Advancing Global Bioethics 13

Nico Nortjé · Willem A. Hoffmann
Jo-Celene De Jongh *Editors*

African Perspectives on Ethics for Healthcare Professionals

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Volume 13

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Foreword

The functioning of society at large is based on the notion of attaining what is good and has consequently developed various traditions, theories and declarations to guide this aspiration. The African continent is characterised by a multitude of different cultures, each with its unique and different perspectives and histories. During the nineteenth and twentieth centuries, many African countries were colonised by predominantly European empires who enforced their own value system, often in an attempt to suppress or even negate the local traditional value systems. However, the many decades of colonisation were followed in the late 1990s with a general movement that coined the African Renaissance. This movement attempts to overturn and change the widespread negative effects of colonisation by instilling a new focus, renewal and appreciation of all African traditional customs, beliefs and values in every conceivable sector of society. A very significant contribution of the African Renaissance movement to the global ethics discourse is African people's unique perspectives on personhood and "being a good person".

The values and perspectives connected to traditional healthcare in Africa often link illness to an understanding of cosmology where the connectedness of the individual to his/her family (living and dead), clan and society is as important to understanding illness and to healing as the ultimate treatment of the specific illness. Africans at large view healing as a holistic process with porous boundaries where external and internal realities are not sharply separated. This view can potentially result in significant tension in contexts where it comes in contact with predominantly Western views of medicine. This tension may even be exacerbated by the curricula that many healthcare training programmes in African higher education institutions follow, especially when the curricula have not yet critically engaged with and/or integrated African values with the often dominant Western value system and principles. Although one should not negate the valuable contributions that the science of medicine and healthcare has brought to the African continent, the critical question is how African values, principles and knowledge can be effectively disseminated, integrated and practiced in African healthcare contexts that take care of persons who are often more vulnerable than a similar person in a developed world context.

It is with a great appreciation for the uniqueness of the people of this wonderful continent, as well as for the colourful stories and anecdotes of healthcare providers, that this volume was conceptualised. It is our belief and hope as editors and authors of the various chapters that this volume provides a platform for African healthcare providers to contribute to the movement of global bioethics and to inform the world of the exceptional ways that ethics is practiced on our continent.

Leading scholars from various healthcare disciplines, which are normally underrepresented in ethics literature, have combined their years of teaching and practical experience to share their insights into ethical issues faced by practitioners within their respective healthcare disciplines. All the authors are sons and daughters of Africa and have worked in healthcare for several years. Their vast experience brings with it an innate understanding of the uniqueness of the African continent and also the challenges posed in the drive to establish the discipline of ethics across the continent.

The respective chapters in this volume have been arranged in a way that provides the reader an understanding of the specific ethical issues faced by healthcare professionals in a specific discipline on the African continent, followed by another chapter focussing on a more in-depth study of ethical issues by South Africa healthcare professionals in the same discipline. However, it must be noted that this chapter division does not in any way imply, suggest or indicate that South African issues are unique or superior to that of the rest of Africa. Rather, the fact that some chapters focus on South African (regional) issues, while others on more continental issues should be viewed against the aspiration to illustrate the diverse nature of the ethical debate on the African continent, which we hope will ultimately contribute to the richness and diversity of the discussion. The aim of this volume is to establish the importance of Africa as a continent rich in ethical narratives, while recognising that many issues faced by healthcare practitioners in Africa are unique to the continent. All the authors have strived to include indigenous knowledge derived and developed from their experiences and observations of current and past generations in order to inform ethical choices in future situations. As such, this volume is intended to serve as an introductory overview of professional ethics in the context of healthcare provision in Africa, as well as a handbook for educational purposes.

All the chapters were written by experienced academia and underwent three rounds of blind peer review. All the reviewers' comments and suggestions raised in the first round were duly integrated into the chapters by the respective authors and then again reviewed by the same reviewers in the second round. A third round of review by a panel of external expert reviewers took place when the manuscript was formally submitted to the publishing house. Again, all the review panel's comments and suggestions raised were duly integrated into the chapters by the respective authors. We are therefore confident that the scholarly work presented here will inform the debate on ethics in Africa in a positive and constructive manner.

It is our hope that ethics teaching and ethics education will be enriched through this volume.

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Chapter 1
Bioethics and Its Development on the African Continent

Nico Nortjé, Joseph Mfutso-Bengo, and Willem A. Hoffmann

Abstract What makes a good person good? Can a wrong action be a good action and consequently can a right action be a bad action? These are questions which have plagued philosophers and wise persons of antiquity and is still relevant all over the world, including Africa. The aim of this chapter is to position African ethics within the framework of Global Bioethics and initiate the conversation that although ethics in Africa is often still practiced from a Western paradigm, African ethics have developed significantly in the post-colonial era to inform healthcare delivery on the continent. Whilst the chapter will not focus on the development of historical ethical theories, it will take a critical look at Western contributions to the modern-day discipline and how this has influenced ethics on the continent of Africa. This chapter will attempt to sketch the development and influence of ethics in Africa and what the future looks like for the discipline in Africa.

Keywords Bioethics · Indigenous ethics · African bioethics · Africa

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1.1 Introduction

A common denominator of peoples across the globe, from the great lakes of Africa to the island dwellings of the South Pacific to the rain forests of South America, are the ideas of what is right and wrong, and what is a good or bad person. Opinions and teachings on what these traits entail are then translated into the idea of what is acceptable in behaviour between different members of society at large as well as individuals and unique groups, in order to keep the harmony between all the members who adhere to these behavioural rules and assist in living a just and compliant society.

These rules are often codified in specific codes and found in particular in religious manuscripts and conduct rules; it is referred to as moral codes of conduct. As can be imagined there could be conflicting opinions about what is right and wrong based on moral codes from different groups. One example could be female genital cutting. In many countries in North Africa, from the Atlantic coast to the Horn of Africa, the practice is morally permissible while members of other groups may think it to be an immoral act of violence against a vulnerable group (WHO 2017). Often one's own group membership's opinion and or teaching may be in conflict with that of another which often creates tension and animosity against the other group's moral beliefs. Before the great migrations of people across the globe during various eras in the history of civilisation which normally went hand in hand with imperial and colonial expansions, this would not have been much of an issue because different groups were isolated from each other and only needed to be concerned with their neighbouring tribes' believes—which would have been relatively similar to their own and hence create a general definition of what was acceptable and deemed good and bad. These moral codes were internalised by members of the group and guided their behaviour. Often, because of proximity, the neighbouring tribes would respect each other and accept minor differences from the norm.

With the dawn of transport and trade many of the isolated groups started to make contact with other groups and intermingled, which consequently also led to the redefinition of many moral codes and acceptable behaviours. Many philosophers from the ancient Western civilisations (i.e. Babylonian, Persian, Greek, etc.) of the time realised that the homogeneity of the core group has changed and rather than only referring to moral codes to guide a person's behaviour, there arose a need to define what constitutes a good person and behaviour in a pluralistic group (Fullerton 2005). Many of the early philosophers realised that behaviour could not only be guided by moral standards anymore, given that not all citizens were privy to the same socialisation (upbringing by the same parental and societal value systems), and hence there existed a need for a universal code of conduct to guide behaviour. This need translated into the birth of ethics (Fullerton 2005).

Often *morality* and *ethics* are used interchangeably, but there exist definite differences which would be paramount to the discussions in the rest of the chapters. Morality refers to individually held believes of what is right and wrong, and is enforced by socialisation. Ethics refers to a universal code of what is right and wrong (Bochenski 1963). When referring to universality one needs to be cautious to assume that one size fits all as different collective groups still hold different ethical viewpoints which are enforced by their unique value systems. Although the fact that most of the best-documented ethics came from the Greek and Roman empires, there are also a great many writings on African ethics which were informed by the ancient people of the continent (Fullerton 2005; Mbiti 1991).

This book is by no means an attempt to isolate African ethics as the only ethical framework acceptable on the continent, but an attempt to give acknowledgement of the differences and similarities of African ethics to the rest of the globe's ethics principles and ideas. One cannot deny the fact that the world is greatly interconnected and that a new pseudo-value system has been created with the coming of the internet and information age. Therefore, one needs to be cognizant of other ethical systems, while also regarding the ethical system of the continent as important. According to ten Have and Gordijn (2013, p.635) "the confrontation with different ethical traditions and cultures is challenging ethics to rethink and transform its content, character, methods and sources of validation".

Global bioethics is an emerging bioethics approach inter alia underpinned by UNESCO's universal approach to bioethics and being supported by many scholars from other parts of the world, including Africa. A notable exception is the Cameroonian scholar Tangwa (1996) who questions whether global bioethics is not just another global Westernisation of bioethics. The primary argument of global bioethics is that human morality has some common and universal aspirations that transcend race, culture and gender, such as common good, beneficence, non-maleficence, solidarity, justice, equity, respect of human rights, dignity and a shared environment (Ten Have 2016). The notion of global citizenship and corresponding responsibilities emerge from the field of global health in, for example, contributions for the realisation of health rights and access to medicines, including compassionate use of patented drugs for public health interest (Doha Declaration 2001).

Global ethics/bioethics recognise what is global common good and what is supposed to be globally diversified (ten Have 2016). The strength of global bioethics is its acceptance and acknowledgement of the principle of harmonisation and standardisation informed and enriched by diversity in ethics. It seeks to achieve a common ethical denominator, consensus and standard in global moral debate and reasoning, with the aim to address common global ethical problems and dilemmas and to achieve equivalent standards and quality (ten Have 2016). UNESCO's Universal Declaration on Bioethics and Rights (2005) is a clear attempt and move to globalise, standardise and promote universal and global ethical standards acceptable to all member states.

In line with the development of global bioethics, and also in assisting the reader of this volume to understand the unique contribution healthcare professionals in Africa bring to the ethical debate, it is paramount to turn our attention to the development of African ethics and also identify the modern developments of African ethics.

1.2 Development of Bioethics in Africa in Context of Globalisation

The development of ethics in Africa has evolved into four main branches, according to Mbiti (1991) and Tangwa (2010) namely:

- Western bioethics/ethics in Africa;
- Indigenous bioethics/ethics;
- African bioethics/ethics; and
- Global bioethics/ethics.

The creation of these four types of ethics in Africa has been influenced and characterised by globalisation (ten Have 2016). There are three types of globalisation processes, namely:

- Convergence of cultures (ten Have 2016)
- Divergence of cultures
- Clash of cultures (Huntington 1993, 1997).

Convergence of cultures here means that Africa is becoming a melting pot of different cultural values, systems and norms; the convergence is the coming together of cultures (Mfutso-Bengo 2001). Examples of convergence of cultures in Africa include the adoption of new social media as a universal standard of communication, the democratisation process, the growing popularity of football and the internationalisation of football team support. As a result, Manchester United football club (based in the United Kingdom) has hard-core supporters in different parts of the world, sometimes in parts characterised by extreme political and cultural differences. The internationalisation of the Universal Human Rights Declaration (1948) is another example of convergence of cultures. Convergence of culture has led to the concept of global bioethics through the coming together of a common interest in common bioethical benchmarks and solutions (ten Have 2016). Similarly, African bioethics seek convergence of indigenous bioethics and other forms of bioethics, creating locally relevant moral and ethical resolutions and solutions.

Divergence of cultures is when a culture separates or goes in a different direction from their original position and then develops a unique identity (Mfutso-Bengo 2001). For example, after slave trade the culture of Black Americans developed independently from the Western African culture. However, divergence of cultures occurs not only due to physical barriers/separations but also due to change of cultural values within the same area or to protect one's cultural moral identity (Mfutso-Bengo 2001).

Trompenaars and Hampden-Turner's model of the seven dimensions of culture differentiates cultures on lines of "universalism and particularism, individualism and communitarianism, specificity and diffusion, achieved status and ascribed status, inner direction and outer direction, and sequential time and synchronous time" (Trompenaars and Hampden-Turner 2011:2). An example of divergence of cultures is the urban culture in African countries that tend to be more individualistic than the culture in traditional rural societies. There is also diversity between modern youth and traditional culture within the same societies in Africa that can turn develop into divergent cultures (Mfutso-Bengo 2001). For instance different areas (rural and urban) in Ethiopia have their own alphabet, calendar and language; some of these cultures are more traditional while others are more influenced by Western cultures). Indigenous bioethics is a form of divergence of culture, it seeks to create its own identity and to protect itself from being overpowered by other distorting cultural influences (Mbiti 1991).

The concept of clash of cultures was first used by Samuel P. Huntington in his essay and book called *Clash of Civilizations* (Huntington 1993, 1997). In this context, the process of globalisation has also provoked a process where there is a visible clash of moral values, especially in areas of homosexuality, gender, secularism and in social and religious issues. Some of these clashes of civilisation have become violent, for example ISIS (Middles East and Northern Africa) or Boko Haram (Nigeria, Niger and Chad).

1.2.1 The Influence of Western Bioethics on Bioethics in Africa

The precolonial phase of bioethics started with Hippocrates through the introduction of the Hippocratic Oath for physicians during 460–377 BCE (Bochenski 1963; Fullerton 2005). The influence of the Greek philosophers was felt in all countries surrounding the Mediterranean Sea, including Northern Africa. Indigenous concepts and ideals on morality of life have existed in African traditional societies and religions ever since and include—despite local variations—basically the concepts of preservation of life and culture, mutual sacrifice, living in the natural time zone, interconnectedness of spirit and body, humans as religious beings and communalism (Mfutso-Bengo 2001). Disease was not understood as the problem of an individual but as the problem of a community that is out of harmony. Another important concept is the idea, that growing maturity in humanity and good relations turn a biological human being into a full human being (for more details, see Indigenous bioethics below).

In 1803 Thomas Percival came up with the new term “medical ethics” (Fullerton 2005). This was during the time of the slave trade and colonisation. The concepts of equality, human autonomy and dignity of all human beings regardless of skin colour, tribe, gender and race were not fully developed or accepted. One can even notice the sentiments of slavery in the Hippocratic Oath (Bochenski 1963; Fullerton 2005). Hippocrates had been the first individual to underline the importance of respecting the dignity of human beings in medical practice and the need of professional ethics. There was a growing ethics awareness, especially among Abolitionists who were mostly Christian, that slave trade was anti-human and evil (Fullerton 2005).

It was a German scholar by the name Fritz Jahr who in 1926 first used the German word *Bioethik* which means in English *Bioethics* (ten Have 2016). However, an American biochemist, Van Rensselaer Potter, who in his article "The Bioethics, The science of Survival" was the first to integrate medical ethics into bioethics combining human values and biomedical science (Potter 2015).

The Human Rights movement after World War II and the Nazi atrocities did not only lead to the 1947 ground-breaking Nuremberg Code of Ethics in Research but was also an important milestone for the decolonisation of Africa in the 1960s. During colonialism and the early post-independence years concepts of Western medicine with the then prevailing patriarchal attitude of doctors was adopted in clinical practices, while the focus of the human rights movement had been more on political freedoms. Bioethical issues in the context of socio-economic rights only gained official recognition later (Mbiti 1991; Mfutso-Bengo 2001).

Callahan (1973) made bioethics an academic discipline that has specific methodologies and theories for decision making. It was Potter (2015) who defined medical ethics in 1970, and who regarded animal ethics and environmental ethics as part of bioethics. Shriver and Hellegers were the first who proposed the need for institutionalising bioethics through the creation of a bioethics institute called the Kennedy Center of Bioethics in the USA which later played a crucial role in the development of bioethics in Africa (Reich 1994). It was through the work of Zik Emmanuel, David Wendland, Christine Glady, Nancy Kass, Levine, Solomon Benatar, Thaddeus Metz, Ruth Macklin, Godfrey Tangwa, T Metz and many others who spread the ideas of research ethics in the period 1999–2002 in a massive drive of conferences and trainings targeting the African continent (Emmanuel et al. 2000). A meeting in Malawi 2001 resulted in the drafting of benchmarks for ethical review of research trials in developing countries (Emmanuel et al. 2000). The fair benefit framework has gained ground globally too (Emmanuel et al. 2000).

Western bioethics in Africa is characterised by using theories, principles and guidelines such as deontology, consequentialism, casuistry and rights-based approaches (Mbiti 1991). Generally, Western bioethics emphasise respect of individual autonomy. Western ethical principles such as beneficence, precautionary principles, autonomy, freedom, non-maleficence and rights-based principles have found acceptance in Africa, especially in the field of bioethics, mainly in the form of research ethics, biomedical ethics, environmental ethics, ethics of genomics, genetic engineering, biotechnology and public health ethics (Mbiti 1991). The precautionary principle of environmental ethics has had a great impact on environmental legislation in Africa through the requirement of environmental and social impact assessment in the construction industry. In research ethics the concept of informed consent has gained ground in both medical ethics and research ethics. Rights-based principles have been used by freedom fighters on the African continent to gain political and economic freedom and independence. The rights-based approach is the prevailing ethical principle that has also gained wide usage in gender empowerment, healthcare rights, rights of research participants and political rights (Mbiti 1991; Mfutso-Bengo 2001).

1.2.2 Indigenous Bioethics

Indigenous bioethics seeks to use African indigenous and traditional moral knowledge to come up with ethical principles like ubunthuology/umunthuology (Mfutso-Bengo and Masiye 2011). Behrens (2013) opted to use the concept "African indigenous bioethics" instead of African bioethics. He also makes it clear that the deliberate use of "indigenisation" and not "Africanisation" is not merely semantics but represents a substantive change to underline the need for "authenticity"; thereby indirectly challenging the concept of Africanisation of bioethics/ethics. Furthermore, he bemoans that there is little academic work and few publications on bioethics reflecting indigenous African thought, philosophy and values. The exceptions are Godfrey Tangwa (Cameroon), Segun Gbadegesin, Joseph Mfutso-Bengo (Malawi), Thaddeus Metz and Cletus Andoh (Cameroon) who have contributed significantly in this regard (Behrens 2013).

John Mbiti (1991) summarised the concept of African autonomy, personhood and communalism in a precise and concise manner: "I am because we are, we are therefore I am". It is also a reaction to René Descartes' "*cogito ergo sum'* (I think therefore I am); Mbiti argued that "I am because we are and since we are, therefore I am" (Mbiti 1991). This was also underlined by Bénézet Bujo stating that the human being will become human, not through *cogito* (thinking) but to the contrary through *relatio* (relation) and *cognatio* (blood relationship) (Bujo 2001).

Another concept which has emerged in African ethics is Kenneth Kaunda's concept of African humanism. The concept of African humanism was expanded on by Joseph Mfutso-Bengo and Francis Masiye (2011) in their publication "Towards bioethics of ubuntuology in Africa". According to this concept to be human is "to be" (*ndili*), which means "to be with" (the same word *ndili*) and "to have" *(ndili ndi)*. One first needs to be more in order to have more. To be more means to have integrity, goodness, to seek common good and balance personal interest with common good.

Ubunthuology/umunthulogy is a moral reflection or study of African humanism, personhood, communitarianism and moral systems (Mfutso-Bengo and Masiye 2011). Umunthuology is the main theory of African Bantu ethics. It starts with defining what African humanism is and how one can become humane (Mfutso-Bengo and Masiye 2011). The concept of ubuntuology has found resonance also in business ethics and political ethics (Kanyongolo 2012; Khomba and Vermaak 2012), e.g. the Malawi Constitution was amended in 2012 to include "morality" in section 12 subsection 2 as constitutional principle and umunthuology is a pillar of national development in Malawi.

1.2.3 African Bioethics

African bioethics include the concept of indigenous epistemology, knowledge, moral philosophy and ethics. African indigenous bioethics is similar to African bioethics. However African bioethics recognise other valuable ethical principles and theories from other parts of the globe which have acquired international significance and appreciation, for example the principles of beneficence, non-maleficence, autonomy and justice. African bioethics often apply the text of these principles within the context and the perspective of African value system and societal needs (Tangwa 1996); African bioethics use the same principle but the interpretation will be more relational and communitarian. Hence in the context of African value systems, the principle of autonomy is reinterpreted as a principle of respect: respect of persons, community, harmony, common good, common sense and common environment. This shows that a person's dignity, rights and responsibility are interconnected, interrelated and interdependent to other human persons who also have the same rights, dignity, moral status and responsibility (Mfutso-Bengo and Masiye 2011).

1.3 The Future of Ethics/Bioethics Discourse in Africa in the Context of Globalisation and Africanisation

Among the various types of ethics prevailing in Africa, the African bioethics and African indigenous bioethics will dominate the ethics discourse on the African continent irrespective of the semantics rivalry. However, the term "African bioethics" is used more often in academic work and publications. One can argue that African bioethics include African indigenous bioethics. African indigenous concepts of solidarity, common good, common interest, common humanity and the extended family of all human beings regardless of social, racial, religious or moral differences have found their way into the global bioethics agenda (Mbitit 1991; Mfutso-Bengo and Masiye 2011; Tangwa 2004, 2010).

There is a growing demand for practising African ethics from the context and the perspective of Africa by Africans themselves, as well as by those who want to conduct research, visit or invest in Africa and learn more about African values and culture. African bioethics is sensible and pragmatic and what matters is the context of the ethical text.

The future of African bioethics/ethics is intrinsically linked with the future of global bioethics. The survival of global bioethics depend on its ability to integrate and harmonise diverse value systems including African value systems. Health professionals ought to think globally and act locally with both local and global impact. Throughout the history of Africa the art of moral reasoning has been part of humanity and should stay part of ethical practice of healthcare providers on the continent.

African values and thought processes have a lot to offer healthcare professionals on the continent and it is the aim of this volume to add to the discourse and to recognise the importance of including these processes in healthcare delivery. The rest of the volume will be dedicated to specific disciples in healthcare from both a South African and African perspective.

In conclusion, it is important to acknowledge that there are indeed many differences between the values and perspectives of practitioners across the continent. This volume does not equate all African traditions on the same level, but is merely attempting to create a platform for continued dialogue. Furthermore, the content division of this volume does not imply, suggest or indicate that South African issues are unique or superior to that of the rest of Africa. Rather, the fact that some chapters focus on South African issues while others on more continental issues should be viewed against the idea of illustrating the diverse nature of the ethical debate on the African continent, which we hope will ultimately contribute to the richness and diversity of the discussion.

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Chapter 2
Development of Bioethics and Professionalism in the Healthcare Context

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Abstract Bioethics is concerned with reflections on the actions, thoughts, motivations and intentions of the "good" healthcare professional. These reflections have a long history and continue to expand as healthcare technology and contexts develop and change at a rapid pace. On the one hand it has resulted in the external codification of various principles and the establishment of professional bodies, while on the other hand it has sparked interest in professionalism as an inherent virtue. The first section of the chapter provides a basic definition of bioethics. This is followed in the second section by an overview of the most important developments in bioethics, specifically with regards to the development of various international codes and guidelines following in particular the Nazi atrocities in World War II. An overview is provided of the following codes/guidelines: Nuremburg Code (1947); Universal Declaration of Human Rights (1948); Declaration of Helsinki (1964); Belmont Report (1979); Principlism and the Universal Declaration on Bioethics and Human Rights (2005). The third section focuses on the development of bioethics in South Africa, specifically with regards to the role of healthcare practitioners and professional bodies during Apartheid (pre-1994) and post-Apartheid (1994 till present). The last section of the chapter highlights the important role of professionalism as a healthcare virtue. It describes the basic characteristics of professionals, which is then followed by a description of five focal virtues that healthcare practitioners should possess, namely compassion, discernment, trustworthiness, integrity and conscientiousness.

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2.1 Introduction

This chapter will task itself with a general definition of bioethics, give a general overview of the global developments which lead bioethics to be an influential and necessary subject taught internationally at tertiary level healthcare courses. Thereafter, attention will be focussed on the development of bioethics in South Africa. The last part of this chapter will focus on how we can apply our knowledge of bioethics to the concept of professionalism.

2.2 Definition of Bioethics

If one looks etymologically at the word BIOETHICS, it has two components, namely BIO referring to all living things (from humans, animal, plants and organisms – including genomics, viruses and bacteria) and ETHICS. Therefore *bioethics* can be seen as the study of ethics pertaining to all living things. Historically, the word bioethics was first coined by the German pastor and theologian Fritz Jahr in 1927 (Sass 2007) and reintroduced into literature in the early 1970s by Van Rensselaer Potter (Whitehouse 2003) who wanted to connect the humanities and sciences. Unfortunately, all the aspects of bioethics have not developed equally; medical ethics have by far outranked the others in development. As a result scholars and the public at large often use the concepts *medical ethics* and *bioethics* interchangeably as if they are merely synonyms. The aim of this chapter is not to analyse the linguistic and/or cultural usage of the word, but rather to describe the scholarly landscape covered by medical ethics within the field of bioethics.

In order to appreciate the field bioethics it is paramount to understand the goal and application of it in different situations. Suffice to say that bioethics provide a disciplinary framework, which guides healthcare practitioners to reflect on and answer questions and issues pertaining to the life sciences. Furthermore, it is important to understand that bioethics can never function in a silo – on its own. It needs to be part of an interdisciplinary approach where empirical data and information from relevant fields (i.e. medicine, law, religion, anthropology, etc.) are integrated to address the specific issue in question; it is re-evaluated and revisited with each new case/issue.

At the outset of this chapter it is important to note that one of the biggest current criticisms against the field of bioethics is the fact that it propagates an excessively individualistic approach, specifically, against the background of the Human Rights movement and the developments regarding individual-focussed medical treatments. For the most part, bioethics internationally, specifically in the developed world, is characterised by an inadequate focus on the principles of solidarity and justice. These two principles are vitally important factors to life in Africa and the developing world. While one cannot halt the progress of individual-focused healthcare, the overall aim of this book is to raise awareness of system-focused healthcare that is responsive to the demographics, culture and community contexts of patients.

2.3 Development of Bioethics

Bioethics as a recognised academic field could be traced back to the 1970s. However, as a phenomenon it can be traced back to various texts of antiquity as far back as the Code of Hammurabi around 1750 BCE (i.e. a legal Babylonian code of ancient Mesopotamia), the Hippocratic Oath that originated around 500 BCE (Kuhse and Singer 2009), the Oath of Asaph around 400 CE (Muntner 1968) and the writings of Hali Abbas around 950 CE (Brown 2002). Other influential writings also contributed to the development of the field as medicine grew more prominent, for example, the publication of Thomas Percival's pamphlet on Medical Ethics in 1803 (Riddick 2003). However, it was not until the documented Nazi atrocities of the Second World War II that the world at large started to take notice of the vulnerability of patients and research participants at the hands of healthcare practitioners.

2.3.1 Nuremberg Code (1947)

During the time span of the early 1930s until the end of the World War II (1945) medical experiments were primarily conducted on prisoners of war and other vulnerable communities. It included experiments that tested the endurance of individuals to low temperatures and experiments involving the testing of various vaccines and medicines. The head of the Nazi government's medical research team in Auschwitz concentration camp, Dr. Josef Mengele, will stay synonymous with the most horrific medical experiments done on innocent prisoners of war in order to strengthen the German's Aryan Race ideology. Mengele and his team were also involved in the following twin studies: experimenting on twins by amputating their legs (often without any anaesthetics) and sewing it back on to the other twin; intentionally infecting one of the twins with a disease (often typhus) and observing the reaction it would have on the other; connecting twins to each other and transfusing their blood between each other to see if something would happen to the one or other; and injecting chemicals into the eyes of individuals to see if it would change the colour of their eyes (Baumslag 2005). Another name synonymous with the Nazi atrocities is that of Dr. Ernst Rüdin who served as an expert on racial and population cleansing in the German Reich. As a psychiatrist, he was influential in the mass sterilisation and euthanasia of persons regarded as of an inferior quality (i.e. mentally and physically ill, Jews, Soviets, Roma [Gypsies], sexually deviant [prostitutes and homosexuals] and elderly) (Baumslag 2005). The impact of these racial cleansing and experiments led to the death of approximately 20 million people in as little as 6 years (Baumslag 2005).

In the aftermath of these atrocities the Allied forces held a series of military tribunals to dispense justice to war criminals. Important to the field of bioethics is the trial of the Nazi doctors in 1947 where many of the gruesome experiments were brought into public knowledge. Many of the doctors involved were either sentenced to death or to prison. The recommendations of the four judges (one each from Britain, the United States of America, France and the Soviet Union) eventually became what is known today as the Nuremberg Code. This Code was ironically largely based on the 1931 version of the German Guidelines for Human Experimentation (Grodin 1992). The Nuremberg Code consists of ten points with the first one being the most important in that anyone participating in any medical experiment must give his/her full informed consent. Informed consent in this case means that the individual must be fully aware of all the risks and benefits associated with the research. The Code also guides the doctor's behaviour in that he/she must stop the experiment immediately if he/she finds that the experiment is harming the participant. Another important point of the Code is that a participant may withdraw from the experiment at any time if he/she so wishes without any negative impact on him/her or on his/her care.

Today the Nuremberg Code is still regarded as one of the most important influences on the laws governing human medical research in the USA.

2.3.2 Universal Declaration of Human Rights (1948)

In 1948, the assembly of the United Nations, against the background of the Nazi atrocities, as well as the World War II atrocities in Japan (known today as Unit 731), drafted the Universal Declaration of Human Rights. The formulation of the Declaration was influenced by a large variety of legal and cultural backgrounds that hold one common standard, namely that all members of the human race have human rights and fundamental freedoms and have equality.

2.3.3 Declaration of Helsinki (1964)

The Nuremberg Code, according to McNeill (2001), was not in itself very influential. The World Medical Association issued another code, commonly known as the Declaration of Helsinki, in 1964 which focussed primarily on research and experimentation. The Declaration of Helsinki was well received, especially by the medical profession as it addressed a major issue namely complex questions pertaining to research participants who are in themselves not legally or mentally competent to engage in autonomous decision making. The Declaration of Helsinki acknowledges conflict of interest issues in this context whereby "… the physician seeks the best for his or her patient and yet seeks to pursue medical science for the good of society" (*British Medical Journal* 1996, p. 1414), but likewise informs that healthcare professionals do not have an unconditional duty to obtain informed consent in therapeutic research setting and introduces the concept of guardianship as a way of attaining consent from incompetent research participants (*British Medical Journal* 1996). The greatest value of the Declaration of Helsinki is the assertion that individuals have the right to consent or refusal to medical treatment and/or experimentation – which place a control on institutions (and governments) to unduly influence and abuse individuals to partake in treatment/experiments they would not agree with in large.

2.3.4 Belmont Report (1979)

The Nuremberg Code (1947) emphasises an extreme respect for the voluntary nature of participation in any kind of research, for accurate informed consent and for the particular ethical responsibilities of the researcher to guarantee human wellbeing. However, despite the good intentions of the Code medical scientists kept on conducting unethical and questionable research. The Tuskegee Syphilis Study (Green et al. 2011) is arguably known as one of the most infamous biomedical research studies. Between 1932 and 1972, a group of medical personnel from the United States Public Health Service was involved in a study to observe the development of untreated syphilis in men from African-American origin in the south of the country. This study was conducted under the guise that these men would be exempted from military service and that they would receive meals during treatment, free burial insurance and free health care from the government. About 600 qualifying participants were enrolled in the study. However, after funding was lost none of the participants were informed or received any treatment. Even after penicillin was confirmed to be effective (1942) and became the international standard of care for syphilis (1947), the team did not provide the participants with the medication. Instead, the team actively withheld treatment and information from the participants and also prevented them from seeking treatment from other centres which provided treatment for syphilis. Sadly, the study continued for about 40 years until a whistleblower exposed the atrocity in an article in the *New York Times*, which led to the immediate closing down of the research sites. However, by that time, many of the men had died from syphilis, including 40 wives who were infected with syphilis and it is estimated that around 19 children had congenital syphilis.

The Belmont Report was published in 1979 in response to the Tuskegee Study atrocities. It also resulted in the birth of Institutional Review Boards (IRBs, also known as Research Ethics Committees) who were primarily tasked to oversee the protection of human research participants. The *Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* was published to provide a concise explanation of IRBs' obligation for the ethics review of research involving human research participants (US Office for Human Research Protection

1979). Instruction and procedures concerning the use of human research participants in the USA, and also in other countries, are based and/or informed by the following important elements extracted from the US Office for Human Research Protection's Belmont Report (1979):

Principle	Description	Application
Respect for persons	Individuals should be treated as an autonomous agent	An autonomous person is an individual who is able to consider his/her own situation and to make informed decisions based on information received, which is understandable, and without any coercion or force.
	Persons with diminished autonomy are entitled to protection	Diminished autonomy could either be permanent or temporary. Regardless of the time span and cause (illness, mental disability) the person still needs protection to ensure risk of harm and the likelihood of benefit is maximised.
Beneficence	Do not harm	The aim is to ascertain how much risk would be acceptable to maximise benefit.
	Maximise possible benefits and minimise possible harms.	Not only should the person's decision be respected, but the person should be protected from harm by making efforts to protect their well-being (physical and psychological).
Social justice	The burdens and benefits of research should be justly distributed.	Who ought to receive the benefits of research and bear its burdens? It is important to take cognisance of who the research participants are in a study and to make sure it is not always the same people who are being methodically selected based on their ease of availability, compromised position or their manipulability (vulnerability). Those involved in studies to test or develop therapeutic devices and/or procedures should also directly benefit from the devices or procedures by having affordable access to it.

The aforementioned incidents and codes all led to the acknowledgement of the importance of ethical standards within the healthcare context. In addition, different aspects of diverse ethical traditions can be used by various healthcare providers when dealing with ethical issues. However, it was not until 1979 when two academics from George Town University (Washington DC, USA) published the book *Principles of Biomedical Ethics*, that the application of all the previously mentioned principles as illustrated in all the declarations and reports were integrated in an approach known as Principlism.

2.3.5 Declaration of Helsinki

As Ndebele (2013) indicates the Declaration of Helsinki is over 50 years old and has been revised seven times. The Declaration was adopted in 1964 by the World Medical Association and is an effort to regulate research ethics where one of the most important contributions is the concept of informed consent. Important contributions to ethics are where ethical considerations when working with human research participants must always take precedence over local laws and regulations as well as where the subject's welfare must take precedence over the interest of society or science.

2.3.6 Principles of Biomedical Ethics (Principlism)

Tom Beauchamp and James Childress's book *Principles of Biomedical Ethics,* now in its seventh edition (2012), outlines the use of four primary principles in efforts to resolve ethical issues. At the offset it is important to mention that due to the many different variables which may exist in context of a specific issue/case, not all the principles suggested by the authors may be applicable. They argue that none of these principles should be seen as absolutes, but rather only as powerful action guides to address the issue/case. Furthermore, no single principle is more important than the others as they are non-hierarchical. Since it is non-hierarchical and not a top-down approach, principlism is greatly dependent on the context of the issue at hand and any analysis of decisions and actions should be based on concrete facts, moments and circumstances. Therefore, the application of these principles rely greatly on the healthcare practitioner's ability to distil the facts clearly and understand all the stakeholders. Keep in mind that these four principles are in fact not a "new discovery", but merely a new presentation of historical ideas. The four commonly accepted principles, as argued by Beauchamp and Childress (2012), include the following:

Respect for Autonomy
Autonomy is a deontological principle and notion of moral decision making which hold that a rational person (defined by age and mental ability) has the capacity to make informed and voluntary decisions. Such a person would need to duly consider and comprehend the risks and benefits of each choice, based on clear (understandable) information and without any controlling influences (e.g. fear, coercion, bribery).

Non-maleficence
Non-maleficence is a deontological principle which holds that no intentional or foreseeable harm or injury should be levied against a person, either through acts of commission or omission. This principle is based on the Latin phrase "Primum non nocere" which translates into English as "First do no harm". The concept of intention is important in an understanding of non-maleficence. It holds that if a person intended to not harm first, but the end result was harmful, he/she did not act immoral. This is often referred to as the *double-effect* in medicine; at times a good intention could lead to a bad outcome, for example the administration of chemotherapy. In essence, chemotherapy is a highly toxic substance which has to result in reduced cellular and molecular functioning in the area where it has been administered. In

itself it could be argued that this is an immoral act, however the healthcare practitioner's intention administering the therapy is not to do harm, but to do good – which is morally permissible.

Beneficence
Beneficence is a utilitarian principle which holds that a healthcare provider has a duty to be of benefit to the patient. It includes a duty to take positive steps to prevent and to remove harm from the patient. It is argued by some that non-maleficence is a constant duty (one never should harm another), while beneficence is a limited duty as at times society's benefits could outweigh that of the individual patient.

Justice
Justice is a utilitarian principle which can in its most elementary way be defined as a form of fairness. The most applied form of this principle pertains to the fair distribution of goods in society. As with most things in life, there is a limited supply and the question of distributive justice hinges on how one can and should fairly distribute that which is in short supply.

It is important to note that the aforementioned four principles are not the only principles, or even the only primary principles, in bioethics. They are merely one of the current prominent guiding frameworks that can be used to address, analyse and/or reflect on ethical issues.

2.3.7 *Universal Declaration on Bioethics and Human Rights (2005)*

In 2005, the General Conference of the United Nations Educational, Scientific and Cultural Organisation (UNESCO) unanimously adopted the *Universal Declaration on Bioethics and Human Rights* (UDBHR). This marks a significant deviation from other guides and frameworks that have up to this point only been adopted by special interest groups. The primary aim of the UDBHR is to offer a universal outline of principles to direct the international community in the design of their regulation, legislation and procedures in the field of bioethics while taking into account their diverse cultures, traditions and schools of thought. The UDBHR outlines 15 principles that are applicable to a range of moral objects (see Table). These principles are closely linked to human rights and reflect an innovative balance between individualist, communitarian, social and environmental moral perspectives (Ten Have 2016).

Moral objects	Principles
Individual human beings	Human dignity (Article 3)
	Benefit and harm (Article 4)
	Autonomy (Article 5)

(continued)

Moral objects	Principles
Other human beings	Consent (Articles 6–7)
	Human vulnerability (Article 8)
	Privacy and confidentiality (Article 9)
	Equality, justice and equity (Article 10)
Human communities	Non-discrimination and non-stigmatisation (Article 11)
	Cultural diversity and pluralism (Article 12)
Humankind	Solidarity and international cooperation (Article 13)
	Social responsibility and health (Article 14)
	Sharing of benefits (Article 15)
All living things and the environment	Protecting future generations (Article 16)
	Protection of the environment, the biosphere and biodiversity (Article 17)

Adapted from: *Universal Declaration on Bioethics and Human Rights*

Let's now turn the attention to the development of bioethics on the African continent. The case study of South Africa pre- and post-apartheid will be used to illustrate the challenges and turmoil of bioethics in Africa.

2.4 Bioethics in South Africa

The South African bioethics story can be divided into two parts of events which happened before the first democratic election in 1994 (i.e. Apartheid era) and what happened after 1994 (i.e. post-Apartheid era). Essentially, Apartheid was a legal system of enforced segregation in all spheres of society based on race classification. The segregation in South Africa meant that "Bantustans" or homelands were formed in rural areas, while townships were established in urban areas. These areas were police-patrolled. Black (i.e. non-white) South Africans who lived there had limited access to healthcare facilities. To illustrate this point, a report of 1990 (Savage 1990) indicated that in 1984 the budget of two of the largest homelands (Kwazulu and Ciskei) was equivalent to that of the Groote Schuur Hospital in Cape Town where predominantly white South Africans were treated. The meagre budget allocations were a direct result of the segregation-focused political intention of the day and resulted in poor living conditions which in turn advanced the spread of communicable diseases such as tuberculosis. The policy of segregation was not only applied on a macro-level, but on a micro-level as well where even a visit to a healthcare facility was regulated by laws. Black patients were not allowed to use the same entrance as whites to healthcare facilities (i.e. doctors' consulting rooms or clinics). In a study done around Johannesburg in 1988 (Jamieson 1988) it was found that only 12% of white doctors had consulting rooms for non-white patients. Furthermore, in 1990 only 5.5% of South African doctors practiced in rural areas where over half the black population lived (Bell 2006).

The Apartheid Government's policies severely hindered black students from attending medical schools in South Africa. Williams (2000) indicates that between 1968 and 1977 a total of about 3% newly trained doctors were black. Black medical students were also not allowed to be trained in "white" hospitals and were also not allowed to work on the bodily remains of any white person. In the event of pathology sessions, black students had to wait outside the facility while their white fellow students could dissect cadavers (Moodley 2007). Bell (2006) narrates one incident to illustrate how the restrictive policy of the Apartheid government even impacted negatively on white citizens. During this time, ambulances were divided in "Europeans" (whites-only) or "non-Europeans" (non-whites) ambulances. Mr. Jenkins was stabbed with a knife by his wife and an ambulance was called. However, his neighbours watched in horror as a "non-European" ambulance arrived; the despatcher assumed Mr. Jenkins was a non-white. The paramedics refused to take Mr. Jenkins, who was bleeding severely, to the local hospital as he was from European descent. A neighbour eventually took Mr. Jenkins to the local whites-only hospital where he died shortly after arriving and his death was related to the long delay before getting medical attention.

A significant turning point for medicine in South Africa came with the death of Bantu Stephen Biko on 12 September 1977. Wendy Orr, one of the commissioners of the Truth and Reconciliation Commission in South Africa, as well as a whistleblower of inhumane treatment of inmates in 1985 while she was the district surgeon in Port Elizabeth, summarises his death as follows (Orr 2015, p. 976):

> One of the watershed cases in the sorry history of the medical profession during those years was the death of Steve Biko while in detention in 1977. He had been assaulted by police and, as a result of gross negligence on the part of the district surgeons responsible for his care, had died of head injuries sustained in the assault. I was given access to Steve Biko's file from that final period of detention, and I read through the reports that were regularly completed (and filed and apparently not acted on) by the district surgeons who visited him. The doctor did nothing, the magistrate who was also required to make regular visits did nothing, and Steve Biko died a few weeks later because the people who were supposed to take care of him, who were meant to protect his human rights and put his needs first, saw him as less than a human being and undeserving of any kind of dignity or respect.

South African bioethics and the Biko case in specific had to contend with the larger concept of the influence of politics (and power in specific) on the care of the person as a human being entitled to humane treatment as enshrined in the 1948 Universal Declaration of Human Rights. The Biko case contributed to the already fragmented and sceptical views of members of the South African Medical and Dental Council (SAMDC) and Medical Association of South Africa, as to the bodies' ability to uphold the notions of the Hippocratic Oath and to protect patients. Many progressive doctors then initiated the formation of an alternative association, namely, the National Medical and Dental Association (NAMDA) in 1982. They were strongly opposed to detention and torture of anyone. Also, they provided medical assistance to ex-detainees and actively campaigned against the abuses (Dowdall 1991). During this time various professional associations existed in South Africa, which was evident of the healthcare fraternity's fragmented state. It was only in

1995 that an Interim National Medical and Dental Council of South Africa was established through the merger of SAMDC and the Transkei and Ciskei Medical Councils. In 2000, the Health Professions Council of South Africa (HPCSA) was established (Dhai and Mkhize 2006). The HPCSA was specifically tasked to focus on "… promoting the health of the population, determining standards of professional education and training, and setting and maintaining excellent standards of ethical and professional practice" (HPCSA 2017). The HPCSA is a statutory body in South Africa that inter alia monitors ethical and professional standards of all its members. Healthcare practitioners are required to register at the HPCSA in order to practice in South Africa. Also, registered practitioners need to engage in ethics training as part of continuous professional development. Lastly, the HPCSA requires from tertiary institutions to expose healthcare students to formal ethics training.

However, compliance to externally codified ethics codes and regulations is not in itself enough to ensure ethical conduct in the healthcare context. It must coincide with internalised personal virtues and duties. As such, the last section of this chapter focuses on professionalism and professional conduct among healthcare practitioners.

2.5 Professionalism

Professionalism is not a simple idea to explain, as the word "profession" is almost synonymous with "occupation", in general speaking terms today. Downie (1990, pp. 148–157) proposes the following six characteristics of professionals:

1. The professional has skills or expertise proceeding from a broad knowledge base.
2. The professional provides a service based on a special relationship with those whom he or she serves. This relationship involves a special attitude of beneficence tempered with integrity.
3. To the extent that the public recognises the authority of the professional, he or she has the social function of speaking out on broad matters of public policy and justice, going beyond duties to specific clients.
4. Professionals must be independent of the influence of the State or commerce.
5. The professional should be educated rather than trained and should continue to develop her or his knowledge and skills within a framework of values.
6. A professional should have legitimised authority and credibility in the eyes of the general public.

Beauchamp and Childress (2001) argue that healthcare practitioners have various professional roles, often linked to institutional expectations and professional practices which they have to fulfil. These roles incorporate virtues (trait of character that is socially valuable) as well as obligations. Hence they identified five focal virtues (pp. 32–38) that healthcare practitioners "should possess: compassion, discernment, trustworthiness, integrity and conscientiousness".

2.5.1 Compassion

The virtue of compassion in the healthcare context is a trait that combines an outlook of active regard for another's well-being with a creative consciousness and emotional retort of deep understanding, sensitivity and uneasiness at another's pain, hardship or misery. Compassion presupposes sympathy and is articulated in actions of beneficence that endeavour to ease the hardship or anguish of another person. Contrasting integrity, which is motivated by looking at the self, compassion's focus is others.

2.5.2 Discernment

The virtue of discernment conveys profound understanding, acute judgment and understanding to act in the healthcare context. It is the capacity to appreciate and perceive what conditions mandate in the way of human awareness. Discernment includes the capacity to make decisions void of undue influence by superfluous concerns, uncertainties, personal interests and the like. For example, a discerning medical practitioner will display sensitive insight into when a despairing patient needs consolation or privacy. Discernment is also required by healthcare practitioners in deciding *how* to follow and/or implement rules that guide behaviour in a particular case; in this context, discernment is independent from ensuring *that* the rules apply.

2.5.3 Trustworthiness

Trust is an assertive faith in and reliance upon the moral character and ability of another person. Trust involves an assurance that another will act with the right intentions and in agreement with fitting moral norms. In the healthcare context trust is one of the most important elements in a patient's choice of one healthcare practitioner rather than another.

2.5.4 Integrity

Some scholars is of the opinion that integrity should be regarded as the primary virtue in the healthcare context. Healthcare practitioners often support their actions to act (or not) on the base that it would undermine or violate their integrity and/or core beliefs if acting otherwise. The virtue of integrity involves at least two personal character aspects. The first is the coherent and harmonious integration of one's emotions, aspirations and knowledge. The second is the deep striving and intention to be true to moral values and defending it when it is threatened.

2.5.5 Conscientiousness

A person acts conscientiously (diligently) if he or she is encouraged to do what is right because it is right. Furthermore, such a person would try, through due diligence to define what is right, and then to follow course.

2.6 Conclusion

A good understanding of bioethics and the ability to apply ethics principles and skills in the healthcare context is vitally important for all healthcare practitioners. Such understanding and application should be fostered during the formal training of healthcare practitioners and it should continue as part of each practitioner's continuous professional development for as long as they practise their profession. In order to foster an appreciation for the field of bioethics, the first section of the chapter provided a basic introduction to the definition of bioethics. This was followed by an overview of the most important historical developments in bioethics, specifically with regards to the development of various international codes and guidelines following the Nazi atrocities in World War II. In line with the main focus of this book on healthcare professions in Africa and South Africa, the third section of the chapter focused on the development of bioethics in South Africa, specifically with regards to the role of healthcare practitioners and professional bodies during Apartheid (pre-1994) and post-Apartheid (1994 till present). The last and concluding section of the chapter focused on the important role of professionalism as a healthcare virtue. Ultimately, it is the hope of the authors that students, educators and healthcare practitioners alike will be able to use this book in their endeavours to serve the people of the African continent.

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Chapter 3
Ubuntu-Botho Approach to Ethics: An Invitation to Dialogue

Nhlanhla Mkhize

Abstract The discipline of Psychology has been challenged for its over-reliance on Western philosophical pre-suppositions about what it means to be a human being. The taken-for-granted relationship between the knower and what is to be known, namely an objective, disinterested stance towards the object of one's knowledge, has also come under scrutiny. The dominant codes of professional ethics, which have their roots in Europe and North America, have not escaped this criticism. Using the idea of the person as the point of departure, this chapter critiques the philosophical basis of mainstream psychological ethics. The chapter challenges the dominance of the Kantian tradition in ethics and goes on to provide a rationale for an approach to ethics that is informed by indigenous African epistemologies. The ethics of Ubuntu, or Botho, provides an alternative to the individualistic Western orientation towards ethics, which prize human rationality above human life (impilo, phelo). The main tenets of an Ubuntu-Botho-based approach to ethics, as applicable to psychology, are outlined and discussed. Ultimately, the idea is to show that ethics is not a matter of abstract individual legislation, but a semiotic process that involves a negotiation of different meaning systems. The chapter concludes by outlining a process that can be used to negotiate between competing ethical points of view.

Keywords African ethics · Ubuntu-Botho · Respect for life · Human and ecological solidarity · Dialogic ethics

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3.1 Introduction

From its inception, the discipline of psychology has relied on Western philosophical pre-suppositions about what it means to be a human being. The relationship between human beings and their surrounding environment, the nature of the universe (ontology), the nature of knowledge as well as the ways and means of knowing (epistemology) are also underpinned by Western philosophy. From this has emerged the notion of an individualistic, disinterested, or self-contained self (person) that permeates most psychological textbooks and other psychological products, such as the professional codes of ethics. Using the idea of the person as the point of departure, this chapter provides a critique of the dominant codes of ethics, principlism in particular. In the first instance, it is argued that ethics are rooted in historically particular metaphysical ontologies, incorporating what it means to be a person among others. The relationship between ethics and culture is discussed. The chapter proceeds to present the main tenets of the African-centred worldview, with a particular focus on the idea of Ubuntu, and how it relates to the field of psychology. It is out of these ideas that emerges a different understanding of ethics as a cultural practice and not a set of universal principles that can be applied without due cognisance to the context.

Preliminary ideas concerning what could constitute some of the main tenets of an African approach to ethics are proposed. A question arises, however, on the possibility of having a single ethical framework that applies to all members of a group, given the rapid social and cultural changes taking place in the world, as well as human complexity, in general. It is argued that the idea of ethics, as a semiotic practice or dialogue between moral agents, could assist us to address the problem of ethical decision making in the context of cultural complexity and change.

3.2 Individualism as a Basis of The Western (Principled) Approach to Ethics

In the recent Western history of ideas, abstract individualism has been the dominant paradigm to understand what it means to be a person. Individualism arose from a positivist or naturalistic approach to social science. With its roots in the scientific revolution in the 16th and 17th centuries (Cushman 1990; Richardson and Fowers 1998; Richardson et al. 1998), positivism aims to explain human consciousness in terms of universal psychological laws that are divorced from history and culture. During the 16th and 17th centuries in Europe, there was a shift from a religious or community orientation, towards an "unprecedented kind of scientific materialistic outlook, one that served as an effective tool for executing the modern rebellion against unthinking traditionalism and arbitrary authority" (Richardson and Woolfolk 2013, p. 18). Arising from this approach was an understanding that people can be separated from the world and each other, as well as the social realm, including traditions and customs (Richardson and Fowers 1998). Descartes, as one of the early proponents of the idea of an ahistorical and disembodied personhood, posited an “I” or “ego” that is “immediately, transparently, and irrefutably present to itself as a pure extensionless consciousness, already established in being, without a body and with no acknowledged complicity in language, culture, or community” (Dunne 1995, p. 138). Similar claims were made by Hobbes as well, who sought to establish a scientifically-grounded social philosophy, based on “assertions [that were] valid independently of place, time, and circumstances, and to permit an enduring foundation for communal life, regardless of the historical situation.” (cited in Bernstein 1983, p. 186). Thus was lost the ancient/traditional view that the individual, other people and the world in general, are bound together inextricably, from the beginning (Faulconer and Williams 1990).

3.2.1 The Body as a Container of Psychological Attributes

With the abovementioned history of ideas as the background, the transcendental view of the self, also known as self-contained individualism (Sampson 1993), became the central focus of psychological investigations. The affirmation of individualism is an important aspect of the modern definitions of psychology, distinguishing it from other social sciences disciplines such as anthropology and sociology (Faulconer and Williams 1990). The container metaphor is used to illustrate the disembodied view of the self, the idea that the boundary of the person coincides with the body. The human person is thus defined with reference to inner psychological attributes such as thoughts and emotions (Markus and Kitayama 1997; Sampson 1993). It should be noted, as Sampson (1993) and Cushman (1990) argue, that the idea of the self as a container emanates from a historical and a cultural orientation that has grown to privilege an objective, disentangled view of the self.

As a moral and scientific ideal, the aspiration towards individualism and separateness, argues Taylor (1991), reflects an anti-authoritarian and liberationist attitude of the modern era. Self-contained individualism and its shutting out of issues that “transcend” the self (e.g. religious, political, cultural) is not neutral, it involves a powerful moral ideal “of being true to oneself in a specifically modern understanding of the term” (Taylor 1991, p. 15). The moral ideal constitutes “a picture of what a better or higher mode of life would be, where ‘better’ and ‘higher’ are defined not in terms of what we happen to desire or need, but in terms of what we ought to desire” (Taylor 1991, p. 16). Having positioned itself independently of its surroundings, the individualistic self becomes free to change and organise (conquer) the universe so as to secure a better welfare for itself and others (Dunne 1995; Richardson et al. 1998), so the argument goes.

3.2.2 *Individualism: Influences in Psychological and Ethical Theory*

Several theories in psychology, such as those of Maslow, Rogers and psychoanalytic approaches, are premised on the individualistic view of the self. The individualistic bias in these theories is reflected in what they consider to be the primary goal of psychological development, such as self-actualisation (Maslow) and individuation (psychoanalytic theories). Commensurate with the idea of an autonomous (self-governing) and rational self, the dominant Western approaches to ethics, such as principlism, regard ethical decision making as a matter of individual legislation: it is guided by abstract universal principles that are by and large free of context, culture and time. These ethical principles reflect the "original position"; any rational moral agent can discover them, even if they are positioned behind a veil of ignorance (Rawls 1972), meaning that they have totally disregarded their backgrounds or historically particular horizons of understanding. In professional practice, according to Myers (2004), the abstract Western conception of the person also leads to the understanding that there can be a clear separation of the professional and social relationship (relational boundaries). There is an emphasis on privacy and confidentiality in order to strengthen boundaries and enhance personal agency and self-integrity. Likewise, therapist self-disclosure is limited: the focus is on the patient and the professional nature of the relationship. The therapeutic space is arranged in segments of about 50 min or so; the idea being that the patient or client needs to be assisted to accept limits. Without detracting from the potential therapeutic value of some of the abovementioned ideas and arrangements, it should be noted that other cultures have different notions about relationships (boundaries) and time (Booth 1975; Janca and Bullen 2003). Hence, a linear conception of time may not be in the service of the therapeutic relationship: where value is placed on establishing positive human relationships, pre-occupation with time segments may impact negatively on the therapeutic relationship and patient care.

Several authors have argued that the idea of an autonomous self is not the primary basis of societal organisation in most societies; this is more so in non-Western cultures, where human solidarity and interdependence, is prized. According to Geertz (1979):

> *… the western conception of the person as a bounded, unique, more or less integrated motivational and cognitive universe … organized into a distinctive whole and set contrastively both against other such wholes and against a social and natural background is, however incorrigible it may seem to us, a rather peculiar idea within the context of the world's cultures.* (p. 229)

Given that the idea of the person differs from culture to culture, and taking into consideration that conceptions of ethics and personhood are intertwined, it follows that principlism or any universalistic approach to ethics, for that matter, is insufficient, as it cannot account for ethical definitions and understandings across contexts, history and time. It is becoming evident that the tendency to import Western philosophical and ethical presuppositions, to understand practices such as informed consent, beneficence and justice, to mention a few, may be in conflict with the local ontologies and epistemologies (Onuoha 2007). Not only do different cultures present with different understandings of what it means to be a human person, variations also exist when it comes to illness explanatory models, leading to different clinical realities (e.g. the meaning of illness, its perceived causes and course and the preferred treatment outcomes) (Kleinman 1980). Johnston (cited in McKay 1976) rejects the idea that ethics and culture are independent and goes on to state that, as human beings live and conduct their affairs according to culture-bound values and heritages, the imposition of the values of one cultural group, on other groups, under the pretext of universality, is itself a matter of ethics.

Challenges posed by Western (principled) ethics are most evident in conflicts between the idea of autonomy, versus the understanding that the human person is inseparably and dynamically bound to a social and moral community, apart from which personhood is inconceivable. To fully appreciate these dynamics and their bearing on ethical issues, it is important to introduce the main tenets of an indigenous African worldview. From here the chapter proceeds to present the idea of Ubuntu-Botho as a foundation of an African-based approach to ethics.

3.3 African Psychology and Worldview

According to Much and Harre (1994), a culture's psychological discourse is based on historically-particular metaphysical ontologies, out of which are derived theories about the person (i.e. the meaning of personhood), as well as the social and natural order. Much and Harre (1994) write:

> *… all psychologies do and must secrete moralities or part of moral systems, and … any concept of psychological well-being itself explicitly or implicitly presupposes moral values. The crucial question is what is it about the language of particular psychologies that motivates the moralities that arise from them? We suggest that it is the fact that all psychologies themselves are connected to underlying metaphysical ontologies which (explicitly or implicitly) order things in specific ways with regard to what is 'good' and 'bad,' 'right' and 'wrong' about conditions of life, and advance teleological aims for envisioned forms of life.* (p. 308)

In the section that follows, the chapter draws from a number of authors (Bynum 1999; Myers 1985, 1987; Nwoye 2006, 2015; Jegede 2002; Karenga 2004; Hampâté Bâ 1981) to present some of the main assumptions that influence understandings of psychological topics from an indigenous African perspective. The chapter does not address the question whether these tenets apply to all African peoples, as we are of the view that an expectation of this nature is not only misdirected but also fails to appreciate the dynamic, fluid, complimentary and inclusive (di-unital) epistemology that underpins the indigenous African worldview (Grills 2004; Nabudere 2011). Rather, the idea is to build on these understandings to show that an ethic that is based on these presuppositions is not commensurate with the idea of abstract or autonomous, spirit-less, personhood. As we illustrate, in indigenous African thought

"… no one person or situation or thing is ever ultimately separate or autonomous from anything. Psychological and emotional boundaries are a matter of emphasis or focus, not a matter of absoluteness" (Bynum 1999, p. 88). This leads to a different approach to ethics, which privileges connections and interdependences, through the shared Life principle.

