UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

DOCTOR OR SOLDIER FIRST?
ETHICAL AND LEGAL DICHOTOMIES IN THE PRACTICE OF MEDICINE IN THE ARMED FORCES

Gary Owen Muller

92143807

Submitted in partial fulfilment of the requirements for the degree

Doctor Legum

in the

Faculty of Law

University of Pretoria

Supervisor: Prof A G McKay (Nienaber)

© University of Pretoria

DECLARATION OF ORIGINALITY

I, the undersigned, hereby declare that this thesis, which I submit for the degree Doctor Legum in the Faculty of Law at the University of Pretoria, is my own work and has not previously been submitted for a degree at another university.

I have correctly cited and acknowledged all my sources.

Signed: ___ Gary Owen Muller ___________
Gary Owen Muller

Date: _25/01/2023_______________________

Supervisor: __Annelize G McKay______________
Prof A G McKay

Date: _25/01/2023_______________________

© University of Pretoria

SUMMARY

Soldier or doctor first?

Ethical and legal dichotomies in the practice of medicine in the armed forces

The armed forces maintain medical support to servicemen and women in times of peace and during armed conflict. In the South African National Defence Force, the responsibility to provide healthcare services to servicemen and servicewomen befalls the South African Military Health Service. Due to the comprehensive medical service that is provided, soldiers are able to place their lives in harm's way to defend the state knowing that, if needed, help is at hand to restore function and to heal wounds. Military healthcare, apart from restoring battlefield wounds, has the responsibility of maintaining a fit-for-service soldier population.

In order to facilitate this support, healthcare professionals volunteer to serve alongside regular soldiers in the armed forces. Serving as both a soldier and a doctor at first glance does not appear to make sense. While a soldier is expected to kill and destroy in defence of a country, doctors are entrusted with the task of healing and restoring to health patients under their care. To some extent, therefore, military doctors are expected, conceptually at least, to fulfil two roles. These roles are not compatible with one another, and this can lead to role conflicts or contradictory role obligations (described as dual loyalties).

In the thesis dual loyalty dilemmas faced by South African military healthcare professionals in executing their function as healthcare professionals and professional soldiers are examined in the context of domestic and international law. The healthcare professional's obligations towards their patients, founded in the bioethical principles of autonomy, beneficence, non-maleficence and justice, form the overarching framework of this examination.

Being the first study of its nature in a South African setting, the conclusions drawn and recommendations made are aimed at assisting South African military healthcare professionals in identifying and defusing situations that may create conflict in their dual roles under military authority. Among these conclusions, the need for a legal framework and continued bioethical training are highlighted, reinforcing the independent status of the military healthcare professional. The inclusion of draft rules of conduct for healthcare professionals in the military environment is recommended.

© University of Pretoria

DEDICATION

For Lize

© University of Pretoria

ACKNOWLEDGEMENTS

To the dedicated military healthcare professionals who have served and continue to serve this country during peace and during times of armed conflict. Without your dedicated care to the ill and wounded this thesis would not have been possible.

To my colleagues in the military legal and medical fraternity who listened to and supported my proposals for building a better military healthcare structure.

Academics, authors and scholars who dedicated their time in the pursuit of military medical ethics and the future researchers on the subject who may be inspired to continue to develop the topic.

To Professor McKay, for remaining with me all the while she changed universities, hemispheres and surnames. Thank you.

Gary Owen Muller
January 2023

© University of Pretoria

TABLE OF CONTENTS

DECLARATION OF ORIGINALITY	ii
SUMMARY	iii
DEDICATION	iv
ACKNOWLEDGEMENTS	v
TABLE OF CONTENTS	vi
ABBREVIATIONS AND ACRONYMS	xix

CHAPTER 1 INTRODUCTION

1	Contextual background	1
2	Research problem	3
2.1	Legal and ethical obligations of the healthcare professional	3
2.2	Legal and ethical obligations of members of the healthcare professions serving in the armed forces	3
2.3	Dual loyalty conflicts	5
3	Purpose of the thesis	7
4	Research questions	8
5	Significance of the study	8
6	Existing studies	9
7	Research methodology	10
8	Limitations of the study	10
9	Overview of chapter contents	11

CHAPTER 2 MEDICAL LAW IN UNIFORM OVERVIEW OF MEDICAL LAW THAT APPLY TO MILITARY HEALTHCARE PROFESSIONALS

© University of Pretoria

1.	Introduction	16
2	The Constitution of the Republic of South Africa, 1996	17
2.1	Introduction	17
2.2	Prohibition of unfair discrimination	18
2.3	The right to life	19
2.4	Freedom and security of the person	20
2.5	Right to privacy	20
2.6	Right to healthcare	21
2.7	Rights of children	22
2.8	Right to information	22
2.9	Right to just administrative action	23
2.10	Rights of prisoners	23
2.11	Security services and the Constitution, 1996	23
2.11.1	State of emergency	24
2.11.2	State of national defence	26
2.12	Conclusion	26
3.	National legislation relevant to military medical practice	27
3.1	Introduction	27
3.2	National Health Act	28
3.2.1	Emergency medical care	29
3.2.2	Informed consent	30
3.2.3	Dissemination of information	30
3.2.4	Record-keeping and access to records	31
3.2.5	Complaints procedure	31
3.2.6	Confidentiality	31
3.2.7	Health services for experimental or research purposes	31

© University of Pretoria

3.3	Health Professions Act	32
3.4	Nursing Act, Allied Health Professions Act and Pharmacy Act	33
3.5	Defence Act	34
3.5.1	General Regulations to the Defence Act	36
3.6	Implementation of the Geneva Conventions Act	39
3.7	Conclusion	41
4.	Military law	42
4.1	Introduction	42
4.2	Military discipline	43
4.2.1	The Military Disciplinary Supplementary Measures Act and the Military Disciplinary Code	43
4.2.2	The military legal system and the Constitution, 1996	43
4.3	Conclusion	45
5.	International treaties and conventions	46
5.1	Introduction	46
5.2	International Humanitarian Law or IHL	47
5.2.1	Law of the Hague	47
5.2.2	Law of Geneva	48
5.3	The United Nations Charter	49
5.4	International Human Rights Law	49
5.4.1	Universal Declaration of Human Rights	49
5.4.2	International Covenant on Civil and Political Rights	50
5.5	Charter of the International Military Tribunal at Nuremburg	50
5.6	Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment	51
5.7	Convention on or Restrictions on the use of Certain Conventional	

© University of Pretoria

Weapons which may be Deemed to be Excessively Injurious or have Indiscriminate Effects 52

5.8 Convention on the Rights of the Child 53

5.9 Rome Statute of the International Criminal Court 54

5.10 Conclusion 55

CHAPTER 3 OVERVIEW OF ETHICAL PRINCIPLES THAT APPLY TO MILITARY HEALTHCARE PROFESSIONALS

1. Overview of medical ethics 57

1.1 Introduction 57

1.2 Medical ethics through history 58

1.3 The main theories of medical ethics 59

1.4 Ethical principles and the military: An example 62

1.5 South African medical ethics 63

1.6 Conclusion 64

2. Military medical ethics 65

2.1 Introduction 65

2.2 Military ethics 65

2.3 Military medicine and bioethics 68

2.3.1 Military medical ethics 68

2.3.2 International Humanitarian Law and military medical ethics 69

2.3.3 Medical ethics and the Geneva Conventions and Additional Protocols 70

3. Conclusion 79

CHAPTER 4 THE PROFESSIONAL SOLDIER AND THE PROFESSION OF MEDICINE: POLAR OPPOSITES?

© University of Pretoria

1. Introduction 82

2. The profession of arms 82

2.1 Introduction 82

2.2 Models of military professionalism 85

2.2.1 Huntington's *The soldier and the state* 85

2.2.2 Allen Millet: *Military professionalism and officership in America* 87

2.2.3 Moskos: *The institutional and occupational military professional* 88

2.3 The professional soldier? 89

2.4 Conclusion 91

3. The medical profession 92

3.1 Introduction 92

3.2 Medical profession in South Africa 93

3.3 Medicine and the models of professionalism 94

3.4 Comparison between the medical and the soldiering professions 95

3.5 Conclusion 98

4. Dual loyalty dilemmas 98

4.1 Introduction 98

4.2 Polarisation of the topic of dual loyalties in military medicine 100

4.3 Approaches to resolving dual loyalty conflicts 102

4.3.1 Messelken/Baer approach 102

4.3.2 Howe's approach 103

5. Conclusion 105

CHAPTER 5 TOP SECRET: MEDICAL CONFIDENTIALITY AND THE MILITARY

1. Introduction 108

2. Scenario: Sergeant Pepper and the mission 109

© University of Pretoria

3. Dual loyalties and medical confidentiality 110

3.1 Real or perceived duality? 110

3.2 Legal and ethical principles regarding confidentiality 111

3.3 Medical confidentiality and international instruments 112

3.4 Limitation of the right to medical confidentiality 115

4. Assessing the given scenario using domestic law, medical ethics and international instruments 117

4.1 Introduction 117

4.2 Scenario applied to South African law 118

4.3 Ethical considerations 119

4.4 Application to international humanitarian law 120

4.4.1 First Additional Protocol I Article 16 120

4.4.2 Second Additional Protocol Article 10 121

4.5 Convergence: Managing military and medical priorities regarding confidentiality 122

5. Righting the wrong: An example from the British Armed Forces 123

6. Commentary: Application in South African law 126

7. Protecting medical confidentiality in the SANDF: Medical classification 127

8. Confidentiality post-mortem: The president and the general 128

9. Conclusion 129

CHAPTER 6 CHOICES: THE EXERCISE OF MEDICAL AUTONOMOUS DECISION-MAKING IN THE MILITARY

1. Introduction 133

2. Autonomous soldier, an oxymoron? 133

2.1 Introduction 133

© University of Pretoria

2.2	The soldier and autonomy	134
2.3	Principle of autonomy	135
2.4	Inability of the healthcare professional to elicit consent	137
2.5	Conclusion	138
3.	Medical paternalism, treatment without consent and medical research: The state knows best	139
3.1	Introduction	139
3.2	Ordered not consented: Waiving informed consent	140
3.2.1	Historical perspective	140
3.2.2	Waiving Consent: Pyridostigmine Bromide, Anthrax Vaccine and Botulinum Toxoid	140
3.3	Medical research and the soldier	147
3.3.1	Introduction	147
3.3.2	The legal and ethical basis for informed consent in medical research as applied to the military	148
3.3.3	Dilemma of informed consent for military participants in research	153
4.	Respecting Autonomy	155
4.1	Introduction	155
4.2	Autonomy on the battlefield	155
4.3	Withholding consent: Refusal of treatment in the military	157
4.3.1	Refusal of care: On the home front	157
4.3.2	Refusal of care: The operational theatre	161
4.4	Conclusion	162
5.	Autonomy and the prisoner of war: IHL and consent	163
5.1	The prisoner of war and refusal of medical treatment	163

© University of Pretoria

5.2 Commentary: Honour or compel? 163

5.3 Application to South African law 166

6. Conclusion 167

CHAPTER 7 BENEFICENCE: THE BEST INTERESTS OF THE SOLDIER OR THE STATE?

1. Introduction 169

2. Defeating the best interests of the patient 170

2.1 Introduction 170

2.2 Fighting fit 172

2.3 Penicillin and military necessity: Favouring the mission over medical ethics 172

2.4 Medical record-keeping during military operations 174

2.5 Conclusion 175

3. Duty of care: Military vs civilian practitioners 175

3.1 Introduction 175

3.2 Duty of care: The battlefield vs the metropolitan city 176

3.2.1 Strategic differences 177

3.2.2 Clinical differences 177

3.2.3 Environmental differences 178

3.3 Battlefield conditions: Different environment but the same duty of care 178

3.4 Conclusion 180

4. Triage on the battlefield 181

4.1 Introduction 181

4.2 Triage and the law 181

4.3 Principles and practice of triage: Benefiting the most 183

© University of Pretoria

4.4 Battlefield triage: Salvage, save or assess? 185
4.4.1 Medical need 186
4.4.2 Salvage 186
4.4.3 Assessing the battlefield 187
5. Conclusion 188

CHAPTER 8 NON-MALEFICENCE – FIRST DO HARM

1. Introduction 191
2. Battlefield euthanasia 192
2.1 Introduction 192
2.1.1 Passive euthanasia 192
2.1.2 Active euthanasia (battlefield euthanasia) 193
2.2 Legal principles 194
2.3 Bioethical principles in battlefield euthanasia 198
2.4 Dichotomies in battlefield euthanasia 199
2.4.1 Introduction 199
2.4.2 Battlefield euthanasia: Requested by the mortally wounded 200
2.4.3 Battlefield euthanasia: Military necessity 201
2.4.4 Battlefield euthanasia: Difficult choices 202
2.4.5 Ethical analysis of battlefield euthanasia options 203
2.4.6 Conclusion 206
3. Doctors: Combatant or non-combatant? 207
3.1 Introduction 207
3.2 Domestic and international humanitarian law 207
3.2.1 Combatants 207
3.2.2 Non-combatants 208

© University of Pretoria

3.3 The doctor as combatant 210

3.4 Conclusion 212

4. Manufacturing harm: Military healthcare professionals and weapons development 213

4.1 Introduction 213

4.2 Prosecution of Dr Wouter Basson 214

4.3 Professional conduct: Dr Wouter Basson and the HPCSA 215

4.3.1 The professional conduct inquiry 215

4.3.2 Defences raised in the professional conduct inquiry 218

4.4 Conclusion 225

5. Ethics abandoned: Doctors and torture 225

5.1 Introduction 225

5.2 South Africa: Torture, cruel, inhumane, degrading treatment and punishment 226

5.2.1 Steve Biko 226

5.2.2 Domestic legislation and torture 227

5.2.3 International law and torture 228

5.3 Doctor and torturer: The dichotomy 230

5.3.1 Introduction 230

5.3.2 Psychology of the physician-torturer: Lessons from the "Nazi doctors" 231

5.3.3 Why physicians torture: Post Second World War and into the new millennium 235

5.3.4 A role for the doctor in torture? 237

5.4 Accountability for those who torture 240

5.5 End of physician involvement in torture 242

6. Conclusion 242

© University of Pretoria

CHAPTER 9 DISTRIBUTIVE JUSTICE: AN EQUAL SHARE AND THE BATTLEFIELD

1. Introduction 245
2. South African military healthcare system 246
3. Distribution of resources on the battlefield 248
3.1 Introduction 248
3.2 Military necessity versus medical need 249
3.3 Distributive justice on the battlefield: Scenario-based evaluation 249
3.3.1 Principles of distributive justice 250
3.3.2 Distributive justice and international humanitarian law 250
3.3.3 Application of international humanitarian law and bioethics to the scenario 251
3.3.4 Conclusion 257
4. Military medical neutrality: An unrealistic goal? 258
5. Conclusion 260

CHAPTER 10 CONCLUSIONS AND RECOMMENDATIONS

1. Introduction 262
2. Overview of chapter findings 263
2.1 Regulation and differentiation: Military medicine, law and ethics 263
2.2 Dual loyalties: Between doctoring and soldiering 264
2.3 Dual loyalties and the four-principles approach of bioethics 264
3. Conclusions 267
3.1 Domestic legislation, international humanitarian law and medical ethics 267
3.2 Dual loyalty conflicts 272
3.2.1 Conflicts of maintaining confidentiality against military necessity 272

© University of Pretoria

3.2.2 Autonomous medical decision-making and military service 273

3.2.3 Failing to care: Conflicts to benevolent actions 276

3.2.4 First (above all) do no harm: Duality in the principle of non-maleficence 278

3.2.5 Dichotomies and dual loyalty dilemmas in distributive justice 280

3.3 Training the military healthcare professional 280

4. Recommendations 282

4.1 Introduction 282

4.2 Recommendations regarding the drafting of legislation, ethical guidelines and internal military policies addressing military medical law and ethics 283

4.3 Recommendations regarding the status of healthcare professionals in the South African National Defence Force 285

4.4 Recommendations regarding training of military healthcare professionals and soldiers in aspects of military medical law, ethics and IHL 288

4.4.1 Initial or basic training for all military members 289

4.4.2 Specific military medical law and ethics training for military healthcare professionals 289

4.4.3 Mission-specific training prior to the deployment of military healthcare professionals 289

4.4.4 Continued Professional Development 290

4.5 Identification of dual loyalty dilemmas and ethical decision-making 290

4.6 Doctor or soldier first? 293

5. Closing remarks 295

© University of Pretoria

TABLE OF AUTHORITIES 297

BIBLIOGRAPHY 305

© University of Pretoria

ABBREVIATIONS AND ACRONYMS

ACHPR	African Charter on Human and Peoples' Rights
AIDS	Acquired Immunodeficiency Syndrome
AP	Additional Protocol to the Geneva Conventions
CAT	Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
CW/BW	Chemical and Biological Warfare
CRC	Convention on the Rights of the Child
CSANDF	Chief of the South African National Defence Force
DOD	Department of Defence
FDA	Federal Drug Administrator
GC	Geneva Convention
HPCSA	Health Professions Council of South Africa
HIV	Human Immunodeficiency Virus
ICC	International Criminal Court
ICJ	International Court of Justice
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic Social and Cultural Rights
ICRC	International Committee of the Red Cross and Red Crescent
IHL	International Humanitarian Law

© University of Pretoria

IHRL	International Human Rights Law
IND	Investigational New Drug
IRB	Institutional Review Board
LOAC	Law of Armed Conflict
MCC	Military Command Council
MDC	Military Disciplinary Code
MDSMA	Military Disciplinary Supplemental Measures Act
MRC	Medical Research Council
NGO	Non-Governmental Organisation
NHA	National Health Act
OSD	Occupation Specific Dispensation
PAIA	Promotion of Access to Information Act
POPIA	Protection of Personal Information Act
RFMCF	Regular Force Medical Continuation Fund
SAMHS	South African Military Health Service
SANC	South African Nursing Council
SANDF	South African National Defence Force
SAHPRA	South African Health Products Regulatory Authority
SCA	Supreme Court of Appeals
SOFA	Status of Forces Agreement
STI	Sexually-Transmitted Infections

© University of Pretoria

UDHR	Universal Declaration of Human Rights
UK	United Kingdom
USA	United States of America
UN	United Nations
UNICEF	United Nations Children's Emergency Fund
WHO	World Health Organisation
WMA	World Medical Association

© University of Pretoria

CHAPTER 1

INTRODUCTION

OUTLINE

1. Contextual background
2. Research problem
2.1 Legal and ethical obligations of the healthcare professional
2.2 Legal and ethical obligations of members of the healthcare professions serving in the armed forces
2.3 Dual loyalty conflicts
3. Purpose of the thesis
4. Research questions
5. Significance of the study
6. Existing studies
7. Research methodology
8. Limitation of the study
9. Overview of chapter contents

1. Contextual background

> As it was more than three years before I decided to put together these painful recollections, which I had never meant to print, it will be understood that in the meantime they may have become a little blurred, and further, that they should be abbreviated as regards the scenes of pain and desolation which I witnessed. But if these pages could bring up the question (or lead to its being developed and its urgency realized) of the help to be given to wounded soldiers in wartime, or of the first aid to be afforded them after an engagement – if they could attract the attention of the humane and philanthropically inclined – in a word, if the consideration and study of this infinitely important subject could, by bringing about some small progress, lead to improvement in a condition of things in which advancement and improvement can never be too great, even in the best-organized armies, I shall have attained my goal.

H Dunant *A memory of Solferino* (1959)

© University of Pretoria

The armed forces maintain comprehensive medical support to servicemen and women in times of peace and during armed conflict. Because of the nature of the medical service that is provided, soldiers are able to place their lives and limbs in harm's way to defend their country knowing that, if needed, help is at hand to restore function and to heal wounds. This has a tremendously positive impact on morale.

In order to facilitate this support, healthcare professionals are recruited to serve alongside regular soldiers in the armed forces. Serving as both a soldier and a doctor[1] at first glance does not appear to make sense. While a soldier is (lawfully permitted) and even expected to kill and destroy in defence of a country, doctors are entrusted with the task of healing and restoring to health patients under their care. To some extent, therefore, military doctors are expected, conceptually at least, to fulfil two roles. These roles are not always compatible with one another, and this can lead to role conflicts or contradictory role obligations (or "dual loyalties").

Military healthcare professionals are afforded protection under international humanitarian law.[2] This protected status, however, does not address the ethical and legal complexities that arise during military medical service in armed conflict and during peacetime. As well, basic and advanced military training does little to prepare healthcare professionals for the legal and ethical dichotomies that they will need to face during their military careers.

---

1 "Doctor" and "healthcare professional" are used in this study to collectively describe the myriad of healthcare professionals employed by the armed forces. These include medical doctors, professional nurses, paramedics, and ancillary health care workers such as psychologists, social workers and counsellors.

2 General Convention for the Amelioration of the Condition of the Wounded and the Sick in Armed Forces in the Field, opened for signature on 12 August 1949, 75 UNTS 31 (entered into force 21 October 1950); Arts 24-32 GC I Ch IV, Arts 36 & 37 GC II, Ch IV, Art 33 GC III Ch IV, and Arts 27-34 GC IV Part III and Protocol Addition to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts, 1125 UNTS 3 (Arts 6, 8, 11 & 15); Protocol Addition to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflicts, 1125 UNTS 609 (Arts 9 & 10).

© University of Pretoria

2. Research problem

2.1 Legal and ethical obligations of the healthcare professional

Legislation regulates the healthcare professions in South Africa. The Health Professions Act,[3] the National Health Act,[4] Nursing Act,[5] the Allied Health Workers Act[6] and related pieces of legislation prescribe the professional duties that the health care professional has towards patients (or "healthcare users") and the broader community.

The various healthcare professionals are all attached to statutorily enacted professional councils. These statutory authorities[7] prescribe ethical conduct and practice to be adhered to. Transgressions of the respective codes could result in sanction that may range from a reprimand or suspension to deregistration of the healthcare professional.[8]

Many regard the founding principles of medical ethics to be that of autonomy, beneficence, non-maleficence and justice.[9] Medical ethics and medical practice further have developed to be in keeping with the core principles of human rights law, which include the right to dignity, to access healthcare, the right to be informed of decisions that will affect one's health, and the right to privacy (or confidentiality).[10]

2.2 Legal and ethical obligations of members of the healthcare professions serving in the armed forces

In South Africa, compulsory military service was suspended in 1994. All current serving members of the military ("member" as per the definition in the Defence Act 42 of 2002) are subject to the Military Disciplinary Code (MDC),[11] together with the Military Disciplinary Supplementary Measures Act (MDSMA).[12] The MDC and the

---

[3] Act 56 of 1974.
[4] Act 61 of 2003.
[5] Act 33 of 2005.
[6] Act 63 of 1982.
[7] For example, the Health Professions Council of South Africa; the South African Nursing Council.
[8] Ch IV Health Professions Act 56 of 1974.
[9] TL Beauchamp & JF Childress *Principles of biomedical ethics* (6th ed) (2009) 12-13.
[10] Examples being sec 14 Constitution of the Republic of South Africa, 1996; the National Health Act 61 of 2003; and the Universal Declaration of Human Rights, GA Res 217A (III), UN Doc A/810 at 71 (1948).
[11] Defence Act 44 of 1957, Ch XI Discipline, Legal Procedure and Offences.
[12] Military Discipline Supplementary Measures Act 16 of 1999.

© University of Pretoria

MDSMA are the rules applicable to uniformed military members, much the same as the professional and ethical conduct rules that apply to a medical professional.

A transgression of these military codes of conduct and the Act results in disciplinary measures being imposed on the officer in question and a possible statutory offence being investigated and sanctioned by the military justice system.[13] A system of military courts is structured under the MDSMA, whilst the MDC prescribes sentences ranging from a reprimand, to discharge from the service, and to imprisonment.[14] Violations of military discipline often carry sentences of imprisonment.[15] Similar transgressions of the rules of conduct in a civilian workplace are unlikely to be met with the same severe sanctions as in the armed forces.

Members of the South African National Defence Force (SANDF) are obliged to obey lawful commands issued by superior officers[16] and to practise their professions within the statutory prescripts of their respective professions.[17]

A modern armed force comprises various musterings (professional groupings) charged with the mandate of the specific defence force. These musterings include professionals

---

13 First Schedule to the Defence Act 44 of 1957 (The Military Disciplinary Code). Eg, sec 6; Offences in Relation to Conduct in Action; sec 7 Offences relating to failure to report activities likely to endanger safety of force; and sec 14 Absence without leave and non-attendance where required to attend.

14 Sec 15 First Schedule of the Defence Act 44 of 1957 (Military Disciplinary Code); Assaulting a Superior Officer; sec 17 Using threatening, insubordinate or insulting language and sec 32 Scandalous behaviour.

15 As above.

16 Defence Act 42 of 2002. Definition of 'Superior Officer': "in relation to another member of the Defence Force, means any officer, warrant officer, non-commissioned officer or candidate officer of the Defence Force who holds or is regarded by or under this Act to hold, a higher rank than such other member of the Defence Force or the same or an equivalent rank as such other member of the Defence Force, but is in a position of authority over that member".

17 General Regulations to the Defence Act, Ch XV Definition of a "medical officer" means "a person entitled to practice as a medical practitioner in terms of section 17 of the Health Professions Act, 1974 (Act 56 of 1974), and who-
(a) is serving as a medical officer or dental officer or specialist medical or dental officer in the Regular Force;
(b) is undergoing training or is performing service as a medical officer, dental officer or specialist in the Reserve Force;
(c) is employed on a whole or part-time basis by the State as an employee of the DOD and holds the post and carries the responsibility of a medical officer or dental officer or medical or dental specialist;
(d) is employed on a contractual basis by the State and carries the responsibility of a medical officer or dental officer or medical or dental specialist; and
(e) has, in terms of regulation 11(2)(f), been designated as a medical officer either generally or in relation to a specific patient."

© University of Pretoria

such as doctors, nurses, lawyers, engineers and so forth.

2.3 Dual loyalty conflicts

As the South African National Defence Force must be maintained and structured as a disciplined force,[18] serving in the Force places a dual responsibility on military healthcare professionals, as registration with their relevant statutory authority, compliance with the rules of the respective authority and the obligation to the oath taken in service of the state as a uniformed military member are required.[19]

From the above it should be clear that, in certain circumstances, the demands of military operations might be in conflict with the principles of medical ethics which healthcare professionals are bound to uphold. It is in such situations that the dual obligations of the military healthcare professional create conflict. Military operations are conducted according to the principles of the law of armed conflict or international humanitarian law (IHL).[20] These principles are military necessity, distinction, proportionality and the avoidance of unnecessary suffering.[21] It may be argued that, for example, the IHL principle of military necessity stands in stark contrast to all the principles of medical ethics and the prescriptions of medical law and ethics as the obligation on the healthcare professional to "first do no harm" often conflicts with the principle of military necessity: "Military necessity and the needs of the armed forces do not repudiate a soldier's rights but they do restrict them by subordinating individual interests to collective goals".[22]

The question then arises: When military healthcare professionals are confronted with situations where dual obligations exist, which obligation takes precedence or which obligation *should* take precedence? Put differently, are they soldiers or doctors first?

Doctors dedicate their lives to serving the best interests of their patients.[23] When a conflict arises between the interests of the doctor and that of the patient, the patient's

---

[18] Sec 200 Constitution of the Republic of South Africa, 1996.
[19] Fn 14, 15 & 17 above.
[20] Implementation of the Geneva Conventions Act 8 of 2012.
[21] N Melzer *International humanitarian law, A comprehensive introduction* (2016) 17-20.
[22] ML Gross "Bioethics and defence, military medical ethics, a review of the literature and a call to arms" (2013) 22(1) *Cambridge Quarterly of Healthcare Ethics* 93.
[23] L Edelstein *The Hippocratic oath: Text, translation and interpretation*, available at https:/philpapers.org (accessed 15 January 2019).

© University of Pretoria

interests must prevail.[24] For example, although a doctor has a choice to continue to treat the patient or to refer him or her to another practitioner,[25] such as when the religious convictions of the doctor preclude him or her from performing or advising on an elective abortion, the doctor is obligated to refer the patient to another practitioner. In a military setting, however, a military doctor may refer a wounded soldier to a facility comprising more definitive care or diagnostics only to have a military commander override the medical advice and order the soldier to return to duty.

Dual loyalty dilemmas are not unique to military medical practice. Situations often exist in civilian medical practice where a healthcare professional has obligations additional to those of the well-being of the patient. This happens in instances where, for example, the obligation to treat medical information about a patient confidential may conflict with the interests of public health (the reporting of communicable diseases to health authorities), or the reporting of domestic violence, gunshot wounds and child abuse to the authorities in violation of the patient's right to privacy or medical confidentiality. In a civilian context, the healthcare professional is able to withdraw from a situation that causes the conflict by referring the patient to another practitioner, so managing the dual loyalties, or the healthcare professional is compelled to comply with legislation that compels a certain action (such as reporting a communicable disease to the authorities) and may use statuary authority in any action against him or her to justify such actions in a claim for breach of confidentiality.[26]

In a military environment, however, withdrawal from situations that cause conflict may not be as simple as it is in a civilian context. An important principle in the military is the effective maintenance of a fighting/combat-ready, deployable, fit force to execute military operations.[27] Referring or abandoning a patient in the military environment would firstly not be possible owing to the unique operational situation and, secondly,

---

24 MA Dada & DJ McQuoid-Mason *Introduction to medico-legal practice* (2001) 7; HPCSA *Guidelines for Ethical Practice* Booklet 1 2, available at https://www.hpcsa.co.za (accessed 31 May 2019).

25 As above.

26 Sec 14 National Health 2003 which states: "all information concerning a user inclusive of information related to his/her health status, treatment or stay in a health establishment is confidential. Subject to sec 15 of the Act, no person may disclose any information contemplated above unless with the written consent of the user, a court order, legislature that requires disclosure or non-disclosure would result in a serious public health risk".

27 General Regulations to the Defence Act, Ch XV Part I Medical Fitness.

© University of Pretoria

would amount to a refusal to execute orders and be a dereliction of duty which may lead to disciplinary action taken against the military healthcare professional.

When a situation presents itself where there exists a conflict between the demands of ethical medical practice and the principles of military necessity, an appropriate choice has to be exercised between these two divergent paths. In situations of dual obligations, one obligation necessarily would have to take precedence over another.

In short: The doctor serving in the armed forces, therefore, is faced with a dilemma. Which is to take precedence; the oath taken in allegiance to the state (the collective); or the oath taken to the best care of the patient (the individual)?

3. Purpose of the thesis

A systematic investigation is necessary to compare the demands of the principles of IHL to that of the requirements of the principles of medical law and ethics. Only when clarity is obtained on the nature of potentially-conflicting obligations, resulting from a military healthcare professional's dual loyalties, may a path be charted on how to deal with these conflicts in an ethically-defensible and legally-compliant manner.

The thesis, therefore, is aimed at showing whether current legislation and international instruments are able to address the dichotomies healthcare professionals experience during their service in the armed forces and, if it is found that current regulation fails to do this, to suggest a way forward. The analysis in the thesis is undertaken with a focus on healthcare practice in the South African military context.

Military healthcare professionals serve in uniform; however, their wearing a uniform and their inclusion in the traditional military rank system serve to intensify the dichotomies that were outlined in the previous paragraphs: the wearing of a uniform and the military command structure contribute to the blurring of lines between the clearly-demarcated roles of military officer and healthcare professional. As one of the consequences of this, military healthcare professionals' compliance with unlawful orders by senior military practitioners based solely on a military rank structure continues to compromise the professional integrity of the healthcare professional.

© University of Pretoria

4. Research questions

4.1 What are the systems of law and medical ethics governing the conduct of healthcare professionals in the military and how does the regulation of military medicine differ from the regulation of civilian healthcare practice?

4.2 Which specific ethical and legal challenges are presented by the practice of military medicine and how do these challenges lead to so-called 'dual loyalties'? Additional or special military medical training required for serving as a military healthcare practitioner so as to better equip the healthcare practitioner to identify, manage and remain within lawful and ethical practice.

4.3 When facing these challenges (as outlined in question 4.2 above) which path should a military doctor choose? Or, phrased differently, when faced with orders that may be contrary to medical practice, from the military command, how should a military doctor act ethically and legally in a given situation?

4.4 What methods may be devised to resolve the dichotomies that are described in the thesis? What role does the law have to play in solving these dichotomies?

5. Significance of the study

Significant advances have been achieved in how the armed forces of a nation recover, treat and rehabilitate soldiers wounded in battle. This progress has happened since the writings of Henry Dunant quoted at the beginning of the chapter, and is admirable. However, advances in military medical practice do not happen without mistakes being made along the way. The constantly changing nature of warfare and new challenges faced in modern warfare have resulted in the blurring of the beneficent role of the doctor towards their patient against the collective obligation towards the military structure in winning the battle. Dunant's vision of a developed medical structure to ameliorate the suffering of those who are wounded on the battlefield exists today. However, the idealist intention of medical care in an autocratic military structure often succumb to abuse and exploitation to attain a military advantage.

As current legislation does little to address the distinction of the role of a military healthcare professional and the management of legal and ethical dichotomies in

© University of Pretoria

military medical practice, a definite approach must be developed. This will result in the legal and ethical practice of all military healthcare professionals in service with the armed forces.

The conclusions that are drawn in the study may be incorporated in proposed draft regulations to the Defence Act, 2002. The numerous military training programmes offered by the armed forces and, specifically, the South African National Defence Force, should be developed to include specific training for healthcare professions in military medical law and ethics.

6. Existing studies in the field

Very little academic writings, including published academic articles and textbooks, exist in the field of South African military medical ethics. Considering the restrictions on the fulfilment of human rights of some during the apartheid era and the (past) autocratic system of military conscription, scholars have restricted their publications to short articles mainly focused on medical ethical dilemmas and not on military medical law and ethics generally.

The vast majority of academic texts are found from writers in the United States of America and European countries.[28] Considerable work has been done over the past two decades (post 9/11) regarding the abuse of power by military healthcare professionals and their command structures in the fight against asymmetrical warfare belligerents in the war on terror.[29]

South African examples are often referenced in these texts. These examples include breaches in medical law, international (humanitarian) law and medical ethics, exemplified in the *Basson* case,[30] the death of Steve Biko and other military medical malpractices of the apartheid government.

---

28 ML Gross & D Carrick (eds) *Military medical ethics for the 21st century* (2013), ML Gross *Military medical ethics in war and peace* (2015); DE Lounsbury & RF Bellamy (eds) *Military medical ethics* (vols 1 & 2) (2003).

29 KJ Greenberg & JL Dratel *The torture papers: The road to Abu Ghraib* (2005).

30 *S v Basson* 2005 (12) BCLR 1192 (CC).

© University of Pretoria

The International Committee of the Red Cross (ICRC) has published comprehensive texts on the behaviour of medical personnel during armed conflict.[31] Meant to be widely distributed amongst military healthcare professionals, these texts however do not address legal and ethical consequences that the military healthcare professional will face in a practical dualist environment.

7. Research methodology

The study takes the form of a desktop-based analytical, comparative, descriptive and critical scrutiny methodologies of the most important principles of South African and international medical law and medical ethics, as well as the rules of IHL, as they relate to the healthcare professional in the service of the armed forces.

The first chapters will describe the law in South Africa pertaining to medical and military matters before progressing to ethical principles applicable to the military healthcare professional.

Analysing the elements of medical ethics in relation to military medical practice over the past two centuries.

Progressing to a literature survey that critically analyses earlier research conducted by authors in the field of military medical law and ethics.

Comparative literature study where the foundations of medical ethics is used to address the dichotomies that a military healthcare professional may be faced with in service.

Finally, the inclusion of IHL principles is surveyed to show the importance of its application in military medical practice.

Sources such as legislation, case law, international treaties and academic articles by authoritative scholars and academic books on medical ethics are consulted.

8. Limitations of the study

Medical law and ethics in a South Africa military context are the primary focus of the study. Despite very little scholarly work being available on the topic in a South African

[31] Health Care in Danger *The Responsibilities of Health Care Personnel Working in Armed Conflicts and other Emergencies* (2012); ICRC *Safeguarding the Provision of Health Care: Operational Practices and Relevant International Humanitarian Law Concerning Armed Groups* (2015).

© University of Pretoria

setting, South Africa does not lack experience with dual loyalty conflicts in medical practice in the armed forces. The majority of academic writings that exist canvass the experiences of the United States, British and European forces, often in the so-called war on terror.

The study is limited to the recent history of the South African military, dating from the Second World War.

A further limitation of the study is the restriction on the utilisation of military medical information in the South African National Defence Force. Protocols, procedures and instructions carry a military restricted classification, which must be authorised for use in academic writings. This limitation was overcome by utilising only sources that are available in the public domain.

9. Overview of chapter contents

Chapter one, the introductory chapter, outlines the scope, research questions and methodology of the thesis. The significance of the thesis together with existing studies in the field of South African military medical practice are introduced. The introduction concludes with an outline of the limitations of the study.

Chapter two represents an overview of South African medical law that applies to military healthcare professionals in the South African military as well as of international humanitarian law. A concentrated approach to outlining existing legal precedence in medical law and international law is followed in order to lay the foundations of the study. South African law and international humanitarian law present the cornerstones of the chapter.

The third chapter presents an overview of bioethical principles that apply to military healthcare professionals. The chapter briefly examines the bioethical theories employed in the thesis before continuing to describe their application in medical ethics. Military law and military medical ethics are used to differentiate between what it means for a soldier and a healthcare professional to serve in the armed forces, and it is argued that service in the armed forces by healthcare professionals is both lawful and ethical.

© University of Pretoria

Chapter four closely examines the professions of soldiering and healthcare. A comparison is drawn between the two professions and the dual loyalty conflicts that are inherent to these diverging careers are discussed. Ways to resolve dual loyalty issues are outlined.

Chapters five through to nine concentrate on examining the bioethical principles of autonomy (confidentiality), beneficence, non-maleficence and distributive justice in the context of military healthcare practice. These bioethical principles are used as a framework for the discussions in these five chapters.

Commencing with an examination of confidentiality in chapter 5, a scenario is offered to practically examine the dual conflicts that military doctors encounter in their practice of medicine. Legal and ethical principles governing confidentiality are examined before the chapter embarks on explaining the limitations that confidentiality holds in a military context. The chapter examines the development of patient confidentiality in the British Armed Forces before concluding with the rights of the deceased in the context of medical confidentiality.

Chapter six of the thesis deals comprehensively with the soldier and their autonomous decision-making when confronted with medical issues. Principles of autonomy lay the basis for examining medical autonomous decisions and medical paternalism. A well-known historical situation is used as a basis to examine the waiving of consent based on military necessity. The participation in medical research by soldiers and an examination of the autonomous decision-making capability of the prisoner of war conclude the chapter.

Chapter seven begins by explaining the application of the ethical principle of beneficence in the armed forces. Use is made of the penicillin triage applied during the Second World War to describe the conflicting roles of beneficence a doctor may encounter during their service. The practice of triage is examined in the austere conditions of the battlefield. Triage represents one of the greatest ethical challenges a doctor may be faced with, either in civilian or military environments.

Chapter eight examines the duty of the doctor to first (above all) do no harm. Battlefield euthanasia, the doctor as non-combatant, participation in medically-useful

© University of Pretoria

military weapons development and the acts of doctors perpetrating torture, cruel, inhumane and degrading treatment are studied in relation to the non-maleficence principle.

The principle of distributive justice describes the obligation of the doctor to manage the limited or scarce resources afforded military health care on the battlefield. This principle is the focus of chapter nine of the thesis. The balance between ethical obligations and international humanitarian law in the dispersal of medical care is examined. A discussion of military medical neutrality concludes the chapter.

The final chapter of the thesis, chapter ten, draws conclusions based on the discussions in the preceding chapters and offers recommendations to apply the premises of the study to practical situations. The research questions posited in chapter one are revisited. Recommendations are made to offer solutions to the dichotomies described in the preceding chapters of the thesis. The question whether the military healthcare practitioner is doctor or soldier first is answered definitively in a manner that is intended to assist both the medical professional and the military commander to effectively act within the ambit of medical law, international law and medical ethics.

Below the discussion turns to an examination of the legal rules that apply in the context of South African military healthcare practice.

