words technical errors. Violations of ethics have to be reported to the Health Professions Council of South Africa, which then has the legal obligation to investigate. The fact of the matter is that any medical negligence or suboptimal treatment is an ethical matter. Medical negligence equals unethical behaviour on the part of the physician. It seems as if medical councils are more prone to concentrate on the pursuit of technical errors than violations of the Declaration or other oaths. What also happens in reality is that a patient sues a physician for medical malpractice. In an effort to keep the suit contained a financial settlement is agreed upon between the two parties to avoid a court appearance and a long stretched out court case with increased legal costs. In the final agreement in most cases a confidentiality clause is included which prohibits the plaintiff (patient) to disclose the particulars of the case to the relevant professional council or any other third party, allowing the physician to continue to practice medicine.

One should be able to apply moral principles in a practical manner in the daily practice of medicine. Millard and Peel are of the opinion that three moral principles can be useful in governing clinical practice in a practical manner.

"1. Treatment of patients must reflect the inherent dignity of every person irrespective of age, debility, dependence, race, colour or creed.
2. Actions must reflect the needs of the patient…
3. Decisions taken must value the person and accept human mortality."

Medical care based on these moral principles will be possibly limited by the physician's skills, resources and expert opinions available, but it should always be patient centered (1998: 1749). One can ask if such an approach to medicine is still possible in a society fragmented by different moralities beliefs, and moral values, or even the absence thereof? Due to the complex nature of the healthcare industry in the 21st century a physician can only strive to place the interests of the patient first, but it is becoming more difficult due to all the demands that need to be satisfied from all the different aforementioned external sources.

To conclude, in this chapter I evaluated the various pledges of the Declaration of Geneva. I have shown that each of the respective pledges fails to a certain degree to address the contemporary issues in medicine. In my opinion it seems as if the Declaration of Geneva cannot address the developments of modern medicine fully and can merely be seen as a symbolic moral guide rather than a working document in the socially and morally fragmented world in which the modern day physician has to work. It seems as if the pledges in the Declaration of Geneva should be the ultimate goal in the physician-patient relationship and the moral physician can at best only strive to fulfill the moral obligations and duties required in the Declaration of Geneva.

In the next chapter I will explore the possibility of a new medical professionalism that could guide the physician on a more practical level through the complexity of modern day medicine with its demands from society, patients and physicians.

CHAPTER SIX

From Oaths / Declarations / Codes to Medical Professionalism

6.1 Introduction

In this thesis I have tried to demonstrate that neither the Hippocratic Oath, nor the Declaration of Geneva, can be seen as an active moral guide for medical students as well as qualified physicians. These two documents also cannot serve the interests and the demand of modern pluralistic societies due mainly to moral fragmentation. As I have demonstrated in previous chapters, the Declaration of Geneva is too vague and non-specific to give guidance on specific moral issues that arise in the complex context of modern medical practice. It seems as if oaths, declarations and codes have become inadequate to address the demands and realities of modern medicine mainly because of radical changes at the scientific and technological level. Changes at the social, political and economic level in societies across the world demand a newer perspective regarding a moral guide for physicians in clinical practice. It seems as if the usefulness and applicability of oaths and declarations have declined and one can ask whether oaths and declarations still have any moral relevance, or whether they are documents of a merely symbolic nature. Therefore the central moral question of this thesis: Should the medical profession move away from oaths, declaration and codes and establish a new medical professionalism where more emphasis is placed on virtues?

In this chapter I will focus on arguing for the reconstruction of a medical professionalism and continued education in medical professionalism at the undergraduate as well as the post-graduate level. Oaths, declarations and codes do not adequately address the requirements of modern medicine on a moral level anymore. This has led to the need for a newer medical professionalism to address the changes that threaten the very nature and

values of medicine as a profession. The reconstruction of medical professionalism should be based on the moral principles of patient welfare, patient autonomy as well as social justice keeping in mind the higher values of medicine and the virtues required of a moral physician. This goal can only be attained if physicians become a unified moral community adhering to a common set of moral precepts. It is also imperative that these principles of medical professionalism be advanced through continued medical education on all levels throughout the physician's career.