3.3.1 Life Energy, Spirit and Transformations

According to Myers (1985, 1987) and Nabudere (2011), the Afrocentric psychological paradigm is holistic; it does not draw distinctions between the material and spiritual realms. This paradigm proposes that reality is both material and spiritual at once. According to this paradigm, which has been called *personalism,* "the essence of reality is taken to be the personhood of persons, objects, situations, and forces" (Bynum 1999, p. 86). The universe is alive; it is permeated by interconnected life energies that constantly interact with each other, in non-linear space-time (Bynum 1999). This means that all categories of be-ing, including *umu-ntu* (human person) and *izi-nto* (material objects), participate in -*ntu,* the life energy or Spirit, known by different names, such as *Moya* (Nguni, South Africa/Zimbabwe) (Baloyi 2008; Muthwa 1964), *seriti* among the Sotho/Tswana in South Africa (Setiloane 1986), *chi* among the Igbo of Nigeria (Achebe 1998; Martin 2008), etc. According to Muthwa (1964), apart from the person being Spirit (Moya), all parts of the human body are comprised of their own *moya,* hence there is *moya of* the liver, heart, lungs, intestines, etc. This is an affirmation of the principle of consubstantiation, meaning that the whole is contained in its co-constituent parts and vice versa (Myers 1985).

The Spirit (-*Ntu, Moya*) also extends to non-living, material objects. Thus writes Akiwowo (1980, p. 17, cited in Bynum 1999, p. 87):

> *Africans, to my mind, perceive spiritual beings in the world around them. They perceive that the true substances—that is real selves of such objects as man, trees, rivers, hills, desert-land, fishes, crocodiles, horses and the like—are these forces which continue in being after the physical forms of the objects have been rendered inactive somehow. As illustrations, they aver that when a fire is extinguished its real self is sheathed in ashes awaiting the next occasion to burst forth in flames; that when a banana tree matures, the real banana assumes new expressions in offshoots, and that a tree cut down by a wood cutter, comes out as a tender sapling. The capacity of human beings to reproduce their kinds is merely one way of expressing the substance or realness of humans.*

From the above we can deduce that there is nothing as a lifeless universe in the indigenous African point of view, as all creations share in the Life principle (Ruch and Anyanwu 1981). Ultimately, this entails that matter and spirit, object and subject, are not separable; they are dynamically intertwined. As Karenga (2004) notes, the idea of the Life principle (energy) is also derived from the continuity thesis, the understanding that humans and all of creation are extensions of and continuous with the Ultimate Source of Life (God, *Umvelingqangi*, *Modimo, uThixo*). Writes Karenga (1999, p. 51) "For all that exists … emanates from the Creator who in the process of creation broadens out … and invests himself in the construction of existence and brings into being being itself and then all beings thereafter". This is commensurate with the Zulu conception of God, as *uM-veli-ngqangi*, the prefix "*Um"* denoting a number (i.e. derived from Class 1 nouns, indicating a general or abstract noun, until it is concretised, i.e. a single or unitary being); −*veli*, being derived from the verb -*vela*, meaning to emerge; and -*ngqangi,* literally meaning the one that emerged first, but specifically indicating no particular origin and no direction; a continuous, ever-present being that is not bound by space and time (Baloyi and Ramose 2016), a being that permeates the universe. "Life", according to Nobles et al. (2016, p. 41), "rightly directs us to the underlying core principle of African being and becoming, that is, TO BE". They continue to argue that, according to peoples of Bantu-Congo origin, "[t]he existence of everything is in (Be)ing … the universe is living, mobile and dynamic, and that in (Be)ing there is an intense complimentary rhythmic connection between the person and all of reality. TO BE as represented by the idea of 'LIFE' is the human imperative" (p. 41). In the sections below, the author argues that affirming the Life principle, inherent in everything, is at the core of an indigenous African approach to ethics.

The continuity of Life principle renders ontological *separation between mind and matter,* body and soul, human beings and other human beings, living and deceased, God and humans, ultimately meaningless, as all are manifestations of or differentiations from a single source (Karenga 2004). According to Bynum (1999), "in this worldview is rooted the notion and implicit perception of continuous transformations, including the re-incarnation of all beings high and low" (p. 87). The transformation motif informs the understanding that there is a reciprocal communication between the living and the living-dead (ancestors) Bynum (1999, p. 91) notes:

> *In this active perception of transformations in all of the life processes in creation, personal or egoic death is seen as real, yet an illusion to the soul and a radical shift in spiritual consciousness. There is an inherent belief in the levels of consciousness as reflected in the perception of the presence of deceased family members at different levels of subtle embodiment and our capacity to make contact with them.*

Among indigenous black communities in South Africa, this communication is effected by means of ongoing dialogues with the deceased, from the moment it is announced that they have passed on (Ogbonnaya 1994). The nature of the dialogue varies from clan to clan, although the use of the *mphafa* or *mlahlankosi* tree (*Ziziphus mucronata* subspecies) branches and the burning of *impepho* (incense) feature prominently. The *mphafa* is regarded as a holy tree, and as such it is used as a medium to communicate with the deceased, especially during funeral ceremonies, to ensure that the spirit (*Moya*) of the deceased is not lost but is able to find its way home.

At this stage, a practical example that is likely to be familiar to Nguni and Sotho/Tswana speakers in Southern Africa is useful to illustrate this idea of the shared Life principle, the consciousness that is implicit in everything (Bynum 1999). When members of the abovementioned groups meet to exchange greetings, they inquire in particular about the person's life as well as their family's life. The greeting is always in the plural (e.g. *Sanibona*, *Sawubona*, literally, we see you [plural] or we see your family). This does not refer to the actual act of perception, as that is self-evident; it is an inquiry into the life of the person, her or his family, their compound, livestock, community, etc. The person being so greeted usually responds by affirming that they have life (*si ya phila*, *re a phela*), meaning that their life energies are still in harmony with those of their neighbours and the energies of whatever they exist in relation to, such as their animals and crops. Illness, suffering, death, failure of the crops or conflicts with the neighbours, to mention but a few examples, indicate that the principle of life, which connects one to everything that exists, has been diminished by wrongdoing or other means. Harmonisation or restoration processes (Nobles 2006) are required to re-invigorate the life energies. According to this worldview, therefore, the primary purpose of existence, and hence the ethical and moral standard, is to co-exist with one's surroundings and to strengthen the life forces that exist within the community and all of creation (Kasenene 1992; Ruch and Anyanwu 1981). Failure to do so is perceived in ethical and moral terms.

3.3.2 Holism

Contrary to the fragmented European epistemology, which seeks to separate reality into its most basic constituent parts, indigenous African epistemology is grounded on a holistic worldview: nothing exists in isolation, as everything is dynamically connected to, and interacts with, its surroundings (Karenga 2004; Luyaluka 2016; Nabudere 2011). From an indigenous African worldview, arising out of the Nile valley civilizations (Diop 1974; Hampâté Bâ 1981; Nabudere 2011), "reality is undivided and exists in its wholeness and interconnections as a force of energy, which is constantly in motion as matter. Matter exists only as a vehicle through which energy and force (or power) can manifest themselves" (Nabudere 2011, p. 105). This holistic understanding of the world means that everything is inherently connected to, and echoes that which it is not, hence the idea of di-unital, as opposed to unital, logic (Myers 1985, 1987). This is also known as the participation mystique or complementarity principle. Di-unital logic (Dixon 1970), reflecting the simultaneous co-existence of opposing forces, which complement each other (*oneness in two-ness*), is one of the major principles of the Dogon (Mali) understanding of the world (Griaule 1965; Nabudere 2011). It conceives "life's development as 'the perpetual alteration of opposites—right and left, high and low, odd and even, male and female—reflecting the principle of twin-ness which ideally should direct the proliferation of life" (Davidson 1969, p. 39, cited in Nabudere 2011, p. 106). The idea of twin-ness (*ububili, ububini*) or mutual co-existence finds articulation in the proverbs and sayings of the Nguni in Southern African, such as *izandla ziyagezana* (the hands wash each other), and *ubucu obuhle buhamba ngababili* (beads are beautiful only if they go in pairs).

According to Myers (1985), Bynum (1999) and Nabudere (2011) the modern sciences are beginning to open up to the holistic, indigenous worldview that recognises the mutual participation of human beings and the universe. For example, Anshen (1986, pp. xi–xii, cited in Nabudere 2011, p. 109) writes as follows:

> *This universe of which we human beings are particles may be defined as a living universe, its respiration being only one of the many rhythms of life. It is evolution itself. Although what we observe may seem to be a community of separate, independent units, in actuality these units are made of subunits, each with a life of its own, and the subunits constitute smaller living entities. At no level in the hierarchy of nature is independent reality. For that which lives and constitute matter, whether organic or inorganic, is dependent on discreet entities that, gathered together, form aggregates of new units which interact in support of one another and become an unfolding event, in constant motion, with ever increasing complexity and intricacy of their organization.*

Wholeness means that the separation of moral and ethical conduct from people's aspects of life, such as their community, art and lived experiences (participation), is meaningless (Bujo 1998; Verhoef and Michel 1997). Whilst in the Western tradition, moral and ethical conduct reflects the behaviour of individuals according to rules and principles that have been abstracted from the context, from an African perspective, ethical conduct has to be grounded in communal life (Verhoef and Michel 1997).

3.3.3 Harmony and Balance

In African indigenous thought, God, the ancestors, plants, animals, living and non-living objects, co-exist together, in harmony and balance (Luyaluka 2016; Verhoef and Michel 1997). This arises from a holistic ontology "that places humans in the midst of a world in which they share a common origin and common substance [spirit] with all modalities of being" (Karenga 1999, p. 51). According to the African worldview, we live in a communicative and vibrating universe, which is always emitting and receiving messages. Hampâté Bâ (1981, p. 171) writes:

> *The visible universe is thought of and felt as a sign, the concretization of or the outer shell of an invisible, living universe, consisting of forces in perpetual motion. Within this vast cosmic unity everything is connected, everything is bound solidly together; and man's behavior both as regards himself and as regards the world around him … is subject to a very precise ritual regulation.*

In the worldview espoused above, the goal of becoming a human person is not to extricate oneself from this vibrational (rhythmic) universe; rather, human beings, in their actions, speech, deeds, etc., are expected to live in harmony with and promote life's vital connections. This is obtained when there is social harmony and equilibrium between the unit (individual) and the whole (community) (Kasenene 1992). Violation of natural laws, the intricate balance that exists within the whole, constitutes a moral and ethical transgression. These transgressions are not limited to the individual being in disharmony with nature; they destabilise the natural order itself

(Ruch and Anyanwu 1981); this requires that steps be taken to bring about restoration, through healing. It is important to note that rhythm (e.g. speech that is chanted rhythmically, rhythmic dance such as the one performed by the *izangoma* [spiritual healers], singing, etc.) is essential in re-establishing the equilibrium or balance of energies (forces). In the indigenous African worldview, rhythm (vibrations, patterns) frees oneself from the ordinary (egoistic) consciousness, and in so doing, enables the individual to be one with, and participate in, the multidimensional universe. It is a common form of healing (restoration of harmony) among the traditional (indigenous) healers in Africa (Bynum 1999). This affirms the idea of an individual-in-continuous-participation with other people and its surroundings. The following section turns to the discussion of this idea of the person (*Umu-ntu*), in detail.

3.3.4 Communal Personhood: Umuntu Ngumuntu Ngabantu

In indigenous African thought, becoming (psychological development) does not entail a process of individuation or the actualisation of one's innermost psychological attributes, independently of the family or community of which one is a part (Kinoti 1992; Menkiti 1984; Verhoef and Michel 1997). Commensurate with the idea of holism and the dynamic interdependence between the parts and the whole, it is by means of participation, in a community of mutually defined (ethical) selves (*aba-ntu*), that a human being finds self-definition and meaning in life. This view of self-hood has been referred to in various ways, for example as the extended self, the communal self, the social self, communal consciousness, an interdependent self, etc. (Bynum 1999; Karenga 1999; Mkhize 2004; Myers 1985). Mbiti's (1969) well-known maxim, "I am because we are, and since we are, therefore I am" (p. 214), sums up the importance of the community in African indigenous understandings of what it means to be a human person. The Nguni or Sotho/Tswana sayings, *umuntu ngumuntu ngabantu* or *motho ke motho ka batho,* meaning a human being is a human being because of other human beings, affirms the understanding that one cannot be in isolation, independently of participation in a community of other people. To be human, argues Ramose (1999), is an ethical and moral imperative: it calls upon one to affirm the humanity of others, thus establishing just and human relationships with them.

The maxim, *umuntu ngumuntu ngabantu,* points towards the understanding that being human is not located inside the person; it involves a ceaseless becoming, a flow, movement, or dialogue with one's surroundings as one participates in the community and vice versa. Karenga (1999) affirms that the ethical ideal, according to an indigenous Kemetic (African) worldview, is defined with reference to be-ing and participation. He argues that being human entails participation in an ongoing challenge to establish just relationships in the multiple spheres constituting the vibrational universe. A human being is thus not an isolated entity; she or he can be defined as her/his practices—in relationships, a be-ing in motion (Karenga 1999). In support of this view, Ramose (1999, p. 51) defines *umuntu* as follows:

> *[Umuntu] is the specific entity, which continues to conduct an inquiry into experience, knowledge, and truth.* ***This is an activity rather than an act. It is an ongoing process impossible to stop. On this reasoning, ubu- may be regarded as be-ing becoming and this evidently implies the idea of motion***. (emphasis added)

Becoming, or movement, is realised as people participate in the life of the community, by fulfilling their responsibilities. As Menkiti (1984) argues, the community refers to the organic relationship between the individual and their social and ecological milieu: a sense of community exists if people fulfil their duties and responsibilities to each other as well as everything to which they stand in relation. Menkiti (1984) has referred to this as the "processual" nature of be-ing, meaning that, having been born into a human community, the person goes through various rituals of incorporation, in order to develop the excellences that are thought to be truly definitive of what it means to be a person.

The term "community refers" to the past, current, as well as the future community. As Bynum (1999, p. 97) notes, the idea of the communal unconscious includes:

> *[n]ot only the somatic expression of the body but also the health of the family, the community, and a person's relationship to the gods. There is a subtle bias towards nurturance and interconnectedness with the wider ecology, a relational and resonate affinity in one's perceptions with a de-emphasis, but* ***not*** *negation, of objectification and market values. (*emphasis original)

Human beings are thus ontologically connected to, and live in relation with, those who are yet to be born (future generations), the current or contemporary community, and those who have come before them, the living-dead or ancestors. The severance of these connections, by failing to fulfil one's ethical and moral obligations is considered in ethical and moral terms. Thus, being human is not defined by virtue of one's physical and psychological properties—which are also important—rather, personhood is something that must be earned. The next section focuses on the ethical and moral ideals that arise from the abovementioned ideas.

3.4 An African Indigenous Approach to Ethics

> *At first glance it would appear that culture and ethics are unrelated. But let me state that, in general, men and women conduct their affairs, enterprises and lives according to the values that they have derived from their cultural heritage. And because the values of each cultural heritage differ in some form and degree, there may at times be conflict.* ***It becomes a matter of ethics when the resolution of cultural and value differences and conflicts is made to the advantage of one party and to the disadvantage, harm, and distress of another***. (Johnston, cited in McKay 1976, p. 173, emphasis added)

Having presented some of the main tenets of an African indigenous worldview or approach to life in general, the chapter moves on to discuss the ethical ideals arising from this understanding of life. These tenets are not to be understood as abstract principles that are to be applied to all peoples of African ancestry, as so doing would reduce ethical decision making to a technique, and not an art that arises out of, and affirms the relationships between two or more humans (*abantu).* An African indigenous understanding of ethics is based on the hermeneutic paradigm; it involves two or more parties entering into and establishing a relationship of mutual understanding and trust. This is based on the view that an ethical moral agent cannot have predetermined solutions; rather ethical decision making calls upon us to listen attentively and respectfully to the Other, paying special attention to the horizons of understandings (worldviews) by means of which they make sense of their experiences (Gadamer 1975). Predetermined ethical solutions are incommensurate with the idea of the world in flux (becoming). Ethical resolution *emerges* out of the dynamic encounter between the knowledge traditions (worldviews), as well as the interplay of the multiple components (traditions) comprising the human person.

At times, the traditions and worldviews referred to above will be in conflict, be it between people or communities (as in the conflict between African indigenous and Western traditions), as well as within the intrapsychic community of selves (worldviews) comprising each person (Ogbonnaya 1994). A truly ethical stance does not proceed from the perspective that one ethical tradition is a priori superior to others; in fact, the whole question of superiority versus inferiority disappears in favour of discourse (*legotla, ingxoxo,* a conversation between equals). In the book, *Monocultures of the Mind,* Shiva (1993) is highly critical of the violence that was unleashed by the dominant Western tradition against local knowledges. Often labelled as "primitive" and "unscientific", local knowledges are denied the position of a systematic knowledge. Noting that all forms of knowledge are incomplete without the pieces of the puzzle emanating from other knowledge traditions, Ramose (1999) and Nabudere (2011) are critical of the totalising tendencies of the Western knowledge tradition, which has led to what they refer to as epistemicide (the colonial act of killing knowledge). Together with De Sousa Santos (2014), they call for cognitive justice, meaning the recognition of the potential contribution of all knowledge traditions towards the resolution of the world's challenges.

It is with the abovementioned background in mind that the ethical ideals that arise from an African indigenous worldview, are presented. While the author recognises that other indigenous communities may share similar ideals, they have been referred to in this chapter as "African", as it is through this background, constituting the author's location (standing), that he has come to know, appreciate and attempt to live them. Although the section below relies primarily on the work of Onuoha (2007), the ideals are drawn from a number of authors, such as Gbadegesin (1993), Karenga (1999, 2004), Mkhize (2006), Rakotsoane and Van Niekerk (2017), Tangwa (1996, 2000) and Toldson and Toldson (2001), to mention a few. Further, the ideals are by no means exhaustive; they constitute an invitation to a dialogue. They are: *respect for life*, *human and ecological solidarity*, *justice in health care* (Onuoha 2007) and *dialogue*.

3.4.1 Respect for Life (Spirit-ness)

Respect for the autonomy of the individual is one of the most important ethical principles in the Western tradition (Beauchamp and Childress 2013; Ssebunya 2017), it undergirds a number of professional and research codes of ethics. Out of this ethical principle arises other considerations such as the primacy of the individual in negotiating informed consent, be it for research or clinical purposes (Doumbo 2005). It is important to point out that in principlism it is the rational and autonomous (self-governing) moral agents who are capable of thinking and deciding their own fate, that are deserving of respect. This excludes those who are comatose, the senile, foetuses, and the like, as they are not capable of autonomy and rationality. While recognising the individuality of persons, the indigenous African worldview subsumes respect for persons under the broader principle of respect for life in general. This emanates from the understanding that everything, humans, non-humans, etc., being deviations from a single source of Life, *uMvelingqangi* (God), are worthy of respect, irrespective of the quality or nature of the life in question. It is not rationality or autonomy that guarantees respect. Rather, respect is accorded to all and everything, in all stages of enfoldment, by virtue of their participation in the Life principle. The comatose, the non-rational, the unborn foetus across all stages of development, the earth, trees and all life forms, etc., are all objects of respect. The spirit or *moya,* which human beings share with everything, necessitates this respectful attitude towards life. According to Onuoha (2007), in the Igbo worldview, each individual is a unique source of value by virtue of the *emi*, the divine spirit or breath in which they partake. Similarly, Karenga (1999, p. 45) argues, “This ontological understanding is the ground for the concept of human dignity, which posits that human beings and human life are of transcendent value and worth independent of social status or achievements or other attributes”.

The continuity (of life) thesis, as discussed above, as well as the understanding that life is a series of transformations, from one state of bei-ng to another, leading ultimately to wholeness or unification with the Ultimate source of life (Bynum 1999), reinforce the idea of respect for life in general. The researcher or clinician is likely to come across several ethical challenges which emanate from the belief in the idea of respect for life. These challenges include, but are not limited to, African people’s attitudes towards abortion and organ donation, blood donation, suicide (including assisted suicide), childlessness, surrogate/assisted pregnancy, adoption, to mention a few (Gbadegesin 1993). For example, in indigenous African thought, the manner of death (i.e. the process by means of which one makes a transition to the next world) is of special significance. It is understood that death by accident, as well as suicide, renders the deceased unclean and not worthy of continuing their journey to the next level of being, in the reincarnation cycle. A person, who has died by accident or suicide, has the potential to pollute the entire community; usually, his or her corpse is not allowed back into the family compound. Over and above, cleansing the deceased’s body is necessary in order to reaffirm the equilibrium of life forces, which have been thrown into disarray by the suicide act. The family also undergoes a ritualistic cleansing process. It is understood that the failure to undertake this restoration process will lead to more suicides in the family, in future. This attitude towards suicide is aptly captured in Chinua Achebe's (1958) novel, *Things Fall Apart,* in which the tragic hero, Okonkwo, completes suicide. His fellow kinsmen and women refuse to bury his body or even touch it, leaving such to the outsiders. Okonkwo, in killing himself, had violated the Life principle itself. Indigenous African attitudes towards suicide (including euthanasia, assisted suicide) should be understood against this background.

As with all the ethical ideals presented in this chapter, the abovementioned discussion does not mean that all African communities adopt a blanket approach towards euthanasia or abortion for that matter. Cultural and within-cultural differences do exist, and this may extend to variations within a person over a period of time. African individuals, even those that adhere to the worldview mentioned above, will and do complete suicide and abortion. Indeed, Gbadegesin (1993) argues that the Yoruba idea of *Ikuyajesin* (meaning death is preferable to loss of dignity), spells out the conditions under which euthanasia is permissible. Ethical considerations, however, are not limited to whether an act should be committed or not, they extend well after the act. Ethical dilemmas also include the individuals' internal dialogues with the multiple components of the person (Spirit-ness in particular), the contemporary and ancestral community, and the gods. It is thus the purpose of the chapter to equip researchers and clinicians with a body of knowledge that will assist them to understand ethical complexities in different cultural contexts. Ethical decision making is not dictated by an a priori knowledge of the person's culture or worldview. While such knowledge is extremely important, it is the moment-by-moment conversation, in a respectful and trusting environment, in which all voices are given an equal say that makes ethical decision making meaningful.

3.4.2 Human and Ecological Solidarity: Ethics of Ubuntu

Ubuntu leads to an understanding that the survival of the community is an important ethical consideration. As indigenous African approaches to ethics are grounded in social and communal life, human and ecological solidarity becomes an important moral and ethical imperative. People are expected to maintain the balance of forces in the universe, in their actions and speech (words). An imbalance leads to the destabilisation of the family, community and the social equilibrium of the universe as a whole. On these grounds, Verhoef and Michel (1997) have referred to African indigenous ethical and moral systems as covenantal and circular. The community is always in a state of flux; it is strengthened if individuals fulfil their moral and ethical responsibilities, while failure to do so brings about communal disintegration and separation. The social equilibrium is re-established should community members work interactively to address the sources of destabilisation (Verhoef and Michel 1997). *Ubu-ntu*, *ubu-* meaning the process of becoming, and *-Ntu* meaning spirit (−*moya*), refers to a be-ing that is oriented towards the affirmation of the Spirit-ness that binds all phenomena. Many authors translate the word Ubuntu to mean humanness. However, this is a very narrow definition of this polysemic term. We concur, together with Karenga (1999) and Mkhize (2006, 2008) that the word *umuntu,* and hence the word, Ubuntu, points towards a being whose actions are guided by the high laws of Maat, an ancient Kemetic (Egyptian/African) term which incorporates the idea of caring (*uku-nakekela*, *ubu-mnene*), justice/law (*umthetho*), truth (*iqiniso*), righteousness (*ubu-lungiswa*), balance (*uzinzo*), order (*ukuhleleka*), etc. Hence, the king was regarded as the embodiment of Maat, *umlomo ongathethi manga*, meaning the mouth that does not utter the untruth (i.e. a strict observer of the principles of Maat). This means the king was the custodian of the Ubuntu ethics, as defined above. The Maatian or Ubuntu ideal is the fundamental basis of an African approach towards ethics: it reflects actions of a be-ing-in-motion, a bei-ng that is grounded in social life.

The worldview espoused above means that living in solidarity with other people as well as one's environment becomes an important ethical consideration. The idea of *umuntu ngumuntu ngabantu*, means that an individual's dignity is incomplete, unless it is intertwined with the dignity of fellow human beings. Similarly, the saying *inkosi inkosi ngabantu* means the king is incomplete without the people, thus affirming the principle of mutual interdependence. To be a human being, therefore, is an ethical project par excellence: it requires one to promote the dignity of others as well as living in harmony with the surrounding environment. The welfare of the individual is interwoven with the welfare of others; hence it is in everyone's interest to promote and protect the common good. It is important to point out, however, that human and ecological solidarity is attained if people live according to and observe the high moral ethical principles of Ubuntu (justice, caring, truth, righteousness, balance, etc.).

At the level of clinical practice, human solidarity finds expression at the aetiological, diagnostic and treatment levels. In indigenous African societies, the causes of illness or the explanatory models, are not limited to the individual; they include a spirit dimension of which the individual is a part (Nobles et al. 2016). Hence the focus on supernatural causation, even if the psychological or physical causes of illness are well-known. Likewise, the treatment is usually extended beyond the individual; it includes all those who are part of the person's inner circle, such as the family. Thus, there is solidarity with the individual affected by the illness. The system as a whole is considered to be in disarray and in need of intervention. This has several ethical implications in terms of how we understand the plight of others, in a world in which pandemics such as HIV and AIDS are having a huge impact on our communities. Do we feel implicated in and moved by the plight of others who are less fortunate than us? An ethic of Ubuntu calls upon us to do so. We would be equally moved by the devastating effect of the Ebola virus in West Africa, and, feeling the pain as our own, take action. A similar attitude would be adopted towards the environment: the ethics of *Ubu-ntu* calls upon us to recognise the environment as a living entity in its own right; it is endowed with -*ntu* (Spirit), all creations being deviations from a common source. Hence our own survival (definition) is implicated in the survival (definition) of the environment. The environment can be exploited to the extent that it is necessary to support human life, and not as an end in itself. To this end, a traditional healer is allowed to harvest medicinal plants only after having performed the necessary rituals and prayers. The harvesting should be done in such a way that the plant itself is not destroyed and can regenerate.

3.4.3 Justice in Health Care

The healthcare system is characterised by gross disparities between Northern and Southern nations, as well as within the Southern nations themselves (Brodwin 2001; Onuoha 2007). Many countries in Africa and the South are still grappling with diseases that have been eliminated or are completely under control in the Northern hemisphere. That in itself constitutes a matter of grave ethical concern. An Ubuntu approach to justice, it is hereby pointed out, calls upon us to make life-saving treatments available to everyone, independently of their standing or social status such as wealth. In a world in which nurturing the Life principle is paramount, availability of treatment should not depend on the patient's ability to afford the cost thereof. Indeed, it was the responsibility of the traditional healer in an indigenous African setting to treat everyone, without the expectation of being paid. Healers often received gifts from the community to enable them to fulfil their call to heal.

Justice would also entail that professionals are trained in such a way that they are equipped to deal with the problems emanating from all sectors of society. For example, the training of health professionals such as psychologists, medical practitioners, nurses and social workers, should involve minimum competency in indigenous African languages (Drennan 1999; Pillay and Kramers 2003; Pillay et al. 2013). Patients should not be denied services or be subjected to situations where they are given substandard care (e.g. through the use of interpreters in counselling) because professionals are not au fait with their languages. In the author's opinion that constitutes an injustice within the healthcare system. The use of interpreters does not obviate this problem. This is not only because usually they are not well-trained, but also because the patient or client is forced into a situation in which she or he has to divulge her or his problems to a non-clinically trained person. The silencing (exclusion) of indigenous languages, epistemologies and theories of illness, constitute cognitive injustice. As De Sousa Santos (2014, p. 207) points out, "There is no global social justice without global cognitive justice". Extending the idea of cognitive justice to healthcare requires us to undertake research into the issues affecting the local populations, using indigenous theories of illness or explanatory models, while remaining cognisant of competing alternative explanations. This constitutes an ethical (justice) imperative without which the knowledge domain will remain an incomplete project.

3.5 Case Studies in African Ethics

To illustrate the relevance of African perspectives in ethical deliberation, below are presented a summary of case studies, which have been sourced from professional practice. The purpose is not to imply the dilemma inherent in each case can be resolved one way or the other; as that would imply a view that ethics is about technical applications (see below). Rather, the aim is to bring to the readers' attention, the importance of understanding the background life world of the person, their worldviews, as it is against this background that the ethical dilemma unfolds.

First Presenting Case: Clinical/Professional Ethics

Nontobeko was raised in a traditional African family in Northern KwaZulu-Natal, South Africa. Her family observed all the rituals and practices associated with their clan. Her grandfather, a school principal, was very passionate about the education of girls; he wanted the best education for his granddaughter. As a result, when Nontobeko was 14 years old her grandfather arranged for her to attend a girls' boarding school in Durban. The idea was to get her to a good high school, in preparation for the matric examination. A few months into the year, after starting in her new school, Nontobeko discovered that she was pregnant. She was scared to discuss the matter with her mother or members of her family. Instead, she opted to seek the counsel of her friends, who advised her about the option of an abortion in one of the public hospitals in Durban. The abortion was performed without complications and Nontobeko returned to school to finish her matric. She went on to complete her university degree, and, at the age of 24, got married to her boyfriend of many years. They were blessed with a baby girl.

Of late, Nontobeko has been having dreams, in which she sees visions of her aborted child, now a grown boy of 11 years. The boy always appears crying, complaining that he is hungry, without a name and destiny. The dream repeats itself, and Nontobeko has grown thin due to her lack of appetite. This has attracted the attention of her husband, and their relationship is becoming strained. It is at this stage that the couple presents before a psychologist for counselling with the strained marital relationship being the problem.

Presenting Case Number 2: Consent and Revealed Knowledge

Nomageja is a Masters student; he is in the process of completing his dissertation. He has always been intrigued by the existence of two parallel healthcare systems in South Africa, namely one based on allopathic medicine, which has wide recognition, and another based on indigenous healing/medicine. He decided to study the attitudes of traditional healers and Western trained practitioners towards an integrated healthcare system. When he visited his first traditional healer to seek consent for the interview, the healer listened patiently. Thereafter the healer told him to come back in about 2 weeks for an answer. He explained that he (the healer) was not in charge of the knowledge; he was a mere vehicle of the ancestors, who reveal the knowledge to him. As a result he first needed to burn incense, fast and seek the guidance of the ancestors, as to whether to participate in the study, and which *knowledge to reveal, and how. Nomageja relayed this information to his supervisor, who concluded that the healer was obfuscating the research process and advised him to pursue another study.*

Presenting Case Number 3: Community Participation and Authorship
Zenzele, a PhD student, presented to a rural community with an ethical clearance letter from an esteemed university. He wanted to enter the community in order to collect data for his study. The council of elders in the community convened. After a long discussion the elders informed Zenzele that they had never heard anything about the study, be it from his university or supervisor. Many people had been coming in and out of the community, collecting vital information and not even acknowledging the elders as the source of this information. In the long term the knowledge is archived in university libraries, as the invention of the researchers, while the original owners are silenced or written out of the projects. They also informed him that as a community they were experiencing their own challenges; they would appreciate it if they are a part of the process to identify the problems to be researched, and how. The elders also advised Zenzele that they did not recognise the piece of paper he was carrying. A person of honour, they said, does not rely on a piece of paper to validate his or her genuineness; many before had come to the community with such papers and never came back after the study. They advised him that he needed to start afresh and engage the council. Zenzele discussed the matter with the supervisor, and the project was delayed by a year.

It is not the purpose of the chapter to discuss the above-mentioned case studies at length. Rather, the intention is to show that, in engaging ethical dilemmas of this nature, the practitioner, researcher or reader needs to invest in knowledge traditions other than those emanating from the West. For example, it would be difficult to make sense of the first case study if one is not aware of the indigenous African understanding of the person, as well as the idea of respect for Life (Spirit-ness) (Nobles 2006). According to this view, death is an illusion; life involves a series of transformations, from one state of be-ing to another (Bynum 1999). Thus, it would appear that the aborted child is still partaking in the journey of life; this requires the family to undertake some ritual processes associated with death (e.g. naming the child, cleansing the body, mourning the loss, etc.) to assist him or her to complete this process.

Likewise, the second case study requires one to be familiar with different forms of knowing, including revealed knowledge. The spiritual basis of knowing also needs to be acknowledged, as well as the idea that it is not the research participant per se that gives consent. In addition, there is an invisible audience of the living-dead, the real owners of the knowledge, who ought to be consulted. The final case study relates to how one goes about establishing a relationship of mutual trust and respect between researchers and communities, as co-participants to the research process (Doumbo 2005). It also borders on issues concerning the ownership of knowledge; how communities can be recognised as the genuine producers of knowledge (co-researchers) and not as sites from which knowledge is to be harvested. The above highlights that an ethical stance would recognise that no knowledge tradition is complete on its own. This in turn calls upon the moral agent to engage in a genuine dialogue with other ethical traditions in order to enhance his or her understanding.

3.6 Lessons from Africa – Ethics of Dialogue

> *The principle of incompleteness of all knowledges is the precondition for epistemological dialogues and debates among different knowledges. What each knowledge contributes to dialogue is the way in which it leads a certain practice to overcome a certain ignorance* (De Sousa Santos 2014, p. 189).

The debate whether scholars and practitioners in Africa should follow "universal" Western ethics, such as those expounded in Beauchamp and Childress' (2013) principlism, namely beneficence, non-maleficence, autonomy and justice, or a distinctly African bioethics, is ill founded. This debate conceptualises ethics as a complete project that has been discovered or as something that is hiding somewhere, awaiting a genius to uncover it. This either-or approach, which is commensurate with Western logic, is not compatible with the holistic view towards knowledge. Wholism (Nabudere 2011) seeks to establish affinities even between incompatible points of view, in line with the idea of di-unital logic. We are of the view that the final word has not been spoken as far as the ethics debate is concerned. This necessitates a different approach towards ethics, namely dialogic or conversational ethics (e.g. Gurevitch 1990; Strang 1999). Similarly to the maxim, *umuntu ngumuntu ngabantu*, dialogic ethics calls upon us to recognise the Other, who is different from us. It involves the obligation to speak, the obligation to listen and the obligation to respond (acknowledge) the utterances (e.g. languages and epistemologies) of the Other (Gurevitch 1990). Dialogic ethics cannot be pursued from behind a veil of ignorance without the knowledge and appreciation of the horizons of understanding that condition one's thoughts (cf. Gadamer 1975). Any ethical consideration begins with an understanding of the culture, epistemologies, languages, philosophies, axiologies and theories of illness of the groups in question. Immersing one in the life-world of the Other, without taking a stance of superiority, is a prerequisite to ethical conduct. To this end the author concurs with Brodwin (2001) that ethics students should be instructed in multiple competing ethical traditions. Instruction in African philosophy, theology and indigenous moral and ethical thought, among others, is essential. The author also agrees with Ssebunya (2017) that most funded ethics programmes in Africa have focused on applied or empirical ethics in order to assist researchers and scholars to serve in ethics committees. Hence theoretical and conceptual thinking that could inform the ethics debate from an African epistemological perspective, lags behind. Solace needs to be taken in the knowledge that ethics is multidisciplinary and interdisciplinary by nature; there is a wealth of philosophical, theological and Afrocentric scholarship to draw from.

The ethics of dialogue is commensurate with the indigenous African tradition of *lekgotla*, *inkundla* or palaver (Bujo 1998), which involves gathering under a tree in order to discuss and exhaust all possibilities of a given topic. In the *lekgotla*, the truth is not pre-given; it emerges from the conversation in which all the participants are given an opportunity to voice their opinions, no matter how inconsequential they may appear to be (Ramose 1999). The dialogue is aimed at arriving at a consensus. Knowledge is thus constructed socially and communally, through negotiation. From this perspective, ethical discussion moves away from the concern with principles—although they too remain important—to the kinds of skills and attitudes that are necessary to negotiate tensions and exploit the possibilities that arise from the joint moral space that is created by the dialogue. Each of the participants to the dialogue bring different histories, traditions, as well as gendered realities, all of which need to be negotiated and balanced, in order to arrive at an ethical solution. For example, the critical question is not whether informed consent in African settings should be individualistic (autonomous) or communal. Obviously, there are instances where individual (autonomous) consent will be sufficient, while in some instances it will be grossly inadequate and fail to meet the ethical obligation. In some cases both will be required. We should thus be concerned with the kind of knowledge, skills and attitudinal dispositions that will be required of us to negotiate informed consent in diverse cultural settings. This requires training in the art of becoming a *phronimos,* in the Aristotelian sense, namely, mastering the skill of negotiating and making context-sensitive judgments, according to the demands of the situation (Mkhize 2006). This is a higher level skill than the mere knowledge of principles (*techne*), be they Western or African. Unfortunately, ethics training does not often incorporate the human sciences (medical humanities). Some researchers and clinicians think an approach of this nature delays research.

The critical question, of course, concerns the possibility of a genuine dialogue in the context of gross power imbalances between the participants. While it is beyond the scope of this chapter to address this question, it is important to point out the emerging scholarship from the South, which critiques the insularity of Western logic. For example, in introducing the idea of the *ecologies of knowledges,* De Sousa Santos (2014, p. 176) argues that "the logic of the monoculture of scientific knowledge and rigor, must be confronted with the identification of other knowledges and criteria of rigor and validity that operate credibly in social practices pronounced non-existent by metonymic reason". De Sousa Santos goes on to say that "[t]he ecology of knowledges focuses on the concrete relations amongst knowledges and on the hierarches and powers generated among them" (p. 190). The ethics of dialogue, as it is envisaged here, would entail a critique of the power relations between the different parties constituting the dialogue.

3.7 Conclusion

This chapter began with an overview of the influences of individualism in dominant Western psychological theorising. The idea of an abstract, autonomous self, it was argued, permeates most psychological theories, particularly those emanating from the West. It has been argued that self-contained individualism is not the dominant basis of societal organisation in most non-Western cultures, where the idea of a communal, interdependent self, is prized. As a result, ethical decision making that is wholly informed by the idea of an autonomous self, to the exclusion of other ideas, is not sufficient. Indeed, the universalising tendencies of the Western knowledge industry, has come under severe scrutiny from many quarters (De Sousa Santos 2014; Shiva 1993). In introducing the Afrocentric psychological perspective, the idea was to show that it is indeed possible to arrive at different understandings of what constitutes ethical dilemmas, as well as the relevant ideas to address them. Drawing from a holistic indigenous African perspective, which sees reality as fundamentally interconnected, three ethical ideals were introduced: (1) respect for life; (2) communal and ecological solidarity; and (3) justice in the healthcare system. These ethical ideals arise from the idea of Ubuntu, which conceptualises bei-ng as Spirit. Given the incompleteness of all knowledge traditions, the chapter calls for dialogue between equal voices and epistemologies. Ultimately, it is not the knowledge of principles and frameworks per se that makes our practices ethical: it is listening with one's body and spirit.

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Chapter 4
Ethics in Occupational Therapy – An African Perspective

Thuli Godfrey Mthembu

Abstract Occupational therapy is a client-centred profession seeking to enable people to attain/maintain good health and well-being through their participation in daily life activities. Recent developments in the profession have heightened the need for the inclusion of ethics from an African perspective and also the importance of the involvement of all stakeholders namely, occupational therapy students, educators, clinicians, regulatory bodies and the population being served. The first section focusses on the current gaps and challenges in ethics within the practice of occupational therapy in Africa. A synthesis of African literature is provided on how ethical issues are addressed in occupational therapy education and practices. Contextualised examples of ethical issues encountered by students, educators and therapists are presented. The second section of this chapter discusses the socialised model which promotes the principle of respect for patient autonomy and protection of patients' rights and the mutual relationship model which promotes the cultural belief, bio-psychosocial and patient-centred approaches. Furthermore, the integration of the ethical principles, legal expectations, policies and Acts that govern the occupational therapy profession are highlighted. Furthermore, the unique ethical dilemmas faced by occupational therapists practising in Africa are emphasised. In the third section, the relevance of ethics in material principles of distributive justice in occupational therapy practice in Africa is presented, specifically given the resource-poor nature of many African countries. The concept of occupational justice is evolving and gaining recognition among occupational therapists and occupational scientists in Africa and its implications in ethics are further explored in this section. In the last section, recommendations are provided for maintaining ethical standards in line with the ambit and ethos of the profession. In the conclusion, areas that require further research in ethical practice of occupational therapy with individuals, groups and communities in the African context are elucidated.

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4.1 Introduction

Ethics is defined as an application of values and morals to human activities (Monsudi et al. 2015) which are "grounded on socio-cultural, philosophical and/or religious beliefs of what is good and bad" (Gabr n.d.: 2). In addition, ethics includes "social dimensions and it is regarded as part of justice, rights, respect for human dignity, autonomy of the individual and respect of the community at large" (Gabr n.d.: 2; Mthembu et al. 2017a). However, it has been identified that most of the literature and teaching on healthcare ethics seem to adopt the westernised perspective from countries like the United States and the United Kingdom (Monsudi et al. 2015). Recent developments in healthcare have heightened the need for the inclusion of ethics from an African perspective for all health professionals, including occupational therapy (Monsudi et al. 2015). Occupational therapy is a client-centred profession seeking to enable people to attain or maintain good health and well-being through their participation in daily life activities. Therefore, there is an increasing recognition of the significance of ethics in the profession of occupational therapy and the importance of the involvement of all stakeholders, namely occupational therapy students, educators, clinicians, regulatory bodies and the population being served (Nortjé and De Jongh 2016; Van der Reyden 2008). Hence, the African perspective may need to consider individual socio-economic, geopolitical, religious and cultural background as part of ethics in occupational therapy to contextualise the focus in Africa. To understand and have a better insight into an African perspective of ethics in occupational therapy, the following aspects are addressed in this chapter:

(a) Highlighting the current ethical gaps and challenges faced by occupational therapists in Africa;
(b) Exploring models of practice that are relevant to ethical practice of occupational therapy with reference to Africa;
(c) Discussing the implications of the concept of ethics in material principles of distributive justice in occupational therapy practice in Africa; and
(d) Providing suggestions for addressing ethical challenges in occupational therapy in the African context.

4.2 Gaps and Challenges

It is acknowledged by various authors that the gaps in knowledge and practice of healthcare ethics are related to a lack of training and awareness of healthcare professionals with regard to ethics and law as separate courses (Monsudi et al. 2015;

Nortjé and De Jongh 2016). There has been a concern about poor ethical conduct and increase litigation against healthcare providers in Africa (Monsudi et al. 2015; Oosthuizen and Verschoor 2008). Oosthuizen and Verschoor (2008) suggest that health sciences education should make provision for the integration of human rights issues, medical law and bioethics in the undergraduate training programmes of healthcare professionals.

A synthesis of African literature on how ethical issues are being addressed in health sciences education indicates that practitioners need to be conscious of the legal and ethical discourse around issues related to practitioner-patient relationship (Oosthuizen and Verschoor 2008). The issues of concern are that practitioners need to be aware of contractual relationship, confidentiality in the practitioner-patient relationship, right to privacy, ethical and legal bases for informed consent as well as legal issues in mental health in different practice settings. It is imperative that health sciences educators, students and clinicians incorporate the knowledge and skills of ethical principles and legislative requirements as part of health sciences education (Oosthuizen and Verschoor 2008). The teaching of ethics education in occupational therapy could be facilitated through case studies, role-playing, critical reflection and journaling.

Being able to assess students' understanding of ethics education is an important aspect for educators and clinicians. Hoffmann and Nortjé (2015) argue that educators have a part to play in the assessment of students' learning of ethics education and facilitation of effective recognition of ethical issues and critical thinking. Furthermore, it is believed that students who can recognise and analyse ethical issues appear to make informed decisions (Hoffmann and Nortjé 2015). There are sub-aims of ethics education assessment which can be used to facilitate learning. These sub-aims include:

- Ethical sensitivity, where students' capability and consciousness to ascertain ethical issues in context are assessed;
- Ethics information, where students' understanding of and insight into information about law, regulations and professional codes are assessed;
- Value explanation, where students' competencies related to identification and description of scopes, ethical principles, facts and concepts are assessed; and
- Ethical judgement, where students' abilities to engage in an ethical analysis and argumentation together with course of action in relation to identified ethical issue are assessed.

4.3 Models of Practice in Relation to Ethics Occupational Therapy

By exploring the models of practice in relation to the discourse of ethical practice of occupational therapy in an African perspective could empower practitioners to learn to change their attitudes, behaviour and show respect towards their clients and clients' families. It is envisaged that these models could further strengthen interconnectedness and interdependence in occupational therapy practitioners and the people they serve in practice. Additionally, the models of practice could provide practitioners with better understanding of ethics in an African perspective that advocate and accentuate for Afrocentric, socialised, mutual relationship, cultural and religious diversity.

4.3.1 Afrocentric Worldview of Ethics in Occupational Therapy

It is significant for occupational therapists, educators and students to have an insight into the African perspective of ethics in occupational therapy. This echoes the theory of Afrocentricity which highlights the importance of "thought and action in which the centrality of African interests, values, and perspectives predominate" (Asante 2003:2). The theory of Afrocentric promotes the role of African people as a centre of any analysis in relation to the African phenomena. According to Watson (2006), the Afrocentric worldview considers "people's interdependence for what they are and have, community functions and determines their right" (p. 152). Thus, Ramugondo (2015) asserts that occupational consciousness can be considered as a strategy that "provides language through which people can describe how their individual and collective everyday doing can resist and challenge hegemonic practices that sustain all forms of unequal power relations" (p. 488).

It is essential for occupational therapists to use the lens of humanistic and holistic approaches to promote individual and collective worldviews (Diaz-Laplante 2007; Watson 2006). A humanistic approach has been defined as a framework that promotes engagement in all levels of human being by considering intellectual, spiritual, physical and social aspects, within the context of their community and intimate relationships (Diaz-Laplante 2007; Mthembu et al. 2017b). This leads occupational therapists to value humanity as a major foundation in focusing on the expansion of human potential to learn how to do what they need to do and want to do in life (Watson 2006; Casteleijn and Graham 2012). Diaz-Laplante (2007) highlights that there are times when healthcare providers tend to be ignorant or turn a blind eye to grow and expand human potential to meet their physical, mental and spiritual potential. Thus, ethics in occupational therapy may need to be viewed from an African perspective in order to value the human potential through adopting a socialised model approach. In an occupational therapy context, occupational therapists should learn to adopt a collective approach related to discourses of comprehensive understanding of societal conditions, citizen participation and vulnerable groups such as children, women and older people.

4.3.2 Socialised Model

The value of the socialised model as part of ethics in occupational therapy acts as a source of knowledge about the individuals as part of the community, population and citizens because they share communal life and traditions. Furthermore, the socialised model in occupational therapy relates to the collective efforts that support the notion of Ubuntu. Ubuntu is about "human interconnectedness, or how people's humanity is constantly shaped in interaction with each other, assigning responsibility to both the individual and the community for each other's existence" (Cornell and Van Marle 2005: 205). It is further deliberated that Ubuntu promotes connectedness as an interactive ethic whereby individuals are considered as social beings who engage in social participation which is shaped by interaction with family, peers, community and practitioners (Cornell and Van Marle 2005). This African philosophy supports the "process of becoming a person or, more strongly put, how one is given the chance to become a person at all" times (Cornell and Van Marle 2005: 206). Dolamo (2013) asserts that Ubuntu is the core of African ethics which is concerned with issues of liberation, development, identity, integrity and human dignity.

It can be argued that the African perspective of Ubuntu of interactive ethics appear to contribute to the ethics in occupational therapy which is grounded within the socialised model. Furthermore, this accentuates the importance of collective efforts whereby individuals, groups and communities together with occupational therapy educators, students and clinicians work as a team towards social cohesion (Ramugondo 2015). It is therefore important to ensure that occupational therapy educators, students and clinicians may provide individuals with the opportunity to engage with others and to use their abilities and capabilities to participate in meaningful and purposeful activities. In an African context, people living with disabilities tend to be socially excluded in some of the occupations such as leisure, play, work and education. Therefore, occupational therapy practitioners could form partnerships with people living with disabilities to advocate for social inclusion and respect of their human rights.

An African perspective of ethics in occupational therapy may lead towards the promotion of humanness by ensuring that inclusion, diversity, social justice, participation, advocacy, interdependence and freedom are of importance for the profession. Consequently, the occupational therapy professionals may transform their interactive ethics in order to promote humanness through social participation. This supports Dolamo (2013) who indicates that "every individual is born human and that the formation of humanness comes through the process of socialisation" (p. 3). Broodryk (2008) argues that Ubuntu embraces the African view which values humanness, caring, sharing, respect, compassion and how it relates to values. This explanation of Ubuntu provides some background for ethics in occupational therapy. Mthembu et al. (2017a) indicate that human interactions and interconnectedness in diverse communities appear as enablers of spirituality and relationships among community members who embrace the same values, norms and principles. Thus, occupational therapy practitioners might need to build policies that promote human interactions and interconnectedness in practice. Furthermore, occupational therapists could facilitate social interaction and connectedness to strengthen relationships in occupational therapy groups as part of communities.

4.3.3 Mutual Relationship Model

The mutual relationship model promotes that individuals are not supposed to be submissive followers of authority, but should be self-determining free agents who may exercise their human rights in order to make informed decisions on their health and well-being (Rowe and Moodley 2013; Tangwa 2000; Watson 2006). It is crucial that occupational therapists should consider their clients as individuals with self-conscious, rational, free, and self-determination (Tangwa 2000) with rights as part of the profession's ethical code (Watson 2006). The mutual relationship model supports what is morally good for occupational therapy in order to promote "dignity, respect, contentment, and prosperity to others, self and the community at large" (More 2004: 149). In addition, More (2004) highlights that respect is an essential part of mutual relationships no matter what people's circumstances in life may be. This has an implication for occupational therapy professionals in that they have to value their clients at the levels of social, economic and political relationships.

Beauchamp and Childress's (2001) explanation of the principle of autonomy highlight the positive commitment to respect the decision-making capabilities of self-directed and reasonable choice as part of the Western autonomy-based approach. However, the African Charter on Human and People Rights (1986) indicates that "every human being shall be entitled to respect for his life, dignity and integrity of his person" (p. 2). Despite the importance of Beauchamp and Childress' principle of autonomy, an African perspective appears to value a community-based approach more than individual rights-based approach (Ndebele et al. 2008). Therefore, the African Charter on Human and People Rights (1986) together with Beauchamp and Childress (2001) support the need to promote the principle of autonomy occupational therapy profession so that practitioners could "protect the individual with diminished autonomy from inappropriate paternalism, exploitation and abuse" (Van der Reyden 2008:23).

Within an African perspective, the mutual relationship model encompasses the respect of clients' confidentiality. It should be noted that health professionals including occupational therapy educators, students and clinicians face challenges of confidentiality as some information about the client's medical condition is known and this has implications on the family members (Nortjé and De Jongh 2015, 2016). It could be argued that within the African context this could have a negative influence on the quality of the mutual relationship between the occupational therapy professional, their client and the client's family members, given the interconnectedness within society from the Ubuntu perspective.

Concerning an individual confidentiality and Ubuntu, it is crucial to note that in the occupational therapy profession the concept of individual confidentiality act as part of an ethical principle of persons and autonomy which strengthens the mutual relationship and trust between the practitioner and the client. In an African perspective, occupational therapists provide services to clients who experience ill health such as non-communicable and communicable diseases which appear to be barriers to engagement in meaningful activities. Consequently, previous studies have shown that families tend to take care of the human needs of the significant one who is sick, but it can be risky (Dolamo 2013; Monsudi et al. 2015). The issue of individual confidentiality seems to influence how healthcare professionals deal with clients' information (Monsudi et al. 2015). Therefore, Nortjé and De Jongh (2016) found that occupational therapy students felt that individual confidentiality should not be breached unless law mandates a healthcare provider and the finding resonates with the Western notion of individual human rights. This contradicts with the African perspective that promotes enabling connectedness of the clients, clients' families and community as a whole. In addition, it seems to have an implication for social justice of other family members involved in the lives of clients treated by the healthcare professionals. On the other hand, it may mean that occupational therapy practitioners should therefore find possible solutions as collective to protect the individual human rights and family members' rights through proper communication and apply relevant rules and laws to guide them. Therefore, it is essential that within the mutual relationship model, occupational therapy practitioners should enhance their insight into clients' cultural and religious diversity in occupational therapy practice.

4.3.4 Cultural and Religious Diversity

Cultural and religious diversity play a vital part in the ethics of the occupational therapy profession. According to Dolamo (2013), both culture and religion are cornerstones of Ubuntu in Africa. Occupational therapy practitioners should consider how cultural and religious backgrounds of individuals tend to influence autonomy, decision making and behaviour in practice as part of their personal and professional improvement (De Witt 2016; Govender et al. 2017; Van der Reyden 2008). Donkor and Andrews (2011) indicate that nurses in Ghana appeared to approach ethical issues by making use of the institutional setting and the cultural environment.

Nortjé and De Jongh (2016) and Tangwa (2000) suggest that healthcare students should be exposed to common law and traditions which value the role of elders of a clan when making decisions. From an African perspective, cultures accommodate extended family systems in healthcare decision making as part of collective culture (Donkor and Andrews 2011; Nortjé and De Jongh 2016). It is further suggested that students should be sensitive to the broader cultural beliefs and traditions of their clients. Donkor and Andrews (2011) argue that in an African context an individual does not make the health decisions but the family does. According to Monsudi et al. (2015) the family and the community carry an enormous value system and that is the reason why they participate in the decision-making process. This has an implication on ethics in occupational therapy, as occupational therapists must consider the family members' autonomy as important in the decision-making process in healthcare. It can be argued that families seem to be the ones who ensure that they bring clients to hospital and sometimes settle the hospital fees (Mthembu et al. 2016). However, the Eurocentric approach promotes individual autonomy which appears to be different from the African perspective which values the collectivist approach with families involved (Monsudi et al. 2015; Nortjé and De Jongh 2016).

The African Charter on Human and People Rights (1986) argues, "every individual may freely take part in the cultural life of his or her community". Therefore, Watson (2006) concurs that culture provides occupational therapists with an understanding of how people live socially and not simply as individuals. This resonates with cultural sensitivity in occupational therapy practice because engagement in occupation seems to be influenced by the context of the individual, groups and population. Within an African perspective, people value their religion and according to Mthembu et al. (2017b), community members engage in community projects which relate to their religious observations. Occupational therapists practicing in Africa should take into consideration the religious observation of their clients as individuals as well as the autonomy of collectivists. Furthermore, occupational therapists should demonstrate ethical and professional behaviours that may promote them as change agents of occupational justices. It is imperative that therapists should create a supportive environment in occupational therapy services in order to respect their clients, respect for culture, respect for religion and the family members who bear the caregiver burden of illnesses of their significant one.

4.4 Ethics in Material Principles of Distributive Justice

Discussing the implications of the concept of ethics in material principles of distributive justice in occupational therapy practice in Africa can contribute to the individual and collective approaches. The occupational therapy profession in Africa is ethically bound and legally obliged to respect the clients' autonomy, wishes and choices in all planning and decision-making processes related to their occupational needs (Law et al. 1995; Van der Reyden 2008). As part of the African perspective of ethics in occupational therapy, practitioners are expected to enable human beings to engage in meaningful and purposeful occupations which enhance their human dignity, health and well-being (Van der Merwe 2010). However, occupational therapy practitioners are working in health care systems which experience absolutely scarce resources such as assistive devices. As a result, the practitioners seemed to be experiencing the ethical dilemma of how to decide who shall receive assistive devices. This indicates that practitioners might have to make decisions about a selection to be used to promote the material principles of distributive justice. According to Sullivan (2001), principles of distributive justice refer to fair, unbiased and proper sharing in society of a privilege, benefit or services. Correspondingly, the concept of occupational justice is evolving and gaining recognition among occupational therapists and occupational scientists in Africa because it assists in addressing the struggles that citizens and population deal with on a daily basis. By promoting equitable sharing of assistive devices based on the clients' needs and efforts could assist the practitioners in making effective contributions to human potential.

The relevance of the material principles of distributive justice to occupational therapy practice in Africa plays an imperative role in the process of distributing goods and assistive devices that enable clients to engage in their meaningful activities. It has been noted that African countries appear as resource poor; therefore, the principle of distributive justice might be useful for occupational therapists. It will be useful to ensure that therapists act as change agents by advocating for allocation of sufficient funds and ordering of assistive devices as part of a human rights issue. The occupational therapists tend to experience ethical tensions related to budgetary constraints which appear as part of injustices that influence clients' quality of life. Therefore, occupational deprivation is one of the outcomes of occupational injustice considered as externally enforced obstacles to valued, meaningful occupations needed for health and well-being (Hocking 2017). Occupational therapists within an African context are facing similar ethical tensions related to resource limitations and lack of services in order to promote the "Ethics of Care" (Durocher et al. 2016). With regards to resource limitations, occupational therapists have to deal with inadequate funding, space, employment or time to promote quality and effective occupational therapy services to the population. For that reason, the limitation of resources seems to be a barrier to material principles of distributive justice because the allocation of goods and the issuing of assistive devices such as wheelchairs, splinting and pressure garments might be a problem. In addition, Carrier et al. (2010) indicate that long waiting times affect the material principles of distributive justice which on the other hand, compromises the right to quality services and human rights. This tends to affect the occupational therapists' motivation to facilitate clients' engagement in meaningful occupations because there is not enough to provide for clients that need assistive devices.

4.5 Conclusion

By providing suggestions for addressing ethical challenges identified in theory, education and practice of ethics in occupational therapy, it is recommended that occupational therapy educators, students and clinicians should consider human rights issues, medical law and bioethics in education. Essentially, it is clear that legal and ethical discourse around issues related to practitioner-patient relationships should be part of health sciences education, including occupational therapy. This could add to the body of knowledge about the importance of ethics education that values the Afrocentric worldview whereby African people are considered as contributors to occupational therapy practice.