© University of Pretoria

CHAPTER 2

MEDICAL LAW IN UNIFORM

OVERVIEW OF MEDICAL LAW THAT APPLIES TO MILITARY HEALTHCARE PROFESSIONALS IN SOUTH AFRICA

OUTLINE

1. Introduction
2. The Constitution of the Republic of South Africa, 1996
2.1 Introduction
2.2 Prohibition of unfair discrimination
2.3 The right to life
2.4 Freedom and security of person
2.5 The right to privacy
2.6 The right to health care
2.7 The rights of children
2.8 The right to information
2.9 The right to just administrative action
2.10 The rights of prisoners
2.11 Security services and the Constitution
2.11.1 State of emergency
2.11.2 State of national defence
2.12 Conclusion
3. National legislation relevant to military medical practice
3.1 Introduction
3.2 National Health Act
3.2.1 Emergency medical care
3.2.2 Informed consent
3.2.3 Dissemination of information
3.2.4 Record-keeping and access to records
3.2.5 Complaints procedure
3.2.6 Confidentiality
3.2.7 Health services for experimental or research purposes

© University of Pretoria

3.3 Health Professions Act
3.4 Nursing Act, Allied Health Professions Act and the Pharmacy Act
3.5 Defence Act
3.5.1 General Regulations to the Defence Act
3.6 Implementation of the Geneva Conventions Act
3.7 Conclusion
4. Military law
4.1 Introduction
4.2 Military discipline
4.2.1 The Military Disciplinary Supplementary Measures Act and the Military Disciplinary Code
4.2.2 The military legal system and the Constitution, 1996
4.3 Conclusion
5. International treaties and conventions
5.1 Introduction
5.2 International Humanitarian Law
5.2.1 Law of the Hague
5.2.2 Law of Geneva
5.3 The United Nations Charter
5.4 International Human Rights Law
5.4.1 Universal Declaration of Human Rights
5.4.2 International Covenant on Civil and Political Rights
5.5 Charter of the International Military Tribunal at Nuremburg
5.6 Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
5.7 Convention on or Restrictions on the use of Certain Conventional Weapons which may be Deemed to be Excessively Injurious or have Indiscriminate Effects
5.8 Convention on the Rights of the Child
5.9 Rome Statute of the International Criminal Court
5.10 Conclusion

© University of Pretoria

1. Introduction

In order to present an overview of medical law[1] and medical ethical principles[2] pertaining to military healthcare professionals and non-military (or civilian) healthcare professionals, it is necessary to distinguish between the various medical laws and ethical principles that apply to healthcare professionals in these two contexts in South Africa. In examining this, similarities and differences between military and civilian healthcare practice are highlighted.

The aim of the study is not to argue that healthcare professionals should be excluded from serving in the armed forces, but rather to establish which function (that of doctor or soldier) takes precedence in the practice of medicine in the armed forces when faced with dual or competing responsibilities, whether in times of peace or armed conflict.

It will be established whether all medical law is applicable to military and non-military healthcare professionals and whether applicable legislation may be subject to a hierarchy in which the importance of certain legislation over other laws must be pursued and in so doing assist the military healthcare professional in solving issues related to dual loyalty conflicts.

It will further be established in this chapter whether military healthcare professionals are subject to additional legislation or excluded from certain aspects of medical law that could have the potential to create conflict between their roles as soldier and doctor.

The above would apply equally in the application of medical ethical principles. To practice in South Africa, health care professionals are required to be registered with their respective statutory regulation bodies.[3] These statutory bodies prescribe a code of conduct or ethical rules that have to be followed. If transgressions occur, the respective

---

1 J Herring *Medical law and ethics* (2010): 1-2. Medical law (*ius medicum*) is a branch of law that includes legal provisions in relation to the practice of medicine, healthcare professions and the rights of healthcare users (patients). Medical law is made up of various branches of law, including, the law of delict contract law, family law, criminal law, public law, human rights law and in this thesis, international humanitarian law.

2 Medical ethics are the moral principles that pertain to the ethical practice of medicine. Four basic medical ethical rules are recognised by many writers: autonomy, beneficence, non-maleficence and justice.

3 The Health Professions Council of South Africa and the South African Nursing Council.

© University of Pretoria

disciplinary bodies may restrict practice or even remove healthcare professionals from the roll.[4]

The prescripts of international humanitarian law (IHL) cannot be separated from the law and ethical principles that apply to military healthcare practice and will thus be included in the examination. The provisions of the Implementation of the Geneva Conventions Act[5] place obligations on military medical personnel of the South African National Defence Force (SANDF) during peacetime and during armed conflict. The Geneva Conventions and their Additional Protocols are among the most important sources of law regulating the conduct of military personnel during armed conflict. As was pointed out above, different pieces of legislation[6] and the ethical rules of the different professional bodies regulate both civilian and military healthcare practice and no one may practice medicine in the South African military unless registered with one of these bodies.[7]

Below the domestic law of the Republic of South Africa pertaining to healthcare professionals is examined, followed by an examination of international agreements relevant to the practice of military medicine. The discussion below is confined to an examination of legal rules as Chapter 3 concentrates on the ethical principles applicable to military healthcare professionals.

2. Constitution of the Republic of South Africa, 1996

2.1 Introduction

South Africa's first fully democratic elections of 1994 heralded the introduction of the Interim Constitution, followed by the Constitution of the Republic of South Africa, 1996. According to section 2, the Constitution, 1996 is the supreme law of the Republic. Access to healthcare services is enshrined in section 27 of the Constitution, 1996, in the Bill of Rights.[8]

---

4 Sec 42 Health Professions Act 56 of 1974 and the Sec 47 Nursing Act 33 of 2005.
5 Sec 17 Implementation of the Geneva Conventions Act 8 of 2012.
6 Health Professions Act, 1974, Nursing Act, 2005 and the National Health Act 61 of 2003.
7 Sec 17 Health Professions Act, 1974.
8 Sec 27(1)(a) Constitution of the Republic of South Africa, 1996.

© University of Pretoria

As the Constitution, 1996 is the supreme law of the Republic, any law or conduct that is inconsistent with it is invalid; and obligations imposed by the Constitution must be fulfilled.[9] The Constitution, 1996 is the starting point when analysing healthcare professionals' obligations under domestic and international law.

The Bill of Rights is the cornerstone of our democracy[10] and affirms and protects the rights of people in the country and the democratic values of human dignity, equality and freedom.[11] The Bill of Rights applies to all law,[12] and rights enshrined in it may only be limited in accordance with law, including the general limitations clause in section 36 of the Constitution, 1996.[13]

The Constitution recognises that all have inherent dignity and that such dignity is to be protected and respected.[14] The practice of medicine touches personal dignity in that patients seeking medical attention are confronted with medical examinations of a deeply person nature. To enable the healthcare professional to diagnose and treat a patient accurately, a comprehensive medical history and examination are required. The potential to infringe on the dignity of patients would, for example, entail sharing such knowledge with third parties not authorised to be privy to the information.[15]

2.2 Prohibition of unfair discrimination

Section 9 of the Constitution, 1996 (the equality clause) guarantees that neither the state nor anyone else may discriminate unfairly against anyone. The prohibition in section 9 further includes a list of grounds of prohibited discrimination by the state,

---

9 As above, sec 2.
10 As above, sec 7.
11 As above.
12 As above, sec 8.
13 (1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including -
(a) the nature of the right;
(b) the importance of the purpose of the limitation;
(c) the nature and extent of the limitation;
(d) the relation between the limitation and its purpose; and
(e) less restrictive means to achieve the purpose.
(2) Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights.
14 Sec 10 Constitution, 1996.
15 Sec 14 National Health Act.

© University of Pretoria

including discrimination against a person living with a disability.[16] The SANDF has been taken to task repeatedly for its discrimination against persons living with disabilities.[17] But it is not only discrimination based on disability that has been an issue, as the *SASFU* and *Dwenga* matters[18] highlight problems related to the recruitment, deployment and promotion of persons living with HIV and AIDS in the South African military.[19]

The constitutional guarantee of equality is further given concrete substance in the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000, the provisions of which also apply to military healthcare practice, including the provisions contained in the schedule to the Act. These provisions include the prohibition on subjecting persons to medical experimentation without their informed consent, unfairly denying persons access to healthcare facilities (refusing access to medical facilities for enemy combatants who have become *hors de combat*), refusal of emergency medical care (battlefield triage) and refusal to provide health services to the vulnerable (such as the elderly or children in the civilian populace).[20] Although unfair discrimination is listed as a non-derogable right in the Constitution, 1996,[21] discrimination based on disability is not included in the schedule to the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 as military service would require the deployment of fit and physically capable individuals in military operations such as war.

2.3 Right to life

The right to life is protected by common law and legislation in South Africa. Importantly, section 11 of the Constitution, 1996 enshrines the right to life and this

---

16 This constitutional right has been given effect in the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000.

17 The United Nations Convention on the Rights of Persons with Disabilities (A/RES/61/106) that came into force 3 May 2008 describes disability as an evolving concept and states that disability results from the interaction between persons with impairments and attitudinal and environmental barriers.

18 *South African Security Forces Union v Surgeon General AO* Case 18683/07 (2008) and *Dwenga and four others v Surgeon General of the South African Military Health Service AO* Case 40844/2013.

19 The Court in both matters found that the SANDF had placed a "blanket" exclusion on the promotion, deployment and recruitment of persons living with HIV, contrary to its own policies.

20 Schedule to Act 4 of 2000.

21 Non-derogable rights as contained in Ch 2 of the Constitution, 1996.

© University of Pretoria

right is listed as a non-derogable right.[22] This guarantee of the right to life is discussed later in the thesis as it has important implications for military healthcare practice: during armed conflict the actions of armed forces are such that loss of life is inevitable in realising legitimate military objectives.[23]

2.4 Freedom and security of the person

Section 12 of the Constitution, 1996 provides (in subsection 2) that everyone has the right to bodily and psychological integrity. This includes the right to make decisions about reproduction, to the security and control over one's own body and not being subjected to medical (and scientific) experimentations without express informed consent.[24] The right to freedom and security of the person is listed as a non-derogable right, but its non-derogable status is limited to three subsections of the section.[25] These three subsections have a contemporary application to military medicine and medical ethics which is discussed later in the thesis.[26] The medical ethical principle of autonomy in the realisation of decisions made about life, health treatment and care is fundamental to this section.

2.5 Right to privacy

Section 14 of the Constitution, 1996 describes the protection of privacy in broad terms.[27] The patient expects the healthcare professional not to make unnecessary disclosures to others regarding the patient's condition.[28] Privacy can, however, be

---

22 As above.

23 *Ius ad bellum* or the conditions under which a state may resort to armed conflict or the use of force generally and *ius in bello* regulate the conduct of parties engaged in armed conflict; *Handbook on International Rules Governing Military Operations, International Committee of the Red Cross* (2013).

24 Sec 12(2) Constitution, 1996 and further described at secs 6-9 & 11 NHA.

25 Sec 12(1)(d) not to be tortured in any way, sec 12(1)(e) not to be treated or punished in a cruel, inhuman or degrading way. Sec 12(2)(c) prohibits the performance of medical/scientific experiments without informed consent.

26 The use of torture to extract information from prisoners of war and the unethical medical and scientific experimentations that have been conducted by numerous armed forces in the name of the advancement of the medical and scientific knowledge base.

27 Everyone has the right to privacy, which includes the right not to have -
(a) their person or home searched;
(b) their property searched;
(c) their possessions seized; or
(d) the privacy of their communications infringed.

28 A principle that remains intact today in the citation of the modern Hippocratic Oath and other oaths administered upon health care professionals once qualifications and registrations are achieved.

© University of Pretoria

limited. Members and employees of the SANDF are subject to limitations described in the Defence Act 42 of 2002.[29] The National Health Act[30] (NHA) realises the patient's right to privacy and confidentiality in that all information about the user's health status, treatment and/or admission to a healthcare facility is confidential.[31] The release of any health information is subject to written consent by the user, a court order or any applicable law that requires disclosure without written consent and where non-disclosure would represent a serious public health risk.[32]

2.6 Right to access healthcare

Section 27 deals *inter alia* with healthcare and provides that:

(a) Everyone has the right to have access to healthcare services, including reproductive health care.[33]

(b) No one may be refused emergency medical treatment.[34]

Members, their dependants, military veterans and other authorised persons within the structures of the SANDF are not burdened in the same manner as civilian persons are with regard to accessing a comprehensive healthcare system, as medical care is provided (at no cost) to serving members (and their authorised dependants) and also to retired military veterans who contributed to continued healthcare services in their active duty years.[35]

---

29 Sec 50 Defence Act 42 of 2002 (Limitations of rights):
(1) Subject to the Constitution, the rights of members or employees may be restricted in the manner and to the extent set out in subsections (2) to (7):
(2) To the extent necessary for purposes of military security and safety of members of the Defence Force and employees, such members and employees may from time to time be subjected to:
(a) searches and inspections;
(b) screening of their communications with people in or outside the Department;
(c) security clearances which probe into their private lives; and
(d) shared accommodation or privation in accordance with the exigencies of military training and operations.
(3) To the extent necessary for security and the protection of information, members of the Defence Force and employees may be subjected to restrictions in communicating any kind of information, and where appropriate, may be subjected to prohibition of communication of information.

30 Act 61 of 2003.

31 Sec 14 National Health Act, 2003.

32 Sec 7.

33 Sec 27(1)(a).

34 As above.

35 Reg 13 General Regulations to the Defence Act, 2002.

© University of Pretoria

Despite comprehensive[36] medical care being available, restrictions[37] are placed on care received outside the South African Military Health Service's (SAMHS) military medical establishments.[38]

2.7 Rights of children

The Constitution, 1996 provides that every child has the right to basic healthcare services.[39] Children would ordinarily not be considered part of a military structure, save as dependants of serving members. No person under the age of 18 years may serve in the SANDF or any of its auxiliary services.[40]

It is, however, all too commonplace to encounter children on the modern battlefield, whether as internally/externally displaced persons, war orphans or child soldiers. The United Nations Security Council's Resolution 1261 of 1999, titled Children in Armed Conflict, was adopted to address the plight of children during armed conflict.[41] The above resolution calls on all nations to protect, take care of and enforce the rights of children in conflict, together with reinforcing the Geneva Conventions and the Additional Protocols regarding the protection of child victims to conflict and the discouragement of recruiting children in the armed forces.[42]

2.8 Right to information

Everyone has the right to access any information held by the state and any information held by another person that is required for the exercise of their rights.[43] The right to access medical information applies *mutatis mutandis* to serving military members, as it applies to their civilian counterparts.[44]

---

36 Reg 13(1) "all-inclusive multi-disciplinary health capability to the SANDF and its members".
37 Part III & IV General Regulations to the Defence Act, 2002.
38 Sec 1 National Health Act, 2003: Definition of a "military health establishment".
39 Sec 28 Constitution, 1996.
40 Sec 51(1) Defence Act, 2002.
41 Security Council Resolution 1261 (1999) Children in armed conflict (S/RES/1261 (1999)).
42 As above.
43 Sec 32 Constitution, 1996.
44 Promotion of Access to Information Act 2 of 2000 and Sec 15 National Health Act, 2003.

© University of Pretoria

2.9 Right to just administrative action

Everyone has the right to administrative action that is lawful, reasonable and procedurally fair, including the right to be given written reasons for administrative action affecting a person's rights adversely.[45] Application of this right is found in disciplinary action instituted by statutory regulating bodies such as the South African Nursing Council (SANC) and the Health Professions Council of South Africa (HPCSA) against military healthcare practitioners.[46]

2.10 Rights of prisoners

The rights of arrested, detained and accused persons are contained in section 35 of the Constitution, 1996. The section provides that such persons have the right to conditions (in detention) that are consistent with human dignity and access to medical care at state expense. Members of the SANDF are subject to military law and a system of military courts, including detention barracks.[47] While the provisions of the Military Disciplinary Supplementary Measures Act 16 of 1999 (MDSMA) and the Military Disciplinary Code (MDC) regulate members of the SANDF, the Geneva Conventions[48] and their Additional Protocols would find application to enemy belligerent forces in time of armed conflict. This is discussed later in the thesis.

2.11 Security services and the Constitution, 1996

States have at their discretion security services that include military and police forces. South Africa's security services are described in Chapter 11 of the Constitution, 1996. The governing principles of national security reflect the resolve of South Africans, individually and collectively, to live in peace and harmony.[49] This prevents citizens from taking part in national or international armed conflict except as prescribed in legislation.[50] National security vests with Parliament and the National Executive and must be within the ambit of the law, including international law.[51]

---

45 Sec 33 Constitution, 1996.
46 Fn 4, 6 & 7 above.
47 The Military Disciplinary Supplementary Measures Act 16 of 1999 and the Military Disciplinary Code (First Schedule to the Defence Act 44 of 1957).
48 Geneva Convention relative to the treatment of prisoners of war of 12 August 1949 Schedule 3.
49 Sec 198(1)(a) Constitution, 1996.
50 Sec 198(1)(b).
51 Sec 198(1)(c and d).

© University of Pretoria

The SANDF is the only lawful military force in South Africa.[52] Section 199(8) of the Constitution, 1996 states:

> To give effect to the principles of transparency and accountability, multi-party parliamentary committees must have oversight of all security services in a manner determined by national legislation or the rules and orders of Parliament.

Members of the security services must not obey manifestly illegal commands.[53] The National Defence Force must be structured and managed as a disciplined force with the primary objective of defending the territorial sovereignty of the Republic within the prescripts of international law.[54]

Only the President as head of the National Executive can employ the National Defence Force in co-operation with the police service, in defence of the Republic and to fulfil an international obligation.[55] The National Defence Force will be called upon during a state of emergency[56] and a state of national defence,[57] but may be deployed during a state of disaster.[58]

2.11.1 State of emergency

The declaration of a state of emergency by an Act of Parliament would be necessary to restore peace and order if the Republic is threatened by war, insurrection, disaster, invasions or any other public emergency.[59]

During a state of emergency certain rights enshrined in the Bill of Rights may be derogated only to the extent that is required by the emergency, is consistent with international law, derogates from the listed non-derogable rights listed in the Constitution, 1996 and indemnifies the state or an individual from any unlawful act.[60]

The derogation from certain fundamental human rights is a temporary deviation in the way of detracting from many of the rights enshrined in domestic and international

---

52 Sec 199(2)
53 Sec 199(6).
54 Sec 200.
55 Sec 201.
56 Sec 37.
57 Sec 203.
58 Disaster Management Act 57 of 2002.
59 Fn 56 above.
60 As above.

© University of Pretoria

law.[61] Human rights, including healthcare rights, are at greater risk of being transgressed during the derogation of rights and as such require greater protection.[62]

The Universal Declaration of Human Rights (UDHR)[63] states in Article 29(2):

> In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

The UDHR does not contain a derogation of rights clause; however, the International Covenant on Civil and Political Rights (ICCPR)[64] in article 4 (the derogation clause)[65] remedies this. This clause was drafted shortly after the Second World War and as a consequence of the malicious nature of the conflict.[66] The non-derogable rights listed in article 4 mirror those of the Constitution, 1996.

The rights to equality, dignity, life, not to be tortured and not to be subjected to medical/scientific experimentation without informed consent relate directly to the conduct of military healthcare professionals in that they may be ordered to perform acts contrary to medical ethics for the sake of military necessity.[67]

---

61 HJ Steiner & P Alston (eds) *International human rights in context* (2000) 144.

62 University of Minnesota *The administration of justice during states of emergency (the administration of justice)*, available at http://hei.unige.ch/humanrts/monitoring/adminchap16.html (accessed 12 January 2021).

63 GA Res 217A (III) UN Doc A/810 (1978).

64 UNTS 17, 6 ILM 368 (entered into force on 23 March 1976).

65 Art 4 reads:
1. In time of public emergency which threatens the life of the nation and the existence of which is officially proclaimed, the States Parties to the present Covenant may take measures derogating from their obligations under the present Covenant to the extent strictly required by the exigencies of the situation, provided that such measures are not inconsistent with their other obligations under international law and do not involve discrimination solely on the ground of race, colour, sex, language, religion or social origin.
2. No derogation from articles 6, 7, 8 (paragraphs 1 and 2), 11, 15, 16 and 18 may be made under this provision.
3. Any State Party to the present Covenant availing itself of the right of derogation shall immediately inform the other States Parties to the present Covenant, through the intermediary of the Secretary General of the United Nations, of the provisions from which it has derogated and of the reasons by which it was actuated. A further communication shall be made, through the same intermediary, on the date on which it terminates such derogation.

66 Fn 63 above.

67 The concept of military necessity will be examined in the subsequent chapters. Military necessity was first described in the Liber Code of 1863 as the "necessity of those measures which are indispensable for securing the ends of the war and which are lawful according to the modern law and usages of war".

© University of Pretoria

2.11.2 State of national defence

A declaration[68] of a state of national defence is made by the President in accordance with section 203 of the Constitution, read together with section 89 of the Defence Act, 2002, and describes the reasons for, the place of deployment of the National Defence Force and the number of persons deployed.[69]

Regulations[70] that are required to be promulgated include reference to limitations on certain rights;[71] however, a comprehensive list of non-derogable rights is not included in this section as with a state of emergency. The reading of section 37(5) of the Constitution, 1996, however, would make the application of the listed non-derogable rights equally applicable to a state of national defence as contemplated in a state of emergency.[72]

2.12 Conclusion

The Constitution, 1996 is the supreme law of the Republic and is central to the development and implementation of health law and policies. Government has a positive duty to take all reasonable legislative measures within its available resources to achieve the progressive realisation of the right to access healthcare.

The primary objective of the National Defence Force is the defence and protection of state sovereignty. This must be executed in accordance with the Constitution, 1996 and the principles of international law regulating the use of force. So too military medicine has to execute its mandate in accordance with constitutional provisions and must apply

---

68 "The President may, by proclamation in the Gazette, declare a state of national defence contemplated in section 203 of the Constitution if, among other things, the sovereignty or territory of the Republic-
(a) is threatened by war, including biological or chemical warfare, or invasion, armed attack or armed conflict; or
(b) is being or has been invaded or is under armed or cyber attack or subject to a state of armed conflict."

69 Sec 203 Constitution, 1996.

70 Sec 91 Defence Act, 2002.

71 Freedom of movement, curfews, service in the Defence Force and freedom of the press.

72 Sec 37(5) Constitution, 1996 states that:
No Act of Parliament that authorises a declaration of a state of emergency, and no legislation enacted or other action taken in **consequence of a declaration (my emphasis)**, may permit or authorise -
(a) indemnifying the state, or any person, in respect of any unlawful act;
(b) any derogation from this section; or
(c) any derogation from a section mentioned in column 1 of the Table of Non-Derogable Rights, to the extent indicated opposite that section in column 3 of the Table.

© University of Pretoria

international law in situations where the National Defence Force is deployed. In situations of states of emergency and states of national defence, the SANDF is obligated to provide medical care in line with the provisions of non-derogable rights listed both in the Constitution, 1996 and in international law.

3. National legislation relevant to military medical practice

3.1 Introduction

The Constitution, 1996 including Chapter 2 (Bill of Rights), is the supreme law of the land; and states that, "the Bill of Rights applies to all law, and binds the legislature, the executive, the judiciary and all organs of state".[73] Thus, human rights that are set out in the Constitution apply to and guide every law in South Africa.

South Africa has a healthcare system consisting of healthcare users predominantly making use of public healthcare establishments and a small minority who are able to afford or have employee benefits to a medical aid scheme.[74] The Constitution guarantees everyone access to health services[75] and this access is either via a fee for service private healthcare network or a state-run public healthcare system. Members of the SANDF receive free comprehensive healthcare services via the SAMHS, an arm of service of the SANDF.[76]

A legal framework that tries to respect, protect, promote and fulfil people's human right of access to healthcare services is developed mainly through policies and the laws that try to enact these policies. The categories of laws that deal with healthcare are:[77]

- Laws dealing with overall population health such as the National Health Act, 2003 that regulates the county's healthcare system.
- Laws dealing with aspects of health such as the Choice of Termination of Pregnancy Act 92 of 1996 and the Medicines and Related Substances Act 101 of 1965.

---

73 Sec 8(1) Constitution, 1996.

74 African Institute for health and leadership development *Minimum data sets for human resources for health and the surgical workforce in South Africa's health system* (2015) available at www.who.int/workforcealliance/031616south_africa_case_studiesweb.pdf (accessed 16 November 2020).

75 Sec 27 Constitution, 1996.

76 Reg 13 General Regulations to the Defence Act, 2002.

77 H Hassim *et al The National Health Act 61 of 2003; A Guide* (2008).

© University of Pretoria

- Laws ancillary to healthcare such as occupational health and safety [78] environmental laws[79] and laws on water and sanitation.[80]
- Statutorily enacted councils that regulate a specific health profession, such as the South African Nursing Council (SANC) and the Health Professions Council of South Africa (HPCSA).

3.2 National Health Act

The NHA provides uniformity in respect of health services. This is achieved by establishing a national health system of public and private providers.[81] The Act sets out, *inter alia*, the rights and duties of healthcare providers, health workers, health establishments and users. The Act upholds the aims of protecting, respecting, promoting and fulfilling the rights of the people of South Africa in the realisation of their right to access healthcare.[82]

Military medical establishments are defined in the Act.[83] Unlike other health establishments, a military health establishment is not under the control of the Minister of Health but rather the President (as Commander-in-Chief of the South African National Defence Force) and the Minister of Defence and Military Veterans. The established National Health Council[84] includes a seat for the "head of the South African Military Health Service", the Surgeon General.

The wording "military health establishment means a health establishment,**[85]** the whole or part of a public or private institution, facility, building or place, whether for profit or

---

78 Occupational Health and Safety Act 85 of 1993.
79 National Environmental Management Act 107 of 1998.
80 Water Services Act 108 of 1997.
81 Preamble National Health Act, 2003: "To provide a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services; and to provide for matters connected therewith".
82 Sec 2 NHA.
83 A "military health establishment" means a health establishment which is in terms of the Constitution and the Defence Act, 2002, the responsibility of and under the direct or indirect authority and control of the President, as Commander in Chief, and the Minister of Defence, and includes-
(a) the Institutes for Aviation and Maritime Medicine;
(b) the Military Psychological Institute;
(c) military laboratory services; and
(d) military training and educational centers.
84 Sec 22 NHA.
85 Sec 1 NHA (definitions).

© University of Pretoria

not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services"[86] is interpreted to mean that although the control of the military health establishment vests with another executive authority, the military health establishment has to comply with all provisions of the NHA regarding health establishments. No other provisions of the NHA describe military medicine. Military health establishments can, however, be deployed in either a temporary or permanent capacity in support of SANDF operations in foreign states and, as such, military healthcare professionals remain under the jurisdiction of military courts.[87] Military healthcare professionals, deployed in such military health establishments, have to be registered with their respective professional councils and may have to be temporarily registered with the professional council of the receiving state as determined in the agreement between the states or the Status of Forces Agreement (SOFA).[88]

The NHA describes the structure of the healthcare system, assigning power and responsibility at various levels of government and providing for public and private components within the system.[89] The Act is designed to create the framework for delivering healthcare services and providing for the rights and duties of healthcare personnel, the governance of health facilities, the quality of healthcare services and human resources planning.[90]

The NHA, details a number of rights, each of which is described below.

3.2.1 Emergency medical care

Section 27(3) of the Constitution states that "no one may be refused emergency medical treatment". The Constitution does not define the ambit of or what precisely emergency medical treatment encompasses. In *Soobramoney*[91] the court described

---

86 As above.
87 Sec 5 Military Disciplinary Supplementary Measures Act 16 of 1999.
88 Sec 3 Secretary-General's Bulletin ST/SGB/1999/13 dated 6 August 1999, Observance by United Nations forces of international humanitarian law.
89 Sec 21 NHA: General functions of the national department of Health.
Sec 25 NHA: Health services and general function of the provincial departments.
Sec 29 NHA: Establishment of the District health system.
Sec 46 NHA: Obligations of the private health establishments.
90 Chs 3 - 6 NHA.
91 Thiagraj Soobramoney v Minister of Health (Kwazulu-Natal) 1997 12 BCLR 1696 (CC).

© University of Pretoria

emergency medical care as meaning a "dramatic, sudden situation or event that is of passing nature in terms of time and not a chronic terminal illness". The Medical Schemes Act[92] defines a medical emergency as "the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy". The provision of emergency care within the military environment and especially on the battlefield will be examined later in the thesis.

3.2.2 Informed consent

Informed consent includes the right to be informed so as to gain full knowledge about one's health status,[93] the various procedures available,[94] the reasonable risks, costs and benefits of the procedures,[95] and ultimately the right to refuse treatment. [96]

Where informed consent is not obtained from the user or patient, the Act describes the hierarchical procedure to be undertaken in the best interest of the user.[97] The healthcare provider is obligated to take all reasonable steps to gain the informed consent of the user.[98] Where consent for treatment cannot be reasonably gained from the healthcare user, the health care provider is required to continue to treat the user at a health establishment within the prescripts of the provisions described in section 9 of the NHA, 2003. Collectively, these rights encompass the principle of autonomy in health-related decisions and the user's (or patient's) participation in issues related to their health.[99]

The autonomy of soldiers in decision-making regarding their health status will be examined later in this thesis.

3.2.3 Dissemination of information

---

92 Act 131 of 1998.
93 Sec 6(1)(a) NHA.
94 As above, sec 6(1)(b).
95 Sec 6(1)(c).
96 Sec 6(1)(d).
97 Sec 7.
98 Sec 7(2).
99 Sec 8.

© University of Pretoria

The NHA stipulates that adequate and comprehensive information must be distributed about all aspects of health services that would be useful to the public, including information about user rights and duties, timetables for access to services, types of services available and complaints procedures.[100]

3.2.4 Record-keeping and access to records

Every user of a healthcare service has the right to access their medical information in line with prescribed procedures that will ensure the maintenance of confidentiality.[101] Access to medical records for healthcare professions, users or third parties is strictly regulated and breaches are sanctioned in law.[102] Thus, the person in charge of a health establishment is obligated to maintain the security of such records.[103]

3.2.5 Complaints procedure

Healthcare users have the right to lay complaints regarding the service received at a health establishment using the prescribed procedures that have to be made visible to the users.[104] Healthcare providers are obligated to investigate such complaints.[105]

3.2.6 Confidentiality

Confidentiality in health matters represents a cornerstone in bioethics[106] and medical law[107] and is enshrined in the Constitution, 1996.[108] The NHA prescribes under which strict conditions the medical information of a user may be released.[109]

3.2.7 Health services for experimental or research purposes

The regulation of medical research on human participants has, since the end of the Second World War, received international attention and violations of medical research

---

100 Sec 12.
101 Secs 13-17.
102 Sec 17(2).
103 Sec 13.
104 Sec 18.
105 As above.
106 TL Beauchamp & JF Childress *Principles of biomedical ethics* (6th ed) (2009) 1.
107 Sec 17(2) NHA makes it an offence to divulge medical information without the proper authority.
108 Sec 14 Constitution, 1996. Sec 14 is a general right to privacy; however, the right to medical confidentiality is supported by the right to privacy.
109 Sec 14 NHA, all information of a user who has made use of a health establishment is confidential and may only be disclosed if it is in the best interests of the user, if the user consents to such, by order of a competent court, by any law requiring such and only if non-disclosure would represent a threat to public health.

© University of Pretoria

ethics (and gross human rights violations) conducted during the war were of such a nature that international conventions[110] have been entered into between nations to prevent its recurrence. The NHA regulates health services for experimental or research purposes in section 11 and in other sections of the Act.[111]

3.3 Health Professions Act[112]

The Act encapsulates the rules governing the functioning of professional bodies of a vast variety of healthcare professions in South Africa.[113] The Health Professions Act establishes the HPCSA, which provides for control over education, registration and training of healthcare professionals and their practising of the various professions.[114]

The Nursing Act[115] and the Allied Health Professions Act[116] regulate the numerical superior numbers of healthcare professionals in the fields of nursing and the allied health professions. Much the same as the Health Professions Act, the Nursing Act and the Allied Health Professions Act regulate their allotted professions.

No person practising a profession listed in the above-mentioned acts may do so without being registered at the respective councils. Military healthcare professionals or medical officers[117] are required to hold the appropriate medical qualification together

---

110 Charter of the International Military Tribunal at Nuremburg, Augustus 8, 1945, 59 Stat. 1546, 82 UNTS 279; Belmont Report *Ethical Principles and Guidelines for the Protection of Human Subjects of Research* Report of the United States National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research (1976).

111 The health establishment is obligated to inform the user that the health service is of an experimental/research nature or project. The health establishment may not conduct experiments/research on a user without being provided, in writing with authorisation by the user, the health care provider primarily responsible for the user's care, the head of the health establishment, the relevant research ethics committee and the person vested with authority, as the case may be.

112 Act 56 of 1974.

113 Health care professions bodies under the Health Professions Act:
Dental and Nutrition; Dental Assisting, Dental Therapy and Oral Hygiene; Emergency Care; Environmental Health; Medical and Dental (including Medical Science); Medical Technology; Optometry and Dispensing Opticians; Occupational Therapy, Medical Orthotics, Prosthetics and Arts Therapy; Psychology; Physiotherapy, Podiatry and Biokinetics; Radiography and Clinical Technology; and Speech, Language and Hearing Professions.

114 Preamble, Health Professions Act, 1974.

115 Act 33 of 2005.

116 Act 63 of 1982.

117 Ch XV General Regulations to the Defence Act: Definition of a "medical officer" means 'a person entitled to practise as a medical practitioner in terms of section 17 of the Health Professions Act, 1974 (Act 56 of 1974), and who -
(a) is serving as a medical officer or dental officer or specialist medical or dental officer in the Regular Force;

© University of Pretoria

with current registration at their respective councils in order to perform their duties as healthcare professionals in the SANDF.[118] Such current registration is required for practise within the borders of South Africa and as the specific operation (military mission) requires, temporary registration with a foreign state's medical professions council for the duration of the operation may be required.[119]

Military healthcare professionals, like their civilian counterparts, can be held liable for unprofessional conduct[120] by their respective professional bodies and can be held liable for criminal prosecution in matters that may arise from their professional practice. In this regard, extra-territorial jurisdiction applies to transgressions committed by military members when on official duty in a foreign state.[121]

The HPCSA publishes guidelines[122] which serve to inform healthcare professionals on a range of subjects, from guidelines to professional practise to ethical issues such as patient autonomy and confidentiality. These guidelines govern military healthcare practice as well as civilian healthcare practice, and therefore have important implications for military medical practice. This point is revisited later in the thesis.

3.4 Nursing Act, Allied Health Professions Act and the Pharmacy Act[123]

The acts listed in the heading above regulate the professions of nursing, allied health professions and pharmacists.[124] As contained in the Health Professions Act, these acts

---

(b) is undergoing training or is performing service as a medical officer, dental officer or specialist in the Reserve Force;
(c) is employed on a whole or part-time basis by the State as an employee of the DOD and holds the post and carries the responsibility of a medical officer or dental officer or medical or dental specialist;
(d) is employed on a contractual basis by the State and carries the responsibility of a medical officer or dental officer or medical or dental specialist; and
(e) has, in terms of regulation 11(2)(f), been designated as a medical officer either generally or in relation to a specific patient.'

118 As above.

119 Fn 88 above.

120 The Health Professions Act's definition of unprofessional conduct: "means improper or disgraceful or dishonourable or unworthy conduct or conduct which, when regard is had to the profession of a person who is registered in terms of this Act, is improper or disgraceful or dishonourable or unworthy".

121 Sec 5 MDSMA.

122 Published on the HPCSA website (www.hpcsa.co.za) and included under Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act, 1974 BN 26 G. 36183 (1 March 2013).

123 Act 53 of 1974.

124 Contained in the Preambles of the respective Acts.

© University of Pretoria

also describe the education, registration and training of these categories of health professions. The Acts make provision for disciplinary action in cases of unprofessional conduct.[125] Military nurses and pharmacists are required to be registered in order to practise within the National Defence Force.[126].

3.5 Defence Act[127]

The principles of the Defence Act are described in section 2:[128]

> The primary object of the Defence Force is to defend and protect the Republic, its people and its territorial integrity.[129]

The military command referred to in section 202(1) of the Constitution, 1996 includes, inter alia, the Surgeon General as head of the SAMHS.[130] Further, the Defence Act constitutes the structure of the SANDF in section 12 to include the SAMHS. The President appoints the members of the military command as listed in section 4A.[131] In addition to the deployment of the National Defence Force as contemplated in section 201(2) of the Constitution, the President may authorise the deployment of the National Defence Force within the Republic or international waters in order to preserve life or health, provide essential services and support any other department of state.[132] The

---

125 Ch 3 Nursing Act, 2005, Sec 29 Pharmacy Act, 1974 and Ch 3 Allied Health Professions Act, 1982.

126 Reg 3(1)(h) General Regulations to the Defence Act, 2002.

127 Act 42 of 2002.

128 Principles:
The Minister and any organ of state defined in section 239 of the Constitution, as well as all members of the Defence Force and any auxiliary service and employees, must, in exercising any power or performing any duty in terms of this Act, have regard to the following principles:
(a) The formulation and execution of defence policy is subject to the authority of Parliament and the national executive.
(b) The primary object of the Defence Force is to defend and protect the Republic, its people and its territorial integrity.
(c) The Defence Force must perform its functions in accordance with the Constitution and international law regulating the use of force.
(d) The Defence Force must have a primarily defensive orientation and posture.
(e) No member of the Defence Force may obey a manifestly illegal order.
(f) Neither the Defence Force nor its members may, in the performance of their functions, prejudice a political parry interest that is legitimate in terms of the Constitution, or, in a partisan fashion, further any interest of a political party.
(g) The Defence Force must respect the fundamental rights and dignity of its members and of all persons.

129 Sec 2(b) Defence Act, 2002.

130 As above, sec 4A.

131 Sec 13(1) A.

132 Sec 18.

© University of Pretoria

Minister of Defence may promulgate regulations regarding the standards of health and the compulsory immunisation of employees of the Department.[133]

A member of the National Defence Force means any officer or any other rank and includes a person of a foreign force visiting the Republic.[134] Employees are described as persons employed in the National Defence Force subject to the Public Service Act (Constitution of the Republic of South Africa: Rationalisation of Public Administration: Replacement of laws on public services), 1994 (Proclamation 103 of 1994).[135]

As already has been pointed out, the SANDF must be maintained and structured as a disciplined force.[136] As such the structure maintained is a system of military ranks comprising superior officers.[137]

The limitation of SANDF members' and employees' rights is detailed in Chapter 8 of the Act.[138] To maintain military security and the safety of other members of the National Defence Force, a member may be subjected to searches and inspections, monitoring of communications, security clearances probing personal matters and restrictions on privacy in accordance with exigencies of operations or training. Members of the National Defence Force are also restricted in their political activities, dissemination of information, demonstration, picketing and/or industrial action. Members may be required to serve anywhere in the Republic or the world. Members may not be appointed members of parliament, serve as police officers or as reserve force members while in the employ of the SANDF.[139] An officer must relinquish any dual citizenship held and any member must be a South African citizen.[140] Serving

---

133 Sec 82(1)(j).
134 Sec 1 Definitions.
135 As above.
136 Sec 200 Constitution, 1996.
137 Defence Act, 2002. Definition of 'Superior Officer': in relation to another member of the Defence Force, means any officer, warrant officer, non-commissioned officer or candidate officer of the Defence Force who holds or is regarded by or under this Act to hold, a higher rank than such other member of the Defence Force or the same or an equivalent rank as such other member of the Defence Force, but is in a position of authority over that member.
138 Fn 29 above.
139 As above.
140 Sec 54(2).

© University of Pretoria

members are obliged to continue to serve at the onset of war, a state of national defence or a state of emergency.[141]

The provisions of the Defence Act include provisions applicable to healthcare professionals in the SANDF as healthcare professionals serve in uniform and are thus members of the SANDF, including the restrictions set out in the Act. Healthcare professionals who are employed in the (civilian) public and/or the private sector may not have these specific limitations on their employment.

All currently serving members of the military are subject to the Military Disciplinary Code (MDC),[142] together with the Military Disciplinary Supplemental Measures Act (MDSMA). The MDC and the MDSMA apply to uniformed (military) members, including healthcare professionals in the South African military.[143]

The Defence Act further describes that medical care is provided to members and their dependants while on military service or undergoing training, once they have reached the mandatory retirement age and during the fulfilment of an international obligation.[144]

3.5.1 General Regulations to the Defence Act

Chapter XV of the General Regulations to the Defence Act 42 of 2002 (Regulations) regulates the medical fitness, nature, extent and administration of medical treatment, the medical benefits applicable and the regular force medical continuation fund (RFMCF) of the SANDF. The Regulations describe the extent of medical fitness required to serve in the National Defence Force and the medical benefits of those serving and dependant members as authorised by either the Chief of the SANDF (CSANDF) or the Surgeon General. The Surgeon General forms part of the military command structure of the South African National Defence Force as stipulated in section 202(1) of the Constitution.[145] The Surgeon General is described in the

141 Sec 58.
142 Defence Act 44 of 1957, specifically Ch XI Discipline, Legal Procedure and Offences.
143 As above.
144 Sec 56(4) Defence Act, 2002.
145 Fn 130 above.

