

MEDICINE AND THE LAW

The Life Esidimeni tragedy: Moral pathology and an ethical crisis

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The Life Esidimeni tragedy highlights several ethical transgressions. Health professionals' ethics are put to the test when their own interests are balanced against competing claims. Core values of compassion, competence and autonomy, together with respect for fundamental human rights, serve as the foundation of ethical practice in healthcare. These values are increasingly being challenged by governments and other third parties. The duties conferred on healthcare practitioners require them to act responsibly and be accountable for their actions. Codes in healthcare serve as a source of moral authority. The Gauteng health authorities exerted tremendous power and created a culture of fear and disempowerment among healthcare practitioners. When health professionals choose to support state interests instead of those of patients, problematic dual-loyalty conflicts arise.

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'In time, we shall be in a position to bestow on South Africa the greatest possible gift – a more human face.' (Steve Biko^[1])

The Gauteng Mental Health Marathon Project highlights shocking ethical transgressions. While the Health Ombud's report^[2] underscored the three most senior officials in the Gauteng Department of Health (GDoH) as the most culpable, several other health professionals were also implicated. However, many others attempted to avert the predicted disaster by drawing on ethical values in medical practice and their technical and clinical skills. It is sad that their efforts were ignored by the two senior members in the Department, the Head of Department (HoD) and the Director Mental Health Services, both health professionals who could have challenged the overall head and member of the Executive Committee, GDoH, rather than succumbing to the pressure she exerted. The tragedy raises several ethical issues, including the ethical dimensions of healthcare practice, the moral authority of codes and oaths, dual-loyalty conflicts and human rights violations. It serves as a harsh warning for the need to return to basics to understand the meaning of being a healthcare professional.

The ethical dimensions of healthcare practice

Health professionals' ethics are put to the test when their own interests are balanced against competing claims. Practice in healthcare, whether at policy decision-making level or in management, administration or the patient-practitioner relationship, requires the effacement of self-interest even to the point of personal risk. Altruism remains a moral obligation in this context. Certain obligations specific to healthcare distinguish it from other careers:^[3]

- Ill-health results in patients being vulnerable, dependent, relatively powerless and exploitable. A health need can be likened to a moral claim on those that have been trained to help.^[2]
- An education in healthcare is a privilege. It involves invasions of privacy such as dissecting the human body, training using sick patients, and clinical research. Because society permits this, healthcare professionals automatically become parties to a collective pledge.^[3]

- New graduates publicly acknowledge the pledge when the oath is taken at graduation, a promise that the gravity of their calling is understood. There is also a promise to be competent and to use that competence in the interests of the sick.^[3]

The World Medical Association (WMA) states that practitioners must know and exemplify the core values of medicine, especially compassion, competence and autonomy. These values, together with respect for fundamental human rights, serve as the foundation of ethical practice in healthcare. While compassion, competence and autonomy are not exclusive to healthcare practice, its practitioners are expected to epitomise them to a higher degree than in many other professions.^[4]

Compassion, described as understanding and concern for another's distress, is essential in healthcare.^[4] It is a crucial trait required to deliver morally good care and is closely linked to caring. Empathy, where practitioners put themselves in the patient's situation of pain and suffering and recognise their care needs, is essential for caring. Caring practitioners engage with the needs of patients and undertake to meet these professionally.^[5]

A high degree of competence is expected and required from healthcare practitioners because incompetence can result in serious morbidity or death. A truly competent healthcare professional requires scientific knowledge, technical skills, and also ethical knowledge, skills and attitudes.^[4]

Autonomy or self-determination is the core value that has undergone change over time. Globally, practitioners have accepted the notion of patient autonomy, which mandates patients to make decisions in matters that affect themselves. Moreover, practitioners have traditionally enjoyed a high degree of autonomy in managing patients. However, governments and others have increasingly challenged the core foundational values of practitioners.^[4]