6.2 Problems with Oaths, Declarations and Codes

In my discussion on oaths, declarations and codes, I came to the conclusion that although these documents are interdependent, and have different functions, not one of these documents can have a meaningful impact on the ethical behaviour of a physician. The intention is that oaths and declarations supposedly should act as moral guides, but the question remained as to whether these documents have an active role in clinical medicine, or whether they are merely of a symbolic nature? Codes on the other hand can be used as an instrument through which medical councils can hold a physician legally accountable for ethical transgression using the adopted ethical guidelines. The moral function of codes is however debatable as physicians could very easily function within the constraints of the guidelines without acting morally, leading to the phenomenon known as checklist ethics.

Despite the World Medical Association's efforts to formulate a new universal document to be used by all physicians internationally in the Declaration of Geneva, as well as numerous revisions thereof, this attempt has been unsuccessful. I clearly demonstrated this by the fact that so many different versions of oaths and declarations are being used. It seems as if the Declaration of Geneva is used as a guideline to formulate different versions of oaths and declarations. No universal oath or declaration is being used by all prospective physicians worldwide.

By looking at the consequences of the changes to the Hippocratic Oath, I came to the conclusion that the well-intentioned changes are merely symbolic in clinical medical practice. It was shown that these changes had little effect on many physician's moral behaviour. There is even tension between the more practical requirements of codes and the required moral values and standards of the Declaration of Geneva. It seems as if the humanitarian goals set by changing the Hippocratic Oath to the Declaration of Geneva are ideals towards which the medical profession constantly must strive but that in clinical practice it seems as if these goals are not easily attainable.

Even if one evaluates the various pledges of the Declaration of Geneva, it is evident that each of the respective pledges fails to address relevant issues in modern medicine. It seems as if the Declaration of Geneva did not keep pace with modern advancements in clinical medicine and therefore can only be seen as a symbolic moral guide rather than a working document. One has to come to the conclusion that while the goals of the Declaration of Geneva should be the ideal in the physician-patient relationship, a moral physician can only strive to fulfill these moral obligations and duties but that this commitment is often thwarted in modern clinical practice.

6.3 Development of Medical Professionalism

The apparent deficits of the Declaration of Geneva have led to the need for the development of a new medical professionalism. In 2002 the ABIM Foundation, American College of Physicians Foundation and the European Federation of Internal Medicine jointly wrote and compiled the document, 'Medical Professionalism in the New Millennium: A Physician Charter'[10]. This publication was seen as a watershed event in medicine.

The Charter mainly addresses certain fundamental principles and professional commitments. The principles that are addressed are patient welfare, patient autonomy and social justice. Important commitments that are discussed are

[10] Physician Charter. 2002. [Online]. Available: http://abimfoundation.org/Professionalism/Physician-Charter.aspx [2015, October 17]

improving access to high quality health care, cost effective distribution of limited resources and managing conflicts of interest to maintain trust.

According to Miles (2002: 46) the “Charter on Medical Professionalism” states that modern day physicians are frustrated by the fact that changes in health care delivery systems threaten the nature and values of medicine. The main threats include “increasing disparities among the legitimate needs of patients, the resources to meet those needs”, “market forces that are transforming health care” and “the temptation for physicians to forsake their traditional commitment to the primacy of patient interests” (cited in Miles 2002: 46). Swick (2006: 263) is of the opinion that the need for a new medical professionalism is driven by the following factors: “intrusions of government business and other external forces of change, the transformation of medical practice from a professional to a business model, a perceived erosion of social responsibility and concern within medicine and indeed throughout society about what constitutes a profession and hence the nature of ‘professionalism’”.

6.4 What is a Profession?

According to Swick (2006: 263) a profession must fulfill the following criteria: “work that is intellectual and involves the application of a specialized body of knowledge; work that is pursued primarily for others and not for oneself; public recognition of the ability to oversee and regulate practice standards; and a commitment to service”.