© University of Pretoria

Regulations to include "a medical officer to whom the Surgeon General has delegated specific functions."[146] A medical officer is defined in the Regulations.[147]

The CSANDF may issue orders in terms of the Regulations relating to the provision, management and control of medical, dental, hospital, psychiatric and rehabilitative services, assistance and support to serving members and other authorised patients. The CSANDF may also issue orders regarding the class of members and dependants who may access the services and determine the scale or aggregate amount of contributions to be made by such members. CSANDF may furthermore determine the rights, privileges and obligations of serving members and their dependants, including all matters necessary for the administration, regulation, operation, maintenance and extension of such service/support.[148]

The Surgeon General must:

i. Consult with the CSANDF, staff or supporting division to determine the standard of physical and mental fitness required in peace or wartime of every member.[149]

ii. Such standards are dependent on the Code of Remuneration and the Personnel Management Code of the member.[150]

iii. Take responsibly for the determination of the standards of physical and mental fitness of every person serving, applying for service and/or obliged to report for service/training.[151]

iv. Allocate a category of fitness to each member and advise the command structure of such allotted fitness.[152]

---

146 Reg 1 General Regulations to the Defence Act Ch XV.
147 Fn 117 above.
148 Reg 7(1) General Regulations to the Defence Act, 2002.
149 As above, Reg 2.
150 The employment and utilisation for service had come under scrutiny numerous times in the recent history of the SANDF. In *Dwenga and Others v Surgeon General and Others*, case 40844/2013 (the *Dwenga* case), the High Court had found in previous proceedings that the blanket exclusion of anyone living with HIV from being employed, deployed and promoted (in the SANDF) to be unconstitutional and an unjustifiable and unreasonable infringement of the right of non-discrimination (Section 9(3) of the Constitution, 1996) and to dignity (section 10 of the Constitution, 1996).
151 Reg 3(1) General Regulations to the Defence Act Ch XV.
152 Reg 3(2).

© University of Pretoria

v. Determine unfitness for service of either permanent or reserve force members of the SANDF.[153]

vi. Arrange for the offering to authorised patients of medical, dental and hospital treatment as required in respect of disease, injury, antenatal, post-natal, pregnancy, preventive, prophylactic and immunisation treatment.[154]

vii. Arrange all medical devices, including but not limited to medication, bandages and so forth for the care of authorised patients.[155]

viii. Provide the stipulated medical services to all authorised patients within military medical establishments where possible and arrange for such care in public or private health establishments where no military medical establishments exist. This includes the referral of authorised patients to practitioners not in the employ of the SANDF, transferring of patients between facilities and the transporting of remains in the event of death.[156]

The Surgeon General may:

i. Restrict the nature, extent and place of that person's employment permanently or temporarily, allocate a temporary fitness category and alter an allocated category.[157]

ii. Convene a medical board for the purpose of establishing the medical fitness of a member (or dependant of the member).[158] The Surgeon General further determines the procedure to be followed in conducting such a medical board.

iii. Periodically order examinations of members (in the member's own interest and that of the SANDF) to confirm the member's medical fitness to continue performing duties and direct that such examination be conducted in terms of regulation 3(1).[159]

---

153 Reg 6.
154 Reg 7.2.
155 Reg 10.
156 Reg 11.
157 Reg 3(2).
158 Reg 3(4).
159 Reg 5(2)(a).

© University of Pretoria

iv. Perform medical procedures and examinations on members and their dependants with allocated funds from Treasury.[160]

v. Request any member or employee to undergo periodic comprehensive health assessments, any other health assessment or immunisations determined necessary.[161]

Serving members of the SANDF (whether full-time or reserve force members) and their dependants benefit from a comprehensive medical system regardless of where in the Republic or world they serve.[162] Benefits for which the serving member or their dependants are entitled are described in Parts II and III of the General Regulations. Such benefits may only be restricted in terms of the Regulations and by the appointed functionaries. Medical care sought outside of the authority of the Surgeon General is for the member's own expense.[163] The Regulations do not exclude serving members and their dependants to make use of private and/or state medical facilities at their own expense.[164] Members and dependants are also not prohibited from being members of medical schemes as described in the Medical Schemes Act 131 of 1998 at their own cost.

The Regular Force Medical Continuation Fund is described in Parts IV and V of the Regulations. The fund is established to provide medical and dental care for permanent force members who have retired.[165]

The Regulations read much the same as matters for which rules shall apply issued to beneficiaries of a medical scheme;[166] however, the RFMCF is not subject to the Medical Schemes Act. The General Regulations do not describe the conduct of military healthcare professionals.

3.6 Implementation of the Geneva Conventions Act[167]

The Preamble to the Implementation of the Geneva Conventions Act reads as follows:

---

160 Reg 5(4).
161 Reg 5(5).
162 Reg 13.
163 As above.
164 As above.
165 Reg 17.
166 Sec 29 Medical Schemes Act 131 of 1998.
167 Act 8 of 2012.

> To enact the Geneva Conventions and Protocols additional to those Conventions into law; to ensure prevention and punishment of grave breaches and other breaches of the Conventions and Protocols; and to provide for matters connected therewith.

The Act provides for the prosecution of war crimes that had been committed extraterritorially[168] by South Africans and allows for the prosecution of foreigners who are suspected of grave breaches of IHL.[169] The Act also provides that superiors[170] be prosecuted for war crimes committed by their own forces. The Act further imposes a positive duty to investigate and punish subordinates for breaches.[171] The late enactment of these important international law instruments by the South African government had been criticised as partially being due to the possible retrospective prosecution of IHL breaches of the apartheid regime.[172]

The Act places upon military commanders and members of the armed forces a positive duty to uphold, disseminate and provide education on the conventions and protocols.[173]

Section 17, read with section 14 of the Act, places a duty on personnel[174] (including equipment and structures) of the SAMHS to display the Red Cross both in times of peace and armed conflict.[175] The provision of protection under the Red Cross originates from articles 19 to 31 of the First Geneva Convention, articles 22 to 45 of the Second Geneva Convention and articles 8 to 31 of the First Additional Protocol. Exclusively, medical personnel from international relief organisations (such as the International Committee of the Red Cross (ICRC) and Red Crescent), who during times of armed conflict make themselves available to the military medical services of a belligerent state, will have the same protection as that of personnel of the military

---

168 Sec 5(1).
169 Sec 5(3).
170 Sec 6(1) and (4).
171 Sec 6(2).
172 M Du Preez "The Geneva Conventions and South African Law" (2013) *Institute for Security Studies Policy Brief* available at www.issafrica.org (accessed 11 May 2020).
173 Sec 6 Implementation of the Geneva Conventions Act, 2002, with regard to military command responsibility.
174 As above sec 17(1). Note that the wearing of the Red Cross is for all "personnel" of the SAMHS and not restricted to medical personnel. Support staff such as drivers, administrators, catering and so forth have to comply with the provisions as well and are afforded the same protection (with the corresponding obligations) under international humanitarian law. Religious personnel are specifically included.
175 Sec 17(1).

© University of Pretoria

medical corps.[176] This is in line with articles 26 and 27 of the First Geneva Conventions. Medical personnel of international relief organisations fall under the command of the military medical command of the belligerent state.[177] Breaches of the use of protective emblems (with reference to medical protective emblems) are an offence, as detailed in section 15 of Act 8 of 2002 and military members (subject to the MDC) by military justice.[178] "The provisions of this Act must not be construed as limiting, amending, repealing or otherwise altering any provision of the Implementation of the Rome Statute of the International Criminal Court Act, 2002 (Act 27 of 2002, the ICC Act)".[179]

3.7 Conclusion

The South African military healthcare system is unique in that it is under the control of the President as Commander-in-Chief of the National Defence Force and the Minister of Defence and Military Veterans, not the Minister of Health. Military healthcare is, however, regulated by the same legislation as public or private healthcare. The provision of healthcare services in the National Defence Force is subject to the NHA and other legislation regulating healthcare in the Republic.

Regulations to the Defence Act describe the mandate the CSANDF and the Surgeon General have in the provision, management and control of medical services to serving and other authorised members of the National Defence Force. Their mandate extends to the setting of standards for fitness or unfitness to serve, arranging comprehensive medical care and authorising medical care outside of the military health system at either public or private health establishments.

Healthcare professionals serving in the National Defence Force are subject to the applicable regulating authorities in their respective professions in the same ambit as their colleagues in private or public practice. In addition to being subject to all the applicable regulatory authority of their specific practice, all military healthcare

---

176 Sec 17(3) and (4).
177 As above.
178 Secs 4, 5, 6, 7, 19, 49 & 47 First Schedule to the Defence Act, 1957 (The Military Disciplinary Code).
179 Sec 20 Implementation of the Geneva Conventions Act, 2012. The effect of the Implementation of the Geneva Conventions Act does not exempt any person from executing a duty imposed by the ICC Act of 2002.

© University of Pretoria

practitioners are also subject to military jurisprudence. This includes military discipline, limitations of rights under defence legislation and obligations under international law. The military healthcare professional thus has two hats to wear in their career, the one as soldier and the other as healthcare professional.

4. Military law

4.1 Introduction

In order to understand the nature of a military force in a democracy and the origin of a military legal system that investigates and prosecutes by military legal practitioners both criminal and disciplinary offences of soldiers, the following dictum refers:[180]

> The ultimate objective of the military in time of peace is to prepare for war to support the policies of the civil government. The military organization, to meet this objective requires, as no other system, the highest standard of discipline, [which] can be defined as an attitude of respect for authority that is developed by leadership, precept and training. It is a state of mind which leads to a willingness to obey an order no matter how unpleasant the task to be performed. This is not the characteristic of the civilian community. It is the ultimate characteristic of the military organization. It is the responsibility of those who command to instil discipline in those who they command. In doing so there must be the correction and the punishment of individuals …

The military forces of the world generally have, as part of their force structures, various levels (or capacities) of medical support (care) for actively serving members, military veterans and their dependants. The SANDF is no different.[181] The General Regulations to the Defence Act describe in Chapter XV the ambit of medical care available to members.[182] Serving members and their defined dependants receive comprehensive medical services (within reasonable limitations) at no cost.[183] Healthcare professionals are an integrated part of the modern military. The military healthcare professional enhances the nation's ability to execute the mandate of the armed forces by providing medical care, preventing disease and ensuring a fit fighting

---

180 BV James "Canadian Military Criminal Law: An examination of military justice" (1975) 23 *Chitty's Law Journal* 120 & 123.
181 Sec 12 Defence Act, 2002.
182 Reg 7 General Regulations to the Defence Act, 2002, Ch XV.
183 As above Reg 13.

© University of Pretoria

force.[184] Medical services not available within the Military Health Service may be sourced from service providers external to the military health structure.[185] The various healthcare professionals who provide this service serve in uniform alongside their fellow comrades in arms. Below follows an investigation of military discipline in the SANDF.

4.2 Military Discipline

4.2.1 Military Disciplinary Supplementary Measures Act and the Military Disciplinary Code[186]

The Military Disciplinary Supplementary Measures Act 16 of 1999 (MDSMA) provides for a (new)[187] system of military courts with a view to aligning the enforcement of military discipline with the Constitution, 1996. Members of the National Defence Force are subject to a military court system for transgressions of either a disciplinary nature or certain criminal offences.[188] The extra-territorial application of the Act is unique for serving members deployed to foreign states.[189] Nothing excludes military healthcare professionals from being tried under the military court system promulgated in the Act.[190] The Defence Act 44 of 1957 has been wholly repealed by section 106 of the Defence Act, save for the provisions listed in Chapter XI (Discipline, Legal Procedure and Offences, the Military Disciplinary Code (MDC). The MDC prescribes sentences ranging from a reprimand to discharge from the service, to imprisonment.[191] Violations of military discipline often carry sentences of imprisonment. Similar transgressions of the rules of conduct in a civilian workplace are unlikely to be met with the same severe sanctions as in the armed forces.

4.2.2 Military legal system and the Constitution, 1996

[184] DE Lounsbury & RF Bellamy *Military Medical Ethics* (Vol 1) (2003) 271.
[185] Reg 11(2) General Regulations to the Defence Act, 2002, Ch XV.
[186] First Schedule to the Defence Act 44 of 1957.
[187] Preamble to the MDSMA.
[188] Sec 3(1) MDSMA .
[189] Sec 5 MDSMA.
[190] Sec 3 MDSMA.
[191] Sec 15 First Schedule of the Defence Act 44 of 1957 (Military Disciplinary Code); Assaulting a Superior Officer, sec 17; using Threatening, insubordinate or Insulting Language and sec 32 Scandalous behaviour.

© University of Pretoria

The Constitution, in section 200[192] describes the National Defence Force and further creates the obligation that the National Defence Force may only act in accordance with the Constitution and principles of international law regulating the use of force.[193] As healthcare professionals serve in the armed forces of states, they are subject to military law. In South Africa, uniformed members of the SANDF are also subject to military law contained in the Defence Act, the MDC and the MDSMA. The concept of "discipline" is not defined in any of the above pieces of legislation, nor in the Constitution, 1996. The plain meaning of the word "discipline" is "control gained by enforcing obedience or order and orderly/prescribed conduct, self-control".[194]

Military disciplinary offences are defined in the MDSMA as any offence in terms of the Code and any offence deemed in law to be an offence in terms of the Code, for which the maximum punishment prescribed in the Code does not exceed imprisonment for a period of one year.[195] Thus, military members (including military healthcare professionals) are subject to military disciplinary sanctions if found guilty by the appropriate military court.

Constitutional certainty regarding the status of military disciplinary proceedings was achieved in the Constitutional Court judgment handed down on 5 October 2001 in *Minister of Defence v Potsane and Legal Soldier (Pty) Ltd and Others v Minister of Defence and Others*.[196] These two cases were consolidated and heard together as the underlying constitutional issue was common to both.[197] The respondent in the first case and the applicants in the second case (the soldiers) contended that section 179 of the Constitution invested the National Director of Public Prosecutions (NDPP) with

---

192 Section 200 Constitution, 1996: Defence Force:
(1) The Defence Force must be structured and managed as a disciplined military force.
(2) The primary object of the Defence Force is to defend and protect the Republic, its territorial integrity and its people in accordance with the Constitution and the principles of international law regulating the use of force.

193 Sec 200(2).

194 Available at https://www.merriam-webster.com/dictionary/discipline (assessed 15 April 2020).

195 MDSMA, definitions clause.

196 CCT29/01, CCT14/01) [2001] ZACC 12; 2002 (1) SA 1 (CC); 2001 (11) BCLR 1137 (5 October 2001) Case CCT 14/01.

197 The common constitutional point is whether the provisions of the Military Discipline Supplementary Measures Act 16 of 1999 (the Act) conferring authority on military prosecutors to institute and conduct prosecutions in military courts are to be struck down for their inconsistency with the provisions of section 179 of the Constitution, 1996. This section creates the office of the National Director of Public Prosecutions (the NDPP) and governs its powers and functions.

© University of Pretoria

exclusive prosecutorial authority, which was infringed by the competing authority conferred on military prosecutors by the MDSMA. According to the argument, prosecutions in military courts should be conducted by or under the authority of the NDPP. A second point raised was whether the provisions of the MDSMA that were queried for inconsistency with section 179 were not to be struck down by reason of their unjustifiable infringement of the equality rights guaranteed by section 9 of the Constitution.[198]

The Constitutional Court considered the historical context of both the establishment of the NDPP and the drafting of the MDSMA. The NDPP brought about a single prosecuting authority in South Africa from a historically fractured Attorney-General system.[199] The MDSMA also brought the administration of military justice into constitutional compliance by doing away with a military court martial system, which was deficient in many aspects, including proceedings being conducted by line officers who were not legally trained.[200]

Thus, the MDSMA made a clean break from the court martial system to establish a radically new military court system to "provide for the continued proper administration of military justice and the maintenance of discipline".[201]

Chapter 14 of the Constitution, 1996 describes the general provisions of, inter alia, the application of international law within South African jurisprudence. Section 233 of the Constitution, 1996 describes the application of international law in South Africa.[202] The application of international law to matters of medical law and ethics within the armed forces will become apparent when described later in this chapter.

4.3 Conclusion

The military healthcare professional is subject not only to the national laws regulating civil life, but also the sanctions prescribed for transgressing ethical or conduct rules set by the respective health professional body. In addition, serving military healthcare

198 *Minister of Defence v Potsane and Legal Soldier (Pty) Ltd and Others v Minster of Defence and Others,* Case CCT 14/01 (paras 2 & 3).

199 Para 17.

200 Para 10.

201 Sec 2 MDSMA.

202 "When interpreting any legislation, every court must prefer any reasonable interpretation of the legislation that is consistent with international law over any alternative interpretation that is inconsistent with international law."

© University of Pretoria

professional are subject to military-specific offences as described in the Defence Act, the MDSMA and the MDC. Where conflict between the healthcare professional's roles as soldier and physician occurs, the military healthcare professional faces the dichotomy presented by their choice of career.

To equip the military healthcare professional to deal with such dichotomies, awareness of and appropriate responses to the dichotomy of service are paramount. This can only be achieved through a deep-rooted understanding of the conflicts that may arise and the appropriate response to such a situation, even if the response is that external guidance is required.

The application of military justice in courts of military judges and courts of senior military judges is unforgiving to the transgressor who, as a soldier, is positioned in society as an example of integrity and leadership. Healthcare professionals too, are purported to have a higher level of trustworthiness, integrity, knowledge and moral fibre than the ordinary citizen. The dually assigned military healthcare professional is elevated above the ordinary soldier and must display the utmost traits intrinsic to the healthcare and military professional.

5. International treaties and conventions

5.1 Introduction

It is contended that the dichotomies that exist in the practice of medicine within the armed forces cannot be separated from IHL. Military healthcare professionals will be exposed to international deployments whether in military exercises or operations.[203] Insofar as the obligation exists on the command elements of the SANDF to provide for training specific to such deployments,[204] military healthcare professionals are not excluded. The obligation to appropriately train and equip[205] members for deployment

[203] Exercises are military preparatory deployments in which scenarios are exercised while operations can be either war or operations other than war (humanitarian assistance, deployment in support of law enforcement and disaster relief); fn 138 above.

[204] Sec 20(11) Defence Act, 2002: "Members of the Defence Force employed in terms of subsection (1) must receive appropriate training prior to such employment and must be equipped accordingly."

[205] As above.

© University of Pretoria

includes appropriate training for military healthcare professionals in their specific conduct in times of armed conflict.[206]

While basic military training does introduce the military healthcare professional to the most rudimentary aspects of international law, it is further contended that there remains room for specialised and refresher training to military operations and exercises, of which military health is always a part.[207] Military healthcare professionals require specific knowledge of, inter alia, IHL and human rights law.

5.2 International humanitarian law or IHL

IHL applicable to healthcare professionals includes the principles of *jus in bello.*[208] This law encompasses the treatment of prisoners of war, the sick and wounded, civilians in armed conflict and restrictions on the methods/means of weaponry deployed.[209] Modern IHL has an entrenched medical basis in the observations of Swiss banker and philanthropist, Henry Dunant, of the suffering experienced by soldiers wounded in battle.[210] As witness to the battle of Solferino (and other battles) of the Franco-Austrian war of the 19th century, Dunant laid the foundation for the Geneva Conventions[211] and the establishment of the ICRC.[212]

Treaties adopted in the Hague in 1899 and 1907 dealt with the laws and customs of war. Subsequently, modern updates of the Hague Law were drafted in 1949 and 1977. Consequently, IHL often is referred to as the Law of The Hague and the Law of Geneva.[213] The International Court of Justice, in an advisory opinion on the legality of the threat or use of nuclear weapons,[214] concluded that The Hague Law and Geneva Law have become "so closely inter-related that they are considered to [have] gradually formed one single complex system, known today as international humanitarian law".

5.2.1 Law of The Hague

---

[206] As above.

[207] *Defence Review* (2015) 10-17 available at http:/www.dod.mil.za/documents/defencereview.pdf (accessed 16 September 2020).

[208] The law governing the conducting of war (military operations).

[209] J Dugard *International law A South African perspective* (2013) 519.

[210] H Dunant *A Memory of Solferino* International Committee of the Red Cross (1959).

[211] Geneva Convention on the Amelioration of the Condition of the Wounded in Armies in the Field of 1864.

[212] Dugard 519.

[213] As above, 520.

[214] *Legality of the Threat or Use of Nuclear Weapons* 1996 ICJ Reports 226, 257.

© University of Pretoria

This law determines the rights and duties of parties to a conflict in the conduct of military operations and restricts the deployment of various weapons systems.[215] The Hague Regulations drafted from the 1907 Hague Conventions deal with the limitation of means and methods of weapons used in warfare, the status of belligerents, the conduct of hostilities and the termination of hostilities.[216] South Africa is a signatory state.

Collectively, military conduct in armed conflict is encompassed in the principles of IHL. These principles are military necessity, distinction, proportionality and the avoidance of unnecessary suffering.[217] Healthcare professionals serving in the armed forces may encounter these principles in the practice of medicine on the battlefield, as will be shown in subsequent chapters.

5.2.2 Law of Geneva

Geneva law concerns the protection of persons not actively and/or no longer taking part in armed conflict.[218] The Geneva Conventions and the Additional Protocols[219] provide the military medical practitioner with further rules of conduct in addition to medical ethical rules. The incorporation of Geneva law in South African legislation further reinforces the positive obligation all parties and individuals to armed conflict have.[220]

---

215 Dugard 520.

216 A Roberts & R Guelff (eds) *Documents on the Laws of War* (2000).

217 N Melzer *International Humanitarian law: A comprehensive introduction* (2016) 17-20.

218 Includes the sick and wounded, civilians, children, religious personnel and medical personnel.

219 General Convention for the Amelioration of the Condition of the Wounded and the Sick in Armed Forces in the Field, opened for signature on 12 August 1949, 75 UNTS 31 (entered into force 21 October 1950).
General Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea, opened for signature on 12 August 1949, 75 UNTS 85 (entered into force 21 October 1950).
Geneva Convention Relative to the Treatment of Prisoners of War, opened for signature on 12 August 1949, 75 UNTS 287 (entered into force 21 October 1950).
Geneva Convention for the Relative to the Treatment of Civilian persons in Time of War, opened for signature on 12 August 1949, 75 UNTS 135 (entered into force 21 October 1950).
Protocol Addition to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts, 1125 UNTS 3.
Protocol Addition to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflicts, 1125 UNTS 609.

220 Implementation of the Geneva Conventions Act 8 of 2012.

© University of Pretoria

The Geneva Conventions advance special protection to defined categories of persons in armed conflict. Medical personnel are afforded this special protection only if they are assigned and exclusively engaged in the care, evacuation and search for the wounded or sick.[221] Under South African law, the assignment of medical personnel is addressed in the Implementation of the Geneva Conventions Act.[222] Thus, by virtue of being a member of the SAMHS, protection as contemplated by the Conventions[223] exists for the healthcare professional as long as the SAMHS member is engaged in the exclusive treatment, care, search, collection, preventative, administrative and evacuation tasks described in the Conventions.[224] By virtue of the status of all SAMHS members, no SAMHS member may thus be utilised in any capacity other than those mentioned in article 24 of the first Geneva Convention. Nor may a SAMHS member revoke, whether partially, temporarily or in full, their status of a protected person.[225]

5.3 United Nations Charter[226]

Following the aftermath of the Second World War, a new international organisation was established to reaffirm "faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women".[227] The UN Charter is a constituent treaty[228] enacted shortly after the Second World War, consisting of member states. The member states pledged to maintain international peace and security, uphold international law, strive to improve the standard of living, address social, economic and health problems and promote universal respect for human rights.[229] The UN Charter shares numerous fundamentals that are consistent with

221 Arts 24 - 26 GC I.
222 Sec 17 Act 8 of 2002.
223 Fn 174 above.
224 Art 24 GC I, Art 36 GC II, Art 33 GC III, Art 8(c) AP I & Art 9 AP II.
225 Art 7 GC I: "Wounded and sick, as well as members of the medical personnel and chaplains, may in no circumstances renounce in part or in entirety the rights secured to them by the present Convention, and by the special agreements referred to in the foregoing Article, if such there be."
226 1 UNTS XVI, 24 October 1945.
227 Preamble to the UN Charter.
228 An aggregate of fundamental principles/precedents that constitute a legal basis for the organisation.
229 Fn 226 above.

© University of Pretoria

medical ethics.[230]

5.4 International human rights law

5.4.1 Universal Declaration of Human Rights[231]

The Universal Declaration of Human Rights (UDHR or Declaration) is a landmark declaration in the history of human rights. Drafted by delegates with different legal and cultural backgrounds from all over the world, the Declaration was proclaimed by the United Nations General Assembly in Paris on 10 December 1948 as a common standard of achievement for all peoples and all nations. It sets out, for the first time, fundamental human rights to be universally protected.[232] The Declaration served as the impetus for later declarations[233] on human rights and as template for the drafting of national legislation regarding human rights law.[234]

5.4.2 International Covenant on Civil and Political Rights [235]

South Africa is a signatory state to the International Covenant on Civil and Political Rights (ICCPR or Covenant) and the South African Constitution, 1996 mirrors a vast number of the rights described in the Covenant.[236] Like the Constitution, the Covenant recognises that some rights may be restricted in the event of a public emergency, but describes certain rights from which no derogation may occur.[237]

5.5 Charter of the International Military Tribunal at Nuremburg[238]

The victors[239] of the Second World War had decided to bring to an (hitherto unknown)

---

230 Namely, autonomy (freedom of states to seek internal solutions to their situations, beneficence (acting in the best interest of others), non-maleficence (to do no harm) and justice (the use of remedies available to the organisation to reach solutions).

231 GA Res 217A (III) UN Doc A/810 (1978).

232 Available at https://www.un.org/en/universal-declaration-human-rights (accessed 25 November 2020).

233 Eg the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights and note 192 above.

234 Dugard 326.

235 UNTS 17, 6 ILM 368 (entered into force on 23 March 1976).

236 Torture, cruel, inhuman and degrading treatment (Art 7), freedom and security of the person (Art 9), freedom of movement (Art 12), freedom of religion (Art 18), unfair discrimination (Art 26).

237 Art 4 ICCPR.

238 8 August 1945, 1546, 82 UNTS 279.

239 The United States of America, the Union of Soviet Socialist Republics, the United Kingdom and France (collectively, the Allied powers).

© University of Pretoria

international military tribunal[240] the Nazi leaders captured during and after the war on charges of inter alia crimes against humanity. The precedent that emanated from the Nuremburg trials (and the similar Tokyo tribunals) were that immunity from prosecution for egregious human rights violations was no longer possible on the basis that municipal law or superior orders were being executed.[241]

The Doctors' Trials,[242] like the Nuremburg trials, took place before United States military courts (not the international military tribunal) and brought before the court 23 defendants (twenty physicians and three government bureaucrats).[243] The charges were for the "mercy killing" (or euthanasia) of psychiatric patients and human medical experimentation on prisoners from various concentration camps around Europe.[244] On 20 August 1947, sixteen of the physicians were found guilty; seven received the death penalty and nine were sentenced to prison terms ranging from ten years to life imprisonment. All those imprisoned were subsequently released early, with none serving more than eight years for their crimes. Seven defendants were found not guilty.[245] The Nuremburg Tribunal and the Doctors' Trial illustrate the precedent that is to this day followed in the prosecution of crimes against humanity.

5.6 Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment[246]

Torture,[247] including acts of inhuman and degrading treatment, is prohibited by numerous conventions,[248] customary international law and the prohibition of which has

---

240 The Nuremburg Trials.
241 Dugard 322.
242 *United States of America v Karl Brandt et al (case 1)* 1947
243 FH Moll, M Krischel & H Fangerau "Nazi Medical Crimes and the Nuremburg Doctors' Trial" (2012), available at https://www.researchgate.net/publication/294419257 (accessed 25 November 2020).
244 As above.
245 As above.
246 New York, 10 December 1984.
247 Art 1: "For the purposes of this Convention, the term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions."

© University of Pretoria

been recognised as a norm in *jus cogens*.[249] From Auschwitz[250] to Guantanamo Bay,[251] when healthcare professionals take part in torture a particularly egregious violation of IHL occurs, so too of medical ethics and human rights law.

The ICRC made public the fact that US interrogators used psychological and physical coercion on detainees during the so-called war on terror and enlisted the participation of medical personnel in what it described as "a flagrant violation of medical ethics".[252] Healthcare professionals practise under defined ethical rules. The prohibition on participation in torture, inhuman treatment and any other degrading practice has been captured in the Tokyo Declaration.[253] The Declaration contains guidelines for medical doctors confronted with situations where torture and other cruel, inhuman or degrading treatment or punishment is evident in relation to detention and imprisonment.[254] Healthcare professionals deployed with armed forces and military medical practitioners have a duty to report injuries and death consistent with torture and/or other acts of inhuman or degrading treatment.[255]

South Africa is a state party to the Convention and entrenched the probation of these practices in the Constitution, 1996 at section 12(1)(d). The Prevention and Combating of Torture of Persons Act 13 of 2013 gives effect to the United Nations convention much the same as the incorporation of the Geneva Conventions in South African Law.[256]

---

248 ICCPR, European, American and African regional conventions on human rights, the European Convention for the Prevention of Torture and the 1985 Inter-American Convention to Prevent and Punish Torture.

249 Dugard 336.

250 Fn 242 above.

251 RJ Lifton "Doctors and torture" (2004) *The New England Journal of Medicine* available at https://www.nejm.org (accessed 25 November 2020).

252 SH Miles "Abu Ghraib: Its legacy for military medicine" *The Lancet* (Vol 364) 9435 available at https://casebook.icrc.org/case-study/iraq-medical-ethics-detention (accessed 26 November 2020).

253 The Tokyo Declaration; adopted by the 29th World Medical Assembly in Tokyo, Japan, October 1975.

254 As above.

255 Art 4 Tokyo Declaration.

256 Implementation of the Geneva Conventions Act 8 of 2012.

© University of Pretoria

5.7 Convention on or Restrictions on the Use of Certain Conventional Weapons which may be Deemed to be Excessively Injurious or have Indiscriminate Effects[257]

The Convention on or Restrictions on the Use of Certain Conventional Weapons which may be Deemed to be Excessively Injurious or have Indiscriminate Effects (Convention) reiterates the IHL principle of avoiding unnecessary suffering in the employment of certain weapon systems.[258] The Convention lists certain weapons and means/methods of warfare as being prohibited.[259] Obligations exist that require party states to disseminate information on and educate its forces as widely as possible on the Convention during times of peace and armed conflict. Military healthcare professionals may encounter wounds consistent with weapons (and means of warfare) restricted under this Convention via medical and/or forensic evidence. Such evidence will aid in the reporting and subsequent prosecution of transgressors.

5.8 Convention on the Rights of the Child[260]

The Convention on the Rights of the Child (the Convention) recognises that childhood is entitled to special care and assistance.[261] The Optional Protocol to the Convention on the Rights of the Child on the involvement of Children in Armed Conflict[262] was drafted to specify the conditions under which children must be treated and protected during armed conflict. The exploitation of children during armed conflict necessitates the enforcement of IHL and municipal law to prevent the recruitment,[263] training and utilisation of children in the armed forces of a nation.[264] The fourth Geneva Convention guarantees special care for children and Additional Protocol I lays down the principle of special protection: "Children shall be the object of special respect and

---

[257] 1342 UNTS 137, 19 ILM 1524, 10 October 1980.

[258] Preamble to the Convention.

[259] Protocol I: Non-detectable fragments, Protocol II: Mines and booby-traps, Protocol III: Incendiary weapons.

[260] Convention on the Rights of the Child, adopted and opened for signature, ratification and accession by General Assembly Resolution 44/25 of 20 November 1989. Entry into force 2 September 1990, in accordance with art 49.

[261] As above, Preamble.

[262] General Assembly Resolution A/RES/54/263 of 25 May 2000.

[263] South African municipal law has incorporated the limitation of minors (18 years and less) into the SANDF. Sec 52(1) Defence Act 2002 states that the regular force consists of members not younger than 18 years of age.

[264] ICRC Advisory Service on International Humanitarian Law *Legal Protection of Children in Armed Conflict* (2003) available at https://www.icrc.org (accessed 26 November 2022).

© University of Pretoria

shall be protected against any form of indecent assault".

The Optional Protocol on the involvement of children in armed conflict generally strengthens protection for children in armed conflict by:

(1) Ensuring state parties must take all feasible measures to ensure that members of their armed forces who have not reached the age of 18 years do not take direct part in hostilities (Art 1);

(2) Compulsory recruitment into the armed forces of persons under 18 years of age being prohibited (Art 2);

(3) State parties raising the minimum age for voluntary recruitment from 15 years. (Art 3);

(4) Armed groups distinct from the national armed forces should not, under any circumstances, recruit (whether on a compulsory or voluntary basis) or use in hostilities persons under the age of 18 years, and the state parties must take legal measures to prohibit and criminalise such practices (Art 4).[265]

Healthcare professionals deployed with the armed forces have a special obligation[266] to apply all provisions of international and municipal law in the special protection of children. Co-operation with relief agencies[267] is a priority in conflict zones in order to protect children.

5.9 Rome Statute of the International Criminal Court[268]

The International Criminal Court (ICC) is a permanent institution[269] and has the power to exercise jurisdiction over persons for the most serious crimes of international concern.[270] The unfolding of crimes against humanity perpetrated during the Second World War acted as a catalyst for the adoption of treaties addressing the most egregious crimes against humanity. The Rome Statute of the International Criminal Court (Rome Statute or Statute) is intended to be complementary to national criminal

265 As above.
266 Sec 32 Children's Act 38 of 2005.
267 World Health Organisation, United Nations International Children's Emergency Fund (UNICEF).
268 UN General Assembly *Rome Statute of the International Criminal Court* (last amended 2010), 17 July 1998, available at https://www.refworld.org/docid/3ae6b3a84.html (accessed 26 November 2020).
269 Not within the United Nations structure.
270 Art 5 reads "The jurisdiction of the Court shall be limited to the most serious crimes of concern to the international community as a whole. The Court has jurisdiction in accordance with this Statute with respect to the following crimes:
(a) The crime of genocide;
(b) Crimes against humanity;
(c) War crimes;
(d) The crime of aggression".

© University of Pretoria

jurisdictions, as is the case with that of South Africa.[271] The provisions of the Rome Statute govern the jurisdiction and functioning of the courts to try perpetrators of crimes listed in the Rome Statute. The ICC exercises jurisdiction in three ways; if the crime occurred in the territory of a state party, committed by a national of a state party and finally if the crimes are referred to the prosecutor by the UN Security Council.[272] Immunity from prosecution is only available to persons who are under the age of 18 at the time of commission of the offence.[273] Thus it is clear that medical professionals, whether military or civilian may be held personally liable before the ICC for crimes in which they had acted in their capacity as medical professionals.

South Africa is a signatory to the Statute and has incorporated it into municipal law.[274] The object of the Implementation of the Rome Statute of the International Criminal Court Act is to provide for effective implementation of the Rome Statute in South Africa, conformity to the obligations arising therefrom, to provide for the crimes of genocide, crimes against humanity and war crimes, together with prosecution in domestic courts of persons accused of such crimes in South Africa and extraterritorial prosecutions. The Act also provides for the arrest of persons accused of the said crimes and handing them over to the court (in certain circumstances).[275]

Thus, perpetrators of the described crimes, including medical professionals, can be prosecuted and/or handed over to the ICC if they are found to be within the Republic.

5.10 Conclusion

International law dictates that its subjects (such as states) are bound by international agreements in a number of ways.[276] The effectiveness and level of incorporation of these agreements are determined by the status of international law in national legal

---

271 Implementation of the Rome Statute of the International Criminal Court Act 27 of 2002.
272 Part II Rome Statute of the International Criminal Court.
273 As above.
274 Implementation of the Rome Statute of the International Criminal Court Act 27 of 2002.
275 As above.
276 AO Enabulele & CO Imoedemhe "Unification of the Application of International Law in the Municipal Realm: A challenge for contemporary international law" (2008) 12 *Electronic Journal of Comparative Law (EJCL)* 7, available at https://www.ejcl.org/123/art123-1.pdf (accessed 15 January 2021).

© University of Pretoria

systems.[277] South African law regards international law as a separate form of legal system that requires adoption of its instruments into national legislation.[278] South African courts are mandated to consider international law when interpreting the Bill of Rights.[279]

Military healthcare professionals may be deployed to operations or exercises in which the application of international law would be paramount to the performance of their duties. The listed instruments, whether IHL or human rights law, affect the military professional in acting lawfully and ethically. History has recorded numerous instances in which both military and civilian healthcare professionals have derogated from municipal and international law and have been held personally accountable.[280]

Under South African law, an obligation rests with the state to train all members of the National Defence Force adequately prior to deployment under the provisions of the Defence Act.[281] This includes healthcare professionals serving in the SANDF. Military healthcare professionals would require additional training (and refresher training) in the specific fields of medical law and ethics when practicing in the military environment.

In the next chapter the discussion turns to an examination of the ethical principles that apply to healthcare professionals in the military.

277 As above 6.
278 Sec 231(1) Constitution, 1996.
279 As above sec 39(1)(b).
280 Fn 251, 252 & 253 above.
281 Fn 204 above.

© University of Pretoria

CHAPTER 3

OVERVIEW OF ETHICAL PRINCIPLES THAT APPLY TO MILITARY HEALTHCARE PROFESSIONALS

OUTLINE

1. Overview of medical ethics
1.1 Introduction
1.2 The essence of medical ethics through history
1.3 The main theories of medical ethics
1.4 South African medical ethics
1.5 Ethical principles and the military: An example
1.6 Conclusion
2. Military medical ethics
2.1 Introduction
2.2 Military ethics
2.3 Military medicine and bioethics
2.3.1 Military Medical Ethics
2.3.2 International Humanitarian Law and Military Medical Ethics
2.3.3 Medical Ethics and the Geneva Conventions and Additional Protocols
3. Conclusion

1. Overview of medical ethics

1.1 Introduction

This chapter briefly introduces general ethical principles that are applicable to healthcare professionals in civilian as well as military environments. The intention is not to dissect medical ethics comprehensively, but to present a short description or a cursory overview of the most important developments applicable today. This is done by firstly defining medical ethics and the corresponding basis of the doctor-patient relationship. The development of medical ethical theories is discussed and the principal medical ethical theories employed in medical decision-making are placed in a military context.

© University of Pretoria

The doctor-patient relationship is the cornerstone of medical ethics.[1] This concept shapes the decisions made in clinical practise.[2] Standards of good or bad professional practise are set by medical ethics.[3] The military, much the same as the broader public health, contains societal goals that have to be balanced against the doctor-patient relationship.[4]

Ethics is a field of study that concerns itself with understanding and examining the moral life.[5] Beauchamp and Childress describe morality as norms about right and wrong human conduct that is so widely shared that they form a stable but incomplete social agreement.[6] Thus, morality entails standards of conduct, moral principles, rights, rules and virtues.[7]

Bioethics (Greek *bios* means life and *ethos* being behaviour) is ethics concerned with guiding physicians and scientists.[8] Its aim is to protect patients and medical research participants in terms of issues such as the doctor-patient relationship, informed consent, research and reproductive choices.[9] These issues exist in military medicine in the same way they exist in civilian medical care.

1.2 Medical ethics through history

The Hippocratic oath was born as an attempt by a small group of physicians detaching themselves from the medical ethical norms of their time.[10] Acceptance of the oath into the major religions of the world served as the catalyst for the dissemination and practice of its core values.[11] It was not till the late Middle Ages that physicians accepted the text as the standard for ethical conduct.[12] The practise of Hippocratic ethics continued deep into the 20th century but it was at this time that a change of thought brought about by ethicists, physicians and the general public challenged its

---

1 DE Lounsbury & RF Bellamy (eds) *Military Medical Ethics* Vol 1 (2003) 5.
2 As above.
3 As above.
4 As above.
5 TL Beauchamp & JF Childress *Principles of biomedical ethics* (6th ed) (2009) 1.
6 As above, 2.
7 As above.
8 AG Nienaber "Ethics and human rights in HIV-related clinical trials in Africa with Specific Reference to Informed Consent in Preventative HIV Vaccine Efficacy Trials in South Africa" Unpublished LLD thesis, University of Pretoria (2007) 83.
9 As above.
10 O Temkin *Hippocrates in a world of Pagans and Christians* 1991 as cited in Lounsbury & Bellamy 5.
11 As above.
12 RJ Bulger (ed) *Hippocrates revisited: A search for meaning* (1973) as cited in Lounsbury & Bellamy 5.