Professionalism and professional integrity

Practice in healthcare, irrespective of the context, is a moral and social contract between the profession and the public. Its nucleus is

professionalism and professional integrity, against which patients and the public measure their expectations of healthcare professionals.^[6] In healthcare, professionalism has been defined as ‘... an occupation that is characterised by high moral standards, including a strong commitment to the well-being of others, mastery of a body of knowledge and skills, and a high level of professional autonomy.’^[7]

The goals of healthcare are always caring for the sick, promoting health interests and wellbeing, and striving towards a healing environment.^[8] Healthcare practitioners bridge the gap between science and society and are important agents through which scientific knowledge is applied to human health. However, practice in healthcare is also about experiences, feelings and interpretations of human beings in often extraordinary moments of fear, anxiety and doubt. In this vulnerable position, professionalism underpins the trust that the public has in healthcare practitioners.^[9] Professional integrity and honesty are pivotal for upholding their reputation and credibility.

Professionalism in healthcare is regulated to protect the public from unsafe practices; to set professional and ethical standards to ensure quality service; and to confer responsibility, accountability, identity and professional status upon practitioners.^[6] The duties conferred on healthcare practitioners require them to act responsibly and be accountable for their actions, with responsibility denoting a duty to satisfactorily perform some function, and accountability that of giving an account of one’s acts or omissions.^[6] In some situations control of healthcare has steadily been moved away from healthcare practitioners to professional managers and bureaucrats, and sadly, some see healthcare practitioners as obstacles rather than partners.

The moral authority of codes and oaths

Codes serve as a source of moral authority and are used among professionals and lay persons to set standards for ethical conduct, to define new ethical issues, and to support positions in ethical discourse.^[10] Despite the Hippocratic Oath being over 2 500 years old, the principles have remained relevant and have been included in modern versions of the oath by the WMA^[11] and the International Council of Nurses (ICN)^[12] and nationally by statutory councils including the Health Professions Council of South Africa^[13] and the South African Nursing Council (SANC).^[14] South African (SA) health science faculties have also developed their own versions of the oath.

Nursing codes and oaths

The Florence Nightingale Pledge,^[15] first taken in 1893, is an adaptation of the Hippocratic Oath emphasising the following principles: Leading by example, Faithfulness, Accountability, Responsibility, Confidentiality, Devotion and Quality. An international code of ethics for nurses was first adopted by the ICN in 1953, its latest revision being in 2012.^[16] While the SANC Code of Ethics for Nursing Practitioners^[17] was promulgated in May 2013, the Nurses’ Pledge of Service^[18] as mandated by the SANC to be taken by all nurses is nearly 50 years old. Service to humanity, practising with conscience and with dignity, pursuing justice and advocating on behalf of vulnerable and disadvantaged patients are the principles that resonate through the codes and oath.

Despite the public promise of allegiance to these values, the Director of Mental Health, a nurse by training, ruthlessly executed the Gauteng Mental Health Marathon Project, albeit being advised by concerned clinicians against the move. At the Health Ombudsman’s enquiry, she stated that she understood the risks raised by specialists,

and yet went ahead and licensed non-governmental organisations (NGOs) to take over the ‘care’ of the patients whose discharge and transfer she was directly responsible for. The Ombud concluded that she was responsible for several faulty decisions that at times changed the final course of events in the project and were central to the disaster. She was key to the rushed and chaotic transfers without medical records and discharge summaries to ill-equipped, unprepared and poorly staffed NGOs.^[2] She issued licences without service level agreements (SLAs) and did not specify the service level requirements. When the SLAs were later issued, they did not even make it obligatory for meals to be adequate to meet patient needs. While she admitted that community services for intellectual disabilities were not well established or developed, she attributed the deaths to winter due to the vulnerabilities of the patients. Staff at the NGOs were untrained, unqualified, and lacked basic competence or experience (including lack of leadership and managerial staff). Regrettably, NGOs could not distinguish between the professional care requirements of these patients and a business opportunity.^[2] Patients were objectified as commodities, for sale in a marketplace, and as business prospects.