Ethics education in occupational therapy could adopt the socialise model that promotes the integration of Ubuntu that emphasises the ethics of collectivist rather than individualism. Attention to Ubuntu will provide opportunities for interactive ethics that may enhance social cohesion, participation and interdependence. This will enable occupational therapy educators, students and clinicians to develop a sense of humanness, caring, sharing, respect and compassion as part of ethics of care.

Within an African perspective, the mutual relationship model supports what is morally good for the occupational therapy profession in order to promote human dignity, respect, satisfaction and success to others, self and the community at large. Considering these elements of the mutual relationship model, it has the potential to create supportive environments that could facilitate cultural and religious diversity. In addition, occupational therapists would be able to value family members as part of the decision-making process regarding the health issues of individuals.

The essence of this chapter highlights the need for occupational therapists to have an in-depth understanding of ethics and material principles of distributive justice in order to promote occupational justice. As a result of this, occupational therapists will be able to ensure that they advocate for equitable and fair distribution of resources such as wheelchairs, splints and assistive devices. It is believed that the systematic constraints may be addressed using the legislative rules, ethics and laws in order to address the injustices caused by the limitation of resources.

In conclusion, this chapter has considered ethics in occupational therapy from an African perspective to identify the gaps in theory, education and practice. In addressing the challenges, occupational therapy clinicians, educators, and students need to ensure that the Afrocentric worldview of Ubuntu is used through interactive ethics to enable mutual relationships. Additionally, cultural and religious diversity must be part of the occupational therapy profession to strengthen holistic and humanness in practice. This will empower individuals, groups, communities and families to exercise their human rights to collective autonomy and interdependence. Lastly, ethics in occupational therapy will promote occupational justice whereby the population will receive quality services not compromised by limited resources.

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Chapter 5
Reflecting on Ethics in Occupational Therapy Within Community Development Practice in South Africa

Jo-Celene De Jongh, Lucia Hess-April, and Nikki Vermeulen

Abstract The landscape of occupational therapy is unpredictable, particularly in the field of community based care. Occupational therapists have to work with complexity and uncertainty in a fast-changing world. The Health Professions Council of South Africa (HPCSA) highlights the importance of ethical behaviour of healthcare professionals towards clients and believes that registered healthcare professionals should act accordingly. Occupational therapists experience many sources of conflict in their daily practices, while at the same time, they have to uphold professional values, responsibilities and duties.

The first part of this chapter will set the landscape in which occupational therapists are working on a daily basis in South Africa. The second part of this chapter discusses and defines community development within community practice settings, whereas the third part of this chapter unpacks the ethical challenges experienced by occupational therapists working in community development practice settings. The fourth part of this chapter presents an example of a case study within the Fisantekraal community practice setting and in the fifth part of this chapter, the ethics principles that underpin community development practice for example in Fisantekraal, are applied and discussed. This chapter concludes with a summary of the importance of human rights, empowerment and equity as core ethical dimensions of community development practice that all healthcare professionals, including occupational therapists, should be aware of.

Keywords Ethics · Community development · Community practice setting · Occupational therapy

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5.1 Introduction

The landscape of occupational therapy is unpredictable, particularly in the field of community-based care. Occupational therapists have to work with complexity and uncertainty in a fast-changing world. In South Africa, occupational therapists abide by the regulations of the Health Professions Council of South Africa (HPCSA) as the statutory body for the profession. All practicing healthcare professionals must be registered with the HPCSA as it is a criminal offence for a healthcare professional to practise a regulated profession without an existing registration (Nortjé and Hoffmann 2015). Furthermore, it is a infringement of the Health Professions Act 56 of 1974 (HPA). Since the democratically elected government in 1994, South Africa adopted a primary health care (PHC) approach in alignment with the World Health Organisation principles (WHO 1978), with the aim to provide equitable, efficient and effective healthcare services to all. Such an approach did not only build on changes within healthcare but, also linked with areas of social and economic development. This health reform in South Africa led to a healthcare system that embraced a social justice and rights-based approach to health care (Dayal 2010). Occupational therapists working within a primary healthcare approach have to work with individuals, groups, organisations and communities from diverse backgrounds and within different community contexts. Not only do they have to function effectively, but they also have to adapt to sometimes harsh physical, health and social realities such as poverty, limited resources and poor access to opportunities that enhance health and wellbeing (Reid 2002), be culturally competent (Van der Merwe 2010) and be proactive towards the needs of the community in which they practise (Duncan and Alsop 2006).

The HPCSA (2008) places great importance on ethical conduct towards clients and expect registered professionals to act in line with these expectations. Also, society trusts that healthcare professionals will institute and impose principles for ethics and ability in their daily interventions with clients and all other stakeholders within these different community contexts (Nortjé and De Jongh 2017).

5.2 Community Development in Community Practice Settings

Community development practice encompasses critical occupational therapy practice where occupational therapists engage with power relations and the patterns of distribution of power and consider how these may be used to realise the goals of well-being for the individual and the community (Galheigo 2011). Community development is defined by Lauckner et al. (2011) as a complex process that is driven by communities themselves and that leads to the empowerment of communities that enables them to affect social change that increase opportunities for occupational engagement in the community. Occupational therapists engaging in community development practice focus on occupational needs which refer to individuals' needs for expression of self-identity, culture, social connectedness and fulfilment through occupational engagement (Townsend and Wilcock 2004). According to Doble and Santha (Doble and Santha 2008, p.186 occupational needs also include the need for "accomplishment, affirmation, agency, coherence, companionship, pleasure and renewal". Such practice focuses on the needs of the community, rather than the agenda of project funders. Underpinning community development is intervention that empowers members of the community and minimises occupational injustices. This is demonstrated through community development practice that seeks to establish partnerships with community members and utilise local community assets to support community-based initiatives to address community issues. The physical and non-physical environments, including the political, cultural and spiritual aspects of the community should be recognised through inclusion processes.

5.3 Ethical Challenges Encountered in Community Development Practice

Occupational therapists experience many ethical challenges in their daily practices, while at the same time they have to uphold professional values, responsibilities and duties as described by the Occupational Therapy Association of South Africa's Ethical Code of Conduct (OTASA 2005). Also, a variety of stakeholders are working in community practice settings. These stakeholders come from different backgrounds and different training regimes which could mean that subgroups within dominant cultures may respond differently to similar situations. The integral commitment of community practice to work together in partnerships that involve shared decision making, widens the scope for multi-faceted ethical issues to arise (Banks et al. 2013). One such challenge experienced by healthcare professionals working in specific community practice settings is their difficulty to apply the standard ethics codes and guidelines. The primary reason being that they tend to embrace principle-based and regulatory approaches to ethics which focusses on people's rights and professionals' duties. It is argued that ethics which focusses on issues of accountability and the responsibilities one carries in a particular relationship, such as the ethics of care, are also very important when working in community practice settings (Banks et al. 2013). Ethical practice is about working with the community in the community's interest, the underpinning principles being to promote social justice, inclusion and diversity; in other words, ethical practice is about working for *social change*. Factors critical to the success of empowerment involve community ownership of problems and solutions and people taking action on these problems (Lauckner et al. 2011).

One major challenge experienced by healthcare professionals is to think beyond the needs of the individual and address the needs and strengths of the community at large. Accordingly, it is important for healthcare professionals to differentiate between empowerment and community capacity building as opposed to merely providing a service via problem solving where healthcare professionals identify problems and develop strategies to address these problems. The approach of focusing on what is wrong, shows a complete disregard for the community's own problem-solving abilities thereby, encouraging dependency and helplessness. This perpetuates the perception that change in a community can only occur through the service provision of outsiders (Mathie and Cunningham 2002) which infringes on people's sense of agency and human dignity. According to Russel (2016) four unintended harms can be caused by using a method that only focuses on what is wrong in groups. The first unintentional harm is that communities become defined by their needs and problems and not by what they could possibly contribute towards making a difference in their own communities. The second consequence of using this approach is that funding that is often sourced to address the needs of a community is provided to healthcare professionals to render a service, rather than to the community itself. The third unintended consequence is that with the increase of professional presence and expertise in the community, the community loses its power to take action and to respond at a grassroots level. Lastly, communities that are vulnerable start to internalise that their only solution is a healthcare professional "expert" with programmes, projects and money that will "rescue" them. What Russel (2016) is inferring by drawing attention to these four unintentional harms, is that healthcare professionals should take cognisance of applying the principles of ethics of care in community development practice (Lachman 2012).

In the next section, Fisantekraal as a specific community development practice setting is presented to highlight some social injustices faced by the community members.

5.4 Fisantekraal Case Study

The community of Fisantekraal is situated approximately 30 km from Cape Town's city centre in South Africa and was established in response to farm workers from the surrounding farms needing a place to live. A population of 12,362 community members resides in this community with very limited resources and services available to them. Fisantekraal is characterised by low socio-economic conditions, in particular poverty, and has high rates of joblessness which can be seen particularly during the day when there are numerous individuals on the street lazing around. There is also a high rate of substance use, particularly alcoholism with drug use also being prominent. Through a process of getting to know the Fisantekraal community, engaging with the community in community activities and listening to their stories of success, the occupational therapist in Fisantekraal became aware that women are experiencing occupational marginalisation due to the hegemonic views regarding the status of women in this community. One way that this is manifested in the community is the perception that women should not be employed in order to take care of children during the day. In line with this, the women in the community's occupational choices are restricted and they are often subjected to gender-based inequalities such as sexual abuse and gender-based violence.

Through collaboration with the women a women's group was established which aims to build a support system for women in Fisantekraal. Together the women determined how the group would run. They agreed that the group would be open to all the women of Fisantekraal who were able to attend in order to assist them to develop income generation skills. The women acquire and share business skills from each other and also other members of the community. The women's group provides a safe place for the women to get help as well as develop skills and knowledge in income generation. To this end, income generation occupations in alignment with cultural practices resulted in the women engaging in sewing, beading and needlework while simultaneously learning entrepreneurial skills.

5.5 The Application of Ethical Principles That Underpin Community Development Practice in Fisantekraal

5.5.1 Social Justice, Human Rights and Utilitarianism

The ethics principles of *social justice* refer to the duty to respect all human beings and relate to community members' human dignity, human rights, occupational rights, self-determination and access to resources. It is best represented by a rights-based approach in ethics that emphasises the protection of the dignity of humans as occupational beings that acknowledge the importance of human agency and the fostering of people's empowerment (Galheigo 2011). When understanding that social injustices are factors that are ethically unjust and often violate the human rights of people in their own environments and communities, one can then begin to understand occupational injustices as a result of their occupational rights to participate in occupations being inflicted upon. These occupational rights are based upon the foundation of human rights and seen as "the right of all people to engage in meaningful occupations that contribute positively to their own well-being and the well-being of their communities" (Hammell 2008, p. 62). The women in Fisantekraal are prone to gender disparity, gender stereotyping, gender violence and frequently exploitation (physical and sexual). This results are not only their human rights being violated, but also their occupational rights infringed upon. Considering that some people are socially included in that they have access to occupational engagement opportunities that allow them to exercise occupational choice and do what they want or need to do, while others are socially excluded in that they lack opportunities, resources and access for engagement, and are thus unable to engage in their choice of occupations (as is the case of the women of Fisantekraal) the central point of departure for occupational therapists is that social and occupational injustice result when social structures (i.e. patriarchy) restrict occupational participation through the power it exerts. Therefore, an occupationally just society is regarded as a society that empowers people to choose, access and engage in occupations that meet their needs and generates meaning for themselves and their communities (Blakeney and Marshall 2009).

When a person's human rights are violated, the ethics principle of autonomy, which applies to practice that addresses social injustice and works towards optimising occupational justice, comes to the forefront. Community-wide initiatives may however not be viewed as beneficial to all individuals in the community. Occupational therapists are often put under pressure by employers and practice managers to be cost-effective and to offer short-term interventions which focus on individual benefit (Hess-April et al. 2016). However, community development practice, which aims to ultimately benefit the community as a whole, fits with a utilitarian approach. This means that ethical practice in community development requires advocacy for the benefit, well-being and protection from harm for all people in general, and for community groups who are vulnerable in particular, at large.

In the case of the women of Fisantekraal, the utilitarian approach is particularly observed when the effects of social/occupational injustices on their occupational rights are analysed and relate to the conditions of their lives (Hammell and Iwama 2012). For healthcare professionals addressing social justice thus involves challenging the ways in which social relations of oppression and privilege are enacted in the broader community. For example, the hegemonic practice of placing women in positions of powerlessness in Fisantekraal is one such injustice that should be addressed through adopting the utilitarian approach.

5.5.2 Removing One's "Professional Hat" Through Character and Relationship–Based Approaches to Ethics

Being aware of one's social obligations and behaviours when entering a community, require of healthcare professionals to understand the communities' cultural norms and behaviours as well as what is expected within a community in order to maintain the respect of the community. It is through community entry that the occupational therapist could adopt character- and relationship-based approaches to ethics in practice. Community entry is the process that gives rise to the understanding about the community that healthcare professionals develop while working in a community (Vermeulen 2015). Parasyn (2005) states that arrival and entry into a community setting should consist of passively engaging with and getting to know the community, being aware of one's social obligations and behaviour and reciprocal engagement with community members. Parasyn (2005) defines this as a state of "being" with the community in order to build trust and respect prior to engaging in any action with the community. Failure to remove one's "professional hat" during this process displays to the community a sense of cultural superiority and disengagement or disinterest in gaining an understanding of who the community really is, and by extension what they deem important. According to Vermeulen (2015) healthcare professionals need to be aware of their objectives and behaviours while becoming immersed in a community as it is essential to live and experience the culture of a community first, rather than, simply observe it from an outside perspective.

If this was not achieved in Fisantekraal, the occupational therapist would not have been able to gain the trust and collaboration of the women's group. Honest and quality time spent with the women's group without a project-initiated agenda opened doors for the occupational therapist to build relationships with the women, to know their goals and aspirations and eventually, get to a point where they could work together to empower, enable and capacitate themselves to address, develop and implement solutions for change.

5.5.3 Focusing on What Is "Strong" Not on What Is "Wrong" to Ensure Sustainability

A key ethical dimension in community development practice is the facilitation of a communities' agency, determination and ownership so as to prevent the unintentional harms of powerlessness and the dependency and reliance on the outside "expert". Asset-based Community Development (ABCD) is an approach to creating sustainable change and development (Boyd et al. 2008) by identifying and working with community assets. This includes the communities' capabilities, abilities, potential and social connections and relationships (Mathie and Cunningham 2002). The approach of ABCD allows healthcare professionals to focus on what is strong within the community, and use that strength to facilitate change, as opposed to only focusing on what is wrong. Focusing on the strengths that exist in communities, leads community members to take complete ownership of projects as it then becomes based on their own drives and motivations. It is evident that focusing on the strengths that exist in Fisantekraal, led the women to take complete ownership of the income generation project as it was based on their own motivations. The approach of ABCD allowed the occupational therapist to focus on what is strong within the community of Fisantekraal, for example existing skills in beading and needlework, and to use those strengths to assist in facilitating change. It is important to make a distinction between being *the expert*, and having *expertise*. The latter does not preclude accountability to the broader community. Occupational therapists must take care not to define themselves as sole experts. This is because community members are experts themselves in understanding their strengths and priority needs and must therefore participate in finding and implementing their own solutions to their problems. By identifying the strengths of the women in Fisantekraal they were able to recognise how their own abilities could be used in income generation and to contribute to their development as entrepreneurs thereby laying the foundation for future sustainability and to foster an ethics of care.

5.5.4 Facilitating Community Participation, Collaboration and Empowerment

A major underpinning ethical principle of community development practice is *participation*, which refers to the importance of collaborative action. In community development practice, participation is valued both as a means and as an end. Participation as a means refers to the community's involvement in identifying their priorities and setting objectives, while participation as an end refers to the empowerment of the community to continue to take responsibility for their own development. This is illustrated in the case study of Fisantekraal where the women work together to establish and run their own entrepreneurial project. Though challenging, community participation is fundamental to effective community development practice and requires commitment and sustained efforts. Healthcare professionals working in communities tend to display the tendency of "pushing their own agenda" with good intentions, without giving the community enough opportunities to engage with the idea and to let it become part of their dialogues. It is essential for healthcare professionals to understand the needs and realities that community member's face on a daily basis to determine whether this agenda is relevant and realistic. Respecting the needs of the community allows the community time to build relationships in order to collaborate on ideas collectively built, and therefore allowing the development of group autonomy unique to the attributes of the group.

Through the combined application of the principles of participation (i.e. supporting people to take part in decision making), as well as empowerment (i.e. facilitating personal agency and supporting the rights of people to make their own choices), communities articulate their priorities. Consequently, they develop and implement solutions to satisfy priority needs, utilising existing strengths to further their capacity in sustaining their own projects. Income generation occupations were identified as being of value to the women of Fisantekraal as they shared feelings of being overlooked, due to gender prejudices, and were frequently jobless as a result of this. This allowed the women to visualise a future where they would be able to participate in significant occupations and generate an income, created a sense of hope which contributes to personal agency and feeling empowered (Hammell and Iwama 2012) therefore supporting group beneficence. By working in collaboration with the women, the intention of the occupational therapist was to facilitate their agency and empowerment by helping them to understand their occupational rights and to self-advocate and work towards their rights being met. This is an example of occupational therapists being change agents in community development practice (Hammell and Iwama 2012). This is a break in contemporary practice where colonial idealism of group control is broken down and self-regulation in unique cultural circumstances is developed. Cognisance needs to be taken that no two groups' developmental progress will look the same.

5.5.5 Cultural Sensitivity, Diversity and Ubuntu

Other important ethics principles manifested in this form of community development practice and illustrated in the case of Fisantekraal are *cultural sensitivity* and *diversity* as addressed above as an important aspect of community entry. From a South African cultural perspective, collective occupational well-being should be a principal focus of practice when adopting a community development approach and requires a conceptualisation of human agency as collective (Ramugondo 2012). Drawing on the ethics of *Ubuntu*, Ramugondo and Kronenberg (2013) assert that occupational therapists have a responsibility to recognise occupational prejudices which negatively impact on communal occupational welfare. According to Ramugondo and Kronenberg ((Ramugondo and Kronenberg 2013, p.2)) Ubuntu implies an interactive ethics in which relationships and who people are as human beings are always shaped by their interaction with other people and by what they are able or unable to do within the context of their community. In the Fisantekraal case study, the women chose the collective occupations of sewing, beading and needlework as most meaningful to them. Recognising the cultural relevance of these chosen occupations and its value to their collective well-being, equipped the occupational therapist to appreciate how an income-generating project could lead to empowerment for the women of Fisantekraal. For all healthcare professionals, being culturally sensitive for instance, taking Ubuntu into consideration and acknowledging who communities are as a collective, are of vital importance.

5.6 Conclusion

Clearly, ethical community development practice moves beyond resolving conflicts as a result of ethical dilemmas in relation to individual relationships, to practice that involves addressing human rights, structural inequality, empowerment, equity of access and broader social change as ethical dimensions of practice (Galheigo 2011). Foremost, in considering ethical practice the occupational therapists' accountability is to the values of community development practice, namely fairness, human rights, enablement and social/occupational justice. It is however important to note that community development practice may be influenced by a number of complexities which may be difficult to manage. Working towards social and occupational justice and empowerment of communities is a slow and lengthy process which can be difficult to achieve as the healthcare professional has to deal with several complexities as a nature of practice. They must therefore be prepared to manage situations where values, roles and responsibilities within their organisations of employment may come into conflict. Community development practice necessitates the application of participatory ethics that address issues of power, seeking to address unequal relations of power, raising questions regarding collaboration and most importantly, accountability to communities who should be the primary focus of community development practice.

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Chapter 6
Ethics in Nutrition – An African Perspective

Edelweiss Wentzel-Viljoen, Amos Laar, and Maryse Umugwaneza

Abstract The chapter provides a context of nutrition/dietetic professions in Ghana (Sect. 6.1) and Rwanda (Sect. 6.2), giving background information about the current training. Training in ethics and professional conduct, regulatory ethics guidelines and code of ethics in each of the countries are emphasised. The role of relevant stakeholders in the teaching of ethics, as well as organisations responsible for guiding and regulating same is described. Ethics decision making and ethical issues faced by practitioners in the work environment and situations in the country, and other ethical issues in relation with the food system are also described. Ethical issues in the context of personalised nutrition advice, as well as ethical dilemmas regarding the food system are covered (e.g. the policy of "one cow, one family" in Rwanda). The final section of the chapter focuses on an analysis of the various country-specific ethical issues faced and addressed by nutrition professionals in the two countries. The country-specific analyses are preceded by a synopsis of the contemporary African nutrition landscape.

6.1 The Contemporary African Nutrition Landscape

The nutrition landscape of Africa is very complex with the co-existence of malnutrition and non-communicable diseases (NCDs) (for example overweight, obesity and hypertension), sometimes in the same household. Dr. Anna Lartey (from Ghana)

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and the current Director of the Nutrition and Food Systems Division, Food and Agriculture Organisation of the United Nations (FAO) stated: “We are facing a global nutrition crisis” (UNSCN 2017:1). Although there is a reduction in hunger over the past two decades, globally nearly 800 million people do not have enough food to eat and still go to bed hungry (UNSCN 2017). Data of 2015 indicated that 156 million children (5 years or younger) were stunted (a sign of prolonged malnourishment) and 50 million were wasted (a sign of critical malnourishment) (UNSCN 2017). In addition, millions of people develop a deficiency of essential vitamins and minerals. As in the rest of the world, Africa is also now facing the challenge of children (even before they turn five) and adults becoming overweight with an increased risk of developing NCDs (United Nations System Standing Committee on Nutrition 2017).

The Global Nutrition Report of 2017 reported that 88% of countries worldwide face a grave affliction of either two or three forms of underfeeding (Global Nutrition Report 2017). Africa is not different from the rest of world, but it is not easy to calculate the scale of malnutrition in Africa. It is possible for the same person to suffer from more than one type of malnutrition at the same time. Some figures of malnutrition is given in the box below (from Global Nutrition Report, Africa Brief 2015).

- 58 million children under age five are too short for their age (stunted)
- 13.9 million weigh too little for their height (wasted)
- 10.3 million are overweight (none of these children are growing healthily)
- 163.6 million children and women of reproductive age are anaemic
- 220 million people are estimated to be calorie deficient
- 8 percent of adults over 20 years of age are obese
- Adult obesity is on the rise in all 54 African countries (2010–2014)
- 13 countries in Africa are having to manage serious levels of stunting in children under 5 or anaemia in women of reproductive age and adult overweight

In many African countries, only a minority of children are growing healthily. In the Democratic Republic of the Congo, Ethiopia and Nigeria, for example, the percentage of children under five who are not stunted or wasted, ranges between 43 and 48 percent.

Source: Adapted from *Global Nutrition Report, Africa Brief* 2015

The importance of nutrition has been demonstrated by the development of, for example, the Millennium Development Goals (MDGs), Scaling Up Nutrition (SUN), Sustainable Development Goals (SDGs) and recently the declaration of the United Nations General Assembly proclaiming the UN Decade of Action on Nutrition from 2016 to 2025 (WHO 2017).

6.2 Ghana

6.2.1 Overview of Nutrition Situation in Ghana

Ghana is located on the west coast of Africa, the Republic of Ghana is a relatively stable democracy in relation to its neighbours. The national population is currently estimated to be 28 million – based on projections from the 2010 National Population and Housing Census. The level of literacy among the youth is roughly 70% for males and 60% for females (GSS 2012). Attaining per capita GDP of US$1652.00 in 2011, the World Bank admitted Ghana into the club of lower-middle income (LMIC) countries (Moss and Majerowicz 2012).

Notwithstanding the growing economy and some improvements in social and human development outcomes, health and nutrition challenges persist with maternal and child undernutrition, overnutrition, maternal morbidity and mortality being the most pressing needs (Laar et al. 2017). The Demographic and Health Survey (DHS) report of 2014 indicated that 6% of Ghanaian women of reproductive age are undernourished (Body Mass Index [BMI] $< 18{,}5$ kg/m^2), with higher rates among those in the lowest wealth quintiles and in the three northern parts of the country (GSS, GHS and ICFI 2015; Laar et al. 2017). The survey found that micronutrient malnutrition is highly prevalent and persistent: two-thirds (66%) of Ghanaian children between the ages of 6–59 months are anaemic and over 40% (42%) of the women aged 15–49 are anaemic (GSS, GHS and ICFI 2015; Laar et al. 2017). The same reports indicates that among Ghanaian children aged 5 years or younger, nearly a fifth (19%) are stunted (too short for their age), 5% are wasted (too thin for their height), while more than 10% (11%) are underweight (too thin for their age). Breast feeding is very high in Ghana and almost all children (98%) are breastfed at some point in their life, with more than half (52%) of them breastfed exclusively for 6 months (Laar et al. 2009). In addition, the 2014 DHS estimated about 40% overweight or obesity among Ghanaian women (GSS, GHS and ICFI 2015). A recent systematic review concluded that 43% of all Ghanaian adults are overweight or obese (Ofori-Asenso et al. 2016). Thus, underweight and overweight are occurring simultaneously and sometimes in the same household.

To address the excessively high rates of malnutrition among the vulnerable Ghanaians, the Government of Ghana committed to the global Scaling Up Nutrition (SUN) movement in 2011. A lot has been achieved since, but challenges remain. Laar and colleagues presented the progress made by the Ghana SUN Academic Platform concerning solidifying nutrition capability in Ghana. They concluded in their paper that both corrective and interdisciplinary capacity is required for effective SUN efforts in Africa (Laar et al. 2017). They suggested an approach that utilises cross-sector/inter-professional, peer-learning and experiential learning initiatives (Laar et al. 2017).

6.2.2 Nutrition and Dietetic Capacity Development

The landmark Lancet Series on Maternal and Child Nutrition in 2008 and 2013 suggested that a key obstacle to reducing the high burden of undernutrition is inadequate human capacity, especially among vulnerable women and children in resource-constrained settings (Black et al. 2008, 2013). Following these, many calls have been made for nutrition capacity building as a requirement for translating available effective approaches into optimal nutrition outcomes. Conventionally, nutrition capacity building has concentrated only on the physical aspects of the human with no or limited attention to the developmental or social characteristics. Current proof provides insight and better appreciation of how the various skills and abilities beyond physiological aspects of nutrition are needed to scale up nutrition activities. For example, researchers have suggested that both horizontal (i.e. across sectors) and vertical (i.e. from national to district and community levels) coordination of nutrition actions is needed in addition to the appropriate capacities needed to achieve this (Fanzo et al. 2015).

6.2.3 State of Nutrition/Dietetics Training and Practice in Ghana

Over the years, the training of nutritionists, and recently dieticians, in Ghana has utilised two approaches—pre-service and in-service capacitation. Training of the category of workforce has predominantly utilised pre-service approaches. Two recent publications on pre-service capacity building in nutrition paint a sufficient picture of the situation in Ghana and elsewhere in West Africa. In early 2014, a regional valuation was done by the West African Nutrition Capacity Development Initiative of nutrition capability, using a mixed methods approach of country visits, consultations and desk reviews of nutrition teaching programmes in 16 countries of the West Africa sub-region (Sodjinou et al. 2014). The assessment described current nutrition degree teaching programmes, output of these teaching programmes, as well as limitations regarding participation for the programmes. The study shows that Ghana and two other countries in the West African sub-region (Nigeria and Niger) have adequate institutional ability to train nutritionists at the pre-service level. It is worth noting that these countries with satisfactory training ability do not produce enough nutritionists to meet the needs of their countries. The capacity to train nutritionists is restricted by finances and insufficient equipment and expertise.

In Ghana, additional evidence on pre-service capacity in nutrition is reported by the Ghana Health Services and other partners. The report contains findings from a valuation of the understanding and capabilities of instructors in ten pre-service institutions which train nurses, midwives and other mid-level public health personnel in Ghana. The instructors in all the institutions demonstrated a weak or average knowledge of essential nutrition actions. Further, all the trainers demonstrated poor capability in nutrition status assessment as well as toddler and young child feeding treatment. The rather poor performance of the instructors is indicative of the poor capacity in nutrition by the graduates who emerge from these pre-service nutrition training institutions. The work of Sodjinou and colleagues (2014) had earlier showed similar findings of limited practical exposure of the nutrition programmes. Usually, the syllabus was not updated to include emerging concepts, latest strategies, policies and approaches already accepted for addressing nutrition challenges at the national level (Sodjinou et al. 2014). The potential negative impact of such outdated curricula on both the technical and ethics skills and competencies of trainees is real as observations by the authors indicate. Higher education institutions training various cadres of nutrition professionals include the University of Ghana (UG), University of Cape Coast (UCC), Kwame Nkrumah University of Science and Technology (KNUST), the University for Development Studies (UDS), and the University of Health and Allied Sciences (UHAS). Graduates from these institutions and others with international training currently contribute to the activities of the Ghana Nutrition Association. The Association facilitates continued professional development training for its members. Compared to pre-service, the dearth of evidence on in-service training in nutrition in Ghana is even greater. With the exception of a few tangential, the training of dieticians in Ghana can be compared to the training of nutritionists in Ghana. The historical evolution of the dietetic training in Ghana is presented below as a case study.

6.2.4 *Historical Overview of and Current Dietetic Training in Ghana*

The development of the dietetics profession in Ghana, based on perspectives of retired dieticians, is summarised in a recent report by Aryeetey et al. (2014). According to the report (Aryeetey et al. 2014), three key phases can be identified in the development of the dietetics profession in Ghana. The first phase (pre 1960s) and was characterised by dietary services provided by catering officers—providing services in institutional management. The primary sources of the information contained in the report could not recall any situations to trained dieticians practicing in any hospital in Ghana during this time. The second phase of the history of dietetics in Ghana commences in the early 1960s when Ghanaian dieticians (who trained abroad) were hired to practice in the hospitals. The introduction of dieticians in the hospitals resulted in severe role conflict between “these two groups about who had superior decision-making authority over patients' diets and supervision of meal preparation (Aryeetey et al. 2014, p. 221). Because there were only a few dieticians then, only hospitals in major metropolises (such as Accra and Kumasi) had dieticians. Unfortunately, many of those who were subsidised by government to get trained as dieticians abroad refused to return to work in Ghana, resulting in a growing need for dieticians. To address this challenge, a 6-month intensive training programme in dietetics was introduced in the beginning of 1998 at Korle-Bu, Ghana's premier Teaching Hospital. The programme focussed on the skill-base needed and the programme quickly got the name as the "stop-gap programme". The programme allowed students with a bachelor in nutrition and home sciences to enrol. This programme marked the beginning of the third major phase in the history of dietetics practice in Ghana. The programme trained two cohorts of dieticians who met the dire dietician need in the Ministry of Health. Following this the School of Biomedical Allied Health Sciences (SBAHS) of the University of Ghana (UG) began a graduate dietetic programme in 2004 and subsequently an undergraduate programme in 2009. In 2012, three additional dietetics programmes were started at the University of Health and Allied Sciences, the University of Cape Coast and the Kwame Nkrumah University of Science and Technology.

The UG programme is the oldest and is emblematic of the others. The training involves a 4-year degree programme in Dietetics or a 2-year postgraduate study in Dietetics for those with a first degree in any related nutrition programme. Degree or post-graduate students who have successfully passed their exams are mandated to do a compulsory 1-year internship in an approved hospital to sharpen their clinical skills, after which they write a licensure exam organised by Allied Health Professional Council (APHC) before they are ordained as registered/licensed dieticians. With the goal to instil the standards, values and ethic literacy needed to safeguard and protect the integrity of the profession, the pre-service training package includes training in ethics. These cover five basic principles of professional ethics in Dietetics: Professional competence, Relationship with clients and patients, Relationship with colleagues, Provision of services in competitive environment and Legal and social responsibility.

There is a 2-year "professional" MSc programme at the University of Ghana. The training consists of 2 years of coursework and research together with clinical rotations both during the semester and during vacations. In addition to the usual nutrition-laden content it covers the following courses: Dietetic Professional Practice, Social Psychology, Clinical Attachment, Biostatistics and Research Methodology, Communication Skills and Health Promotion and Principles and Practice of Management. Training in ethics content is essential if dieticians are to uphold the standards, values and ethical issues they encounter and to safeguard and protect the integrity of the profession. Although no specific course is designated to it, there are five basic principles of professional ethics in the Ghana dietetic training: Professional competence, Relationship with clients and patients, Relationship with colleagues, Provision of services in competitive environment and Legal and social responsibility. A mandatory year of clinical internship is required for registration and is done after successful completion of the Bachelors or Master's programme. During this period interns work under the supervision of a registered dietician.

6.2.5 The Context of Nutrition/Dietetics Practice in Ghana

Nutritionists and dieticians are recognised as healthcare professionals providing specialised services to their clients. The core mandate of nutrition and dietetics practice is the application of nutrition knowledge to prevent, manage and treat diseases. The usual places where these services are provided include hospitals, industrial units/companies, community services, sports clubs/directorates, as well as education and research centres. In 2013, a nationwide enquiry identified only 35 qualified dieticians practicing in different public and private institutions/hospitals in Ghana (Aryeetey et al. 2014). Of note, 80% of the 35 dieticians were practicing in the Accra area with the other working in four other regions. The report further indicated that there is only one dietician for every 685,000 Ghanaians. Three regions of Ghana do not have the services of any qualified dieticians.

6.2.6 The Code of Ethics of the Ghana Health Service

In Ghana, the regulatory and ethics guidelines for dietetic practice is clearly defined in the Code of Ethics of Ghana Dietetic Association (GDA). The GDA guidelines cover a range of pertinent issues: dietician and the patient, dietician and the next of kin, dietician in private practice, relationship with industry or commerce and dietician and research. These guidelines are situated within the larger Ghana Health Service Code of Ethics (http://www.ghanahealthservice.org/ghs-subcategory.php?cid=2&scid=45), and the Patient's Charter (http://www.ghanahealthservice.org/ghs-subcategory.php?cid=2&scid=46). The Code of Ethics for the Ghana Health Service defines the universal moral values and guidelines of conduct for all service personnel in the Ghana Health Service (including dieticians). The guidelines instruct that such "services shall be performed by persons of integrity, trained to a high standard to deliver a comprehensive equitable service for the benefit of patients/clients and society as a whole". Relevant extracts from the Code include: "All Service personnel shall be competent, dedicated, honest, client-focused and operate within the law of the land; All Health Professionals shall be registered and remain registered with their Professional Regulatory Bodies; All Service personnel shall respect the Rights of patients/clients, colleagues and other persons and shall safeguard patients'/client' confidence …" (http://www.ghanahealthservice.org/ghs-subcategory.php?cid=2&scid=46).

Of note, the above morally-binding codes are also legally enforceable through the Ghana Health Service Council, Disciplinary and Welfare Committee of the Ghana Health Service Council, per the Ghana Health Service and Teaching Hospitals

Act, 1996 (Act 525). The Act mandates the appointment of the Disciplinary Committee of the Ghana Health Service Council with a key responsibility to the Ghana Health Service Council.

6.2.7 The Patient's Charter

The Ghana Health Service's Code of Ethics expects healthcare institutions to adopt and adhere to the patient's charter to guarantee that health providers and patients/clients and their families comprehend their rights and responsibilities. The Charter "aims to protect the rights of the patient, specifically the following: (1) Right of the individual to an easily accessible, equitable and comprehensive healthcare of the highest quality within the resources of the country; (2) Respect for the patient as an individual with a right of choice in the decision of his or her healthcare plans; (3) Right to protection from discrimination based on culture, ethnicity, language, religion, gender, age and type of illness or disability; (4) Responsibility of the patient/client for personal and communal health through preventive, promotive and simple curative strategies; (5) Responsibility of the patient/client to cooperate fully with healthcare providers; and (6) Responsibility of the patient/client to respect the rights of other patients/clients and health service personnel". Details on the Charter are accessible here http://www.ghanahealthservice.org/ghs-subcategory.php?cid=2&scid=46.

6.2.8 Challenges Dietetic Professionals Face When Making Ethical Decisions in Different Working Environments

The dietetic practice in Ghana has developed from an era of limited technical ability to the current state where there are over 200 professionally qualified dieticians. Nevertheless, these professionally qualified dieticians face several challenges to practice dietetics. These include among others inadequate access to in-service training and tools to practice (job instruments including pedagogy), poor remuneration and rewards systems, and lack of applicable legal and governing structures to guide dietetic practice. Dieticians regularly express frustrations about the tendency that unqualified persons act as dieticians due to the lack of a legal and regulatory framework. The public is then mislead to use diet therapies which are not evidence-based and not approved. Aryeetey et al. (2014) refer to accounts in the media of deliberate misuse of the profession as persons with no dietetics training pretending to be dieticians.

Other challenges relate to ethical decision making. In making challenging ethical decisions, actions are usually based on the values of solidarity, equity, cultural diversity, autonomy, responsibility, trustworthiness, and empathy; it also includes objectivity of judgment in such matters as confidentiality and conflict of interest and social values. Our collective personal and professional experience enable us provide below, a sampling of key ethical issues faced by dieticians in Ghana:

- Sale and advertisement of some food supplements to patients in the clinical setting;
- Care given to relatives, friends and senior colleagues of dieticians ahead of other patients who visit the same facility where the dietician happens to practice;
- Provision of artificial support (e.g. nasogastric feeding) to unconscious patients without their consent especially when there is no available caregiver;
- Conflict of interest for dieticians working in the food industry and the promotion of products in a manner which compromises professional morals or standards; and
- Confidentiality dilemmas when patients opt for non-disclosure of a serious prognosis (e.g. HIV positive status) following counselling in the case of potential risks/harms to a partner, spouse, close relative or caregiver.

6.2.9 Case Study: Experiences of a Woman Seeking Care for a Diet-Related Disease in a Typical Ghanaian Clinic

The case study illustrates ethical issues in the context of personalised nutrition advice. Madam A is a 40-year old woman who recently moved to Accra (capital city of Ghana) to work for a family as a live-in nanny. For the past week she has been feeling dizzy, tired and irritable. Her employer decides to bring her to the hospital for a check-up. Madam A was told by the medical practitioner that she was obese and has diabetes. As a result, she is referred to see a dietician as part of her care plan. At the dietician's office her dietary intake and health history is reviewed. The dietician suggests some dietary changes that could improve her blood sugar level. Madam A states that she eats what the family eats and can't afford to cook her own meals. She goes on to implore the dietician not to let her employee know that she has developed diabetes. In the middle of their appointment, the dietician received a call to come to the next office to attend to a senior hospital staff member. After 20 min, the dietician returns from the next office. He apologises for the delay and recommends the use of some diet and vitamin supplements displayed in his office as very good for weight management and gives Madam A free samples to try before their next scheduled appointment.

The core emanating from this case study relates to how the dietician could provide effective counselling taking into consideration the personal circumstances of Madam A. Why doesn't Madam A want her status disclosed to her employer? How can the promotion of dietary and vitamin supplements affect the delivery of optimal care to the patient? How does leaving patients unattended for extended periods of time affect the quality of care? These things aside, the specific ethical tensions that could be derived from the case study include conflict of interest, conflict of commitment and conflict of loyalty, among others.

Conflicts of interest (COI) occur when individuals or institutions engage in multiple endeavours. With multivalent interests at play, a COI situation arises when such interests clash. In this case study, the dietician effectively is acting as a sales representative for a diet and vitamin supplement. The promotion of the product, irrespective of whether the patient could afford it, only benefits the financial interest of dietician. Based on the dietician's healthcare authority, patients may be forced to patronise a product that they can't sustainably use; they may also give up on trying other evidence-based options because they perceive products as the ideal way of getting better.

A conflict of obligation or a perceived conflict of obligation occurs when the commitment to external undertakings of a member harmfully impacts, or appears to impact, his or her capability to meet his or her official responsibilities. The case presented above illustrates unequal commitment to the patient. Madam A was treated with less respect. Consultation time that could've be used to find realistic solutions tailored to her situation was used for another patient known to dietician. This obviously leads to inefficient dietetic care for Madam A.

Conflicts of fidelity frequently arise where, in considering an issue, a member of a decision-making organisation owes a duty or is influenced by a relationship with an entity for which the issue is being discussed. In this case study, the loyalty is divided between industries the dietician represents and offering the best individualised care to patients. Confidentiality rules prevent sharing information with an employer (who in this case is also a caregiver) who could help with diet adjustments of the patient for better health outcomes.

6.3 Rwanda

6.3.1 Training of nutrition/dietetics in Rwanda

Due to the shortage of trained nutritionists in Rwanda, in many health facilities nutrition activities are run by non-nutrition professionals. In a recent survey of professionals in charge of nutrition activities in health facilities in Rwanda, only 17.1% of the 164 participants surveyed had been trained in human nutrition, others were trained in sociology (51.8%), food science, social work and other (25%), general nursing (4.9%) and education (1.2%). They are generally given hands-on training to do routine nutrition activities of the health facilities such as growth monitoring and management of moderately acute malnutrition.

Currently in Rwanda, human nutrition and dietetics training is offered by two universities. Ethics is not taught as a stand-alone module, but streamed through the curriculum in different modules' outcome. The nutrition/dietetics professionals in

Rwanda follow the ethics guidelines of the allied health professionals. However, the ethical issues faced by nutrition professionals in Rwanda have not documented.

There are two higher learning institutions in Rwanda offering nutrition/dietetics training. Both the University of Rwanda (UR) and the Catholic University of Rwanda (CUR), offer BSc programmes. The BSc programme of the UR requires 4 years of full-time study. As a part of this course, students of the University of Rwanda are required to complete an internship in one of the health centres, hospitals and administrative districts or non-governmental organisations. The UR has graduated about 40 nutritionists yearly since 2015.

In the two programme curricula, ethics is not taught as a stand-alone module. However, "practicing professional ethics" is stated as a learning outcome of the UR programme and appears regularly as an attitudinal learning outcome in different modules of the UR programme. The methods of teaching ethics are not specified in the curricula, nor the assessment of ethics education.

6.3.2 The Regulatory Ethics Guidelines and Code of Ethics in Rwanda

The Rwanda Allied Health Professions Council (RAHPC) is a statutory body established under the RAHPC Act No. 46/2012 of 14/01/2013 and is committed to protecting the public interest through regulating and enforcing the professional standards of practice, conduct and ethics of registered allied health professionals in the country (RAHPC 2016).

The following are regarded as unprofessional conduct against which the Council may take disciplinary actions (RAHPC 2016):

- Unauthorised advertising;
- Over-servicing of patients;
- Criminal convictions;
- Improper relationships with patients;
- Improper conduct of practitioners;
- Operational procedure without patient's permission or consent;
- Disclosure of information in regard to patient without his or her permission;
- Incompetence in regard to provision of healthcare services;
- Excessive fees charged/overcharging;
- Insufficient care towards patients;
- Racial discrimination;
- Rude behaviour towards patients;
- Prescriptions to already addicted patients; and
- Any other conduct contrary to standards of healthcare professionals.

In Rwanda, the BSc degree alone is currently not enough for professional registration; graduates have to pass a test to register with the RAHPC. However, the training is protected by law because the curricula have to be approved by the Rwanda Education Board for students to graduate with recognised degrees. The Rwanda Nutrition Society (RNS) on the other hand, is the national professional association for dietetics and nutrition professions in Rwanda. Its mandate is to serve the interest of dieticians in matters relating to the growth and development of the profession. Membership of nutrition professionals with the RNS is voluntary.

6.3.3 Ethics Decision Making and Ethical Issues Faced by Practitioners in the Work Environment and Situations in Rwanda

Ethical issues that nutritional professionals face in Rwanda have not been documented in the literature. In the context of limited resources in which they work in Rwanda, nutritional professionals may have to make ethical decisions in their clinical or community-based practice about informed consent, confidentiality, intra/interprofessional competence issues and resource allocation, among others. For example, they may face ethical tensions in the allocation of resources for community-based management of severe acute malnutrition (SAM). The protocol for the management of SAM states that children clinically diagnosed with severe acute malnutrition (weight for age) without complications remains in their community and households while receiving supplementary feeding. If all the malnourished children have the right to receive supplementary feeding (i.e. fortified porridge flour and cow milk), then how should the nutritionist decide which children will actually receive supplementary feeds when the supplementary feeds are limited? The policy currently is that a malnourished child cannot be exited from the programme before full recovery from malnutrition. Because there is a limited number of children that can be admitted in the supplementary feeding programme, new malnutrition cases may wait several months before being admitted into the programme.

6.3.4 Girinka – "One cow, one family" Programme and Livestock Asset Donation in Rwanda

Girinka (pronounced ghee-ring-ha) or the "one cow per poor family" is a national programme implemented in Rwanda since 2006. The programme distributes a dairy cow to identified poor households. "Exotic" cow breeds, having a higher milk production compared to other local breeds, have been distributed. These include Friesian/Holstein and Jersey varieties. It was expected that hybrids between these diversities and the local breed to perform predominantly well, given their increased resistance to temperature and indigenous parasites. Girinka aims to reducing child malnutrition rates and increase the domestic revenue of underprivileged farmers (Rwanda Agriculture Board 2014).

Livestock can contribute to better nutrition in rural households directly through the consumption of high value protein in the form of milk and meat by those that produce them and indirectly by increasing income that households can use to purchase nutritious foods. In Rwanda, cow-owning households were found to consume more dairy products than comparable households that do not own cows. Also, children in homes that received dairy cows had lower levels of stunting than similarly qualified households that did not receive cows (Rawlins et al. 2014). However, another study in Uganda found that, while ownership of cattle may increase intake of related animal basis nourishments such as meat and milk, and reduce the prevalence of underweight, stunting is not affected (Azzarri et al. 2015).

Livestock asset donation, as a nutrition sensitive intervention, poses an ethical dilemma for the nutrition professional. On the one hand is the prospective positive effects of dairy development on nutrition. But on the other hand the prospective negative effects on child nutrition should to be taken into consideration. Greater production of Animal Source Foods can adversely impact children's nutrition via increased workload for women. It is usually the mothers/women taking care of the dairy cattle. This demands more of their time and can thus be detrimental to the health of young children since time for child care and child feeding is compromised. Researchers report that that females from households with a higher dairy production are more likely to compromise exclusive breastfeeding by introducing cow's milk to babies before they reached 6 months than females from families not producing any dairy (Wyatt et al. 2015). Furthermore, evidence suggests that child anthropometry and health consequences in emerging countries may be adversely affected by contact to livestock and their faeces (Headey et al. 2017).

Case Study: A Community Nutritionist Has to Decide Whether or not to Donate a Dairy Cow to a Very Poor Family

The case study illustrates ethical issues faced by a community nutritionist in the context of a nutrition sensitive intervention. Madam D is a 32-year old woman, single parent of two children aged 2 and 4 years. Madam D lives in a rural area of Rwanda, she is poor and qualifies for receiving a dairy cow, through a livestock asset donation programme of a local non-governmental organisation (NGO). Madam D hopes the cow will produce plenty of milk to sell and for her children to drink. She plans to feed the dairy cow with uncultivated grasses, together with napier grass produced on field edges as well as banana plant parts. Her younger child has been diagnosed with severe acute malnutrition when he was 15 months old and has not yet caught up with the standard weight-for-age growth curve. Madam J, the nutritionist of the local NGO, is in charge of the cow distribution programme. During her field visit to the future recipients of cows, Madam J finds chicken faeces in the backyard of Madam D, she also sees an unclean pig's shed. When the nutritionist asks about the poor hygiene of the backyard and the pig's shed, Madam D explains that she does not have enough time to clean the pig's shed and remove all the chicken faeces from the backyard every day. The nutritionist realises that the

2-year old child of Madam D plays in the backyard unattended and is therefore exposed to ingesting soil and chicken faeces during exploratory play, which carry a risk of infections.

Several factors complicate the task of balancing the potential benefits and risks involved in donating a cow to Madam D. Cow ownership for Madam D means she has to take care of livestock fodder which will increase labour demand, therefore decreasing the time and quality of care for children. Also, Madam D is already struggling to find time for child care, household hygiene and animal care. The cow would certainly be an additional asset, but it comes with additional work and costs related to veterinary services. Won't the cow bring more household chores to the already busy Madam D, which would result is less time for her to care for her children?

In this case study the nutritionist is faced with an ethical tension as she is not sure that the cow donation will benefit the Madam D and her children and not cause harm. The principle of non-maleficence requires the practitioner to withhold a harmful intervention. In this case, not to giving the dairy cow to this family. However, Madam D would like to get a cow and the autonomy principle requires the nutritionist to take into account Madam D's wish when taking the final decision since Madam D qualifies for a cow.

6.3.5 Imihigo – "Performance Contract" for Nutrition Professional and Ethics

The performance contract called Imihigo (pronounced i-mi-hi-go) is a traditional Rwandan practice—for a person to publicly state and demonstrate what he can do and is committed to, and then be held accountable to his word. Under Imihigo, which is supported by the President of Rwanda, a contract is signed between the President and region mayors on behalf of their voters annually (Ministry of Health Rwanda et al. 2014). The nutrition-specific and sensitive services delivered under this performance-based approach are for example distribution of insecticide-treated mosquito nets, oral rehydration treatment, nutritional supplementation and safe water structures. Some evaluation reports have found a tendency to inflate accomplishments due to eagerness for higher ranking by the professionals involved in collecting and reporting achievements (Klingebiel et al. 2016). Because the reporting of falsified data can negatively impact nutrition policy and funding of nutrition activities, the nutrition professional must exercise honesty, accuracy and integrity even when the achievements promised are not met. Yet failing to meet the promised achievement could negatively affect the nutrition professional's performance evaluation.

The general objective of precautionary ethics is to advance healthcare quality by recognising, prioritising and addressing healthcare ethics issues on an organisational level. For example, to address problems of inflating numbers, nutrition professionals may be strengthened through training on the ethics and the potential negative impacts of reporting falsified data.

Case study: A Hospital Nutritionist Faced with High Prevalence of Stunting in his Catchment Area
Mr. K is a nutritionist at a rural district hospital in Rwanda. One of his duties is to compile child-growth monitoring reports from all the health facilities in his catchment area. One of the indicators monitored in children below 5 years on a monthly basis is the mid-upper arm circumference (MUAC), an indicator of acute malnutrition. At the beginning of the year, Mr. K signed a performance contract with his supervisor, the hospital director, in which Mr. K committed to reduce the prevalence of severe acute malnutrition (SAM) in the district, and he will be evaluated against this commitment at the end of 1 year. For the last 6 months, he has been receiving reports of increasing numbers of children below 5 years suffering from SAM. This situation threatens his position at the hospital.

The nutritionist knows he must conduct himself with honesty and integrity while compiling the numbers from different health facilities. On the other hand he knows reporting increased numbers of SAM to the director of health could make him lose him position. In this case study the nutritionist is faced with a conflict of interest.

6.4 Conclusion

African countries, within the context of limited resources, are faced with a high prevalence of undernutrition and emerging diseases related to over nutrition such as obesity and other non-communicable diseases. In addition, the burden of HIV/AIDS is high and refugee camps a reality. Nutrition professionals in Africa face many challenges making ethical decisions in different working environments and situations. The drivers or values of ethical decision-making are based on the values of solidarity, equity, cultural diversity, autonomy, responsibility, trustworthiness and empathy, objectivity of judgment in such matters as confidentiality and conflict of interest and social values.

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Chapter 7
Ethics for the Dietetic Profession – A South African Perspective

Ernie Kunneke, Rina Swart, and Nico Nortjé

Abstract The profession of dietetics has its foundation in science and dieticians are experts in food; diet and nutrition in improving the health of society. A dietician in South Africa, as a healthcare provider, practices in the fields of therapeutic nutrition, community nutrition, food service management and research and are faced with ethical decision making in these domains. As a profession guided by the Professional Board of Dietetics and Nutrition of the Health Professions Council of South Africa (HPCSA), all practicing dieticians in South Africa are guided and regulated by legal statutes which influence ethical and professional conduct. The professional body for dieticians in South Africa, the Association of Dietetics in South Africa (ADSA), also has a code of ethics for their members. Since 2007, eight cases of misconduct by dieticians had served at the HPCSA. Other ethical issues that dieticians in South Africa face are issues regarding conflict of interest, endorsement of products and sponsorship and there are possible ethical reasoning approaches, i.e. the principled or reasoned approaches that can be applied to guide dieticians in the process. In the three different practising fields for dieticians in South Africa, it is important that practitioners can reflect on ethical theories such as egalitarianism (deontology) or utilitarianism to guide ethical decision making. Jonsen's method of analysing ethical issues can be applied especially in therapeutic cases to assist in analysing the ethical issues at hand. Dietetic practice in South Africa is characterised by diverse ethical issues that makes ethical decision making complicated.

Keywords Ethics · Dietetics · South Africa · Therapeutic nutrition · Community nutrition · Public health nutrition

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7.1 Introduction

This chapter presents the context of ethics in South Africa for the dietetics profession. The scope of practice for dieticians in South Africa is presented and ethical issues and ethical decision making as it pertains to this scope of practice are discussed.

7.2 Context of Ethics for the Dietetics Profession in South Africa

7.2.1 Introduction

The profession of dietetics has its foundation in science and dieticians are experts in food diet and nutrition in improving the health of society (Palermo 2015). It is essential that all professional activities of dieticians are conducted in an ethical, credible and transparent manner, whether it involves patients, clients, teaching or research (Tappenden 2015). This is essential to maintain the trust of other medical professionals and society.

The majority of training in ethics of dieticians in South Africa is based on ethical theories that include libertarian, egalitarian (deontology/duty-based) and utilitarianism. Bioethics and research training are based on the four clusters of moral principles, thus principilism, i.e. *respect for autonomy*; *non-maleficence* (avoid causing harm which include physical harm, psychological harm, moral harm, social harm and financial harm), *beneficence* (providing benefits and balancing benefits against risk and cost) and *justice* (distributing benefits, risk and cost fairly) (Beauchamp and Childress 2001).

7.2.2 Scope of Practice of Dieticians in South Africa

The scope of practice of dieticians in South Africa and therefore also the ethics and professional conduct of the dietetics profession are regulated and guided by the Professional Board for Dietetics and Nutrition of the Health Professions Council of South Africa (HPCSA) (HPCSA 2007).

This statuary body was established under the Health Professions Act of 1974. This act includes the ethical rules of conduct for practitioners registered under the health professions act of 1974 and these specific rules of conduct also pertain to the Professional Board of Dietetics and Nutrition which is the regulatory board for dieticians and nutritionists, as well as to students within these two professions. The professional Board for Dietetics and Nutrition serves as a self-regulating body for the profession to keep dietetic practitioners accountable and also serves as a complaint mechanism for the public.

In South Africa, the scope of practice for a dietician was established by an act of the Parliament of South Africa, i.e. the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974), and includes

> “in South Africa the scope of practice for a Dietician was established by an act of the Parliament of South Africa i.e. the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No 56 of 1974), Regulation 891 and includes:
>
> (a) The application of knowledge and skills by:
>   (i) the establishing and applying of guidelines for the maintenance of healthy nutritional practices for individuals;
>   (ii) the applying of dietary principles as part of the treatment of an individual, relative to a specific disease and following prescription by a medical doctor;
>   (iii) the establishing and applying of guidelines for adequate food and nutrition in the community in institutions for healthy and or ill persons;
>   (iv) participation in research on aspects of dietetics; and
>   (v) participation in formal and informal education in the field of dietetics.
>
> (b) The promotion of community nutrition by –
>   (i) the accurate interpretation of the science of normal and therapeutic nutrition;
>   (ii) the professional communication of scientifically based nutrition knowledge, according to need, to individuals and groups within the community in order to motivate them to maintain or change nutritional behaviour in order to improve quality of life and to prevent nutrition-related diseases.
>
> (c) Contributing to therapeutic nutrition by the compilation and application of scientifically-justifiable dietary measures as part of the treatment of a patient or client following referral by, or consultation with, a medical doctor.
> (d) The promotion of food service administration by – the planning, development, control, implementation and evaluation of and guidance in respect of suitable food service systems for the provision of balanced nutrition to groups in the community and in institutions for healthy and/or ill persons”.

The regulatory guidelines and policies of the HPCSA for health professionals include “ethical rules of conduct; guidelines of good practice; the patients right charter; informed consent; confidentiality; protecting and providing information; guidelines withholding and withdrawing treatment; ethical guidelines for management of patients with HIV; reproductive health; keeping of patients’ records; telemedicine; guidelines on over servicing, perverse incentives and related matters; guidelines for the management of health care waste; general ethical guidelines for health researcher and guidelines for business practice” (HPCSA 2016, p. 1). All of these guidelines are of great importance in the practice of dietetics in South Africa.

The aforementioned rules of conduct are based on core ethical values and standards which include respect for people; best interests of people; human rights: autonomous decision-making, integrity, truthfulness, confidentiality, empathy, patience, justice, professional competence and highest level of knowledge and skills. Healthcare practitioners should endeavour to contribute to the enhancement of society in accord with their professional abilities and standing in the community.

Other than the professional board, there is also a non-statutory board (with voluntary membership) name, the Association for Dietetics in South Africa (ADSA) also has a code of ethics for the profession (ADSA 2008).

7.2.3 The Code of Ethics from the Association of Dietetics in Southern Africa (ADSA)

ADSA is the professional organisation for dieticians registered with the HPCSA in South Africa. This professional body has an “ADSA Code of Ethics for the Profession of Dietetics in South Africa” and a “Code of Conduct/Standards of Professional Practice”. In the code of ethics, professional competence, relationships with colleagues, relationships with clients and legal and social responsibilities are addressed (ADSA 2008).

Other guiding documentation regarding training in ethics used in South Africa is the Constitution of SA, the Bill of Rights, the Patient Rights Charter, the *Batho Pele* Principles and the Human Rights Standards for Professionals.

7.3 Ethical Issues in Dietetics Practice

A dietician in South Africa thus practises in the fields of therapeutic nutrition, community nutrition, food service management and research and are faced with ethical decision making in these domains. The context within which they practise are characterised by diverse ethnicity and cultural beliefs, a multiple burden of disease, i.e. under- and over nutrition – sometimes in the same household, limited access to health care, limited resources, diverse religious beliefs and value systems, gender issues and huge disparities in economic status.

The following discussion will highlight some of the most prevalent conduct and ethical issues dieticians face in South Africa.

7.3.1 Professional Conduct and Competence in Dietetic Practice

Professional conduct is based on values, attitudes and beliefs and an understanding of your role as a dietician as well as an understanding of the obligations and dilemmas in dietetic practice. Professional conduct in dietetics practice entails conduct with compassion, discernment, trustworthiness, integrity, conscientiousness, honesty, integrity and fairness (Beauchamp and Childress 2001). This supports and promotes high standards of professional practise to the public, your clients, the profession, colleagues and other health professionals.