© University of Pretoria

prescripts.[13] These challenges, acting both independently and cooperatively, have changed the medical ethical landscape and branched new theories.[14] Pellegrino theorises that this is due to the upheaval in social values (particularly in the 1960s), interest in medical ethics by philosophers, and the rise of bioethics and postmodernism/moral philosophy.[15] Many authors' interpretation of the development of medical ethics since the 1960s is that it lends itself to a formal philosophical contemplation on the Hippocratic moral principles and that it uncovered a sincere need for their justification beyond affirmation.[16] According to Lounsbury and Bellamy, this has changed medical ethics from a set of free moral assertions into a reasonable ethical business.[17]

1.3 The main theories of medical ethics

Knowledge of ethical theories is required in order to understand how bioethics developed. All ethical theories originate from efforts to explain and justify moral decisions.[18]

The origin of medical ethics is based in religion, culture, society and philosophical thought. Efforts to explain and justify decisions about the moral life resulted in three traditional theories being described. Teleological (telos = end and logos = science; utilitarian/consequentialist theory) ethics emphasises the importance of what we do, deontology (deon = duty and logos = science) emphasises the significance of duties and obligations, and virtue theory considers the merits of virtue and its importance in living a good life.[19]

David Thomasma describes three branches of medical ethics in his writings published in Lounsbury and Bellamy.[20] These three major branches of medical ethics, which deal with the moral problems that are brought about by the practice of medicine in the modern world, are public policy medical ethics (which must address issues of a broad societal nature); applied medical ethics (which discusses applying medical ethics to the many medical challenges faced by practitioners); and clinical ethics which brings all of this into focus by the bedside of the patient.[21] Part of applied medical ethics is the

---

[13] As above.
[14] As above.
[15] ED Pellegrino "The moral foundations of the patient-physician relationship: the essence of medical ethics" in Lounsbury & Bellamy 5.
[16] Lounsbury & Bellamy 7.
[17] As above.
[18] Lounsbury & Bellamy 28.
[19] Lounsbury & Bellamy 24.
[20] As above.
[21] As above.

© University of Pretoria

contemplation of the analysis of the dichotomies faced in the practice of medicine within the military, evident in the successive chapters of the thesis. Of particular importance is applied medical ethics' four principle-approach developed by Beauchamp and Childress, Veatch and Engelhardt.

The four principle-approach of autonomy, beneficence, non-maleficence and justice is used and continues to be considered by many to be the cornerstone of bioethics today.[22] In bioethics, autonomy refers to the individual's capacity to make an informed and un-coerced decision.[23] Autonomy incorporates respect for persons in that individuals should be treated as autonomous agents and that individuals with diminished autonomy are entitled to protection.[24] Autonomy respects and adds value to the autonomous person's (considered) opinions and choices, while refraining from obstructing their actions unless clearly detrimental to others.[25] The denial of autonomy would repudiate that person's considered judgements, deny the individual the freedom to act on these considered judgements or withhold the information necessary to make considered judgements when there are no reason to do so.[26]

In civil rights movements that dominated the latter half of the 20th century, campaigners included patient rights in the movement for advancing basic human rights. This resulted in a shift from a paternalistic[27] type of medical ethos to one in which the patient's autonomy (personified in informed consent, privacy and confidentiality) prevails.[28] Patients not only have the right to be informed of available treatment, but may exercise their right to refuse a particular course of treatment.

In the context of medical ethics beneficence is an action intended to benefit others.[29] The oaths prescribed for healthcare professionals embody the principle of beneficence in the care of patients, such as the oath taken by healthcare professionals to "first, do no harm". Patients, therefore, must not be harmed in any way; their decisions are to be respected and their well-being is to be secured.

---

22 Earliest use was in the Belmont Report (Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research. Report of the United States National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research (1976)).
23 Beauchamp & Childress 99.
24 As above.
25 As above.
26 As above.
27 Or "doctor knows best".
28 ML Gross *Military Medical Ethics in War and Peace: Routledge handbook of military ethics* (2015) 1.
29 Beauchamp & Childress 197.

© University of Pretoria

The moral and ethical responsibilities that accompany beneficence place a great responsibility and burden upon the military healthcare professional.[30] Sharply contrasted to the function of a modern military power, beneficence is the tightrope the military healthcare professional has to walk both in peacetime and in war.

Healthcare professionals have an obligation not to cause harm in the practice of their professions – they must act non-maleficently. This obligation includes that the knowledge gained (from studying medicine) must be used exclusively for the benefit of mankind. Often equated with beneficence, non-maleficence requires a net-benefit to the patient.[31]

"Primum non nocere", the one phrase that remains with medical healthcare professionals, is "first (above all) do no harm". The maxim has been engraved on the collective mind of healthcare professionals and it is quoted relentlessly to reinforce the noble nature of the art of medicine. Claimed as a fundamental principle of the Hippocratic Oath, it does not appear in the corpus[32] of the Oath. Modern versions of the Oath proclaim a benevolent and humanitarian role for the healthcare professional, with no reference to "first, do no harm".

In the context of medical ethics, justice refers to fairness, both in the distribution of resources and what is deserved.[33] The concept of justice entails fairness, desert and entitlement.[34] These explanations infer justice as fair, equitable and appropriate treatment in light of what is due to a person. Standards of justice are needed whenever persons are due benefits because of their particular circumstances, such as being productive or having been harmed by another person's acts.[35] A holder of a valid claim based in justice has a right and therefore is due something.[36]

Justice in healthcare is also the fair distribution of resources within a community or population. This concept is dependent on the available funds to provide for an

---

[30] World Medical Association *Regulations in times of armed conflict and other situations of violence* adopted at the 10th World Medical Assembly Conference, Cuba in October 1956.

[31] Beauchamp & Childress 149.

[32] 'I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing.' Further in the corpus, 'Into whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrong-doing and harm …' RM Veatch (2000) *Cross Cultural Perspectives in Medical Ethics* 3; L Edelstein "*Introduction: The Hippocratic Oath: Text, translation and interpretation*" available at https:/philpapers.org (accessed 15 January (2019).

[33] J Herring *Medical law and ethics* (2010) 28.

[34] As above.

[35] Beauchamp & Childress 241.

[36] As above.

© University of Pretoria

equitable distribution of healthcare.[37] Aspects such as unequal access to healthcare for marginalised groups in the population (ethnicity and socio-economic factors)[38] would be determining factors in fairness of distribution.[39]

1.4 Ethical principles and the military: An example

The principles of utilitarian and deontological ethics are applied to military medical situations below with the use of a historical example of the distribution of penicillin during the Second World War.[40]

A limited pharmaceutical (penicillin) supply meant the distribution of the medication would be administered to the sick and wounded who would make the quickest recovery (in order to return to service) rather than to the patients who had the most critical need.[41] Penicillin was administered to soldiers suffering from venereal disease rather than to their wounded comrades whose medical need was far greater. The order that was given supported recovery from venereal disease and would thus be quicker and would ensure adequate numbers for the on-going campaign. The outcome of the Allied campaign may not have been a decisive victory if there had not been sufficient fit men to fight. The assessment of the military need influenced the ethical distribution of a scarce medical resource and thus benefited only the soldiers who could return to duty in the shortest period as opposed to those who had the greater medical need.[42]

Utilitarian ethics is a version of consequentialist ethical theories.[43] Despite different variations of utilitarian ethical principles, the basic premise is to maximise utility and prioritise communal happiness.[44] When applying the utilitarian approach to the above conflict, the rightfulness or wrongfulness of a selected action is decided according to whether the action would maximise a positive outcome (bring less pain and more pleasure) to the most people.[45] Thus, distributing the medication to the soldiers with venereal disease will ensure their recovery and usefulness to return to the battle and thus ensure a successful invasion, which in turn will place the Allies on the path to victory in Europe over the Nazis.

---

37 As above.
38 As above.
39 As above.
40 See the discussion in Ch 7 below and Lounsbury & Bellamy 297.
41 As above.
42 Gross & Carrick 263.
43 Lounsbury & Bellamy 28.
44 As above.
45 As above.

© University of Pretoria

The deontological approach, on the other hand, is duty-based in terms of universal moral obligations.[46] Maintaining that every person has value means that dignity and respect for each individual should be emphasised.[47] Thus, in contrast to utilitarianism, deontology principles refer to the ethics of duty in which no harm is allowed despite the consequences.[48] Thus, whether an action is moral is evaluated by the nature of the action, not its consequences.[49] It would thus be immoral to withhold treatment from soldiers suffering combat wounds and only administer the penicillin to the venereal disease sufferers.

In this example, the decision to administer the scarce resource rested with the government and not the military authorities. This utilitarian ethical approach may have been taken from the hands of the military healthcare professionals, but an understanding of the different ethical approaches may lead to a better understanding for the difficult decisions that have to be effected during armed conflict.

1.5 South African medical ethics

The objectives and functions of the Health Professions Act 56 of 1974 (HPA) are outlined as follows:

> 3(b) to promote and regulate inter-professional liaison between health professions in the interest of the public;
>
> (j) to serve and protect the public in matters involving the rendering of health services by persons practising a health profession;
>
> (m) to uphold and maintain professional and ethical standards within the health professions;
>
> (n) to ensure the investigation of complaints concerning persons registered in terms of this Act and to ensure that appropriate disciplinary action be taken against such persons in accordance with this Act in order to protect the interest of the public;
>
> (o) to ensure that persons registered in terms of this Act behave towards users of health services in a manner that respects their constitutional rights to human dignity, bodily and psychological integrity and equality, and that disciplinary action is taken against persons who fail to act accordingly;…[50]

The objectives and functions of the HPA stated above clarify the obligation placed on healthcare professionals, including military healthcare professionals, to behave in accordance with ethical standards. Breaches of rules of conduct prescribed by the Health Professions Council of South Africa (HPCSA) may result in disciplinary action

---

46 As above 29.
47 As above.
48 As above.
49 As above.
50 Sec 3 Health Professions Act 56 of 1974.

© University of Pretoria

against the professional.[51] Sanctions include a reprimand to removal from the respective register.[52] Inquiry by the respective professional boards of the HPCSA and the manner in which these professional conduct committees function are set down in the Act.[53]

Further, a professional board may charge a member with unprofessional conduct if the member has been convicted of an offence by a competent court which, according to the professional board, constitutes unprofessional conduct. As well, if during proceedings in a criminal court it appears that there is *prima facie* evidence of unprofessional conduct by the member, the court shall order that a copy of the record of proceedings, including the judgment, be forwarded to the professional board.[54]

The Health Professions Act provides that the HPCSA may determine the acts or omissions for which the respective health professions boards may institute disciplinary actions.[55] Healthcare professionals, including military healthcare professionals, must adhere to a prescribed list of rules published under the Health Professions Act.[56] Booklets published by the HPCSA contain guidelines for good practice in the various healthcare professions to assist all healthcare professionals to adhere to the obligations imposed by their profession.[57] Thirteen core principles describe the ethical practice of all healthcare professionals registered under the Act and translate well to other healthcare professionals such as nurses, pharmacists and allied health workers.[58]

1.6 Conclusion

Medical ethics in the 21st century has undergone and will continue to undergo changes as society changes. The impact of a global COVID-19 pandemic has caused us to reassess the ways we approach not only healthcare but also life in general. So too will military medical ethics evolve, as there seems no end in sight to armed conflict. A metamorphosis occurred in medical ethics in the 1960, so recently that it is within living memory.

---

51 Sec 3(n).
52 Sec 42.
53 Sec 41 & 41A.
54 Sec 45(2).
55 Sec 49.
56 Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act 56 of 1974.
57 Health Professions Council of South Africa *Ethical guidelines for good practice in the health care professions* available at https://www.hpcsa.co.za (accessed 1 September 2020).
58 Note that despite the medical professions of nursing, pharmacy and allied health workers being regulated by their respective acts, these professions too maintain ethical practice codes that, if transgressed would see the practitioner face similar sanction as listed in the Health Professions Act.

© University of Pretoria

Despite the numerous ethical theories advocated by scholars, academics, physicians and philosophers, the approach that published ethical guides follow seem to fit neatly into the four principle-approach of Beauchamp and Childress.[59] The principles of autonomy (effected in confidentiality, informed consent), beneficence, non-maleficence and justice form the core of ethical civilian and military medical practice in South Africa. As they present us with a lens through which medical practice may be examined, these principles are used in the rest of the study.

2. Military medical ethics

2.1 Introduction

The question is whether military medical ethics is a separate branch of medical ethics or whether medical ethics in the military is the same as medical ethics in the civilian sector. The World Medical Association has declared that medical ethics is the same in times of armed conflict as it is in times of peace, which may bring us a little closer to answering the question.[60] The following section examines the general ethical principles applied in military medicine and the medical ethics that bind a military power during peace and armed conflict.

2.2 Military ethics

In the previous chapter military discipline and military law were described. The Defence Act 42 of 2002 (Defence Act) describes offences for which sanction is prescribed for both members of the National Defence Force and civilians.[61] As was pointed out in the previous chapter, the Military Disciplinary Code (MDC) embodies sanctions for offences committed by members of the National Defence Force in service both within the Republic and extraterritorially.[62] The Military Disciplinary Supplementary Measures Act 16 of 1999 (MDSMA) provides for the administration of military justice and the maintenance of discipline by creating military courts and ensuring access of accused persons to a fair trial and the High Court.[63]

The offences for which military members can face disciplinary sanction (including detention, discharge, fines and reduction in rank) would not ordinarily be the same for

[59] World Medical Association Declaration of Helsinki; Declaration of Tokyo; and the Regulations in times of armed conflict and other situations of violence, adopted at the 10th World Medical Assembly, Cuba in October 1956.
[60] World Medical Association Regulations in times of armed conflict and other situations of violence, revised 63rd WMA Assembly in Thailand in October 2012.
[61] Secs 22, 24, 69 & 105 Defence Act, 2002.
[62] Sec 5 MDSMA.
[63] Preamble MDSMA; see the discussion in Ch 2 above.

© University of Pretoria

civilians employed in the state or in private companies. The basis for this is derived from the constitutional prerogative in section 200 that states that the Defence Force must be structured and managed as a disciplined military force. This was reaffirmed in the constitutional matter of *Minister of Defence v Potsane and Legal Soldier (Pty) Ltd and Others v Minister of Defence and Others*.[64] Thus, military law is a self-regulator of the conduct of members of the National Defence Force and achieves this by imposing disciplinary action for breaches of the behavioural norm.

International Humanitarian Law (IHL) further regulates the conduct of soldiers during peace and armed conflict.[65] The conduct of soldiers during armed conflict (*jus in bello*) is the cornerstone by which all acts or omissions are evaluated.[66] The incorporation of the Geneva Conventions and the Additional Protocols in South African legislation has further created the obligation on uniformed members to abide by, report and disseminate information on the conduct of National Defence Force members during times of peace and armed conflict.[67]

Military ethics developed over centuries, beginning with the writings of Judeo-Christian teachings, St Augustine, Thomas Aquinas and others.[68] Such writings developed into the modern-day law of armed conflict (LOAC). The United Nations Charter sets out the lawful or ethical reasons for entering into armed conflict (*ius ad bellum*) and the Geneva Conventions and Additional Protocols, the lawful and ethical conduct in war (*ius in bellum*).[69] Military ethics concerns itself with *ius in bellum* principles that include the principles of military necessity, proportionality (avoiding unnecessary suffering) and distinction.[70]

Military forces the world over impart in their members a code of ethics or conduct they expect their soldiers to maintain in their profession.[71] The South African National

64 *Minister of Defence v Potsane and Another, Legal Soldier (Pty) Ltd and Others v Minister of Defence and Others* (CCT29/01, CCT14/01) [2001] ZACC 12; 2002 (1) SA 1 (CC); 2001 (11) BCLR 1137 (5 October 2001) para 10.

65 Such as the Geneva Conventions and Additional Protocols, peremptory norms, treaties entered into by state parties.

66 Principles of the law of war which require the soldier to distinguish between combatants and non-combatants, use the necessary amount of force to reach the military objective (proportionality), only attack targets to gain a distinct military advantage (military necessity) and to limit the harm inflicted (avoiding unnecessary suffering).

67 Implementation of Geneva Conventions Act 8 of 2012.

68 ML Gross & D Carrick *Military medical ethics for the 21st Century* (2016) 265.

69 As above.

70 As above.

71 P Cook "A Profession Like no Other" in Lucas (ed) *Routledge Handbook of Military Ethics* (2015) 26m writes: "What distinguishes the military profession as a profession? All professions use intellectual achievement and learning, and all professions render service. The profession of arms is the ultimate in each of these respects, involving academic learning in several

© University of Pretoria

Defence Force (SANDF) similarly has a Code of Conduct for uniformed members. The Code, although non-binding (as it is not legislation), enshrines the principles every member has to strive to maintain. Breaches of the Code results indisciplinary action by the military authorities.

The Code of Conduct for uniformed members reads as follows:[72]

- I pledge to serve and defend my country and its people in accordance with the Constitution and law and with honour, dignity courage and integrity.
- I serve in the SANDF with loyalty and pride, as a citizen and a volunteer.
- I respect the democratic political process and civil control of the SANDF.
- I accept personal responsibility for my actions.
- I will obey all lawful commands and respect all superiors.
- I will refuse to obey an obviously illegal order.
- I will carry out my mission with courage and assist my comrades-in-arms, even at the risk of my own life.
- I will treat all people fairly and respect their rights and dignity at all times, regardless of race, ethnicity, gender, culture, language or sexual orientation.
- I will respect and support subordinates and treat them fairly.
- I will not abuse my authority, position or public funds for personal gain, political motive or any other reason.
- I will report criminal activity, corruption and misconduct to the appropriate authority.
- I will strive to improve the capabilities of the SANDF by maintaining discipline, safeguarding property, developing skills and knowledge, and performing my duties diligently and professionally.

The Code acknowledges the supremacy of the Constitution, 1996 and the rule of law. Thus, from the onset, only lawful acts are sanctioned. No citizen serves without their explicit consent (full volunteer force). The democratic order and civilian control of the SANDF are emphasised. The SANDF is not a power onto itself and civilian oversight is accepted.[73] Accountability, courage, integrity, loyalty and honour feature as the core values necessary for service. Constitutional principles of non-racialism, non-sexism, dignity, gender equality and so forth are pledged. The obligation to report criminal activity, corruption and abuse of position is created. The code ends with an undertaking to improve the capabilities of the SANDF and a promise to maintain

disciplines, and the dedication of both body and soul in service to the public. The profession is unique in that the aspiration toward its most salient activity, killing, would disqualify the aspirant from membership in it. All professions have a code of conduct, but the military has, in addition, a complex, in some ways convoluted, moral arena that its members must navigate."

[72] Available at https://www.researchgate.net/figure/Code-of-Conduct-for-Uniformed-Members-of-the-SANDF (accessed 1 February 2021).

[73] Sec 202 Constitution, 1996.

© University of Pretoria

professionalism. The "profession of arms"[74] calls upon military officers to be "self-regulating members of a venerable body of experts whose values and standards sanction their activity."[75] Military ethics is thus strongly rooted in the just war doctrine.[76]

2.3 Military medicine and bioethics

In the previous section, medical ethical theories were described as theories of public policy medical ethics, applied medical ethics and clinical ethics. Military medical ethics brings together or combines medical ethics and military ethics. The practice of medicine in the military is fraught with conflict between the healthcare professional's duty to the patient and their duty to the state. It is this dual loyalty that plagues the military healthcare professional in the lawful and ethical execution of medical practice within the armed forces.[77] During peacetime, medical ethics in military medicine remains largely the same as in a civilian setting. The four-principle approach of autonomy, beneficence, non-maleficence and justice are maintained in the doctor-patient relationship.[78]

2.3.1 Military medical ethics

Medical ethics is put to the test during extreme situations such as during armed conflict.[79] International humanitarian law provides for the protection of the wounded and the sick during armed conflict.[80] The ethical practice of medicine on the battlefield is central to the protection of the wounded and sick in war under international humanitarian law.[81] Both violations of law and ethics may result in the healthcare professional being personally accountable for their acts or omissions.

During armed conflict the dichotomy of physician roles between obligations to the individual (soldier-patient) versus the obligation to the collective (state or military command) creates situations where there is conflict with the precepts of traditional medical ethics. Unique stressors for decision-making are introduced on the battlefield and medical decisions are not spared.[82] Conflicts between medical and military ethics include, but are not limited to, triage principles, participation of physicians in torture,

---

74 Cook in Lucas 374.
75 As above.
76 Lounsbury & Bellamy 223. War may only be pursued if it is both moral and lawful, conforming to international law of war.
77 Gross & Carrick 266.
78 The four principles-approach developed by Beauchamp and Childress, Veatch and Engelhardt..
79 MJ Gunn & H McCoubrey *Medical Ethics and Laws of Armed Conflicts* 133.
80 As above.
81 As above.
82 Lounsbury & Bellamy "Forword" xiii.

© University of Pretoria

returning soldiers to the battlefield before they are ready, breaches of confidentiality and so forth.[83]

Messelken and Baer describe three approaches to dealing with conflicts between military ethics and medical ethics.[84] First, that the military obligation and medical obligation are dilemmatic in that physicians have dual loyalties to the military and their patients. Second, by prioritising the role of the physician over that of the military; and third, situations where military necessity will trump medical ethical obligations.[85]

Howe[86] presents yet another approach to dealing with dual loyalty conflicts that plague military healthcare professionals based on the practitioner either adopting a military-centred approach or a discretionary approach to dual loyalty ethical issues.

2.3.2 International Humanitarian Law and military medical ethics

Military medical ethics has developed over time[87] but it was not until the recorded observations[88] of Henry Dunant during the 19th century battles in Northern Italy that the first drafting of the Geneva Conventions[89] would create binding obligations on signatory states (and later customary international law) on the battlefield in the care of those fallen and the infirm.

The beginning of the modern legal code of battlefield medical ethics lies in the 1864 (first) Geneva Convention.[90] Of the most important ethical principles that were established in the 1864 Convention (that persist till today) are the neutrality of those who collect and care for the sick and wounded and the obligation to provide treatment to all sick or wounded parties (the principle of beneficence), regardless of which nation they belong to.[91]

The armed conflicts that followed the adoption of the First Geneva Convention increased in brutality and in the scale of destruction of both lives and property.[92] The Conventions reacted and adapted to each new scale of conflict till the drafting of the 1949 Convention and the adoption of the Additional Protocols in 1977. The 1949

83. Lounsbury & Bellamy 296.
84 Gross & Carrick 266.
85 As above, 269.
86 Howe as cited in Lounsbury & Bellamy ch 12.
87 Gunn & McCoubrey 133.
88 H Dunant *A Memory of Solferino* International Committee of the Red Cross (1959).
89 First Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field (1864).
90 Gunn & McCoubrey 135.
91 As above.
92 Gunn & McCoubrey 136.

© University of Pretoria

Conventions and the Additional Protocols were uncontroversial with regard to military medical ethics, they restated and detailed many of the existing principles.[93]

2.3.3 Medical ethics and the Geneva Conventions and Additional Protocols

Article 12 of the First Geneva Convention describes medical ethical principles consistent with general medical ethical principles.[94] These are outlined below.

Respect, protection and care of the wounded [95]

Consistent with the principles of autonomy, beneficence and non-maleficence, Article 12 places an obligation on the party (irrespective of which side of the conflict they find themselves) to respect (autonomy), protect (non-maleficence) and care for (beneficence) the sick and wounded. The wounded soldiers of belligerent parties, therefore, were the first to receive codified protection under the 1864 Geneva Conventions, due in part to the observation and work of Henry Durant.[96] Article 12 of the First Convention is considered the foundation of the legal protection of the wounded and sick that is still applicable today.[97] Obligations are created for parties to an armed conflict to act or to refrain from acting in certain ways.[98]

The protection and care of the wounded and sick, however, are further described in other articles of the Conventions.[99] The protection of the wounded and sick has developed to such an extent that today it forms part of customary international law.[100] Article 15[101] compliments Article 12[102] of the First Geneva Convention in that further

---

93 As above.

94 (1) Members of the armed forces and other persons mentioned in the following Article, who are wounded or sick, shall be respected and protected in all circumstances.
(2) They shall be treated humanely and cared for by the Party to the conflict in whose power they may be, without any adverse distinction founded on sex, race, nationality, religion, political opinions, or any other similar criteria. Any attempts upon their lives, or violence to their persons, shall be strictly prohibited; in particular, they shall not be murdered or exterminated, subjected to torture or to biological experiments; they shall not willfully be left without medical assistance and care, nor shall conditions exposing them to contagion or infection be created.
(3) Only urgent medical reasons will authorize priority in the order of treatment to be administered.
(4) Women shall be treated with all consideration due to their sex.
(5) The Party to the conflict which is compelled to abandon wounded or sick to the enemy shall, as far as military considerations permit, leave with them a part of its medical personnel and material to assist in their care.

95 (1) Members of the armed forces and other persons mentioned in the following Article, who are wounded or sick, shall be respected and protected in all circumstances.

96 Fn 88 above.

97 GC I Commentary (2016) 1322.

98 As above.

99 Art 12 GC II; Art 16(1) GC IV; Art 10 AP I; Common Art 3 of the Geneva Conventions; Art 7 AP II.

100 ICRC *Study on customary international humanitarian law* (2005) Rules 109-111.

101 (1) At all times, and particularly after an engagement, Parties to the conflict shall, without delay, take all possible measures to search for and collect the wounded and sick, to protect

© University of Pretoria

obligations arise for the respect and protection of those *hors de combat* during international armed conflict. The obligation to (without delay) search and collect the wounded and sick and then offer protection against ill-treatment and pillage, is in line with the beneficent and non-maleficent bioethical principles.[103] The second and third paragraphs of the article provide means and methods of achieving these obligations.

Non-discrimination

Non-discrimination[104] entails that the wounded and sick includes allied and enemy forces and all other persons (including but not limited to civilian actors).[105] In order to qualify for the protection afforded, persons need not only be wounded and/or sick but must no longer take part in any form of hostile action.[106] Due to their inflictions the further provision is that medical care is required.[107] The non-discrimination of the wounded and sick does not merely apply to military (or civilian) medical personnel but to all other persons directly (combatants) or indirectly (civilian population) involved in armed conflict.[108] The persons placed as *hors de combat* are neutralised[109] and no distinction other than medical criteria may be employed.[110]

As the nature of warfare has changed and developed over the centuries, so too has the involvement of woman in warfare. Women today play an increasingly active part in all spheres of military service, from frontline combat duties to support functions both on and beyond the battlefield.[111] Article 12(4) is an important provision in the Conventions that draws on the positive obligation to distinguish the needs of women in the phrase “all consideration due to their sex”.[112] The non-discriminatory nature of the article mirrors the modern-day Hippocratic Oath as proclaimed in the World Medical

---

them against pillage and ill-treatment, to ensure their adequate care, and to search for the dead and prevent their being despoiled.
(2) Whenever circumstances permit, an armistice or a suspension of fire shall be arranged, or local arrangements made, to permit the removal, exchange and transport of the wounded left on the battlefield.
(3) Likewise, local arrangements may be concluded between Parties to the conflict for the removal or exchange of wounded and sick from a besieged or encircled area, and for the passage of medical and religious personnel and equipment on their way to that area.

102 GC I Commentary (2016) 1476.
103 Art 15(1) GC I.
104 Art 12(1) GC I ‘members of the armed forces and other persons” and Art 12(2) GC I ‘without any adverse distinction founded on sex, race, nationality, religion, political opinions or any other similar criteria’; Art 12(1) GC I Commentary (2016) 1392.
105 Art 12(1) GC I. The article is drafted broadly as not to distinguish on which side of the battlefield the wounded or sick originated from.
106 GC I Commentary (2016) 1343.
107 As above.
108 GC I Commentary (2016) 1361.
109 Gunn & McCoubrey 138.
110 As above.
111 GC I Commentary (2016) 1426 & 1427.
112 GC I Commentary (2016) 1437.

© University of Pretoria

Association's Declaration of Geneva (1949 and subsequently amended by the 68th WMA General Assembly, Chicago, USA of October 2017).[113] Protocol I additional to the Geneva Conventions, 1977 enunciates the 1949 Geneva Conventions at Art 10(2).[114]

Duty to care

Article 12(2) imposes positive actions upon the state party on the territory of which the wounded and sick find themselves. The obligations created are not restricted to the acts of medical personnel but are on all who are party to the conflict.[115] The article specifies the non-discrimination principle, the obligation to respect and the obligation to protect. Included in the article are the specific medical ethical principles of non-maleficence (prohibition of extermination, experimentation and torture), beneficence (obligation to provide care, obligation not to abandon the wounded and sick without medical care) and not to worsen the condition by creating contagion and infection.

The provision of care to the wounded and sick as stipulated in the article raises medical ethical dilemmas. The article provides that "medical assistance and care" be afforded. However, the standard of care is not specified in the article but is described in the 1977 Additional Protocol 1 at article 10(2) as to be to the "fullest extent practicable".[116] Therefore, care should be provided to the fullest extent practicable[117] by the state providing the care and not simply the minimum necessary.[118] Article 15(1), too, refers to "adequate care". This provision clearly identifies that the medical capabilities of states party to a conflict may not be equal.[119] Resources and the structuring of the military of a particular state will determine the standard of medical care available at the

113 The Physician's Pledge: "As a member of the medical profession: I solemnly pledge to dedicate my life to the service of humanity; The health and well-being of my patient will be my first consideration; I will respect the autonomy and dignity of my patient; I will maintain the utmost respect for human life; I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing, or any other factor to intervene between my duty and my patient; I will respect the secrets confided in me, even after the patient has died; I will practice my profession with conscience and dignity and in accordance with good medical practice; I will foster the honour and noble traditions of the medical profession; I will give to my teachers, colleagues, and students the respect and gratitude that is due; I will share my medical knowledge for the benefit of the patient and the advancement of healthcare; I will attend to my own health, well-being and abilities in order to provide care of the highest standard; I will not use my medical knowledge to violate human rights and civil liberties, even under threat; I make these promises solemnly, freely, and upon my honour."

114 'In all circumstances they shall be treated humanely and shall receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition. There shall be no distinction among them founded on any grounds other than medical ones'.

115 GC I Commentary (2016) 1370.

116 GC I Commentary (2016) 1383.

117 Art 10(2) AP I.

118 GC I Commentary (2016) 1383.

119 As above.

© University of Pretoria

various levels of the battlefield.[120] As regards standards of medical ethics, the World Medical Association has provided guidance on the minimum requirements of medical ethics and professional conduct.[121] The provision of medical care must remain within the guidelines of medical ethics.[122]

Where situations arise that may warrant the evacuation of forces but the specific situation would require the wounded and sick to remain due to certain exigencies, the command must provide for continued medical care.[123] Remaining medical personnel and material must provide such care, thus ensuring the beneficent continued care despite falling into enemy hands.[124]

Priority in the order of treatment: Triage principles

Deciding on priority in the order of treatment constitutes one of the most difficult medical and ethical challenges any healthcare professional will face in their career, whether in combat or in civilian practice.[125] Triage, or the sorting of the wounded and sick into order of priority is practiced daily in any medical establishment receiving multiple patients at any given time.[126] Care is prioritised according to who requires care first based on the severity of their injuries.[127]

However, in the extreme circumstances that exist on the battlefield, where volumes of wounded (or sick) may exceed resources available, prioritisation of care follows a path where the wounded who are most likely to survive are treated first.[128] This situation does not mean that the most seriously wounded or those who require medical resources beyond the capabilities of the military medical facility simply are not afforded any care.[129] Article 12(3) of the First Geneva Convention prohibits treatment priorities

---

120 GC I Commentary (2016) 1384.

121 Instruments concerning medical ethics in times of armed conflict, especially: the World Medical Association's Regulations in Times of Armed Conflict (adopted by the 10th World Medical Assembly, Havana, Cuba, October 1956, as amended or revised in 1957, 1983, 2004, 2006 and 2012); Rules Governing the Care of Sick and Wounded, Particularly in Time of Conflict (adopted by the 10th World Medical Assembly, Havana, Cuba, October 1956, edited and amended in 1957 and 1983); Standards of Professional Conduct regarding the Hippocratic Oath and its modern version, the Declaration of Geneva, and its supplementary International Code of Medical Ethics (adopted by the 3rd WMA General Assembly, London, England, October 1949, as amended in 1968, 1983 and 2006). See also ICRC, *Health Care in Danger: The Responsibilities of Health-Care Personnel Working in Armed Conflicts and Other Emergencies*, ICRC, Geneva, 2012 55–62.

122 GC I Commentary (2016) 1385.

123 Art 12(5) GC I.

124 As above.

125 ICRC *First Aid in Armed Conflicts and Other Situations of Violence* (2010) 116.

126 C Merrick (ed) *ATLS® Advanced trauma life support: Student Course Manual* (10th ed) 6.

127 As above.

128 Gunn & McCoubrey 146.

129 "Obviously those who have no chance of survival will be treated after those who have a chance of survival, but however badly a patient is hurt, even if he is dying, he will be properly cared

© University of Pretoria

other than urgency of medical care.

This situation has the potential to evoke severe conflicts of interest in the military medical practitioner when faced with wounded and sick from own forces, enemy forces and civilians at a single moment. At first instance, the military medical practitioner would either gravitate towards treating own comrades regardless of the severity of their condition or be ordered by their military command to attend to their own forces first. Thus a distinction is drawn on the nationality of the wounded/sick which may constitute a breach of international humanitarian law.[130] According to IHL, however, the military healthcare professional is permitted to draw a distinction based solely on the severity of their patient's medical condition.[131] First Protocol Additional to the Geneva Conventions reiterates the prioritisation of the sick and wounded according to medical ethical principles in that "they shall be treated humanely and shall receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition".[132] The rules of medical ethics will dictate to the military medical practitioner the order of treatment, as the Conventions do not define "urgent medical reasons".[133] This dilemma is discussed more fully in the chapters that follow.

The Protection of Medical Ethics

Notwithstanding transgressions of law relating to the conduct of healthcare professionals, the Health Professions Act of 1974, the Nursing Act 33 of 2005 and the Allied Health Professions Act 63 of 1982 describe sanctions for practitioners found guilty of unprofessional or unethical conduct.[134] A sanction, after due professional conduct hearings are held, may be imposed on the transgressor.[135] No distinction is made to professional conduct of healthcare professionals during times of peace or armed conflict.[136] Thus the military healthcare professional is obligated to adhere to professional conduct as prescribed by law and respective statutory professional bodies.

IHL has identified the importance of ethical professional conduct, not only in the belligerents to an armed conflict but has codified the conduct of healthcare

for and be comfortable" Col Kaj Mollefors, Commander of a Swedish Medical Unit in the First Gulf War, cited in Gunn & McCoubrey 146.

130 GC I Commentary (2016) 1421.

131 GC I Commentary (2016) 1423.

132 Art 10(2) GC I.

133 GC I Commentary (2016) 1422.

134 Health Professions Act, 1974 defines unprofessional conduct as "improper or disgraceful or unworthy conduct or conduct which when regard is had to the profession of a person who is registered in terms of this Act, is improper or disgraceful or dishonourable or unworthy".

135 Sec 42 Health Professions Act, 1974.

136 See above.

© University of Pretoria

professionals.[137] Article 28 of the First Geneva Convention describes the obligation on parties to an international armed conflict towards medical and religious personnel[138] and article 28(2)[139] specifies that medical personnel must carry out their profession in accordance with professional ethics and their spiritual and medical duties.

Civilian healthcare professionals, military healthcare professionals and ordinary persons are protected from any sanction that may be brought in relation to the execution of tasks relating to medical care that are not in accordance with medical ethics.[140] Persons who act against the prescripts of established medical ethical principles will not be able to rely on the defence of acting under the orders of a superior.[141]

In addition to the cited articles in the Conventions, the ICRC's study on customary IHL and their publication thereof reinforce the obligation to ethical conduct of belligerents. Adherence to medical ethical principles is protected in rule 26: "Punishing a person for performing medical duties compatible with medical ethics or compelling a person engaged in medical activities to perform acts contrary to medical ethics is prohibited during either International Armed Conflict/Non-International Armed Conflict."[142]

Autonomy

---

137 Art 28 GC I, Art 16 AP I & Art 10 AP II.

138 Art 24 & 26 GC I.

139 (2) Personnel thus retained shall not be deemed prisoners of war. Nevertheless they shall at least benefit by all the provisions of the Geneva Convention relative to the Treatment of Prisoners of War of 12 August 1949. Within the framework of the military laws and regulations of the Detaining Power, and under the authority of its competent service, they shall continue to carry out, in accordance with their professional ethics, their medical and spiritual duties on behalf of prisoners of war, preferably those of the armed forces to which they themselves belong. They shall further enjoy the following facilities for carrying out their medical or spiritual duties.

140 Arts 16(1) & 16(2) AP I: Respect and application of medical ethics:
'1. Under no circumstances shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of the person benefiting therefrom.
2. Persons engaged in medical activities shall not be compelled to perform acts or to carry out work contrary to the rules of medical ethics or to other medical rules designed for the benefit of the wounded and sick or to the provisions of the Conventions or of this Protocol, or to refrain from performing acts or from carrying out work required by those rules and provisions.'
Art 10 AP II General protection of medical ethics:
'1. Under no circumstances shall any person be punished for having carried out medical activities compatible with medical ethics, regardless of the person benefiting therefrom.
2. Persons engaged in medical activities shall neither be compelled to perform acts or to neither carry out work contrary to, nor be compelled to refrain from acts required by, the rules of medical ethics or other rules designed for the benefit of the wounded and sick, or this Protocol'.

141 Arts 8 and 6 respectively of the International Military Tribunal at Nuremburg and the International Military Tribunal (Far East) at Tokyo.

142 J-M Henckaerts *Study on Customary International Humanitarian Law* Annex: List of Customary Rules of International Humanitarian Law available at https://www.icrc.org (accessed 24 November 2020).

© University of Pretoria

Autonomy, or at least the respect for the autonomous decision making of an individual with regards to medical treatment and medical experimentation, is a cornerstone of medical ethics.[143] Under South African law, healthcare professionals have no right to treat without obtaining the informed consent of their patients, without which serious violation of bodily integrity occurs.[144] This requirement remains true in a military medical environment. Ordinarily, in peacetime the uncomplicated provision of medical care to uniformed members will follow the legal and ethical prescripts of a civilian or private encounter. It is however in the extreme conditions of battlefield situations that eliciting informed consent is met with a plethora of challenges.[145]

Article 11 of the First Protocol Additional to the Geneva Conventions describes matters related to the principle of autonomy, particularly that of consent.[146] The article applies to "persons who are in the power of the adverse Party or who are interned, detained or otherwise deprived of liberty as a result of a situation". However, it is

---

143 Beauchamp & Childress 99.

144 Sec 12(1) Constitution, 1996.

145 Unconsciousness, extreme pain, acute episodes of depression, hypovolemic states with altered mental acuities and so forth all contribute to a truly informed consent process from being applied. The autonomous nature of decision-making in the military is examined in chapter 6 of this thesis.