Medical codes and oaths

The Hippocratic Oath embodies the highest aspirations of the healthcare professional and stipulates two categories of duties: to the patient and to other members of the profession. It emphasises the duty of the practitioner to help and not harm patients:^[19] ‘I will apply dietetic measures for the benefit of the sick according to my ability and judgement; I will keep them from harm and injustice.’

The WMA Declaration of Geneva,^[20] adopted by the second General Assembly of the WMA in September 1948 and amended several times including in June 2017, is the modern version of the Hippocratic Oath. Its pledge is to devote life to the service of humanity, to practise with conscience and dignity, to ensure the health of the patient as the doctor’s first consideration, not to allow certain considerations, including political affiliations, to intervene with the doctor’s duty to the patient, and to maintain the utmost respect for human life. Graduates from SA medical schools take modified Hippocratic Oaths before commencing medical practice. While the texts differ, all pledge devotion to the service of humanity and conscientious and dignified practice.

The HoD, GDoH, was unaware of the number of deaths when interviewed by the Health Ombud, but reduced the issue to a ‘number game’. He did not correlate the deaths with poor planning, but admitted that it was inhumane to move patients between NGOs. He stated that staff were put under extreme pressure because of the project and that this led them to cut corners and make errors during implementation. He indicated that junior officials were constrained to do as directed.^[2] He was aware that communities had not matured to the extent of deinstitutionalisation. He agreed that the project could have been done differently, and that leadership got too involved and made the managers commit serious errors in execution. He admitted that families were forgotten in the process. The Ombud found that his evidence was evasive and contradictory and stated that following the interview, Dr Selebano back-dated all the licences to 1 April 2016 and did not indicate the date on which he signed them.^[2]

Despite knowing that the approach to the project and the implementation processes were wrong, and despite being ‘sidelined’ when putting a viable alternative on the table, Dr Selebano continued to administer the wrong actions as HoD. He was aware that communities had not matured and were not ready and that

deinstitutionalisation was premature, yet as HoD he allowed it. Professional integrity and honesty are measures of the extent to which the professional's reputation and credibility remain untainted, yet he back-dated licences and did not include the date on which this was done on the documents.

It is perplexing that despite the immense scale of the tragedy, he did not inform the Ombud where the pressure came from and who stalled the process of the purchase of Life Esidimeni, and therefore by inference was 'protecting' someone. As a doctor, he needed to use his professional judgement and not to have allowed extraneous factors to interfere. The fundamental role of healthcare professionals is to alleviate the distress of their fellow human beings, and no motive, whether personal, collective or political, must prevail against this higher purpose.^[21]

Medical and death certificates

The Ministerial Advisory Committee's report on this tragedy states that there was no evidence to show that patients were evaluated to determine functionality or acuity levels before placement with NGOs. Neither were they medically and functionally examined and assessed on admission to the NGOs. In some cases patients arrived at facilities already very ill, frail, weak and with severe bedsores; most were profoundly disabled.^[2] The unanswered question is who discharged these patients from Life Esidimeni, especially in light of there being no evidence of evaluation prior to discharge. According to the Ombud, only 13 of the 38 that his report was confined to were regarded as fit enough for transfer.^[2]

In terms of the Mental Health Care Act,^[22] different forms are to be completed when a patient is discharged, transferred or remains an assisted mental healthcare user (MHCU). Should the patient's condition improve to the extent of being able to make an informed decision and provide valid informed consent, the patient is then discharged to outpatient care as a voluntary MCHU. A Form 03 is required for this together with clinical evidence of recovery in capacity to consent. It was found that Form 03s were completed for 11 patients as discharge forms. However, only one patient had clinical evidence of recovery of capacity to consent. There was no evidence of this recovered capacity in the other 10 because of the irreversible nature of the primary cognitive impairment.^[2]

The Births and Deaths Registration Act^[23] provides for medical practitioners who attended to patients before their death to issue a Notification of Death Certificate stating the cause of death conditional to being satisfied that the death is due to natural causes. Where the practitioner has not attended to the patient prior to death but examines the corpse and is satisfied that the death was due to natural causes, a prescribed death certificate may be issued. If a medical practitioner is of the opinion that the death was not due to natural causes, the Notification of Death Certificate requires that 'unnatural' is certified and the police informed.