Pivotal to a profession are its moral and ethical dimensions as well as the commitment to service. This commitment to service brings about the dimension of public value and public responsibility. Swick (2006: 264) is of the opinion that this ethos of public responsibility means that physicians are not only responsible to their own patients but also to society which implies that they should assist in addressing the challenges experienced not only by their own patient but also by the wider society. Medicine is different to other professions due to the demand for a high level of service that “transcends

personal gain". This is the main characteristic of true professionalism. Medicine further differs from other professions due to the fact that medical professionalism has to include higher values for example, beneficence, compassion and altruism. These values are grounded in a virtue-based ethic. These values should be emphasized in the early training of medical students in order to form the basis of true medical professionalism so that the goal of service that clearly transcends self-interest can be attained. Only then, one can speak of a true medical professionalism.

6.5 Reconstruction of Medical Professionalism

According to Miles (2002: 47) "The Charter on Medical Professionalism" defines the new medical professionalism as commitments to: "patient confidentiality", "quality of care and reduction of error", "improving access to care", "fair distribution of finite resources", "scientific knowledge", "maintaining trust by managing and disclosing conflicts of interests", "maintaining professional competence", "honesty with patients", "fulfilling professional duties for the oversight of the profession and as needed to "improve the quality of health care" and "avoiding financial or sexual exploitation of patients". According to the charter, the three ethical principles of importance to satisfy these commitments include the primacy of patient welfare, patient autonomy and social justice.

These commitments can be seen as a list of duties and obligations towards the patient and to a lesser extent towards society, but is duty enough? No mention is being made of the higher values of medicine as mentioned previously as well as the fact that the medical profession should be seen as a moral community. Although the importance of virtues is implicit, very little emphasis is placed on the role of virtues as well as virtue ethics.

Swick (2006: 274) makes a distinction between basic and higher professionalism. Basic professionalism has to do with "doing the right thing well" and higher professionalism differs in that it is "service that clearly transcends self-interest". It is this requirement of subordination of the

physician's own interest that should form the core of medical professionalism, and not only a list of duties and obligations as suggested by the Physician Charter of Medical Professionalism.

Pellegrino (1990: 221) is of the opinion that medical professionalism could only succeed if the medical profession recognizes the fact that they are a moral community: a group dedicated to a common set of moral precepts. As oaths and declarations are no longer the binding force which it used to be the idea of a collective moral identity has suffered severe erosion, due to social and cultural forces as discussed earlier on in the thesis. This deterioration of medicine as a moral community has led to severe consequences for the profession and society. These consequences include: no collective voice for patients, the undermining of ethics due to the dominance of market forces, the endangerment of patient welfare as well as the privileging of personal survival over moral purpose. It seems as if patient care is no longer a primary concern. This lack of moral cohesiveness by the medical profession can only be seen as self-defeating. This has led to a loss of control and authority by the medical profession and has handed the control of the profession effectively to external role players where economic influence is the dominant factor.

Furthermore Pellegrino argues that medicine can be seen as a "de facto moral community", not only because of a common purpose and a set of ideals, but purely because these ideals are morally grounded. He identifies four aspects of medicine that give moral status to the members of the profession: "the inequality of the medical relationship, the nature of medical decisions, the nature of medical knowledge, the ineradicable moral complicity of the physician in whatever happens to his patient." (1990: 226). The moral community of medicine with its collective moral power and support is imperative for the profession, as no physician can fulfill the obligations required of him/her alone. Without collective moral support it will be very difficult for physicians to adhere to the moral obligations and duties as required by oaths, declarations and codes.

In practical terms Pellegrino (1990: 229) emphasizes that if we do not address the constant tension between the market-based ethos and the moral nature of the physician-patient relationship, a collective moral identity remains an unattainable ideal. Moral erosion due to external forces severely compromises the moral integrity of the medical profession. One can only start to develop a new medical professionalism if physicians start to take action to resist the influence of external forces, not only on physicians, but on patients first and foremost.