146 Art 11 AP I: Protection of persons
'1. The physical or mental health and integrity of persons who are in the power of the adverse Party or who are interned, detained or otherwise deprived of liberty as a result of a situation referred to in Article 1 shall not be endangered by any unjustified act or omission. Accordingly, it is prohibited to subject the persons described in this Article to any medical procedure which is not indicated by the state of health of the person concerned and which is not consistent with generally accepted medical standards which would be applied under similar medical circumstances to persons who are nationals of the Party conducting the procedure and who are in no way deprived of liberty.
2. It is, in particular, prohibited to carry out on such persons, even with their consent:
(a) physical mutilations;
(b) medical or scientific experiments;
(c) removal of tissue or organs for transplantation,
except where these acts are justified in conformity with the conditions provided for in paragraph 1.
3. Exceptions to the prohibition in paragraph 2 (c) may be made only in the case of donations of blood for transfusion or of skin for grafting, provided that they are given voluntarily and without any coercion or inducement, and then only for therapeutic purposes, under conditions consistent with generally accepted medical standards and controls designed for the benefit of both the donor and the recipient.
4. Any wilful act or omission which seriously endangers the physical or mental health or integrity of any person who is in the power of a Party other than the one on which he depends and which either violates any of the prohibitions in paragraphs 1 and 2 or fails to comply with the requirements of paragraph 3 shall be a grave breach of this Protocol.
5. The persons described in paragraph 1 have the right to refuse any surgical operation. In case of refusal, medical personnel shall endeavour to obtain a written statement to that effect, signed or acknowledged by the patient.
6. Each Party to the conflict shall keep a medical record for every donation of blood for transfusion or skin for grafting by persons referred to in paragraph 1, if that donation is made under the responsibility of that Party. In addition, each Party to the conflict shall endeavour to keep a record of all medical procedures undertaken with respect to any person who is interned, detained or otherwise deprived of liberty as a result of a situation referred to in Article 1. These records shall be available at all times for inspection by the Protecting Power'.

© University of Pretoria

contended that this article would apply *mutatis mutandis* to uniformed members during the ordinary course of their service.[147] This is because autonomous decision-making relating to medical decisions is the cornerstone of medical ethics.[148] Medical service during peacetimes remains the same with the exception that the soldier should be informed of service consequences should certain treatment/procedures not be consented. Medical autonomy and the soldier is discussed in chapter 6 under paragraph 2.

Confidentiality[149]

Privacy and medical confidentiality, or doctor-patient privilege, are considered the most fundamental aspect of the doctor-patient relationship and the ethical practice of medicine.[150] When seeking medical care the associative expectation of confidentiality is of a practical nature. Medical confidentiality would encourage persons to seek medical intervention without the fear of being shamed or embarrassed.[151]

Commentary to the First Additional Protocol of 1987 describes Article 16(3) as not concerning "medical confidentiality", but rather the denouncement of the sick and wounded by all persons engaged in medical care.[152] The provision was discussed at length by various international law commissions and within medical circles to conclude that because of the experiences of the Second World War, persons engaged (not restricted to medical personnel) in the care for the wounded and sick, were to be protected from being persecuted for concealing those under their care regardless of which side they were from.[153] However, the provision does leave a very wide discretion on those providing care to denounce or inform on those under their care if the particular situation warrants such or if national legislation requires it.[154] The mandatory disclosure of communicable diseases is placed on all that care for the sick and wounded much the same way as is required by South African national

147 Sec 12(1) Constitution 1996 and *Castell v De Greef* 1994 (4) SA 408 (C).
148 Fn143 above.
149 Art 16(3) AP II: Confidentiality:
'No person engaged in medical activities shall be compelled to give to anyone belonging either to an adverse Party, or to his own Party except as required by the law of the latter Party, any information concerning the wounded and sick who are, or who have been, under his care, if such information would, in his opinion, prove harmful to the patients concerned or to their families. Regulations for the compulsory notification of communicable diseases shall, however, be respected".
150 H Bloom & M Bay (eds) *A practical guide to mental health, capacity, and consent law of Ontario* (1996) 379; GT Laurie "Challenging medical-legal norms: The role of autonomy, confidentiality, and privacy in protecting individual and familial group rights in genetic information" (2001) 22 *Journal of legal medicine* 15a.
151 MA Hall *et al Health care law and ethics in a nutshell* (2nd ed) (1999) 118.
152 AP I Commentary (1987) 670.
153 As above 671 & 672.
154 As above 676.

© University of Pretoria

legislation.[155]

The Second Additional Protocol contains similar provisions with regard to the protection of those engaged in medical activities at article 10.[156] Distinction is drawn between paragraphs 3, where the obligation is for the ethical practice of medical confidentiality and paragraph 4, where protection is afforded those who provide medical care.[157] Both provisions are subject to national legislation.[158]

Although the First and Second Protocols Additional to the Geneva Conventions describe confidentiality, commentators have reiterated that the confidentiality is not purely based on that of medical confidentiality of the doctor-patient relationship. This does not mean that the ethical obligation of medical confidentiality is not protected but rather that the obligation is protected under provisions detailing respect and protection for medical ethical practice.[159]

Mandatory disclosure of medical information

Article 16 of the First Geneva Convention concerns the identification of the wounded, sick or deceased that fall into the hands of the adverse party.[160] Disclosure of personal information is made only under the conditions where belligerents fall into the hands of the adverse party. The obligation created by Article 16 is the identification (via prescribed procedures) of the sick, wounded and dead back to their respective

---

155 Art 16(3) AP I and AP I Commentary 679.

156 Art 10 AP II: General protection of medical duties
1. Under no circumstances shall any person be punished for having carried out medical activities compatible with medical ethics, regardless of the person benefiting therefrom.
2. Persons engaged in medical activities shall neither be compelled to perform acts or to carry out work contrary to, nor be compelled to refrain from acts required by, the rules of medical ethics or other rules designed for the benefit of the wounded and sick, or this Protocol.
3. The professional obligations of persons engaged in medical activities regarding information which they may acquire concerning the wounded and sick under their care shall, subject to national law, be respected.
4. Subject to national law, no person engaged in medical activities may be penalized in any way for refusing or failing to give information concerning the wounded and sick who are, or who have been, under his care.

157 AP II Commentary (1987) 4696.

158 As above 4698.

159 Fn 156 above.

160 Art 16 GC I:
Parties to the conflict shall record as soon as possible, in respect of each wounded, sick or dead person of the adverse Party falling into their hands, any particulars which may assist in his identification.
These records should if possible include:
a) designation of the Power on which he depends;
b) army, regimental, personal or serial number;
c) surname;
d) first name or names;
e) date of birth;
f) any other particulars shown on his identity card or disc;
g) date and place of capture or death;
h) particulars concerning wounds or illness, or cause of death.

© University of Pretoria

authorities so that families may be informed.[161] Included in the list of particulars to be recorded is the disclosure of medical conditions.[162] Commentators take cognisance of the ethical obligations of healthcare professionals and the disclosure of medical information.[163] Firstly, healthcare professionals must be involved in the recording of medical information and, secondly, consent should be gained for the disclosure of the medical information.[164] However, it is commented that statutory provisions (in this case article 16 itself) serve as the authority to disclose medical information in lieu of patient consent.[165]

3. Conclusion

The chapter explored the origins and the nature of medical ethics. The core 'mantra' of bioethics (autonomy, beneficence, non-maleficence and justice) as these principles relate to international and domestic law was examined and will be expanded on in subsequent chapters. Ethical guidelines or principles, unlike legislation, do not have the force of the law. Ethics remains legally unenforceable; professional sanction is the only sanction for the transgression of ethical rules. History is rife with medical ethical transgressions that continue to this day. The application of ethical principles in military medicine, together with continued education and developments in the field, will eventually enable the ethical military medical practitioner to identify, dissect and defuse bioethical tribulations in the military environment.

Healthcare professionals employed in the armed forces will be confronted with a dual loyalty scenario in their careers. The pressure under which military healthcare professionals will be placed will generate difficulties unknown to civilian practitioners. The guidelines for ethical practice in such austere situations must be clearly defined and accessible to reference. In so doing, military healthcare professionals placed under extreme pressure to act unethically will have the courage, integrity and legal resolve to weather the storm and act in the best interests of their patients.

The principles listed in this chapter do not represent an exhaustive list of all ethical guidelines to be employed in practice but rather are a minimum standard to comply with. At the very least, care must be provided within the realistically available resources and considering the exigencies of the combat situation.

161 GC I Commentary (2016) 1527.
162 Art 16(2) GC I.
163 GC I Commentary (2016) 1578.
164 As above.
165 As above.

© University of Pretoria

The following chapters examine more closely the dichotomies that are faced by military medical practitioners in the provision of treatment for the sick and wounded in a military operational environment while applying the standards of bioethics and international humanitarian law.

© University of Pretoria

CHAPTER 4

THE PROFESSIONAL SOLDIER AND THE PROFESSION OF MEDICINE: POLAR OPPOSITES?

OUTLINE

1. Introduction
2. The profession of arms
2.1 Introduction
2.2 Models of military professionalism
2.2.1 Huntington's The soldier and the state
2.2.2 Allen Millet: Military professionalism and officership in America
2.2.3 Moskos: The institutional and the occupational military professional
2.3 The professional soldier?
2.4 Conclusion
3. The medical profession
3.1 Introduction
3.2 The medical profession in South Africa
3.3 Medicine and the models of professionalism
3.4 A comparison between the medical and the soldiering professions
3.5 Conclusion
4. Dual loyalty dilemmas
4.1 Introduction
4.2 Polarisation of the topic of dual loyalties in military medicine
4.3 Approaches in resolving dual loyalty conflicts
4.3.1 The Messelken/Baer approach
4.3.2 The Howe approach
5. Conclusion

©University of Pretoria

1. Introduction

> Making doctors into soldiers was difficult, maybe impossible, maybe because of the value judgments learned in our schooling and in our caring for the ill. Making doctors of soldiers would probably be easier …[1]

The previous chapters described the legislation, international instruments and bioethical principles embodied in medical ethics that regulate the medical profession. It was established that military healthcare practitioners are subject to the same legislation and ethical principles as are their civilian counterparts, with the additional demands of military law and obligations under international treaties and conventions.

This chapter compares the professions of soldiering to that of medicine by examining the profession of arms and the medical profession. On the face of it, it may seem that the two professions are polar opposites, never to be considered in the same context. However, just as a magnetic field, the flow of particles around the respective poles creates something most useful if applied correctly. So too can the professions of soldiering and medicine co-exist.

The skilled surgeon may have to remove the diseased organ or tissue in order to save the body whilst the soldier may destroy property and lives in order to save a nation. This simple analogy will be described in greater detail so as to lay the basis for the subsequent analysis of the legal and ethical dichotomies that are faced by the military healthcare professional.

2. The profession of arms

2.1 Introduction

Modern professional militaries expend a great amount of time to train all members of the armed forces in basic soldiering skills, before progressing to more advanced and specific military training.[2] Soldiers are members of the armed forces of a nation.[3] The

---

1 JA Parrish *A doctor's year in Vietnam* (1972) 9 as cited in DE Lounsbury & RF Bellamy, *Military Medical Ethics* vol 1 (2003) 271.

2 Sec 63-65 Defence Act 42 of 2002 describes the obligation created to train members of the SANDF in skills learned at military training institutions and/or tertiary training institutions.

3 Sec 199(1) Constitution, 1996 creates a single defence force for the Republic.

South African National Defence Force (SANDF) prescribes a Code of Conduct[4] which is enforced by a Military Disciplinary Code (MDC) and a military courts system structured under the Military Disciplinary Supplementary Measures Act 16 of 1999 (MDSMA).[5] Healthcare professionals are required to be registered with their respective professional councils in order to practice in the SANDF.[6] Soldiers are paid according to their specific rank group and mustering,[7] or according to an occupational-specific dispensation (OSD) applicable to certain professional mustering.[8]

The history of military service in South Africa reflects the political landscape of the respective times of its adjustment.[9] Compulsory military service for white male South Africans was for two years and included compulsory periodic service[10] totalling 270 days.[11] Conscription was suspended on 24 August 1993 by the then Minister of Defence, Kobie Coetzee.[12] However, reserve service call-ups continued.[13] Military service in the new SANDF was (and remains) voluntary.[14] The professional soldier is free to serve as long as their conditions of service permit.[15] The exception to voluntary military service for serving members is restricted by the obligation to serve in times of war, states of national defence and during a state of emergency.[16]

The task of a military force is primarily to defend the territorial sovereignty of the state.[17] The SANDF can be deployed to protect the interests of the state and assist other state departments during times of disaster, assist other law enforcement agencies, effect border control or where a specific need arises and is requested.[18] The defence force of a state employs a diverse cadre of members able to execute various tasks, but

---

4 Available at https://www.researchgate.net/figure/Code-of-Conduct-for-Uniformed-Members-of-the-SANDF (accessed 1 February 2021).

5 The Military Disciplinary Supplementary Measures Act 16 of 1999 and the Military Disciplinary Code (First Schedule to the Defence Act 44 of 1957).

6 Ch XV of the General Regulations to the Defence Act: Definition of a "medical officer" means 'a person entitled to practise as a medical practitioner in terms of section 17 of the Health Professions Act 56 of 1974".

7 Sec 55 Defence Act, 2002.

8 Inter alia medical and nursing practitioners and legal practitioners.

9 TJ Stapleton *A Military History of South Africa. From the Dutch Koi Wars to the End of Apartheid* (2010) 153-159.

10 As above, 158.

11 As above.

12 Defence Amendment Act 69 of 1967.

13 As above.

14 Fn 4 above.

15 Sec 59 Defence Act, 2002.

16 Sec 48 Defence Act, 2002.

17 Sec 200 (2) Constitution, 1996.

18 As above; sec 201(2) & sec18 Defence Act, 2002.

the primary (and numerically superior enlistment) function is that of combat troops and their support elements.

Modern military forces are a product of centuries of conflict. Modern armies have only been in existence since the 17th century.[19] Prior to such establishments, soldiers and soldiering developed from ancient times in which the protection of the self, family and communities was the highest priority.[20] With the development of agriculture, societies (and later states) and technological advances, the need to protect collective interests by dedicated armed forces also grew.[21] With modern established armies came dedicated military schools tasked with the development and training of a professional officer corps in Europe and North America dating back to the beginning of the 19th century.[22]

Military training began with introductory schools that taught basic soldering skills before channelling cadets into more specialised fields.[23] Military training is not only primarily focused on the technical skills required to perform a specific mustering (infantry, signal corps, artillery, sailor, airman and so forth), but places emphasis on military ethics and the law of war.[24]

The modern soldier in the SANDF serves as a volunteer armed with specific technical skills to execute lawful commands from superior officers. The soldier is a combatant[25] and, as such, certain rights and obligations are bestowed upon them.[26] The profession is also like no other, calling upon the individual to make the ultimate sacrifice in the execution of their tasks, to be exposed to dangers others would ordinarily not be exposed to, and to be deployed in situations that could potentially be hazardous to their

[19] Lounsbury & Bellamy 132.
[20] As above.
[21] As above, 133.
[22] As above, 137.
[23] As above, 139.
[24] Secs 14(i), 20(11) & 63(3) Defence Act, 2002.
[25] Art 42(2) AP I: "Members of the armed forces of a party to a conflict (other than medical personnel and chaplains covered by Article 33 of the Third Convention) are combatants, that is to say, have the right to participate directly in hostilities".
[26] J Henckaerts & L Doswald-Beck *Customary International Humanitarian Law* (2009) 11. Available at https://casebook.icrc.org/glossary/combatants (accessed on 20 April 2021). Combatants are the members of the armed forces of a state with the exception of medical personnel and chaplains (Art 43(2) AP I). Combatants are permitted to take part in hostilities provided they adhere to the laws governing armed conflict, including the wearing of uniforms, carrying arms openly and are under responsible command. The status of a combatant may be changed to that of non-combatant in the events of becoming *hors de combat* that includes being captured, injured or surrenders (Common Art 3(1) to the Geneva Conventions).

©University of Pretoria

well-being. Further, the profession of arms would call upon the incumbent to take lives and destroy property.[27]

2.2 Models of military professionalism

A profession is the practice of a learned skill to render a service.[28] Professionals (as the embodiment of persons who practice a profession) share the following attributes; specific learning of a skill, membership of an association that prescribes an ethical code with the ability to self-regulate, rewards for the achievement of work completed and a commitment to serve their communities' best interests.[29] "Professional" versus "amateur" denotes that as a professional, payment is received for the specific profession as opposed to the amateur pursuit for which no payment is claimed, such as a pass-time or hobby. On the face of it, a soldier thus satisfies the above prerequisites of being a professional.

Major Workman discusses three models of professionalism in relation to the military.[30] The models of Samuel Huntington, Allan Millet and Charles Moskos describe what professionalism in the armed forces encompasses and are universally applicable. The paragraphs that follow draw upon their work.

2.2.1 Huntington's *The soldier and the state*

In his book *The soldier and the state*,[31] Huntington describes the professionalism of the officer corps in relation to society. Three essential characteristics of persons working in an occupation would distinguish it as a profession, namely expertise, responsibility and corporateness.[32]

Expertise

Expertise is the skills and knowledge acquired over years of education and experience.[33] Huntington states that those skills and knowledge are a lifetime pursuit

---

27 Lounsbury & Bellamy 277.
28 P Cook *A Profession like no other. Routledge Handbook of Military Ethics* (2015) 32.
29 As above, 32 & 40.
30 RS Workman *The Profession of Arms* available at https://www3.nd.edu/ (accessed 23 February 2022).
31 SF Huntington *The Soldier and the State* (1959).
32 As above 8.
33 As above.

that distinguishes professionals from laypersons.[34] With expertise, the professional displays a technical component (that exists only in the present and consists of learning an existing skill without reference to prior practice, for example, a surgeon learning to master certain diagnostic surgical procedures); a theoretical component (the intellectual historical origin of the profession, for example, legal philosophy); and a broad-liberal component (the ability to understand the role of a profession in the economic, political, social and cultural setting of society).[35]

Responsibility

The establishment of the client-professional relationship occurs when society (the client of all professions) places trust upon the professional to competently execute a task that is specialised to such a degree that a layman's understanding would not equip a person with the proper conceptualisation of that specific skill.[36] The client of a professional service accepts the expertise and the solution to the problem offered.[37] The client would not be in a position to evaluate whether the professional service provided had met the standard of the specific profession. Only professionals themselves would be competent to stand in judgment of the service provided.[38] Professional regulatory bodies act as the watchdogs for the client (and society at large) for the conduct of professionals. This is evident in the professional bodies of the medical profession,[39] the legal profession[40] and so forth.

Huntington's model of professional responsibility demands professionals practice within their competencies (or specialities), act ethically, act only in the best interests of the client, with integrity and not have personal prejudices cloud their conduct.[41]

Corporateness

Huntington describes this as the common bond or identity professionals exhibit amongst themselves due to the extensive years spent mastering the profession.[42] A

34 As above.
35 As above.
36 As above 9.
37 As above.
38 As above.
39 Health Professions Council of South Africa; South African Nursing Council.
40 Legal Practice Council, various Bar Associations and Law Societies.
41 Huntington 8 & 9.
42 As above.

©University of Pretoria

need also exists to share experiences and expertise in formal ways by establishing societies for the advancement of the profession.[43]

2.2.2. Allan Millet: *Military professionalism and officership in America*

Millet summarises six qualities found in professions (much the same as Huntington).[44] Firstly, a profession is a fulltime and stable undertaking, providing a service to society whether it is needed or not.[45] The chosen profession is much more than a "job" but is a calling. The devotion to the profession is often central to the practitioner's life.[46] Thirdly, the profession has the ability to regulate itself. That is to stand in judgment of fellow professionals' conduct.[47]

Millet requires of the professional to have formal theoretical training. Training that will set the practitioner apart from someone who has a mere practical competency.[48] Continued professional development is a key component of the professional.[49] Much the same as Huntington, Millet describes the fifth attribute of professional practice as being the client-professional relationship.[50] The trust the client places in the professional to act with the necessary competence expected is central to this relationship.[51]

Finally, Millet places the autonomous professional above all other attributes. Due to the high ethical standards and trustworthiness displayed by the professional, society grants them a great deal of autonomy.[52] This attribute is described as being essential in a society for the performance of unpleasant tasks. Such as the lawyer defending an accused, a doctor being faced with life-or-death situations based on ambiguous moral issues.[53]

---

43 Including professional organisations such as the South African Medical Association and the South African Medical Legal Association.

44 AR Millett *Military Professionalism and Officership in America* (1977) 2-29.

45 As above. Persons blessed with good health may never need the services of a neurosurgeon, regardless that the profession is available for others.

46 As above.

47 Fn 39 above.

48 Eg, the first aider may be equipped to respond to medical emergencies but is in no way trained to the level of expertise to definitively treat a patient in a hospital.

49 Fn 44 above.

50 Fn 31 above.

51 As above.

52 Fn 46 above.

53 As above.

©University of Pretoria

2.2.3. Moskos: *The institutional and the occupational military professional*

Moskos's[54] model of an institutional and occupational military professional explains the soldier's identification with the profession of arms as either being a calling or merely a job.[55] Moskos describes an institution as: [56]

> An institution is legitimated in terms of value and norms, that is, a purpose transcending individual self-interest in favor of a presumed higher good.

Military members who identify with the institutional model consider their service to be a calling. Integrity, service and excellence are traits often used as a way of life in their military profession.[57] An occupational model is described as: [58]

> An occupation is legitimated in terms of the marketplace. Supply and demand, rather than normative considerations, is paramount.

Obligations set under a contract of employment will determine the conditions of service and the salary of employees. The interests of the employee are placed before those of the employer.[59] Military professionals with this orientation would consider their benefits and remuneration, security and work conditions as paramount.[60]

Moskos is of the opinion that both models exist within a modern military structure. The move towards an occupational model creates occupation-specific incentives to recruit and retain the services of scarce skilled professionals such as healthcare professionals, technicians, pilots and submariners.[61] This shift in a single "soldier" salary has been evident in the South African National Defence Force with the implementation of Occupation Specific Dispensation for certain skilled members as from 2007.[62] This in turn leads to professionals identifying with other similarly skilled

---

54 Military sociologist and professor at Northwestern University in the USA.
55 CC Moskos *Institutional and Occupational Trends in Armed Forces. The Military: More Than Just a Job?* (1988) 27-38.
56 As above.
57 As above.
58 As above.
59 As above.
60 As above.
61 As above.
62 Public Service Coordinating Bargaining Council (PSCBC) Resolution 1 of 2007: provided the framework for occupational specific remuneration and career progression dispensations to address unique remuneration structures, consolidation of benefits and allowances into salary, frequency of progression, grade progression opportunities career pathing and performance based progression.

©University of Pretoria

and remunerated professionals outside of the military institution.[63] Institutionally orientated professionals identify closely with the specific unit attached to and work and live within the military base. This is in contrast to occupational orientated professional who tend to be decentralised.[64] The end result of military professionals who either identify with the occupational or institutional models is summarised by Wakin:[65]

> The military leader who views his oath of office as merely a contractual arrangement with his government sets the stage for a style of leadership critically different from the leader who views that oath as a pledge to contribute to the common good of his society. For the former, "duty, honor, country" is a slogan adopted temporarily until the contract is completed; for the latter, "duty, honor, country" is a way of life adopted for the good of all and accepted as a moral commitment not subject to contractual negotiations.[66]

Moskos's model distinguishes between the self-sacrificing and the self-serving military professional.[67] Professionalism requires a measure of virtue beyond academic qualification and experience.[68] Makin shares the sentiment in that he requires a moral aspect to be added to being called a professional together with a competence aspect.[69]

2.3. The professional soldier?

Having explained the three models of military professionalism, the question remains whether the soldier fits the mould of being a professional. It must be borne in mind that the military is an autocratic organisation with an established hierarchy. This hierarchy is displayed in a clearly-defined rank structure of non-commissioned officers (NCOs), warrant officers (WO) and officers.[70] This means that each rank must be subservient to the next higher rank in that lawful instructions (orders) must be obeyed without question. The discussed models of military professions distinguish between officers

---

[63] Fn 55 above.
[64] As above.
[65] Former head of the department of philosophy at the United State Air Force Academy, Colorado.
[66] Fn 30 above.
[67] Fn 55 above.
[68] As above.
[69] As above.
[70] Defence Act, 2002. Definition of 'Superior Officer': in relation to another member of the Defence Force, means any officer, warrant officer, non-commissioned officer or candidate officer of the Defence Force who holds or is regarded by or under this Act to hold, a higher rank than such other member of the Defence Force or the same or an equivalent rank as such other member of the Defence Force, but is in a position of authority over that member.

and "enlisted" members.[71] Officers are predominantly used as embodying the characteristics of a professional in the different models.

Huntington's conclusion is that the officership meets the criteria of professionalism.[72] However, a closer examination of Huntington's criteria of professionalism supports degrees of professionalism dependant on the specific task of the officer.[73] Officers charged with complex command over thousands of men and material would have a higher degree of professionalism than a junior officer tasked with lesser missions.[74] Huntington acknowledges that non-commissioned officers too display professional competencies in an increasingly technologically advanced military environment.[75]

Expertise is gained by extensive training at various levels together with continued education and training in specific fields.[76] The responsibility towards society is the maintenance of state security or state sovereignty. This is a task exclusively entrusted to the military.[77] The shared sense of belonging amongst soldiers is referred to as camaraderie, a bond amongst brothers unique to military service. The corporateness criterion is displayed in the close association with fellow military members both in own and allied forces.

Millet's model has much in common with Huntington's analysis in that the military officer displays the attributes of a professional.[78] The need exists in society to have a full-time military dedicated to matters of defence.[79] Millet is of the opinion that the soldier enters military service under a deeper obligation than just finding employment.[80] This, Millet describes as a "calling" and a sense of belonging and identification with fellow soldiers.[81]

---

71 Enlisted members of the United States Armed Forces are equated to non-commissioned officers in the SANDF or ranks other than officers.
72 Fn 31 above.
73 As above, 28.
74 As above.
75 As above.
76 As above, 27.
77 As above.
78 Fn 31 above.
79 As above.
80 As above. 31.
81 As above.

©University of Pretoria

The self-regulatory aspect of a modern military is evident in standards set with regards to performance and the enforcement of a military judicial system that is able to severely sanction disciplinary and criminal transgressions.[82] The attribute of having undergone formal education and continued training is well vested in modern military organisations.[83] Millet maintains that society grants the military great autonomy and trust to execute their mandate as per legal prescripts.[84]

Moskos's institutional/occupational model best explains the professional nature of the military organisation. A complementing mix of both institutional and occupational models would serve professionalism in the military.[85]

2.4. Conclusion

The modern military is a profession and those who serve are professionals. When applying the models presented above to the South African National Defence Force, it can be concluded that various musterings constitute and function coherently in a clearly defined constitutional mandate. Traditional professional musterings aside (such as healthcare professionals, legal practitioners, engineers, pilots and so forth), the soldier, once trained in the basic military skills, embarks on a life-long learning path which develops the soldier to a competent, expert, responsible individual bestowed with a collective identity in their fellow officers.

Workman summarises the professional models of Huntington and Millet by concluding that a professional status is conferred on persons at different times in their career. He states that the professional status would primarily depend on continuous education, practice and experience of the young soldier. Finally, the internalisation of the core values of military service would depend on the character and commitment of the officer.[86]

3. The medical profession

[82] As above. Within the SANDF the Military Disciplinary Supplementary Measures Act, 1999 and the First Schedule to the Defence Act, 1957 creates a system of military courts, describes offences and has prescribed sentencing.
[83] Secs 63-65 Defence Act, 2002.
[84] Fn 52 above.
[85] As above, 38.
[86] Fn 30 above.

©University of Pretoria

3.1 Introduction

The expectation society has of the medical profession is the prevention and treatment of illness and injury together with the amelioration of the associated pain and suffering it brings.[87] The medical profession and healthcare professionals are not restricted to medical doctors in this study but include all healthcare professionals registered in terms of their respective professional regulatory bodies[88] to provide a prescribed standard of healthcare within the promulgated scope of practice. Each medical profession stands to abide by both a legal prescript and an ethical code that has developed over centuries.[89]

The evaluation of medicine as a profession is again measured against the pillars of what constitutes a profession.[90] The medical profession, like soldiers, expend years of general and specific tertiary education to produce a vast variety of healthcare professionals from specialised medical schools.[91] The profession has self-regulatory associations to which healthcare professionals who wish to practice have to belong,[92] and a clear self-regulatory function for professional misconduct.[93] Healthcare professionals are permitted to receive remuneration for their services by employment in either the private or public sector. Finally, a commitment to serve their communities best interest ranks in the forefront of medicine is evident.[94]

To understand the medical profession requires an understanding of the development of medicine. The medical profession is one of the oldest professions.[95] The oldest written evidence of the healing arts dates back 3500 years BC in Egypt.[96] After the demise of the Egyptian dynasties and the rise of the Greek civilisations, the god Aesculapius

---

87 Lounsbury & Bellamy 277.
88 Health Professions Council of South Africa, South African Nursing Council, the Allied Health Professions Council of South Africa, etc.
89 Lounsbury & Bellamy 5. The Hippocratic Oath became the standard for ethical conduct for medical doctors. The oath although not formally prescribed to medical doctors on completion of their studies, exhibits the attributes central to the provision of medical care once the practitioner accepts the patient; to act for the benefit of the patient (and later developed to include the interests of society as a whole) and a medical paternalism (which has to a large extent been developed to include respect for the individuals right to choose the outcome of his/her treatment).
90 Fn 28 above.
91 Sec 16 Health Professions Act 56 of 1974.
92 As above, sec 17.
93 As above, sec 41.
94 Sec 2 National Health Act 61 of 2003.
95 Lounsbury & Bellamy 273.
96 As above.

©University of Pretoria

became the embodiment of Imhotep, an ancient Egyptian physician.[97] Lippi[98] identifies three different trends in the study of the history of medicine;[99] philosophic scholars examined the scientific development of medicine with an emphasis on the speculative approach; historians concentrated on the development of healthcare systems; and medical doctors examined the development of medicine largely from the teachings of Hippocrates.[100]

Madden and Carter[101] describe the physician as fulfilling three roles throughout the history of medicine; that is, as priest, philosopher and scientist.[102] The specific role of the physician, at a specific time in history, corresponds to the understanding of the nature of disease.[103]

3.2 Medical profession in South Africa

The Health Professions Act 56 of 1974 provides for the establishment of the Health Professions Council of South Africa (HPCSA), which in turn controls the educating, training and registration, together with the practicing of health professions registered under the respective professional bodies.[104] The Nursing Act 33 of 2005 establishes the South African Nursing Council (SANC), which is responsible for, inter alia, maintaining professional conduct and practice standards, standards and quality of nursing education and upholding of professional and ethical standards in nursing.[105] These two bodies regulate the majority of healthcare professionals employed in the National Defence Force.

The HPCSA describes thirteen core ethical values and standards for the healthcare professional in its *Guidelines for Good Practice in Health Care Professions* booklets.[106] These 13 values and standards embrace the core medical ethical principles of (patient) autonomy, beneficence, non-maleficence and justice. Constitutional mandates such as respect for persons and human rights form part of the values together

---

97 As above.
98 D Lippi *A Short History of Medicine* (2015) available at http://search-ebscohost.com uplib.idm.oclc.org (accessed 13 June 2022).
99 Lippi 9.
100 As above.
101 Lounsbury & Bellamy, Ch 10 Physician-soldier; a moral profession.
102 Lounsbury & Bellamy 274.
103 As above.
104 Preamble Act 56 of 1974.
105 Sec 2 Nursing Act 33 of 2005.
106 https://www.hpcsa.co.za.

with integrity, truthfulness, compassion, tolerance and a sense of community.[107] Healthcare professionals are reminded of the obligation of confidentiality and are finally expected to maintain professional competence and self-improvement.[108] The various professional boards of the HPCSA have the mandate to investigate and sanction healthcare professionals for the transgression of any of the core ethical values or standards in what is defined as unprofessional conduct.[109] Similarly, the SANC may conduct hearings into the professional conduct of its members and levy sanctions against members found to be in breach of the ethical values and standards of the nursing profession.[110] Serious infractions of professional practice, such as assault, indecent acts, culpable homicide and unregistered practice are dealt with under the respective statutory enactments or common law of the Republic. Civil actions for breach of the doctor-patient contract may result in the award of damages in the courts of the Republic.

Besides the disciplinary functions that the HPCSA and SANC are entrusted with, the Councils fulfil other equally essential responsibilities towards the health professions. These include the maintenance of registers for persons qualified to register their respective profession, control over the training of healthcare professionals, ensuring the standards of accredited training institutions and universities and offering an entry point for members of the public to lodge complaints against healthcare professionals.[111]

3.3 Medicine and the models of professionalism

Historically and conceptually, the medical profession requires less analysis in order to be considered a profession. Whether the above is due to society's intrinsic respect for those engaged in the diagnosis, treatment and care of the infirm or whether the health profession demands years of dedicated post-basic education, the healthcare professions naturally and effortlessly fit the models of professionalism discussed above.[112]

[107] HPCSA *Booklet 1 General Ethical Guidelines for Health Care Professions* (2016) 2.
[108] As above.
[109] The Health Professions Act defines unprofessional conduct as "improper or disgraceful or unworthy conduct or conduct which when regard is had to the profession of a person who is registered in terms of this Act, is improper or disgraceful or dishonourable or unworthy".
[110] Sec 46 Nursing Act, 2005.
[111] Sec 3 Health Professions Act, 1974 and sec 2 Nursing Act, 2005.
[112] See para 2.2 above.

Huntington's model of expertise (years of dedicated training to achieve the status and meet the statutory requirements for registration as a healthcare professional), responsibility (the establishment of a client-professional relationship and the self-regulating trait displayed by statutory bodies) and corporateness (establishment of societies to reinforce the common bond shared amongst practitioners) applies equally well to the profession of medicine as to the profession of arms.[113] Millets' six characteristics of a profession also place the healthcare professional within the parameters theorised.[114]

3.4 Comparison between the medical and soldiering professions

Despite the medical profession fitting the theoretical models of both Huntington and Millet,[115] a comparison between the two professions may elicit some differences and surprise with similarities.

The main object of a military force is the defence of the territorial sovereignty of a state.[116] Military power can also be deployed in lawful actions against aggressors.[117] War is characterised by the use of force defeating the enemy either by physically disabling (causing injury or death) or psychic dominance (removing the will to fight).[118] The theatre of war is often not conducive to a healthy environment with situations like over-population, deprivation of basic amenities such as sanitation, exposure to the elements and malnutrition, which may cause the spread of disease, injury and accidents.[119]

As warfare evolved, so too did the care of those taking part in warfare.[120] Developments in medical care and the efficient evacuation of the sick and wounded to various levels of capable medical facilities have dramatically reduced mortality on the battlefield.[121] Those who provide for health and care under fire are trained military healthcare professionals who form a part of the modern armed forces in much the same

---

113 As above.
114 Fn 44 above.
115 As above.
116 Sec 200(2) Constitution, 1996.
117 UN Charter Ch VII and Art 52.
118 Lounsbury & Bellamy 277.
119 As above.
120 H Dunant *A Memory of Solferino* International Committee of the Red Cross (1959); Lounsbury & Bellamy 131; JE McCallum *Military Medicine, From Ancient Times to the 21st Century* (2008) xii-xxii.
121 As above.

©University of Pretoria

way as the frontline combat troop.[122] Military healthcare professionals receive, at least, basic soldiering skills and are trained to defend themselves using small arms.[123]

It is thus not disputed that healthcare professionals may lawfully form part of a military structure. The difference between the role and ethos of the healthcare professional and that of the soldier is where the distinction lies.

Madden and Carter describe the term "physician-soldier" in a comparative study between the role and ethos of the doctor as a serving member of the armed forces.[124] They conclude that acting as both a healthcare professional and a military member is not ethically conflicting nor is the ethos of the two professions contradictory.[125] This is drawn from each profession's duty towards society. The specialised nature of each of the professions' tasks is described as, on the one hand, the soldier as the servant of the state whilst the doctor would serve the interests of their individual patient whilst taking cognisance of the greater needs of the health of society.[126] The soldier may only act under the lawful command of the political heads of a state,[127] whilst in contrast the healthcare professional may only act under the informed consent of their patient.[128] Madden and Carter view the end result of the medical profession as being the restoration to health of the individual and society together with the role of the prevention of disease and disability in both (attaining health goals).[129] Soldiers, by contrast, act in defence of the sovereignty of the state.[130]

While these roles of the soldier and the doctor exhibit similar results for both society and the individual, distinguishable elements are highlighted by Madden and Cater. These differences are in the means and the obligations of the respective professions.[131] Soldiers are obligated to either obey orders from superiors or to disseminate orders to subordinates, that will lead to the death of others or themselves and the destruction of property.[132] Society expects of its soldiers to make the ultimate sacrifice in the defence

122 Lounsbury & Bellamy 277.
123 Lounsbury & Bellamy 271 Art 22 GC I.
124 Lounsbury & Bellamy Ch 10.
125 Lounsbury & Bellamy 289.
126 Lounsbury & Bellamy 281.
127 As above.
128 As above.
129 As above.
130 As above.
131 As above.
132 As above.

of the state.[133] The risks faced by the medical profession, including risks of communicable diseases and violent patients, do not compare to the risk to life and limb faced by the military profession.[134] The means that soldiers execute their tasks with the weapons of war and violence that bring about destruction while healthcare professionals are primarily armed with the tools of medical technology and their supportive relationships with patients.[135]

The ethical obligations of healthcare professionals stand in contrast to that of the military professional. Society expects a soldier to kill and destroy during armed conflicts; however, centuries' old ethical standards developed into modern codes and laws to prevent healthcare professionals from being party to actively causing the death of those under their care. The contrasting ethical roles of the doctor and the soldier are what theorists such as Parrish, Sidel and Levy purport to be the basis of their argument that doctors cannot serve in the armed forces.[136]

Madden and Carter, too, identify that the ethical codes of the profession of arms bear no similarity to that of the ethical codes of medicine.[137] The authors conclude that the healthcare professional is free to accept or decline patients; free to practice when, where and how they wish and are free to leave the profession.[138] These freedoms are not available to the soldier, who lacks certain autonomies.[139] Madden and Carter explain that the fundamental conflict between the two professions is that which drives the dual-loyalty dichotomies when a physician is called to serve in the armed forces, that is being both a physician and a soldier.[140]

Huntington theorises that although doctors serve in uniform, they are not really members of the profession of arms.[141] As non-combatants,[142] they do not identify as a

---

[133] As above.
[134] As above.
[135] As above.
[136] As above and Lounsbury & Bellamy Ch 11.
[137] Lounsbury & Bellamy 280.
[138] As above.
[139] As above; sec 58 Defence Act, 2002 restricts members of the SANDF from resigning in certain circumstances that include a state of national defence, a state of emergency or during war.
[140] As above.
[141] As above.
[142] IHL identifies members of the medical services of an armed force as non-combatants; persons who may not engage directly in hostilities but that are allowed to muster arms for their and their patients protection. Even when captured, medical personnel are not classified as prisoners of war but rather as retained persons; Arts 24-28 GC I.

©University of Pretoria

warrior-soldier but only function administratively as a soldier.[143] Their role is that of the healthcare professional within the military. They will not be relied on for their military skills once the battle ensues, but rather their professional medical competencies to treat the sick and wounded.[144]

Huntington concludes that nothing in the ethos of the two professions prohibits a doctor from serving in the armed forces. Both doctor and soldier serve society by providing an essential service. Despite the soldier's ends being that of causing death and destruction and the doctor's being that of preventing death and restoring to heath, their roles remain compatible.[145]

3.5 Conclusion

From ancient to modern times, the profession of medicine has been respected for its dedication to the society it serves by healing the sick and preventing disease. So too in the military society the medical profession functions to maintain a fit force ready for battle and in the amelioration of illness and wounds brought about by battle. As shown above, healthcare practitioners fulfil the requirements of a profession. In examining the similarities and differences in the profession of arms and medicine, it was established that the sole distinction between the two exists in the means and obligations of the two professions. However, it is the different ethical roles of the two professions that cause dual loyalty dichotomies when a doctor is also a member of the armed forces. Such dual loyalty conflicts are introduced below.

4. Dual loyalty dilemmas

4.1 Introduction

Dual loyalties (double agency, divided loyalties) should not be viewed as conflicts of interest. Conflicts of interest are addressed in ethics, law and business, relating to a real or apparent conflict between one's personal interest in a matter and one's duty to another or to the public in general regarding the same matter.[146] Dual loyalties too, can exhibit conflict but the conflict is between two external responsibilities that are

---

143 Lounsbury & Bellamy 280.
144 As above.
145 Lounsbury & Bellamy 281.
146 *Webster's new law dictionary* available at www.yourdictionary.com/law/conflict-of-interest (accessed 21 April 2021).

discordant.[147] As an example, a conflict of interest would arise when a practitioner over-services a patron with the intention to gain greater compensation from the patron or the patron's insurance whilst a dual loyalty situation would arise where a healthcare professional has an obligation to report an infectious disease to a public health authority contrary of the patient's right to confidentiality.[148]

The establishment of and work completed by the 2003 International Dual Loyalty Working Group proposed a set of guidelines on dual loyalty conflicts titled Dual Loyalty and Human Rights in Professional Practice (DLHR).[149] The Working Group defined a dual loyalty as a clinical role conflict between professional duties to a patient and obligations, whether express or implied, real or perceived, to the interests of a third party such as an employer, insurer or the state.[150] A dual loyalty conflict has the potential for legal violations and ethical breaches of the trust (or fiduciary) relationship between the provider of services (a healthcare professional) and the consumer (the patient).[151] The relationship between the physician and patient has been described as being special, even sacred.[152] The trust relationship established between doctor and patient, however, is not absolute. The fiduciary relationship cannot be ranked above any other fiduciary relationship between a professional and their consumer/client in that the professional is faced with decisions that weighs benefits and risks between the consumer/client against purported benefits for an organisation or the society at large.[153] One such example is the legal obligation to report a serious risk to public health threat exhibited by a patient contrary to embedded confidentiality.[154] In summary: [155]

> Whenever someone represents another and agrees to consider that person's interest paramount, a fiduciary relationship is created and with it, some potential for moral discord should a claim arise that conflicts with the client's interests.