The HPCSA has specific generic guidelines for good practice in the healthcare professions based on a promulgation in the Government Gazette R17/2006 which includes guidelines on "advertising and canvassing or touting, information on professional stationery, naming of a practice, itinerant practice fees and commission, partnership and juristic persons, sharing of rooms, impeding a patient, professional reputation of colleagues, professional confidentiality, retention of human organs, signing of official documents, certificates and reports, issuing of prescriptions, professional appointments, secret remedies, defeating or obstructing the council in performance of its duties, performance exploitation, medicine and medical devices, financial interests in hospitals, referral of patients to hospitals and reporting of impairment or of unprofessional and unethical conduct" (HPCSA 2016, pp. 4–5). Most of the aforementioned are also applicable to the practice of dietetics and all future and presently registered dieticians should take cognisance thereof.

The ability to adhere to these rules as laid out by HPCSA does not per se make a practitioner a good and ethical practitioner. Khan and Ramachandran argue that competency is greatly important and define it as "the ability to make satisfactory and effective decisions or to perform a skill in a specific setting or situation" (2012, p. 921). Healthcare in general places a great amount of importance on competence and argues, as is supported by the HPCSA's requirements, that those registered in the field of dietetics are ethically obliged to uphold proficiency in their field of practice by continuing to learn new techniques, how to use technology, new skills and acquiring new evidence-based knowledge, thus building and developing their knowledge and skills obtained during training.

Dietetic professionals in South Africa have to comply with a continuous professional development (CPD) programme to update their knowledge and abilities through education for the advantage of their clients and patients and to prevent causing harm. Every practitioner is required to accrue 30 Continuing Education Units (CEUs) per one calendar year of which five of the units should focus on ethics, medical law and human rights. Recognised CPD activities include conferences, workshops, seminars and journal clubs, but it must be accredited with the HPCSA as a CPD event. To ensure compliancy, the HPCSA does, on an annual basis, audit a random sample of registered dieticians.

7.3.2 Ethical Misconduct

The Health Professions Act 56 of 1974 defines unprofessional conduct (Section 1) as "improper, disgraceful, dishonourable or unworthy conduct when the profession of a person who is registered in terms of this Act is taken into consideration". According to the Health Professions Act 56 of 1974, Annexure 2, Section 1, subrule (a) (amended 2009) a dietician "shall confine him or herself to the performance of professional acts in the field of dietetics in which he or she was educated and

Table 7.1 Specific misconduct by guilty dieticians (2007–2013) within each transgression cluster (Nortjé and Hoffmann 2015)

Negligence or incompetence in treating patients or clients	Failure to communicate proper treatment to the patient.
	Failure to collect appropriate information from the patient.
	Failure to treat the patient for the diagnosed problem.
Improper professional role conduct	Sexual harassment: Grabbed and kissed a colleague against her will.
	Advertising transgression: Placed an article in a glamour magazine and on the internet.
Fraudulent conduct	Incorrect billing, i.e. double billing.
	Charged for services not delivered, i.e. claimed from medical aid for treatment not given.

trained and in which he or she has gained experience; and (b) shall not fail to communicate and cooperate with other registered practitioners in the treatment of a patient".

Nortjé and Hoffmann (2015) reviewed ethical misconduct cases among dietetic practitioners in South Africa from 2007–2013. This study was based on all guilty verdicts by the HPCSA against dietetic practitioners that breached professional standards and ethical misconduct in this period. They found that only five out of seven cases that served were found guilty of misconduct (See Table 7.1.). These researchers put these transgressions as a violation of the ethical principles of respect, trust and non-maleficence. The guilty verdicts of unethical behaviour against dietetic practitioners in comparison to other health professions in South Africa are very low and are mainly improper professional conduct and incompetent treatment of patients/clients. Since 2014, only one dietetic practitioner was found guilty by the HPCSA and that was for fraudulent billing. The penalty for most of these transgressions was financial. Therefore, Nortjé and Hoffmann (2015) suggested that part of the penalties should be ethical awareness training for transgressors. These authors also stressed that there should be in-depth training in ethics which include bioethics and professional integrity for dietetic professionals on undergraduate and postgraduate levels. In a study done on undergraduate dietetics students regarding what these students think professionalism entails, it was found that professionalism traits are not achieved constantly for dietetic students (Marais et al. 2012).

Nortjé and Hoffmann (2015) further suggest, based on their findings, that for professional conduct to adhere to ethical principles, clients/patients must not be treated as a means to an end, thus observing the deontological principle of respect. The dietician is obligated to take care of a client/patient who is in a vulnerable position when they consult a dietician, thus focusing on causing no harm, including exploitation, thus non-maleficence and strive for beneficence in order for the client/patient to benefit from consulting a dietician.

7.3.3 Conflict of Interest

Few professions are affected as much by culture, religion and legislation as nutrition. Similarly, few professions are affected as much by direct marketing links as dieticians. For example, many religions have dietary rules which are adhered to by various degrees. Research indicates that historically religious beliefs as well as moral codes of researchers and practitioners have influenced their advice to patients, their views on the production of food and the acceptability (or not) of nutrition-related interventions (Rucker and Rucker 2016). An example of the aforementioned is the choices between genetically modified foods or the origin of food (plant vs. animal, chemical vs. natural such as in nutritional supplements). Often these ethical dilemmas are addressed in one of two ways. A utilitarian approach (the greatest good for the greatest number) is often applied to justify nutrition interventions within community nutrition whilst deontology (the rightness of given features of an activity versus the outcome of the activity) may guide general acceptability of dietary prescriptions or food products (Rucker and Rucker 2016).

A conflict of interest (CoI) may arise when professional decision vis-à-vis a primary concern is unjustifiably influenced by a secondary concern (Newton et al. 2016). These secondary interests are also referred to by Lucas (2015, p. 176) as influent interests and can include:

(a) financial interests where an individual's personal finances may be influenced by the decision that he or she has made.;
(b) non-financial issues which make it difficult for the individual to consider questions objectively such as personal relationships, business associations and membership in a political party or other groups; or
(c) ideological conflicts, for example a libertarian view which puts emphasises on individual choice versus a concern regarding the broader social impact of those choices. (Newton et al. 2016).

Rowe et al. (2009) equate CoI to potential bias in research. Bias is defined as "a deviation of either inferences or results from the truth, or any process leading to a systematic deviation or skewed conclusion" (Rowe et al. 2009, p. 267). Although some authors hold the opinion that a conflicted professional will not unavoidably be less impartial than a non-conflicted counterpart (Hurst and Mauron 2008), Newton et al. (2016) concluded that empirical data from psychological research indicate consistently that an individual with fiscal or other links to a establishment will likely support that establishment, intentionally or unintentionally. This link suggests that CoI compromises the quality of academic evidence and undermines "evidence-based" decisions.

CoI may bias behaviour (Newton et al. 2016). As there is great difficulty in distinguishing subtle, unintentional partiality from deliberately concealing impropriety. It implies that being "conflicted" should include to mean "potentially conflicted". This potential for bias requires consideration of CoI to:

(i) Ensure objectivity;
(ii) Ensure good governances by identifying, preventing and resolving CoI; and to
(iii) Maintain trust.

The United National (UN) General Assembly in 2011, was a breakthrough moment for the field of CoI which formalised the comprehensive acknowledgement of the matter of CoI. For the first time in history, Col was on the agenda of the Member States which were represented by Heads of State and not limited to food, nutrition and health establishments only (Gomes 2015). At this time the UN was also challenged by a partnership of 160 national, regional and international networks and associations to provide a clear distinction between public-interest and business-interest organisations. Recently, the WHO also initiated a public discussion on its draft principles and policies of engagement with non-state sectors in an attempt to draw a distinction between stakeholders in the public and in the commercial interest and the circumvention, deterrence and management of conflicts of interest (Gomes 2015).

Research into the potential influence of industry funding on the outcome of, as well as the publication of scientific evidence, has led to the development of guidelines on declaration of potential conflict of interest by many regulatory bodies within the profession. CoI can potentially shape the policy and legislative landscape as well as the research and thus the evidenced-based practice landscape (Rucker and Rucker 2016).

Following an analysis of different organisations in the UK, Newton et al. (2016) concluded that CoI is inevitable if associations enlist a representative range of specialists to recommend on evidence-based guidelines and that observance to the Nolan Principles of Public Life (See Table 7.2) might provide a source to make CoI controllable. It was suggested that government organisations accountable for policy advancement and execution must institutionalise an method to recognise thus disclose and manage by mitigation or ideally elimination, of perceived and actual CoI to increase public confidence in government resolutions.

7.3.4 Endorsement, Incentivisation and Sponsorship

Requests for endorsement of products by registered dieticians are an ethical dilemma. Sound scientific justification is always needed when endorsement is required which can be guided by the aforementioned principles of Nolan.

Another ethical dilemma linked to the food industry is that of sponsorships for events such as continuing education, congress attendance or for research purposes and incentivisation. Approaches to dealing with these include a reasoned approached (Rucker and Rucker 2016) where decisions should be based on transparency and disclosure of funding sources and the acceptance that scientists/researchers are in principle objective if allowed independent decision, fixed principles suggested by Gomes (2015) that any employment, remunerated work, considerable association

Table 7.2 Nolan principles of public life (Newton et al. 2016, p. 735)

Principle	Explanation
Selflessness	Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
Integrity	Holders of public office should not place themselves under any financial or other obligations to outside individuals or organisations that might seek to influence them in the performance of their official duties.
Objectivity	In carrying out business, including making public appointments, awarding contracts or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
Accountability	Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
Openness	Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
Honesty	Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
Leadership	Holders of public office should promote and support these principles by leadership and example.

with food, drink, weapons, tobacco or pharmaceutical commerce as well as affiliation or association with non-profit/charitable organisations whose governing body has more than 25% members with such activities should be viewed as a conflict of interest or a conflict of interest framework (Cohen 2009) as discussed earlier. Several arguments have been raised for and against a principled approach (applied for example by the World Public Health Nutrition Association [WPHNA]) as well as a reasoned approach (applied for example by the European Food Safety Agency's Conflict of Interest Practices Committee and the North American Working Group of the International Life Sciences Institute [ILSI]) (Rucker and Rucker 2016). Gomes (2015) argues that professionals seeking research funding or considering evidence, should not only focus on the products manufactured by companies, but they should also take into consideration the practices and policies, as well as the initiatives, companies or organisations that a potential funders get involved in (see Table 7.2). Subscription to either of these approaches will have implications for the dietetics practitioner and therefore practitioners should have some basic understanding of the different approaches, their personal biases and the consequences of their decisions and actions.

7.3.5 Social Media

The use of social media has increasingly become popular as a tool for communication over the last decade. For dieticians in South Africa this has become a platform to increase professional networks and to use for education. However, all the development and progress in social media now presents healthcare professionals with ethical and legal trials and it poses a danger to privacy and the confidentiality of patients, clients, associates and companies (Kubheka 2017). Kubheka (2017) stresses that for professionals, the same ethical and legal principles that relate offline, should also apply online and that healthcare professionals need to understand that they are responsible to their professional boards and the law for their online activities and warns against the cyber psychology phenomenon called the "online disinhibition effect". The recent case of Prof Noakes which received a lot of media interest attested to the fact of the murky waters of online opinions.

7.4 Case Studies to Demonstrate Ethics Challenges in Dietetics Practice

The next section of this chapter will attempt to illustrate by virtue of case studies and opinion pieces some of the ethics challenges faced by dieticians in practice.

7.4.1 Therapeutic Nutrition

Dieticians working in the field of therapeutic nutrition in South Africa are either hospital-based or in private practice. Cohen (2009) points out that there is an imbalance of knowledge and power in any professional-client relationship.

7.4.1.1 Scenario 1

Solomons and Nortjé (2013) described a case-study from one of the paediatric hospitals in South Africa, of a child with cerebral palsy, born deaf and blind because of in-utero rubella infection and who was at an end-of-life situation. The decision was that the child be classified as an intervention level 1 patient which excludes any active resuscitation, intravenous antibiotics or blood transfusions. However, 2 weeks after admission it was decided to perform a Nissen fundoplication as well as insert a feeding gastrostomy. The protocol of only normal feeding being allowed led to a difference of opinion between the dietician and the rest of the medical team thus resulting in an ethical conflict. The ethical question which arose in this case was that whether the team, given the patient's prognosis and classification as intervention level 1, still should have continued with evasive therapy? The ethical tension intrinsic in all paediatric cases when the diagnosis is negative is compounded by medical ambiguity. The team fundamentally needs to ask whether one owes a duty of care to young vulnerable children or whether one should do everything in one's control as healthcare practitioners to save a child irrespective of the consequence (Solomons and Nortjé 2013). The patient died 3 days after the Nissen fundoplication due to surgical complications (Solomons and Nortjé 2013).

7.4.2 Community Nutrition

To illustrate the range of ethical challenges that exist within the community nutrition area of practice, a few scenarios are described indicating the potential for ethical challenges or conflict of interest.

7.4.2.1 Scenario 1: Dietary Guidelines

Any dietary recommendation has implications for food producers. Dietary guidelines for health advancement and disease avoidance such as the food-based dietary strategies adopted by the South African Department of Health endorses consumption patterns based mostly on grains, fruit and vegetables, and with smaller amounts recommended for meat, fish, poultry and dairy foods, and lesser amounts of foods high in fat and sugar. Nestle (2000) argues that even though such diets are health promoting, following these diets impacts on the food industry and thus impacts on the relationship between dieticians and the food industry. A move to a predominately plant-based diet could affect the commercial interests of particular manufacturers of food and food products. It will also affect the environment, food expenses, and commercial trading with emerging and industrialised countries and will influence relationships between the food industry, government organisations at national and international level and food and nutrition specialists in a free market economy. According to Nestle (2000), consideration of ethical dilemmas in the choice of healthy diets might suggest that "food choices are political acts that offer opportunities for all parties concerned to examine the consequences of such choices and 'vote with forks'". Once again the dietician needs to be aware of the conflict of interest argument, as discussed earlier.

7.4.2.2 Scenario 2: Prevention of Child Malnutrition

Similar to the impact of general dietary guidelines on individual companies or commodities, recommendation of specific food products may impact on the sales (and thus financial benefit) as well as popularity by the population at large as they may argue that the benefit may extend beyond malnourished children. In addition, these consumer responses may trigger a market response resulting in the cost of a product now placing it in a category where it is not as desirable as a solution, yet undoing that message is almost impossible. One example is improving the energy density of weaning foods of young children. It is often recommended to add margarine or peanut butter to cereal-based meals of children as it will increase energy density as well as reduce viscosity and thus contribute to overall energy intake of the child. However, the nutrition composition of products that are effective in the short term may result in undesirable health outcomes in the long term. Fanzo (2015) argues that most food security programmes focus on overall production and consumption of energy in bulk and do not consider overall nutritional outcomes or quality of the diet. Consideration of both, short and long term consequences are therefore important to ensure adherence to the principle of non-maleficence.

7.4.2.3 Scenario 3: Prevention of Mother-to-Child Transmission of HIV

> Ms Y, a Dietician, working in a peri-urban community health centre, supports breastfeeding but finds it difficult to advise HIV positive women to breastfeed as she “would not do it herself if she was HIV positive”.

At the peak of the HIV/AIDS pandemic in South Africa, an intervention was announced by the HIV/AIDS directorate of the Department of Health of South Africa (2010), to provide free breast milk substitutes as a measure to prevent mother-to-child transmission (PMTCT). Public health advocates argued against this intervention on the basis of

(i) the mortality and morbidity risk of gastro-enteritis for infants living in poor sanitary environments;
(ii) the impact of handing out of free formula by health practitioners on the breastfeeding, and particularly, exclusive breastfeeding practices, of women with young infants;
(iii) the conflict between the intervention and the code for marketing of breast milk substitutes that was in place at the time; and
(iv) the risk of mixed feeding resulting in increased mother-to-child transmission for women from poor socio-economic situations.

Subsequently, the policy was amended and no free formula was provided whilst counselling on infant feeding together with counselling on family planning and a Nevaripine protocol was implemented (Department of Health, Republic of South Africa 2010).

Many public health interventions such as the revised PMTCT programme follow a utilitarian approach, i.e. consider the greatest good for the greatest number. Turoldo (2009) argues that a narrow application of the principle of autonomy is inadequate and challenging for public health ethics. He argued that accountability, both antecedent and consequent, is comparable to acting in an astute manner which resembles neither a automated application of intangible guidelines nor a trial and error solicitation of guidelines that proceeds thoughtlessly without the directorial guidance of guidelines. Whoever acts in a responsible way knows the rules of ethics and applies them while learning from own experiences, utilising their own discernment and letting themselves be guided by their habit of acting well (Turoldo 2009). Turoldo's assertion is in line with the Ethics of Responsibility as argued by Hans Jonas. Jonas' philosophy is seen as neo-Kantian in that one needs to apply the rules, but all within context of responsibility to the situation at hand.

7.4.3 Foodservice Management

Ethical issues that dieticians in a foodservice management milieu have to deal with are often related to human resource management. Barkley (2008) used the following example to demonstrate such a challenge.

Scenario 1
A foodservice employee is observed taking prepared food from the kitchen. There is no policy in place to allow for any foods, including foods that are considered as left over or wasted food, to be taken home. This employee has worked for many years in the facility and is a productive employee and has been nominated by the facility as "employee of the month" by peer workers and also does not have any other disciplinary issues. The foodservice supervisor does not want to counsel or discipline this employee because the administrative assistants to the CEO were observed taking catering leftovers from the facility.

(Scenario from Barkley (2008, p. 1240).

As can be seen from the aforementioned scenario there is a clash of duties and ethical principles. On the one hand, the supervisor uses the argument that "what is good for the goose is good for the gander" when she sees the behaviour as not serious in light of what the assistant to the CEO did. On the other hand, the ethical principle of justice applies in as much that the food is not allocated to the employee and that those who it was allocated towards will not benefit from it. The individual is therefore left with a dilemma as the outcome of both scenarios are not preferred and someone is going to get hurt either way.

If principalism is applied in this scenario, it will require the dietician to consider the following:

(i) Integrity: the use of food from the organisation for personal purposes equates to theft.
(ii) Justice: Fairness should be demonstrated to all parties.

(iii) Confidentiality: Management of the situation must be done in a manner that will protect the confidentiality of all parties concerned.

Often in ethics the "Boiling Frog Scenario" is cited which argues that if a frog is put into a pot of cold water it will stay there. Once the heat is turned up gradually, the frog will get accustomed to its surrounding and adapt. This trajectory will continue until the frog boils to death. One needs to be vigilant that one does not argue that unethical behaviour is acceptable and "not as bad" as the outcome could be that the behaviour which could follow it could be proportionally worse, but still acceptable as it is not too far from the previous. This scenario illustrates again the importance of ethical and conduct guidelines to assist the healthcare practitioner in choosing what is right and what is wrong.

7.5 Conclusion

A South African perspective on the ethics for the dietetic profession has shown that dieticians are faced with varied ethical challenges in the three fields of practice within a society characterised by diverse ethnicity and cultural beliefs, a multiple burden of disease, i.e. under- and over-nutrition, sometimes in the same household, limited access to health care, limited resources, diverse religious beliefs and value systems, gender issues and huge disparities in economic status that make ethical decision making complicated.

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Chapter 8
The Role of Social Work in the Provision of Healthcare in Africa

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Abstract As a profession, social work seeks to help and empower vulnerable individuals, families and groups in society. It thus concerns itself with the welfare of persons who have difficulty functioning fully in society due to conditions, such as illness. In view of the fact that medical social work is one of the major areas of social work practice, this chapter discusses the role of social workers in healthcare delivery in Africa. The chapter commences with introduction of social work as a profession and its history in Africa. In addition, the chapter emphasises the roles of social workers in the healthcare system. Furthermore, drawing on two case studies, challenges encountered by medical social workers in healthcare settings are highlighted. Moreover, ethical issues that core healthcare practitioners and medical social workers in Africa need to be acquainted with as they collaborate to meet patients' needs are discussed. Given the importance of multi-professional teams in the administration of healthcare, suggestions are made regarding how medical social workers could be professionally aligned with core healthcare practitioners to provide effective and efficient healthcare in Africa. This would offer medical social workers the opportunity to enhance their productivity, recognition and image within African healthcare settings.

Keywords Ethics · Healthcare · Medical social work

8.1 Introduction

Social work is a helping profession practised across diverse fields, including healthcare. Within the healthcare setting, the social worker is usually referred to as a medical social worker. Medical social workers often work in hospitals, mental health facilities and clinics. They also practice in community health agencies, nursing homes, and drug rehabilitation facilities. They are trained professionals who take

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care of the counselling, emotional, social and after-care needs of patients. Unfortunately, many health professionals in Africa do not recognise the essential roles social workers play or could play within the healthcare system. Where healthcare professionals are aware of the presence of medical social workers, collaboration between the two is often not maximised for optimum benefit of healthcare users.

Drawing on case studies, this chapter aims to highlight the strengths that medical social workers bring to bear on the healthcare system as a whole as they work collaboratively with core healthcare professionals. Recommendations are provided regarding how to improve such collaborations, taking into consideration various ethical principles that ought to guide social workers and healthcare professionals in the medical field. Besides, the knowledge shared in this chapter would awaken stakeholders involved in healthcare in Africa to actively engage medical social workers for the delivery of comprehensive healthcare.

The chapter focuses on the following: (a) Introduction of social work as a profession and its history in Africa, (b) Roles of social workers in the healthcare system, (c) Professional and ethical challenges of medical social workers in Africa, and (d) Ethical issues and professional collaboration between healthcare professionals and medical social workers. The chapter concludes with recommendations on the way forward for comprehensive healthcare delivery in Africa.

8.2 History of the Social Work Profession in Africa

Many factors have influenced and facilitated the development of social work in Africa (Chitereka 2009). Key among them are extant socioeconomic and cultural challenges (Mwansa 2012). The social work profession and provision of formal social welfare services are relatively new phenomena on the continent. This is mainly because the extended family system was primarily responsible for providing for the welfare of its members in many African countries (Sottie and Boateng 2014). The extended family as a self-sufficient unit catered for the requirements of its members in terms of food, shelter, social education and insurance against sickness, old age, and consequences of death.

With the passage of time, globalisation, urbanisation and social development gradually eroded the important role of the extended family system, rendering it inadequate as the primary provider of welfare and other services for its members. Thus, the traditional problem-solving mechanisms through the support of family and social networks are no longer realistic (Baffoe and Dako-Gyeke 2014). Conceivably, a vacuum has been created at the individual, family and community levels, which necessitates the services and interventions of professional human service professionals, such as medical social workers.

As a Western phenomenon, social work in Africa has navigated several stages, such as the indigenous, colonial and independence epochs. Modern social work practice in Africa has been influenced by several factors, such as traditional customs and practices (such as mutual aid); charity work of early missionaries; pre-and post-colonial influences (Soni 2009). For instance, in 1969 and 1971, the United Nations impressed upon the colonial administrators at the time to introduce social work education and practice in their respective countries, and tasked Western professionals to assess their specific needs and make recommendations accordingly (Gray et al. 2014).

In pre-colonial times, social problems were mainly addressed within the traditional system, which included chiefs, queen mothers, community leaders and family heads (Apt and Blavo 1997). In addition to these traditional systems, there were religious missionaries who worked closely with traditional authorities and provided numerous assistance for families in need. Due to increasing social and technological changes, the family and the church are no longer able to meet the holistic welfare needs of their members, although they are still critical in the provision of welfare in Africa (Rwomire and Raditlhokwa 1996). Also, prior to the arrival of the colonialists into Africa, there were many mutual aid societies that offered assistance to its members, whether they were family, kin, cultural or faith based (Midgley 1997).

Formal systems of social welfare provision were introduced into Africa by various colonialists from Britain, France and Portugal (Mupedziswa 2005). The first objective of the colonial administrators was to serve the needs of the European populations in the colonies and secondly to protect urban areas where the colonial power was concentrated. Statutory social welfare intervention was limited and directed at dealing with a narrow range of problems, such as delinquency, vagrancy, drug abuse and crime, which were perceived as threats to law and order in urban areas (Apt and Blavo 1997). Largely, rural areas were left to fend for themselves, except with the assistance of missionaries and voluntary organisations (Apt and Blavo 1997).

From the 1960s, when many African countries began to attain independence, these countries inherited the kind of social work being practised in the colonial states. A major hurdle was to find harmony between traditional African social norms and values and inherited Western traditions of social welfare, which sometimes led to conflicts, especially in terms of *who* provides *what* service to *whom* and at *what time*. This suggests the need for social work models that are built on socio-cultural, economic, political and environmental conditions prevailing in Africa.

8.3 Roles of Social Workers in the Healthcare System

Social work's relationship with healthcare provision is as old as the profession itself. Since the beginning of the twentieth century, social workers have been involved in the delivery of healthcare services, especially for the elderly and patients with chronic health conditions. In 1977, the World Association of Social Work published the first set of standards for the provision of healthcare services in hospitals (Parast and Allaii 2014). As a profession, social work seeks to help and empower vulnerable groups, including people living with chronic diseases like HIV/AIDS. It concerns itself with the welfare of persons who cannot function fully in society due to conditions, such as illness. Some events (e.g. the bubonic plague or the Black Death) in the wake of the Industrial Revolution and the great depression in Europe and Latin America gave birth to the social work profession. Since these periods, social workers have concerned themselves with alleviating human suffering in many settings.

Providing holistic healthcare entails understanding the patient's social environment, as well as the prevailing factors contributing to the patient's condition. Social workers "utilize the strengths-based, person-in-environment perspectives to provide the contextual focus necessary for client- and family-centered care" (NASW 2016, p. 5). This is a unique asset social workers bring to bear in the provision of quality healthcare to patients. It is, therefore, important that social workers play active roles in healthcare settings at all times. Medical social workers collaborate with core and allied healthcare workers to provide holistic care to patients in- and outside the hospital setting. Medical social workers are integral to every multi-disciplinary healthcare team. They provide care that is focused on patients across the care continuum by assisting them and their families to manage medical conditions through mobilisation of resources and partnership with healthcare and community stakeholders to deliver post-discharge support services (Parast and Allaii 2014).

According to the Ontario Association of Social Workers (OASW 2016), medical social workers play diverse roles within the healthcare setting, which include:

Risk management: ensuring effective communication between patients and other health professionals by addressing possible conflicts/complaints and/or in reply to a distress.

Programme development**:** providing leadership and participating in programme planning and evaluation.

Research: generating psychosocial initiatives, which can be discipline-specific or interdisciplinary.

Teaching/Education: presenting workshops, rounds, conferences, and classes to healthcare colleagues, students, staff, patients and families.

The National Association of Social Workers (NASW 2016, p. 21) identifies the roles and responsibilities of social workers in healthcare settings to include:

> biopsychosocial-spiritual assessment, client (patient) and family engagement in all aspects of social work intervention and case management/care coordination/healthcare navigation; discharge and transition planning; client concordance with and adherence to the plan of care; advance care planning; palliative care, including pain and symptom management; and hospice and end-of-life care; identification of child/elder/vulnerable adult abuse, trauma, neglect, exploitation, crisis intervention; facilitation of benefits and resource acquisition to assist clients and families; an understanding of related policies, eligibility requirements and financial and legal issues; advocacy with other members of the interdisciplinary team within the healthcare institution to promote clients' and families' decision making and quality of life; client, family, interdisciplinary and community education; family systems issues like the impact of healthcare concerns, illness and disease on family relationships, life cycles and care-giving roles and support needs (p. 21).

8.4 Challenges Faced by Medical Social Workers in Africa

8.4.1 Case Studies

8.4.1.1 Case Study 1: Complicated Case and Delay in Receiving Medical Social Work Services

Kiki is 23 years old and 4 months pregnant. She is visiting the Alawe Government Hospital for prenatal care for the first time. Although her pregnancy is progressing normally, the nurses she interacted with were unfriendly towards her because she had waited for so long before reporting for her first prenatal visit. During her health assessment, she indicated that she consumed one or two alcoholic drinks on regular basis after work to relieve herself of the stresses from her job. In addition, there were social events on weekends with family and friends which usually involved light to moderate alcohol drinking. However, the medical team was not aware that Kiki hailed from a village where social drinking was normal, even for pregnant women. On subsequent prenatal visits, she continued to defend her drinking behaviour to the extent that the medical team, out of frustration, threatened not to attend to her if she remained recalcitrant. One of the nurses eventually referred Kiki to the district social worker. However, the social worker was in charge of three large hospitals, and thus, only visited the Alawe Government Hospital once every fortnight.

8.4.1.2 Case Study 2: Optimism About Non-existent Medical Social Work Services

Nelson is a 60-year-old man with type 2-diabetes mellitus and had been newly diagnosed with cirrhosis. He had been in and out of hospital admissions, but due to limited treatment options available at the advanced stage of cirrhosis, Nelson was asked to seek palliative care services after his last discharge from the hospital. Unfortunately, the cost of palliative care was too high for Nelson to consider as an option. Besides, the nearest palliative care institution was far from the city where the hospital was located. He received care from his wife, Maria, at home. The hospital staff and medical team had been very friendly to Nelson and Maria, but they needed more help. Nelson and Maria had two children aged 37 and 34 years who resided in different parts of the country and only visited them about three times a year. Although their father's condition had worsened and more funds were needed for his treatment, both children sent remittances on an ad hoc basis. Prior to Nelson's condition of ill health, he was engaged in casual work, but quit the job with the onset of his sickness. Maria also had to quit her job following Nelson's diagnosis to provide fulltime care. Nelson and Maria requested to make financial arrangements with the hospital, but the hospital administrator emphasised that without health insurance, the hospital could not make alternate arrangements except if they paid out of pocket. There was no social worker at the hospital. However, Maria had watched a television programme that gave her hope that if they could find a social worker, they would receive help to resolve some of the challenges they were encountering with accessing healthcare for Nelson.

8.4.2 Discussion of Case Studies

The involvement of multi-professional teams in the administration of healthcare has become necessary in recent times (Powell et al. 2016). In issues relating to drug and alcohol treatment, end-of-life care and other healthcare problems, the medical team in collaboration with other relevant professionals could attend to the holistic needs of patients. Multi-professional healthcare teams may consist of physiotherapists, occupational therapists, psychologists and social workers (Brown and Walter 2014; Maramaldi et al. 2014). In spite of the fact that social workers play indispensable roles in healthcare systems in Africa, they are likely to face unique challenges in the discharge of their duties. Many governments do not place much priority on social workers' roles in their healthcare systems. This is evident in many public hospitals with limited or no social workers among professional teams that often work there (Chitereka 2010; Kiyange 2010).

In case study 1, for example, Kiki's baby is at risk of acquiring Foetal Alcohol Syndrome due to her drinking habits. While this is well-known to the medical team, they do not understand why Kiki would rather defend her alcohol intake instead of ceasing to drink during the time of pregnancy. This is a typical case that requires the intervention of a social worker in order to understand Kiki's socio-cultural background [as one that condones social drinking for pregnant women] and her lack of concern that the foetus may be at risk [probably because she has seen many children born to mothers who drank alcohol and were growing up "normally"]. A social worker in this case will have the skills to delve into Kiki's background, understand her orientation to alcohol intake in relation to pregnancy and advise Kiki and the medical team on how they could move forward in their prenatal interactions. However, with only one social worker available for the hospital, Kiki's situation could be worsening with each passing day that she does not see the social worker.

In the second case, Nelson and Maria have more than Nelson's healthcare problems to deal with since they do not have sufficient funds to support Nelson's life-threatening health condition. Their two children do not seem to appreciate the gravity of their father's ill health, and there is no social worker to coordinate financial or other assistance for the family. Undeniably, in healthcare facilities, there is ranking of the clinical requirements of patients and their families over and above their psychosocial needs, as the clinical needs are deemed to be more important (Kiyange 2010). Most often, the recruitment of social workers as core members of palliative care teams is not seen as important in many facilities across Africa, Kiyange (2010) asserts.

An additional challenge is the perception that the healthcare facility is a secondary practice setting for a social worker. While other disciplines within the healthcare system have succeeded in asserting their professional status, social workers are still grappling with this (Davis et al. 2005). Furthermore, Chitereka (2010) argued that many hospitals tend to be authoritarian with a strict hierarchy of medical doctors being most senior, nurses assuming intermediate positions and social workers regarded as least important. This illustrates the lack of understanding of inter professional responsibilities and roles in the healthcare system.

While medical social workers may be part of healthcare teams, many medical doctors and other healthcare professionals do not adequately understand or recognise their roles in hospital settings. The services provided by medical social workers are usually regarded as secondary, which could be performed by volunteers or non-professionals. In this regard, Kiyange (2010) acknowledged that there is the erroneous assumption that psychosocial needs of patients and their families are met when they are treated nicely in hospital settings. It is important to emphasise that social workers have expertise in the management of intricate psychosocial needs and clinical interventions that cannot be provided by volunteers and community care providers (Kiyange 2010).

Furthermore, some hospitals focus on training core healthcare personnel on good interpersonal skills with the motive that it would meet patients' psychosocial needs. While this may be helpful, it does not, and cannot take the place of social work interventions for patients who require such services. Also, more often than not, African governments have challenges with funding medical social services, as the quantum of funds required to cover healthcare costs are usually far beyond their means (Kiyange 2010). As a result, few countries that recognise and acknowledge the role of social workers in healthcare facilities may not be able to afford the services of more than one social worker to handle the needs of all the patients in big hospitals. This poses significant practical and ethical challenges to the effectiveness of social work interventions when managing several caseloads with complicated psychosocial needs and inadequate resources (Kiyange 2010).

Case study 1 provides a clear picture of the work overload of hospital social workers in Africa. To have only one hospital social worker assigned to three large government hospitals certainly has implications for effective healthcare provision. Maramaldi et al. (2014) argue that in healthcare settings, once patients are medically stable, an interdisciplinary care team is required to investigate and understand their home environment and resources in order to extend treatment beyond the medical facility into patients' communities. However, in Africa, social workers may not be available in healthcare settings to execute these roles; even when they are available, the resources with which to effectively discharge their duties may be insufficient or unavailable.

Both case studies represent the myriad of situations in hospital settings that require the services of medical social workers, but are seldom present. While most often, medical social workers are not present in healthcare facilities, in those instances that they are part of the medical team, they are likely to be confronted with situations that evoke some ethical concerns. These are discussed in the ensuing section.

8.5 Ethical Issues and Professional Collaboration Between Healthcare Professionals and Medical Social Workers

The ethical environment in healthcare settings is important for all professionals in a hospital context (Pugh 2015), including medical social workers. However, many studies on hospitals' ethical environment have focused on the perceptions of core healthcare professionals, such as nurses, while those of ancillary staff (e.g. medical social workers) have been left relatively unexplored (Dennis et al. 2014; Pugh 2015). Medical social workers are frequently confronted with ethical dilemmas (McCormick et al. 2014) that cannot be ignored. Given that the social work profession is rooted in a set of social values, ethical principles, and moral dilemmas, there may be conflicts that result from social workers setting priorities among values in the provision of services to patients (O'Donnell et al. 2008), clients, families and communities.

Even though social work values may be common to other professionals on the healthcare team and integrated in organizational mission statements, a difference exists in the hierarchy and importance of values held by healthcare team members and the organization (O'Donnell et al. 2008), and this could deter successful collaboration. For instance, in their efforts to facilitate patients' right to autonomy in their care plan, social workers may be in conflict with the medical team as they provide what they believe is best for patients. A typical example was presented in case study 1 where Kiki defended her drinking habits although she was pregnant.

Whereas drinking during pregnancy is medically prohibited, Kiki's stance calls for a social worker to engage her beyond medical caution. Kiki needs to get to the point of understanding that although her predecessors engaged in that habit, there is ample evidence to show that it did their children more harm than good. This engagement needs to go on until Kiki accepts that it is not wise to drink while pregnant. That self-determination, which social workers usually seek in their clients, may conflict with the medical team's sense of urgency in the matter at hand. Of course, social workers also engage in crisis intervention, and would not in all cases insist on lengthy engagements where expedite medical action is required.

Another area of concern with regard to ethical dilemmas for medical social workers is the use of technological advances in interventions, especially at the beginning and end of human life (Landau 2001). Challenges related to technological interventions may be present in varied forms. For example, decisions about whether to sustain a person on life support machines that is very costly versus loss of life due to lack of resources on the part of the patient and the hospital. Also, the decision to provide blood transfusions in order to save life could be a dilemma for medical teams, including social workers, as some cultures or religious beliefs in Africa reject it. In such cases, patients and/or their families would rather opt for death than compromise their beliefs.

Unfortunately, in some hospitals or units, physicians do not invite or encourage social workers' participation in these ethical deliberations, although social workers often possess insight and information on patients, their families and other caregivers that should be taken into consideration when discussing patients' ethical issues (Jansson and Dodd 2002). In addition, the needs of individual patients may conflict with healthcare facilities' commitment to judiciously allocate its limited resources (O'Donnell et al. 2008).The imbalance between demands from patients and limited resources is a major source of ethical dilemma for medical social workers (Holland and Kilpatrick 1991). In many countries in Africa, resources may genuinely be unavailable to facilitate optimal actions that need to be taken about patients' cases in healthcare facilities (Dako-Gyeke and Kofie 2017).

Social workers' perspectives on ethical decisions are often unique to healthcare teams (Dennis et al. 2014). In case study 2 for example, there was an ethical issue in relation to the medical team's decision to discharge Nelson, knowing very well that he could not afford palliative care, and that both he and his wife were without a regular source of income. If a social worker was present at the hospital and was included in the decision to discharge Nelson, he or she could have connected Nelson and Maria to a funding source or worked through options that would not leave the poor couple to face their medical challenge all on their own. Moreover, social workers are uniquely skilled to counsel patients and their family members about decisions taken concerning their medical conditions (Chitereka 2010).

With reference to case study 2, the social worker could involve the two grown-up children of Nelson and Maria in counselling, so that their ability and willingness to support their father in seeking further healthcare would be assessed. Thus, when medical practitioners recognise and understand important roles played by social workers as part of interdisciplinary health teams, it would go a long way to ensure that ethical decisions regarding patients are the best the team could offer and not just the potentially skewed judgment of core healthcare professionals that does not ensure optimal team functioning.

8.6 The Way Forward: A Comprehensive Healthcare Delivery in Africa

Although it is regarded as one of the major domains of social work, many medical social workers lack general acceptability in Africa. Practitioners often find it difficult to perform their professional roles in healthcare settings mainly because their services are not recognised by core medical professionals. Given that medical social workers are specifically trained to play an important role in healthcare provision at the intersection of individual, family and community levels, they need to demonstrate more how they could assist interdisciplinary teams in unique ways. This is crucial because individual healthcare team members have different levels of understanding regarding the roles and competencies of other healthcare professionals. Once these roles and responsibilities are duly clarified, medical social workers would be better placed to justify their inclusion and space in collaborative healthcare teams.

Furthermore, medical social workers would be more effective and efficient in discharging their duties if they are involved in ethical decision-making processes regarding patient care because they have the capacity to build strong trustworthy relationships with their clients, families and communities. Quality collaborative healthcare requires centralised decision making, which is ultimately necessary for improving patients' healthcare condition. Respecting and utilising each team member's expertise and specialty, especially those of medical social workers, would help improve communication and reduce power differentials among team members. This would eventually enhance healthcare outcomes and outputs of users and providers of the healthcare system respectively.

Moreover, it would be difficult to fully benefit from collaborative interdisciplinary healthcare teams if they are resource constrained. An increase in the number of medical social workers in healthcare facilities would help reduce caseloads and waiting lists for medical social services, as well as improve upon follow-up of patients. Successful and comprehensive healthcare provision would be achieved in Africa if infrastructural and financial needs and challenges of healthcare providers are duly addressed. This would ensure the effective and efficient functioning of medical social workers and consequently enhance their productivity and image within healthcare settings in particular and the African continent as a whole.

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Chapter 9
Ethics and Social Work – A South African Perspective

Marcel P. Londt

Abstract The prevalence of violence against South African women and children is reflected in the statement that every girl child born is more likely to be a victim of rape than be enabled to read. More reliable South African data regarding the frequency and scope of sexual violence against females, children, as well as vulnerable groups are now available. The implications are that social workers are placed at the coal face of working with both the victims/survivors, as well as the offenders of sexual violence. The South African code of conduct provides clear descriptions of those values, principles, obligations and rules with which social workers enter their worlds of work and perform their social work tasks. Social workers already possess the very values and commitment to pursue social justice, anti-oppression and recognition of human worth for all their clientele systems. However, some of these values and expectations need to be interrogated through a different lens, to achieve ethical practice and professional integrity of the highest level, when dealing with violent sex offenders.

Keywords Sex offenders · Sex offender intervention · Sexual violence · Social justice · Ethics · Social work principles · Social work values · Ethical decision making

9.1 Introduction

Patel (2005) asserts that the path of social work in South Africa is enmeshed with the country's history of imperialism and colonialism. This dictated that the essence of social work practice was highly associated and influenced by the dominant paternalism which shaped all welfare policies in South Africa, not only sustaining, but also maintaining white privilege and elitism. This discourse was articulated across the education of social workers per se, and generally, all social workers in practice

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implemented those very policies and laws, appropriately disbanded, when democracy prevailed in South Africa (Smith 2014). This created the context that social workers were foot soldiers for the government of the day, to implement policies and legislation of the dominant discourse. These policies and legislative instruments were oppressive, racist, unjust and lacked recognition of the pride, person or dignity of a targeted segment of the population. As South Africa entered a new dispensation of democracy, there was a strong recognition and commitment to transform the apartheid-driven society to one that would demonstrate the intent of the new-found democracy.

The current transformation of the South African landscape, the significance of social justice, anti-discriminatory discourses, creation of a rights-based society, impact of social media, as well as the demands for ethical and best practice, has markedly influenced the overall education of social workers. However, this transformation is also associated with different challenges for all social workers in South Africa. Some of the current challenges include the shift in political discourse, globalisation, social media, ineffective economic policies—its impact and consequences, as well as the endemic proportions of brutality towards women and children. Notwithstanding these challenges, social workers are also faced with a different clientele grouping, in the course of their practice. The levels of gender-based violence and sexual abuse dictate that social workers are confronted with providing services to both offenders and survivors. This expectation is further fuelled by the expectation that every social worker is obligated to pursue social justice for all their client systems, which implies that the clientele system will inevitably include offenders of violence, albeit sexual or intimate partner violence.

Although this historical path of the transformation of social work teaching and practice is significant, in this chapter, the focus is on social workers and their engagement with sex offenders in South Africa. Many social workers choose not to intervene with adults, who are accused or convicted of a sexual crime against women, children or vulnerable populations. Working with sex offenders in the South African context, emerges as a minefield of ethical dilemmas and these situations are often juxtaposed with those tenets and philosophies deemed important in social work.

9.2 The Scope and Context of Sexual Violence in a South African Context

In South Africa, the scope and incidence of crimes of a sexual nature dictate that the individual, seeking the intervention of a social worker, may very well be an unidentified sex offender requesting support for unrelated matters. Sex offenders are not necessarily a distinct grouping of individuals, easily recognisable or distinguishable from any other clientele groupings; since all the evidence confirm that sex offenders are a heterogeneous group (Davids et al. 2015; Robertiello and Terry 2007). This means that a social worker in practice may very well encounter an individual, who has a proclivity towards sexual violence or an interest in non-consenting adults or children, without being aware of the individual's inappropriate tendencies or behaviours (Londt and Roman 2010). The statistics on the prevalence of sexual brutality in the South African context imply that social workers could be faced with a sex offender, more often than they realise, since a large section of the sex offending population is not removed from society, or the provision of health care services (Londt and Roman 2010).

This shift in the constitution of the client system propels the social worker into a field of practice fraught with ethical challenges and decision making. Hugman and Smith (1995) concur that social work practice, generally, cultivates issues and dilemmas of an ethical nature, suggesting that the ways in which ethics were traditionally addressed, are inadequate. Banks (2004) offers a remedy and strongly advocates that those in the social work profession should explore the ethical discourses with a different lens. This coincides with the notion that the concept of the old rules, principles and values, may be insufficient to equip the social workers to enter this changing landscape of their world of work, a predicament not exclusive to the social work profession.

9.3 Ethical Dilemmas and Challenges for Social Workers: Sexual Violence and Sexual Offenders in an African Context

Ward and Salmon (2011) assert that practitioners are daily confronted with ethical questions, regarding their interaction with sexual offenders. An additional dilemma for social workers is maintaining a balance between the protection of society and the best interest of their offending clients. Some of the fundamental principles in social work include service, social justice, the self-worth of all persons, the significance of human interrelatedness, character and proficiency. Social workers often feel that their adherence to some of these values is compromised when they are confronted with the statutory obligation to report their sexual offending clients. Essack and Strode (2015) concur that social workers are often of the opinion that reporting sex offenders would undermine the trust of the social worker-client relationship. While other social workers constantly assert that there are very specific South African Laws (Children's Act No. 38 of 2005 [as amended], The Constitution of the Republic of South Africa Act No. 108 of 1996, Criminal Procedures Act No. 51 of 1997, Domestic Violence Act No. 116 of 1998, Sexual Offenses and Related matters Amendment Act No. 32 of 2007, Older Person's Act 13 of 2006), which compel social workers to report a sex offender or a suspected sex offender to a police officer or a child protection organisation. In addition to these legislative instruments, there are also clear policy guidelines and directives to follow, when sexual violence has occurred in South Africa (South African Police Services [SAPS]

2008; 2012). All the available policies and laws strongly demonstrate that the problem of sexual violence is widespread internationally, as well as in South Africa and the African continent. Internationally, the issue of sexual offending and sexual crimes against anyone is complex and controversial, with the perpetrators' sexual misconduct presenting a diverse set of actions, indicating that this problem needs to be addressed comprehensively. Therefore, legislative remedies, without capacitating those professionals who have mandatory obligations to provide services to all client systems, are inadequate to address sexual violence.

Over the past 40 years, the African continent has witnessed a continued scourge of violent conflict and human rights abuses (Hirsch and Wolfe 2012). South Africa is largely regarded as a country where words, such as "rape town" and "rape culture" are easily bandied about, and often used in the media to portray the incidence of sexual violence (Londt and Roman 2010). Naidoo (2014) introduces her doctoral study with a compelling quotation by Dempster (2002), "… a female child born in South Africa has a greater chance in her life time of being raped, than learning to read" (p. 1), strongly suggesting that, in South Africa, sexual offenses against children, specifically, are widespread and common, and by implication, the majority of sex offenders are not hidden away from society in a prison or in seclusion.

It is widely accepted that the prevalence rate of violence towards women and children in the South African context, is high; however, before 2016, reliable nationally representative data were unavailable, according to Krieger (2016), deputy representative of UNICEF, South Africa. The Optimus study findings (Burton et al. 2016) reveal that many studies conducted in South Africa have methodological and geographical shortcomings that influence the rate or incidence of reported cases. Some of the varying estimates include a study in 1988, conducted by Jewkes et al. (2002), which reported a 1.6% of the population prevalence rate for rape victims under the age of 15 years (where the strict criterion applied, underestimated the prevalence of child abuse of a sexual nature).

While outlining the scope, incidence and challenges of sexual offending in South Africa, the dilemma of determining accurate prevalence is identified by Burton et al. (2016). The most recent efforts to provide studies that reveal the development of nationally representative and reliable data, to address this problem with greater rigor and efficacy, are commendable. The Optimus study, conducted by Burton et al. (2016), examines all the studies in South Africa to date, and offers findings that move society towards multiple level interventions, which are desperately required.

Another study, conducted by Jewkes et al. (2010), concluded the following prevalence rates: 9.6% (women) and 16.7% (men) of the population in a rural area, where a broader definition of sexual abuse was used. Similarly, Madu (2003) concluded prevalence rates for physical abuse, sexual abuse and emotional abuse, as 15.2%, 25.6%, and 26.9%, respectively, in a study at the University of the North. In contrast, Madu and Peltzer (2000), who conducted a study in the Northern Province, with high school learners, established a prevalence rate of 54.3% for child sexual abuse, (which concurs with a study conducted by Carey et al. (2007), which revealed that 53% of young people in their study sample were referred for psychiatric treatment after disclosing experiences of child sexual abuse.

The findings of the Optimus study (Burton et al. 2016) caution that at least 35.4% of the child population in South Africa (approximately eight million children), have experienced child sexual abuse. To date, this is the most accurate finding for the prevalence of sexual abuse against children in South Africa. Clearly, sexual offenses against children are not unique to South Africa; however, the incidence and scope of this type of violence, directed against children, as well as vulnerable individuals, families and communities, may very well be specific to South Africa.

Some authors assert that Africa must be one of the most violent continents in the world, especially with sexual violence increasingly being used as a weapon of war in African countries, ravaged by political conflict and instability (Hargreaves 2001; Ward and Hirsch 2004). Sexual torture has been wielded to unimaginable levels of frequency and severity (Maciejczak 2013). The Democratic Republic of Congo is an example of the scope and nature of sexual violence in Africa. All warring parties in the Democratic Republic of Congo routinely wield sexual violence as a weapon of warfare, as well as a tool of social control (Maciejczak 2013). Due to their gender inequality and status in society, women in the DRC are and will unfortunately stay vulnerable, despite the continuing emancipation and women's liberation globally. By contrast, sexual violence against men and boys are also escalating; however, it is less understood or acknowledged (Londt and Roman 2010). Wartime rapes are not new (Harder 2006). Since the advent of human warfare, women were perceived as nothing more than "war bounty" (Maciejczak 2013, p. 130). Coomaraswamy (1998) refers to it as an accepted practice of conquering armies.

9.4 Social Workers' Ethics and Code of Conduct in South Africa

The available data and trends emerging from local and international studies reveal that most sexual perpetrators know their victims, and are not all incarcerated (Gantana et al. 2015; Londt and Roman 2014). Social workers, working in the sexual violence and child abuse arena, specifically, are often divided into two groups; firstly, those who offer services to the victims and secondly, those who attempt to work with sex offenders. The terminology used include terms such as, the paedophile, the child molester, the violent offender, as well as the broader grouping of sex offenders. Generally, attitudes towards those guilty of or accused of sexual violence towards others are negative and fear based. However, these attitudes shape intervention efforts, legislative development and policy making (Church et al. 2008). Social workers often hold the view that intervening with sex offenders constitutes a betrayal or compromises the safety and protection of the victims, as well as society, in general.

The current prevalent data (Burton et al. 2016; Jewkes et al. 2012) highlight that sex offenders will form part of the interventions by social workers at some point. The South African Constitution is clear that *all* its citizens have a right to remedies if, and when it is required (Act 108 of 1996). It is, therefore, acknowledged that every South African citizen is entitled to those interventions and remedies that will assist them to achieve positive behavioural outcomes, which will reduce the level of risk they pose to children, families or communities. In fact, this implies that it *is* a constitutional right to be provided with remedies to change negative behaviours.

Social workers, therefore, are encouraged to explore those strategies and practices that will develop best practice outcomes. The core values of social work imply that it would be a direct contravention of those key aspects of the profession, to decline services to the sex offender, based simply on a discomfort of working with this clientele population or based on the belief that sex offenders cannot be rehabilitated effectively. The following values are identified as the key values in social work: Service, Social justice, the self-worth of every individual, the significance of human interrelatedness, character and proficiency (South African Council for Social Service Professions [SACSSP] 2017). The core values of social work are also implied in an international social work definition: "Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledges, social work engages people and structures to address life challenges and enhance wellbeing" (International Association of Schools of Social Work [IASSW] 2014, p. 22).

The notion of social justice and acceptance by social workers, for instance, is considered against the statement by Smith (2014, p. 321)

> The 1994 elections were characterised by hope for social justice. The Truth and Reconciliation Commission attempted to bring about healing after centuries of oppression and injustice and the South African Constitution, adopted in 1996, is considered to be one of the most progressive in the world, ensuring protection of human rights for all.

Work with sex offenders, or dangerous offenders, generally places the spotlight on the different ethical and other obligations that social workers face. Myers (2008) cautions that social workers must be given the knowledge and skills that will equip them to work with this clientele group. Curricula in Social Work adequately address issues of causality, incidence and proposed management of sex offenders; however, students are often not encouraged to adopt reflexivity in their practice as a tool to understand their responses to this type of clientele grouping. Some authors argue that working with violent offenders or sex offenders is more exacting on social workers than other healthcare professionals, in terms of ethic obligations, because of the nature of the social worker-client relationship (Barry 2009; Londt and Roman 2010).

9.5 Social Workers, Obligations and Responsibilities towards all Client Systems

The ethical obligations that apply to social workers are often directed at the relationship with colleagues, the clients and overall decision making, related to their practice, as well as obligations to the social work profession and the broader society (SACSSP 2017). The code of ethics (SACSSP 2017) that apply to social workers in South Africa describes the responsibility towards the profession, towards the client system, ethical obligations in practice locations and ethical obligations towards the general public. This code is described as a list of statements or guidelines by which every registered social worker should carry out their duties and tasks.

The overall intent and mission of the South African code of ethics for social workers is to ensure that they all understand and are familiar with the obligations towards their clients, the profession and the broader society. An important requirement is that social workers remain aware of their mandated responsibility to enhance the well-being of all, and to ensure that specific actions are directed at empowering vulnerable, disadvantaged and poverty-stricken communities. In addition, social workers in South Africa are tasked with promoting social justice and social change, on behalf of their client systems, which refer to individuals, families and communities. The code of ethics further includes obligations regarding social workers and research, providing direct services, teaching students, doing managerial, administrative, editorial or consultative functions, as well as being an expert witness or executing any other role as a social worker in practice.

Additionally, this document identifies the ways that these obligations are disseminated to the social work population in South Africa. These include promoting it through education, peer reviews and consultation, creating and executing systems or procedures to assist social workers monitor the ethics of their conduct and opinions, arbitrating complaints of unethical behaviour and taking remedial action when social workers transgress the obligations and rules. Although the code of ethics for social workers in South Africa is fairly descriptive of the various obligations and rules, specific reference is made to how clients, who are HIV/AIDS affected, should be treated. No other references are made to violent offenders, and this seems to be subsumed by the broader obligations of social workers towards the client systems.

However, the following six factors are crucial to the obligations expected of social workers, social work students, as well as social auxiliary workers. The fundamental values of the social work mission are identified in the code of ethics document as:

- A broad summary is provided of those ethical principles that reflect the core values of the profession and establishes a set of clear, specific standards to guide the social worker;
- The code is designed to assist social workers to identify relevant considerations when they are confronted with conflicting obligations or an ethical dilemma occurs;
- It provides standards by which the broader public can hold social workers to account;

- The code provides orientation to newcomers to the field by clarifying the mission, vision, ethical principles and ethical standards;
- The code articulates a set of guidelines that enable the social worker to determine whether their conduct is acceptable or ethical (SACSSP 2017, p. 5).

South African social workers are also required to consider the Social Services Act (No. 110 of 1978) that provides further clarification for the social service professions in South Africa. Another key instrument available to the social worker is chapter 2 of The South African Constitution of the Republic of South Africa (Act No. 108 of 1996). This chapter deals with the Bill of Rights that enshrines the rights of all persons, by which all social workers are bound. There are no specific guidelines to define or manage an ethical dilemma, but the code of ethics provides sufficient rules, principles and values for the social worker to apply his or her mind in dealing with an ethical dilemma in practice.

It is important to recognise that personal and professional ethics are naturally intertwined with the practice of social work; however, the expectation is that the best interest principle always applies as the priority in maintaining decision making for the client. The South African Code of Ethics complies with the international demand that an established code of ethics or set of standards is provided to all healthcare professionals, who could interrogate every action they take in relation to client systems, or those to whom they are tasked to provide services. The assumption is that this set of standards, values and principles is based on a foundation of theory, research and knowledge that enables a healthcare professional to achieve self-regulation, ensuring best practice outcomes. The Constitution of South Africa (Act No. 108 of 1996) and the Social Services Act (No. 110 of 1978) provide the context in the provision of this set of standards that contributes to professional self-regulation and accountability.

In terms of the South African Code of Conduct, the regulations that hold implications for those social workers working with sex offenders, is contained, partly, in chapter 5 of the code of ethics. Some aspects are extracted from chapter 5 to direct attention to those potential conflicting standards:

- *Confidentiality* – the ethic standard of maintaining privacy for the client is expected to be held at the highest regard and takes into account two aspects, namely, the right against intrusion and the right to confidentiality. The right against intrusion is that the client has the *right to withhold any information from the healthcare professional*. This has further implications for the social worker, who, "irrespective of legal or ethical duties" is to respect this right, as well as show the respect for the person. There are clear obligations for those situations when confidential material must be shared, and the procedures to effect this, for instance, a written contract at the outset of the relationship with the client system.

  The *confidentiality standard* obligates the social worker to take every reasonable step to ensure the privacy of the client system's information; however, it is acknowledged that this privacy aspect is not recognised by the South African courts. The issue of private privilege is recognised between a lawyer and his or her client, in terms of Section 201 of the Criminal Procedures Act (No. 51 of 1997). This implies that a social worker may be summoned by a court of law to disclose confidential client information. In this situation, the code of ethics requires that social workers have a duty to inform, in a written contract with the client, that this possibility exists.

Another dilemma is that, in certain settings, for example, a community health centre, where a 15-year-old girl requests a termination of pregnancy, and reluctantly reports that the father of the unborn child is a 40-year-old taxi driver, the social worker is often faced with the challenge of reporting rape of a minor or maintaining the confidentiality of the matter, as requested by the teen seeking the termination of pregnancy. The legislation is clear that a minor may give consent for such a procedure, without the knowledge or consent of a parent or significant caregiver, although the minor must be advised to consult her parents, caregiver or family (Choice on Termination of Pregnancy Act No. 92 of 1996). Many social workers experience this as an ethical dilemma, because such a service (termination of pregnancy) may not be withheld, if the parents were not consulted by the minor.

Similarly, if a sex offender discloses the names of child victims of his or her paedophilic behaviours, the social worker is compelled to report these offences and to inform the client that there is a mandatory obligation of reporting. This may be daunting for the social worker, if, many years after the alleged incidents, an aged client reports these activities that occurred during his or her adolescence or middle adulthood.