In this thesis I have pointed out the deficits and problems with oaths, declarations and codes extensively. These documents seem to be only of a symbolic importance but lack practical moral guidance for the modern day physician due to a variety of reasons. It seems as if medicine as a profession has lost its collective voice and thereby its control and authority regarding patient welfare as well as physician welfare. In my opinion the only way that the medical profession as such can regain control and its authoritative voice is by once again recognizing the collective moral force as a profession on a practical level. Physicians as a unified group should emphasize the importance of values and virtue ethics and place patient welfare and patient care as their primary concern. Instead of succumbing to external forces, mainly of an economic nature, physicians should recognize the erosion that these forces have on patients and subsequently patient care and welfare. This can only be accomplished if physicians view themselves as a unified moral community with not only shared moral commitments and ethical principles as described in the Charter on Medical Professionalism, but also shared moral values and virtues. By educating prospective physicians from early on in the undergraduate years in medical professionalism, I believe this can be accomplished to re-establish the lost unified collective moral voice and force of physicians internationally.

6.6 Education and Medical Professionalism

As previously discussed professionalism is on the decrease due to a failure to satisfy the expectations of patients, society as well as physicians themselves. It seems as if the lack of dedication to the core values of the profession is to blame for this state of affairs. This brings one to the following question: How does one transform a person on entry to medical school into a professional physician, even when there is seemingly a lack of intrinsic virtues?

According to Smith (2005: 439) the core of medical professionalism is the personal transformation of the self that should happen during the early years as a medical student. This transformation could only happen if medical students embrace physicianhood and the personal transformation that is of the utmost importance in establishing medical professionalism. Medical students will have to prioritize patient care first and deliver this care with quality, honesty and integrity. In order to accomplish this, the future physician has to possess certain essential attributes specific to being a physician. These attributes include the following according to Smith (2005: 441): “embrace being a physician, caring and altruistic, honesty and integrity, team player, strive for excellence, accept the duty for serving patients and society as well as courage and heroism”.

Medical students will have to understand, accept, and transform into their new role as physicians. This is, according to Smith (2005: 441) the most critical element in developing medical professionalism.

The aforementioned raises the question, how does one go about establishing medical professionalism in medical schools? Larkin (2003: 168) argues that virtue driven aspirations and ideals could serve as the map to good clinical practice, but these virtues must be developed with practice and repetition. Larkin calls this process virtue promotion. Virtue promotion can only happen if the teaching institution leads by example. The responsibility to guide a prospective physician regarding ethics, professionalism, interpersonal skills and multicultural agency lies largely with the teaching institution. This can be

done by constant ongoing education in medical ethics and not only one or two modules over the lengthy period of undergraduate education. Ethics and professionalism should form part of every aspect of the different subjects and modules in the medical course. Students should not see it as a different entity that can be used on an intermittent basis. The goal of teaching ethics and professionalism should form an integral and daily part of medicine to form a firm base on which the prospective physician can develop his/her own morality on a practical level. Education should take the form of practical interactive discussions based on personal experience to make them sensitive to moral issues in the daily practice of medicine. Furthermore Larkin (2003: 171) is of the opinion that academic medicine can only make positive strides if they recognize human excellence and make a concerted effort to nurture the concept of model clinicians. Further steps that can be taken include the concept of mentorship at the undergraduate as well as at the post graduate level. Mentorship can have a dual purpose in, not only monitoring behaviours but also providing mentor-driven remediation in the cases of unprofessional behavior with the emphasis on helping and not necessarily punishing. This advisory role of academic staff can be seen as an integral part of their professional life. Larkin (2003: 174) is of the opinion that mentoring also enhances the mission of lifelong learning.

One can no longer assume that all prospective physicians have the necessary virtues and moral conscience on entering medical school. Although oaths, declarations and codes can serve as a symbolic moral guide, one needs to look at more innovative ways to nurture a moral mind in modern medicine, even if unconventional methods are required. Only then can a newer universal medical professionalism be developed to supplement and support the goals of oaths, codes and declarations.

6.7 Conclusion

Pellegrino (2006: 65) is of the opinion that universal agreement on moral issues between physicians and patients as well as amongst physicians themselves is no longer possible. However, he believes that a reconstruction

of a new professional ethics is possible as well as necessary based on the appreciation of what a true healing relationship is between patient and physician.

In this thesis I have shown that oaths and declarations are no longer the moral binding force that they used to be. Oaths, declarations and codes are limited in what they can achieve establishing a moral environment in which a physician can function in modern medicine. Certain demands from society as well as from physicians cannot be met any longer by these aforementioned documents as discussed in this thesis.