---

147 JR Williams "Dual Loyalties and how to resolve ethical conflict" (2009) 2 *South African Journal of Bioethics and Law* 8.

148 Sec 14(2)(c) National Health Act.

149 Physicians for Human Rights, School of Public Health and Primary Health Care, University of Cape Town available at http://physiciansforhumanrights.org/ library/documents/reports/report-2002-duelloyalty.pdf (accessed 21 April 2021).

150 As above.

151 DA Rascona "A Moral Obligation for Military Medical Service in the United States" (2007) 9 *Virtual Mentor American Medical Association Journal of Ethics* 722-724.

152 As above.

153 As above.

154 Fn 149 above.

155 Fn 152 above.

Dual loyalty conflicts have been examined at length in the health sector. The outcome of the Truth and Reconciliation Commission[156] on the complicity of South African healthcare professionals in failing to report torture, failing to apply international medical ethical principles in the distribution of health services to the population and other human rights violations involving medical care led to the establishment of the International Dual Loyalty Working Group in 2000.[157] Scholars from around the world shared experiences to accumulate findings and recommendations on dealing with dual loyalty conflicts in a report completed in 2003.[158] Amongst their findings was that dual loyalties exist in the health sector between the healthcare practitioner and their patient and a number of third parties.[159] The defence force of a state was identified as a situation in which such conflicts may arise.

4.2 Polarisation of the topic of dual loyalties in military medicine

Writers on the subject of military medical ethics over many years have examined issues that result in the dichotomy of the question of whether the healthcare professional is doctor or soldier first. The nature of warfare has changed significantly from ancient times to the Renaissance to modern wars.[160] None so much than in the 21st Century.[161] Warfare evolved from the meeting of armies on a designated rural battlefield to engagement in urban populated areas resulting is immense destruction and the greater loss of civilian lives than combatants.[162] The veterans of the Second World War have all but left this mortal coil leaving only combatants who were engaged in the proxy wars of the Cold War. Modern soldiers know exclusively of dissimilar or unconventional guerrilla type warfare waged by combatants who display no respect for international humanitarian law.[163]

156 Available at www.justice.gov.za/trc/reports/finalreport/volume%201.pdf (accessed 21 April 2021).
157 Fn 150 above.
158 As above.
159 As above. Dual obligations to patient family members, the state, insurance companies, sports teams and employers.
160 RA Gabriel *Between flesh and steel, A history of military medicine from the Middle Ages to the war in Afghanistan* (2013) Ch 1.
161 As above.
162 As above and Health under difficult circumstances: The impact of war, disasters and sanctions on the health of populations. World Health Organisation Regional Committee for the Eastern Mediterranean: EM/RC 49/Tech Disc July 2002 1-2.
163 M Gross *Moral dilemmas of modern war. Torture, assassination and blackmail in an age of asymmetrical conflict* (2010) 13-20.

©University of Pretoria

So too in the administration of military medicine, military healthcare professionals are faced with the same issues as their combatant comrades.[164] Targeting of medical personnel has in a great part become the norm for extremist combatants who wish to use any means necessary to inflict the most amount of destruction (both physically and psychologically) on the adversary.[165] Military medical support has moved to the forward battlefield with deployed assets available to the fighting man in the field.[166] Practice has shown that early effective medical treatment greatly reduces mortality on the battlefield.[167] Medical support (such as combat medics) deployed with frontline troops naturally comes with the risks of facing immanent threat of being targeted by enemy combatants, whether intentional or not.[168] Frustrations mount when military healthcare professionals identify too closely with the fight and instances of unlawful and unethical practice have occurred and will continue to occur in these situations.[169]

The military doctor is faced with dual loyalties in their practice not only from the military command exerting the mantra of the "greater good" or military necessity, but internally from their own convictions as to how to manage a situation that at times seems out of control.[170]

The academic works produced by writers of medical ethics and specifically military medical ethics during armed conflict have differing views supported in part by actual military service as military healthcare professionals.[171] As such the texts produced by these writers are influenced by their experiences in a military environment. Writers such as Sidel and Levy staunchly oppose the service of doctors in the armed forces due to the overriding pressure from command in executing military necessity

---

164 As above.

165 ICRC *Health Care in Danger: The Responsibilities of Health-Care Personnel Working in Armed Conflicts and Other Emergencies* available at https://shop.icrc.org (accessed 22 April 2021); and UNSC Res 2286 (2016) *Strongly Condemning Attacks against Medical Facilities, Personnel in Conflict Situations* available at http://www.un.org/press/en/2016/sc12347.doc.htm (accessed 22 April 2021).

166 Gabriel Ch 6.

167 As above.

168 As above.

169 IMAP/OSF Task Force *Ethics Abandoned: Medical professionalism and detainee abuse in the "War on Terror"* (2013).

170 Lounsbury & Bellamy Ch 9; VW Sidel & BS Levy Physician-soldier A moral dilemma" in TE Beam *et al* (eds) *Military Medical Ethics* (Vol 1).

171 E Langer "The court-martial of Captain Levy: Medical ethics vs. military Law" (1967) 153 *Science* 1346-1350.

©University of Pretoria

considerations above adherence to medical ethics.[172] Writers such as Messelken take a more lenient approach to the service of doctors in the armed forces but still display a cautionary tone to their employment, while emphasising that medical personnel are always medical personnel first.[173]

Ethics watch-dog, Miles takes it upon himself to gather and report on unethical practices of doctors in the military.[174] Proponents of the service of doctors in the armed forces, such as Gross, feel that the rules of medical ethics change during armed conflict, thus freeing the otherwise entrapped doctor to more effectively support the military mission first.[175] Howe, on the other hand, has worked to produce a compromise between the duality of military and medical service by suggesting an ethical analysis of individual situations.[176]

4.3 Approaches to resolving dual loyalty conflicts

Messelken and Baer describe three approaches in dealing with conflicts between military ethics and medical ethics.[177] Howe presents another approach to dealing with dual loyalty conflicts that plague military healthcare professionals, proposing the practitioner either adopting a military-centred approach or a discretionary approach to dual loyalty ethical issues.

4.3.1 Messelken/Baer approach

Dilemmatic[178] *obligations*

Dual-loyalty conflicts are not unique to military medicine but exist in other fields where the physician has an obligation to an insurer, an employer or the state.[179]

Military healthcare professionals experience conflicts originating from the medical and the military professions and the practitioner is forced to choose between an individual (patient's) need and the necessities of the military.[180]

---

172 Lounsbury & Bellamy 312.
173 D Messelken "Conflict of roles and duties – why military doctors are doctors" (2015) 1 *Ethics and Armed Forces* 43-46.
174 SH Miles *The Torture Doctors: Human Rights Crimes and the Road to Justice* (2020).
175 ML Gross & D Carrick (eds) *Military medical ethics for the 21st century* (2013) 268-272.
176 Lounsbury & Bellamy 333-334.
177 Gross & Carrick 266.
178 A situation that requires a choice between options that are or seem equally unfavourable.
179 Gross & Carrick 267. Clinical role conflict between professional duties to a patient and obligations, express or implied, real or perceived, to the interests of a third party such as an employer, an insurer or the state (International Dual-Loyalty Working Group (2008) 16).

Approaching dilemmatic conflicts between military and medical ethics is problematic, as no solution may flow from the issue; Messelken and Baer suggest the approach of Bschleipfer in that the physician's character is expected to address the conflict.[181] Dilemmatic conflicts identify an issue that requires further attention.[182]

Extending bioethics to prioritise the role of the physician

Extending the scope of bioethics to include the military context and its problems is an approach favoured by the World Medical Association[183] and Geneva Conventions.[184] The role of the physician as healer remains the priority and all decisions/dilemmas confronted with are to be resolved within prescribed bioethical principles.[185]

Military necessity dominates bioethical principles

This approach posits that the administration of medical care should not be in accordance with medical grounds or medical ethical principles but solely on military usefulness.[186] In essence, the collective is favoured above the individual in providing medical care on the battlefield.[187]

The dual loyalty dilemmas that are intrinsic to the practice of medicine within the armed forces will be examined in greater detail later in the thesis.[188]

4.3.2 Howe's approach

Howe suggests that when the interests of the military and the individual soldier-patient collide, two categories are identified.[189] The first is that of the military doctor who applies the needs of the military above those of the individual soldier-patient. This situation occurred prior to the invasion of US-led coalition forces in the first Gulf War (1991).[190] With the imminent threat of Iraq using chemical and biological weapons on advancing troops, the US Department of Defence and the US Federal Drug Administration concluded that protective agents, unproven for safe human

---

180 Gross & Carrick 267.
181 As above.
182 As above, 268.
183 World Medical Association *Regulations in times of armed conflict and other situations of violence* rev 63rd WMA Assembly (2012).
184 Art 16(1) AP I.
185 Gross & Carrick 116.
186 Gross & Carrick 269.
187 Gross & Carrick 270.
188 Autonomy: Ch 5 & 6; Beneficence Ch 7; Non-maleficence Ch 8 and justice Ch 9.
189 Lounsbury & Bellamy 335.
190 Lounsbury & Bellamy 338.

consumption, was the best defence available at the time to protect troops against such attacks.[191] After a government sanctioned decree, troops were ordered to ingest the unproven drugs.[192]

The second category is when the military doctor exercises discretion as to whose needs should dominate.[193] Howe describes instances where the overriding military need lessens and a discretionary approach is allowed in the management of the ill and wounded by the military physician.[194] Once such example would be the breach of medical confidentiality in grounding a physically or mentally impaired military pilot.[195] Howe, in substantiating this discretionary approach, sites numerous instances of pilots intentionally being involved in fatal accidents that had not only cost millions in revenue but the lives of others.[196]

Reporting to command an unsafe pilot may well be within the legal and ethical obligations of a physician and will display the overriding obligation towards individuals rather than the organisation.[197] This concept is based on situations when the military's needs are absolute (first category) and when the military needs are not absolute (second category).[198] Howe also identifies a third, less important category, in which the military doctor will follow a purely medical specific role where the patient's interests are paramount;[199] for example, protecting medical confidential information contained in the medical records of the soldier-patient. In this instance, the medical-legal principle is sound; no disclosure of medical information without the consent of the patient, except in situations where the law dictates or it is in the best interests of another where imminent harm is expected.

Considering the approaches of Baer, Messelken and Howe in solving dual loyalty conflicts within the military medical environment, the most workable solution lies in that which Messelken and Baer propose - extending bioethics to prioritise the role of

---

191 As above.
192 As above and see Ch 6 below.
193 Lounsbury & Bellamy 335
194 Lounsbury & Bellamy 343.
195 As above, 344.
196 As above.
197 As above.
198 As above, 335.
199 As above, 335.

©University of Pretoria

the physician.[200] This statement will be substantiated and expanded on as the thesis develops and ultimately will form part of the recommendations of the final chapter.

5. Conclusion

In examining that which makes a person a professional, the military officer fits the criteria of theorists such as Huntington, Moskos and Millet. Society demands of its servants that they exhibit the traits consistent with professional practice, accountability and expertise. Even when the profession is not required, such as the case of the military officer during peacetime, the assurance must be there that the military professional will fulfil the mandate bestowed on them. The healthcare professional, traditionally viewed to be a professional without much analysis, has an obligation to serve similar to the obligation of the military professional. The medical professional is regarded as always ready if needed and when the need arises, an utmost confidence that the professional duty, whether towards the individual or society at large, will be satisfied.

When both hats are worn, in that the healthcare professional serves in the armed forces, a potential for dual loyalty conflicts arises. The first step in addressing such conflicts is the identification thereof. With a little help from theorists and armed with the ability to manage such conflicts, there exists no reason that the healthcare professional may be excluded from serving society as a uniformed member of the armed forces.

Physicians employed by the military will at some point or another experience dual loyalty conflicts despite the intrinsic bioethical character they have developed throughout medical school or medical practice. The rest of this thesis, therefore, is dedicated to identifying and discussing these dual loyalties with reference to domestic law, international law and medical ethical principles.

In the next chapter medical confidentiality in the context of the military is examined.

---

200 Fn 185 above.

©University of Pretoria

CHAPTER 5

TOP SECRET: MEDICAL CONFIDENTIALITY AND THE MILITARY

OUTLINE

1. Introduction
2. Scenario: Sergeant Pepper and the mission
3. Dual loyalties and medical confidentiality
3.1 Real or perceived duality
3.2 Legal and ethical principles regarding confidentiality
3.3 Medical confidentiality and International instruments
3.4 Limitation of the right to medical confidentiality
4. Assessing the scenario using domestic law, medical ethics and international instruments
4.1 Introduction
4.2 The scenario applied to South African law
4.3 The ethical consideration
4.4 Application to international humanitarian law
4.4.1 Additional Protocol I Article 16
4.4.2 Additional Protocol II Article 10
4.5 Convergence: Managing military and medical priorities regarding confidentiality
5. Righting the wrong; An example from the British Armed Forces
6. Commentary: Application to South African law
7. Protecting medical confidentiality in the SANDF: Medical classification
8. Confidentiality post-mortem: The President and the General
9. Conclusion

©University of Pretoria

1. Introduction

Medical confidentiality, or doctor-patient privilege, is considered the most fundamental aspect in the doctor-patient relationship and is pivotal to the ethical practice of medicine.[1]

> All that may come to my knowledge in the exercise of my profession… which ought not to be spread abroad, I will keep secret and never reveal.[2]

Medical care and the associative obligation of confidentiality are the fiduciary responsibility of the physician.[3] Medical confidentiality encourages persons to seek medical intervention without the fear of being shamed or embarrassed.[4] Without the patient trusting the healthcare professional with their most intimate and private medical history and condition, the healthcare professional will not be placed in a position properly to diagnose and treat the patient.[5] The consequence of not having trust in the healthcare professionals that have been consulted would be that the medical condition either worsens to the detriment of the patient or that a greater risk to public health might emerge.[6]

"Privacy" and "confidentiality" are terms often used inconsistently.[7] "Privacy" is described as being multi-dimensional and is a broader concept, often including confidentiality.[8] "Confidentiality" is the principle and practice of keeping sensitive information private, which may not be disclosed without the consent of the individual that disclosed the information.[9] Medical confidentiality is a patient right, a professional duty and the means to properly diagnose and treat a patient to return to a healthy state.[10] There, however, is no absolute right to medical confidentiality as will be

[1] H Bloom & M Bay (eds) *A practical guide to mental health, capacity, and consent law of Ontario* (1996) 379. Laurie "Challenging medical-legal norms: the role of autonomy, confidentiality, and privacy in protecting individual and familial group rights in genetic information" (2001) 22 *Journal of Legal Medicine* 15a.
[2] JK Mason & RA McCall Smith *Law and Medical Ethics* (5th ed) Appendix A (1999).
[3] ML Gross *Bioethics and Armed Conflict. Moral Dilemmas of Medicine and War* (2006) 117.
[4] MA Hall *et al Health care law and ethics in a nutshell* (2nd ed) (1999) 118.
[5] ML Gross & D Carrick (eds) *Military medical ethics for the 21st Century* (2013) 209.
[6] R Bennett & CA Erin (eds) *HIV and AIDS: Testing, screening and confidentiality* (1999) 146.
[7] MA Rothstein *Routledge Handbook of Medical Law and Ethics* (2015) 52.
[8] Gross & Carrick 209.
[9] As above.
[10] As above.

explained in the coming sections.[11]

Service in the armed forces is an entry into an authoritarian culture with a clearly defined command structure.[12] Healthcare professionals in service thus have a duty to obey the lawful commands of their superior officers as well as to maintain professional medical legal and ethical standards in their treatment of their individual patients.[13] The question arises whether a soldier, merely by serving in the armed forces, relinquishes their right to medical confidentiality or if a military healthcare professional is obliged to breach patient confidentiality at the command of a superior officer.

2. Scenario: Sergeant Pepper and the mission

Given the authoritarian nature of military service, is it that medical confidentiality can be breached if there is an order to do so. The following scenario is presented as being a common instance where a military healthcare professional faces a dilemma in terms of service obligations, in peace time or during armed conflict. The issue of lawfulness and the ethical implications of compliance with an order to disclose medical confidential information are presented in the following scenario.

Sergeant Pepper, a specialist radio operator, reports to his base hospital and is consulted by a military healthcare professional Captain (Dr) Salt. The condition Sergeant Pepper is diagnosed with is that of a sexually transmitted disease, which, by Sergeant Pepper's own admission, is embarrassing. Sergeant Pepper requests Dr Salt not to divulge the diagnosis to his comrades or to his commanders. Sergeant Pepper's sexually transmitted disease is a notifiable condition and Captain (Dr) Salt has reported it to the National Institute of Communicable Diseases. The doctor prescribes medication and a duty restriction of confinement to barracks for 5 days. The medication prescribed has the known adverse effect of causing drowsiness and gastro-intestinal distress including diarrhoea and impacts on judgement. Sergeant Pepper is to be deployed on an important mission that evening and due to his specialist radio operator skills is the only soldier who is readily equipped for deployment. Colonel Saunders, Sergeant Pepper's commander, receives word that his radio operator has

---

11 Sec 14(2) National Health Act 61 of 2003 and MA Dada & DJ McQuoid-Mason *Introduction to medico-legal practice* (2001) 17.

12 Gross & Carrick 209.

13 As above.

©University of Pretoria

been declared unfit for duty. Clearly, a Colonel outranks a Captain (the doctor) or a Sergeant (the patient).

Colonel Saunders questions Captain (Dr) Salt demanding to be told why Sergeant Pepper is unfit for duty. In an aggressive tone he stresses that without Sergeant Pepper on the mission the entire deployment will be compromised and the mission postponed or cancelled.

Captain (Dr) Salt refuses the demand to divulge the diagnosis and merely confirms that Sergeant Pepper consulted him earlier that day and that medication is prescribed together with a duty restriction for 5 days.

Colonel Saunders insists that Sergeant Pepper is feigning illness and insists on being told the diagnosis. He asserts the diagnosis of Sergeant Pepper is a matter of military necessity and, as commander of the mission, it is his decision whether to utilise the Sergeant regardless of the duty restriction. Captain (Dr) Salt refuses to disclose his diagnosis. Colonel Saunders promptly institutes military disciplinary measures against the Captain Salt for insubordination and disobeying a command.

3. Dual loyalties and medical confidentiality

3.1 Real or perceived duality?

The above scenario emphasises the challenge a military healthcare professional encounters in a situation of dual loyalty arising from the orders of a commander. It must be established if the dual loyalty challenge is real or is merely perceived. A resolution of this question is the first consideration for a military healthcare professional in order to forestall legal and ethical challenges. The identification of a dual loyalty issue is the first step that needs to be addressed.

A registered healthcare professional is legally and ethically bound to place the needs of the patient above all else.[14] However, as an enrolled member of the defence force, in

[14] I Edelstein *The Hippocratic Oath: Text, translation and interpretation* available at https://www.philpapers.org (accessed 15 January 2019); Dada & McQuiod-Mason 7; HPCSA *Guidelines for Ethical Practice, Booklet 1* 2 available at https://www.hpcsa.co.za (accessed 31 May 2019).

©University of Pretoria

this instance Salt, he is legally bound to obey the orders of a superior officer.[15] Colonel Saunders, a superior officer, ordered Captain (Dr) Salt to disclose the diagnosis of Sergeant Pepper's condition on the grounds he must decide if Sergeant Pepper will be sent on the mission as there is no other soldier qualified as a substitute for Sergeant Pepper.[16] In these circumstances there is an identifiable conflict between a duty to the patient (as an individual) versus the order of a superior officer based on the disclosure on the ground of military necessity. The dual loyalty conflict is Dr Salt is legally and ethically obliged to maintain confidentiality and is not mandated by his patient to disclose the diagnosis to his commander or comrades combined with a requirement to obey the order of a higher-ranking officer. The duality in this situation is real but needs further analysis.

3.2 Legal and ethical principles regarding medical confidentiality

Medical confidentiality is a rule that is centuries old and is a cornerstone of ethical medical practice.[17] The combination of medical ethics and medical law produces legislation that protects the patient's right to privacy. This determination is echoed in international instruments.[18] In the scenario described above the medical officer has to balance the suggestion of military necessity (the mission) with the individual's right to confidentiality.

Privacy and the protection of personal information in the Protection Of Personal Information Act 4 of 2013 (POPIA) encapsulates what is protected by privacy guarantees. What the term "personal information" encompasses is comprehensively defined in the POPIA[19] On the other hand, "confidentiality" references that personal

[15] Sec 200 Constitution, 1996; Code of Conduct for Uniformed Members of the National Defence Force.

[16] The Military Disciplinary Code (First Schedule to the Defence Act, 1957) states at sec 19(1) "Any person who in wilful defiance of authority disobeys any lawful command given personally by his superior officer in the execution of his duty, whether orally, in writing or by signal, shall be guilty of an offence and liable on conviction, if he committed the offence while on service, to imprisonment for a period not exceeding five years, and in any other case to imprisonment for a period not exceeding two years". The code of conduct for uniformed members of the SANDF provides that all lawful orders must be obeyed. Disciplinary action can be instituted for the disobeying of commands but a defence for such would be that the command was manifestly unlawful.

[17] D Giesen *International medical malpractice law* (1988) 406-407.

[18] Sec 14 National Health Act, 2003; Art 12 Universal Declaration of Human Rights; Protocol I Additional to the Geneva Conventions: Art 10 Protocol II Additional to the Geneva Conventions.

[19] Ch 1 "definitions" Protection of Personal Information, 2013.

©University of Pretoria

information that is shared with an attorney, doctor, therapist, spiritual leader or any other individual may not be divulged to a third party without the explicit consent of the person who shared that information.[20] Medical confidentiality relates specifically to the fiduciary relationship between patient and doctor.[21] A breach of confidentiality may result in a claim of damages based on defamation and an invasion of privacy in that the relationship of trust had been breached.[22] "Confidentiality" is defined in law as well as being described in ethical guidelines by the Health Professions Council of South Africa's Ethical Guidelines for Good Practice in Health Care Professions (2016).[23]

3.3 Medical confidentiality and international instruments

International instruments listed in the previous chapters and which pertain to military medical law and ethics delineate the individual's right to privacy but do not address medical confidentiality specifically. International human rights instruments such as the Universal Declaration of Human Rights protect privacy and enforce the prevention of interference in the private affairs of individuals.[24] The International Covenant on Civil and Political Rights, too, references privacy and protects the individual from state interference.[25]

The four Geneva Conventions (discussed in chapter 3 above) list the protections of medical personnel in providing medical care,[26] the First Geneva Convention (GC I) at article 12 provides that only urgent medical needs will be considered in the order of treatment given, whilst article 28 medical personnel conduct their treatment according to their professional ethics.[27] Similarly, the protocols additional to the conventions provide that no person shall be punished for carrying out medical activities compatible with professional ethics.[28]

The First Geneva Convention does not address specifically medical ethical principles

[20] Health Professions Council of South Africa *Booklet 5: Confidentiality; Protecting and Providing Information* (2016) 103.
[21] As above.
[22] JL Taitz "The rule of medical confidentiality v the moral duty to warn an endangered third party" (1990) 78 *South African Medical Journal* 29.
[23] As above.
[24] Art 12 Universal Declaration of Human Rights,
[25] Art 17 International Covenant on Civil and Political Rights, GA Resolution 2200A (XXI) of 16 December 1966.
[26] Arts 24-26 GC I.
[27] Arts 12, 28 GC I, Art 16 AP I & Art 10 AP II.
[28] Art 16 AP I & Art 10 AP II.

©University of Pretoria

regarding confidentiality but references elements of medical ethics in its articles.[29] Articles 1 and 2 of the First Geneva Convention list numerous medical ethical principles.[30] Article. 12(3) of the First Geneva Convention highlight the ethical principle of triage - the order in which the wounded are given attention.[31] Subparagraph 5 of the same article stipulates that the wounded or sick may not be abandoned.[32] Despite the fact that the First Geneva Convention does not mention specifically the protection of medical confidentiality, both Protocols Additional to the Conventions address medical ethical practice.

Article 16(3) of the First Protocol Additional to the Geneva Conventions (Additional Protocol I or AP I) states as follows with regard to the dissemination of information to third parties:

> 3. No person engaged in medical activities shall be compelled to give to anyone belonging either to an adverse Party, or to his own Party except as required by the law of the latter Party, any information concerning the wounded and sick who are, or who have been, under his care, if such information would, in his opinion, prove harmful to the patients concerned or to their families. Regulations for the compulsory notification of communicable diseases shall, however, be respected.

The above paragraph has been interpreted incorrectly as relating to the ethical principle of the protection of medical confidentiality. Other commentators have argued this paragraph rather relates to a principle that the wounded should not be denounced nor be informed on.[33] During the Second World War under the threat of severe punishment local health care providers disclosed and denounced wounded enemy combatants whom they cared for.[34] An acceptable interpretation would be that the article provides that the person administering care or who has administered care (whether or not they are a healthcare professional) cannot be compelled to disseminate any information

29 Arts 12 & 28 GC I.
30 Non-discrimination, access to, are respect (autonomy), beneficence (care, assistance with the wounds/illness that has befallen them), non-maleficence (protection from further harm such as torture, extermination, experimentation).
31 "Only urgent medical reasons will authorize priority in the order of treatment to be administered".
32 "The Party to the conflict which is compelled to abandon wounded or sick to the enemy shall, as far as military considerations permit, leave with them a part of its medical personnel and material to assist in their care".
33 AP I Commentary (1987) 680-681 available at www.ihl-databases.icrc.org (accessed 21 June 2021).
34 As above, 681.

about the wounded/sick;[35] specifically, that does not refer to the physical medical condition of the wounded/sick but rather to information regarding their activities or position or even mere existence.[36] Subparagraph 2 of article 16 applies to medical personnel and the obligation to maintain medical ethical practice.[37]

The obligation on the provider of medical care covers not only present treatment but includes care administrated previously[38] and is based on the view that information gained during the relationship of the wounded and their caregivers be free from any doubt if the medical care truly is to be effective.[39]

Medical personnel shall not be compelled to give information about the wounded and sick in their care;[40] that information is interpreted to be confidential and is harmful if disclosed to the patient or their family.[41] There are exceptions in respect of the compulsory reporting of certain communicable diseases and where the national laws of a state party compel medical personnel to disclose information.[42] South African law regulates medical confidentiality in the National Health Act, 2003 and expands on the practice of protecting confidentiality in guidelines issued by the HPCSA.[43] The 1987 commentary on the First Additional Protocol to the Geneva Conventions reiterates the importance of the maintenance of medical confidentiality contained in the First Additional Protocol article 16(3).[44] Maintaining a feeling of trust between the healthcare professional and the sick/wounded is described as privileged and part of the healing process and not as a means of extracting information from captured combatants.[45]

Sub-articles 10(3) and 10(4) of the Second Protocol Additional to the Geneva Conventions (AP II) similarly state:

---

35 As above, 682.
36 As above.
37 2. Persons engaged in medical activities shall not be compelled to perform acts or to carry out work contrary to the rules of medical ethics or to other medical rules designed for the benefit of the wounded and sick or to the provisions of the Conventions or of this Protocol, or to refrain from performing acts or from carrying out work required by those rules and provisions.
38 As above.
39 As above.
40 Art 16 AP I & Art 10 AP II.
41 A Baccino-Astrada *A Manual of the rights and duties of medical personnel in armed conflict* (1982) 33.
42 As above.
43 Fn 20 above.
44 AP I Commentary (1987) 644 available at www.ihl-databases.icrc.org (accessed 21 June 2021).
45 Art 16(3) AP I.

©University of Pretoria

> 3. The professional obligations of persons engaged in medical activities regarding information which they may acquire concerning the wounded and sick under their care shall, subject to national law, be respected.
>
> 4. Subject to national law, no person engaged in medical activities may be penalized in any way for refusing or failing to give information concerning the wounded and sick who are, or who have been, under his care.

The above articles describe the application of medical confidentiality in non-international armed conflicts and are compatible with the First Additional Protocol Article 16(3), save for the exclusion of mandatory reporting of communicable diseases and the Second Additional Protocol providing for the protection from prosecution of medical personnel who fail to report (as required by national legislation) patients under their care.[46] The aim in the paragraphs is to maintain respect for information gained during the administration of medical care, to protect medical activities and preserve medical confidentiality;[47] an exception is if the disclosure of medical information is subject to national law.[48]

Physicians cannot be compelled to inform on patients under their care; they retain the discretion to do this on the basis that the physician may legitimately wish to prevent the patient from returning to activities that may be dangerous to others, that is, returning to a combatant status.[49]

3.4 Limitation of the right to medical confidentiality

Ferguson[50] comments that the General Medical Council (GMC), as the statutory authority governing the medical practice in the United Kingdom, has soldiers relinquish certain medical confidentiality rights. In recognising that due to the extreme circumstances under which military healthcare professionals have to work, including the casual link between the individuals interests and the interests of the group, information needs to be shared more often than in a civilian environment.[51] When

[46] AP II Commentary (1987) 4684 Available at www.ihl-databases.icrc.org (accessed 21 June 2021).
[47] As above, para 4698.
[48] As above.
[49] Gross 119 and AP I Commentary (1987) 676.
[50] Gross and Carrick 210 and quoted from the British Medical Association:
“When People join the armed forces they relinquish some rights and freedoms. One of these is the right to strict confidentiality. Doctors may at times need to balance the interests of the individual patient’s confidentiality and the interests of the unit of which he or she is a part. (BMA 2004)”.
[51] As above.

©University of Pretoria

confidentiality is breached it must be done with the knowledge and consent of the soldier.[52] He correctly states that medical confidentiality is not an absolute patient right,[53] whether in a civilian or military context. Exceptions exist in the United Kingdom and, as in South Africa, are clearly defined in legislation.[54] Service in the South African National Defence Force (SANDF) is not recognised as an exception.[55]

An examination of the rights a soldier relinquishes or has limited before they assume duty in the SANDF clearly demonstrates that it does not include restrictions on the right to medical confidentiality. The Defence Act, 2002 describes many restrictions the serving member is subject to; these include (and are subject to the Constitution and other legislation):[56]

- Being subjected to searches and inspections.[57]
- Being subjected to screening of communications with persons internal and external to the defence force.
- Completing security questionnaires.
- Limited privation or shared accommodation in the exigencies of military training or operations.[58]
- Prohibition of communicating certain information.
- Restrictions to unarmed assembly, demonstration, picketing and petition.
- Entrance and movement in restricted military areas.
- Required to serve and reside anywhere in the Republic or world.
- Restriction in joining trade unions and activities associated with such membership.
- Service in Parliament, the Reserve Force or the South African Police Service whilst an active member.
- Being a citizen of the Republic.
- Relinquish any dual citizenship held if appointed as an officer.
- Being subject to medical examinations to establish a category of fitness and to undergo compulsory immunisations.
- Restriction on freedom of trade in endeavours outside the defence force.

---

52 As above.
53 As above.
54 Sec 14 National Health Act, 2002.
55 As above.
56 Ch 8 & 9 Defence Act, 2002.
57 The Defence Act, 2002 does not specify what could be searched or what may be inspected however this has been interpreted as being searches and inspections of military living quarters and issued equipment.
58 As above but the inclusion of the word privation with accommodation leads to an interpretation of the restriction to be of a physical nature, a restriction to private amenities (single quarters) that an ordinary citizen would have reasonable access to.

©University of Pretoria

- May not further or prejudice the interests of any political party.
- Be apolitical and not express any party-political allegiance in the execution of duty.
- May only hold ordinary membership to a political party.

No absolute privilege covers the communications between doctor and patient in South Africa.[59] A healthcare professional may disclose medical information obtained during consultation with the patient under the following circumstances:

- Express written consent of the patient[60]
- Order of Court[61]
- Release required by legislation[62]
- Non-disclosure would represent a serious threat to public health[63]
- Non-disclosure would represent a serious or imminent threat to another person(s)[64]
- Where the medical practitioner is an accused or a defendant in a criminal or civil action and the information is necessary to mount a defence.[65]

Disclosure of medical information outside of the listed exceptions may result in the patient having an action against the healthcare professional for breach of contract, defamation and invasion of privacy.[66]

4. Assessing the given scenario using domestic law, medical ethical guidelines and international humanitarian law

4.1 Introduction

As outlined by the scenario of Sergeant Pepper above, the situation may arise that a military commander or the command structure requests or demands medical

---

59 D Pearmain & PA Carstens *Foundational Principles of South African Medical Law* (2007) 981-1016; SA Strauss *Doctor, patient and the law* (1991) 112 & 454; N Van Dokkum "Should doctor-patient communications be privileged" (1996) *De Rebus* 748; and Giesen 414.

60 Sec 14(2) National Health Act, 2003.

61 As above.

62 As above

63 As above

64 Common law duty to protect third parties from harm. As may be the case where the patient is a pilot or a professional driver of public transport who suffers from a condition that may impair the ability to operate such vehicles. *Carmichele v Minister of Safety and Security and another* 2001 JDR 0524 (CCT).

65 Taitz 30.

66 Taitz 29.

information that relates to specific soldiers. This situation may arise in specific circumstances. Military commanders need information regarding those they command and the military assets at their disposal in order to effect the correct tactical decisions. This situation is similar to one in which a manager of a factory needs to know stock levels, workers on duty, specialist workers available to perform critical production functions and so forth in order to keep production moving effectively. The military commander, too, needs to know how many combat aircraft are serviceable or troop transports are available, as well as fuel, rations and fit for service troops to execute a successful mission.

The dilemma arises if a commander or the command structure demands *specific* medical knowledge about a *particular* soldier or sailor. Military functions are highly structured so that the order may be that of a non-medical person or a medical command element that holds a higher rank than that of the treating healthcare professional. Inexperienced military healthcare professionals can perceive the order to be a command and be compliant due to it being issued by higher-ranking officers. The healthcare professional may be fearful of transgressing military law by disobeying a command or they identify more strongly with the military structure than with their patients.[67] The command may have been issued in circumstances of extreme stress such as during combat operations where the healthcare professional complies under the assumption of military necessity.[68]

4.2 Scenario applied to South African law

South African law, which describes situations where confidentiality can be breached without the consent of the patient,[69] suggests a discretionary "wiggle" room for healthcare professionals.[70] However, the situations that are defined do not address military medicine or the dual loyalty issues that may arise. It is submitted that Dr Salt is correct to assert doctor-patient privilege in relation to his diagnosis and to defy what is presented as an order as it is the basis for demanding the information that is not valid under South African law.[71]

---

67 DE Lounsbury & RF Bellamy *Military Medical Ethics* (2003) 298.
68 Lounsbury & Bellamy 296; Gross & Carrick 44.
69 Sec 14 National Health Act, 2003.
70 Taitz 30.
71 Fn 66 above.

©University of Pretoria

The description of the facts in the scenario is an instance of the requirement that certain communicable diseases are notifiable under the National Health Act[72] and do not need the patient's consent for them to be reported. The disclosure without the consent of the patient is to the appropriate government health department and not to the line of military command.[73]

In the above scenario the Colonel cannot rely on "military necessity" to demand the disclosure of Sergeant Pepper's condition. He claims to need the medical information in order to decide on utilising the sergeant's expertise. Military necessity is discussed in greater detail later in this thesis but suffice it to comment here that military necessity always presents a dilemma to be confronted in military medical ethics.[74] O'Brien and Arend contend that military necessity often is a concept that is misinterpreted in that an "unchallengeable and open-ended" licence is issued to make use of whatever means are necessary to gain a military victory.[75] As well as it being poor planning to have only one skilled specialist, military necessity offers thin motivation to rely on in ordering a breach of doctor-patient confidentiality. Knowing the condition of Sergeant Pepper bestows no military advantage. Had Captain (Dr) Salt disclosed the requested information, he would have been in breach of the trust relationship between doctor and patient and may face a professional ethics complaint or a civil claim for breach of contract, invasion of privacy or defamation.[76]

4.3 Ethical considerations

The question that arises at this point asks if medical confidentiality primarily is an ethical consideration, or a legal prerequisite or dictate. An obligation to maintain medical confidentiality dates to the writings of Hippocrates.[77] Although a professional ethical obligation exists, the law may prescribe instances where confidentiality may be lawfully breached.[78] The development of privacy rights, not only in South Africa but globally, further develops an obligation on medical practitioners by requiring compliance with statutory provisions regulating confidentiality. Transgression of

---

72 Regulations for notifiable diseases under sec 90 National Health Act, 2003.
73 As above.
74 Lounsbury & Bellamy 230.
75 As above. From the *Kriegsrasion* doctrine of 19th and 20th Century German legalists and strategists, in that "necessity knows no law".
76 Dada & McQuiod-Mason 17.
77 Fn 1 above.
78 Fn 60 - 65 above.

medical confidentiality may result in the imposition of sanction for unprofessional conduct or the institution of a civil claim.[79] Captain (Dr) Salt's conduct fits the statutory obligation of confidentiality and the steadfast defence of the doctor-patient relationship in defiance of military authority and a threat of military discipline is ethically admirable. It is argued that identification of a dual loyalty dichotomy requires an ability to act within the legal prescripts and ethical considerations that assure the best interests of the patient without compromising a military mission.

4.4 Application to international humanitarian law

Doctor, patient and commander reside in the same military establishment. The applicable Geneva law is found in article 16(1) and 16(2) of First Additional Protocol and article 10(1) and 10(2) of the Second Additional Protocol (AP II) (dependent on the nature of the military operations). These articles would nullify the successful prosecution of military discipline against the doctor.

4.4.1 First Additional Protocol Article 16

> General protection of medical duties
>
> 1. Under no circumstances shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of the person benefiting there from.
>
> 2. Persons engaged in medical activities shall not be compelled to perform acts or to carry out work contrary to the rules of medical ethics or to other medical rules designed for the benefit of the wounded and sick or to the provisions of the Conventions or of this Protocol, or to refrain from performing acts or from carrying out work required by those rules and provisions.

The article reinforces the respect and protection that medical personnel must be afforded in order to execute their functions and that any person who is able to provide such care be protected from any form of intimidation.[80] The first paragraph of the article concerns those who are able to provide medical care to the ill and wounded and in so doing improve the care available to them.[81] The inclusion of the words "any person" is broad enough to include any person that is able to provide such care but at the same time limiting to those persons who perform medical activities within medical ethical guidelines.[82] Persons who engage in medical activities may not be punished for

[79] Fn 22 above.
[80] Commentary AP I (1987) 640.
[81] As above, 647.
[82] As above, 649.

©University of Pretoria

their actions.[83]

Medical activities compatible with medical ethics requires of the carer to firstly be a medical practitioner who acts in accordance with the national and international codes of medical ethics.[84] Persons providing care who are not bound by ethical rules are included as the interpretation of ethical conduct extends to common sense knowledge that any person should possess when providing any type of medical care to the ill or wounded.[85] More refined medical ethical issues such as euthanasia and/or abortion would not be applicable to the layperson in such circumstances.[86] The article prescribes the pure and impartial care of the wounded, for the carer neither to abuse the dependence he has over the wounded nor to act in conflict with the wounded persons best interests.[87]

The second paragraph addresses the important obligation that medical personnel not be forced to act contrary to medical ethics.[88] Military healthcare professionals compelled or ordered by higher authorities to execute functions contrary to medical ethics would be protected under article 16(2) in that such orders, when disobeyed would see the medical practitioner having a defence if military disciplinary charges are brought against him.[89]

4.4.2 Second Additional Protocol Article 10

> General protection of medical duties
>
> 1. Under no circumstances shall any person be punished for having carried out medical activities compatible with medical ethics, regardless of the person benefiting there from.
>
> 2. Persons engaged in medical activities shall neither be compelled to perform acts or to carry out work contrary to, nor be compelled to refrain from acts required by, the rules of medical ethics or other rules designed for the benefit of the wounded and sick, or this Protocol.