- *Competenc*y – The South African code of ethics provides a clear standard that social workers have to be competent for their practice and that they have a duty to ensure that they practise within the scope of this competency. Therefore, the critical question that begs a response is, “Are social workers trained to assess, intervene and provide services to the cadre of sexual offenders, or violent offenders, per se, with the current knowledge base or skill sets that they possess?”

  The South African Council for Social Service Professions’ Code of Conduct highlights that employers of social workers have an obligation to ensure that all social workers receive continuing professional development, which implies that employers must find those courses or interventions that will equip a social worker to deal with different client systems, as the landscape in South Africa changes. Social technology and media is increasingly used to perpetrate sexual offenses against children, for instance, and this means that social workers must be exposed to specific and further training to address this social dilemma (Badenhorst 2011).
- *Social justice* – The transformed social work curricula internationally, and specifically in South Africa, favour the pursuing of social justice as an integral part of the social worker’s practice and thinking. However, this is experienced as a dilemma for some, with the confusion that social justice for the community and the client system may have very different outcomes for the sex offender client. Social justice for the sexual offender is remaining in the community, adhering to

a legal sanction, but not necessarily spending his or her life in a prison, while social justice for the community implies the removal of those persons who pose a risk to the safety, protection and innocence of children, for an extended period.

In compliance with international standards, the South African ethics and principles demonstrate a code of behaviour at its highest level of integrity. The competency and skill of the professional is highlighted to ascertain and maintain the best interest of the client system and the community at all times.

This is experienced as a dilemma for working with sex offenders, where specific statutory obligations of reporting or monitoring apply. This may be the nexus for many social workers, the obligation to maintain the highest standard of privacy, regard for the trusting relationship and regard for the person, as well as their right to privacy. For many social workers this is experienced as an all or nothing situation. However, the code of ethics is clear that this obligation must be introduced with a written contract early in the professional relationship, and that the social worker has recourse to a remedy, where specific information is required by the courts (SACSSP 2017).

- *Mandatory obligations* to report provide a daunting challenge for newly qualified social workers especially in terms of specific pieces of legislation. Some of these include the Children's Act (No. 38 of 2005) and the Criminal Law (Sexual Offences and Related Matters Amendment Act No. 32 of 2007) as well as the Domestic Violence Act (No. 116 of 1998) and Older Person's Act (No. 13 of 2006). Hendricks (2014) cautions that, despite mandatory reporting of, for instance, child sexual abuse, many health care practitioners and social workers fail to report it, both locally and internationally. Often the reluctance to report abuse, in many forms, is because the social worker may have a relationship with the perpetrator and is of the opinion that poor responses by other social service agencies are too cumbersome and often yields negative outcomes for all.

9.6 Conclusion

In conclusion, the South African code of ethics clearly provides detailed descriptors for the rules, obligations and expectations of all registered social workers, in dealing with their client systems in practice. A range of instruments is identified that suggest how the vision, mission and values are dispersed to the social work population, in order to ensure both adherence and familiarity with the code. This document also provides instruments for, among others, protesting that the confidentiality and privacy of the client will be compromised when the court subpoenas confidential information which the social worker may hold about a client system. The code of ethics reminds all social workers that the client-social worker privilege is not acknowledged by the South African courts, as the lawyer-client privilege is protected in Criminal Law statutes.

The values and principles included in the education and, thereafter, practice of the social worker, social work student or the social auxiliary worker, clearly position social workers to work with most client systems in a respectful, engaging relationship that favours those discourses, which empower, support and guide client systems to develop their strengths and own resources with challenges that they experience. However, the work with sex offenders pose somewhat of a challenge to social workers on many levels. The existing skill sets, values and knowledge geared towards social justice, service, anti-discriminatory and anti-oppressive practice, equips the social worker to intervene with a diverse clientele population. The code of ethics is clear that every social worker should be provided with the skills and that they should take the responsibility to up skill, in response to clientele needs and dynamics. While social workers may possess the basic intervening skills with a dangerous clientele system, they lack the more specialised skill sets that will enable them to assess risk (Grady and Abramson 2011; Van Niekerk 2006). This may be one of the marked features of sex offender work, the ability to determine risk against developed risk assessment criteria, which were tested and refined through rigorous research protocols. The responsibility to equip student social workers or practising social workers, remains the ethical duty and responsibility of curricula developers in tertiary institutions (Grady and Abramson 2011).

The incidence of sexual violence in South Africa, reported earlier, also implies that many of those studying or practicing social work, may have experienced unwanted sexual incidents, placing them in the clientele grouping of survivors, which may agitate their willingness to work with sex offenders, whether it is a young offender or even a pre-pubescent child with sexual behaviour problems. This can be remedied by altering the way social work students are educated regarding ethics, as well as the importance of self-recognition and self-nurturance, which implies that reflexivity and reflective practice are concepts that must be included, when conversations regarding ethics and the ethics of care are developed; for self, as much as for the clientele systems.

The dilemmas regarding how social workers construct or apply principles of confidentiality also require more robust interrogation. Although the South African code of ethics addresses the nuances of confidentiality against the two aspects of the right to privacy and the right against intrusion (SACSSP 2017), this proves somewhat of a contradiction. The work with sex offenders and the right against intrusion pose a dilemma when the social worker attempts to retrieve information about those undisclosed victims or the undisclosed sexual acting out that presented as precursors to the known victim of the offender. The prerogative of not sharing compromising information may confront the social worker as a daunting task, while still trying to adhere to those values of regard, respect and patience, ostensibly embedded in the social worker-client relationship.

9.7 Summary

The way forward is to assist social workers to understand and familiarise themselves, fully, with the code of conduct in South Africa, which provides them with the obligations, rules, remedies and values to perform at their best. The additional skill sets for intervening with sex offenders must be expanded to risk assessment, to ensure that intervention is tailored to the possibilities of reducing the risk of ongoing sexual violence. The transmission of these skills must be shared by institutions of higher learning, which must be viewed as an ethical obligation to ensure that social workers are appropriately equipped to respond to sex offenders. This is of particular importance, since the age of the offender appears to be becoming younger, as evidenced by the escalating incidence of sexual violence by youth.

The South African context is mired by accusations of corruption, where resources are misused for purposes of self-enrichment. Social workers have very specific, statutory obligations regarding several important laws, which are geared towards protecting vulnerable groupings, as well as ensuring social justice for victims of different types of violence. However, this also includes those statutory obligations that many law courts depend on, regarding the sentencing structure of offenders, many of whom are young sex offenders. It is the ethical duty of all institutions of higher education to ensure that every social work student, auxiliary social worker and social worker in the field is equipped with the best skill sets, values, knowledge and reflexivity, which will enable them to deliver their work of the best and highest ethical standards and integrity.

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Chapter 10
Ethics in Physiotherapy Practice – An African Perspective

Ajediran I. Bello and Babatunde O. A. Adegoke

Abstract Appalling incidences of disabling diseases, its attendant consequences for rehabilitation and the underlying ethical implications in healthcare practice occur daily in Africa. The practice of physiotherapy is often confronted by many moral issues that may not have been duly clarified either during training or years of professional practice. Apart from the shortage of physiotherapists to confront the prevailing rehabilitation needs, physiotherapy practice in Africa presents peculiar ethical concerns given the cultural peculiarities, pervading level of illiteracy and widespread poverty. The struggle to align physiotherapy practice in Africa with global trends however seems to have obliterated the physiotherapists' focus on the peculiar ethical requirements of most illnesses on a continental basis. Previously, studies investigating ethical issues in physiotherapy practice have been tailored to the Western culture though cultural beliefs and values are crucial to the planning and implementation of healthcare services. There is hence the need to present ethics guiding the practice of physiotherapy in the cultural, societal, regional and geographical contexts. In a resource poor society where patients may not be fully aware of their rights, patients' rights and dignity may be advertently or inadvertently violated. This chapter is therefore aimed at presenting the African perspectives on ethical concerns in physiotherapy practice.

Keywords Rehabilitation · Physiotherapy practice · Ethics · African culture

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10.1 Introduction

The increase in healthcare provision in Africa is beginning to serve as a stimulus for the concomitant increase in the awareness of ethics as an important topic in healthcare. The significant economic and psychological burden of disease and disability in Africa calls for an effective healthcare system in which the individual understands his or her rights through population-specific ethics. From time immemorial, the moral dimension has been part of healthcare practices and it remains the yardstick with which to differentiate the "rights" from the "wrongs" in the course of practice. A code of ethics deals with multiple realms of ethical issues and serves as a key indicator for professional recognitions. It sets out professional standards and delineates moral issues which are peculiar to a given profession (Kirsh 2009).

In African societies, resource availability and human rights records are contentious issues hence the risk of unintentional violations or abuse of patients' rights and dignity by healthcare providers is high (Hoffmann and Nortjé 2015). This underscores the need for exploring physiotherapy practice in relation to African moral values and beliefs and the continent's socio-cultural state. Although ethics have been part of physiotherapy practice and training over many decades, the African perspective has not received much attention hence, most information on the topic is rooted in the Western culture. Indeed, when attempts have been made to make a case for Africa, it has largely tilted towards medical and paramedical practices even though all healthcare professions are required to work within specific frameworks of ethics due to their respective approaches which may have implications for ethics. Given that ethical understanding and moral deliberation may be linked to culture, there is the need for an in-depth look at the healthcare practice in Africa with special focus on ethics as it relates to physiotherapy practice.

This chapter therefore seeks to set the stage for exploration of context of ethics in physiotherapy practice in Africa so as to establish priorities of concerns among practitioners, clients and informal caregivers. The first section of the chapter will demystify the conceptual definition of ethics as related to physiotherapy practice. The second section will focus on the burden of disabling diseases and ethical tensions in Africa. The third section will be on the professional challenges of physiotherapy practice in Africa, while the fourth will present the potential ethical issues that are peculiar to physiotherapy practice particularly within the African Region. The concluding part will focus on the development of a conceptual framework for ethical consideration in physiotherapy practice for Africa.

10.2 Upsurge in the Burden of Disabling Diseases and Ethical Tension in Africa

The deleterious effects of communicable and non-communicable diseases (NCDs) continue to arouse global attention. The World Health Organisation (WHO) has identified Africa as the continent that is most susceptible to high incidences of trauma, lifestyle-related diseases and infectious diseases due to factors such as growth and ageing of population, poverty, infection-prone environment, natural and man-made disasters, urbanisation associated with unhealthy diet, obesity and inactivity (Bradshsaw et al. 2007). The continent has the world's fastest rate of population growth owing to urbanisation and increase in life expectancy which underlies the evolving disease profile (WHO 2016). While Western countries have been able to reduce the scourge of communicable diseases to the minimum, African countries are still inundated by this challenge. The obvious "lag" could be attributed to poor human and material resources amidst competing demands for other social responsibilities from African governments.

Although Sub-Saharan Africa represents 12% of the global population, it accounts for a quarter of the world's burden of healthcare delivery system amidst acute shortage of healthcare professionals (Balogun et al. 2016). The resultant morbidity, in the form of disabilities, from these diseases not only imposes physical and psychosocial burdens on the sufferers but also huge economic and social responsibilities on the part of the governments and social support systems. The recent outbreak of Ebola in four West African countries coupled with internal crises mostly in the West and East African countries occasioned by natural and artificial disasters, have all contributed massively to the appalling incidence of disabilities in the continent. Undoubtedly, the regional healthcare systems in terms of health policies and priorities, are largely influenced by the socio-cultural and socio-political diversity of the Africa continent.

A study of the global burden of diseases suggests that age standardized mortality occasioned by the affliction of NCDs, is directly related to socio-economic factors as higher rate of mortality was recorded in selected Sub-Saharan African countries than in high resource ones (Dalal et al. 2011). It is thus evident that there is a high level of physical, mental, psychosocial and economic disabilities arising from these diseases in Africa which deserves utmost attention in terms of health promotion, prevention and rehabilitation in order to address the ethical tensions and challenges.

10.3 Professional Challenges of Physiotherapy Practice in Africa

The persistent overwhelming burden of disabling diseases in Africa explains why there is a dire necessity for the full complement of healthcare personnel. Ironically, Africa remains one of the continents of the world with the least resources to meet its healthcare needs (Balogun et al. 2016). Roadside beggars and internally displaced persons with appalling disabilities are common sights in the streets of major cities in Sub-Saharan Africa. Physiotherapy practice in Africa is yet to meet the standards set by developed countries due to many outstanding challenges. The formidable challenges confronting physiotherapy practice in Africa have ethical implications that can be viewed broadly as follows.

10.3.1 Human Resources

The average number of physiotherapists per country in Africa is grossly inadequate and the distribution varies widely (Table 10.1). Although it is difficult to obtain the actual number of physiotherapists per country, particularly, from the non-member

Table 10.1 Physiotherapists-resident ratio in selected African countries

Country	Physiotherapist per resident ratio	Year reporting
Benin	1:137,801	2017
Congo DRC	1:474,262	2016
Egypt	1:135,833	2017
Ethiopia	1:3,858,022	2016
Ghana	1:1,910,441	2017
Kenya	1:115,295	2016
Malawi	1:554,505	2017
Mauritius	1:27,262	2017
Namibia	1:23,315	2017
Niger	1:477,702	2016
Nigeria	1:532,877	2017
Rwanda	1:81,064	2016
South Africa	1:14,650	2017
Swaziland	1:62,874	2017
Tanzania	1:1,387,256	2016
Togo	1:102,559	2017
Uganda	1:694,216	2017
Zambia	1:86,189	2017
Zimbabwe	1:320,348	2017

Source: WCPT-A (2017)

states of the World Confederation for Physical Therapy-Africa (WCPT-A), the West African Sub-Region seems to be the zone with the lowest physiotherapy workforce in the world. For instance, the number of available physiotherapists in the whole of Sierra Leone is less than five which is grossly inadequate to serve the country with over 450,000 people living with residual disabilities caused by civil war (WCPT 2016). This situation may not be particularly different in other countries within the other WCPT-A sub-regions and the shortfall raises concerns about the capability of the affected countries to meet the rehabilitation needs of their citizens.

10.3.2 Research-Practice Gap

The necessity for research stems from its value in ensuring high quality practice so as to create pathways for professional development. In essence, research and dissemination of its findings are essential to the survival of the education of any healthcare professional. However, in Africa, there seems to be a disconnect between research and practice in physiotherapy due to parallel modus operandi of researchers and practitioners in terms of foci of interest, heavy workload amidst low work force, lack of motivation and time constraint (Frantz and Amosun 2011). The quantity and quality of research papers available to the clinicians in the area of healthcare and rehabilitation services are additional problems.

10.3.3 Socio-Economic Factors

The health crisis in Africa is partly due to inadequate attention being paid to the motivation of healthcare workers, including physiotherapists. Many factors have been adduced as the root causes of this situation among which are low per capita expenditure on healthcare by governments, poor financing arrangements, inadequate fiscal space and poor financial arrangements (Kirigia 2007). Frequent industrial actions due to poor salary and inadequate conditions of service are also common occurrences in most African countries, thereby resulting in low work output which in turn contravenes professional and ethical principles.

10.3.4 Healthcare Policy Planning and Implementation in Africa

Policy planning and implementation remain poorly addressed issues in physiotherapy practice. There seems to be a lack of strong will on the part of the practitioners and low commitment on the part of governments to develop and implement policies for effective physiotherapy service. The WCPT policy thrust (WCPT 2016) emphasised the need for policy as a legal framework for the member organisations. In many African countries however, the physiotherapy organisational structure is bereft of policy on professional issues as it affects physiotherapy training and practice.

10.3.5 Professional Regulation

The modes of practice and regulation of physiotherapy in Africa is varied and far removed from the required standards. The WCPT policy on physiotherapy regulation prescribes adequate educational programmes as a prerequisite for professional practice at the entry level. Also, it emphasises continuing standards of professional competence, as well as a professional code of ethics and maintenance of a register of licensed physiotherapists (WCPT 2016). However, many African countries still train and rely on physiotherapy assistants for practice, based on the need to provide rehabilitation services to low resource societies and communities.

10.4 Potential Ethical Issues in Physiotherapy Practice in Africa

Physiotherapy is essentially a rehabilitation science which is meant to identify, prevent or correct and alleviate impairments and movement dysfunction of anatomical or physiological origin (WCPT-A 2017). The practice of physiotherapy involves close human interaction on issues pertaining to patients' presenting conditions right from the evaluation stage to the point of treatment. The overall goal of treatment is geared towards effective delivery of health care and the protection of patients' dignity and interest. In Africa, the characterisation of disabling conditions with regard to direct and indirect costs may elicit a series of ethical dilemmas and challenges between the trio of physiotherapist, client and family. The ongoing global professional expansion has also challenged physiotherapists to adhere to all social etiquettes associated with their practice on a daily basis. As with other healthcare professionals, healthcare ethics for physiotherapists is founded on the framework of the four-principle approach enshrined in bioethics, namely: autonomy, beneficence, non-maleficence and justice (Unger and Hanekom 2014).

Physiotherapists must ensure sound professional decisions, particularly in societies where people lack knowledge of their rights or privileges. Given the dearth of information on the topic in Africa, it appears that ethical decision making is not duly appreciated as a component of clinical judgement during patient's evaluation by physiotherapists. In any clinical practice, irrespective of settings and geographical locations, healthcare professionals are confronted with ethical dilemmas in the context of clinical decision making. O'Sullivan (2003) opined that the determinants of clinical decision making can be viewed in three domains, namely: clinician goals, patient/client characteristics and environmental factors. These domains are especially challenging for physiotherapy practice in Africa compared to Europe, Asia and America due to the array of health-related social challenges. In the light of this, the determinants of ethical tensions in physiotherapy are discussed in the following subsections.

10.4.1 Cultural Competency Practice

Respect for patients' individual lifestyles, beliefs and practices is part of the tenets of physiotherapy practice; thus cultural competence should be central to overall professional competence and capability (O'Shaughnessy and Tilki 2007). The authors presented a useful model for developing cultural competence focussing on four areas such as self-awareness of personal culture, awareness of other cultures, sensitivity to such other cultures and developing competence in diverse cultures. Physiotherapy practice in Africa is faced with the challenge of meeting the cultural demands of patients due partly to its diversity and less attention being paid to cultural competency. In reality, cultural competence connotes the ability of the individuals to institute productive interpersonal and working relationships that overweigh cultural variations. Although, a population-specific study by Bello and Lawson (2013), found good awareness and active participation of physiotherapists in Continuing Professional Development (CPD), the topic of cultural competence has not been given adequate attention in most CPD programmes in Africa. Indeed, clinical practice laden with cultural incompetence may most likely be faced with the risks of misdiagnosis on account of ineffective patients' evaluation, poor treatment outcome and compromised adherence to physiotherapy management.

10.4.2 Patient Autonomy

Physiotherapy practice conforms with biomedical and biopsychosocial models of care, hence it is subject to ethical tenets of autonomy. Thus, it respects patients' right to choice of care and the right to accept or refuse treatment. An institution-based study in Northern Nigeria showed similar opinions between physicians and non-physicians (including physiotherapists) as to whether or not they considered patients' wishes before taking major decisions on their care though there was a gap between knowledge and practice among the participants (Monsudi et al. 2015). Patients' autonomy is often disregarded where there is a high level of illiteracy, low socio-economic status, inadequate practice regulation, lack of social protection for patients, weak health policy, human rights issues and paucity of blueprints on ethics as found in Africa. Most physiotherapists still seem attached to the old practice of "medical paternalism" whereby clients remain passive in decision making regarding their care to the detriment of patient autonomy.

10.4.3 Informed Consent

Informed consent in physiotherapy varies from country to country according to local laws, customs and norms (Chigbo et al. 2015). It is an essential part of clinical reasoning and for its utilisation to be meaningful, it must then be tailored to the local needs. A study on the penalties meted out to physiotherapists who were found guilty of ethical misconduct in South Africa between 2007 and 2013, indicated a wide variety of penalties where physiotherapy approaches and modalities were administered without obtaining informed consent from their patients (Hoffmann and Nortjé 2015). In addition, the preponderance of lower cadre healthcare personnel (e.g. physiotherapist assistants) due to high patient-physiotherapist ratios, has negatively affected the concept in Africa.

10.4.4 Inter-Professional Relationships

The existence of egoism among healthcare providers often results in ethical and interpersonal tensions at the expense of patient beneficence. In many African countries physiotherapy has not been legislated for inclusion in the primary healthcare system; hence practice is based largely on referrals from physicians (Odebiyi et al. 2010). This, in turn, potentially sets the stage for interprofessional and ethical conflicts between physicians and physiotherapists over status. The ethical tensions often emanate from discordant referrals wherein attempts are made by physicians to unduly influence physiotherapy interventions. It has been argued that whilst physiotherapists are well trained to make clinical judgements based on patient evaluations and within the scope of their practice, physicians also reserve the professional right to show concern about the safety and care of their patients (Asem 2004). In Africa, the involvement of physiotherapists in the management of patients mostly depends on the belief and values of the first contact healthcare provider regarding the efficacy of physiotherapy; physiotherapy at best being taken as a prescription rather than referral entity, thereby putting patients at risk of deprivation of an essential rehabilitation component (Odebiyi et al. 2010).

10.4.5 Physiotherapists-Patient Relationship

In Africa on a daily basis many ethical issues abound between physiotherapists and patients. In spite of physiotherapists' basic theoretical ethics knowledge, they are still constantly being challenged by the influence of institutional and/or societal rules. Given a direct link between moral conflict and the ethical dimensions of healthcare practice, African physiotherapists have had to contend with various ethical issues such as patient satisfaction, confidentiality, family interference, health disparity, available resources, time allocation, values, client preference for physiotherapist by gender, as well as the influence of culture and religion (Chigbo et al. 2015). Overfamiliarity between physiotherapists and patients is another challenge due to its potential for ethics violations.

10.4.6 Resource Distribution

The African continent has the lowest (i.e. worst) healthcare professional to population ratios in the world with most countries falling short of the benchmark set by the World Health Organisation. Nigeria, Tunisia and South Africa have 1.7, 12 and 13 physiotherapists per 100,000 people respectively in contrast to 49.4, 61.4 and 64.7 for Canada, Australia and the USA respectively (Balogun 2017). Worst still, the majority of the available physiotherapists in Africa prefer to work in the cities, thereby leaving rural communities to the care of physiotherapist assistants or even quacks. Furthermore, a high percentage of the physiotherapists trained in Africa often fall prey to the "brain drain" phenomenon hence the available physiotherapists are under pressure to, rather unethically, commit less time to the treatment of individual patients in order to cope with the overwhelming number of patients.

10.4.7 Training Curricula

Physiotherapy training institutions in Africa offer varied entry level programmes with diverse curricular contents that vary between regions and within countries. The most important variations being in the course duration, course subjects, ethics, professionalism and values. The ongoing change in the profile of disease and resultant disorders add to the concomitant burden on personal and government resources to continuously adjust healthcare education programmes. However, the development of most physiotherapy programme curricula in Africa is mostly based on craft knowledge and individual experience without due input from education professionals (Unger and Hanekom 2014). In most cases, the ethics components of the curricula fail to address the peculiar ethical situations in Africa since they mostly only mirror Western healthcare contexts. This development leaves young physiotherapists with little insight into the core values of their practice with regards to context-specific cultures and customs (Kirsh 2009). Consequently, they are exposed to precarious ethical situations such as professional malpractice and patient exploitation that leaves many patients in a vulnerable position (Hoffmann and Nortjé 2015).

10.5 Development of a Conceptual Framework for Physiotherapy Practice in Africa

Having identified the peculiar intricacies of physiotherapy practice in Africa (see Sects. 10.4 and 10.5 above), there is a clear need for a continent-specific conceptual framework that could assist in addressing the identified ethical issues. Consequently, six main areas have been identified for a conceptual framework that engenders ethical considerations in physiotherapy practice within the African context (See Fig. 10.1).

10.5.1 Curriculum Modification

The curriculum provides a conceptual framework that includes the incorporation of new concepts relevant to the advancement of any discipline. A broad-based curriculum has been recommended to add values to content topics such as "safety, group work (team, organisation and community), evidence-based practice, professionalism, problem solving, ethical practice and lifelong learning" (Unger and Hanekom

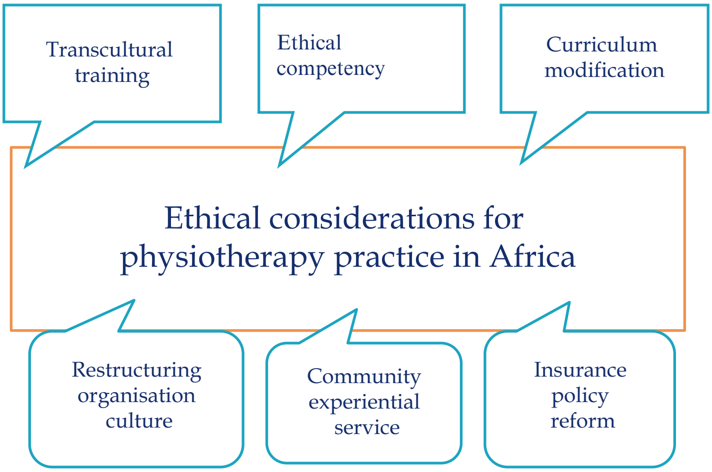

Fig. 10.1 Conceptual framework for physiotherapy practice in Africa

2014, p. 222). Balogun (2017) advocated a two-pronged approach, namely teaching and modelling for adoption by African academics in conveying the core values associated with professionalism to aspiring physiotherapists. In addition, the content of lectures should be responsive to professionalism and ethical values, tenets of the Hippocratic Oath and the codes of conduct of physiotherapy; and these should be accompanied by local core values and beliefs to reinforce lecture content and information.

10.5.2 Restructuring the Health Organisational Culture

There is the need for the reorganisation of healthcare settings in Africa to enhance mutual respect among healthcare providers, patients and healthcare facility managers. Intuitively, the healthcare provider-manager relationship may influence the quality of health care should the former feel slighted due to unfavourable recognition. For instance, inclusion of physiotherapy in primary healthcare settings could facilitate a paradigm shift from institutional-based care to community and society-based practices where beliefs, culture and values are palpably felt. A primary healthcare approach emphasize on providing health care to the disadvantaged, using the values of accessibility, affordability, sustainability, availability and suitability to satisfy ethical obligations (Mash et al. 2013).

10.5.3 Transcultural Physiotherapy Training

Cultural competence underscores the physiotherapist's behaviour and readiness to interact and act as found appropriate to the patients' values and beliefs and it remains a requisite skill for every healthcare provider (De Beer and Chipps 2014). Given the complex nature of culture and its diversity, incorporation of healthcare ethics can only be possible with culturally competent practicing physiotherapists particularly in Africa society with its abundant taboos and cultural beliefs. Cultural competence thus forms the pivot around which technical know-how for physiotherapy practice revolves. O'Shaughnessy and Tilki (2007) advocated a transcultural skill development model which is premised on four key pillars of cultural awareness, cultural competency, cultural knowledge and cultural sensitivity. The following strategies are recommended for developing cultural competence in physiotherapists by physiotherapy associations across Africa:

- Directorates of Physiotherapy should work closely with ethnic minority communities within all African countries and sub-regions;
- Special training of practicing physiotherapists on attributes of professionalism and ethical values, tenets of the Hippocratic Oath and the relevant codes of conduct;

- Healthcare stakeholders should recognize the cultural concerns of their patients and enrol it into the mainstream healthcare delivery system;
- Provision of adequate information by taking into consideration the multilingual composition of the health care consumers and by ensuring effective communication;
- Formulating new policies and procedures to accommodate cultural diversity and
- Advocating physiotherapy practices that are based on relevant and African-based research and experiences.

10.5.4 Insurance Policy Reform

As a result of the procedural nature of physiotherapy practice, patients and their family members commonly experience significant financial and emotional burdens given the required multiple treatment sessions. In addition, Africa is characterised by scarce and poorly distributed resources at all levels of the society. Most often, alteration of treatment regimens with regards to its duration and/or termination is not uncommon in order to cushion the effect of financial strains among the patients. In these situations, physiotherapists are often faced with the dilemma of having to balance the ethical principles of their profession with financial considerations in the care of the patients (Chigbo et al. 2015). To curtail this situation, physiotherapy should be fully incorporated into the mainstream of National Health Insurance schemes across Africa to avail Africans with optimal rehabilitation benefits. Further, there should be a pragmatic drive for aggressive national and regional campaigns to inform Africans of the benefits of health insurance coverage.

10.5.5 Community Experiential Service Learning

One of the workable strategies to bring healthcare services to the community level is the infusion of service learning components into the healthcare training curricula in Africa. Service learning experience at community level should ideally commence at the entry level of physiotherapy training. This can potentially create early sensitivity to community services under the purview of community-based education and rehabilitation. Service learning in different contexts will elicit professional development and guarantee cultural literacy and competence for patients and physiotherapists respectively. According to Mostert-Wentzel et al. (2013), reflective learning and practice is the most effective way to ensure professional growth on a long-term basis and it stands to foster justice even in an environment with low resource allocation. Early exposure to community engagement will likely keep the students abreast of different cultural backgrounds and ethics that can positively impact physiotherapy practice.

10.5.6 Continuing Ethical Competency

Ethics remain one of the grey areas lacking the deserved attention in most organised Continuing Professional Development (CPD) programmes in Africa. Most CPD programmes don't include substantial ethics components, thereby depriving practising physiotherapists the opportunity to upgrade their knowledge on the topic (Bello and Lawson 2013). Ethics training will create room for critical thinking, objective analysis and clinical reasoning processes to inform decision making in different contexts and patients' backgrounds which should be free of bias (Nortjé and de Jongh 2015). Given that ethical judgement plays an increasingly important role in the clinical decisions of physiotherapists, there is an urgent need to infuse ethical theory and skills into their daily decision-making processes.

10.6 Conclusion

Apart from the profound demands for physiotherapists to rehabilitate patients affected by movement and postural disorders, various ethical issues abound necessitating the need for the review of codes of ethics that guide the practice of physiotherapy in Africa. In physiotherapy practice, the demand to contribute to the optimal wellbeing of patients is constant and it entails a holistic approach to patient management with underlying ethical principles in the course of practice. The challenges identified in this chapter deserve continent-specific solutions on a wide scale.

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Chapter 11
The Ethics of Care as Applied to Physiotherapy Training and Practice – A South African Perspective

Theresa Burgess and Jennifer Jelsma

Abstract Many philosophical approaches can be brought to the solving of ethical dilemmas in the healthcare professional arena, but in this chapter, we suggest that care ethics or the ethic of care might be the most appropriate within the context of physiotherapy.

The **aims** of this chapter are the following:

(a) Introduce readers to the concepts of the ethics of care or "care ethics". This includes a brief description of the history, principles and criticisms that have been levelled against care ethics.
(b) Discuss how care ethics is relevant to the ethical issues in physiotherapy training and clinical practice, with an emphasis on the South African situation.
(c) Present a case study that demonstrates how care ethics might inform ethical decision making in the clinical setting.

The first section of the chapter focuses on the principles of care ethics, history and criticisms. The second section of the chapter focuses on ethical issues in physiotherapy training and practice in South Africa. This includes a discussion of the imperative to train physiotherapists who are fit for the purpose, i.e. able to provide accessible, effective and culturally appropriate care to all South Africans. The final section of the chapter focuses on a case study of an ethical dilemma in clinical practice, with discussion of how care ethics can inform decision making. The "web of care" in this case includes consideration of the community service (junior) physiotherapist, the patient, their caregivers or families, the physiotherapist's colleagues and lecturers, as well as the wider community from which all are drawn.

Keywords Ethics of care · Physiotherapy · Contextual factors · Care giver · Care receiver

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11.1 Introduction

Many philosophical approaches can be brought to the solving of ethical dilemmas in the healthcare professional arena. In this chapter, we suggest that care ethics or the ethics of care might be the most appropriate within the context of physiotherapy. As physiotherapists, we realise that the management of patients should be individualised and that "one size does not fit all". For example, the management of an elderly grandmother cared for by her daughters may be very different from that of a young single professional woman, although their health conditions may be very similar. In addition, the conceptual framework of the International Classification of Functioning (ICF) developed by the World Health Organisation (WHO 2001) is increasingly being used to guide assessment and therapeutic management of patients within the healthcare system. The important contribution of the ICF is that the environment is recognised as playing a foundational role in modifying the experience of disability and function. The ICF includes not only the physical context but also the attitudes and availability of support as part of the environmental factors that may impact on the individuals seeking therapy.

In the light of the above, we propose that situating patients and their caregivers or families within a "web of care" might result in a more humanised therapeutic environment. The web of care should extend not only to the recipients of care, but also to the providers of care, in this case the caregivers or family members, physiotherapists and other members of the healthcare professional team. Thus, not only the context of the care receiver or patient, but also the learning and teaching environment should be taken into account. This approach may well lead to the provision of more holistic care, based on the bio-psychosocial model of health care, rather than the more entrenched medical model. Care, thus becomes a skill to be learned, an attitude to be inculcated and a yardstick by which to gauge the healthcare professional's moral actions (Lachman 2012).

In the following sections the ethics of care will be defined and then, to understand the conceptual framework of the model, the roots and development of this theory will be discussed. Furthermore, some of the key ethical issues in physiotherapy training and practice in the South African context will be highlighted. Finally, a case example to demonstrate how the application of this theory may inform action in the teaching and clinical environments will be presented.

11.2 Conceptual Clarification/Definition of Ethics of Care

Care ethics or the ethics of care (EoC) differs from "rule-based" ethics in which decisions are made behind a "veil of ignorance" and are based for example, either on non-negotiable moral principles or the calculus of the greatest benefit that will accrue to the population at large. Care ethics arose in part due to the critique of the rule-based ethical theories that feminists such as Gilligan (1982), Noddings (1984) and most notably Tronto (1993) developed over the decades. Care ethics is more concerned with the individual who both receives and provides care and the context in which this takes place. Care ethics is similar to virtue ethics as it does not represent a moral theory as such, but rather the development of a habit of good character and caring behaviour. As it is argued that we all need and give care, whether in our personal or professional lives, it follows that, although the focus of action may be the individual, the implications of this action must also be considered within the broader context of a web or network of caring relationships. One of the main criticisms of care ethics is the ambiguity and lack of clarity regarding the core concept of "care". Tronto, one of the strongest proponents of care ethics, defines caring as being a human activity which encompasses everything that humans do to ensure the sustainability and upkeep of the physical and psychological aspects of human life and the environment within "a complex, life sustaining web" (Tronto 1993, p. 103).

One of the key aspects of care ethics is that it encompasses "responsibility" ethics in which the departure point is the relationship with others, rather than the obligation that one has to act in a certain way. The ethic of care involves developing "a habit of mind to care" (Tronto 1993, p. 127) and can be regarded as both an attitude and a form of action (Sevenhuijsen 1998). Tronto (1993) proposes that we cannot simply be passionately motivated by the predicament of others, but we should be positioned to help them as well. Tronto (1993) also addresses criticisms of partialism that are often attached to care ethics by including a role for fairness and states that "a theory of justice is necessary to distinguish among more and less urgent needs" (Tronto 1993, p. 138).

Tronto (1993) highlights how care ethics involves both believe and deeds, and thus, that ethics of care may be conceived not just as an ethical theory, but as a practice. Within the context of clinical practice, Tronto (1993) describes "four phases of caring" (p. 105) and "four elements of caring" (p. 127). The four phases of care are the following: (1) caring about; (2) taking care of; (3) caregiving; and (4) care receiving. *Caring about* requires "noting the existence of a need and making an assessment that this need should be met" (Tronto 1993, p. 106); while *taking care of* involves "assuming some responsibility for the identified need and determining how to respond to it" (Tronto 1993, p. 106). *Caregiving* involves the actual practice of delivering care; while the last phase of care "recognizes that the object of care will be affected by the care it receives" (Tronto 1993, p. 107).

The four elements of care are listed as: (1) attentiveness; (2) responsibility; (3) competence; and (4) responsiveness of the care receiver to the care (Lachman 2012). Perhaps the most important element in the African context is the last element, namely responsiveness. Tronto (1993) highlights the individual vulnerability that is associated with needing care. She also emphasises the dangers of creating a dependent relationship between the carer and the individual being cared for by being too caring. Tronto (1993) states: "The moral precept of responsiveness requires that we remain alert to the possibilities for abuse that arise with vulnerability" (p. 135). This is something that is especially relevant to physiotherapy practice as healthcare professionals often care for people who are dependent and vulnerable due to impaired functioning or disability. The setting of boundaries to caring is a moral question which “centres on whether care-givers can or should establish limits to their emotional involvement, intimacy and tenderness” (Sevenhuijsen 1998, p. 2), and this emphasises the possible tensions between professionalism and emotion.

More recently, Gastmans (2006) has described care ethics as “a ‘moral perspective or orientation’ from which ethical theorising can take place” (p. 146). These concepts have been further developed and applied to the “changed social structures and conditions of late modernity” (Vosman and Niemeijer 2017, p. 3). These authors maintain that ethical conduct should be based on the needs of both the recipients and givers of care. Vosman and Niemeijer (2017) state that care ethics “explicitly emphasizes and privileges the relational, the local and the particular, over or often in rejection of concepts of the universal, the generalizable and the autonomous individual” (p. 3). Of particular interest to South Africans Bolt (2016) further draws an explicit link between the concept of care ethics and Ubuntu, an African humanist and ethical world view, which Berghs (2017) maintains is a normative ethical framework which mandates how people should interact with one another in order to attain their full humanity. It is therefore evident that care ethics may be considered as a moral compass that would guide practical action rather than an abstract theory (Lachman 2012). The next section of this chapter presents some key ethical issues faced by the physiotherapy profession in the South African context, and that will highlight tensions within an ethics of care.

11.3 Ethical Issues Faced by Physiotherapists

11.3.1 Resource Scarcity

In society, the demand for healthcare exceeds available resources. This is particularly evident in developing countries such as South Africa. The healthcare system is faced with the challenge of promoting health and preventing disease at one end of the spectrum and prolonging life and treating chronic diseases at the other end of the spectrum. Health care also competes for resources with other fundamental services, such as education and the provision of basic services (for example, clean water and sanitation). As the demand for healthcare services continues to increase, there is a need to control healthcare costs and to establish a just system for the allocation of healthcare resources (Ram-Tiktin 2011). Priority setting requires careful consideration of values of equality, equity, effectiveness and efficiency (Daniels and Sabin 2002). In the face of significant disease burdens, a utilitarian approach is often adopted to allocate resources and maximise public health benefits. As a result, rehabilitation healthcare services, including physiotherapy, are frequently resource constrained which limits both the availability and the quality of patient care. This presents a conflict in care ethics, where clinicians have a moral responsibility to care about individuals in need of physiotherapy services; but in practice, clinicians frequently lack adequate resources to optimise physiotherapy care.

11.3.2 Inequality of Access

Issues related to access to healthcare services present significant ethical challenges in the context of the South African healthcare system. The most vulnerable individuals, including the elderly, chronically ill and individuals with disabilities are least able to access appropriate healthcare services, including physiotherapy. There are several issues contributing to unequal access of healthcare services. A significant influencing factor is the marginalisation of the elderly and individuals with disabilities due to stigmatisation and discrimination. There has also been a historical lack of prioritisation of the needs to these populations in healthcare resource allocation (Breslin et al. 2005). Unequal access is compounded in socioeconomically disadvantaged individuals, where poorly developed social and transport systems do not support safe or easy access to healthcare services. In addition, the elderly or individuals with disabilities are often easy targets for criminals, which may further compromise access.

The two-tier (public-private) healthcare system in South Africa heightens unequal access to healthcare services. Wealthy patients who can afford private healthcare insurance are able to access healthcare services more quickly; they may be able to access a better standard of care in the private sector than patients in the public sector. There is also inequitable distribution of healthcare providers in the two-tiered healthcare system. While approximately 84% of the South African population is served by the public healthcare system, only 30% of medical practitioners work in public hospitals (Mayosi and Benatar 2014). These major inequities significantly impact on the ability to give and get care.

A lack of visibility and cultural familiarity of physiotherapy services may further contribute to inequality of access to care (Kirschner et al. 2001). In the South African healthcare system there has been a strong shift towards a primary healthcare approach (Department of Health 2009) that situated physiotherapy services within the community. However, physiotherapy services are therefore often not available at every clinic (Louw 2016), which limits both visibility and access to care.

In addition, the highly individualised nature of rehabilitation often results in discrepant outcome goals among patients with similar diagnoses and differential access to physiotherapy services (Murray et al. 2012). Care ethics emphasise the importance of a contextual, case-based approach, as well as the need for attentiveness and responsibility in clinical practice, which support the individualised nature of rehabilitation. However, patients and their caregivers and families may perceive individualised care as unjust, and this may negatively impact on caregiving and care receiving.

11.3.3 Gaps in Evidence Base

Clinicians are professionally and morally obligated to ensure that their decisions are informed by current scientific evidence and reflect best healthcare practices. Clinicians have a responsibility to search and appraise available evidence so that informed options can be shared with patients. Clinicians also have a responsibility to contribute to the evidence base through research. An improved evidence base for physiotherapy and rehabilitation can facilitate advocacy for improved resource allocation (Caplan et al. 1987). Evidence-based practice is thus an important component of the competency element of ethics of care. However, there are currently significant gaps in the evidence base for physiotherapy. As a result, many clinical decisions regarding individual patient care may have some link to scientific evidence, but may be inherently value-based. This is a key challenge within care ethics, as there may be uncertainty regarding when the best care decision, or even an acceptable care decision, has been made. Quality of care may therefore be dependent on both the competence of the practitioner, but also on individual moral behaviour that may influence the practitioner's responsibility towards patient care.

11.3.4 Clinician-Led Versus Patient-Led Rehabilitation

There is an emerging body of evidence in many areas of physiotherapy that supports a shift from hospital- or clinic-based care led by a physiotherapist, to home-based care led by the individual patient or their caregivers or families (Louw 2016). A strong shift to patient-led care may facilitate optimal use of available resources and may improve patient autonomy and responsibility for rehabilitation outcomes. However, within a low to middle income country context, patients are frequently discharged to suboptimal home environments which may limit the effectiveness of patient-led rehabilitation (Louw 2016). Additional issues, such as, poor health literacy and limited cultural familiarity of physiotherapy may also negatively impact on patient-led rehabilitation and the continuum of care.

11.3.5 Short Term Harm/Long Term Gain

Physiotherapists may on occasion be confronted with an apparent ethical dilemma. Numerous physiotherapy interventions require pain and discomfort to be inflicted upon the patient receiving care. This short term harm/long term gain is perhaps most evident in the physiotherapy treatment of patients who have sustained burn injuries. The interventions that are needed to maintain joint range of motion result in significant pain to the patient receiving care, despite combining physiotherapy treatment with analgesia. However, this treatment is essential to prevent contracture development and to restore function post-burn injury. The deliberate infliction of pain may be extremely distressing to the patient and the clinician. This is seemingly at odds with an ethics of care. Although the clinician may have identified the four phases of care ethics and may be attentive, responsible and competent in the practice of care, the responsiveness element is in conflict. By inflicting uncomfortable or painful interventions on a patient who is highly dependent, the act of caregiving is increasing patient vulnerability and seems to conflict with common understandings of caring. The clinical situation may often be further compounded by the nature of physiotherapy and rehabilitation; that is, the benefits and positive outcomes of painful interventions are often only realised in medium- to long-term care. Therefore, in the early stages of physiotherapy management, the harms associated with pain and discomfort may outweigh the benefits, which again seems contrary to the concept of caregiving and may be a significant cause of moral distress for practitioners, patients and their caregivers or families.

11.3.6 Unprofessionalism Creep

Professionalism includes fundamental standards associated with care, namely empathy, compassion, selflessness and virtue. However, students in healthcare professions often have difficulty to cultivate a professional uniqueness when faced with challenging academic and clinical demands within complex learning and healthcare environments (Byszewski et al. 2012). Frequently, an erosion of values is observed as students' progress through clinical training. This may broadly influence the caring about, taking care of, and caregiving phases of ethics of care, and may thus impact on the attentiveness, responsibility and competence elements of care ethics. Byszewski et al. (2012) identified role modelling as the single most important component in the development of students' professional identities (Nortjé and De Jongh 2017). There is also evidence that critical values such as empathy can be effectively role-modelled, which emphasises the importance of the web of care involving students, practitioners, patients and their caregivers and families.

We have highlighted some of the key ethical issues faced by physiotherapists in the South African context. However, as Lachman (2012) points out, the essential question that previous authors such as Gastmans (2006) sought to answer was, "What is the best way to care for this patient at this time?" We therefore present a case study in the next section to highlight how the application of ethics of care principles might lead to ethical conduct that differs from healthcare interventions that are based on rule-based ethics.

11.4 Case Study

Mr A is a community service (junior) physiotherapist working in an urban area that is under-resourced. There are many social problems and the provision of services is poor. Ms Y is a member of an immigrant community whose family has come to South Africa to avoid the social unrest taking place in her home country. Her husband has passed away and she stays with her extended family. The family is very religious and have fundamentalist beliefs with regard to codes of conduct and divine intervention. Ms Y has a two-year-old girl who is severely physically and mentally impaired. She has been referred to the Paediatric Physiotherapy Out-patient Clinic which takes place once a week. Her knowledge of South African languages is poor and she requires an interpreter when available. She has attended the clinic for 6 months with her child and some progress has been made with regard to the child's sitting ability and his interaction with his mother. However, the child has considerable functional limitations and improvement is slow. Her father and mother have not supported Ms Y in attending treatment sessions with her child. They maintain that it is Divine Will that the child should be disabled and that physiotherapy intervention is going against this. They do not see much improvement and feel that their daughter is wasting resources, money for transport and time which could be spent working in the family business. They have forbidden her to continue taking her child for treatment. This decision is deeply disappointing to the community service (junior) physiotherapist who has become very attached to the child. He feels that the child is making some progress and fears that this will be lost if treatment is discontinued. He is also concerned that it is his fault and that his lack of experience has led to the decision to discontinue treatment.

What issues arise from this situation and how may care ethics assist in guiding the community service (junior) physiotherapist and other stakeholders?

In an ethics of care the community service (junior) physiotherapist needs to be genuinely concerned with the well-being of the patient or receiver of his care. He needs to pay attention to the individual before him and to be sensitive to her within her moral, cultural and social context. In addition, the care receiver needs to be approached as a member of a community, which may not only provide support, but may also set limits on her own autonomous behaviour. Although the child and his mother are the most obvious stakeholders, it is useful to consider the web of care to identify which other people are involved. The child is most obviously a recipient of care, but not only of the care provided by the physiotherapist and the medical system. The child is also cared for by her mother, her extended family and the refugee community of which she is part. She also receives support through social grants and thus local authorities are also caregivers. The mother is both a recipient and a giver of care. She receives care from the physiotherapist, her family and members of her community, whereas she gives care to her child and very possibly to older community members, including her own parents. The physiotherapist, too, both gives care and should in turn be supported and cared for by the senior physiotherapists, his lecturers and the rest of the multidisciplinary team members.

When seen against this network of caring relationships, benevolence has a broader implication as all members of the network both give and receive care. The issue of autonomy emerges as part of the ethical dilemma in which the therapist finds himself. Should he take the matter further and possibly report the mother to social services for failing in her duty to provide adequate care for her child? Although a basic principle of ethical practice is a respect for autonomy, this may not always be in the best interests of all concerned. On the one hand, the mother may be coerced into withdrawing from therapy by her family and thus, she may not be acting autonomously. On the other hand, it is her family that provides her and her child with shelter and support and the consequences of acting autonomously and going against their wishes, may result in a greater risk to her child than the possible benefits of ongoing treatment. In fact, Elliott (2001) argues that autonomy is culturally relative and that "[t]he legal focus on autonomy in Western health care evolved as a result of the perceived and somewhat actual threat of paternalistic choices on patients' lives … However, it is essential to recognize that the individualism associated with American culture is a minority paradigm in relation to the world's population and cultural frameworks" (p. 328). Any action on behalf of the physiotherapist or healthcare providers that might convince her to continue with therapy, could have severe long-term consequences within her own support network.

In what way can further action be informed by care ethics? It is not enough for the physiotherapist to simply "care about" the mother and child, he also needs to "take care of, give care and receive care". It is clear that if the mother and child are isolated from their extended family in the decision making regarding therapy, autonomy may well be served, but will justice be done to the child who may never reach her full potential?

Care ethics highlight the central role of dialogue and discussion to strengthen the web of care. It is clear that the mother cannot be engaged in isolation and the community service (junior) physiotherapist needs to facilitate this dialogue between healthcare professionals, the mother and her extended family. Family conferencing, home visits and engagement of social workers in discussions that acknowledge the need for care as well as the caregiving roles of the physiotherapist, mother and her extended family might lead to a positive resolution. The need for care of a disabled child may be unlimited and the boundaries of care need to be included in these conversations.

The clinical competence of the community service (junior) physiotherapist is another important issue that may influence the outcome. The physiotherapist needs to take responsibility for the care recipient and her needs and provide an effective, most likely evidence-based management. This is not always easy, as the care needs of recipients very often extend far beyond the clinical situation and the inexperienced physiotherapist may need to set boundaries on the extent of his intervention.

However, a physiotherapist who has the required skills to manage children with disabilities and who is continually striving to improve his expertise, may be more likely to give appropriate, effective management. If the child is showing functional and other improvement, the mother and her family are more likely to have confidence in the therapist and the situation of withdrawing the child from therapy may not arise. The more knowledgeable the physiotherapist, the more likely he is able to negotiate realistic goals for intervention and give useful advice to the mother with regard to an appropriate home programme. Although continuing education is the responsibility primarily of the physiotherapist, he should be supported in this by his colleagues and mentors. Care ethics recognise the importance of the teaching relationship and identified the aspects of modelling, dialogue, practice and confirmation as being essential caring components of this relationship (Owens and Ennis 2005). This implies that the lecturers who taught him and the senior clinicians that he works with should model a concerned, engaged and attentive attitude towards patient care, as well as a high level of professional skill. In addition, the community service (junior) physiotherapist, in this situation, has moved from the one who cares to the one who needs care and it is important that there are strong channels of communication that allow him to consult with mentors to decide on the most appropriate course of action. He also needs confirmation, defined as "an act of affirming and encouraging the best in others" (Owens and Ennis 2005, p. 396) as he lacks confidence and feels responsible for the withdrawal of the mother and child from therapy.

11.5 Conclusion

In this chapter, the authors have suggested that care ethics is an appropriate framework in which to both identify and address the needs of all those involved in the caring relationship which is central to the provision of effective, holistic physiotherapy. Whereas, we do not in any way suggest that the four ethical principles of autonomy, beneficence, non-maleficence and justice should not be guidelines to ethical practice, these should be tempered by a deep regard for each individual and their situation in a "web of care". This approach will help the practitioner to appreciate the complexity of the lives of their patients and to acknowledge their own need for support and care. In addition, as the essence of care ethics relates to caring action, the requirement of a high level of skill and continuing education to provide the best care possible is embedded in this philosophical approach.

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Chapter 12
Ethics in Nursing – An African Perspective

Miriam Carole Atieno Wagoro and Sinegugu Evidence Duma

Abstract Most of the literature that nurses in Africa refer to when confronted with ethical challenges is from high-income countries. Examples from such literature often do not resonate with the African socio-cultural and religious contexts. In this chapter, the authors introduce the nurses to the African perspectives on ethical dimensions of professional nursing practice. The authors provide nurses with an understanding of ethical theories, principles and decision-making tips applied in patient or client care. In this regard, the authors present case examples selected across Africa. These cases aim to facilitate understanding of how ethical issues are analysed and argued to make clinical decisions in ethical dilemmas.

Keywords Nursing · Ethical challenges · Bioethics · Nursing ethics · Ethical principles

12.1 Introduction

Nurses, in professional nursing practice, are constantly faced with situations in which they have to make decisions of what is morally right or wrong. The decisions, other than being ethically sound, must be consistent with what the nurses' practice act stipulates. In most African countries, nursing practice is regulated through an act of parliament. For instance, nursing practice in Kenya is regulated by the Nurses' Act, Chapter 257 of the laws of Kenya while in South Africa, the practice is regulated by Nursing Act No. 33 of 2005.

Most of the situations that nurses come across in professional nursing practice are complex, challenging and involve matters of life and death. The interaction

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between technological advancement, socio-cultural, political and religious contexts in Africa are complex, dynamic and unique to the African nurses and their clients. Most examples used when discussing ethical theories, principles and guidelines present situations in high income countries. These examples often times do not resonate with the African socio-cultural and religious contexts. Consequently, many nurses are challenged and are unable to guide clients whom they have a duty to care for in terms of unique African principles.

Developments within health research and education have resulted in the expansion of the roles of the nurse practitioners. These expanded roles are consistent with Nightingale's cautions for nurses that they should not be left in the wrong as the world moves on (McDonald 2009). In their expanded roles, nurses are increasingly making decisions on complex ethical issues. Nurses in the African continent need to refer to guidelines that take their unique socio-cultural contexts into consideration. In this chapter, the authors provide information on the unique African ethical dimensions of contemporary professional nursing practice. The authors envisage that understanding the presented information and contextualised examples could assist nurse practitioners in making sound clinical decisions when faced with ethical dilemmas in practice.

12.2 Concepts in Bioethics and African Ethical Dimensions of Contemporary Professional Nursing Practice

12.2.1 Concepts in Bioethics and Nursing Ethics

Understanding the ethical significance of the problems nurses encounter in practice is the first step in making effective responses. Concepts and terminologies are the key points of nursing ethics. A clear understanding of the concepts, terms and distinctions that are commonly used to express moral or ethical concerns enables nurses to identify what is ethically significant in a clinical situation and the ethical approaches that can be utilised.

12.2.1.1 Values in Nursing Ethics

In determining whether a nurse has demonstrated professional values, ethics can be used systematically to analyse and distinguish matters of right and wrong and good and bad in relationships between nurses and their clients or patients (Weis and Schank 2009; Lai and Pek 2012; Poorchangizi et al. 2017). Carvalho et al. (2012) assert that many of the problems that nurses encounter arise from conflicting values such as dignity, empathy, honesty, altruism, trust, doing good, having a choice and fairness. Each person's morals are dynamic, develop over a lifetime and originate from a variety of values. Values are hierarchical according to an individual's prioritised importance. Nurses practise in diverse cultural environments and must take care not to offend patients' values and beliefs.

Nurses in training and in practice are encouraged to clarify their values so as to understand why they interact in various ways despite sharing professional values. For instance, all nurses agree on sanctity of life as a value. However, treatments given in respect of this value may differ across continents as far as euthanasia is practised. Uustal (2001) argued that if a nurse does not take time to examine and articulate own values, he or she will not be fully effective with clients under her or his care. Furthermore, nurses' values may be the framework on which he or she bases her or his judgement about patients, yet professional values require nurses to remain non-judgemental in all circumstances of nurse-patient interactions.

12.2.1.2 Code of Ethics

In professional nursing practice, codes of ethics for nurses support their practice and reduce their moral distress. In Kenya, professional groups such as National Nurses Association of Kenya (NNAK) and Nursing Council of Kenya (NCK) have developed a code of ethics to guide nurses (NNAK 2009; NCK 2012). These codes are derived from the International Council of Nurses and describe ethical expectations of nurses that not only relate to patients, but also to colleagues, the nursing profession and society at large. In all types of relationships emphasised in the code of ethics, caring remains the core value in nursing ethics and practice (NNAK 2009; Brown 2011; NCK 2012).

12.2.1.3 Nursing Ethics

Yeo et al. (2010), describe nursing ethics as the expressed ethical norms of nursing profession. Nursing ethics include values, virtues and principles that govern and guide nurses in everyday practice. Nursing ethics are phrased with moral injunctions such as "be truthful to your patients" or "respect patient's confidentiality". These norms are stated in the professions' code of ethics and serve to guide nursing practice. In this section we focus on two of the three definitions of nursing ethics provided by Yeo et al. (2010). The first definition refers to the terminology as a set of actual or ideal norms that guide nurses' moral behaviour or professional nursing practice. The second definition conceptualises nursing ethics as a growing body of writing in books and professional journals which guide the moral dimension of nursing.

Nursing ethics is also described in relationship to its application in practical reasoning such as good, right, duty, obligation, virtue, freedom of choice and rationality, where professional reasoning forms the basis for moral principles in nursing practice (Liddell and Cooper 2012). Knowledge of morality in nursing ethics goes beyond simply knowing the ethical codes to include making the judgment of right and wrong (Carper 1978). For instance, the duty of a nurse to a neighbour who participated in burning the nurse's house during political violence is to do good.

Globally, professional nursing care is founded on therapeutic relationships between nurses and patients underpinned by respect for human dignity. We assert that nurses demonstrate respect for human dignity when they protect patients' rights to safety, quality care, autonomy and justice. The right to human dignity is not only an ethical issue, but also a human rights issue enshrined in many African constitutions. For instance, the African Charter on Human and Peoples' Rights declares that, "Every individual shall have the right to respect of dignity inherent in a human being". Similarly, the Kenyan Constitution of 2010, Article 28 of Chapter 4 declares that "[]every person has inherent dignity and the right to have that dignity respected and protected". But, the interplay of technological innovations, limited resources and nurses' individual and professional values generate ethical conflicts that impact on nurses' duty to care. In the subsequent subsection, ethical dimensions and contemporary professional nursing practice will be discussed.

12.2.2 Ethical Dimensions in Technological Innovations and Contemporary Professional Nursing Practice

The field of professional nursing practice is characterised by rapidly changing technological innovations that often change the way nurses care for patients. Nurses need to continually update their knowledge on technical innovations and their impacts on nursing care. We assert that technological innovations at times generate new ethically challenging situations that only professional nurses with specific ethical competences can overcome. In the subsequent paragraphs, the ethical issues that pose a challenge in the wake of new technologies are presented.

12.2.2.1 Patient Autonomy, Confidentiality and Information Technology Advancements

Nurses are advocates of patients and ensure that patients' rights to autonomy and confidentiality are protected. In most African countries, the doctrine of informed consent is entrenched in legislation and policies as a fundamental prerequisite for administering treatment to all patients (Global System Mobile Association ([GSMA] 2015). However, communication technological advancements such as social media, internet health (e-health) and mobile health (m-health) that are increasingly being exploited in health care and clinical research compromise patients' autonomy and confidentiality. Norman et al. (2011) and Denecke et al. (2015) observed that availability of data and information on social media and internet is useful for e-health care, but preserving privacy and confidentiality of online users as well as providing means for patients to express concerns on data usage remain a concern.