According to the Ombuds Report, several of the deceased had died from illnesses that questioned the conditions/circumstances under which they were being cared for and the quality of care they received at the NGOs, e.g. fits, dehydration, aspiration pneumonia, acquired pneumonia, cardiac arrest, 'being found dead in the morning without night observations'. These deaths were recorded as natural in the death certificates.^[2] This is corroborated by a review done by Health-E News of 34 family affidavits and death certificates which revealed that 85% of deaths were certified as natural and some were in contravention of SA law.^[24] Notification of Death Certificates were signed by different medical officers, showing a trend across the health profession in which they ignored or did not

see the signs of neglect and abuse that pointed to poor treatment of these patients. Almost 50% were incorrectly completed, some with cause of death left blank and some with only natural causes filled in.^[24] Given the conditions surrounding the deaths of these patients, it is problematic that so many deaths were from 'natural' causes and it is of concern that the Births and Deaths Registration Act^[23] was probably infringed.

Issuing a medical certificate highlights doctors' unique privilege and power. Accordingly, attention to integrity, truthfulness and responsibility is ethically essential. The actions of these doctors were not consistent with the oaths taken to practise their profession with conscience and dignity and to uphold the honour of their profession. The fraudulent signing of the medical and death certificates is an unhappy reminder of Steve Biko's death. Despite the fact that he had been walking with an ataxic gait and had evidence of lacerations and bruising, the medical certificate provided by the doctor stated that there was no evidence of abnormality or pathology on the patient.^[25] Submissions on false medical reports were made in SA's Truth and Reconciliation hearings on the health sector. Extensive complicity of health professionals in falsifying death certificates and medical records to move responsibility away from state forces was reported. Records failed to mention bullet wounds, neglect and trauma from prolonged abuse.^[26] While employment relationships may increase the difficulty of complying with duties to the human rights of patients, health professionals must comply with the oaths taken at graduation and the several other international and local codes and declarations. There is no place for lip service to oaths in the context of healthcare.

Conclusions

When health professionals choose to support state interests instead of those of patients, problematic dual-loyalty conflicts arise. Repressive governments generate some of the gravest human rights violations because of dual-loyalty conflicts.^[27] However, as seen by the Life Esidimeni tragedy, this can also occur in open societies where policies imposed by state actors and pressure to yield to their powerful interests violate healthcare rights. Pressures include the culture of the institution and fears or threats of professional harm. Third-party interests that conflict with patients' medical interests, are irrelevant to the health professional's concern for the 'patient as a patient'.^[25] An understanding of the gravity of their calling is necessary so that they can have the courage to withstand institutional pressures. The three key players identified in the Ombud's report^[2] exerted tremendous power and created a culture of fear and disempowerment. The Director and HoD clearly did not take the gravity of their calling as health professionals seriously. This tragedy also highlights that political appointments fail our patients and our country and result in politics determining ethics – a moral pathology that must be eradicated for the ethical crisis to be comprehensively addressed. The treatment of mentally ill patients in the Gauteng Mental Health Marathon Project is a reminder of how most citizens in our country were treated before 1994 – oppressed, subjected to the repressive apartheid regime, and considered to be subhuman, lacking human dignity and of decreased or no moral status. The apartheid government conducted itself with impunity. The leadership of the Gauteng Mental Health Marathon Project conducted itself with impunity, and in so doing betrayed our Constitution and their oaths taken as health professionals.

Steve Biko died for an idea that would live, that of bestowing on SA the greatest possible gift – a more human face. We cannot allow that idea to be killed by those who do not care.

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