This thesis posed the following central question: Should the medical profession move away from oaths, declarations and codes and establish a new medical professionalism where more emphasis is placed on virtues? In Chapter One, I provided the background to this question by considering the role of pluralistic societies and moral fragmentation in the complexities of modern medicine. I then went on to address this question by discussing the characteristics of oaths, declarations and codes in Chapter Two and by comparing these documents and highlighting their differences. I also looked at the purpose of these documents and explored the duties and obligations entrenched in these documents. In Chapter Three I looked at how the Hippocratic Oath was changed to form the new Declaration of Geneva and discussed the current state of oaths, declarations and codes. In Chapter Four, I discussed the consequences of changing the Hippocratic Oath, with particular reference to the symbolic and practical consequences and argued that these changes did not have the desired effect on the behaviours of physicians. In Chapter Five I specifically evaluated the relevance and applicability of the various pledges of the Declaration of Geneva and argued that this declaration is insufficient to serve as a moral guide for decision-making in practice.

In my opinion, oaths and declarations, although symbolic in nature, should not be discarded altogether but should be used to emphasize the moral nature of medicine as a profession. Ethical codes should be used as standards and rules of behavior for physicians by medical councils, in a practical manner to

address ethical transgressions by individual physicians. However, not one of these documents can function on its own and are interdependent on each other as I have shown in my discussion.

Although all these documents are in use in various forms, ethical transgressions are still the order of the day and seemingly on the increase, demanding a newer approach to medical professionalism as I have argued in this chapter. In order to attain this goal of a medical professionalism, physicians should focus once again on the higher values of medicine and start with the basic common denominator, the patient in the physician-patient relationship. Based on the values and obligations entrenched in this relationship physicians should once again identify with a collective moral identity in order to establish a medical professionalism where the needs and obligations towards the patient are of pivotal importance. Only then the process of moral erosion brought on by external forces can be resisted.

The establishment of a medical professionalism should be seen as a constant work in progress, starting at the admission process of prospective medical students, where more emphasis should be placed in the admission criteria on the individual student's virtues and character and less emphasis on academic excellence. A healthy balance should be achieved between these two very important criteria in allowing a student to study medicine. During the medical course, ethics and medical professionalism should form an integral part in the education process in an ongoing fashion by means of integrating values, norms and standards in all the various disciplines. Only by continued medical education and constant mentorship, reinforcing the values and virtues necessary in the practice of medicine, can one hope to establish a medical professionalism where the patient and the physician-patient relationship will once again be the most important entities in modern medicine.

Addendum A

Hippocratic Oath

I swear by Apollo, the healer, Asclepius, Hygieia, and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgment, the following Oath and agreement:

- To consider dear to me, as my parents, him who taught me this art; to live in common with him and, if necessary, to share my goods with him; To look upon his children as my own brothers, to teach them this art; and that by my teaching, I will impart a knowledge of this art to my own sons, and to my teacher's sons, and to disciples bound by an indenture and oath according to medical laws and no others.

- I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone.

- I will give no deadly medicine to any one if asked, nor suggest any such councel; and similarly I will not give a woman a pessary to cause an abortion.

- But I will preserve the purity of my life and my arts.

- I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners, specialists in this art.

- In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction and especially from the pleasures of love with women or men, be they free or slaves.

- All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal.

- If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all humanity and in all times; but if I swerve from it or violate it, may the reverse be my life.

Addendum B

Declaration of Geneva

- At the time of being admitted as a member to the medical profession,
- I solemnly pledge myself to consecrate my life to the service of humanity;
- I will give to my teachers the respect and gratitude that is their due;
- I will practice my profession with conscience and dignity;
- The health of my patient will be my first consideration;
- I will respect the secrets that are confided in me, even after the patient has died;
- I will maintain by all the means in my power, the honour and the noble traditions of the medical profession;
- My colleagues will be my sisters and brothers;
- I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;
- I will maintain the utmost respect for human life;
- I will not use my medical knowledge to violate human rights and civil liberties, even under threat;

- I make these promises solemnly, freely and upon my honour.

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