Furthermore, many patients in the low income bracket in Africa are so excited to use these technologies that they rarely think about how their autonomy or confidentiality of information transmitted through these technologies is being compromised. For instance, youth recruitment in clinical research is more effectively conducted through Facebook and Twitter as they are clearly excited about the use of social media (Van der Velden and El Emam 2013; Amon et al. 2014; Leonard et al. 2014). The ethical questions raised about this type of recruitment include how assent and parental informed consent are obtained from the interested prospective participants aged under 18 via social media (Amon et al. 2014; Denecke et al. 2015).

In Ghana, advances in electronic health information systems (EHIS) have been linked to violation of patient autonomy and confidentiality (Norman et al. 2011). Norman et al. further argued that many patients in Ghana fear disclosure of personal medical records and therefore do not seek healthcare services from the physician. Concerns about patient autonomy are further corroborated by GSMA (2015) in a study with ten African countries (Cote D'Ivoire, Ghana, Kenya, Malawi, Mozambique, Nigeria, Rwanda, Tanzania, Uganda, Zambia) on m-health regulation. GSMA, like the WHO, acknowledged that e-health and m-health are important strategies for improving accessibility to healthcare services in many African countries, yet guidelines for obtaining consent electronically is unclear. This observation raises doubts on whether the patients' right to self-determination in all areas of treatment is adhered to.

12.2.2.2 Ethical Dimensions in Organ Transplantation

Organ transplantation is a globally recognised treatment innovation that improves quality of life for clients suffering from irreversible and end-stage chronic conditions such as kidney diseases, heart diseases and eye cornea conditions on the African continent (Moritsugu 2013; Muller 2013; Girlanda 2016). However, there is resistance to organ transplantation as it goes against the edicts of some religions (Irving et al. (2012)) or the morals of some communities (Labuschagne 2013). For instance, Irving et al. (2012) observed that, in some traditional Islam literature, organ donation was viewed as "playing with God", yet no one should intervene if a person was "meant" to die. In the same vein, some religions objected organ donation because of the need to maintain body wholeness after death as a precondition for good life after death.

In Kenya, Davis and Randhawa (2006) reported how religious beliefs were hindering organ donations. Davis and Randhawa observed that an eye cornea storage bank was opened in a big eye hospital in Nairobi in 2010. Despite the hospital raising awareness and urging Kenyans to pledge their corneas to the institution, most Kenyans were reluctant because they viewed organ harvesting as mutilation of the body which is against their religious beliefs. The effect of this religious stance is that no consent is given for organ donation.

12.3 Ethical Values, Principles and Theories: The African Contexts

12.3.1 Introduction

The mandate of a professional nurse is to provide high-quality care in both acute and community healthcare settings. Quality nursing care is characterised by adherence to clinical practice guidelines, patient satisfaction and improved patient health outcomes (Wagoro et al. 2008; Fulton et al. 2010). We argue that observance of professional nursing ethical values and principles are the foundation to quality nursing care. Our argument is consistent with the views held by Koehn (2006), Joolaee et al. (2010), Dehghani et al. (2015). The three scholars assert that all practising professionals, including nurses, need to adhere to professional ethics to provide better health services. In this section, we look at components of professional ethics as ethical values, principles and theories that guide clinical decision making in the practice of nursing to facilitate quality care from an African perspective.

12.3.2 Ethical Values

Professional ethical values are the foundation for nursing ethics that nurses apply in practice to deliver quality care to patients. Professional ethical values include human dignity and respect for patients. Shahriari et al. (2013) argue that nurses need ethical knowledge in their practice to provide safe and quality care that respond to clients' dynamic needs. Ethical values are resources that nurses utilise to make rational clinical decisions in challenging ethical situations. Furthermore, values form a framework to evaluate nurses' activities. In the subsequent subsections, three examples of ethical values commonly applied in nursing practice will be discussed.

12.3.2.1 Human Dignity

Steinmann (2016) described dignity from a moral perspective as representing the essence of what it means to be a human being. From a human rights perspective, human dignity legalises the notion that the essence of humanity must be recognised and respected in equal quantum. Globally human dignity is the most discussed and prioritised value. Tariler (2004) observed that respect for patients has the highest priority among nursing ethical values and acts as a basic value to design the nurses' code of ethics. In nursing, respect for the client as an individual, a family or community is an important ethical nursing value. Respect for human dignity in nursing is demonstrated by respect for the clients' beliefs, preservation of the clients' privacy during clinical procedures, keeping clients' information confidential and giving full attention (Pang et al. 2009).

Among some African communities, a male midwife is not allowed to care for a woman in labour and conduct a delivery. The community believes that it is disrespectful for a male to see the "nakedness" of a woman. The nurse ward manager demonstrates respect for human dignity if shifts are scheduled in such a way that a female midwife is included at every shift in the maternity ward. The female midwife will be able to conduct the delivery for clients who strongly feel that male midwives cannot see their "nakedness".

In the same vein, it is important to acknowledge that in African communities' authority flow from the old to the young. Therefore the elderly are respected, in principle, irrespective of their education and rank (Darley and Blankson 2008; Amoako-Agyei 2009). Discussing issues of sexuality may be a challenge with regards to human dignity. The elderly may feel disrespected when young nurses talk with them about sexuality as it may be interpreted as taking instructions. The experience may be worse when the young nurse interviews a man experiencing loss of libido as a side effect of treatment with typical antipsychotics. Equally, a young nurse may not be allowed to discuss family planning or HIV transmission issues with couples. Some of the questions asked or terminologies used may sound disrespectful and the clients may feel their human dignity has been violated. The young nurse may also feel disappointed and guilty when such accusations are made against her or him after having taken all measures to ensure client dignity is respected.

To facilitate human dignity in care, the nurse managers must always consider the clients' culture when planning nursing intervention. Furthermore, culture and its influence on client care is an important subject in most nurses' training curricula in Africa. Nurses are expected to learn about the culture of the patients they care for. This will help them ensure the right mix of skills, gender and age to provide care that respects patients' dignity. In addition, senior nurses must always remain vigilant to ensure that clients who feel violated and young nurses who feel disappointed are supported accordingly.

12.3.2.2 Precision and Accuracy in Caring

This ethical value is demonstrated through holistic, appropriate and quality professional care (Shih et al. 2009). It is the care directed at the prevention of diseases, relief of suffering, promotion of health, comfort and safety. This kind of care is ensured by the nurses' regulatory bodies through licensure. Most nursing councils in Africa such as the Nursing Council of Kenya provide nurses with the practice and retention license upon qualification and every 1–3 years respectively (NCK 2012). The license is an indication of nurses' ability to demonstrate adequate theoretical and clinical skills and knowledge required for precision and accuracy in caring.

A nurse manager observes the value of precision and accuracy in caring by deploying nurses in accordance with the ethical principle of justice in resource allocation. This means that nurses are deployed according to their specialisation, experience and the patients' interests. The current shortage of nurses experienced in Sub-Saharan Africa (Wakaba et al. 2014) challenges the practice of precision and accuracy in caring. Many clinical nurse practitioners are deployed in areas in which they are not specialised. This fact was evident during a recent interview for senior nurse managers conducted by the public service commission (a body mandated to employ public servants), in an African country, where one of the current authors was invited to offer technical expertise. One senior nurse manager replied as follows when asked to give reasons affecting quality of nursing care in the public hospitals:

> "Nurses feel demotivated and dissatisfied with nursing care they provide. So how can we even talk about quality of care if nurses themselves are not happy with the care they offer? How does a peri-operative nurse feel when deployed in a cold gynaecological ward, what quality of care can be expected?"

This statement by a senior nurse implies that there is need for policy makers in health and nursing services to relook at policies on the deployment of staff amidst a shortage of nurses. It is clear that deployment to cover shortage does not necessarily improve quality of care. The policy makers need to consider the mandate of the nursing profession so that deployment facilitates achievement of value of precision and accuracy in care. In addition, causes of shortage in nursing need to be addressed in the long term to avoid situations where nurses are deployed in clinical areas that are not within their specialisation. This inappropriate deployment may contribute to unsafe care (harm), thus contradicting the ethical principles of beneficence and non-maleficence.

In African context, because of an acute shortage of nurses, participation in policy formulation in health resource distribution will greatly contribute to observance of value of precision and accuracy in care for quality nursing. This may not be necessarily so in other continents. A study in Iran by Poorchangizi et al. (2017) for instance, indicated that participation in public policy decisions affecting distribution of resources was rated among the least important values with regards to quality care.

12.3.2.3 Human Relationship

Professional nursing practice recognises the *central importance of human relationships among nurses and their colleagues, other health care workers and clients.* Relationships between the nurse and the client are critical for the achievement of nursing interventions. Mutual respect, trust, confidentiality and privacy are all necessary conditions for human relationships (Shahriari et al. 2013). However, human relationships are characterised by genuineness, empathy, mutual understanding, courtesy and friendliness. Human relationships are the basis of a therapeutic relationship that allows for patient growth in problem solving.

This value requires that the nurse understands the socio-cultural and psychological background as well as experiences that influence the patients' behaviour. Differences in values and belief systems in many African communities influence initiation, sustenance and growth of human relationships as a value in nursing care. Among many African communities, a warm handshake is an initial step in human relationships. Failure to shake one's hand may be interpreted as rude and unwelcoming behaviour. Yet among some Muslim communities in Northern Africa, males are not allowed to shake hands with the females on religious grounds. A patient may mistake a nurse of the opposite sex for demonstrating contempt and this may negatively influence the initiation of relationships. The nurse who is aware of the sociocultural and religious beliefs of the Muslim may need to explain the reason behind not offering a hearty handshake but use other acceptable forms of greetings to initiate human relationships.

Failure to develop relationships limits the quality of information that the nurse requires to determine the patient's problem and the subsequent plan of care. Donatus (2011) observed that the relationship between the healthcare service providers, including nurses and the patients, in Kenya is still not well developed and many times, patients are given wrong medical diagnoses and prescriptions because of the lack of proper a communication relationship.

In the nurse-patient relationship, trust is demonstrated through honesty in engagement with patients (Pang et al. 2009). From literature and our experience over the years, we can confirm that patients prefer and are likely to trust a nurse in whom they can confide, who is respectful and who is reliable (Shahriari et al. 2013). Demonstration of the ethical value of trust is the foundation of all relationships and interventions that nurses plan for patients. Some of the behaviours perceived as demonstrating honesty and genuineness may be interpreted by others as being rude. For example, in some communities, keeping eye contact during communications is an indication of honesty. Yet in others, a young person who maintains eye contact with an elderly person during conversations may be mistaken as rude. Therefore, the nurse needs to learn acceptable behaviours considered respectful or honest when communicating with clients.

12.3.3 Ethical Principles

Beauchamp and Childress (2013) conceptualised ethical principles as the standard theoretical framework from which to analyse ethical situations in medicine. Butts and Rich (Butts and Rich 2015) argue that ethical principles are used as the basis for specific rules or norms that guide towards making justified moral decisions. Kwame (2011) observed that morality in the African perspective is based on humanism, a doctrine that considers human interests and welfare as the basis of all actions. Human interest and welfare are conceived by the African communities as behaviours that bring about social harmony and cooperative living and fairness. We concur that ethical principles provide the nurse with a framework to support clinical decision making with a moral outcome. Although the principles presented by Beauchamp and Childress are often labelled "American ethics", there is value in understanding that these can also be applicable to the nurse practising in Africa. In the subsequent subsections the common ethical principles applied in nursing practice are discussed with their consideration in the African context.

12.3.3.1 Beneficence

The term beneficence comes from the Latin word bene (“well” or “good”) and facio (“to do”) (Yeo et al. 2010). Beneficence involves promoting someone else’s good. The meaning of beneficence, whether from Western world’s or African construct has the same philosophy, i.e. “do good always” (Chukwuneke et al. 2014). However, doing good may be interpreted in various ways from different societies’ and communities’ perspectives. African bioethics looks at doing good from a pluralistic general good of the community rather than from the individual patient’s benefit. For instance, cultural practices such as female circumcision may be seen as controlling women’s promiscuous sexual behaviour for the good of the community without considering its health implications on the individual. In this regard, it appears that the ethical theory of utilitarianism is considered more than the deontology that looks at the nurse’s duty to observe individual patients’ rights.

In professional nursing practice, the principle of beneficence implies that the nurse helps clients realise their health interests, either as the patient understands them or from the nurses’ perspectives on what is good for the patient. Under beneficence, conscious failure by the nurse to do what is best for the patients (if he/she is in a position to do so) is morally wrong. In the example of female circumcision, it is evident that the principles of doing good in the African context leans more towards utilitarianism and may conflict with the patients’ rights. It would be important to look at the effect of practice on the woman’s child birth processes. If it is dangerous to the women, then negotiation should be exercised so that all stakeholders are brought to the table and an amicable solution that will be understood by the community to protect individual women’s health is ensured. We assert that in applying the principle of beneficence, the nurse must weigh risks against benefits and only institute actions that produce ultimate good with minimal harm or inconvenience for the patient. Exception to this rule is where the risk of harm to the society is overwhelmingly evident.

Additionally, in clinical settings in Africa, the principle of beneficence conflicts with the patients’ right of autonomy in some cases. Beneficence is perceived from a paternalistic view implying that it is what the healthcare providers think is good for the patient. The nurse rarely stops to think about the psychological harm that a patient suffers when his or her perspective is not considered. For instance a patient was diagnosed with an ovarian tumour at the age of 52 years in one of the private hospitals in an African country. The woman’s husband and the gynaecologist agreed to perform total abdominal hysterectomy despite the woman’s contrary opinion. The gynaecologist and the woman’s husband argued that they were acting in the woman’s best interests. A few months post-surgery, the woman developed depressive illness and was admitted in the national mental health hospital. Further interviews revealed that for the woman, removing her uterus denied her of being a woman. Holding more discussions and considering the woman’s autonomy could have probably led to a different management which might have led to a better health outcome.

12.3.3.2 Non-maleficence

This is the ethical principle stipulating that one should not do harm to patients. According to Beauchamp and Childress (2013) the guiding maxim of this principle is: “First, do no harm”. In the African bioethics philosophy, this principle is closely related to the principle of beneficence but goes beyond doing good alone, i.e. “do good and cause no harm” (Chukwuneke et al. 2014). However, causing no harm may mean different things to different societies and people. For instance, Chukwuneke et al. (2014) argues that in the current technological advances human embryos are accepted for clinical research in the Western countries to benefit societies while in most African communities, it is regarded as murder. By the principle of non-maleficence, nurses are under obligation to protect their patients from harm by removing and preventing harmful conditions. This principle is consistent with the African bioethics philosophy, Ubuntu which advocates for compassion and humanity among others. We argue that the nurse who applies non-maleficence will strive to cause no harm to patients whether non maleficence is applied from Western or African perspectives.

However, the nurse ensures that harm is not disproportionate to the benefits of treatment. For instance, the nurse as the patient’s advocate protects the patient from receiving futile or ineffective treatments. The ethical principle of non-maleficence must always be balanced against beneficence by determining benefits and risks of any interventions for the patient. The principle of non-maleficence thus supports several moral rules, such as “Do not kill” and “Do not cause pain or suffering”. When used in the African context, abortion would not be allowed because it is immoral, causes harm and involves murder of the foetus. When weighing risks or harm against benefits in clinical situations, the nurse needs to consider the individual and the communities as appropriate. There are issues that can cause harm to an individual person or to a community collectively. However when considering the issue of abortion from the Western bioethics perspectives, then it can be weighed against the life of the mother. As other principles, it is important to remember that the principle of non-maleficence and its requirements are not absolute.

12.3.3.3 Justice

According to Beauchamp and Childress (2013), the principle of justice requires nurses to distribute benefits, risks and costs fairly. The principle of justice guides nurses in procedures of attending to clients as well as allocating health resources and burdens within a clinical situation and the community at large. Furthermore, the nurses’ code of ethics requires nurses to care for all clients without discrimination according to sex, age, colour, race, status, religious affiliation, health condition and ethnic orientation.

Justice can be categorised into procedural and distributive components. Procedural justice refers to methods or processes that the nurse applies or follows when caring for the patients. For example, the nurse ensures that patients are being attended to on the "first come, first served" basis except in an emergency. In the African context with strong family and village affiliations, the authors' experience is that friends and relatives want the nurses to attend to them first on the basis of relationships and not the urgency of their state of health. In such circumstances, nurses face the challenge of demonstrating procedural justice at the expense of being labelled negligent by the friends.

Distributive justice requires that the nurse demonstrates fairness in the distribution of resources (Summers 2009; Yeo et al. 2010). Two examples, in research and clinical situation respectively, will be used to explain distributive fairness. In research, the principle requires that benefits and burdens accruing from research findings are fairly distributed to the study populations. For this reason the research population being studied should not be excluded from the research unfairly. In clinical situations, distributive justice refers to the allocation of healthcare resources to patients/clients. This includes deployment of staff with consideration to their skills and experiences to the category of patients who require their care.

In the African context with poor nursing resources, this aspect poses a challenge to the nursing manager. In many clinical situations, nurses find themselves deployed in areas for which they have neither specialised training nor interest in. In one national mental health referral and training institution, the number of nurses with specialty training in mental health is almost half those not trained in this area. There are various reasons to explain the scenario but the ethical issue this raises is whether there is justice in allocating staff with no specialty training to look after the patients who require specialist treatment.

The nurse may use the principles of justice from the African construct that advocates for pluralism in an approach to prevent diseases and promote the health of a community. In this regard, communities are expected to act together to reduce morbidity and mortality. The concern of the community will be the programmes that meet public health goals and promote the health of the entire population. The nurse who intends to initiate community programmes must ensure the concerns of the community are considered. Justice framework in African construct is regarded as solidarity, which resonates with ethical theory of utilitarianism. Solidarity involves preventing bad health, promoting social justice and working to fulfil the community mandate of equity and community autonomy.

12.3.3.4 Autonomy

The term literally means "self-rule" and is derived from the Greek words auto (self) and nomos (rule or law) (Summers 2009; Rajani 2013). The underlying requirement in this principle is that nurses respect the patients for whom they are and honour the decisions they make with regards to how they want to be taken care of. This is summarised as the individual's rights to self-determination. The nurse demonstrates the application of this principle through seeking informed consent from the patient before administering any treatments, performing any procedures and divulging any patients' confidential information.

In many African communities, patients' families feel that they have a right to make decisions about their loved ones. This feeling is consistent with the African Ubuntu philosophy which expresses the interconnectedness, common humanity and the responsibility of individuals to each other (Khomba 2011). However, a challenge might arise when in exercising autonomy, the patient's choice is incompatible with the nurse's professional judgment or with the health facility's policy guidelines. In such circumstances, the nurse needs to determine if the patient's decision is voluntary or results from undue influence. This is because African ethics emphasise on the individual's conformity to the social group so as to preserve the unity of human relationships. Once the reason for the decision is established, the nurse discusses with her senior colleagues in the institution and profession to reach a decision that is in the best interest of the patient.

While African construct emphasises on the community autonomy, Western construct emphasises on individual autonomy. However, there are circumstances when observing individual autonomy jeopardises the good of the community. For instance, a patient with pulmonary tuberculosis may refuse to take treatment yet he or she poses a risk to the community. The nurse may use the African autonomy that emphasises the idea of community autonomy to force the patient to seek treatment. Community autonomy is consistent with the ethical theory of utilitarianism on which most public health acts are based.

12.4 Conclusion

In this chapter we have presented nursing ethics from an African perspective. We looked at the African bioethics philosophy contained in the Ubuntu framework and the global or Westernised bioethics. We have demonstrated that the moral principles in Ubuntu are consistent with the global moral principles. However Ubuntu philosophy puts into consideration the unique cultural and religious realities of the African communities. The interdependent nature of the communities is seen in the collective moral responsibility for one another. In this regard, Ubuntu philosophy morality is practised from a pluralistic or communalistic stance. The nurse in professional practice in African healthcare systems needs to balance between the Ubuntu and the Westernised dimensions in a manner that individual personal rights are comprehensively protected, if such protection does not pose threat to others, especially in matters of autonomy.

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Chapter 13
Ethics in Nursing – A South African Perspective

Yolanda Havenga, Annie Temane, Tendani Ramukumba, and Anna Nolte

Abstract Ethics and health care in South Africa is largely influenced by biomedical ethical principles and Western values, concepts and theories. The history and highlights in nursing ethics in South Africa has not been well documented. Colonising thinking and actions are spread throughout the nursing profession with the indigenous worldview under-examined in ethics in nursing. There is minimal incorporation of postcolonial concepts, specifically about ethics and indigenous knowledge in health care. For nursing to remain relevant in South Africa decolonisation is critical. The decolonisation process involves, among others asserting and stimulating discussions about indigenous knowledge to reveal the abundance and richness of indigenous languages, worldviews, teachings and experiences. Decolonising of nursing, health care and nursing ethics within the context of the nursing profession is critical to address the current health challenges faced by the population of South Africa.

This chapter addresses the history of ethics in nursing in South Africa, with a focus on colonisation and post-colonisation, current ethical issues in nursing related to healthcare systems and the African ethic perspective of Ubuntu. Strategies for applying ethical principles from a colonisation counter-narrative are described within the context of Ubuntu. Ubuntu is perceived to be at the epicentre of decolonising nursing, health care and nursing ethics. The authors believe that the Ubuntu ethics and indigenous knowledge systems can be incorporated in the nursing profession to promote new ways of caring for healthcare users in South Africa.

Keywords Ethics · Decolonisation · Nursing · Professionalism · Ubuntu · Western values

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13.1 Introduction

The South African healthcare system is primarily nurse-based with nurses responsible for up to 70% of healthcare delivery in South Africa (Zuyderduin et al. 2016). South Africa needs nurses who have the knowledge, skills and ethical competence (White et al. 2015) to manage the country's quadruple burden of disease within an environment of limited resources (Department of Health 2013).

Ethics and healthcare in South Africa are largely influenced by biomedical ethical principles and Western values, concepts and theories while nursing's moral identity and the indigenous worldview is largely under-examined in ethics in nursing. The discussions in this chapter aim to awaken and encourage dialogue and introspection about the preconceived ideas about health care, ethical challenges in nursing and the strategies used to apply decolonised ethical principles in nursing practice, education and research. The first section of the chapter focuses on the history of ethics in nursing in South Africa. The second section of the chapter focuses on current ethical issues in nursing related to healthcare systems, critical social justice, human rights in health care and indigenous knowledge systems in health care. The third section of the chapter focuses on the applications and critique of ethics principles within a colonisation counter narrative based on two case studies. The final section of the chapter focuses on strategies for decolonisation of ethics in nursing practice, education and research.

13.2 Conceptual Clarification/Definitions

The following concepts relevant to this chapter are defined:

- **Colonialism:** Colonialism refers to colonial situations in the past that was a form of empire building and imperialism where colonies outside of Europe were "settled" across the world (McGibbon et al. 2014). Colonialism is still recognised in the form of continued present day cultural, political, sexual, spiritual and economic oppression and exploitation of certain groups (Snyman 2015).
- **Colonisation:** Colonisation is a process of forming indigenous preconceptions to reflect European values and viewpoints (McGibbon et al. 2014).
- **Decolonisation:** Decolonisation emphasises the postcolonial obligation to uncover, oppose and change the continuing existence and influence of colonial courses of action. Decolonisation is a recursive process, rather than an outcome in itself (McGibbon et al. 2014). With decolonisation, the question is asked about the effect of colonisation on modern preconceptions and forms of life (Snyman 2015). In the process of decolonisation, the nature of Western knowledge and values are taken to task for the imprint it left and continue to leave in terms of power relationships (Snyman 2015).
- **Indigenous knowledge:** This refers to the knowledge that is derived and developed from experiences and observations from the current and past generations

within communities; it is the knowledge and skills considered together that people in a specific geographic area have, and that enables them to optimise the use of resources in the natural environment (Odora-Hoppers 2017).

- **Nursing:** Nursing refers to "a caring profession practised by a person registered with the South African Nursing Council, which supports, cares for and treats a healthcare user to achieve or maintain health and where this is not possible, cares for users of health care so that they live with dignity until death" (Nursing Act, No. 33 of 2005, Section 1). In this chapter, the concept of nursing is used in its broadest term including all subspecialties and midwifery.
- **Post-colonial perspectives:** These are perspective or analytic lenses that criticise the historical origins of colonisation and it imperialist foundations. It exposes the colonial processes and viewpoints and its impact on modern-day structures, systems and processes (McGibbon et al. 2014).
- **Professional ethics in nursing** consists of the values, rights, duties and responsibilities of nurses in their interaction with healthcare users, colleagues, other healthcare professionals and organisations. The purpose of professional ethics in nursing is to guide nurses in their role of contributing to developing a healthy society (Kangasniemi et al. 2014).
- **Western principles and values** refer to Euro-American values and principles in the context of this chapter.

13.3 History of Ethics in Nursing in South Africa

Nursing ethics in Western countries have been part of the nursing profession since the 1800s from the period of the British nurse Florence Nightingale (1820–1910). During this time, the focus was to promote a professional nursing ethics that was focussed on altruism and care; it was based on traditional religious pledges and values (Johnstone 2016). Early modern nursing considered nursing ethics to be substantive in the education and practice of nursing with approximately 100 books published between 1800 and 1965 (Fowler 2017).

In 1953, the International Council of Nurses' (ICN) code of international nursing ethics was developed and ratified; it was a dominant focus of attention in academic literature until the 1970s (Johnstone 2016). During the late 1970s and 1980s, bioethics developed as a field, mainly driven and dominated by the medical profession. Nursing literature and practice embraced bioethics fully from the 1970s with ethical issues, dilemmas and decision making based on the biomedical ethical principles of autonomy, beneficence, non-maleficence and justice (Fowler 2017). The influence of bioethics is also evident in nursing ethics literature and practice in South Africa.

The history and mileposts in nursing ethics in South Africa has not been well documented, as in the case of the history of nursing ethics in the United States of America, United Kingdom and more recently, Australia (Johnstone 2016). The original South African influence of nursing ethics is missing in the international discussions on the development of nursing ethics. Most textbooks and dissertations only make mention of a history mostly grounded in the stories surrounding Florence Nightingale and prominent Western world nursing philosophers and theorists such as Virginia Henderson, Dorothea Orem and Martha Roy. The collective influence of the nursing professions' history gives rise to its tradition or shared memories (Johnstone 2016). These shared memories constitute the moral identity of nursing (Johnstone 2016), begging the question about what South African nursing's authentic moral identity is in the aftermath and continued effect of colonisation on its identity.

The values, concepts and theories underlying modern-day nursing ethics are primarily based on Western culture yet, it is portrayed as being universally applicable in various cultural contexts (Johnstone 2015). In South Africa, nursing and nursing ethics knowledge and education is largely based on political, marginalising and racialising discourses. This paradigm could lead to behaviour that portrays ignorance of the political influence and social injustices that are determinants of health which results in a disjuncture with societal needs. There is a dearth of post-colonial knowledge in South African nursing literature (McGibbon et al. 2014).

Nursing has always been tied up in human social history (Landman n.d.) considering the wars, such as the Crimean War and World War II that have led to the development of nursing as a modern-day profession and to the development of ethical codes of conduct for healthcare professionals and research. The trajectory of the South African history is not complete until there is acknowledgement that colonisation was proceeded by apartheid, as well as the damaging effects it has left at all levels of society. According to Snyman (2015, p. 266): "Under conditions of oppression the oppressed and oppressor alike are morally damaged, albeit in different ways". During South Africa's Apartheid era, human rights violations took place with active and passive complicity by healthcare practitioners, including nurses, who were witnesses to the health consequences of such violations (London and Baldwin-Ragaven 2008). How did nursing, as a caring profession with a set of ethical codes, function in a healthcare environment where human right violations were consistently tolerated? In this regard, much was said by the Truth and Reconciliation Commission about nursing education not incorporating human rights in the curricula (London and Baldwin-Ragaven 2008).

According to George (2003) one of the main barriers to decolonising nursing is that social justice and human rights are not in the forefront. The relationship between social disparity and health, especially in public health and rural areas of the country, calls for nurses to be well conversant with advocacy skills. Being able to intervene at different levels of governance such as national, provincial and district will enhance the nurse's ability to be ethical healthcare practitioners. The decolonisation process involves, among others, asserting and stimulating discussions about indigenous knowledge to reveal the abundance and richness of indigenous languages, worldviews, teachings and experiences, that have been excluded from history, contemporary educational institutions with priority given to Eurocentric knowledge (McGibbon et al. 2014).

Decolonising of nursing, healthcare and nursing ethics in South Africa cannot be ignored as seen in the visible symbols of the decolonisation of higher education in

South Africa; the so-called “hashtag revolution” (De Roubaix 2016; Snyman 2015). These student protests do not exclude the nursing education. Currently, relatively unaffected, nursing will be transformed as many aspects of South African social and public health will be decolonised (De Roubaix 2016). In addition, nursing has to consider the impact rapid technological development has on the unique ethical issues that they bring along.

13.4 Current Ethical Issues in Nursing in South Africa

The current ethical issues in nursing in South Africa are addressed in this section with the intention to awaken and encourage dialogue, critical reflection and introspection about the preconceived ideas about the ethical challenges in nursing care and the nursing profession. The following areas are discussed: professionalism and ethics in nursing; codes of ethics in nursing; implementation of universal ethical principles; and African ethics for nursing.

13.4.1 Professionalism and Ethics in Nursing

Despite the development of nursing ethics in the past 100 years, the moral character of nurses is being questioned internationally and also in South Africa, with regard to issues such as horizontal violence, uncaring attitudes and academic dishonesty (Johnstone 2017). The National Nursing Summit held in 2011, addressed the depth of challenges faced by the nursing profession, among others, the challenge of professionalism and ethics in nursing practice and a concern for the declining status of nursing in South Africa (Department of Health 2013).

The declining professional status and ethics of nursing has been attributed in part to limited human and physical resources and poor working conditions affecting nurses’ morale (Department of Health 2013; Joyner et al. 2014). A free primary healthcare system was implemented post-apartheid to address the inequalities and resultant social determinants of health. This healthcare system has led to increased pressures on the health system with limited resources mainly absorbed by nurses (Joyner et al. 2014). The ethical and moral behaviour of nurses have been affected negatively by the consequent burnout and poor working conditions in the hospitals and primary healthcare clinics (Stellenberg and Dorse 2014). Due to the nature of their work, nurses are involved in morally significant relationships with healthcare users, families and communities (Department of Health 2013). Nurses experience moral distress when, due to institutional constraints, the individual feels that he or she cannot do what they think is right and what one ought to do, within these relationships, or when their personal or professional values are dishonoured. Moral distress affects job satisfaction and the quality of nursing care (Ando and Kawano 2016).

Institutional constraints contribute to the adverse conditions in nursing practice that lead to ethical issues that the nursing profession is faced with today. This in turn, leads to the violation of health care users' basic rights to access health care and be treated with dignity (Stellenberg and Dorse 2014). A number of media and research reports (Jewkes et al. 1998; Oosthuizen 2012) have highlighted the lack of professionalism and unethical conduct among nurses, with nurse-health care user relationships characterised by inadequate communication, as well as by incidents of violence and abuse (Department of Health 2013). Some recommendations were made in the 2012/2013–2016/2017 Plan for Nursing Education, Training and Practice (Department of Health 2013) to address these challenges. It specifically focussed on the development and implementation of far-reaching programmes to restore ethics and respect in nursing and to promote the nursing profession at secondary school level by recruiting nurses with the required values and qualities that would result in what is referred to as a "good cadre of nurses". Furthermore, a recommendation was made that ethics should be included in all elementary and advanced nursing programmes, as well as, in-service training and collaborative partnerships that unite nurses.

The national strategy to coordinate and promote nursing ethics in South Africa is a step in the right direction. We argue that these recommendations, however important, require deeper reflection on and internalisation of the moral identity of nursing as a profession in general and within the African philosophy of nursing ethics. Furthermore, the nursing profession should interrogate the concept and implications of a "good cadre of nurses". It is also important that a critical mass of nursing scholars be established in South Africa who have formal education and training in the theoretical underpinnings of African moral philosophy (Johnstone 2016) to drive the colonial counter-narrative in nursing ethics.

13.4.2 Codes of Ethics in Nursing

Internationally, nursing ethics is guided by the most recent 2012 version of the International Code of Ethics for Nurses (International Council of Nursing [ICN] 2012). This ethical code is relational in nature and is divided into four elements, namely: (1) Nurses and people; (2) Nurses and practice; (3) Nurses and the profession; and (4) Nurses and co-workers (a more detailed description can be found on the ICN website (ICN 2012)). The Code of Ethics for Nursing Practitioners in South Africa (South African Nursing Council 2013) is based on this international code of ethics for nurses (ICN 2012) and is a binding document that provides ethical direction for nursing practitioners. The South African document focuses on the ethical principles of social justice, beneficence, non-maleficence, reliability, loyalty, altruism, self-rule and caring (South African Nursing Council 2013). The South African code of ethics has incorporated some of the biomedical ethics principles such as autonomy, beneficence, non-maleficence and justice but also refers to altruism and caring that are central to an African ethics of Ubuntu and personhood (Haegert

2000). In addition, the Code of Ethics for Nursing Practitioners in South Africa (South African Nursing Council 2013, p. 3) mentions in its preamble respect for humans with specific reference to the following: "cultural rights; the right to life; choice; and dignity without consideration of age, race, culture, disability or illness, sexual orientation, gender, nationality, politics and social status". A limitation in the South African Nursing Code of Ethics is that there is a focus on cultural differences (refer to a more detailed discussion in Joyner et al. 2014) and problematising indigenous persons and cultures. Problematising indigenous people within Western theories has personally and collectively had a negative impact on their history, spirituality and wealth (MacDonald and Steenbeek 2015).

13.4.3 Universal Ethics Principles

In South Africa nursing practice, research and the curricula of nursing ethics is aligned with the biomedical ethics principles, namely the respect for autonomy, non-maleficence, beneficence and justice of the American bioethical approach (Johnstone 2015). Nursing students are exposed almost exclusively to theoretical ethics principlism (Johnstone 2015) in learning and teaching while the evidence of application of these principles to deal with ethical dilemmas in practice is not clear. These mainly American principles' origin is based on the work of Beauchamp and Childress' (1979) and the Belmont report (1979) and not per se linked to South Africa's colonialised past but are arguably also Western in nature. We do not imply that ethical principlism is problematic in itself, but it is problematic when it is almost unquestioningly applied to nursing in general and the South African nursing context specifically. In general, applying biomedical ethical principles as a one-size-fits-all, leads to a disjuncture with the unique ethical framework and principles such as the ethics of care (Fowler 2017). Implementing ethical principlism universally without the necessary cultural adaption, diminishes the depth and understanding of the intricacy of lived experiences and real-world ethical dilemmas (Marshall and Koenig 2004). This ethical "blind spot" so to speak, not only undermines indigenous knowledge systems but has the potential to lead to moral harm and distressing value conflicts for nurses (Johnstone 2015).

An example of the tension of the globalisation of bioethics practices are the international guidelines for informed consent that lean heavily on autonomy and personal decision making. In many communities in South Africa, decisions are made within the context of the family or social networks. In some settings, women need their partner's permission to consent, for example, to access contraceptives. This example does not nullify the need for freedom of choice and self-determination but, cautions nurses to be aware of the norms about decision making in families and communities that might not be aligned with the biomedical ethical principles (Marshall and Koenig 2004) of liberal individualism.

13.4.4 An African Ethics for Nursing: Ubuntu

Nursing, as other healthcare professions, is steeped in a tradition of sound, scientific, evidence-based health care, often believed to be the only responsible approach to attaining the objectives of health care. This scientific belief system (e.g. the nursing process) may conflict with traditional African philosophy regarding the nature of the universe that explains existence and natural occurrence of life, religion, health, disease and death in a more convergent manner (De Roubaix 2016). For example, Ramukumba (2012) found that contradictory responses by participants related to obesity where they would express the consequences of obesity in terms of health risks and loss of functionality, while on the other hand, there was the cultural worldview that having a big body could be associated with being rich and healthy.

Ubuntu is an African humanist and ethical worldview (Berghs 2017). The Ubuntu worldview is common to Africans south of the Sahara (Chuwa 2014). In isiZulu, it is expressed as *umuntu ngumuntu ngabantu* which translates (with sizeable loss of culturally relevant meaning) as: “A human being is a human being through (the otherness of) other human beings” (Van der Merwe 1996, p. 76). Central to traditional African thinking about humankind, is community, as individuals see themselves as an extension of their communities. Through this common community identity a person experiences a sense of wholeness, fitting in and value (Haegert 2000). Haegert (2000) explains Ubuntu ethics applied to nursing as follows: “Where communalism is accepted in nursing, we profess that we are nurses not for our own sakes but to give identity and belongingness to all those we care for, staff and patients alike” (p. 499). Caring is the essence of nursing. In African terms, nurses are viewed as people who have compassion and care and have to show Ubuntu that is humanness, caring and compassion in their interaction with individuals, families and communities. Without this community and care-centeredness in the South African context there is a potential for unethical attitudes and behaviours. In the words of Emeritus Archbishop Desmond Tutu: “The person who has Ubuntu is known to be compassionate and gentle and uses his or her strength on behalf of the weak. She or he does not take advantage of others. She or he cares by treating others as human beings” (Tutu 1981, p. 1). As such, Ubuntu can influence the way nurses make decisions to care as well as the reception of services provided.

Haegert (2000) proposes two principles for an African ethic for nursing practice:

- *The principle of Ubuntu*, namely empathetic caring that is ethical, showing respect and dignity, working with communities, evidencing justice though fairness and tolerance and facilitating a process in nursing practice whereby communities are able to maintain themselves independently.
- *The principle of personhood* applied to nursing can be seen as caregiving, being ethical in a context of freedom of choice, done for the sake of another as well as a deep sense of respect through knowing a person and a community. To know means to listen without prejudice, to be tolerant and to be fully present.

Both these principles are deeply rooted in dignity of care, resembling something of the biomedical ethical principle of “respect for persons” included in the Belmont

Report (1979). Respect for persons is more than autonomy and could in fact be extended to respect for communities where, for example, autonomy is applied with contextual relevance.

13.5 Case Studies

Two case studies are presented and discussed based on the ethics principles grounded in the colonisation counter-narrative for nursing ethics of Ubuntu and the principle of personhood (Haegert 2000).

Case Study 1: Disclosure of Traditional Medicine Use in an Outpatient Department

A mother (Anna) brought her child to the regional training hospital accompanied by an elderly woman (Mokgadi) who was identified as the grandmother to the child (Didimalang). On arrival, the child was dehydrated, breathing with difficulty and lethargic with a history of convulsions during the past 12 h and a high temperature for the past 24 h. Before reporting to hospital, Anna and Mokgadi took Didmalang to the family's traditional healer (Vho-Maine) for treatment and to safeguard him against "evil spirits". While at Vho-Maine's place, the child had convulsions and looked very ill. The traditional healer tied green, red and yellow ropes "metlamo" on all the child's major joints and sent them to the hospital for the "Whiteman" (Western medical practitioner). On arrival at the hospital, the child was very ill and had to be carried to the treatment room. The Professional nurse (Sr Lulu) commented that the child was "smelly" and asked the mother whether they had been to a traditional healer. When the mother confirmed their visit to the traditional healer, the nurse became very irritable and said "When are you people going to learn that those witch doctors are useless". She removed the "metlamo" and disposed of them. Koko Mokgadi became very distraught by this action.

An African doctor, Dr. Monnye was the treating physician. He only spoke in English and addressed the family through Sr Lulu. Anna was very quiet and just murmured short answers when asked. When the nurse told the doctor that she cut the "metlamo" Anna started to object by saying they were not supposed to have been removed as they were preventing the child from dying due to evil spirits. Dr. Monnye harshly told Anna that the "stupid witch doctor knew nothing" and instructed her never to consult the traditional healer again. The child started gasping and sadly died after a few minutes, upon which the nurse shouted and blamed the mother and grandmother for the child's death announcing to other healthcare users in the treatment area that the child had died due to the family's negligent behaviour. Koko Mokgadi started to call upon the ancestors to fight their case and deal with these "African sons and daughter who had no respect".

Case Study 2: The Use of Herbs in Pregnancy
Zanele is a 20-year-old primigravida (pregnant for the first time). She is not married and lives with her mother. Her mother teaches her everything she should know and do during pregnancy and labour. Her mother has a good knowledge about different traditional medicines which will be good for the mother and the baby during pregnancy and labour. When Zanele was 38 weeks pregnant, her mother brewed her a tea from some dried tree roots. The tea is supposed to bring on labour and to make labour progress faster. Zanele went to hospital for the delivery of her baby. When she arrived at the hospital, the midwife on duty asked her whether she had taken any traditional herbs. She was scared to tell the midwife that she had taken the tea and said no because her friends told her that the midwife would shout at her if she said yes. The nurse still scolded Zanele and warned that she would kill her baby if she had used herbs and that the nurse would not take responsibility for the death of Zanele's baby.

Both case studies tell the story of families making use of their indigenous knowledge systems when confronted with health-related issues. In both cases, the healthcare providers violated the principle of respect for persons when they were treated without dignity, dehumanised and devalued (i.e. contrary to the ethical principle of Ubuntu) in an attempt to prevent harm to healthcare users. Both cases revealed a lack of respect of the child, pregnant woman, their families and their indigenous knowledge systems. Haegert (2000) argues that ethical care originates from a positive view about the individual. In these two case studies, the right of persons to express their needs were denied. In denying healthcare users these rights, nurses forget to pay attention to the needs of these healthcare users. The Code of Ethics of the South African Nursing Council (2013) states that nurses need to be altruistic, respect human life and rights, and treat persons with dignity. This means that nurses need to be attentive of the requests and activities of healthcare users and that the values of the nursing profession and of healthcare users can be in conflict with each other. This points to a need to pay attention to nursing ethics and how nursing professionals can act ethically to best serve individuals, groups, families and communities.

13.6 Strategies for Applying Ethical Principles from a Colonisation Counter-Narrative

Nursing ethics in South Africa has to be decolonised by "undoing and removing the unintentional negative effects of its colonial cultural influences on other systems of nursing ethics" (Johnstone 2015, p. 142). In South Africa, an awareness of critiquing Western ethics assumptions will be the beginning of decolonising the ethics principles that are used in the nursing profession on a daily basis. This can be done through critical reflection on these assumptions, values and principles. It will require of nurses to critically engage with the socio-cultural assumptions underlying Western ethics principles and do so within the cultural and social context in which they are applied in South Africa (Marshall and Koenig 2004). Working towards decolonisation in nursing should also include a commitment to expose colonising beliefs, values and structures implanted in nursing curricula, teaching methodologies and professional development (McGibbon et al. 2014).

In order to consider the strategies for applying Ubuntu ethics principles in the nursing profession, indigenous knowledge should be incorporated into the nursing curricula. Zuyderduin et al. (2016) point out that nursing academics in South Africa should consider the co-existence of Western and African indigenous knowledge systems. An indigenous curriculum advisor can be consulted to expand indigenous pedagogy to enhance the nursing curricula. Stansfield and Browne (2013) caution that there are no checklists in indigenous knowledge, but that it is necessary to define meanings of terms such as conventions, ethical space, cultural safety, cultural mindfulness, discussion, universal sustainability and colonisation. The Western theories and indigenous knowledge systems need to be critiqued in the classroom setting through use of case studies to develop students' critical thinking skills. Young and Paterson (2007) suggest that nurse educators need to be diverse leaders in nursing ethics practice. They should take action outside the classroom and lobby for indigenous knowledge in nursing. This can be done through rethinking curriculum concepts such as "context" and "culture". Collaboration with knowledgeable academics and elders in the community about the use and understanding of indigenous knowledge systems can make a positive impact on nursing education (Young and Paterson 2007). Community members can be invited to use storytelling as a tool to learn about indigenous knowledge in the theoretical and clinical nursing teaching spaces (Stansfield and Browne 2013).

Nursing students need to be prepared in all programmes to develop ethical decision-making skills and be able to advocate and be professionally responsible for the positive realisation of the rights of individuals, families and communities to health care, treatment and rehabilitation (London and Baldwin-Ragaven 2008). In this regard, nurse educators should be role models for ethical nursing practice and should be "in the forefront fighting for health care users' rights, for quality healthcare, for a health system that reinforces rather than, undermines nursing students' quest to advocate for the rights of patients and clients" (London and Baldwin-Ragaven 2008, p. 14). Furthermore, workshops and nursing conferences should address the theme of indigenous knowledge systems, health care and ethics education in nursing. Wasekeesikaw et al. (2014) suggest the following key questions that can be utilised to advance and mobilise indigenous knowledge:

- What are the policy directions that will support indigenous healing practices in the delivery of nursing services?
- What educational frameworks best inform nursing education and address historical issues that affect indigenous health and healing and prepare nurses for culturally safe practices?

Lastly, nursing research can be utilised to determine the required body of knowledge of indigenous knowledge systems through governing research priorities and methodologies. Johnstone (2016) highlights that the core values, beliefs, knowledge and cultural worldviews indigenous to nurses in non-Western countries have to be explored and described in research. This body of indigenous knowledge can then be applied to nursing practice and nursing education (Wasekeesikaw et al. 2014). To this end, indigenous nursing research and decolonised research methodologies should be used to correct systemic disempowerment and enable indigenous participants to practise their right to self-determination (Johnstone 2016; McCleland 2011).

13.7 Conclusion

The history of nursing ethics reveals a predominantly Western viewpoint, with the local narrative of nursing ethics in South Africa underreported and underrepresented in international literature. South African history and human rights violations have significantly impacted on all South Africans and have impacted on the ethics of care within the nursing profession. South African nurses are currently faced with multiple challenges in the provision of healthcare services, which in turn, negatively impact on their professionalism and ethical practices despite an ethical code of practice that embraces social justice, human rights and the principle of care. Decolonisation of nursing ethics will require awareness of how principlism has dominated the nursing ethics discourse in South Africa and the importance of using these principles in a contextually appropriate manner. In addition, a focus on embracing and incorporating indigenous knowledge systems and the principles of Ubuntu and personhood could enhance the integration of care, compassion, tolerance and dignity of individuals and communities into the moral identity and practice, education and research of nursing ethics in South Africa.

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Chapter 14
Ethics for Healthcare Professionals in Radiography – An African Perspective

Chandra R. Makanjee, Muchui J. Thambura, and Penelope Engel-Hills

Abstract The radiography profession is complex and presents multiple layers of possible ethical issues and dilemmas. This chapter presents some of the challenges faced by radiography practitioners in Africa and addresses selected ethical issues that capture the diversity of the countries on the continent from an African perspective. The discussions in this chapter include the following: governance of imaging and therapeutic services within diverse socio-economic environments, equitable access, issues pertaining to inherent risks and harm from a regulatory perspective, matters related to justification of referrals and effective utilisation of imaging services, the importance of effectively relaying messages and interacting within a multilingual context, the ethical principle of beneficence and the ethical standard of informed consent.

African nations are generally considered to be developing economically and might be considered as emerging societies in terms of the awareness of ethics. This includes developing awareness of the ethical dimensions of health and health care among those in the profession of radiography. This is evident in the introduction of continuous professional development in some countries. In several cases it includes continuing education units specifically allocated to learning in ethics. To enable an ethical service in radiation medicine the recommendation is to use a phased approach of increasing collaboration and a collective approach that commences from the

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relevant regulatory bodies that oversee monitoring of ionising and non-ionising radiation to manage the risks to the patient, radiology personnel and the public.

Keywords Radiographer · Radiation technologist · Radiation therapist · Medical imaging · Radiation medicine · Informed consent · Beneficence · Ethics in practice

14.1 Introduction

The radiography profession is inherently complex given the ever evolving and expanding technology of specialty imaging fields such as ultrasound, nuclear medicine, interventional radiology and computerised tomography (CT) and the rapid advances in radiation therapy. Given the vastness and diversity within Africa, the various categories of radiography are also differently represented in the variations of environments that are found on the continent. This accumulates to there being a multitude of possible ethical issues and dilemmas faced by the role players in a radiology or radiotherapy context. To address the ethical issues that resonate with diagnostic and therapeutic radiographers on the African continent this chapter provides a window into some key ethical dilemmas that are exemplars of the ethical complexities and a framework for further in-depth conversations and debate.

14.2 Governance and Access to Services

The massive increase in the use of ionising radiation for diagnosis and oncological treatment is highly evident on the African continent (Hilton et al. 2014). However, even though the relative cost of equipment is reducing, the gap between services in well-resourced and resource-constrained environments is growing and equal access to services is not improving.

A study conducted in Tanzania (Ngoya et al. 2016) was one of the first to map medical imaging equipment in an economically constrained African country. This was also one of the first studies to provide a comparison of diagnostic imaging equipment in a low and middle-income African country. This study therefore made a valuable contribution to deliberations pertaining to specifications for the minimum equipment necessary to provide a service in a poorly resourced country (Ngoya et al. 2016). The World Health Organisation (WHO) suggests that poorly resourced environments approximately 90% of the needs of a medical imaging service can be met through the provision of general radiography and diagnostic ultrasound. It is the remaining estimated 10% of radiology procedures that will depend on the provision of more specialised modalities such as magnetic resonance imaging (MRI) or computer tomography (CT). Extrapolation from the WHO recommendations for the ratio of CT scanners to general imaging equipment indicates that in resource-constrained environments there is a need for one CT per ten general X-Ray units. The reality of there being one CT scanner per 70 general X-ray units in the state hospitals of a country in Africa is a clear demonstration of the challenges in medical imaging on the continent. The problem is, how the gap in both general and specialised medical imaging services can be reduced when the poor economic reality of a particular environment mitigates against this goal. According to (Ngoya et al. 2016) general imaging equipment should be prioritised over the acquisition of specialised imaging modalities. Medical imaging is an integral part of diagnostic decision making and the lack of adequate facilities in some areas has resulted in "health tourism" in that patients seek access to radiology in neighbouring countries. Recently, there have been reports of "healthcare xenophobia" where black foreign patients of African origin are denied lifesaving healthcare services (Idahosa and Vincent 2014). There are no easy answers to these moral and ethical issues on the continent.

The impact of an increasing gap in access can be felt among all practitioners in therapeutic and medical imaging disciplines in Africa. This is exacerbated by the situation that many public hospitals are dependent on aid grants. In some countries or regions, the issue is then not the initial cost of purchasing medical imaging or therapeutic equipment but becomes about the inadequacy of maintenance and repair due to the scarcity of skilled engineers and technicians and the prohibitive costs involved. Furthermore, many regions in Arica have an unstable electrical supply that impacts negatively on service (Falase et al. 2016). Also, there continues to be a shortage of skilled healthcare practitioners and a south to north migration of qualified radiographers and other personnel. According to the International Atomic Energy Agency (IAEA 2017) there is a scarcity of qualified medical physicists, in the radiation medicine departments in most African countries and this shortage is particularly serious in the medical imaging departments (nuclear medicine and diagnostic radiography). This could contribute to sub-optimal imaging procedures and radiation protection with consequences that include; poor image quality and the possibility of patients being over exposed to ionising radiation.

Studies have reported on the shortcomings to financial constraints, political interference in healthcare services, and in many instances, a suboptimal functional supervisory structure at the regulatory level due to low availability of skilled personnel (Inkoom et al. 2011; Iwu 2014; Nwankwo et al. 2013). The re-allocation of government funds resulting in insufficient budgets for the purchase and quality control of radiological accessories, combined with the lack of qualified personnel, such as medical physicists and dosimetrists, have led to regulatory authorities shifting their role to performance of quality control procedures. This places quality assurance and the role of external auditor with the same individuals. A contributing factor is the ongoing migration of healthcare professionals from the developing nations to the developed nations that poses a challenge in terms of Africa's healthcare system. This is a moral dilemma that interferes with the already tenuous relationship between health and poverty (Iwu 2014).

Issues pertaining to the government level, such as monitoring the national effectiveness of professional capacity, cannot be isolated from the day-to-day operations at the hospital or clinic level. Hilton et al. (2014) highlight that challenges related to the implementation of professional roles could be because of poor channels of communication between management and the practitioners. This can be aggravated by the lack of a legal framework to support national standards for the safe use of radiation and mechanisms to management practitioners or entities who do not abide by the rules of safe practice. In such an environment there is likely to be an under estimation of the risks associated with the unsafe utilisation of ionising radiation equipment that does not meet the accepted standards of good practice.

Of note is that ultrasound is important as a non-ionising, non-invasive, safe, freely available and accepted modality that is widely used because of the comparatively low cost of equipment, easier maintenance, transportability and robustness when compared with other imaging modalities. The widespread application of ultrasound in the developed world in the fields of obstetrics and gynaecology has contributed considerably to eradicating maternal and neonatal morbidity and mortality, to a large extend. Despite the enormous benefits of ultrasound, Africa is lagging behind in harnessing these gains when compared to other regions of the world and is yet to fully take the enterprise to entrench the use of ultrasound as part of its healthcare service (Aliyu et al. 2015). To achieve extreme benefits, complete regulations must be applied to guarantee excellence, consistency and safety (Aliyu et al. 2015). However, there is a lack of evidence to support the establishment of point of care diagnostic ultrasound services in resource constrained environments (Henwood et al. 2014).

In Africa, the situation in oncology is that many countries have no or very limited oncology services at public hospitals and where available, the private hospitals are very expensive. Furthermore, while many countries in the developed world have a model of cost-sharing between direct government funding and medical insurance partners, in many African countries the lack of state healthcare plans mean that patients carry the burden of the high cost of expensive medical procedures. This situation can in part be attributed to the low availability of resources, poor allocation of health budgets and the fact that cancer control is the least among the priority list and competes with communicable diseases (Vanderpuye and Yarney 2014). A sad reality is that patients delay accessing oncology services until they cannot manage any longer. The resulting high level of palliative treatment, malignancies that are potentially curable, alongside the inadequate per capita provision of equipment, machine breakdown and extended delays for repairs create a backlog and leads to long waiting lists. This again means that even the small percentage of patients who present early with curable diseases can experience disease progression while waiting for treatment. Another challenge is that few countries have a governance mechanism through a national register. This precludes the availability of good statistics to estimate the role of and national need for radiotherapy so that planning for adequate oncology services is impossible. All these challenges have given rise to much suffering among cancer patients in Africa and to medical tourism for the few who can afford this privilege (Vanderpuye and Yarney 2014).

14.3 Ethical Practice

Many healthcare professionals are faced with operational challenges and ethical dilemmas without having knowledge of regulatory frameworks or ethical principles and approaches to guide their decision making and practice.

14.3.1 Justified and Safe Use of Medical Imaging

In the first instance it is necessary to recognise that the misuse of ionising radiation has the potential for risk for personnel and the public. At an operational level the causative factors for misuse will include deficiencies in training, ethical standards, and protocols and procedures. Although there is a general increase in compliance about obtaining the relevant licence to practise, there are reports of practice by unqualified persons and discrepancies with compliance to standards of patient care and safety that are more critical in cases of high dose such as with fluoroscopy and CT scanning procedures (Vetter and Stoeva 2016).

Medical imaging is a preferred and frequently used diagnostic modality that is relied on heavily in the health care sector. This means that it is a major source of radiation exposure. In all countries there is therefore the need for competent regulatory authorities to measure doses, establish estimations of radiation dose for each X-ray examination (i.e. dose reference levels) and monitor these in every site. From the literature concerted efforts are underway in some African countries to provide baseline dose measurements for patients undergoing various diagnostic procedures. The findings are used as a quality assurance measure for future dose measurements and for developing local and national diagnostic reference level frameworks. One of the positive spin offs is that the competency of imaging providers can be enhanced by retraining of the personnel responsible for the exposure to patients (Olowookere et al. 2011).

In Africa, three IAEA Technical Cooperation projects have been initiated for diagnostic imaging(IAEA 2017) These are; "Promoting Regional and National Quality Assurance Programmes for Medical Physics in Nuclear Medicine" – Phase I (2005–2010) and Phase II (2011–2013); and "Strengthening Medical Physicists' Capacities to Ensure Safety in Medical Imaging, with an Emphasis on Paediatric Imaging Safety" (2014). The main objectives were related to the role of the medical physicist and to enhancing their expertise and skills so that the patients, personnel and public could benefit from improved practice of medical imaging professionals. Furthermore, the Dosimetry and Medical Radiation Physics Section and Radiation Safety and Monitoring Section of the IAEA (2017) have also pursued the development of quality assurance and clinical applications of ionising radiation. There has also been assistance to member states for training programmes to optimise radiation protection in medical imaging. The IAEA (2017) furthermore conducted a training programme for medical physicists, radiologists, radiographers, technologists and radiation protection regulators from the African region in order to enhance practice to achieve higher level of safety in nuclear medicine.

Importantly the motivation for the safe use of ionising radiation must be positioned within the argument for justification of any request for an imaging procedure and the suggestion that globally between 20% and 50% of diagnostic medical imaging procedures are not necessary. The justification process entails all healthcare professionals involved directly or indirectly with diagnostic imaging investigations to ensure the appropriateness of the radiation procedure, and the selection of an imaging techniques to best illustrate the region of interest and to answer the clinical question at hand (Malone 2013). Moifo et al. (2014) elaborate that the lack of justification from a referring health care practitioner could be due to lack of relevant knowledge as a result of inadequate training in radiation exposure and the related doses from diagnostic imaging procedures. In many Sub-Saharan African countries, the documentation and record keeping pertaining to aspects of radiation safety parameters or characteristics of protection are poor. This is largely due to weaknesses in the enforcement of the relevant laws and regulations. Also, of note is the frequent finding of poor levels of knowledge of practitioners in medical imaging regarding radiation protection. Then there is also the absence of a CPD requirement for radiation protection and justification and no guidelines for the appropriate use of diagnostic medical imaging.