The first paragraph of the article provides protection to not only doctors but also all

---

83 As above, 650. Use of the word “punishing” is interpreted to mean than no sanction, whether penal or harassment may be brought against the person providing medical care. This includes sanction from all authorities who are able to do so including national courts who would prosecute persons for assisting wounded enemy combatants (651).
84 As above, 653.
85 As above, 657.
86 As above.
87 As above, 658, 659.
88 As above, 663.
89 As above, 665.

©University of Pretoria

healthcare professionals (nurses, paramedics, radiographers, and so forth).[90] The concept of medical activities is interpreted very broadly to not only include medical care and treatment but all activities, including diagnosis, reporting, administration and advice in the medical context.[91] Medical ethics is interpreted to mean the moral duties compulsory to the profession of medicine.[92] Much the same as AP I article 16, the term punishing is used to describe sanction that can be imposed by any authority upon the medical personnel (both penal and administrative sanction).[93]

The second paragraph ensures that healthcare professionals can work free from compulsion to act contrary to their medical ethical obligations.[94]

4.5 Convergence: Managing military and medical priorities regarding confidentiality

The previous chapter examined and compared the profession of arms and the medical profession. The conclusion drawn was that soldiering and medical practices are considered professions, but the misunderstanding of each specific role may lead to conflict. The experience of the healthcare professional and a comprehensive military medical ethical training alone can create a convergence of medical confidentiality principles under medical law and ethics and the need for effective military operations.[95]

There are times when a medical officer has to disclose patient information to a commanding officer, but the British Medical Association (BMA)[96] stresses the importance of ensuring that this is done with the knowledge and consent of the patient.[97]

As stated above, medical officers are legally obliged to report to the appropriate reporting authority medical information regarding a threat to public health.[98] A breach of confidentiality by giving medical information to the commanding officer or to other members of a unit is great as the requirement to disseminate the information is not to

---

[90] AP II Commentary (1987) 4686.
[91] As above, 4687.
[92] As above, 4688.
[93] As above, 4689.
[94] As above, 4692.
[95] Messelken & Baer in Gross & Carrick 261.
[96] BMA *Ethical decision making for doctors in the armed forces: A tool-kit* (2012) 26-29.
[97] Gross & Carrick 210.
[98] Fn 72 above.

©University of Pretoria

the line of military command line but to the National Department of Health.[99] The medical officer would report that a communicable disease has been identified and that quarantine or other measures must be put in place to curb the spread of the disease among the unit members but without disclosing the identity of the members affected.[100] The outbreak of disease among deployed troops residing in conditions of proximity would result in the outbreak of an epidemic that, despite best practices, will wreak havoc on the combat readiness of troops.[101] Such an outbreak, first, is reportable to the specific authorities and, secondly, to the command structure to plan for a situation that does not compromise the strength of the fighting force.[102] A widespread outbreak of a communicable disease imperils medical confidentiality as a conclusion is drawn that all are suffering from the same communicable disease although other infections and injuries may be present. In this circumstance the medical officer must be extra vigilant in protecting patient privacy.

The above scenario has an element that can produce a breach of confidentiality regarding a notifiable disease but there is not an overriding obligation for the condition to be reported to the commanders. Captain (Dr) Salt has maintained his legal and ethical obligations towards his patient despite the great pressure. Disciplinary action that might result most likely will be dismissed as the order to disclose the condition is not a lawful command.

5. Righting the wrong: An example from the British Armed Forces

The British Medical Association observes that due to the extreme circumstances in which military healthcare professionals operate within the armed forces, together with the causal link between an individual soldier's health, the well-being of others in the unit and military necessity, (medical) information is shared more often than in a civilian environment.[103] In its recognition of the limitation of medical confidentiality rights, the BMA includes dependents of servicemen who have a restricted number of

99 As above.

100 Such a situation will most certainly give rise to speculation and conclusions about who the specific members are who are quarantined, admitted or separated from the unit. This would represent the natural order of things in a closed community and would not represent a breach of confidentiality unless specific utterances had been made about individuals.

101 RA Gabriel *Between Flesh and Steel, A History of Military medicine from the Middle Ages to War in Afghanistan* (2013) 53-54.

102 As above.

103 Gross & Carrick 210.

©University of Pretoria

healthcare professionals to choose from to consult and whose medical well-being may affect the soldier's performance.[104] The regulator of medical matters in the United Kingdom (UK), the General Medical Council (GMC),[105] reiterates that when medical confidential information is required or released to military commanders it always must be with the informed consent of the patient with only the necessary information being disclosed.[106]

Ferguson describes the evolution of patient confidentiality and the convergence of civilian public health policy and military circumstances, the economic impact of the UK's National Health Insurance scheme (NHI) and disclosures ordered by courts as creating challenges unique to the military environment during wartime.[107] The development in medical practice described above in the UK places medical practitioners squeezed between the interests of the individual and the interests of the collective.[108] The impact of military service post World War I saw an increase in divorce cases as a result of servicemen contracting venereal disease (VD).[109] Divorce matters before the courts saw doctors subpoenaed to testify. However, Crown privilege[110] protected the doctors in such cases, although their civilian counterparts consistently were pursued to testify in breach of patient confidentiality.[111] Doctors nonetheless were expected to breach medical confidentiality in order to maintain military effectiveness.[112] The basis supporting this argument is that, as an officer, the doctor has a duty to maintain military discipline by reporting malingering.[113] This dual loyalty dichotomy had consequences for doctor and soldier: A sympathetic doctor would not comprehensively document all clinical observations in medical notes, thus protecting their patient, whereas the soldier, fearing disciplinary action, would not report medical conditions (such as sexually transmitted diseases) timeously for effective treatment.[114]

In the UK, reform of the application of medical confidentiality occurred after a court

104 As above, 210.
105 http://www.gmc-uk.org (accessed 26 April 2022).
106 Gross & Carrick 210.
107 As above 210-211.
108 As above 212.
109 As above.
110 Service medical records were exempt from disclosure in courts, as above 212.
111 As above, 212.
112 As above.
113 As above, 213.
114 As above.

challenge involving the disclosure of medical information of a serving member's wife without the consent of the patient.[115] The disclosure was made in the course of an administrative action within the serviceman's unit. Both the serviceman and the unit commander received the medical information from the attending doctor.[116] The matter became the subject of a serious misconduct enquiry by the GMC. The Surgeon General and counsel defended the action of the doctor.[117] Counsel representing the state (doctor) claimed that while being the recipient of military medical services the complainant was subject to military law.[118] The military law in question provided that the commanding officer of the doctor was entitled upon request to be given (medical) information from the attending doctor.[119] The defense submitted a document titled, Notes for the Guidance of Military Medical Officers on Medical Confidentiality.[120] These Notes were distributed to all serving military medical practitioners and served to supplement guidelines from the GMC. The GMC's preliminary proceedings committee engaged the Surgeon General on various issues including the wording in the above Notes.[121] The clarity sought was based on the same restriction that civilian doctors encounter when ordered by a court of law to breach confidentiality and disclose medical information during a trial.[122] Courts Martial, too, restrict absolute doctor-patient privilege. The Surgeon General's response included the obligation by military doctors to bring to the attention of the commanding officer circumstances affecting the soldiers under their command.[123] The GMC's preliminary committee accepted the Surgeon General's explanation and did not pursue the matter further. The GMC, however, offered guidance in dealing with these matters in the future; this included the obligation of the doctor to seek the consent of the patient before making such disclosures, restricting the content of the disclosure to the essential minimum required and an undertaking from the commanding officer that confidentiality will remain intact at their station.[124]

---

[115] As above, 214.
[116] As above.
[117] As above.
[118] As above.
[119] As above and the GMC 1986.
[120] BMA *Ethical decision-making for doctors in the armed forces: A tool kit. Guidance from the BMA Ethics Committee and Armed Forces Committee* (2012).
[121] Gross & Carrick 214.
[122] As above, 214.
[123] As above, 215.
[124] As above.

©University of Pretoria

The GMC voiced concerns regarding the Notes for the Guidance of Military Medical Officers on Medical Confidentiality and initiated further correspondence with the Surgeon General. The GMC's Committee on Professional Standards and Medical Ethics was engaged to comment on the above case.[125] The Committee identified ambiguities in what constitutes "commanding officer's orders".[126] An explanation was received from the army's legal advisors in that commanding officer's orders were only to mean orders given when the commanding officer sat as a magistrate in summary disciplinary hearings.[127] This fact prompted the GMC to engage the Surgeon General with the advice to amend their Notes to clarify specific issues of medical confidentiality.[128] The Surgeon General accepted the advice of the GMC and amended the military's Notes for the Guidance of Military Medical Officers on Medical Confidentiality, but not before there were further consultations with other arms of the services and the inclusion of the GMC's guidelines forming part of the document as an annexure.[129] The above document was no longer privileged as it was distributed to the families of soldiers.[130]

6. Commentary: Application in South African law

The description above of the evolution in medical confidentiality in the United Kingdom if applied to South Africa reveals similarities and differences in the approach to medical confidentiality in the military. The South African equivalent of the British Medical Association is the Health Professions Council of South Africa (HPCSA).[131] The military, by means of the South African Military Health Service (SAMHS) has a member on the HPCSA's Council, appointed by the Minister of Defence.[132] Healthcare professionals must be registered with their respective professional councils in order to practice within the SANDF.[133] Unfortunately, there are not equivalent guidelines for healthcare professionals in the SANDF but the respective guidelines for good

125 As above.
126 As above.
127 As above, 216.
128 As above.
129 As above, 217.
130 As above.
131 Secs 2 and 3(c) Health Professions Act, 1974.
132 As above, sec 5(e).
133 Ch XV of the General Regulations to the Defence Act: Definition of a "medical officer" means 'a person entitled to practise as a medical practitioner in terms of section 17 of the Health Professions Act", 1974 (Act 56 of 1974),

practice,[134] as disseminated by the respective statutory regulating bodies, apply to military medical practice.[135]

Spouses of serving military members are subject to the Defence Act, 2002, but are not subject to military law as contained in the Military Disciplinary Supplementary Measures Act, 1999 (MDSMA) or the Military Disciplinary Code.[136] The UK has permanent military bases outside their territory[137] that have entire families in residence with the serving members, whereas South Africa does not permit spouses to deploy with members to external mission areas. Spouses (and dependents) of serving members are entitled, however, to comprehensive medical care at the cost of the state, either in military medical establishments or other authorised medical establishments.[138]

Commanding Officers have no inherent right to access or to demand they be given confidential medical information of members or their spouses, without the specific written consent of the individual.[139] Under South African military law, Commanding Officers preside over Commanding Officers' Disciplinary Hearings (CODH). The MDSMA, regulates these hearings.[140] Commanding Officers have no equivalent capacities to those of a magistrate court.[141] Military Courts, other than that of a CODH, may examine witnesses regarding confidential medical information and, as per section 14(2)(b) of the National Health Act, 2003, order that disclosure be made of medical information.

7. Protecting medical confidentiality in the SANDF: Medical classification

The military healthcare professional's duties are described in the Regulations to the Defence Act, 2002 at Chapter XV. The Regulations require that all musterings,

---

134 HPCSA Guidelines for Good Practice in Health Care (2016) available at https://www.hpcsa.co.za (accessed 1 July 2022).

135 Ch XV of the General Regulations to the Defence Act: Definition of a "medical officer" means 'a person entitled to practise as a medical practitioner in terms of section 17 of the Health Professions Act", 1974 (Act 56 of 1974).

136 Sec 3(2) MDSMA.

137 "Overseas Territories: The Ministry of Defence's Contribution" available at https://assets.publishing.service.gov.uk (accessed 26 April 2022).

138 Reg 7 General Regulations to the Defence Act.

139 Fn 22 above.

140 Sec 11 MDSMA.

141 The South African Military courts are "creatures of statute", and derive their competencies from the MDSMA.

©University of Pretoria

appointments, posts and job classifications have a standard of medical fitness required for efficient work performance.[142] A category of fitness is assigned to serving members that determine the nature, place and extent of the member's employment.[143] By allocating a category of fitness in accordance with predetermined standards the medical confidentiality of the individual soldier is maintained. Restriction on the duty to be performed only will be listed and not the medical condition.[144] Should a change in the member's fitness develop due to disease, injury or any other reason, the Surgeon General may convene a medical board to further examine the fitness status of the soldier and either alter the assigned fitness classification or declare the member unfit for further service in the defence force.[145] The Defence Act, 2002 and the specific regulations dealing with medical matters do not address patient confidentiality but exhibit mechanisms whereby patient confidentiality is promoted.[146]

8. Confidentiality post-mortem: The president and the general[147]

The South African Military Health Service (SAMHS) is responsible for the provision of healthcare to serving and retired presidents and deputy presidents.[148] As Surgeon General of the SAMHS,[149] Lieutenant General VJ Ramlakan[150] was responsible for the provision of health care to the former president, Mr Mandela. In 2017 General Ramlakan published a book detailing, *inter alia*, the medical care provided to Mr Mandela leading up to his death in December 2013.[151] The book was quickly withdrawn from bookshelves after a complaint had been received from the president's widow, the Nelson Mandela Foundation and a grandson that authority had not been granted for disclosing information (including medical information) contained in the

142 Reg 2 General Regulations to the Defence Act, 2002.
143 As above Reg 3(2).
144 As above.
145 As above Reg 3(4).
146 As above.
147 DJ McQuoid-Mason "Disclosing details about the medical treatment of a deceased public figure in a book: Who should have consented to the disclosures in Mandela's last days?" (2017) 107(12) *South African Medical Journal* 1072-1074.
148 The Presidency *The Presidential Handbook* available at https://www.gov.za (accessed 28 April 2022).
149 Sec 4A Defence Act, 2002 and the General Regulations to the Defence Act Chapter XV, Medical Matters.
150 Surgeon General of the SANDF 2005-2011.
151 VJ Ramlakan *Mandela's Last Year* (2017).

©University of Pretoria

publication.[152]

Rule 13(2)(c) of the ethical rules of conduct of the Health Professions Council of South Africa states that confidential information of a deceased may be released only with the written consent of the next of kin or the executor of the estate.[153] Further, disclosures are permitted if ordered by a court of law, under the provisions of a statute or if the disclosure is justified in the public interest.[154] Next of kin are not defined in the Rules but the National Health Act, 2003 describes a specific order for the granting of consent for patients incapable of doing so.[155] If the same principle is applied it makes Ms Graca Michel, as the widow of Mr Mandela, the competent person to authorise the release of confidential information. General Ramlakan claimed to have consent from the family of the late president for the publication of (medical) confidential information, however Ms Machel disputed this claim.[156]

In the event that a breach of confidentiality occurs, an interested party (in this case the widow, executors of the estate or other family members) can approach the Health Professions Council and lay a complaint against the healthcare professional.[157]Approaching the courts for relief, however, may be difficult in matters where medical confidentiality had been breached for a deceased as privacy rights vest with the deceased during their lifetime.[158]

The provision of medical care to the chief executive of the Republic is the task of the South African Military Health Service[159] and rendering medical support is a military mission regulated by military law. General Ramlakan, despite having retired at the time of publication of the book, is subject to the Defence Act in so far as unauthorised disclosures are made.[160]

---

152 ANA "Mandela book pulled off shelves by Penguin" *The Mercury* 25 July 2017 1.

153 Rule 13(2)(c) of the Ethical Rules of Conduct for Practitioners registered under the Health Professions Act; GN R717 of 4 August 2006, as amended by GN R68 of 2 February 2009.

154 As above and *Khumalo v Holomisa* 2002 (5) SA 401 (CC).

155 Sec 7(1)(b).

156 Fn 153 above.

157 N Shaik "Graca Machel threat to sue over Mandela book" *The Mercury* 24 July 2017 3.

158 *Spendiff v East London Despatch Ltd* 1929 EDL 113.

159 Fn 148 above.

160 Sec 104(7) Defence Act; , 2002: Subject to the Promotion of Access to Information Act 2 of 2000, any person who, without authority, discloses or publishes any information, or is responsible for such disclosure or publication, whether by print, the electronic media, verbally or by gesture, where such information has been classified in terms of this Act, is guilty of an offence and liable on conviction to a fine or imprisonment for a period not exceeding five

Thus, as medical doctor and military healthcare professional, General Ramlakan was subject to the Health Professions Act and the Defence Act with regard to his conduct. Lieutenant General Ramlakan died in August of 2020.

9. Conclusion

Effective medical care is largely dependent on the trust a patient has in the competent medical practice of their chosen doctor. If trust is maintained the patient will feel free to divulge even most personal details for the doctor to diagnose correctly and to treat them. Confidentiality, however, is not an absolute and in certain situations that have been explored the doctor would have ethical and legal obligations to breach that trust. Maintaining confidentiality between soldier-patients and their military healthcare professionals represents a major legal and ethical dilemma faced in the armed forces. The right to privacy is entrenched in the Constitution as is medical confidentiality in legislation and in ethical rules. Breaches of the right elicit sanction.

Despite there being limitations to confidentiality, service in the SANDF does not represent such a limitation. During operational or wartime conditions breaches of medical confidentiality may be threatened by the military command's stress on the need-to-know information under the cover of the universally applied "military necessity". Military necessity may not be used, however, and is not described in law or in medical ethics as an acceptable exception permitting a breach of confidentiality without the informed consent of the patient. Mechanisms are in place to manage the effective deployment of the soldier and within the ambit of a medical classification which dispenses with the need to disclose medical information unnecessarily. International law prescripts protect the healthcare professional from being ordered to act contrary to medical ethical practices and there is domestic legislation to protect patient-doctor confidentiality. When there is a need to breach medical confidentiality the military healthcare professional must inform the patient, limit the breach to a specific person or persons and disclose only that which is absolutely necessary.

In the next chapter the principle of patient autonomy is further examined by exploring the right to control of bodily integrity and informed decision-making.

---

years.

©University of Pretoria

CHAPTER 6

CHOICES:

THE EXERCISE OF MEDICAL AUTONOMOUS DECISION-MAKING IN THE MILITARY

OUTLINE

1. Introduction
2. The Autonomous soldier, an oxymoron?
2.1 Introduction
2.2 The Soldier and autonomy
2.3 The Principle of autonomy
2.4 The Inability of the healthcare professional to elicit consent
2.5 Conclusion
3. Medical paternalism, treatment without consent and medical research: The state knows best
3.1 Introduction
3.2 Ordered not consented: Waiving informed consent
3.2.1 Historical perspective
3.2.2 Waiving Consent: Pyridostigmine Bromide, Anthrax Vaccine and Botulinum Toxoid
3.3 Medical research and the soldier
3.3.1 Introduction
3.3.2 The legal and ethical basis for informed consent in medical research as applied to the military
3.3.3 The dilemma of informed consent for military participants in research
4. Respecting Autonomy
4.1 Introduction
4.2 Autonomy on the battlefield
4.3 Withholding consent: Refusal of treatment in the military
4.3.1 Refusal of care: on the home front
4.3.2 Refusal of care: The operational theatre
5. Autonomy and the prisoner of war
5.1 The prisoner of war and the refusal of medical treatment

©University of Pretoria

5.2 Commentary: Honour or compel?
5.3 Application to South African law
6. Conclusion

1. Introduction

This chapter examines the rights that the uniformed patient has in exercising autonomous decision-making in respect of their health as well as the impact the exercise of autonomy has on the military healthcare professional. The aim is to answer the questions relating to how the military healthcare professional identifies and manages the autonomy principle in the practice of medicine in the armed forces. Service in an organisation such as the military does not obviate the right of a soldier-patient to active participation in medical decisions that affect their health. These decisions may well have an effect on continuing service in the armed forces if found no longer to be fit for military service.

Aspects of the management of autonomy are analysed in this chapter with reference to soldier autonomy in the medical research environment, general autonomous decision-making with regards to health issues in the armed services and the implications of the incorporation of autonomous decision-making in international humanitarian law.

2. Autonomous soldier, an oxymoron?

2.1 Introduction

> Soldiers are not ordinary patients. Their special status as combatants whose life, liberty and dignity are limited by choice or circumstance attenuates habitual concern for their welfare and autonomy. Soldiers are not fully autonomous individuals nor, unless freely enlisting, have they elected to restrict their liberty.[1]

In democratic societies personal autonomy or freedom and security of the person can be entrenched in a constitution, as is the case in South Africa.[2] The Constitution guarantees various freedoms[3] albeit these are counterbalanced by obligations, particularly those that prevent the rights of others being infringed. The restriction on

[1] ML Gross *Bioethics and armed conflict Moral dilemmas of medicine and war* (2006) 101.
[2] Sec 12 Constitution of the Republic of South Africa, 1996.
[3] Freedom of religion, belief and opinion, freedom of expression, freedom of association, freedom to protest, political freedoms, freedom of movement and residence, freedom of trade and so forth.

©University of Pretoria

freedom is acknowledged as a part of any functioning society, more so in the armed forces. Service in the South African armed forces is voluntary.[4] Citizens voluntarily enter a system with the knowledge that limitations are placed on certain entrenched freedoms[5] and if the limitation of freedom is incompatible with the individual's convictions, they are at liberty to leave the employ of the defence force.[6] The voluntary choice of employment in the armed forces of a state represents an autonomous exercise by the individual to accept the military (as an institution) and as a legitimate source of direction.[7] The healthcare professional enlisting in the armed forces makes the same choice to accept the limitation on autonomous decision-making. The dilemma the military healthcare professional faces relates to the medical management of their military patients and to the exercise of medical autonomous rights as balanced against the practices of an authoritarian system.

2.2 The soldier and autonomy[8]

Military service places restrictions on the choices an individual makes which range from a strictly prescribed dress code[9] to authoritative displays of respect to superiors[10] and restrictions on communications, associations and freedom of movement.[11] Transgressions of military discipline meet with severe sanction under the Military Disciplinary Code.[12]

The primary purpose of the South African National Defence Force (SANDF) is to protect the territorial sovereignty and the Constitution of the Republic.[13] Although tasked to defend the Constitution and the democratic order, the military functions as a non-democratic and authoritarian system.[14] Visser, in Lounsbury and Bellamy, equates

---

4 Code of Conduct for Uniformed Members of the South African National Defence Force available at https://www.researchgate.net/figure/Code-of-Conduct-for-Uniformed-Members-of-the-SANDF (accessed on the 1 February 2021).
5 Sec 50 Defence Act 42 of 2002 Restrictions on freedoms such as movement, communications, freedom to dress as one likes or to have grooming standards that are prescribed and so forth.
6 Sec 59(1)(a) Defence Act, 2002.
7 TL Beauchamp & JF Childress *Principles of biomedical ethics* (2009) 102.
8 Autonomy is described in this section as the freedom to make a choice between different causes of actions without fear of coercion.
9 SL Visser in DE Lounsbury & RF Bellamy *Military Medical Ethics* (2003) 251.
10 Fn 4 above.
11 Sec 50 Defence Act, 2002.
12 1st Schedule to the Defence Act, 1957.
13 Sec 200 Constitution, 1996.
14 Visser in Lounsbury & Bellamy (fn 9 above) 253.

©University of Pretoria

the limitation on freedom the soldier experiences to John Stuart Mill's "harm principle";[15] in terms of that principle a soldier's personal freedom should be restricted to the extent only that harm is not caused to others or to the organisation.[16] In distinguishing the harm principle from an otherwise paternalistic/authoritarian principle (which is a classification of a military organisation and Mill dismisses the paternalistic principle), Visser offers a justification for restricting a soldier's personal autonomy.[17] Thus the rules that soldiers obey or face sanction are intended to prevent harm to the organisation and on that ground are justified.[18]

The above rationalisation has support in that the Constitution requires the defence force to be structured and managed as a disciplined force.[19] The enforcement of discipline within the SANDF is entrusted to an internally-regulated system of military justice which consists of military courts, a defence, a prosecution and a review counsel.[20] Military courts, combined with an authority intrinsic to those in command of others, ensure that transgressors of military disciplinary offences and certain criminal offences are brought before the courts and appropriate punishments are prescribed.[21]

2.3 Principle of autonomy[22]

> Successful relationships between health care practitioners and patients depend upon mutual trust. To establish that trust, practitioners must respect patients' autonomy – their right to decide whether or not to undergo any medical intervention, even where a refusal may result in harm to themselves or in their own death. Patients must be given sufficient information in a way that they can understand, to enable them to exercise their right to make informed decisions about their care.[23]

Informed consent is described in the Constitution, the National Health Act, the Health Professions Council of South Africa's (HPCSA) guidelines for ethical practice and

---

15 As above, 256.
16 As above.
17 As above.
18 As above.
19 Sec 200 Constitution, 1996.
20 Military Disciplinary Supplementary Measures Act 16 of 1999 and the 1st schedule to the Defence Act, 1957 the Military Disciplinary Code.
21 As above.
22 With reference to medical autonomy.
23 Health Professions Council of South Africa *Guidelines for Good Practice in the Health Care Professions. Seeking Patients' Informed Consent: The Ethical Considerations* Booklet 4 (2016) 86.

©University of Pretoria

case law.[24] In the latter part of the Twentieth Century there was a movement away from a paternalistic medical practice[25] to informed consent in a patient-centric practice,[26] which, as elsewhere, influenced the practice of medicine in the military. In this system the patient can expect to be consulted and to give informed consent in accordance with the law.[27] A failure to have the informed consent of the patient to any procedure will result in delictual liability and the possibility of a healthcare professional facing a criminal penalty.[28]

In the aftermath of the Nuremberg trials at the end of the Second World War that investigated the criminal activity of members of the medical profession under National Socialism, the emphasis in biomedical ethics has been on the necessity of consent to medical care and participation in biomedical research so as to give reality to the patient's right to dignity and to have their choice respected.[29] Informed consent not only is an obligation placed on a healthcare professional to disclose accurate information, but also involves an assurance as to the quality of the patient's understanding (and consent).[30] To be able to act autonomously in making decisions about one's health is a form of self-rule that is independent of the influence of controlling authorities and reflects a meaningful understanding of the consequences of one's choice.[31] Autonomy is expressed in the capacity of the patient to give informed consent to a healthcare professional to examine, treat and perform medical procedures.[32]

The World Medical Association declares medical ethics in a time of peace is identical to medical ethics in a time of war.[33] The military healthcare professional has to obtain the informed consent of the soldier-patient in the same way as a civilian healthcare

---

24 Sec 12(2)(c) Constitution, 1996; Secs 6-9 National Health Act; Health Professions Council of South Africa (fn 23 above); and *Castell v De Greef* [1994] 4 All SA 63 (C).

25 Beauchamp and Childress 102-103.

26 As above.

27 Secs 6-9 National Health Act, 2003.

28 *Castell v De Greef* [1994] 4 All SA 63 (C). The court found that the failure of the physician to comprehensively inform a patient of all the material risks associated with a medical procedure constituted assault and not negligence.

29 Beauchamp and Childress (n 7 above) 117.

30 As above, 118.

31 As above.

32 As above.

33 World Medical Association *Regulations in times of armed conflict and other situations of violence* (Rev 63rd WMA Assembly, Bangkok Thailand) (2012).

©University of Pretoria

professional before carrying out a medical procedure.[34] Ethical and practice guidelines disseminated by the HPCSA advise that an explicit consent[35] is obtained from a patient prior to the commencement of treatment. This advice demands more than implied consent, which intrinsically can be challenged as not ensuring that the decision of a patient in consultation with a healthcare professional necessarily can be interpreted as giving consent to a specific intervention.[36] Non-operational or base care situations offer examples in which this practice is evident; however, it is in the severe and extreme situation on the battlefield that explicit consent presents a challenge to the military healthcare professional and raises a conflict of interest.[37] This difficulty is examined later in the chapter.

2.4 Inability of the healthcare professional to elicit consent

A situation can arise when the duty to gain informed consent from the patient prior to carrying out medical treatment is absent; this can be due to the patient being unconscious (an emergency situation), being a minor, or lacking the mental capacity to decide.[38] Consent in relation to medical procedures applies when the patient has knowledge of the nature of the risk, appreciates and understands the nature of the risk, assumes the risk by consenting and the consent is comprehensive in such a manner as to extend to the entire transaction including the consequences.[39]

Provisions in the Mental Health Care Act, 2002 and the Children's Act, 2005 describe the competency of the mentally ill and children with regard to their consent to health care and health rights.[40] These provisions are not examined in depth in the thesis except in relation to a situation where a military healthcare professional may be in contact with the mentally ill or in a situation where children may have to be cared for. The military healthcare professional experiences a situation where the wounded person

---

34 As above, 23.

35 As above. Express consent is consent educed to writing, duly signed and witnessed as opposed to implied consent where the mere conduct of the patient is assumed to be consent for medical procedures.

36 As above.

37 J Kelly *Is medical ethics in armed conflict identical to medical ethics in times of peace?* (2013) 97.

38 MA Dada & DJ McQuoid-Mason *Introduction to medico-legal practice* (2001) 8.

39 As above.

40 The Children's Act stipulates the various ages that children may consent to either medical, surgical or reproduction health interventions. The Mental Health Care Act similarly describes who may act on behalf of a person who is suffering from mental illness.

©University of Pretoria

is unconscious or lacks capacity due to temporary mental incapacity (brought about by an extremely traumatic event). The management of patients who are unable to express their consent to treatment is a reality during military operations and a military healthcare professional needs a proper understanding of the ethical and legal consequences of treatment without explicit consent.

The general rule is that treatment without the consent of the patient is not permitted.[41] Where an otherwise mentally competent patient has not expressed unwillingness to receive medical attention but temporarily is incapable of giving consent (due to unconsciousness, intoxication, physical shock), then treatment relying on the emergency situation and is justified on the grounds of necessity.[42] But it is justified only by true urgency (that is, death or threatened loss of limb/deterioration of bodily function); the patient must be unaware of the treatment commenced or be incapable of appreciating the situation. Treatment should not be contrary to any advance directive that forbids life-saving interventions and the intervention must be in the best interest of the patient.[43] Frequently, a situation arises that necessitates medical intervention by a comrade in arms who is not specifically trained in medicine.[44] Such a situation justifies an intervention under the principle of necessity.[45]

2.5 Conclusion

In South Africa citizens voluntarily enter military service. The Defence Act, 2002 clearly defines the limitations on the freedoms of soldiers. Autonomous decision-making in respect of health is restricted in the military; for example, by determination by examination of fitness for service and certain prophylactic treatments also are prescribed in law. A failure to comply with these restrictions results in separation on medical grounds of service in the defence force. In severe and extreme conditions other rights with regard to free autonomous medical decision-making capability may be limited in the circumstances discussed in this chapter.

---

41 Dada & McQuiod-Mason 16.
42 As above.
43 As above.
44 "Buddy aid" refers to the primary intervention by either the injured person performing a life-saving procedure on herself (such as tying a tourniquet around a bleeding extremity), to the assistance by a fellow lay-person soldier who administers medical care by means of immediate intervention prior to the arrival of qualified and dedicated medical support; ICRC *First Aid in Armed Conflicts and Other Situations of Violence* (2010).
45 Dada & McQuiod-Mason 17.

©University of Pretoria

3. Medical paternalism, treatment without consent and medical research: The state knows best

3.1 Introduction

> Paternalism is the intentional overriding of one person's preferences or actions by another person, where the person who overrides justifies this action by appeal to the goal of benefiting or of preventing or mitigating harm to the person whose preferences or actions are overridden.[46]

The term "paternalism" is defined as the "principle and practice of paternal administration; government as by a father; the claim or attempt to supply the needs or to regulate the life of a nation or community in the same way a father does those of his children".[47] Beauchamp and Childress eloquently explain that in a healthcare setting a healthcare professional, equipped with years of training, experience, knowledge and insight, is in an authoritative position to determine what is best for the patient.[48] Beauchamp and Childress describe paternalistic medical practices as they relate to the individual patient, but in a military environment the paternalistic nature of prescribing a medical intervention involves a sense of maintaining the overall health of the collective.

Beam[49] recognises that the paternalistic nature of military healthcare is present only in extreme situations; on the battlefield or during mobilisation prior to deployment.[50] In peacetime the ethical situation a military healthcare professional confronts is akin to that in private or civilian public medical ethics.[51] Beam argues that military healthcare professionals face mixed agency conflicts; they act in terms of the beneficence of the individual soldier as well as the combat efficacy of the total force.[52] In mind of Beam's presentation instances where informed consent was done away with and soldiers were ordered to comply with a treatment regime are now examined.

---

46 Beauchamp and Childress 208.
47 As above.
48 As above, 209.
49 TE Beam in Lounsbury and Bellamy 379.
50 As above, 377.
51 As above.
52 As above. In respecting the wishes of the individual soldier versus the enforcement of treatment, the principles in the United States Constitution provides that society has a legitimate expectation that the military protects society and its founding principles thus restricting autonomous decision-making.

©University of Pretoria

3.2 Ordered not consented: Waiving informed consent

3.2.1 Historical perspective

Military history is rich in examples of instances where commanders ordered the administration on the battlefield of medication to soldiers with the intention of protecting them from real or potential medical threats. General George Washington ordered smallpox variolation[53] during the Revolutionary War of 1777 to protect his soldiers against an outbreak of the disease that threatened to decimate half of his army.[54] During the Second World War it was ordered the then unproven yellow fever vaccine be administered to troops which resulted in numerous deaths due to the vaccine being contaminated.[55] In the same war an experimental inoculation against influenza with the goal of preventing a repeat of the Spanish flu outbreak of 1918 resulted in the deaths of thousands of troops.[56]

The following headings deal separately with the administration of medication to troops in accordance with instances where informed consent either was waived or simply not gained, and examples of the participation of troops in medical research.

3.2.2 Waiving consent: Pyridostigmine Bromide, Anthrax Vaccine and Botulinum Toxoid

Use of investigational new drugs in the First Gulf War

After Iraq invaded neighbouring Kuwait during August 1990, a United Nations sanctioned response saw the deployment of hundreds of thousands of coalition troops in Saudi Arabia and other states under Operation Desert Shield.[57] The goal was to expel the Iraqi forces from Kuwait if economic and political pressure failed. Iraq was known to have possessed chemical and biological weapons and had used them against Iran in the Iran-Iraq War and against its own population.[58] Saddam Hussein's chemical and biological warfare (CW/BW) capabilities were considered a potential threat to

---

53 The practice of applying the pus of smallpox infected persons by means of a surface scratch to an unaffected person in order to build immunity against the disease.

54 D Jackson *Waiver of informed consent for military service members* (2006) 5.

55 As above.

56 As above.

57 RA Rettig *Military use of drugs not yet approved by the FDA for CW/BW defense. Lessons from the Gulf War* (1999) 1.

58 As above.

©University of Pretoria

coalition troops in the area.[59]

In response to the CW/BW threat the coalition forces deployed early warning detection devices, chemical/biological protective suits, facemasks and medicinal countermeasures.[60] Three drugs were researched and considered by the military to provide protection against Saddam's arsenal; Pyridostigmine Bromide (PB), Anthrax Vaccine (AX) and Botulinum Toxoid (BT).[61] Of the three anthrax vaccine was the only drug licensed for human consumption against inhaled anthrax.[62] PB and BT were classified as investigational drugs.[63] PB was classified as a licensed drug but only for the treatment of myasthenia gravis (muscle weakness brought on by a nervous disorder) and as a reversing agent for certain anaesthetic drugs in humans.[64] BT had been used by persons employed in the agricultural sector to prevent botulism (a toxin that attacks the nervous system).[65] Both PB and BT were classified as investigational new drugs (IND's)[66] for use in the CW/BW theatre under Federal Drug Administration (FDA) Regulations. [67]

Waiving informed consent: Military knows best

The US Department of Defense (DoD) submitted a request to the FDA in which the use of PB and BT was required for defence against CW/BW threats.[68] Further, the DoD required that informed consent be waived as it would "not be feasible"[69] to gain

59 As above, 2.
60 As above, 3.
61 As above, 5.
62 As above. The United States Federal Drug Administration (FDA) classifies drugs as either investigational or licensed depending on its use.
63 As above.
64 As above, 6.
65 As above.
66 As above. The FDA differentiates licensed and unlicensed drugs. Investigational drugs are not synonymous with experimental drugs. Investigational drugs require informed consent prior to their use in humans.
67 As above, 3. The US the Food Drug and Cosmetics Act (FDCA) vests authority with the Secretary of Health and Human Services, who delegates to the Commissioner of Food and Drugs, to regulate development, testing and evaluation of drugs, vaccines, medical devices and other matters. The Federal Drug Administration in accordance with the Act, declares drugs as being either safe for use or safe in use.
68 As above, 7.
69 Rettig 24: Submission by Dr E Mendez: "Our planning for Desert Shield contingencies has convinced us that another circumstance should be recognised in the FDA regulation in which it would be consistent with the statute and ethically appropriate for medical professionals to 'deem it not feasible' to obtain informed consent of the patient, that circumstances being the existence of military combat exigencies, coupled with a determination that the use of the product is in the best interests of the individual. By 'military combat exigencies', we mean military combat (actual or threatened) circumstances in which the health of the individual, the safety of other personnel

©University of Pretoria

the consent of soldiers deployed in the theatre of operations.[70] In response the FDA published an Interim Rule, stating: "Informed consent for human drugs and biologics; determination that informed consent is not feasible for military exigencies".[71]

Waivers for informed consent by soldiers who were to be administered PB and BT was granted days before the incursion into Kuwait.[72] Further procedural limitations were proposed for the "not feasible" aspect of gaining informed consent:[73]

i. Waiver decisions can be made only on a case-by-case basis by the Commissioner of the FDA thus ensuring external military participation.

ii. A written motivation is submitted for the specific use of the drug(s) including the specific military circumstances.

iii. That no satisfactory alternatives exist.

iv. That all available safety and efficacy data support its use.

v. Approval by military institutional review boards (IRBs).

vi. Time constraints must apply to its use.

The interim rule waiving individual informed consent based on the "not feasible" motivation was published for public comment and received a mixed reaction of approval and opposition.[74]

Deliberations between the FDA and the DoD during the application for the waiver of informed consent for the use of the investigational new drugs concluded that the use of PB and BT was for defence against the unprecedented use of chemical and biological weapons in the Gulf.[75] As the drugs would be for the preventive and therapeutic use against chemical and/or biological weapons, the issue of their use in research or experimental situations was dismissed.[76]

Poor record keeping, haphazard distribution, confusion and limitations in supply

and the accomplishment of the military mission require that a particular treatment be provided to a specific group of military personnel, without regard to what might be any individual's personal preference for no treatment or for some alternative treatment".

70 As above.
71 As above.
72 As above.
73 As above, 24.
74 As above.
75 As above, 20.
76 As above.

©University of Pretoria

marred the administration of the three drugs at the outbreak of combat operations in January 1991.[77] At the end of hostilities PB had been implicated as contributing to many war veterans' continued health issues, collectively known as Gulf War Syndrome.[78] Committees were established to investigate the Syndrome and the conclusions pointed to the combined use of PB, BT, AX and other toxic agents readily deployed during the war.[79]

Legal challenge in the District and Appellate Courts

As soon as the FDA's Interim Final Rule came into effect it was challenged in the jurisdiction of the District of Columbia in *John Doe and Jane Doe vs. Sullivan and Cheney* (Secretaries for Health and Human Sciences and Defense respectively). The plaintiffs sought to prevent the administration of the drugs to the troops deployed in the Middle East without first gaining individual informed consent.[80] The court *a quo* denied the plaintiff's motion and granted the defendants the motion to dismiss.[81] The presiding judge ruled that the administration of investigational drugs to service people without their informed consent constituted a strategic military decision and one that the court stood in no position to oppose.[82] The matter was taken on appeal to a higher forum and the appeal there also was dismissed.[83] The court found that the government was within the law in issuing the interim rule waiving informed consent in this situation.[84]

Research/investigational vs treatment: Post-war critique

Annas and Grodin[85] supply commentary to Howe and Martin's report in which they criticise the shift in US military policy away from the principles accepted in the Nuremburg Code.[86] The demarcation between research and treatment is not well

[77] As above, 32-35.
[78] As above, 35.
[79] Rettig 35 and Gulf War Illness and the Health of Gulf War Veterans: Scientific Findings and Recommendations. Research Advisory Committee on Gulf War Veteran's Illness. Washington DC US Government Printing Office November 2008 289.
[80] Rettig 28.
[81] *John Doe and Jane Doe vs Louis Sullivan and Richard Cheney* USDC, District of Columbia, 756F Supp 12 January 31 1991.
[82] Rettig 30.
[83] *Doe v Sullivan* 938F. 2d 1370 US App DC 111 decided July 16 1991.
[84] As above.
[85] G Annas & MA Grodin "Commentary on 'Treating the Troops'" *The Hastings Center Report* (as cited in Rettig 51).
[86] The US Military accepted as policy, the principles of the Nuremburg Code in 1953.