14.3.2 Professional Scope and Scope of Practice

A recent study pertaining to professional scope and scope of practice illustrated that diagnostic radiographers are aware of safety standards and are compliant in applying radiation safety measures in accordance with national and international standards (Ochonma et al. 2015). However, some challenges arose with knowledge of the radiation safety accessories such as lead aprons and gonad shields. Also, many imaging investigations include the administration of contrast media to visualise and establish anatomical and/or physiological status. Contrast administration requires the referring medical practitioner, but more so the radiologists and radiographers, to have the necessary knowledge on contrast media and the possible adverse reactions which can vary from mild, moderate to severe. In this regard the competencies, coordination, communication and the roles and responsibilities of the relevant professionals, sometimes in the absence of training and appropriate guidelines, can put the patient's safety at risk. Scope of practice behaviours can at times lead to disputes between professional groups that can result in the abrogation of professional codes of conduct, between professionals in conflict or involving the patient relationship (Hilton et al. 2014).

Another issue that arises in the consideration of professional scope is the possibility of adopting a skill-mix model as an option to overcome a country's need for clinical services based on the population and health economy. A possible implication is amendment to the radiographer's role description that extends or expands their professional scope of practice, with concomitant changes to level of responsibility and accountability. In this regard, a study (Ashong et al. 2016) found that more radiographers perform ultrasound procedures following amendments that allowed this extension to their role. The advantage is that patients can more easily have an ultrasound imaging procedure with the likelihood of a diagnosis accompanied by improved care. A limitation could be is an increased workload and fatigue among those with an extended role to the extent that this could eventually cause stress and other negative impacts for practitioner and patient (Ashong et al. 2016).

In oncology, the scope of practice of practitioners is linked to the need to reduce the variations found about cancer treatment processes and procedures. It is evident that the specifications for treatment by surgery, chemotherapy and radiation are dissimilar from country to country and even across institutions within a particular country. Because of this there has been an emphasis on the need for and use of standardised treatment protocols in oncology (Vanderpuye and Yarney 2014).

14.3.3 Ethical Conduct and Professionalism

A few studies have emerged regarding the ethical conduct and professionalism related to the delivery of quality healthcare services, with patient satisfaction as a core component. Two of the studies investigated respect, discrimination, unnecessary delaying of patients, informed consent, abuse of professional relationships, privacy, equality, unwillingness to answer patients' questions and rudeness. These studies also investigated patients' awareness of the requisitioned examination, explanation of procedures, and where applicable the side effects, unnecessary exposure to risk, whether radiographers demand or accept unauthorised payments, competence, dedication, honesty, co-operation, care and courtesy (Ochonma et al. 2015; Adejumo et al. 2012).

Although the outcome of these studies revealed that radiographers demonstrated overall excellence in their conduct and professionalism during service delivery, there were key ethical shortcomings such as the informed consent process not being observed due to high workload. Noteworthy is that communication in lay language is of importance to ensure that patients understand what is expected of them and what is going to take place during the procedure. The frequent assumption that patients know the information when in fact they do not, can result in poor cooperation during their diagnostic as well as therapeutic encounter (Ochonma et al. 2015) and can put the patient at risk of a suboptimal procedure. The findings of some studies alluded to radiographers not explaining their competency, expertise and details of the procedure prior to commencing the study is a professional weakness. Other possible weaknesses were that radiographers did not engage the patient on the technical aspects of the procedure and did not have a sustained relationship with patients whilst conducting the investigation. Positive findings were that almost all radiographers treated patients and their relatives with respect and without discrimination and did not intentionally expose them to unnecessary risk during the visit to the radiology department. Since the desire for respect and dignity has been identified as vital among human needs this is an important aspect of ethical conduct and professionalism (Ochonma et al. 2015).

14.4 Autonomy and the Place of Collective Decision Making

It is an accepted ethics principle that the autonomy of the patient ought to be respected. In this ethical framework the patient must know the "what, when, how, and why" of the procedure they anticipate undergoing (Malone 2013). This process serves the legal and ethical purposes of informing and protecting the individual for the person to make an informed decision. According to Malone 2013 the informed consent is not valid if a patient does not know what is going to happen to him or her in the procedure.

Voluntariness in the informed consent process stresses the need for the patient to consent on their accord, free of undue influence or coercion on the part of the practitioner, family or carers. Voluntariness in informed consent is quite challenging to evaluate h because notions of voluntariness are influenced by the diverse medical condition and the cultural norms of the patient. In African traditions, the influence of and respect for family, community and especially the elders is strongly linked to cultural norms and ethos. Therefore, persons frequently consult family, friends, relatives and community members for advice pertaining to their health care. These interferences may be considered as undue influence according to the norms of "Western" cultures that place an emphasis on individual autonomy and rights. People of Africa are somewhat more inclined toward the notion of collective decision making that stems from a concept of autonomy that is not individualistic but derived from Ubuntu or *sumus, ergo sum* (we are, therefore I am) (Chima 2013).

The significance of communication for achieving quality health care for vulnerable patients is often underscored. Communication is a key element of promoting an ethical decision-making process (individual or collective). Africa is known to be the most linguistically diverse continent in the world; it is relatively common for a person to speak several African languages fluently as well as one or more international languages. One of the challenges to respect and dignity is the rising number in migrations between countries in Africa and the resulting language diversity in any healthcare facility. There must be appropriately responded to this to facilitate effective communication essential for avoiding misunderstandings and potentially life-threatening miscommunication. The complexities in interpretation are not easily overcome and solutions such as the intervention of a family member or friend can be inappropriate but also necessary in emergency situations where decisions need to be taken quickly. What needs to be considered in these situations are issues of confidentiality and how this reflects on the standards for good practice. An example of communication challenges is the case of Esterhuizen versus Administrator Transvaal ([1957] (3) SA 710 (T)). This case reports on a 10-year-old diagnosed with Kaposi's sarcoma and who was first treated with low energy radiation following parental consent. The child suffered tumour recurrence and was then treated with high dose radiation. The outcome was severe burns and the limb had to be amputated. The court determined that the initial superficial radiation was delivered following informed consent for a minor, but that the procedure thereafter was performed without any consent. The argument of the defence that previous parental consent provided implied consent for a similar treatment was dismissed by the court, as was the argument that the treatment adhered to the standard of being in the best interest of the individual. The contention was that radical high dose treatment was not like the initial superficial radiation, and that before consent could be considered valid a further process of informed consent was necessary. In this process, the child's parents should have been provided with adequate information of the possible side effects inherent in the new treatment (Chima 2013).

Another consideration is in situations where there is a decision by the patient to discontinue treatment. This can be based on intuition or on cultural beliefs such as that cancer is a curse and may be healed by means other than by modern medicine (Jacobson and Cain 2009). This creates a dilemma if the autonomy of the patient has to be respected and places the radiation therapist in a position whereby the patient may later resume treatment but with more severe symptoms than when they first presented. Also needing consideration is the possible desire for the integration of complimentary therapies and alternative medicine during chemotherapy and radiotherapy. This must be addressed in the African context to create a platform of trust and open communication where the patient is the centre of decision making and can enjoy integrated forms of care to facilitate their holistic healing. The radiation therapist plays a major role in this process as they spend a longer time with any patient during radiotherapy treatment (Jacobson and Cain 2009).

14.5 Conclusion

This chapter highlighted the emergence of technological developments in Africa related to medical imaging and radiation therapy and career-related endeavours to stress the complexities of health care in radiation medicine. The need to address the key ethical issues within radiation medicine (imaging and radiation therapy) in complex relationship with the economic, political and social factors were discussed. The most significant aspect at the level of the regulatory body is the use of a unified approach to the scope and standards of practice. At the operational level there is more need to focus on the conduct of individual professionals. The role of CPD was discussed as crucial for maintaining currency and ensuring safe practice. Also necessary is that equitable access to imaging services and radiotherapy is provided through resource planning of financial aspects, technical and equipment aspects and the employment of appropriately qualified professionals. Lastly, but not to be forgotten, in the ethics conversation is the human aspects of the right to quality health care, the creation of awareness, respect, dignity and informed consent that focus on the vision of health and well-being for all in Africa.

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Chapter 15

Ethics in Diagnostic Radiography in South Africa: A Complex Temporary Encounter Mediated Through Text and Technology

Chandra R. Makanjee and Penelope Engel-Hills

Abstract Diagnostic radiography or medical imaging is a discipline where a broad range of high-technology equipment is used for medical diagnosis in order to guide patient management. The role of the radiographer requires the integration of knowledge, complex technology and advanced technical skills within an environment where effective and caring interaction is needed with patients. The patient engagement tends to be a relatively short, singular event and can be considered as a complex temporary encounter. There is also the need to interact with other healthcare practitioners to facilitate the provision of quality health care and service through a multi-disciplinary team approach. The rapid evolution in medical imaging requires the radiographer to continuously adjust to new emerging technologies and techniques that make continuous professional education essential. Ethical practice in radiography therefore involves a complex interlinking of good clinical decision making, safe and accurate practice, a commitment to empathetic patient relationships, the ability to function effectively within the multi-disciplinary team and honouring of the principles of lifelong learning. A unique aspect of ethical practice in radiography is radiation protection that is underpinned by respect for the principles of justification and optimisation. Radiographers must therefore pay attention to image quality while considering radiation safety for each patient but must also be aware of ionising radiation as a public health issue.

Keywords Ethical decision making · Radiation technology · Medical radiation imaging · Radiation safety · Optimisation · Utilisation

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15.1 Introduction

In this chapter the focus will be on selected ethical issues faced by radiographers (radiation technologists) practising in the diverse healthcare institutions representative of the South African context. Furthermore, selected ethical dimensions of practising in a resource constrained environment will be discussed and awareness of the competing agendas such as utilisation, optimisation, access, cost of service and safe practice will be raised.

The radiography profession in South Africa (SA) is represented by diagnostic radiography, nuclear medicine technology, diagnostic ultrasound and radiation therapy. In all these radiography categories the practitioner must integrate scientific knowledge, professional competence and technical skills, mediated through text (e.g. procedure requests, radiological reports and medical records) and technology (e.g. hospital and radiology information systems, picture archiving systems and medical imaging equipment). However, each category has a specific scope of practice and unique ethical dimensions. The focus of this chapter is specifically on diagnostic radiography but with acknowledgement that some of the discussion will also pertain to the other categories.

In the twenty-first century medical imaging has undergone rapid technological change and has been influenced by the advances in the molecular management of disease. In the South African context there is diversity between state and private medical services, as well as on the continuum from primary health care, through district and regional facilities to the tertiary and academic institutions (Makanjee et al. 2014b). Developments bring new opportunities and a widening gap between the well-resourced environments and the resource-constrained state health system. So for example, advances in antenatal ultrasonography allow for selective foetal therapy while standard ultrasound screening during pregnancy is not available to all. This challenges the ethics principles guiding the performance of any examination and decision-making processes pertaining to the selection of the most suitable procedure, appropriate modification of practice, referral patterns, marketing of services, handling of confidential information and conduct of research (Barron and Kim 2003).

Jonas (1984) discusses the risk of harm to future generations due to the incessant technological developments that are now part of our daily existence. His principle of responsibility emphasises prospective aspects such that to be responsible one must be sufficiently informed and able to reflect on the possible future implications of present actions. This is ability to look forward is the relevance to diagnostic radiography practice as radiation risk is not limited to the patient but can also affect the next generation. Although there is no consensus on the hereditary effects of ionising radiation, responsibility in diagnostic radiography must include a duty towards future generations (UNSCEAR 2001). This ethical imperative exists in an environment of trivialisation of imaging technologies where the first step to improved responsible practice might be to address the lack of knowledge related to the use of ionising radiation for the effective management of the patient. Furthermore, developments in technology mean that the responsible radiographer (radiation technologist) must retain currency in a rapidly changing environment by reading and evaluating relevant research, participating in research, investigating innovative techniques and best practices they can adopt or adapt and sharing information through publications and presentations.

15.2 Regulatory Bodies Governing Imaging Services

Ethical practice in radiography must include radiation protection. The role of the National Department of Health, Directorate: Radiation Control (RCD) is to regulate safe use of ionising and non-ionising radiation for healthcare providers, non-healthcare providers (e.g. engineers and software programmers), patients and the public. To achieve this, RCD provides guidelines, procedures and safe practice requirements for the maintenance and use of equipment. The RCD and the Health Professions Council of South Africa (HPCSA) promote radiation protection including adherence to justification (appropriate and defendable use), optimisation (maximising of desired effect) and limitation (dose not exceeding the recommended dose limit) (ICRP 2007) and the principle of keeping radiation exposure as low as reasonably achievable (ALARA). Regulations also relate to the maintenance of accurate and complete medical records (i.e. a blend of digital and/or paper-based records) which include mediation texts (e.g. request forms, images and radiological reports) (HPCSA 2008b).

In South Africa the Board for Radiography and Clinical Technology (RCT), a committee of professionals and public representatives appointed by the Minister of Health, must meet the goal of the HPCSA to protect the public and guide the professions. The RCT regulates radiography education and registration of clinical training sites, prepares the code of ethics and standards of practice and administers continuing professional development (CPD) of radiographers. The RCT also processes public complaints against radiographers deemed to have acted unethically (HPCSA 2008c).

15.3 Access to Imaging Services

Since South Africa’s first democratic election in 1994 the commitment to equal medical care for all and access to quality healthcare remains dependent on the economic and socio-political status of the individual (Nkwanyana 2017). Equitable access to medical imaging services is pivotal to any healthcare system and the challenge lies in overcoming the geographical discrepancies in distribution of radiological service and per capita levels of imaging capacity. Absence of equitable access is a rights-driven ethical dilemma where the right of all citizens to quality healthcare is not achieved. The challenge for radiographers is to provide ethical and quality care services in diverse contexts.

Within any healthcare institution it is the structural and organisational components that aid or interfere with the effective and efficient functioning of the imaging department. The department's location, infrastructure and type of care and services, should ideally align with the values of the health system as a whole. Furthermore, a high-quality, professional diagnostic service with empathetic patient care is dependent on good communication (i.e. between individuals, healthcare team members, diverse healthcare providers, non-healthcare providers and patients) underpinned by cooperation, coordination and collaboration as key enablers from the point of referral to task completion (Makanjee et al. 2015a) to promote access and appropriate utilisation. The findings of Van Schouwenburg, Ackermann and Pitcher (2014) following an audit of access by first users of magnetic resonance imaging (MRI) services in the public health care sector of South African highlight the need to systematically monitor and evaluate the clinical utilisation of the scarce resource (e.g. MRI radiographer) in order to enable the continued provision of high cost imaging services in healthcare environments with severe funding limitations. The challenge of aligning clinical demands with health system capacity demonstrated the importance of collaboration between executive hospital management and the medical imaging department. Furthermore, there was evidence for the potential for low cost service changes to resulted in significant clinical benefits. The principle of interdependence and interrelatedness organisationally, structurally and at an operational level within the healthcare system is therefore essential (Makanjee et al. 2014b). A mechanism of accomplishing excellence and access in health care is a comprehensive quality assurance management programme of systematic collection and evaluation of data (Papp 2014). In radiography this includes the review of patient care, patient selection parameters, scheduling, management techniques, departmental policies and procedures (e.g. equipment quality control), in-service training and timeliness for reporting.

15.4 Utilisation of Imaging Services

The ethical principles of beneficence and non-maleficence are applicable to utilisation. Non-maleficence is based on the goal to “do no harm”. In radiology this principle is more about reducing harm to the minimum and avoiding radiation exposure whenever and however possible. Hence it may be argued that it is ethical practice to expose an older patient to a diagnostic radiology examination when there is an indication that they have a serious medical condition (e.g. malignant tumour) because the low-dose radiation-induced chronic radiation effects are less significant for older persons. To the contrary it would not be considered as ethical practice to expose persons younger than 40 years of age to mass screening using radiation (e.g. mammography). However mammography may well be justified in the case of a younger person who presents with clinical symptoms or with a relevant family history (Doudenkova and Pipon 2016). The principle of “do no harm” also takes account of potentially harmful risks that are underestimated or unknown. In South Africa this could include such aspects as the use of radiation in preventative care and/or defensive medicine. The concern is the medicalisation of healthy people who are exposed to the associated risks or high technology imaging modalities. Mung’omba and Botha’s (2012) study that was conducted in rural KwaZulu-Natal in South Africa describes the socio-demographic factors that influence the desire for medical imaging procedures. Although not many of the study’s patients had knowledge of X-rays, the factors that influenced their utilisation of imaging included; age, level of education, the anticipated benefits of an X-ray, low levels of awareness and poor interpersonal communication between healthcare personnel and their patients. In order to practice in a paradigm that promotes and defends non-maleficence the healthcare practitioner must engage with the patient and provide clear information regarding the risks and benefits associated with the imaging procedure.

Beneficence (“doing good”) is an ethical measure to do what is in the best interests of the patient. In medical imaging this principle would mean that no procedure should be conducted unless it is deemed necessary. Yet the current medical culture, including the application of “defensive medicine”, is prevalent in the developed world and expanding in developing world contexts. The diverse South African environment with state of the art medical facilities alongside community medicine has growing demands and it appears that justification must be more rigorous to defend a decision not to do a procedure than to do what is not necessary act (Malone and Zolzer 2016). In a country that has inequality of access to medical imaging services it is often the case that the available resources are utilised for the protection of medical practitioners against possible litigation rather than maximising the use of resources for real patient needs. Worldwide there is an increase in the use of medical imaging, as well as reports of its overuse (Doudenkova and Pipon 2016).

15.5 Ethical Practice

Ethics emerged from moral philosophy with key elements of human behaviour and values in order to allow for the evaluation of whether a person’s actions are right or wrong and whether they acted with good or bad intentions. In South Africa there is a national regulatory body (HPCSA) that legislates registration for practice and that provides a governance framework for ethical practice through the provision of practice standards that are aligned to the scope and codes of practice. These high-level documents dictate the responsibilities of individual practitioners and together with the professional association and employers provide guidance on how medical imaging requests are processed and how radiation dose is managed. Some of these components of ethical practice will be discussed in the following sections.

15.5.1 Practice Standards

In radiography the practice standards of the profession define practice, serve as a guide for appropriate behaviour and practice, and establish criteria to determine compliance. Practice standards can be used to establish education requirements and evaluate the quality of practice, service and education in a particular professional category. Furthermore, practice standards can be applied by healthcare facilities to develop job descriptions and practice parameters. Further study allows for extended or specialist practice accompanied by a job description for imaging such as in mammography or ultrasonography. The value of practice standards is that they inform those external to the medical imaging profession, provide an overview of the role and responsibilities of the practitioners as defined by the HPCSA scope of practice and set standards against which a professional can be held accountable and responsible for their action and conduct in performance of their daily tasks (HPCSA 2008a).

15.5.2 Scope and Codes of Practice

Whilst a patient undergoing a diagnostic imaging investigation that involves the potential for harm may be unaware of the risk, they place their trust in the expertise and professional judgment of the radiographer. Radiography practice is influenced by national regulations, professional scope of practice, ethical codes and professional job descriptions. The ethical responsibilities of radiographers include the provision of respect and dignity to all patients by ensuring the patient has privacy and by honouring the ethical standards of confidentiality. Trust is the foundation of the patient/radiographer relationship and of professional and ethical behaviour. It is therefore essential that radiographers meet the required ethical standards and conduct themselves in such a way that they gain the trust and confidence of members of the public e and thereby serve the public interest and the individual patient. The code of conduct for radiographers in South Africa establishes standards of professionalism and ethics that include ensuring that the work environment is safe for everyone, and being accountable for professional acts and possible acts of negligence related to practice (Peer 2003; Beyer and Diedericks 2010).

The shortage of radiologists is a challenge in South Africa, as in many developing countries. This places demands on radiographers to assume roles beyond their scope of practice (Du Plessis and Pitcher 2015). For instance, the lack of senior medical practitioners during after-hours periods in trauma units means that the inexperienced medical officers on duty rely on radiographers for a radiographic opinion. However, establishing revisions and expansions of professional boundaries have not sufficiently progressed in South Africa. According to Du Plessis and Pitcher (2015) the expanding or blurring roles and responsibilities can only be achieved where there is comprehensive preparation and collaboration between the relevant professionals so as to establish sustainable and quality health care. However, radiographers frequently assist medical practitioners despite clear regulation changes. This is especially the case where radiographers have been trained in pattern recognition and when they desire effective and efficient patient management (Makanjee et al. 2015c).In these situations, it may impact negatively on the balance of risks and benefits for the patients, but it should be recognised that the ethical dilemmas that arise do not have simple answers and the principles of non-maleficence and beneficence can be complex considerations for furthering respectful and effective practice.

15.5.3 Registration for Practice

The first requirement of professional registration and practice is educational preparation and clinical competence. The HPCSA requires registrants to continually update their post-qualification professional knowledge, skills and competency; hence CPD is a requirement of maintaining registration. This includes mandatory continuing profession units (CEUs) in ethics, human rights and medical law. Radiographers must therefore have current knowledge and possess the necessary competencies to practise within the evolving scope of practice and emerging technologies in order to optimise patient safety and care. The responsibility for provision of opportunities lies with a variety of stakeholders (e.g. employer and professional association) but accountability rests primarily with the practitioner (HPCSA 2008d).

15.5.4 Request for Procedure

The referring healthcare practitioner takes a decision to refer the patient for radiographic imaging based on their expert knowledge and clinical judgment. The assumption is that the practitioner has the necessary knowledge to support a request for the most appropriate imaging investigation. The referring practitioner is also primarily responsible to duly justify the chosen procedure which in turn should optimise the choice of investigation. However, according to Makanjee et al. (2014b) the traditional paradigm of history taking, physical examination and provisional clinical diagnosis is often replaced by premature requests for imaging investigations. The Radiological Society of South Africa (RSSA) has adapted the Royal College of Radiology (RCR) referral guidelines for implementation in both private and public health sectors (Kabongo et al. 2015). The authors emphasise that referral protocols must be regularly evaluated and adjusted to provide customised diagnostic imaging protocols and procedures that meet the needs of a resource constrained environment in order to reduce the significant and systematic practices of inappropriate examinations and to improve patient throughput. Radiographers are important role players for successful implementation of referral guidelines and while referring practitioners have the primary responsibility to justify requests, radiographers, and where applicable radiologists, have the primary responsibility for examination optimisation. Radiographers are reliant on the quality of the referral request and on the patient perspective to take good decisions and to achieve optimal quality images.

All requests for an imaging procedure must be in writing, signed by the person requesting the examination (s) and the clinical indication must be clearly indicated. In South Africa imaging procedures may only be requested by a registered healthcare practitioner as defined in the National Health Act (Act No. 61 of 2003). In addition, any healthcare practitioner who contravenes the policy and ethical rules in terms of requesting imaging procedures must be reported to the Legal Department of the HPCSA or the South African Nursing Council (SANC). Radiographic reports are processed in terms of the professional conduct provisions of the Radiation Control Directorate of South Africa. A radiographer in his or her professional capacity must evaluate the information provided in any request form and may refuse the request provided that good and sufficient grounds exist. The reasons include the following: requesting clarification of the qualifications and/or competency of the healthcare professional making the request and the possibility the request is unsubstantiated (e.g. the clinical history does not justify or necessitate the performance of the examination requested). From a radiographer's perspective a request must be complemented by confirmation of the clinical information from the patient regarding their condition and the reason(s) for referral (i.e. clinical questioning). The radiographer must also explain the procedure in order to justify decisions with regard to any imaging investigation. This process contributes to the prevention of errors of misrepresentation or misunderstanding of the patient's condition and clinical history. Also, it furthers the aim to complete only correct and necessary projections. As part of the effective healthcare team communication process, radiographers are expected to report any additional knowledge they acquire about the patient. The process flow of request, justification, confirmation and clarification guides good decision making, helps to prevent errors (e.g. imaging an incorrect region of interest) and contributes to good medical management of the patient in the post-imaging phase (Lam et al. 2004; Snaith and Lancaster 2008).

This "gatekeeper" function is sometimes circumvented when healthcare practitioners, including radiographers, collude with or are coerced by referrers and accept incomplete, inadequately justified or otherwise inappropriate examination requests (Makanjee et al. 2015a). The radiographer must therefore be attentive to uncritically assume that a request for a procedure necessarily means that it is medically required; any inadequate justification cannot be merely overlooked based on practice imperative shifts to only perform examinations. In the study by Makanjee et al. (2015a) radiographers indicated that questioning the validity of the request frequently ended up with their voice being silenced and a command by the referring healthcare practitioners to "just do it". They also indicated that medical practitioners were often unaware of the importance of providing a relevant clinical history and do not have high-level knowledge regarding radiographic examinations and projections. The solution to improving request documents that lead to appropriate examinations and the optimisation of radiation dose levels is to increase effective communication between the referring practitioners and the radiographers (RSA 2010).

15.5.5 Radiation Dose

Doing "good" and making requests that are for the good of the patient involve seeking optimal medical care for each patient. Therefore, the imaging request should involve the lowest possible dose of ionising radiation within the specific medical indications. This is especially important when X-rays are used for imaging children who carry a higher potential risk to radiation, as well as for any patient for whom alternative diagnostic options exist. In the context of radiation dose the ethical principle of beneficence requires due justification of the choice of radiographic examination, for example, referring a child for Computed Tomography (CT) because it is easier to access than an MRI requires professional judgment and ethical awareness. That is, exposing the patient to unnecessary radiation risk by preferring the CT versus the cost of an MRI investigation. Within the South African context the private healthcare environment provides largely for persons who have access to medical aid and financial resources; the options available are therefore wider. Public healthcare however is under-resourced with limited available options. This means that standard radiography imaging is more frequent and the availability of specialised services (e.g. MRI and CT) is limited to tertiary and some regional level hospitals that are accessed through referral pathways Makanjee et al. 2014b).

The aim of radiation protection is to utilise radiation in a manner that optimises the benefit. This means that the optimisation of radiological protection in medical exposure acknowledges the dose received by the patient, but requires that this dose is kept "as low as reasonably achievable" (ALARA). This can be explained as managing the radiation dose to the patient by considering the potential risk and benefit related to the patient's medical condition. The optimisation of protection for patients having X-ray procedures also includes ensuring that the equipment design, construction, selection and installation are appropriately done. Management of radiation dose therefore includes equipment design and available technology to manage patient dose and diagnostic refer ence levels (DRLs) determined for the specific local, regional or national context (Do 2016).

15.6 Informed Consent

An obligation to provide information during the practice of comtemporary radiographt involves the key ethical principles of respecting autonomy, doing the what is in the best interests of the patient(beneficence)and avaoiding harm (nonmaleficence) (Doudenkova and Pipon 2016). Respect for autonomy is reflected in healthcare practice by obtaining informed consent from patients for procedures that could potentially undermine dignity and integrity (Beauchamp and Childress 2001). In the medical encounter of referral by means of a request form (text) for an imaging investigation (mediated through technology) a person/patient has the right to take part in the decision making process (HPCSA 2008c). Chapter 2 of the National Health Act (No. 61 of 2003) states that every healthcare practitioner must inform and explain the following to the patient:

- The available diagnostic procedures and treatment options generally available to the patient;
- The benefits, risks, financial implications and possible implications associated with each option;
- The patient's right to decline health services; and
- The risks associated with such refusal

In addition, regarding the disclosure of information and consent for referral for a diagnostic imaging investigation, the HPCSA (2008b) guidelines state the following: "Where a patient has agreed to be referred for an x-ray, referring practitioners may make relevant information available to diagnostic radiologists". It has already been indicated (see Sect. 5.4 above) that radiographers require clinical information to confirm the appropriateness of the investigation requested and the projections needed. This is confirmed by re-interviewing the patient. The patient may not fully understand the relevancy of the re-interview process as they cannot easily appreciate the complexities of the benefit versus risk principle or the need for the selection of the most appropriate diagnostic imaging investigation. One ethical dilemma faced by radiographers therefore is that there is there is often insufficient clinical information provided or adequate justification for referral by the healh care provider. Also, patients interacting with radiographers frequently have little insight on the reason for the referral and /or other possible diagnostic choices (Makanjee et al. 2014a).

Implicit consent is another important ethical consideration in radiography. In South Africa implicit consent is considered sufficient for agreeing togeneral radiographic investigations ("X-rays"). Implicit consent means that a person has made his or her will known in a tacit way. In other words, the patient agrees by being there and not resisting the examination. With regard to complex and invasive medical imaging procedures namely (i.e. biopsy, cardiac catheterisation, angiography, etc.) and that has the potential for relatively high radiation dose (dependent on exposure time), written informed consent is the standard because of known and higher levels of potential risk for the patient. One of the challenges however lies in the communication of the risks to the patient as it cannot be characterised with certainty. There is currently no agreement on the need to inform patients about the radiation risks in contemporary diagnostic imaging practice. This explains why it is infrequent that medical practitioners provide information on these risks to their patients. Informed consent and the appropriateness of raising the question of radiation dose and whether the patient should be informed when older equipment is used that has the potential to deliver higher doses than newer equipment is even more challenging (Robey et al. 2014). This is further complicated because while the latest technologies are more efficient and can potentially reduce the radiation dose to the patient, research has demonstrated that the introduction of modern digital systems in diagnostic imaging, has contributed to increases in radiation dose (ICRP, 2004). It is in fact the case that the advantages in terms of image quality, digital processing capabilities and digital transfer, disguise the potential for increasing the dose to the patient and many radiographers are still not aware that digitalisation has resulted in increased and sometimes unnecessary exposure. Unfortunately this increased dose can even occur without significant increases in image quality.

The confusion regarding the need for informed consent or not and the role of the radiographer in the informed consent process is a challenge, at a time when the ethical and legal standards promote patient participation in decision making. Still it appears that patients are often inadequately informed about the risks associated with ionising radiation (Makanjee et al. 2015b) and patients are seldom questioned by the referring practitioner regarding pregnancy and radiation (Makanjee et al. 2014a). This situation might be better resolved by wider deliberation using the pragmatic value set than based on the legal or ICRP systems alone. Both afford interesting opportunities for reflection and analysis, but the broader perspective of values provides pointers that help view the problem more holistically. The radiographers in these situations are left to solve the informed consent dilemma by choosing to continue with the imaging procedures or to refer patients back to the medical practitioner. In the case of CT examinations, patients were found to be mostly uninformed and were requested to sign consent forms without proper knowledge of the radiation risk or alternatives to CT. The routine nature of radiography as a service can gradually induce "professional blindness" toward risks and can minimise the importance and need to duly inform patients about radiation risks, thereby violating the principle of autonomy. Yet, several aspects of radiography are not known to patients, such as, the use of high-dose imaging technologies in the quest for quality images outweighing arguments for improved patient protection (Makanjee et al. 2014a, b, 2015a, b). Hence the patient may agree to a procedure, but not to the specific imaging technique (Doudenkova and Pipon 2016). So for example a patient may agree to a Barium Enema investigation but without full knowledge of the dose from the projection series. Leading on from this, radiographers in South Africa record the number of projections, the radiation exposure time and in the case of screening procedures, the actual dose. However, these records are not made available to the patients. This raises the question of informing the patient of their actual accumulative dose based on the ethical guidelines that state "… however small the risk, the patient should be informed" (HPCSA 2008b). In the gatekeeper role, the radiographer must balance the possible lack of awareness of the medical practitioner regarding the risks of ionising radiation and the application of the argumentative shortcut, such that the medical practitioner assumes that the patient has the knowledge and understanding of commonly prescribed examinations, and therefore knows the risks involved (Makanjee et al. 2015b). However, literature suggests the opposite about the "presumed" known risks and patient knowledge of associated risks for medical imaging. In fact, patient knowledge has been found to be largely lacking (Makanjee et al. 2015b; Doudenkova and Pipon 2016).

15.7 Conclusion

Radiographers worldwide work in a rapidly-changing and complex environment. In South Africa this is further complicated by the challenges of well-resourced healthcare facilities alongside poorly resourced facilities. Radiographers in South Africa are therefore faced with multiple professional challenges, namely working with ionising radiation, the need for good interpersonal skills to optimise the patient experience, functioning within the multi-disciplinary team and retaining professional competency through CPD. In addition, they must also contemplate the ethics of inequality of access and optimising the available healthcare resources. Helpful ethical approaches for the deliberation of ethical issues and dilemmas include awareness of human rights, non-maleficence, beneficence and social justice. These approaches and principles inform practice-based considerations in the process flow of request, justification, confirmation and clarification. Also, it guides good decision making, contributes to good healthcare management of the patient and helps to prevent professional errors. Possibly the most important message for ethical practice is that the radiographer must be consciously aware at all times.

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Chapter 16
Public Health Ethics and Rights in Healthcare Programmes

Joseph Mfutso-Bengo, Elizabeth Bukusi, and Eva Mfutso-Bengo

Abstract The chapter explains the nature of public health in Africa and discusses the development of public health ethics as an academic discipline. Also, it introduces the reader to basic theoretical frameworks for public health interventions, including the most important ethical principles of public health (e.g. necessity, proportionality, reciprocity, beneficence, consideration, community engagement, common good, common sense, solidarity). Lastly, it describes the context of public health ethics in Africa and discusses the challenges of ethics in the implementation of research and health programmes that affect the public – like quarantine for infectious diseases and the public health concerns of mass immunisation. It is critically important to apply the mentioned principles and to balance between personal rights and choices, and public safety and well-being while only choosing necessary, effective, appropriate and proportional means.

Keywords International health regulations · Ebola · Proportionality · Syracuse principles · Community engagement · Disease control

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16.1 Introduction

The first section of the chapter will focus on the development of public health ethics and rights in Africa, as well as health-seeking behavioural change and communication theories. The second section of the chapter will focus on the principles of public health, namely proportionality, reciprocity, community engagement, beneficence, consideration, common good, common sense and solidarity. The third section of the chapter will focus on exemplifying challenges and ethics of implementation of public health research programmes in Sub-Saharan Africa by drawing on examples of quarantine during outbreaks of diseases of public health concern and the challenges of mass vaccination.

16.1.1 Milestones in Public Health Ethics and Rights in Africa

The reshaping of the African future through the sustainable development goals (SDGs) and the African Union (AU) Agenda 2063 that put healthy and well-nourished citizens as priority goal number 1(3) in its implementation plan and, show that public health has been and is a major priority for African nations. With only 13% of the global population the continent contributes 24% of the global disease burden (Cooke 2009). The successful development and implementation of health programmes require transformative and situational leadership, ethics, health governance and systems at all levels and good governance. This is the foundation for a working and resilient public health system.

In order to discuss public health ethics, there is need to define "public health" and consequently what public health ethics encompass. The breath of what is included in the definition ranges from all actions done as individuals or as societies that promote the well-being of the individual and the society of which they are a part (Blacksher 2014). This may mean the conditions in which people live, the deterrence of illnesses or the prolonging of life considering the individual as part of a community or "public". However, clinical ethics are more focused on the prevention, promotion of treatment of health for an "individual" – and then because of the individual, may involve others who are in relation to the patient. The activities that could be considered are wide-ranging and include, but are not limited to, surveillance, health promotion, research, education, taxation and interventions on socio-economic determinants of health.

16.1.2 The Development of Public Health and the Role of Ethics and Rights in Africa

The first school of public health, founded in 1916 by William H. Welch with funding from the Rockefeller Foundation (The Rockefeller Foundation n.d.), was followed by Harvard, Colombia and Yale in the USA, and the trend spread to Europe and later to Africa.

Public health ethics and rights were furthermore influenced by the Universal Declaration of Human Rights (1948) and the International Covenant on Economic, Social and Cultural Rights (1966), including the right to human dignity, the right to life and the right to health. The influence of the Rights Movement was noticeable even in bioethics so that the rights-based approach became one of the prominent bioethical theories in addition to casuistry, consequentialism and deontology.

However, it was with the Declaration of Alma-Ata (1978) that the issue of public health interest and primary health care strongly emerged. This declaration on primary health care gave community health its impetus to grow as a discipline in African medical schools. Some of the first department/schools of public health in Sub-Saharan Africa were Makerere School of Public Health in Uganda (1974), Moi School of Public Health in Kenya (1998) and Muhimbili School of Public Health and Social Sciences in Tanzania (2001). In West Africa, the University Ibadan Faculty of Public Health in Nigeria was found in 1948, followed by University of Lagos that established its first department of community health in 1962. In 1968 University of Yaoundé 1, Cameroon, created its own department of community health. In the 1950s the Universities of Stellenbosch and KwaZulu Natal in South Africa established community health departments, while the University of the Witwatersrand created its first department of community health in 1979. In 1998, the School of Health Systems and Public Health (SHSPH) was established at University of Pretoria, South Africa (IJsselmuiden et al. 2007). In 1996 College of Medicine of University of Malawi took a decision to create a community health department which would become the cornerstone for medical and health sciences training in Malawi. In 2012 the University of Malawi promoted the Department of Community Health to become a faculty; it was renamed School of Public Health and Family Medicine with its own dean. AfriHealth identified a need for increased training and capacity in 2003 for Africa since overall 29 out of 53 countries (54.7%) offered no postgraduate training in public health, 11 out of 53 countries (20.7%) had one programme and 11 out of 53 countries (20.7%) offered more than one programme (IJsselmuiden et al. 2007).

The author observed that the creation of community health departments in some African countries were met with some early resistance by some conservative clinicians who thought that community health importance in medical education was misguided, dangerous to clinical care, exaggerated and could dilute and endanger the main traditional elements of medical training and teaching. The same sentiments were also seen in South Africa between 1980 and 1989. John Gear states "1980–89 this decade was characterised by carving a niche for academic community health in the hostile corridors of a Medical School steeped in the Oslerian clinical tradition of bedside teaching. There were many who were sympathetic to the need for academic community health but who failed to grasp that its focus was on *population health* and not individual health" (Gear 2013).

The Declaration of Alma-Ata (1978) demonstrated that community/public health had to focus on different ethical principles than the ones traditionally used to achieve the best medical interest in a doctor-patient relation. Thereby it was moving away from a bilateral relationship to a multilateral relationship, prevention and treatment. Public health and medical care are complementary but they are not the same and so clinical care ethics and public health ethics also differ and yet are complementary. Since medical care primarily focuses on the individual person, therefore the principle of autonomy became an ethical and legal standard, whereas public health primarily focuses more on a "group", namely communities in relation to national, regional or international health. This difference in approach necessitated different legal and ethical reasoning and instruments.

The shift from an individual health perspective to population health, also changed how we view violations of the right to health, e.g. the OPERA framework gives a structure to assess violations of socio-economic rights under the International Convention on Economic, Social and Cultural Rights that may refer to the right to health and other socio-economic determinants of health, e.g. water. The OPERA framework considers the following: (a) Outcomes: level and disparities in realisation of rights, (b) Policy Efforts, (c) Resources: resource generation and utilisation, and finally makes (d) Assessment of state violation considering constraints. (Center for Economic and Social Rights n.d.)

With the Declaration of Alma-Ata an ethical dilemma emerged on how to reconcile legitimate public interest with legitimate personal interest. Another question that emerged was: Can legitimate individual rights be limited for public health interest in the case of an epidemic for disease containment or for the purpose of prevention? How would one reconcile such limitations with the Universal Declaration of Human Rights? The Syracuse Conference, which resulted in the Syracuse Principles, was a timely response to this debate (UN Commission on Human Rights 1984). The Syracuse Principles managed to set a clear ethical guideline to govern the limitation of individual human rights for public good. The principles were also meant to avoid the abuse of the limitation of human rights in the name of public interest. In general the Syracuse Principles state that individual rights can be limited/restricted for public good or interest. The Syracuse Principles were incorporated or evolved to become widely recognised public health ethics and rights principles. With globalisation and the growing importance of international trade and innovation, one sees that the ethical principles of Syracuse had some impact on the World Trade Organisation conference in Doha (2001) where trade-related intellectual property rights were discussed. The Doha Declaration permitted the limiting of intellectual property rights for the sake of public health interest to allow compassionate use of patented drugs or the production of generics. The Doha Declaration was crucial in revolutionising HIV treatment by making antiretroviral drugs available, affordable and accessible (Magnusson 2017).

The African Charter of Human and Peoples' Rights (Banjul Charter 1981) had not explicitly included the Syracuse Principles but focused on the duty of each individual to exercise his or her human and civil rights and freedoms with due respect to the rights and freedoms of others, shared safety, morality and shared awareness (Art. 27(2)). Nevertheless, the interpretation by the African Commission on Human and Peoples' Rights ("African Commission") and later the African Court on Human and Peoples' Rights ("African Court") made an assertive step to necessitate the principles of authentic purpose, proportionality and complete requirement as vital circumstances for the restraint of individuals' rights (Ibrahim 2012).

These limitations need to be included in the laws of a particular country. Members of World Health Organisation (WHO) are obliged to implement the WHO International Health Regulations (IHR) (2005) in their respective legislations and administrations (Magnusson 2017, p. 166). This includes the creation of IHR Focal Points in countries to facilitate communication with the WHO, strengthening of health surveillance and response capacity. It also includes the duty of states to notify the WHO within 24 h of a public health emergency of international concern and gives powers to the WHO Director-General to make temporary recommendations.

Public health interventions need to be guided by values and evidence-based decision making and practice. Public health ethics require programmes and intervention to use public health ethical values and evidence for public health decision making (Brownson et al. 2013).

The principles of the ethical and rights approach focus on the protection of individuals from undue, unnecessary and unjustifiable interference of the state with regards to their individual rights and freedoms in the name of public interest. As we will see below, the human rights approach also gives a legal basis for the rights of patients, health workers and their limitations. This is crucial for public health ethics and law, where an individual's rights may be reduced or limited for the sake of the public health interest or public good.

The goal of the health system is to keep individuals and community healthy, thereby realising health rights. A human rights-based approach to health is helpful to define national goals and personal and international responsibilities in accordance to the principle of solidarity. The core content of the right to health must be met by states and at the same time international solidarity is expected to help to achieve this high goal (United Nations Economic and Social Council 2000, Forman et al. 2016). O'Hare et al. (2016) developed a framework to assess the degree to which these rights have not yet been met. Such surveillance in healthcare practice is important for evidence-based decision making and public health programme design. Also, it provides a context for health professionals in clinical care to contribute to better policy making.

16.1.3 Social and Behavioural Science Approach to Public Health

Successful health programmes should be based on a proper understanding of health behaviour and the context in which they occur. Hence social theories and models need to be applied in a particular social text. The classic models are the Health Belief Model (HBM), the stages of change construct of the Trans-theoretical Model (TTM), Social Cognitive Theory (SCT) and Social Ecological Model. Intervention should not only be directed at individuals but should also include social, legislative and environmental factors influencing health behaviour (Glanz n.d.). The Precede-and-Proceed Model (Green and Kreuter 2005) has been developed and improved since 1974 for the design and implementation of health programmes. The Precede Phase of the programme includes three stages:

1. Social diagnosis for identifying social problems, including gaining understanding of the community;
2. Epidemiological, behavioural and environmental diagnosis, which considers additional sources of information, behavioural context and social and physical environmental factors, like socio-economic determinants of health; and
3. Health planners should identify factors whose modification will most likely result in behaviour change, specifically predisposing, enabling and reinforcing factors (e.g. beliefs and attitudes are often predisposing factors, while issues of access are enabling factors; reinforcing factors can include peer reactions and social sanctions that maintain the behaviour).

The Precede Phase is followed by the following Proceed stage (Green and Kreuter 2005):

1. Diagnosis of administrative and organisational concerns before implementation;
2. Implementation;
3. Evaluation of the process of implementation;
4. Impact evaluation (i.e. achievement of objectives and outcome evaluation to the overall changes in health or social benefits); and
5. Outcome evaluation.

16.2 Principles of Public Health Ethics

In Public Health Ethics the focus is not on the individual, but rather the community or “public”; this distinguishes public health ethics from clinical ethics which is more focused on the prevention and promotion of treatment of health for an “individual”, including others who are in relation to him or her (Institute of Medicine 1988). The activities that could be considered within the public health arena which strive to increase the health of a community can be varied and greatly differ in their scope and inclusiveness.

Ethics in the context of public health deals with the moral concepts and includes, but again is not limited to, the considerations of benefits to improve health within a community. When community is mentioned, this of course includes by default the individuals who make up the community. The ethics of public health would therefore take into consideration the distributive justice of risks versus benefits of various public health activities: procedural justice in enabling access of information to members residing in communities; transparency in decision making on whether to participate; protecting “the community” by respecting individual privacy, maintaining confidentiality, and being careful to ensure that stigmatisation is avoided. It is therefore a balance between individual autonomy versus the collective good and, because of this tension, the consequences of the freedom, choices and decisions on the overall community (e.g. mass treatment which would likely be the role of a public of health agency) (The Nuffield Council 2007).

When public health measures limit the rights of an individual one needs a legal and ethical justification. The ethical justification can be derived from reasoning based on the following principles: common good/common sense, necessity, proportionality, reciprocity and consideration, equity and justice, solidarity, (self) responsibility and legality. Also, similarities and differences exist between the principles of medical ethics and public health ethics principles, specifically with regards to respect, beneficence, non-maleficence and justice.

The ethicality of health programmes, research, health litigation and equitable health outcomes depend not only on ethical reasoning but also on the virtue and character, also referred to as moral capital of programme designers, implementers, monitors and evaluators. Ethical decision making is supported by reasoning based on the following ethical principles.

16.2.1 Common Good/Common Sense

Public health programmes need to serve the public interest. Based on utilitarianism it considers what is best for the maximum number of people while minimising cost, risk and harm, which is also an underlying principle of the Ubuntu philosophy. This needs to be considered both when assessing acceptability, accessibility, efficiency, effectiveness and feasibility of programmes and prioritisation of expenses.

Yamin and Gloppen (2011) have demonstrated that the enforcement of health rights can lead to more or less justice and health (in)equity in various countries, e.g. litigation in South American countries to enforce health rights and treatment options for some individuals created health inequity for others, while litigation pressure during negotiations for production for HIV/Aids drugs in South Africa increased health equity. The principle of common good also excludes programme design that is distorted by self-interests. An ineffective programme would not be suitable to serve the common good. For example, vaccination programmes do not only protect the individual (and reduce later treatment costs) but can achieve common good by completely eradicating diseases, especially when herd immunity is achieved and therefore protecting even those who may not have chosen to get vaccinated. Within a community, the common good of the community is a substantive good, and action or activity from which all community members benefit (like clean water) or procedurally in a process in which community members participate for a specific common outcome. An example is the ban on the use of plastic bags in a specific country, like Rwanda and now Kenya, for a "good" environment (see Wachira et al. 2014). Procedurally, the ban of plastics is a legislative process that ethically requires participation of those who will be affected by the ban, both the users, the manufacturers and the environmentally concerned parties.

16.2.2 Necessity

The principle of necessity requires that there should not be unnecessary limitations on human rights and freedoms. The chosen means should be least intrusive and at the same time most effective. For example, quarantine has very drastic reputational and economic consequences and may in some circumstances affect a large number of people (Magnusson 2017). At times milder remedies like isolation and epidemiological tracing of contacts can be as effective but less harmful and disruptive. The means need to be determined by the severity of the conditions at hand and the potential harm of various options under consideration (Kass 2001). Generally, public health interventions on the socio-economic determinants of health and educational levels are more effective (Frieden 2010) and often less intrusive than direct health interventions. As such, it is a challenge to balance between personal rights and choices, and public safety and well-being.

16.2.3 Proportionality

The principle of proportionality, also contained in the Syracuse Principles, is reflected in Human Rights documents, such as the International Health Regulations (2005) and many modern African constitutions in democratic settings. For example, voluntary medical male circumcision (VMMC) in Southern Africa is used to reduce the likelihood of infection with HIV/Aids and inadvertently the likelihood of subsequent incidence of cervical cancer of their sexual partners (Friedland et al. 2013). VMMC requires consent of the man. However, not all men agree to be circumcised even though this would be necessary to achieve a better level of protection for women. On the one hand, most people would consider a mandatory circumcision as not proportional since it affects highly intimate aspects of ones life and is intrusive. On the other hand, it would be highly effective like no other means. The means employed should not be out of proportion to the intended outcome. Proportionality aptly refers to fairness and justice in which a reaction or response is in due measure with the initial action or in "proportion" to the need. In public health, therefore, a measure taken for any public health activity should take due consideration of the nature of the "threat" or potential harm and the activities or measures to be taken should be in line with this, avoiding the proverbial "hitting the fly with the sledge hammer".

16.2.4 Reciprocity and Consideration

Communities thrive by the nature of interaction of the members with each other. Reciprocity refers to the "golden" rule adage which is commonly found in many moral religious and social arenas of "treating others as you would wish them to treat you". The principle of reciprocity also requires that when one limits freedoms, one may also assume responsibilities at the same time, e.g. when one quarantines a traveller one needs to cover the costs of food and accommodation for him or her. Consideration is a principle that is related with the horizontal effect of human rights and could also be understood as a sub-principle to the principle of justice. The horizontal effect of human rights means that not only the state but also private individuals need to respect the human rights of others (Chirwa 2002). It includes the idea that the freedom of one person ends where the freedom of another person starts and may even include positive obligations.

In the African context the concept of consideration can be derived from the principle of ubuntuology/umuntuology. According to Ubuntu being human requires that one considers the needs of others in a community/society and exercise one's power with morality (Mfutso-Bengo and Masiye 2011). Provision of free, open access to health information is a practical example.

16.2.5 Equity and Justice

The principle of equity and justice requires fair, participatory decision-making processes, non-discrimination in health programme design and implementation, and equitable access to health care even for marginalised groups. It can be derived from Rawls theory of justice or a capability approach to justice (Ruger 2004). It also calls for a prioritisation of realisation of core or survival rights both within a country at the budgeting and implementation level and how one is organising healthcare delivery (e.g. triage systems on waiting lines to identify urgent cases in good time). Braveman and Gruskin (2003) suggest a method for measuring equity by defining it as the lack of organised inequalities in health (or its social determinants) between more and less privileged social groups. Social justice also calls for public health systems and structural adjustment with a goal of attainment of equity, access and gender mainstreaming of health services.

16.2.6 Community Engagement

Community engagement is an important principle, which is generally a requirement for value-based and evidence-based decision making for public health intervention and surveillance, especially in the African context. This is in line with the African spirit of communalism, solidarity and community participation. African traditional cultures tend to be more community oriented. Hence, community consultation and engagement is essential to facilitate community ownership, community involvement and participation, as well as essential in identifying gaps, needs, cultural determinants and priorities that are crucial for public health intervention. (Mfutso-Bengo et al. 2008). Consultations are considered as an element of procedural justice that in turn increases quality and acceptance of a public health intervention. Community engagement with collective approaches is helpful to influence health behaviour through change of social norms. A practical example of community engagement is the establishment of health committees at health facility level which involve community members on issues of budgeting and facility healthcare priorities.

Health messages and public health interventions need to fill knowledge and awareness gaps in communities with very diverse education levels and limited access to IT infrastructure. Health education science has shown that communication and social marketing needs to be expanded into health literacy (Nutbeam 2000). Drama, "edutainment", African traditional dancers and other "oramedia" (Ugboajah 1982) are alternative ways to reach people. Berger (2012) identified some typical salient traits of communication in Africa like the frequency of word-of-mouth communications, imported technologies and categories, colonial legacy approaches to media roles, pluri-lingualism (colonial dominant languages vs. local languages), social inequality, particular demographics (rural vs. urban, hybridised cultures, etc.) and a context of political repression (Berger 2012; Nidyaye 2016).

16.2.7 Solidarity

Solidarity is the cornerstone of the African concept of ubuntuology. It is based on "common sense" that all human beings are interrelated, interconnected and interdependent (Mfutso-Bengo and Masiye 2011). Hence solidarity in time of an epidemic is not an option but a necessity. However, Dawson and Verweij (2012) differentiate between two types of solidarity, namely constitutive solidarity as a social concept in human communities that depends on who we are as members of a group, and rational solidarity based on a decision to "stand together" for a particular cause. The principle of solidarity is based on the idea of sharing of possible, actual or experienced suffering and mutual assistance. An example is the think-pink cancer awareness campaign that is driven by breast cancer survivors or joint lobbyism by developing countries on international level for use of generic drugs. Examples for solidarity on a Grand National scale are health insurance schemes or free primary health care and vaccinations financed by taxes and donors, since every citizen runs the risk of falling sick. The principle of solidarity can also justify why citizens should donate blood or participate in vaccination, because only a concerted effort of all who might be affected will lead to the desired effect. The concept of quarantine in an epidemic is enabled by a spirit of solidarity of those who are infected with those who are not (yet) for the sake of prevention and disease containment.

16.2.8 (Self-)Responsibility

The willingness for solidarity is typically less if someone inflicted harm on him- or herself. In this regard the principle of (self-)responsibility can be used in the discussions whether denial of free health benefits are justified when people had put their health at risk through reckless behaviour, like smoking. Other examples are the failure to participate in free dental check-ups that can reduce claims against health insurance for replacement of teeth in Germany.

Using (self-)responsibility may not be appropriate in African context for access to primary basic health care but for extended health care benefits. Incidents of lack of self-responsibility could be refusal to take malaria prophylaxis during pregnancy or the abuse/non-use of freely provided mosquito nets. In Africa the principle of responsibility can also serve as justification for the imposition of high taxes on alcohol, cigarettes or sugar in order to not only reduce the growing non-communicable disease burden by increasing prices but also to finance the increased health bill that is necessitated by the provision of health care for these ailments in the public health sector (Talbot 2012).

Responsibility is not only rooted in causation or assumption of duties but also in the capacity to act and to effect change. Power and responsibility are two interrelated concepts. However, the legal definitions of duty bearers and the social reality of those having influence on the realisation of health rights may differ. That is where ethics can establish responsibilities.

16.2.9 Legality

Public health ethics and rights have to be grounded in legality unless the law contradicts natural justice (i.e. natural law theory as opposed to legal positivism). Any limitation of rights has to be justified by law through a public health act or other laws and regulations; keeping in mind that unjust or unconstitutional law is not binding. The legal principle of "rule of law and democracy" requires a legal basis for state interventions that affect human rights. The prescribed jurisdictions and procedures plus legal requirements for the norm empowering the authorities need to be observed. The human right to fair administration requires the concerned party to be heard as part of a fair procedure. Lawmakers discuss the need to introduce mandatory social impact assessment of major health interventions with possibly wide-ranging impacts. Due to the wide range of human rights, e.g. the right to equality and non-discrimination, there are many overlaps between the principle of legality and other principles of public health (Magnusson 2017).

16.2.10 *Similarities and Differences Between the Principles of Medical Ethics and Public Health Ethics Principles*

The principles of respect, beneficence, non-maleficence and justice are widely used in biomedical ethics, specifically in the context of clinical care and research; these principles have been codified in the Belmont Report (1978) and are extensively analysed and expanded by Beauchamp and Childress (2001). The principle of beneficence seeks to ensure that for each individual (and community), the welfare of the individual or the community is considered as a key focus in the decision-making process, and that an individual (or community) is not expediently dispensed of their rights or welfare for the benefit of the majority. Hence, public health needed its own set of ethical principles to govern its practice which targets public and community interests while at the same time trying to minimise harm to an individual person in the community. The following table by the authors shows similarities and differences between the various principles.

Public health ethics	Medical and research ethics	Human rights framework
Consent or mandatory testing and treatment allowed, if justified	Respect (autonomy, consent of individual, assent, community leaders' consultation etc.)	Right to dignity, personal liberty and consent
	Research must be voluntary and not mandatory	Mandatory testing treatment not allowed.
		A right to health care and a right to refuse testing and treatment
Common good, necessity, solidarity, responsibility, reciprocity, beneficence, non-maleficence (i.e. maximisation of benefits and minimisation of harm to the community and individual)	Beneficence/non-maleficence = first do no harm	Limitation of human rights in the public interest, legitimate purpose, necessity/least intrusive means
	Risk-benefit assessment (lesser evil of two harmful alternatives)	
Common good, equity, proportionality, legality, reciprocity and social justice, just health systems	Justice	Right to life, right to health, proportionality, and legal basis

16.3 Ethical Questions Arising in Past and Current Public Health Challenges in the Context of Sub-Saharan Africa

Sub-Saharan African (SSA) countries have attained independence in the last 50 years. Their governments have inter alia focused on the challenge of dealing with preventable and curable infectious disease agents, initiating childhood immunisation programmes to curb the high infant mortality, and programmes to care for pregnant women. In the midst of making good progress in dealing with these infectious agents, HIV, discovered in the early 1980s, threw many of the healthcare systems into disarray. Especially in East, Central and Southern Africa, HIV took a toll on healthcare systems and made demands on systems that were already struggling to provide optimal curative, prevention and promotive services (Nunn et al. 1993; Fabiani et al. 2003; Gilks et al. 1998).

The situation was not made any easier by the developing middle class in countries with low and middle-income economies. They saw the emergence of lifestyle diseases like hypertension, diabetes and certain types of cancer due to urbanisation and change of nutrition and lifestyle. This resulted in the double epidemic of both communicable and non-communicable diseases which then challenged the health systems even further (Phillips-Howard et al. 2014; Kengne et al. 2013; Streatfield et al. 2014; Sylla and Wild 2012).

With limited diagnostic abilities and even more limited specialised care, many diseases are diagnosed at a late stage with resultant high morbidity and mortality (Ports et al. 2015; Freeman et al. 2016). This is on the backbone of insurance facilities that are not universal, and even when present may have limiting clauses that do not seem to provide extensive coverage for members (Macha et al. 2012).

Tuberculosis (TB) has been closely associated with the HIV epidemic; not just the infection but the extensively drug resistant tuberculosis (XDR-TB) and the multiple drug resistant tuberculosis (MDR-TB) plaguing immunosuppressed persons and causing a public health concern due to the challenges of ease of transmission coupled within crowded, low income and informal housing facilities with limited ventilation and transmission, even with healthcare facilities (Lygizos et al. 2013; Kompala et al. 2013).

While diseases like cholera have long ceased to be of concern in the developed world, it remains a challenge in countries with poor sanitation and a lack of running potable water. Sewage disposal in many large and growing sprawling SSA cities has not been optimally planned and implemented. Coupled with this is the lack of organised and systematic disposal of solid waste, which is often done by private vendors whose knowledge and management of waste are inadequate. As a result, SSA and especially Western and Central Africa have not been spared from emerging and re-emerging epidemics like the Ebola outbreak. In countries with relatively stronger healthcare systems like Uganda, Ebola has been diagnosed in several outbreaks but has been effectively contained (Nsubuga 2014). However in the West African countries of Liberia, Sierra Leone and Guinea, the Ebola outbreak resulted in decimation of entire villages; it was a raging epidemic which left many dead and entire villages decimated in its wake.

From a public health perspective, how does public health ethics resonate with the challenges and needs, and in particular based on the aforementioned principles (see Sect. 16.2 above)?

In the face of the HIV epidemic, randomised clinical trials demonstrated the individual and the public health benefit of voluntary male medical circumcision (VMMC) (Reed et al. 2012). It has also been shown that pre-exposure prophylaxis (PrEP) is effective HIV prevention in individual and public health interventions (Hankins et al. 2015) and that treatment of those infected with HIV is a clear mechanism of preventing further infections once the index person on treatment is HIV suppressed (Cohen et al. 2012). How can such effective public health interventions be made accessible to communities with a clear balance for both individual and group benefit?

In a similar public health interest to control or eliminate new HIV infections, one could ask whether every person tested HIV negative should be compelled to choose a mechanism of protecting themselves from infection. Would this be necessary and proportional?

Further to this, since the key for any decisions regarding HIV needs testing as an entry point for decision making, one could ask whether HIV testing should be made mandatory for public good, or should it remain the individual decision regardless of whether some who are infected will never agree to be tested and remain a node of potential further spread of infections depending on their decisions or lifestyle?

16.4 Examples of Application of Public Health Ethics Principles

16.4.1 Ebola

The Ebola outbreak in West Africa (2014–2016) raised the question on what should be the most appropriate ethical choices in a public health emergency (Center for Disease Control 2016). This outbreak demonstrated the application of the principles of solidarity, necessity and common good by the health workers who risked their lives through their work in trying to offer preventive services, treatment and support to Ebola patients. In these extreme conditions the principle of solidarity cannot be regarded as a normal ethical obligation, but it should rather be described as ethical super-obligation. Dealing with highly infectious diseases requires the identification of the least intrusive and yet most effective, appropriate public health interventions from a range of means for disease control and containment of infections. Mass quarantine has drastic, immediate and long-term social and economic consequences for a country and should be a last resort only, especially when contact tracing and follow-up are inadequate from an ex-ante perspective (Magnusson 2017). In this context public health ethics and rights are complementary; both ought to be informed by evidence from epidemiology and social health science.

The principle of solidarity and common sense also requires that countries notify WHO on an outbreak of public health emergencies of international significance (International Health Regulations 2005) and that it notifies its people.

The principle of community engagement is very crucial in public health intervention when a disease like Ebola can be transmitted through cultural practices like funeral rites.

16.4.2 HIV

Another critical area in public health is the prevention of mother to child transmission (PMTCT) of HIV. This is fraught with ethical issues starting from the use of the PMTCT term itself that has been argued as being stigmatising for the HIV positive mothers; it should rather be termed prevention of parent to child transmission. The available evidence indicates that women who are negative at the start of the pregnancy but become positive during the course of the pregnancy are much more likely to transmit HIV to their newborn; this has led to repeat testing during the course of pregnancy after testing in early pregnancy (Drake et al. 2014).

It also raises questions on the male partners of the pregnant women, specifically whether they should be tested for HIV in order to protect HIV negative pregnant women and their unborn children from possible HIV infection. How do the public health facilities bring/invite the men to the clinic for HIV testing for public good in a manner that is considerate for the public good and is beneficent and just while respecting their autonomy? Can one use the principle of consideration and common good to convince the men to be tested for the good of their partners and unborn infants or is ethical reasoning based on the idea of reciprocity ("I test because the partner tests") or assumption of personal responsibility for one's health more convincing?

As far as the pregnant woman is concerned most programmes in SSA have adopted an opt-out option of PMTCT (Bolu et al. 2007), where testing is the norm unless the pregnant woman communicates that she does not wish to be tested.

This requires time and resources for provision of information in a transparent and open manner, health workers that are willing to accept a dissenting opinion and an environment that allows respect for privacy and confidentiality. However, when fear of stigma and domestic violence can be reasons for refusal of HIV/Aids testing (Turan et al. 2011), it also raises concerns about the "autonomy" of the decision of the pregnant woman and shows that public health interventions need to consider a broader range of means and effects.

16.4.3 Vaccination Programmes

Another context in which the principle of solidarity, necessity, common sense and common good is crucial involves the issue of herd immunity in disease prevention and immunisation, e.g. against measles. Herd immunity means that an outbreak of a contagious disease is unlikely once a critical portion of a community is immunised against the disease. Without solidarity herd immunity is not achievable. While herd immunity is an important target to reach so that the majority of children are protected from specific infections, each child's health needs and welfare ought to be balanced with the needs or welfare of other children (Gostin 2015). According to public health ethics each intervention has to be responsive to public health needs of the population and the community guided by the ethical principles and rights so as to make the intervention value-based and evidence based.

16.4.4 Smoking

For an individual, smoking is (initially) a choice, but the interest of the public good and public health requires the provision of information like listing or even visualising the harms of smoking on packages and high taxes for tobacco products in many countries. Apart from sufficient information for the individual to make an informed and responsible decision many countries have banned smoking in public places or limited smoking of tobacco products to specific locations with good ventilation to reduce exposure to side steam smoke in the interest of public health (Frazer et al. 2016). This is in consideration of common good.

16.5 Conclusion

In conclusion with limited resources and infrastructure, diverse populations and the dual burden of both communicable and non-communicable disease, the implementation of health care with a public healthcare ethical framework remains challenging for most of SSA countries. National governments have adopted and signed the international public health frameworks for a public health approach and human rights implementation. However, the reality at ground level remains one which still needs to be done to reach the goals of achieving the principles of public health ethics in the implementation of programmes for health care.

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Further Reading

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Chapter 17
Ethics and Public Health – A South African Perspective

Suraya Mohamed

Abstract The aim of this chapter is to discuss ethical considerations from a public health perspective in South Africa as distinct from medical ethics. The ethical principles of autonomy, beneficence, non-maleficence and justice as practised in clinical medicine cannot always be applied to public health situations as the philosophy is different. After the introduction, the first section of this chapter focuses on the meaning of public health. Public health is directed at the broader population or communities and therefore, moves beyond health care and medicine to address the social determinants of health. Public health attempts to address issues of inequities, social justice and human rights to promote and protect the health of populations. The second section of the chapter focuses on defining public health ethics. In the third section, some key public health ethical frameworks and related principles used in decision making and justifications for public health action are described, highlighting their similarities and differences. The fourth section focuses on the current dilemmas around public health ethics in South Africa using case studies as illustrations. The chapter concludes by underscoring the relevance of public health ethical frameworks for healthcare professionals of all disciplines. The importance of including public health ethics in their training is also emphasised so that they can make it explicit in their practice.

Keywords Public health ethics · Frameworks and principles · Paternalism · Autonomy versus common good · Moral considerations · Health promotion and protection

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17.1 Introduction

There is growing support for the view that the core principles of public health (to improve equity, ensure social justice and human rights) should guide the efforts to achieve universal health coverage and promote sustainable development. The doctor-patient relationship is at the centre of medicine, focusing on restoring health diagnosing and treating illness at an individual level, whereas the emphasis of public health is on the population level. Therefore, the ethical principles of autonomy, beneficence, non-maleficence and justice as practised in clinical medicine cannot always be applied to public health as "… the philosophy that underlies public health differs from that of clinical medicine" (Upshur 2002, p. 101).

The aim of this chapter is to discuss ethical issues that need to be considered from a public health perspective as distinct from medical or clinical ethics.

17.2 What Is Public Health?

The goal of public health is to ensure that the conditions in which people enact their lives can be conducive for them to reach their optimal health to live a productive life. Public health is directed at the broader population or communities moving beyond personal health care and medicine to address health systems and the social determinants of health. The health needs of communities and the social determinants impacting on their health must be analysed and it is important that social justice contributes to the public's health (Childress et al. 2002). The social determinants of health may occur concurrently at different levels of influence, such as the social, structural and political context. Public health therefore covers a range of population-based preventive, promotive, protective, curative and rehabilitative measures. As a result, public health needs to have interactions with healthcare professionals from different disciplines, as well as with different sectors of government and community members to preserve the health of the population. In fact, many of the measures to preserve population health lies beyond the control of the health sector and also require government interventions such as taxation (Childress et al. 2002).

17.3 What Is Public Health Ethics?

The moral dilemmas of public health extend beyond the boundaries of clinical ethics and therefore public health ethical considerations should be viewed differently (Callahan and Jennings 2002). According to Faden and Shebaya (2016): "Public health ethics deals primarily with the moral foundations and justifications for public health, the various ethical challenges raised by limited resources for promoting health, and real or perceived tensions between collective benefits and individual liberty" (p. 1). Public health ethics are informed by the nature of public health; it is a public good, it focuses on prevention, it often involves government action and it is outcomes oriented.

Historically, public health roots have sometimes been seen as being in paternalism and coercion such as hygiene and sanitary measures for the prevention of cholera quarantining of people during epidemics. According to Anker (2016), public policy is "… paternalistic insofar as it interferes with citizens' ability to choose or otherwise pursue their personal ends in their own best interest and without their consent" (p. 2). This is not dissimilar to clinical medicine, where on an individual level, healthcare professionals see themselves as knowing "what is best for their patients". However, paternalism can be justified because individuals and groups may be able to avoid some harm to their own health but do not have the power or capacity to change what is beyond their control, such as poor water quality or air pollution. On the other hand, the government can easily control issues to safeguard the public's health through coercion such as mandatory immunisation of children or forced isolation to spread an infectious disease. There are certain public health regulations in South Africa such as the fluoridisation of water, compulsory wearing of seatbelts in motor vehicles, helmets for cyclists and the proposed reduction of sugar content in sugar-sweetened beverages which serve as health protection where decisions have been made on behalf of the population.

There are various ways to achieve public health outcomes. However, it is important that justification be given especially when coercive measures are being employed in the prevention of harm to the population. Recently various frameworks, which will be discussed next, have been developed to guide ethical decisions made in public health. These frameworks are different from those of the individualistic medical ethics field. "Frameworks generally serve as guides, highlighting issues and values that would be relevant in a particular situation, and they encourage deliberation. In contrast to theories, frameworks are tools that are more intended for daily practice" (Keeling and Bellefleur 2016, p. 5). In public health it is crucial to find the appropriate framework for a specific context so that the main issues can be identified and decisions can be made and justified.

17.4 Frameworks for Public Health Ethics

17.4.1 An Ethics Framework for Public Health

An ethics framework that is often used in public health is one by Nancy Kass (2001). The framework is presented in six steps when making and justifying decisions around a public health action. Kass (2001) lists these steps in the form of questions as follows:

1. *What are the public health goals of the proposed programme?*
   This should be articulated in terms of health outcomes and/or addressing social inequalities. Formulating the goal will help with prioritising where the focus should be for the public health action.
2. *What are the proposed interventions? How effective is the programme in achieving its stated goals?*
   This is the step where planning starts and needs to be supported by evidence of its effectiveness. Proposed interventions are based on certain assumptions made about what is meant to be achieved. These assumptions need to be interrogated with available evidence. However, strong evidence is not always available and judgements will have to be made as to how much evidence is needed and whether in fact it is needed to justify a programme, especially if there is serious threat to the public's health.
3. *What are the known or potential burdens of the programme?*
   This is the step where all the harms need to be identified especially, who is disadvantaged and how are they disadvantaged? Kass (2001) places risks into three main categories namely: (i) risk to privacy and confidentiality; (ii) risk to liberty and self-determination (freedom of choice); and (iii) risks to justice where burden is not equally distributed (more harm done to some than others).
4. *Can burdens be minimised? Are there alternative approaches?*
   Once a harm has been identified, it is ethically obligatory to find alternatives which are less harmful.
5. *Is the programme implemented fairly?*
   This is where the balance between burdens and benefits are fairly distributed. This does not mean, for example, that resources should be allocated equally, but rather that it can be done unequally in favour of those most disadvantaged to right the inequities in health in the name of social or distributive justice. This becomes important when attempting to address the social determinants of health. Public health ethics look beyond healthcare to consider the social determinants of health that promote or inhibit the optimal attainment of the health of populations. When considering inequities in health status within populations and access to health care, the issue of resource allocation becomes an ethical issue. For example, the public health practitioner has to make a value judgement about the smaller benefits for the quality of life for a big quota of the population (e.g. immunisation) as equated to a life-saving intervention that would profit only a few individuals (e.g. organ transplant).
6. *How can the benefits and burdens of a programme be fairly balanced?*
   Here judgment has to be made about the extent to which benefits outweigh burdens or risks. There will be differing opinions on how burdensome an action might be and, therefore, it is important to reach decisions fairly. The community, including minority or vulnerable groups and those affected, need to be actively engaged to balance competing opinions in what is termed procedural justice. The greater the burdens placed on individuals and communities, the greater the need for transparency and justice.

17.4.2 Public Health Ethics: Mapping the Terrain

Although not referred to as a framework, the "general moral considerations" suggested by Childress et al. (2002) are similar to some of the principles in other public health ethics frameworks and are listed by Childress et al. (2002, pp. 171–172) as:

1. *Producing benefits;*
2. *Avoiding, preventing, and removing harms;*
3. *Producing the maximum balance of benefits over harms and other costs (often called utility);*
4. *Distributing benefits and burdens fairly (distributive justice) and ensuring public participation including the participation of affected parties (procedural justice);*
5. *Respecting autonomous choices and actions, including liberty of action;*
6. *Protecting privacy and confidentiality;*
7. *Keeping promises and commitments;*
8. *Disclosing information as well as speaking honestly and truthfully (transparency); and*
9. *Building and maintaining trust.*

However, even though public health is meant to be grounded in these moral considerations, certain public health measures might cause tension as some of the considerations might be in conflict with one another. For example, when setting priorities, should the worse off be given the most benefit? When do only a few benefits to many people outweigh significant benefits to fewer people? Furthermore, distributing benefits and burdens evenly might impose on the autonomy of individuals to make choices about their health. In order to overcome such tensions, Childress et al. (2002) propose five "justificatory conditions" meant to justify the proposed decisions made for a certain public health action:

1. *Effectiveness*
   The public health measure needs to be justified by showing that even though the action might infringe on one or more of the moral considerations, it will most probably still protect the public's health and therefore, will be effective.
2. *Proportionality*
   All the probable benefits and positive effects of the public health measure needs to be weighed up against the costs and negative effects (harm) to show that the positive effects (benefits) outweigh the negative effects.
3. *Necessity*
   A particular public health action might not be the only way to find a solution to a particular public health issue, especially if it infringes on the moral considerations and is coercive. Therefore, alternatives also need to be sought which might be less intrusive morally. If no alternative is possible, then sufficient justification should be made as to why the coercive approach is necessary.

4. *Least infringement*
   Public health practitioners should choose the least intrusive and least restrictive alternatives to a particular action.
5. *Public justification*
   Public health practitioners have a responsibility towards the public they serve, especially if coercive means are used in public health policy infringing on certain moral considerations. It is therefore imperative that they justify and explain to the public and other relevant stakeholders why they will be infringing on these considerations (e.g. freedom of choice). The public should be treated with respect and as equals which will ensure accountability, transparency and build trust (referred to the transparency principle in some literature).

17.4.3 Principles for Justification of Public Health Interventions

Upshur (2002:101) idenitied four principles in his framework, namely:

1. *Harm Principle;*
2. *Principle of Least Restrictive Means;*
3. *Reciprocity Principle; and*
4. *Transparency Principle.*

Principles 1, 2 and 4 have similar properties to the previous frameworks. The reciprocity principle in this framework is meant to be used when people are expected to comply with the public's health, even if they incur some risk but should be supported and compensated for doing so by the relevant authorities.

17.4.4 Tannahill Framework

In the above frameworks, there is great emphasis on the liberties of the individual and what needs to be done so as not to infringe on these liberties as far as possible. Tannahill (2008), in addition to principles already alluded to, although the terms might be slightly different (Do good, Do not harm, Equity, Respect, Participation, Openness, Accountability), provide additional principles which are oriented towards the values of general health promotion and health improvement.

1. *Empowerment*
   Empowerment, which is one of the key principles of health promotion, can be related to "autonomy, enabling, health literacy, self-efficacy", but also to "community development, solidarity and cohesion" (Tannahill 2008, p. 386). It is about helping individuals and communities to have more control over the

conditions that influence their health and to create opportunities for them to improve their health and well-being.

2. *Sustainability*
   Sustainability relates to long-term effectiveness, to the environment, to citizenship and to accountability. This means making sure that public health actions are sustainable, recognising that sustainable health enhancement will require the protection of resources and the environment and the active involvement of the citizens. Here the sustainable development goals should also be considered.
3. *Social* responsibility
   Social responsibility relates to solidarity, citizenship, environment, community and accountability. Social responsibility is important for the improvement of population health and for addressing inequities. Businesses, organisations and the community, among others, should be encouraged to be involved in social responsibility activities.

The next section will endeavour to illustrate how the aforementioned frameworks can assist in the decision-making process in terms of the laws, policies and public health measures, which have been introduced through the introduction of various case studies. Questions are posed after each case study to assist with critical thinking and reflection of the case study.

17.5 Case Studies of Ethical Issues in Public Health

17.5.1 Forced Isolation for Drug-Resistant Tuberculosis

One ethical issue faced in public health is the effort to contain the spread of infectious diseases. Isolation and quarantine for tuberculosis (TB) have been used to protect the public's health. The following is an extract from an article in *The Lancet* titled*:* "Forced isolation of tuberculosis patients in South Africa highlighting the contentious control measure of involuntary confinement":

> *The recent shooting of a tuberculosis patient at Johannesburg's Sizwe Tropical Diseases Hospital in South Africa, after a protest about conditions turned violent, has raised the contentious issue of forced isolation of patients being treated for resistant forms of the disease* (Baleta 2007, p. 771).

The shooting incident occurred when multi-drug resistant (MDR) and extremely drug-resistant (XDR) TB patients protested about the treatment and conditions under which they were confined comparing it to being in prison. Similarly, in Cape Town, patients escaped from Brooklyn Chest Hospital and faced a court order brought by health authorities forcing them back until their treatment was completed. XDR-TB patients are resistant to ordinary drugs used for TB treatment and only have a 50% chance of being cured. Some justify that isolation is necessary for the protection of the public while others argue that it not only infringes on the right of the individual but it also has consequences for the incumbent's family and livelihood.

Health laws stipulate that patients with infectious diseases can be confined until they no longer pose a threat to the public's health. However, in the case of XDR-TB, this can mean prolonged confinement, in some cases even until death.

The harm principle can be argued for in this case because to protect the health of the collective as a public good can be weighed up against the harm to the individual. However, the argument against forced isolation is that it violates international human rights law and many rights set out in the South African Constitution. When applying the least restrictive means principle, confinement should only be considered when all other efforts have been exhausted such as education, directly observed therapy, adequate housing and nutritious food supply, social support, failing which, voluntary isolation and forced isolation as a last resort. With the high rates of HIV and threat of co-infection in South Africa, isolation was even more of a consideration. However, the risk was that patients deterred from seeking treatment to avoid forced confinement. They feared losing their jobs or social grants (patients did not receive social grants while in isolation), thereby increasing the threat of infection to the population. Another argument against this measure was that undiagnosed patients were inevitably spreading the disease before they were diagnosed (which could take up to 8 weeks) and eventually treated. The threat of nosocomial infections (infections acquired during hospitalisation) was also claimed to be a threat with poor infectious control to contain the spread of TB in public health facilities.

There might be occasions where isolation is the only alternative to control the spread of XDR-TB, but the ethical imperative would be to encourage the patient to *volunteer* for isolation if possible, instead of being coerced. By employing the principle of reciprocity the process can be facilitated by articulating what support the government, the health system and society can give to the patient (transparency and accountability) and in turn how the patient, by being isolated and bearing the burden, can contribute to benefiting the community in protecting their health. Care should also be taken to apply fairness (distributive justice) so as not to discriminate against patients in the public sector who are predominantly poor and often black or coloured. Some white patients and healthcare workers with drug-resistant TB have been known to be treated as outpatients and not in confinement, highlighting inequity.

In a report in *IRIN PlusNews* (23 March 2007), an international network that reports on humanitarian issues, Dr. Eric Goemaere, head of Medecins San Frontieres (MSF), related a story of a single mother in Cape Town who had MDR-TB and was quarantined in hospital in spite of her objection that there was no-one caring for her four children. She left the hospital, having failed to complete the treatment and her children had also developed MDR-TB by then. Dr. Goemaere made the following suggestion in the report: "Instead of focusing on pushing and locking away people, we should see if we can leave them in their home environment, or provide isolation close to where they live, and tackle infection control and adherence issues".

Once again, in this case study, there are conflicting issues of containing a severe infectious illness through restricting individual choices in isolating those with MDR or XDR-TB without due regard for prevailing circumstances which is beyond the control of the individual.

Questions

1. What burdens could such public health measures impose on individuals and their families in quarantining drug resistant patients (economic, social, etc.)?
2. Does it help to quarantine those with XDR after detection and on treatment?
   - Can the health authorities be seen to be acting swiftly on the serious threat of disease to the population without due regard for balancing all the risks and benefits?
3. Is there another alternative to forced isolation and still tackling TB infection?
   - What risks/costs and benefits should be weighed up?
   - Who needs to be involved in that decision?

17.5.2 Foreign Nationals and Healthcare (Alfaro-Velcamp 2017)

Immigrants and refugees have varying degrees of access to health care in South Africa. There is a mismatch between what is in the South African Constitution with regard to access to health care, the various immigration laws and regulations and what is currently being practised in public health facilities. According to the Immigration Act of 2002, healthcare providers should first ascertain whether the foreign national seeking care has the legal documentation that allows them to be in the country before they can treat them and they are meant to report those who do not have the necessary documentation. According to this Act, the healthcare provider can be convicted for treating an "illegal" foreign national. However, it goes against the Constitution which stipulates the right to health care for all (which some argue means not only South African others who are legally in the country), the United Nations' Declaration on Human Rights, and also against the healthcare providers' code of ethics to treat all patients needing care. The denial of healthcare services can compromise the health of patients in need of treatment such as antiretroviral treatment and thus putting others at risk too.

Foreign nationals seeking access to healthcare face challenges such as hospital managers weighing their options because of scarce resources; service providers not knowing or lacking clear understanding of the various regulations related to access to healthcare services for foreign nationals; xenophobic attitudes of service providers; and the misconception that foreign nationals are depleting the resources in the country. On the part of foreign nationals, barriers such as language and culture, not understanding how the health system operates and legislation that is confusing, affect their access to healthcare.

Questions

1. How do the principles of do good, do no harm, equity, respect and empowerment play out in this case study?
2. What are some of the justificatory conditions that could be argued for in this case? How does this relate to the principle of sustainability when non-treatment places others at risk?
3. How ethical is it for the administrators of hospitals to make the decision whether a foreign national should receive treatment or not?

17.5.3 South African Breweries Scheme to Feed Hungry Students

Food insecurity at tertiary institutions in South Africa has come under the spotlight and has been cited as an emerging public health issue. This case study highlights the ethical issues arising when the South African Breweries (SAB) launched a new eight pack of beer sourced from different countries across Africa. The company claimed that this initiative not only intended to support agricultural development in those countries but also to feed hungry students by partnering with Stop Hunger Now SA (SHNSA), an international, non-governmental organisation which provides meals to people in need. They publicised that they would provide a meal for three students for every beer pack sold. The South African Alcohol Policy Alliance (SAAPA) together with Schools of Public Health in the country, the Public Health Association of South Africa (PHASA) and South African Civil Society for Women's, Adolescents' and Children's Health (SACSoWACH) voiced strong concern over this initiative, especially as alcohol abuse has often been reported as a problem among South African youth. Excessive alcohol consumption not only causes individuals health damage but also underpins much of the violence in countries. They acknowledged that hunger was a huge public health issue, but so was alcohol abuse, and the initiative was seen as a marketing ploy for the sale of the beer. After a public campaign against the initiative, the SAB withdrew it. On the positive side, SAB's support for the students' meals continued despite the withdrawal which can be seen as SAB's act of social responsibility.

Questions

1. How ethical is it for a company to make food security dependent on consuming alcohol? Which ethical principles does it conflict with? For example, does it "sit well" with do good, do no harm, equity, respect and sustainability?
2. What would the consequences have been had there been no intervention from SAAPA and others? Are there other alternatives that are ethical?
3. If there are no other alternatives, would it be worthwhile and ethical to accept the SAB offer as long as it was not conditional on alcohol purchase?

4. What ethical principles should be considered to accept or reject future contributions or sponsorship by an industry to address public health problems?

17.5.4 Deaths of Mentally Ill Patients (Office of the Health Ombud 2017)

South Africa has good mental health policies but the implementation thereof are challenging. Individuals who present mental health issues are at large still marginalised within the healthcare system as the following case of the biggest mental health scandal in South Africa to date demonstrates. The death of a large number of mentally challenged patients caused a major outcry when they were moved from the Life Esidimeni care facilities to various Non-governmental organisations (NGOs). The Health Ombudsman's Report into the matter found several violations of the patients' rights and dignity and unethical practices of those in authority. A total of 94 patients died between March and December 2016 with more deaths reported since in Gauteng Province. Many of the causes of death were preventable and were all indications of neglect. The transfers "… violated the Constitution and contravened, the National Health Act (NHA) (Act No. 61 of 2003) and the Mental Health Care Act (MHC) (Act No. 17 of 2002). Some executions and implementations of the project have shown a total disregard of the rights of the patients and their families …" (Office of the Health Ombud 2017, p. 2).

Some of the findings included:

- The speed with which the contract with Isidimeni was terminated could not be justified nor the cost rationale above the rights of the patients to dignity and access to health care.
- All 27 NGOs to which patients were transferred did not have valid licenses. The NGOs had sub-standard caring environments for these patients who needed specialised care and also for co-morbid conditions.
- Transfers occurred despite "widespread professional, expert and civil society stakeholders' warnings and advice" (p. 2).
- Families were not provided with information about the transfers.
- Key authority figures were highly implicated in the report including the MEC for Health. The MEC resigned just hours before the report was to be released which implies that she was evading accountability.

Questions

1. Despite the Constitution, legislations and warnings of Esidimeni's staff, the MEC still ordered the transfer of the patients.
    - To what extent should she be held liable for human rights violations?
    - What does the transfer process reveal about accountability and transparency within the Department of Health?

2. The main reason for moving the patients was for cost efficiency. How should financial interests be deliberated in public health when decisions have to be made?
3. What other ethical considerations should have been taken into account before the transfer of patients?

17.5.5 Tobacco Control in South Africa (Ayo-yusuf 2011)

Smoking carries the burden of illnesses such as respiratory conditions, certain cancers and risk for non-communicable and cardiovascular diseases. Second-hand smoking is another threat. Smoking also comes with socio-economic burdens as increasing poverty has been associated with tobacco use. Furthermore, "… the cost of treating tobacco-related diseases have been found to outweigh any economic benefits that may be assumed to accrue to any government" (Ayo-yusuf 2011, p. 1).

Several policy initiatives have been progressively and successfully implemented in South Africa since the introduction of the Tobacco Controls Act 1993. The policies included smoke-free public places, no tobacco advertising and sponsorship, health warnings on cigarette packaging and increased taxes. However, even though there has been a decline in smoking, it has plateaued at 20% for the last couple of years. The need for further regulations was therefore proposed and includes banning of sale of cigarettes at shop counters, banning cigarette dispensers and standardised plain packaging. However, there were some objections to further restrictions. The Gauteng Liquor Forum argued that harsher smoking laws would drive more patrons to illegal shebeens (unlicensed bars) where smoking might not be regulated.

South Africa is recognised as a global leader in formulating and implementing measures for tobacco control and became a party to the WHO Framework Convention on Tobacco Control on 18 July 2005. What made the policy initiatives effective were strong advocates who worked with healthcare professionals and researchers, the identification of supporters and those against tobacco control in the political arena and continuous communication by exchanging information, including research findings with them. The economic aspects such as increased taxes and the evidence of the cost benefit of reduced tobacco use also influenced the effectiveness of the policies.

Questions

The following statement was made in the *Daily Maverick* on 20 July 2015 by L. Vegter when additional legislation was proposed by the current Minister of Health:

> *Motsoaledi has built the mother of all slippery slopes to nanny-state fascism, and it starts with tobacco products.*

1. What moral justifications can be made to counter this statement?
2. To what extent should public health authorities interfere with personal choice?

17.5.6 Choice on Termination of Pregnancy Act

Abortion is legal up to 20 weeks of gestational age in South Africa. In South Africa the Choice on Termination of Pregnancy Amendment Act (CTOP) of 2008 allows abortion at any age, with permission necessary only from the client as long as the client is fully aware of the consequences of her decision. Termination for gestational age 12 weeks and below is purely by choice. From 13–20 weeks it is allowed if a clinician certified this is needed, including on socio-economic grounds. Above 20 weeks, it is highly restricted. Providers are permitted to refuse to perform an abortion, but are required to refer the client to a willing provider. Ultrasound is not mandatory, as provider estimations have been found to be sufficient. Counselling that could be interpreted as discouraging a client of making her own free choice is not allowed. The South African Constitution enshrines reproductive rights (section 12). The number of poor, black women dying or having serious complications as a result of unsafe, illegal abortions was established as a key equity issue. Prior to 1996 wealthier, white women had greater access to safe, legal abortions. These two factors underpinned the passing of the Act. Mortality and morbidity rates from unsafe abortions decreased by 91% between 1997 and 2002.

The following fictitious case study illustrates how individual rights are at times difficult to assert given conflicting moral and legalistic views of professionals. A 16-year-old school girl approached a health centre for an abortion. The first provider refused to deal with her and made no effort to refer her. She considered going to one of the providers listed on the public billboards which promised a quick, safe abortion at any gestational age. However, she decided against this and approached another health centre, given the fact that she was still under 20 weeks in gestational age. One provider tried to persuade her to bring her parents, but she said she did not live with her parents and did not want them to know about the pregnancy. The girl approached another provider who wanted to have an ultrasound to show the foetus and counsel her on keeping the pregnancy and having the baby adopted. The girl resisted this and successfully had a safe abortion at 19 weeks gestational age—three weeks after her first attempt. Not having had the procedure may have meant she had to leave school or interrupt her schooling and she most likely would have had socio-economic challenges in raising the baby with no or little support from her parents.

Questions

1. In what way does the CTOP Act uphold individual rights rather than possible group rights?
2. What are the ethical issues involved in terms of do no harm, equity etc.?
3. Based on the case study above, how sensible or not is the “no age” restriction?
4. In what way may it be unethical to force the girl to look at an ultrasound and be counselled against terminating?

17.6 Conclusion

Public health actions invariably give rise to tensions, especially when there is conflict between individual rights and the common good for the population and often create ethical dilemmas. Of the cases presented, the tobacco control and abortion policies seem to have positive effects while the rest do not seem to be as effective. Therefore, there is a need to carefully reflect on public health actions and policies through ethical analysis. In this way, moral and ethical challenges can be identified and better understood. By doing so, there will be a better chance of accountability, transparency and resultant trust, especially of the public it serves. Once trust and participation of those affected/marginalised/vulnerable groups are established, there should be better opportunity to resolve tensions or justify actions which are paternalistic. What is most imperative is that the core principles of public health—equity, social justice and human rights should guide all public health ethical decision making for the optimal health of the population it serves.

Public health ethics training of healthcare professionals of all disciplines are essential to ensure that they can analyse the extensive range of public health ethical issues and challenges beyond their own professional codes of ethics. They should be able to reflect on how taking a public health versus a clinical perspective affects their thinking and reasoning about a health problem. The training will enable them to feel more confident when it comes to addressing the issues they will encounter as that goes beyond the healthcare practitioner and patient relationship. They will also be able to question decisions made by authorities that they feel are not ethical and justify their own actions using an ethical framework as a tool. Ethical considerations are what every health practitioners should make explicit in the way they work.

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Chapter 18
Curriculum Guidelines for Teaching Healthcare Ethics at Undergraduate Level

Willem A. Hoffmann and Nico Nortjé

Abstract Undergraduate courses in healthcare ethics should primarily focus on taking students on a journey that facilitates growth in the theoretical and practical areas of deliberation and ethical decision-making skills. A sound knowledge of the most prominent moral theories, together with knowledge of widely-recognised bioethics principles and medical law principles should underpin the course content. Ultimately healthcare ethics courses should result in skills that will empower students to effectively function in their specific professional healthcare fraternities. The first section of this chapter describes the rationale for the inclusion of four broad learning units. Each of these learning units will be subdivided into one or more modules. The Ethics principles learning unit includes the following modules: (1) Overview of ethics; (2) Moral theories; (3) Fundamental ethics principles; and (4) Clinical research ethics. The Ethical reasoning learning unit consists of only one module, while the Professional skills learning unit includes the following two modules: (1) Professionalism; and (2) Communication. The Legal considerations in healthcare learning unit consists only of a Medical law module. The second section of this chapter focuses on a description of each module's specific learning outcomes. The aim of these learning outcomes is to ensure that healthcare students acquire knowledge, skills and attitudes that achieve deep learning and fundamental understanding of ethical principles, ethical reasoning, professional skills and medical law principles. The third section of this chapter focuses on a description of the assessment tasks that can be used in dynamic interaction with theory and practice throughout the undergraduate healthcare ethics course. The various assessment tasks focus on evidence-based endeavours to determine and establish the extent to

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which students have internalised the required sets of knowledge, skills and attitudes regarding ethics concepts and principles, ethical reasoning, professional skills and legal considerations in healthcare.

Keywords Moral theories · Ethics principles · Ethical reasoning · Professionalism · Medical law

18.1 Introduction

In their striving to render optimal patient care healthcare practitioners are faced with increasingly complex professional and ethical challenges in increasingly complex societies. This is linked with rapid developments in technology and the worldwide increase in patient rights awareness (De Bree 2015). Globally the early years in formal ethics education, namely the 1970s, were characterised by great variability in course objectives, course content, teaching methods, assessment strategies and educator experience (Arnold and Forrow 2004). Nowadays it is widely recognised that the development of effective and comprehensive healthcare ethics courses depend on clearly formulated course objectives ("why"), relevant content selection ("what"), optimal course delivery methods and learning activities ("how"), and valid assessment strategies (De Bree 2015; Medeiros et al. 2017).

A key objective of undergraduate healthcare ethics courses is to facilitate the academic journey of healthcare students towards personal and professional growth, specifically to obtain sound knowledge of the theoretical and practical areas of ethics principles, ethical reasoning, professional skills and medical law principles. Ultimately, undergraduate ethics courses should empower healthcare students with skills to effectively function in their specific professional healthcare fraternities, healthcare service contexts and the larger community (HPCSA 2006). The specific objectives of undergraduate healthcare ethics programmes should include the following:

- to empower healthcare students with theoretical knowledge and insight in moral theories, ethics principles and legal aspects applicable to their profession-specific healthcare contexts (De Bree 2015; HPCSA 2006; Moodley 2007);
- to empower healthcare students with critical reasoning skills to identify, analyse and resolve complex ethical dilemmas in clinical care and practice (Arnold and Forrow 2004; Barilan and Brusa 2015; De Bree 2015; HPCSA 2006; Medeiros et al. 2017; Moodley 2007);
- to empower healthcare students with professional skills, values and attitudes to effectively function as full members of multidisciplinary healthcare teams (HPCSA 2006); and
- to empower students with an awareness of national and global ethics challenges in the provision of healthcare services (HPCSA 2006).

18.2 Learning Units and Modules

This section outlines a curriculum framework for a healthcare ethics course at the undergraduate healthcare training level. Healthcare ethics courses for medical and pharmaceutical science students in the Southern African region and the African continent are already relatively well-developed. As such, the curriculum outline is specifically applicable to the following healthcare professions: occupational therapy, dietetics, psychology, social work, physiotherapy, nursing, environmental health, radiography, clinical technology and public health. The development of specific course content for the respective learning units and modules should be duly informed by each of these professions' future work environments (Medeiros et al. 2017).

The curriculum framework for healthcare ethics courses at undergraduate level (Table 18.1) consists of four dynamic and interrelated fundamental learning units: (1) Ethics principles; (2) Ethical reasoning; (3) Professional skills; and (4) Legal considerations in healthcare each of the learning units should ideally follow a systematically linear approach across the undergraduate study years. The focus and intensity of the content gradually increase as students become more familiar with ethical principles, reasoning skills, professional skills and legal principles. Initially the focus is on factual content that is regularly revisited with increased levels of complexity and integration. In addition, students are increasingly exposed to the relevant ethical issues in profession-specific clinical contexts with each subsequent academic year. Ultimately the students should master a progressive understanding, application and integration of knowledge and skills, specifically in the use and application of ethical reasoning skills in dealing with ethical dilemmas and issues regarding professional conduct, patients' rights, clinical research and medical law (Arnold and Forrow 2004; Barilan and Brusa 2015; De Bree 2015; Moodley 2007).

18.2.1 Learning Unit: Ethics Principles

The *Ethics principles* learning unit includes four modules: (1) Overview of ethics; (2) Moral theories; (3) Fundamental ethics principles; and (4) Clinical research ethics.

Many undergraduate healthcare students have not been exposed to any formal ethics training prior to their university studies and are not familiar with the history and jargon of ethics. As such, the primary aim of the *Overview of ethics* module (Table 18.1) is to introduce students to the history of ethics, basic concepts and prominent international codes of ethics (Knox 2017). An overview of the history of ethics from ancient times to today raises awareness regarding the importance of ethics in global and regional contexts, as well as the development and depth of morality and ethics thinking in healthcare (Van Niekerk 2017). Students need to gain an understanding of the definitions and relationship between basic concepts such as ethics, morality and law early in the healthcare ethics course; these concepts overlap

Table 18.1 Curriculum framework for undergraduate healthcare ethics course

Learning unit	Module content
UNIT 1: Ethics principles	**Module 1: Overview of ethics**
	1. Overview – history of ethics
	2. Introduction to morality, values, ethics and law
	3. Overview – prominent international codes of ethics
	Module 2: Moral theories
	1. Deontology
	2. Utilitarianism
	3. Virtue ethics
	4. Social contract theory
	5. Liberal individualism (human rights)
	6. Principlism
	7. Communitarianism and African philosophy (Ubuntu ethics)
	8. Ethics of care (feminism)
	9. Casuistry
	10. Theory of justice
	Module 3: Fundamental ethics principles
	1. Human dignity
	2. Beneficence
	3. Non-maleficence
	4. Autonomy
	5. Privacy and confidentiality
	6. Informed consent
	7. Vulnerability and personal integrity
	8. Equality, justice and equity
	9. Non-discrimination and non-stigmatisation
	10. Cultural diversity and pluralism
	11. Solidarity and international cooperation
	12. Social responsibility and global health ethics
	13. Benefit-sharing
	14. Protection of future generations
	15. Protection of the environment, biosphere and biodiversity
	Module 4: Clinical research ethics
	1. Overview – History of research ethics and research atrocities
	2. Principles of Good Clinical Practice
	3. Research integrity and research misconduct
UNIT 2: Ethical reasoning	**Module: Ethical reasoning**
	1. Critical thinking, critical reasoning and critical self-reflection
	2. Ethical decision-making models

(continued)

Table 18.1 (continued)

Learning unit	Module content
UNIT 3: Professional skills	**MODULE 1: Professionalism**
	1. Characteristics of professionalism
	2. Professional codes of conduct
	3. Professional misconduct
	4. Self-awareness of burnout and self-care
	MODULE 2: Communication
	1. Verbal communication
	2. Non-verbal communication
	3. Interpersonal conflict
UNIT 4: Legal considerations in healthcare	**MODULE: Medical law**
	1. Basic legal terminology and principles
	2. Informed consent
	3. Confidentiality
	4. Pharmaceutical substances
	5. Healthcare malpractice
	6. Patients' Rights Charter

and are often used interchangeably (Beckmann 2017). A number of prominent international codes of ethics significantly influence local and regional ethical reflections, applications and regulations in healthcare. As such, an overview and fundamental understanding of the origin, main objectives and primary implications of each code is essential to healthcare students. The following international codes of ethics should be considered for inclusion in the healthcare ethics curriculum (Ndebele 2016): (1) Nuremberg Code (1947); (2) Universal Declaration on Bioethics and Human Rights (adopted by UNESCO in 2005); (3) Belmont Report (1978); (4) Guidelines for Health-related Research Involving Humans [most recent version prepared by the Council for International Organisations of Medical Sciences (CIOMS) in collaboration with the World Health Organisation (WHO) in 2016)]; and (5) World Medical Association Declaration of Helsinki (most recent version adopted in 2013).

A moral theory is a conceptual framework that can be used by healthcare students and practitioners to provide guidance and norms when confronted with moral problems, dilemmas and decisions in their personal and professional lives (Van Niekerk 2017). To a lesser or greater extend each moral theory provides procedures, criteria, rules and principles to determine the rightness or wrongness of specific actions (De Bree 2015). It is therefore important that the *Moral theories* module (Table 18.1) forms part of the undergraduate healthcare ethics course (Knox 2017). A fundamental understanding and integration of the origin (including sociocultural, sociohistorical and sociopolitical contexts), claims, shortcomings, strengths and implications of each moral theory is essential to healthcare students (Van Niekerk 2017). The following prominent moral theories should be considered for inclusion in the healthcare ethics curriculum: Deontology, Utilitarianism, Virtue ethics, Social contract theory, Liberal individualism, Principlism, Communitarianism and African philosophy, Ethics of care, Casuistry and Theory of justice (De Bree 2015; Knox 2017; Letseka and Ganya 2017; Van Niekerk 2017). Ethics courses in Africa often overlook the importance of indigenous African knowledge and philosophies. As such, Ubuntu ethics needs to be included as a fundamental component in any ethics curriculum taught on the African context.

The *Fundamental ethics principles* module (Table 18.1) aims to instil fundamental knowledge, understanding and integration of the most important ethics principles as encoded in the prominent international ethics codes in healthcare students (Knox 2017). Many of the current prominent ethics principles are often closely linked to human rights, for example in the Universal Declaration of Bioethics and Human Rights (adopted in 2005). Furthermore, it is important to note that in some countries human rights (e.g. the right to privacy) are legally protected and enforced by law (Beckmann 2017; Moodley 2007), for example Chap. 2 (Bill of Rights) of the Constitution of South Africa (1996). The content of the module is specifically based on the framework of the UNESCO Core Curriculum and the Universal Declaration on Bioethics and Human Rights (UNESCO 2008). The Core Curriculum indicates a wide variety of reference sources (e.g. journal articles, textbooks, video clips, casebooks) that can be used as prescribed or recommended study material in the course. An important advantage of the Core Curriculum is its focus on the principles shared by healthcare practitioners from a wide variety of social, cultural and religious backgrounds (Ten Have and Jean 2009). The following fundamental ethics principles are included in the healthcare ethics curriculum: (1) Respect for human dignity; (2) Beneficence; (3) Non-maleficence; (4) Autonomy and individual responsibility; (5) Privacy and confidentiality; (6) Informed consent; (7) Vulnerability and personal integrity; (8) Equality, justice and equity; (9) Non-discrimination and non-stigmatisation; (10) Cultural diversity and pluralism; (11) Solidarity and international cooperation; (12) Social responsibility and global health ethics; (13) Benefit-sharing; (14) Protection of future generations; and (15) Protection of the environment, biosphere and biodiversity.

Healthcare practitioners are often directly or indirectly involved in health and clinical research endeavours that target healthy volunteers and patients as research participants. These endeavours pose significant ethical challenges to balance practitioners' obligations to render optimal healthcare with strict research requirements to collect rigorous and valid scientific data (Moodley 2017). The *Clinical research ethics* module (Table 18.1) aims to instil fundamental knowledge, understanding and integration of the most important research ethics and integrity principles (Emanuel et al. 2004). It includes an overview of the history of research ethics and research ethics codes since World War II, as well as the various research atrocities that have occurred since then (Moodley 2017). Another aspect to address in this module is Good Clinical Practice (GCP). GCP refers to a set of principles to ensure that clinical trials across the world adhere to specific minimum research standards and regulations. The module should extensively cover GCP principles, specifically those related to the protection of research participants, responsibilities of the various role players (i.e. researchers and sponsors), quality assurance processes, data management, multicentred studies and research ethics committees (Moodley 2017).

It is also important for researchers to realise that the value and benefits of health and clinical research depend on the integrity of the researcher and the research process. In contrast, failed research integrity undermines researchers' trustworthiness, credibility, moral accountability and public trust. Failed integrity manifests in plagiarism, data fabrication, data falsification, misrepresentation of data, undisclosed conflicts of interest, misattribution of authorship, dishonesty, fraud, negligence, carelessness and poor procedures (Moodley 2017).

18.2.2 Learning Unit: Ethical Reasoning

The *Ethical reasoning* learning unit includes only one module, namely *Ethical reasoning*. It is important for healthcare students to develop and master critical thinking, critical reflection and ethical reasoning skills to appreciate and engage with ethical challenges and ethical dilemmas in the healthcare context (Knox 2017; Moodley 2007). The educator performs a critical role in this module to facilitate Socratic dialogues. Dialogue focuses on the facilitation of ideas and arguments among a group of students and to raise awareness of the moral complexities that confront healthcare practitioners (Knox 2017). The aim is not to divide the opinions in the group but rather to allow deep appreciation and reflection of the multiple viewpoints among them. As such, critical thinking and ethical reasoning competencies are essential skills that build on the fundamental knowledge of moral theories and ethics principles (Knox 2017) (see Sect. 18.2.1). Ethical reasoning competencies can be further strengthened by introducing healthcare students to one or more ethical decision-making models and different decision-making strategies (Medeiros et al. 2017).

18.2.3 Learning Unit: Professional Skills

The *Professional skills* learning unit includes two modules: (1) Professionalism; and (2) Communication. *Professionalism* refers to healthcare practitioners' contract with society which includes their commitment to master knowledge and skills in a specific area, to strive for competence and expertise, to carry out fiduciary responsibilities, to adhere to ethical principles and to cultivate collegiality and mentoring. It is a multidimensional construct that includes intrapersonal (e.g. maturity, morality and humility), interpersonal (e.g. respect, compassion, integrity and collegiality) and public (e.g. caring, accountability, justice, self-regulation) dimensions. A lack of professionalism includes the following: abuse of one's privileged position to exploit patients and defraud the healthcare system; being arrogant, abrasive and disrespectful to others; lack of due diligence and lack of conscientiousness (Lee et al. 2007). In many African countries healthcare practitioners are guided by specific international and national codes of conduct issued by regulatory bodies. It is important to include profession-specific codes of conduct in undergraduate healthcare ethics courses to facilitate reflections on the ethics principles, virtues, attitudes and skills that inform professional roles and responsibilities. It is also important for healthcare students to gain deep insight into the various categories, types, origins, incidences and professional consequences of professional misconduct (e.g. fraudulent conduct and negligent patient care) (Nortjé and Hoffmann 2016). Another important component of this module is healthcare students' need to obtain knowledge, skills and strategies regarding self-awareness of personal and professional burnout and self-care needs. Healthcare practitioners in the public and private healthcare sectors are often exposed to high workloads, long working hours and suboptimal self-care strategies, all of which significantly contribute to burnout in the long term (ASBH 2009).

Communication skills are essential for effective interactions between healthcare practitioners in healthcare teams, between healthcare practitioners and patients, and between the families of patients and members of the healthcare team (ASBH 2009). It specifically includes the following communication areas: verbal and non-verbal communication, patient-centred communication, empathy, communication in multicultural contexts (including gender-appropriate and spiritual/religious expressions in African healthcare contexts), communication in multi-professional healthcare team contexts, dealing with interpersonal conflict in healthcare contexts and moral distress (ASBH 2009). It is important for healthcare practitioners to obtain skills in identifying and dealing with their own, colleagues' and patients' verbal and non-verbal expressions of moral distress, moral grievance and moral conflicts. These skills will improve the quality of healthcare rendered by healthcare practitioners (De Bree 2015; Howe 2017).

18.2.4 Learning Unit: Legal Considerations in Healthcare

The *Legal considerations in healthcare* learning unit is comprised of a *Medical law* module. Medical law refers to regulations and statutory laws that specifically relate to healthcare and the relationship between providers and users of healthcare (HPCSA 2006; Moodley 2007). It is important for healthcare students to acquire a fundamental understanding and integrated knowledge of relevant national laws, local regulations and policies, as well as relevant international conventions to ensure that they render accountable healthcare services which adhere to legal requirements (Barilan and Brusa 2015; Beckmann 2017; Knox 2017). This module addresses the following areas: the practitioner-patient treatment contract, informed consent (including the duty to inform, legal requirements of informed consent, substituted consent and consent threshold ages), confidentiality (including obligatory disclosure, medical records and protection of private information), pharmaceutical substances (including profession-specific prescription privileges and use of pharmaceutical substances), healthcare malpractice (including negligence and liability) and Patients' Rights Charters (Singh 2017).

18.3 Learning Outcomes

This section focuses on a description of each module's specific learning outcomes. The learning outcomes (Table 18.2) describe the required content and level to reach the objectives of the undergraduate healthcare ethics course. Each of the learning outcomes should be further informed by the country-specific, profession-specific and healthcare context-specific needs and requirements (Moodley 2007). The ultimate aim of the learning outcomes is to ensure that undergraduate healthcare students acquire adequate knowledge and skills that reflect deep learning and fundamental understanding of ethics principles, ethical reasoning, professional skills and legal considerations in healthcare. In addition, the professional focus, depth of content coverage and available time for each module determine the educational strategies and extent to which the specific module and learning outcomes can be achieved (ASBH 2009).

18.4 Assessment Tasks

This section focuses on a description of the assessment tasks that should be used in dynamic interaction with theory and practice throughout the course offering (Hoffmann and Nortjé 2016; Knox 2017). The various assessment tasks focus on evidence-based endeavours to determine and establish the extent to which students have internalised the required set of knowledge, skills and attitudes regarding ethics concepts and principles, ethical reasoning, professional skills and legal considerations in healthcare. Ideally, a variety of assessment tasks should be used to measure the various learning outcomes of the learning units and modules (Arnold and Forrow 2004). The most important assessment tasks in an undergraduate ethics course for healthcare students should include the following: Case study discussions and reports, Socratic debates, Reflective journals, Academic essays and Arts-based approaches. The products and results of the various assessment tasks may also be included in a portfolio that can be assessed at regular intervals throughout the ethics course (i.e. formative assessment) or at the end of each academic year for promotion purposes (i.e. summative assessment) (Hoffmann and Nortjé 2016).

Case Study Discussions and Reports Ethics education endeavours frequently make extensive use of a case-based approach to teach module content and to assess learning outcomes (Medeiros et al. 2017). In terms of assessment, students are required to collect, structure and analyse actual cases or scenarios from local and international healthcare contexts related to their chosen professions. A variety of case report sources can be utilised for this purpose, namely casebooks, audio-visual material, news reports, formal literature and self-developed material. Case study discussions and reports significantly contribute to students' knowledge of theoretical concepts, moral theories and ethics principles, as well as to self-reflection, critical thinking and contextual critical reasoning skills, especially when used in

Table 18.2 Learning outcomes for each module in the undergraduate healthcare ethics course

Learning unit	Module	Learning outcomes
Ethics principles	**Module 1: Introduction**	
	1. Overview of the history of ethics	Understand the most prominent events in the history of ethics as a discipline embedded in philosophy
	2. Introduction to the concepts morality, values, ethics and law	Define, understand and apply the differences between the concepts morality, values, ethics and law
	3. Overview of prominent international codes of ethics	Understand the origin, main focus and status of the prominent international codes of ethics
	Module 2: Moral theories	
	1. Deontology 2. Utilitarianism 3. Virtue ethics 4. Social contract theory 5. Liberal individualism (human rights) 6. Principlism 7. Communitarianism and African philosophy (including Ubuntu ethics) 8. Ethics of care (feminism) 9. Casuistry 10. Theory of justice	Understand the fundamental role of moral theories in ethical reasoning and ethical decision-making contexts Understand, apply and integrate knowledge of the history, fundamental principles, strengths, shortcomings and practical applications of each moral theory

	Module 3: Fundamental ethics principles	
	1. Human dignity 2. Beneficence 3. Non-maleficence 4. Autonomy and individual responsibility 5. Privacy and confidentiality 6. Informed consent 7. Vulnerability and personal integrity 8. Equality, justice and equity 9. Non-discrimination and non-stigmatisation 10. Cultural diversity and pluralism 11. Solidarity and international cooperation 12. Social responsibility and global health ethics 13. Benefit-sharing 14. Protection of future generations 15. Protection of environment, biosphere and biodiversity	Understand, apply and integrate knowledge of the fundamental definitions, concepts, arguments and practical applications of each ethics principle in the clinical healthcare context Understand the moral foundation(s) of each ethics principle Critically analyse case studies that illustrate the complex interactions between the various ethics principles in clinical healthcare contexts
	Module 4: Clinical research ethics	
	1. Overview of the history of research ethics and research atrocities	Understand the most prominent events in the history of research ethics and research ethics codes, including the occurrence of research atrocities
	2. Principles of Good Clinical Practice	Understand, apply and integrate knowledge of Good Clinical Practice principles in health research contexts
	3. Research integrity and research misconduct	Understand, apply and integrate knowledge of research integrity and research misconduct with a focus on plagiarism, fabrication, falsification of data, authorship and conflict of interest

(continued)

Table 18.2 (continued)

Learning unit	Module	Learning outcomes
Ethical reasoning	**Module: Ethical reasoning**	
	1. Critical thinking, critical reasoning and critical self-reflection	Understand, apply and integrate knowledge of critical thinking, critical reasoning and critical self-reflection in the clinical healthcare context
	2. Ethical decision-making models	Understand, apply and integrate knowledge of different ethical decision-making models in the clinical healthcare context
Professional skills	**Module 1: Professionalism**	
	1. Characteristics of professionalism	Understand, apply and integrate knowledge of the various characteristics of professionalism in the clinical healthcare context
		Understand, apply and integrate knowledge of personal and professional integrity in the clinical healthcare context
	2. Professional codes of conduct	Understand, apply and integrate knowledge of statutory profession-specific professional code of conduct in country-specific healthcare contexts
	3. Professional misconduct	Understand the various types and consequences of professional misconduct in the profession-specific and country-specific clinical healthcare context
	4. Self-awareness of burnout and self-care	Understand, apply and integrate knowledge of professional burnout and self-care in the profession-specific clinical healthcare context
	Module 2: Communication	
	1. Verbal communication	Understand, apply and integrate knowledge of the fundamental definitions, concepts and practical applications of verbal communication aspects in a multicultural and multi-disciplinary clinical healthcare context
	2. Non-verbal communication	Understand, apply and integrate knowledge of the fundamental definitions, concepts and practical applications of the various non-verbal communication aspects in a multicultural and multi-disciplinary clinical healthcare context
	3. Interpersonal conflict	Understand, apply and integrate knowledge of interpersonal conflict and moral distress in a multicultural and multi-disciplinary clinical healthcare context

Legal considerations in health care	**Module: Medical law**	
	1. Basic legal terminology and principles	Demonstrate a basic knowledge and understanding of legal terminology and principles applicable to the healthcare context
	2. Informed consent	Understand, apply and integrate knowledge of legal consent, substituted consent, consent threshold ages and consent in medical emergencies in the clinical healthcare context
	3. Confidentiality	Understand, apply and integrate knowledge of the legal requirements regarding due recording, storage, protection and disclosure of personal medical information and medical records in the clinical healthcare context
	4. Pharmaceutical substances	Understand, apply and integrate knowledge of the legal requirements regarding the profession-specific prescription and use of pharmaceutical substances in the clinical healthcare context
	5. Healthcare malpractice	Understand, apply and integrate knowledge of the legal prescriptions and consequences regarding profession-specific occurrences of healthcare malpractice (e.g. negligence, liability) in the clinical healthcare context
	6. Patients’ Rights Charter	Understand, apply and integrate knowledge of the fundamental principles regarding patients’ rights in the clinical healthcare context

individual and/or group-based formative assessment formats (Arnold and Forrow 2004; Hoffmann and Nortjé 2016). Case-based assessments can be evaluated by means of observation protocols and rubrics.

Socratic Debates This assessment task involves a structured exchange of ideas and arguments between two students or student groups who present opposing views about a specific topic, concept, principle, theory, situation, case or moral dilemma (Hoffmann and Nortjé 2016; Medeiros et al. 2017). It is best assessed by means of observation protocols which can be combined with reflective journaling tasks.

Reflective Journals This assessment task refers to written descriptive stories of personal thoughts, lived understandings and insights originating in and from the teaching and learning context. It is a formative assessment that provides student-specific evidence of teaching and learning. Rubrics can be effectively used as an assessment tool for reflective journals (Hoffmann and Nortjé 2016; Medeiros et al. 2017).

Academic Essays Essays is a text-based formative assessment task that focuses on the critical analysis, comparison and evaluation of ethics concepts, principles, topics and moral dilemmas. It requires of students to deeply engage with relevant literature. Academic essays, whether done individually or in groups, demonstrate students' ability to construct well-reasoned arguments and to integrate ethics concepts and principles in scholarly texts. Formative assessment of academic essays is preferred above time-limited written summative assessments which often primarily focus on students' knowledge of facts and theories (Ekberg 2016; Hoffmann and Nortjé 2016). Rubrics can be effectively used as an assessment tool for academic essays.

Arts-Based Approaches The arts-based assessment tasks focus primarily on visual products (e.g. concept maps, collages, paintings and video productions) and performances (e.g. moral games, songs and role plays). The artistic elements in each of these tasks can uniquely express critical thinking and the students' awareness, understanding and integration of ethics concepts and theories. Rubrics and observation protocols are the recommended assessment tools for arts-based assessment tasks (Hoffmann and Nortjé 2016).

18.5 Conclusion

The development, design and implementation of healthcare ethics curricula for healthcare students is a complex process. However, it is also a necessary process to ensure that healthcare ethics courses effectively facilitate the development of ethically-sensitive and patient-centred healthcare practitioners (Arnold and Forrow 2004; Barilan and Brusa 2015). This chapter addressed and contributed to three important aspects in respect of curriculum guidelines for undergraduate healthcare ethics courses. The first section described the rationale for the inclusion of the following four learning units in the curriculum: Ethics principles, Ethical reasoning, Professional skills and Legal considerations in healthcare. It also described the basic module(s) that should be included in each learning unit. The second section described the specific learning outcomes for each module, while the last section described the most important assessment tasks that can be used to effectively assess student progress and performance throughout a healthcare ethics course.

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