©University of Pretoria

defined in this situation; the term "investigational" too is not well defined and the use of the drugs during the conflict fell somewhere between research and treatment.[87]

The question is whether the use of PB and BT as investigational drugs in the circumstances constituted research. Research represents a situation in which the consequences, risks and benefits are not known.[88] Caplan[89] is of the view that the drugs "were used in large populations for purposes other than those for which they were originally designed in circumstances under which they had never been tried". Caplan agrees with Annas and Grobin that the efficacy of PB and BT was not known.[90] Caplan, Annas and Grodin are *ad idem* that it is not sufficient to consider the intent of the researcher but that it is rather the investigational nature of the intervention that determines whether or not the intervention is research or treatment.[91] The Belmont Report[92] comments on the boundaries between research and practice to which Annas, Grodin and Caplin refer in their critique of the intent of the DoD to differentiate between research/investigation and practice/treatment.[93] The critics also point out that the DoD and the FDA accepted the principle of regulation of research activities by applying for a waiver to informed consent for the administration of the drugs to the troops.[94]

Counterpoint to critique: Treatment not research

Rettig argues that the DoD's intention was not that of research or investigation (despite the PB and BT drugs being licensed as investigational new drugs by the FDA) but for

---

87 Rettig 95.

88 Annas & Grodin (as cited in Rettig 55).

89 A Caplan Testimony at the US Senate Committee on Veteran's Affairs "Is Military Research Hazardous to Veterans Health, Lessons from World War II, the Persian Gulf and Today" Hearing held 6 May 1994 (as cited in Rettig 55).

90 As above.

91 As above, 56.

92 National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1979) *The Belmont report: Ethical principles and guidelines for the protection of human subjects of research* US Department of Health and Human Services available at https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/read-the-belmont-report/index.html (accessed 12 January 2022): "For the most part, the term "practice" refers to interventions that are designed solely to enhance the well-being of an individual patient or client and that have a reasonable expectation of success. The purpose of medical or behavioral practice is to provide diagnosis, preventive treatment or therapy to particular individuals [2]. By contrast, the term "research' designates an activity designed to test an hypothesis, permit conclusions to be drawn, and thereby to develop or contribute to generalizable knowledge (expressed, for example, in theories, principles, and statements of relationships)".

93 Rettig 56.

94 As above.

©University of Pretoria

treatment (and pre-treatment) against the real CW/BW threat in the Gulf.[95] The DoD succeeded in having consent for the use of the drugs waived under the following motivations:[96]

i. The CW/BW threat posed by Saddam Hussein, who earlier had deployed such weapons against his enemies, was substantial and threatened massive casualties among coalition troops.

ii. The ethical obligation of the DoD was to protect troops by using the best therapeutic and preventive treatment available and to not use the drugs for research purposes.

iii. The PB and BT drugs were by no means novel (new and untested drugs) but had proven efficacy in humans suffering from conditions other than exposure to CW/BW weapons.

The DoD recognised a claim that drugs classified as investigational could have non-research therapeutic uses.[97] The statutory provision in the FDCA at section 505(i) was the basis for which the DoD received a waiver in respect of informed consent.[98]

Howe and Martin[99] rely on a provision in the Nuremburg Code they claim justifies waiving informed consent on the basis that the use of the investigational drugs would "avoid unnecessary physical and mental suffering" and protect against "even remote possibilities of injury, disability and death".[100] However, their point demonstrates a research component was present in the use of the drugs in that data would be collected on the effects of their use as pre-treatment/treatment for CW/BW agents.[101] Further, the DoD had engaged with external experts in assessing the scientific and ethical risks of the use of the drugs.[102] It had been established in the report filed by Howe and Martin, that there existed a substantial benefit in using the drugs for CB/BW treatment

95 As above, 57.
96 As per the letter submitted to the FDA by Dr Mendez, see above n 69.
97 The basis for this argument, according to the DoD was that section 505(i) of the FDCA in which drugs used in investigational purposes to inform participants or their representatives that the drugs are being used for investigational purposes and that the consent will be gained from the participant or her representative, except "where they deem it not feasible or, in their professional judgment, contrary to the best interests of such human subjects".
98 Rettig 57.
99 EG Howe and ED Martin "Treating the Troops" (1991) *Hastings Center Report* (as cited in Rettig 55).
100 Rettig 49.
101 As above.
102 As above.

©University of Pretoria

and that the risk of harm was small.[103]

Howe and Martin claim that soldiers relinquish some element of autonomous decision-making when they enlist in the military.[104] The right to informed consent is considered a right a soldier relinquishes as the threat of combat approaches.[105] The military mission and the interests of the unit (comrades) override individual autonomy. In return, the military undertakes to protect the soldier during combat;[106] in this case the provision of protective devices and medicinal protection against CW/BW attack.

At the time of drafting this chapter, the COVID-19 pandemic had occurred and the unprecedented global transmission rates together with death tolls affected the way we live our lives. South African responses to contain the spread of the virus saw the mobilisation of the entire South African National Defence Force.[107] Under Operation Notlela, the SANDF was to ensure medical support to the national department of health and the South African Police Service in enforcing regulations promulgated under the Disaster Management Act 57 of 2002.[108]

The Military Command Council (MCC), the highest decision making authority of the SANDF, took a decision to import medication from the Republic of Cuba, believed to be of value in protecting deployed SANDF members from the COVID-19 virus.[109] As with the coalition forces experience during Operation Desert Shield/Storm, the drug was not registered for the intended use but was a known treatment for other medical conditions.[110]

The regulator of medicines and medical devices, the South African Health Products Regulatory Authority (SAHPRA), denied the use of the drug as per the Medicines and Related Substances Act 101 of 1965.[111] Had the drug been authorised for use by the deployed SANDF members, a situation would have faced the South African

103 As above.
104 As above, 50.
105 As above.
106 As above.
107 "Ramaphosa mobilises SANDF in one of the country's biggest deployments in history" *News24* 21 April 2020 available at www.news24.com/news24/south africa/news/sandf mobilised in one of the biggest deployments in country's history (accessed on the 30 November 2022).
108 As above.
109 SANDF defends acquisition of Interferon drug from Cuba. Defence Web 29 January 2021, available at www.defenceweb.co.za/wpcontent/uploads/security/human security/Heberon (accessed 30 August 2022).
110 Fn 92 above.
111 Fn 109 above.

©University of Pretoria

government akin to that what had occurred during the First Gulf War, that is, a possible decision to administer the medication without the consent of individual troops.

While it is the states imperative to provide the best protection for soldiers who face peril on the battlefield, when it comes to unconventional or novel means of protection, the situation may not be so simple as supplying bulletproof vests to the troops. The Gulf War was a victory for coalition forces in that Saddam Hussein was driven out of Kuwait without a full-scale chemical biological attack and the COVID-19 virus was managed by the development of vaccines specifically developed for that purpose.[112] The world may not have seen the end of a situation that requires decisions to be made with limited time to fully address all legal and ethical issues surrounding the informed consent to drugs or measures intended to mitigate a life-threatening scenario. The lesson to be learnt may just be that there have been lessons to learn from.

3.3 Medical research and the soldier

3.3.1 Introduction

> Since ancient times and certainly since Ambrose Paré, the renowned sixteenth-century military surgeon, military surgeons have experimented on wounded soldiers to test new therapies and on healthy soldiers to formulate new defenses. The history of military medicine is often one of medical experimentation on wounded soldiers in an effort to save their lives, reduce suffering, and return them to duty. While the Nazis abused military medicine in a way previously thought unimaginable, it would be a mistake to let Nazi abuses, rather than the long history of medical achievement, guide our thinking.[113]

Medical research law and ethics is an extensive topic that continues to receive the attention of researchers and scholars. However, military medical research is not well-known despite the modern basis for an examination of the conduct of legal and ethical research after the atrocities committed by National Socialist Germany and Imperial Japan during the Second World War.[114] If any good can be accorded to result from the tragedy of armed conflict, advances in medical science in all probability will be ranked first. Modern nursing practices, penicillin advances, tourniquets, antiseptic techniques, anaesthetics and plastic surgery first received application in medicine due to war. The

---

[112] T Le *et al* "The COVID-19 vaccine development landscape" (2020) 19 *Nat Rev Drug Discov* 305-306.
[113] Gross 116.
[114] Gross 112.

©University of Pretoria

ethical (and often legal) practice relating to the conduct that led to these advances remains largely questionable due to a lack of guidelines for ethical practice.

The cornerstone to ethical practice in conducting medical research remains the autonomous decision-making expressed in the informed consent of the participant. It is this aspect of the examination of the role the soldier as research participant that receives the most attention.[115]

3.3.2 Legal and ethical basis for informed consent in medical research as applied to the military

Nienaber comments that international and national systems of ethics co-exist; for example as present in the acceptance (as binding) of international ethical research guidelines by South African research ethics committees.[116] What follows is a brief explanation of the constitutional, legislative, international law and domestic guidelines for conducting human-based research as applied to the military.

Section 12(2)(c) of the Constitution, 1996[117]

The Constitution, as the supreme law of the land, applies to all laws of the Republic of South Africa.[118] As an organ of the state the military is subject to and must apply the provisions of the Constitution, but also serves to protect it. Section 12(2)(c) of the Constitution reinforces the importance of the principle of informed consent:

- The right to informed consent is mentioned in the ICCPR[119] and its inclusion in section 12 of the Constitution may be due to human rights violations (including but not limited to experimentation without informed consent) by the previous political order.[120]
- Informed consent is a civil right applicable to all persons in South Africa (not only citizens).[121]

---

115 As above.

116 AG Nienaber "Ethics and Human Rights in HIV-related Clinical Trials in Africa with Specific Reference to Informed Consent in Preventative HIV Vaccine Efficacy Trials in South Africa" Unpublished LLD thesis University of Pretoria, (2007) 396.

117 "Everyone has the right to bodily and psychological integrity, which includes the right –
(c) not to be subjected to medical or scientific experiments without their informed consent"

118 Sec 8(1) Constitution, 1996.

119 International Covenant of Civil and Political Rights, UNTS 17, 6 ILM 368 (entered into force on the 23 March 1976).

120 Nienaber 474.

121 As above.

- A distinction is made between medical and scientific experimentation.[122]
- No distinction is made between therapeutic and non-therapeutic experimentation.[123]
- Only research participants themselves may consent to experimentation, no proxy or surrogate consent is permitted.[124]
- With application to a state of national emergency, section 12(2)(c) is listed as a non-derogable right.[125]

Domestic legislation

The National Health Act 61 of 2003 has little direct applicability to the military health system other than to define military health establishments[126] and to include the head of the South African Military Health Service in the National Health Council.[127] The Act nevertheless applies to military medicine.[128] Informed consent is a statutory prerequisite for any medical research.[129] The section prescribes the following:[130]

- Research or experimentation may be conducted only in a prescribed manner.[131]
- Consent must be both informed and in writing.
- Information must be disseminated to the participants with regard to the objective of the research or experimentation.
- Participants must be informed of any possible positive or negative consequences to their health.

"Informed consent" is addressed in section 6(1) of the National Health Act and states,

---

122 As above, 475. The interchangeable use of the words "medical" and "scientific" experimentation in international instruments and domestic legislation has been considered In the drafting of the Constitution and represents the inclusivity of both practices where human subjects are involved and the need for informed consent by the participants.

123 As above.

124 As above, 476. It is noted that Nienaber supports the view of Van Wyk (as opposed to van Oosten), in that consent by lawful guardians to therapeutic research would be in line with international practice and for the advancement of medical sciences. See also sec71(2) National Health Act.

125 Sec 37(5) Constitution, 1996.

126 Sec 1 Act 61 of 2003.

127 As above, sec 22.

128 The Act defines that the President as Commander in Chief of the SANDf and the Minister of Defence and Military Veterans exercise control over military health establishments.

129 Sec 71(1) Act 61 of 2003.

130 As above.

131 The prescribed manner is expanded on in the regulations to the National Health Act regarding research on human participants and in the various ethical guidelines published by state regulators.

©University of Pretoria

inter alia, that the medical diagnoses of the health user be communicated to them except in cases where it may be against their best interests, information about diagnostic and treatment options be made available, benefits, risks, costs and consequences of each option and the right to refuse treatment be communicated (with the associated implications, risks and obligations of such refusal).[132]

Section 7(1) describes that treatment may only take place with the informed consent of the user, and lists exceptions that apply when consent cannot be obtained or when treatment without consent is mandatory.[133]

Regulations promulgated in accordance with section 90 of the National Health Act (Research with human participants) provide detailed provisions regarding research.[134] Principles on health research, obligations of researchers, vulnerable research participants, informed consent, the ethics review of proposals with human participants and ministerial consent for non-therapeutic research involving minors are contained in the Regulations and are binding on all researchers in the Republic of South Africa.[135]

The Regulations state that members of the National Defence Force are vulnerable persons in that they are subject to dependent or hierarchal relationships.[136] Despite this recognition, members of the National Defence Force are not excluded from partaking in or conducting medical or scientific research.[137]

The incorporation into domestic law of the Geneva Conventions and the Additional Protocols according to section 231(4) of the Constitution by the Implementation of the Geneva Conventions Act 8 of 2012 (Implementation Act) creates the opportunity for punitive action against both civilian and military persons for breaches of the Conventions.[138] The Act enables prosecution of grave or other breaches of the Conventions and Protocols committed within or outside the borders of the Republic.[139] Military superior officers and civilians who fail to prevent breaches also are liable for

---

[132] Sec 6(1) Act 61 of 2003.
[133] As above, sec 7(1).
[134] National Health Act, 2003 Regulations Relating to Research with Human Participants R719 dated 19 September 2014.
[135] As above.
[136] Reg 4.4.
[137] As above.
[138] Sec 2 Implementation of the Geneva Conventions Act 8 of 2012.
[139] As above, sec. 5.

©University of Pretoria

prosecution.[140]

Conducting experimentation on humans, whether the experimentation is described as biological, medical or scientific, represents a breach of the Geneva Conventions and Additional Protocols.[141] Grave breaches listed in the Implementing Act contain the prohibition on biological and/or medical/scientific experimentation on humans.[142] The Implementing Act unequivocally prohibits the performance of experimentation on persons (whether military members, civilians, captured or otherwise) during armed conflict. The Conventions do not explicitly mention the conduct of experimentation with the consent of the person but the First Additional Protocol prohibits medical/scientific experimentation even with the consent of the person.[143]

International instruments and ethical guidelines

In response to the atrocities committed during the Second World War the Nuremburg Code[144] emerged as the guiding document in respect of ethical medical research.[145] At the beginning of this section of the thesis it was stated that international and national systems of ethics co-exist due to the acceptance (as binding) of international ethical research guidelines by, for example, South African research ethics committees.[146] International and domestic human rights law do not co-exist in this manner.[147] As South Africa is a dualist system in relation to international law, international human rights law (in the form of treaties) has to be incorporated specifically into domestic legislation in order to enjoy the force of law in South Africa.[148] Customary international law, on the other hand, forms part of South African national law, without any act of incorporation.[149]

Following the handing down of judgment for the 23 accused at the Nuremburg (Doctors) Tribunal, ten Codes were drafted for researchers to follow when conducting

---

140 As above, sec 6.
141 Art 12 of GC I and GC II, Art 13 GC III, Art 32 GC IV and Art 11 of AP I.
142 Art 50 of GC I, Art 51 of GC II, Art 130 of GC III, Art 147 of GV IV and Art 11 of AP I.
143 Art 11(2) AP I.
144 The Nuremburg Code from the Trials of War Criminals before the Nuremberg Military Tribunals under Control Council Law No. 10. Nuremberg, October 1946–April 1949. Washington, D.C.: U.S. G.P.O, 1949–1953.
145 Gross 112.
146 As above, 83.
147 Nienaber 397.
148 As above.
149 Sec 232 Constitution, 1996.

experiments on human subjects.[150] The majority of healthcare professionals involved in human experimentation were employed by the German state or where ranking officers of the German army.[151] Heralding a new era in ethical research and medical behaviour, the Code emphasises the voluntary and informed consent of all participants. As such the rights of the participant to have control over their own body was paramount. Further obligations include a risk-benefit analysis that favours beneficial research, the avoidance of unnecessary suffering, researchers to be suitably qualified and the voluntary withdrawal of consent by participants at any time prior to or during the research was enforced. The Code was adopted into the domestic law and medical research ethical guidelines of many nations, as well as by military research ethics councils.

The Belmont Report[152] was drafted to address shortcomings in guidelines with regard to human subject research.[153] The report includes broad ethical principles as an analytical framework intended to assist in solving ethical issues arising from human participation in research.[154] The purpose of the Report is to be of assistance to military medical research in that it addresses informed consent in relation to unjustifiable pressures from persons in a position of authority or commanding influence.[155]

The World Medical Association in the Declaration of Helsinki[156] lists ethical principles for medical research involving human subjects. Although not a legally binding document, the Declaration draws its authority from the influence it has had on national legislation.[157] The first post-Second World War guideline on medical research involving human subjects it, too, references vulnerable populations that are unable to give consent that is free of external coercion or undue influence.[158]

---

150 FN 144 above: The Nuremburg Code from the Trials of War Criminals before the Nuremberg Military Tribunals under Control Council Law No. 10. Nuremberg, October 1946–April 1949. Washington, D.C.: U.S. G.P.O, 1949–1953.

151 As above.

152 Belmont Report Ethical Principles and Guidelines for the Protection of Human Subjects of Research. Report of the United States National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research (1976).

153 J Nwobegahay *et al* "Ethical guidelines for military-based health research: An unmet need in Africa" (2015) *South African Journal of Bioethics and Law* 11-15.

154 As above.

155 As above.

156 64th World Medical Association General Assembly, Brazil October 2013.

157 Department of Health *Ethics in Health Research Principles processes and structures* (2nd ed) (2015).

158 Fn 156 above at arts 19 & 20.

Article 3 of the Universal Declaration of Human Rights guarantees the right of everyone to life, liberty and the security of person; article 5 guarantees that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. The two articles can be likened to the constitutional provision in South Africa that guarantees the same rights that translate to granting individual autonomy.[159] The ICCPR similarly includes the right not to be subjected to medical/scientific experimentation without "free" consent.[160] The ICCPR's inclusion of informed consent makes it a principle of international law that confers enforceable rights on research participants in those states who have ratified the convention.[161]

The Department of Health's Ethics in Health Research (2015 2nd edition), HPCSA's General Guidelines for Health Researchers (Booklet 13 2016) and the South African Medical Research Council's Guidelines on the Responsible Conduct of Research (2018) are further references available to the researcher to ensure compliance with legal and ethical practices for human participant research. These sources are applicable to military health researchers as much as they are to their civilian counterparts. The three documents mirror each other in that they provide the same provisions for the execution of research in line with the Regulations regarding research promulgated in terms of the National Health Act, 2003.

3.3.3 Dilemma of informed consent for military participants in research

Military healthcare professionals are exposed to what are nominated "dual loyalty conflicts" in all aspects of healthcare in relation to the soldier population; a difficulty compounded in extreme situations such as combat. In the circumstance loyalty is owed to the military authority/objectives and to the individual soldier-patient. Conducting medical research with soldiers as research participants is permitted in terms of law and ethical guidelines but researchers must be aware of the following limitations:

- Soldiers live and function in an authoritarian system with clearly-defined hierarchies.
- Soldiers are vulnerable to coercion and undue influence as they exist in a culture where orders are to be obeyed.

---

159 Nienaber 400. As the right to autonomy is included in the right to security of the person and as such the right not to be subjected to medical/scientific experimentation without informed consent.

160 Art 7 ICCPR.

161 Nienaber 401 and Art 2(2) ICCPR.

- Many soldiers live on military bases that make them readily accessible.

It was noted above that serving in the armed forces does not exclude a person from being a participant in medical or scientific research.[162] As a vulnerable[163] population, the greatest risk in subjecting soldiers to medical or scientific research is the voluntariness of their participation. It is an important ethical principle that the inclusion of vulnerable persons should be considered only if non-vulnerable persons would not be suitable subjects for the purposes of the research.[164] Members of the armed forces are suitable research participants if the research is applicable to a situation found only in a military environment, such as exposure to harsh environments, use of military specific gear/equipment, research involving military operations and their effects. A civilian counterparty element would not be conducive in offering results due to their experiences being vastly different from those of military members.

Research with vulnerable persons must be responsive to their health needs and priorities.[165] Battlefield conditions preclude the value of the research being conducted in a civilian population. Research conducted on soldiers under extreme conditions may serve to be of benefit in future troop deployments.[166] Research conducted using soldiers must be the subject of an ethical review and an assessment must be made of the risks.[167] Although the regulations do not stipulate who should conduct the review, it is paramount that it includes an ethical review by a committee not subject to military authority. Proper consent procedures must be enacted when recruiting participants.[168] It is preferable that no command authority is present when soldier participants are briefed or selected. There should be no incentive offered to participate, for example time off from routine tasks, and the voluntary nature should be reinforced to make clear participation is not at the bidding of military command and would provoke sanction if participation is rejected or withdrawn later. The appointment of a research ombudsman

---

162 Fn 136 & 137 above.

163 Vulnerable persons are defined in the regulations to the National Health Act as persons at an increased risk of research-related harm or who exhibit limited freedom in their decision making or incapable of protecting their own interests.

164 National Health Act Reg 4(a) (Human subject research).

165 As above, reg 4(c).

166 Such as been the case with regards to haemorrhage control and the use of tourniquets, haemostatic gauze and blood products on the battlefield.

167 National Health Act, 2003 reg 4(c) (Human subject research).

168 As above.

©University of Pretoria

or external research mentor to assist soldiers who have difficulty during the trials and to act as intermediary between them and researchers is advised.

4. Respecting Autonomy

4.1 Introduction

An entirely autonomous individual would reject any authority or prescribed behaviour whether by a government, a religion or a community.[169] An autonomous person does not submit to an authority or is controlled by others.[170] In choosing to accept enrolment in an institution such as the military, the person may make an autonomous decision and in so doing accept that the institution legitimately provides direction.[171] In a manner similar to a patient accepting the direction of a healthcare professional, it is not submission to a paternalistic authority but rather maintaining a fundamental choice to accept direction.[172]

The principle of respect for autonomy is an acknowledgement of another's right to hold views and to choose actions based on their personal beliefs and values.[173] Beauchamp and Childress require respectful action more than a respectful attitude in this regard.[174] The authors advocate acknowledgement of the decision-making rights of people. Persons must thus be empowered to act freely, keeping their capacities for autonomous acts and alleviating any fear that may upset autonomous actions.[175] The military medical practitioner, despite being in a position as a ranking member of the armed forces and an educated healthcare professional, needs to be aware of this concept in order to respect the autonomy of the soldier-patients.

4.2 Autonomy on the battlefield

During a situation of armed conflict[176] exercising medical autonomous decision-making is to encounter a legal and ethical dilemma on the part of the military healthcare professional. An extreme situation such as combat where massive trauma is

---

169 Beauchamp and Childress 102.
170 As above.
171 As above.
172 As above.
173 As above 103.
174 As above.
175 As above.
176 Including declared war, peace support operations or other situations warranting the deployment of troops.

©University of Pretoria

commonplace is one in which gaining informed consent to treat is similar to a situation in which the patient is incapable of consenting to emergency treatment.[177] Unauthorised administration[178] or necessity is a defence against the accusation of unethical medical intervention as a wounded soldier may be unable to give expression to the principle of medical autonomous decision-making by consenting to treatment. Consent may be absent due to the soldier being unconscious, in a state of shock or incapacitated and thus is incapable of giving informed consent. In this manner the best interests of the wounded soldier, which are paramount, are better served.[179] In instances where the wounded soldier is conscious and capable of consenting, consent to treatment must be sought.[180]

It is questionable that the best interests of the individual soldier are paramount in an extreme situation such as experienced on the battlefield, rather the survival of the group (and the mission) is of primary concern. The expectation of a wounded soldier on the modern battlefield is that medical aid, whether by a comrade in arms, medical orderly or the higher echelons of the healthcare professionals, will be forthcoming and thus an implied consent exists.[181] Limitations to medical care or a situation of an overwhelming number of casualties in a medical facility immediately triggers a triage system of treatment and is inherent in a military medical situation.[182] Regardless of consent being given, the wounded are prioritised for treatment according to the severity of their wounds in consideration of the overall situation on the battlefield.[183] What is happening on the battlefield results in the most severely wounded treated last so that those who are able are returned to the battlefield and continue to fight.[184] Military necessity is not a justification for deviating from the principles in triaging casualties for other than urgent medical reasons.[185] Nevertheless, attention is drawn to

---

177 The Medical Schemes Act 131 of 1998 defines a medical emergency as "the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy.

178 *Negatiorum gestio* (in medical law and ethics) is an act where someone acts on your behalf to administer emergency medical care without obtaining prior consent.

179 ML Gross & D Carrick: *Military medical ethics for the 21st Century* 204.

180 As above.

181 As above, 199.

182 As above, 202.

183 See Ch 7 below.

184 Gross & Carrick 202 and see Ch 7 with regard to military triage principles.

185 GC I Commentary (2016) 1425.

©University of Pretoria

the reality of the situation and unless the battlefield situation is considered resulting in a shift in triage practices aimed at winning the fight, the battle may be lost which is not beneficial to the collective.

Due to the extreme nature of battlefield wounds that require emergency surgery it is commonplace that surgical procedure deviates from the principle of consent;[186] waking the patient to gain consent is not necessarily in their best interests and the intervention is carried out and an explanation is provided following recovery from the anaesthetic.[187] Unlike a civilian situation, access to the next-of-kin is impossible from the battlefield and the best interests of the soldier will be decided by the military healthcare professional to be the guiding light in emergency care.[188]

4.3 Withholding consent: Refusal of treatment in the military

The right to physical integrity is enshrined in the Constitution at section 12(2)(b) and is the basis for autonomy in medical law and ethics.[189] The soldier faces limitations in being able to exercise this right. There are two situations that have to be examined if the military healthcare professional is to be best assisted when faced with the limitations on informed consent; these are a refusal of care during non-operational conditions (peace time); and a refusal of care under severe or extreme conditions experienced on the battlefield (armed conflict).

4.3.1 Refusal of care: On the home front

A situation can arise in which a competent patient refuses medical care; the reasons for that decision include religious conviction (blood transfusions, abortions), fear of pain (phlebotomy procedures), and refusal of vaccinations due to unreasonable external influences or simply a personal choice that amounts to an autonomous decision or the right to maintain bodily integrity. Soldiers may choose to refuse medical treatment for any of the reasons listed above. On the home front a refusal of care follows the same legal and ethical considerations as in civilian practice because the situation is

---

[186] P Carstens & D Pearmain *Foundational principles of South African medical law* (2007) 912-917.
[187] Sec 7(1)(e) National Health Act.
[188] Gross & Carrick 204.
[189] A Nienaber & KN Bailey "The right to physical integrity and informed refusal: Just how far does a patient's right to refuse medical treatment go?" (2016) 9 *South African Journal of Bioethics Law* 73.

©University of Pretoria

controlled, unlike the chaos of battlefield conditions. End-of-life decisions and a refusal to submit to medical examination are examined below.

End of life decisions

Nienaber and Bailey[190] cite the case of *Stransham-Ford v Minister of Justice and Correctional Services*[191] in which a terminally-ill patient approached the court in order to have a physician assist him to end his life after years of suffering. Despite Stransham-Ford dying on the day the judgment was handed down, it represented a victory in the recognition of a competent adult person's right to refuse medical treatment as an expression of the right to bodily integrity and the ethical principle of autonomy.[192] The arguments for and against physician-assisted suicide are too complex to explore in this thesis,[193] but it is submitted that the soldier, as does the ordinary citizen, will be able to rely on the arguments advanced by Stransham-Ford if faced with a similar situation during non-operational conditions. It must be noted that the judgment in *Stransham-Ford* was overturned in the Supreme Court of Appeals (SCA) in 2016. The SCA did not answer the question whether persons seeking physician-assisted suicide or physician-assisted suicide may make a court application to do so. The SCA pronounced that Parliament (representing the people who elected them) should decide such matters and not judges.[194]

Prior to the terminally-ill soldier reaching the same advanced point in their illness as did Stransham-Ford (the point where palliative care is started) the military medical system will have executed medical boarding (or a fit for service investigation) and thus declared such a soldier unfit for service and separated them from active service.[195] Medical boarding of active duty members is a mechanism under the regulations that is available to soldiers who are unable to continue with active service, much the same as exists in the public and private sectors. Thus such a patient will either be under the care of public or private healthcare but may elect to continue to receive medical benefits

190 As above.

191 *Stransham-Ford v Minister of Justice and Correctional Services and Others 2015* (4) SA 50 (GP).

192 Nienaber & Bailey (fn 189 above).

193 Physician assisted suicide in which an action by a health care professional directly causes the death of another.

194 DJ McQuoid-Mason "Assisted Suicide and assisted voluntary euthanasia: Stransham-Ford High Court case overruled by Appeal Court – but the door is left open" (2017) 107 *South African Medical Journal* 382.

195 Regs 3(4) & 6(3) to the Defence Act, 2002.

©University of Pretoria

from the Department of Defence as a member of the Regular Force Medical Continuation Fund (RFMCF).[196] Therefore the law and medical ethical obligations regarding end-of-life decisions will apply.

Submission to medical examinations

The Defence Act, 2002 states that the Minister must make regulations regarding the standards of physical measurement, medical and psychological condition as determined by an examination to establish such (including compulsory immunisation) for members of the National Defence Force.[197] The Regulations to the Defence Act, 2002 further describe compulsory submission to medical examinations and immunisation by all members of the National Defence Force in order to establish a fitness category.[198] The refusal to undergo such examinations or the subsequent refusal to submit to further medical examination in order for the Surgeon General to allocate a fitness category can be met with disciplinary sanction in that a lawful order is disobeyed. In the event that the outcome of a medical examination reveals that a corrective procedure or medial intervention is required there is a question whether the soldier is free to refuse such treatment.

In this matter the limitation placed on the principle of bodily integrity applies.[199] First, according to the Employment Equity Act 55 of 1998, medical testing of an employee is prohibited save for a legislative provision or if it is justified in accordance with medical facts, employment conditions, social policy, fair distribution of employee benefits or if testing would be for the inherent requirements of the job.[200] The Employment Equity Act, however, does not apply to the National Defence Force.[201] The Defence Act, 2002 provides that medical examination is required to establish a category of fitness for members of the National Defence Force.[202] When a member refuses to submit to treatment after a discovery of an injury or disease, the member would be subject to medical boarding that may have the result that service is terminated on medical grounds if determined as such by the Surgeon General.[203] This

---

[196] Reg 21 General Regulations to the Defence Act, 2002.
[197] Sec 82(1)(i) Defence Act, 2002.
[198] Reg 5 General Regulations to the Defence Act, 2002.
[199] Sec 36 Constitution, 1996 Limitations to rights contained in the Bill of Rights.
[200] Sec 7(1) Act 55 of 1998.
[201] As above, sec 4(3).
[202] Reg 3(3) General Regulations to the Defence Act, 2002.
[203] As above Reg 6(3).

©University of Pretoria

decision is as a result of the fact the Surgeon General cannot establish a category of fitness (for purposes of the specific mustering the soldier is employed in) and that the member is lawfully required to submit herself to periodic medical examinations.[204] Nienaber and Bailey conclude that the wish to remain employed is often an overriding motivator for submission to medical examination and subsequent treatment.[205] Although the National Defence Force is not subject to the Employment Equity Act, fair labour practices (as a constitutional right)[206] dictate that the National Defence Force considers placing a member who is not fit for a particular function (or mustering) in another position in order to continue in gainful employment in the Department.[207]

The soldier has a limitation on their right to refuse medical treatment in that the establishment of compulsory medical examinations for the allotment of a medical category is prescribed. Fair labour practices dictate the utilisation of the soldier in their medical/psychological category but if no suitable mustering exists the soldier can be separated from the SANDF.

Disobeying medical staff: The Military Disciplinary Code

Section 19(4) of the Military Disciplinary Code[208] makes it an offence to disobey hospital staff:

> Any person who, being a patient in any hospital, wilfully disobeys any lawful direction concerning his hospital or medical treatment, given to him by any member of the hospital staff within whose hospital duty and authority it is to give such direction, shall be guilty of an offence and liable on conviction to imprisonment for a period not exceeding six months.

The creation of this offence is in contrast to the constitutional principle of bodily integrity (including freedom and security of the person),[209] the National Health Act[210] and the medical ethical principle of autonomous decision-making.[211] The Military Disciplinary Code[212] unfortunately was not amended when the Constitution or the Military Disciplinary Supplementary Measures Act, 1999 were promulgated. Thus, the military disciplinary offence of disobeying an order given by hospital staff may be

204 As above Reg 5(1).
205 Nienaber and Bailey 77.
206 Sec 23(1) Constitution, 1996.
207 Nienaber & Bailey 77.
208 First schedule to the Defence Act, 1957, the Military Disciplinary Code.
209 Fn 2 above.
210 Fn 24 above.
211 Fn 22 above.
212 The Code was part of the 1957 Defence Act.

©University of Pretoria

challenged as being inconsistent with the Constitution, 1996 and the NHA.

4.3.2 Refusal of care: The operational theatre

Gross contends that the refusal of medical care by a soldier undermines discipline, reduces manpower, increases the risk to others and incites malingering.[213] He acknowledges that the refusal of medical care under operational conditions is hypothetical based on his premise that autonomy, as is the case with informed consent, diminishes with military service.[214] Further, Gross comments that the opposite is evident in battlefield heroics where soldiers forgo medical treatment and removal from the battle in order to continue the fight and to rally comrades.[215] During the Second South African War (1899-1902) British soldiers deployed in South Africa refused to be inoculated against typhoid fever.[216] The troops cited their fear of the side effects experienced by some soldiers who subjected to the treatment and an unfounded fear of loss of virility.[217] The consequence of the majority of the army not being inoculated was that more deaths occurred as a result of typhoid than because of battlefield wounds.[218] The respect for autonomous decision-making on the part of the individual patient may result (at worst) in the death of that person. In a military context the refusal of medical treatment results in weakening the deployed force and, ultimately, the successful outcome of the mission.[219]

There is a further question in respect of a soldier refusing medical treatment during an on-going battle. Gross contends that the "salvageable" wounded soldier has no right to refuse medical care on the battlefield as the interests of the collective are dominant and the wounded may be ordered to return to service and thus contribute to the success of the mission.[220] On the other hand, critically wounded soldiers who have no prospect of returning to duty retain a right to refuse care as their status reverts to that of a non-combatant (due to their being *hors de combat*) and, as such, their autonomous decision-making capability returns to them.[221] The question remains whether a soldier

---

213 Gross 103.
214 As above.
215 As above.
216 Gross 106
217 As above.
218 As above. 95% of troops refused the vaccine and as a result 14000 succumbed to typhoid versus the 6000 that perished on the battlefield due to enemy action.
219 Gross 107.
220 Gross 126.
221 As above.

©University of Pretoria

who is only lightly wounded and is able to return to service after minimum medical care can claim to be *hors de combat* and so claim protection under the Geneva Conventions. Commentary to the First Geneva Convention states that soldiers who can receive minor interventions on the battlefield or at an aid station may be returned to the battlefield.[222] The returning wounded soldier once again has the status of a combatant upon return to the fight but must be respected and protected while wounded.[223] The decision to return to service remains with the military command that should act on the advice of the military healthcare professional. Ordinarily, this may be a violation of individual autonomy. Military service is based on the fitness of the soldier to serve. If they are declared fit the command to return to the front will rest on their commanders. If they are declared unfit to return to service by military healthcare professionals, commanders may decide to return the soldier to the front if in their opinion they can be useful and not endanger the lives of others due to a gross medical incapacity. It is contended that such a scenario is rare and that the return to service of the wounded by military command would only be in extreme situations where every last soldier is needed to fight otherwise the battle may be lost. Such an extreme decision will be outside of medical advice and not have the military healthcare professional be liable for command decisions.

4.4 Conclusion

The active battlefield presents a complex and chaotic situation which requires split-second decision-making by the military healthcare professional who is conflicted between a duty of beneficence to the individual patient and the interests of the group and the success of the mission (the military priority). The practice on the battlefield to respect the decision of the wounded to refuse treatment cannot be equated with a civilian situation no matter how extreme a form it takes.[224] The conclusion Gross reaches is that the situation in terms of soldier-patient rights (including the right to autonomous decision-making) is that they are diminished on the battlefield due to the overwhelming need to consider the interests of the collective.[225] The military healthcare professional is well aware that they face this dilemma. Despite the doctor

[222] GC I Commentary (2016) 1425.
[223] Art 12 GC I.
[224] Gross 107.
[225] As above 136.

acting in the best interests of their soldier patient, the decision to return to the soldier to service rests with the military command.

5. Autonomy and the prisoner of war: IHL and consent

5.1 The prisoner of war and refusal of medical treatment

The dual loyalty conflict that arises in a situation that combines the principle of patient autonomy and the treatment of prisoners of war is discussed with reference to an actual event that took place in eastern Afghanistan during the United States led war on terror. Although the analysis provided by the selected commentators is based on international law and the domestic law of the United States, the situation is discussed using South African law as well as international law.

The United States armed forces deployed in eastern Afghanistan took captive (what they believed) was a high-ranking member of the Taliban who was suspected of having information vital to the pursuit and capture of other Taliban commanders.[226] After his capture the prisoner of war was transferred to an undisclosed military hospital where it was discovered that he was in renal failure and required renal dialysis as a life-saving measure. The prisoner refused treatment, stating that he did not wish to be a prisoner of the United States. The treating military specialist nephrologist reported the matter to her military commanders. Subsequent consultation up the chain of command resulted in the US Secretary of Defense issuing an order that the prisoner will receive renal dialysis despite his refusal of care. The justification was "pressing national security interests" so as to provide interrogators with the opportunity to extract information necessary for the capture of other highly-valued Taliban operatives.

5.2 Commentary: Honour or compel?

Academic commentators are divided in their opinions on the matter of the medical treatment of a prisoner of war against their consent.[227] Commentators apply international law together with domestic (American) law and precedent to comment on this example of dual loyalties faced by military healthcare professionals.

---

[226] D Zupan, G Solis, R Schoonhoven & G Annas "Dialysis for a prisoner of war" (2004) 1 *Hastings Cent Report* 11.

[227] Zupan, Solis and Schoonhoven were in agreement whilst Annas took a different approach.

©University of Pretoria

Zupan, Solis and Schoonhoven argue that giving dialysis to the prisoner of war represented no violation of both domestic and international law or the law of armed conflict.[228] These commentators are in agreement that the Third Geneva Convention is applicable in this situation;[229] prisoners of war are to be collected and cared for.[230] The commentators are of the opinion that the prisoner's refusal to be provided with renal dialysis falls outside the remit of the Conventions. This is not supported as the conflict in Afghanistan is considered an international armed conflict residing under the First Additional Protocol.

Further, is not fully supported as the withholding of consent (the exercise of an autonomous decision) by the prisoner forms part of the doctor-patient relationship and thus of the medical ethical considerations of the treating specialist.[231] The commentators respond that the US, although signatory to the Additional Protocols, to date has not ratified the Protocols.[232] This argument raises the question whether the Conventions and Protocols now forms part of customary international law[233] and supports the opinion by referencing a domestic precedent in the *In re Quinlan* matter,[234] which does not have bearing on the facts in this matter. In support of the argument which favours the continuing of treatment for the purposes of interrogation, the commentators turn to the law of armed conflict and justify its continuation as not causing unnecessary suffering and the suffering would not be disproportionate to the military advantage gained, that of significant military intelligence.[235] The commentary offered by Zupan, Solis and Schoonhoven ends with a reference to the prisoner's intention to commit suicide and the legal and moral ramifications which surround that decision. This explanation is not supported and is irrelevant to the case at hand.

---

228 Fn 226 above.

229 Geneva Convention relative to the treatment of prisoners of war of 12 August 1949.

230 Arts 13, 15 & 17 GC III.

231 Art 16 AP I & Art 10 AP II.

232 The exception of the customary international law status that the Additional Protocols have together with the application of common article three of the Conventions to situations described above.

233 ICRC databases *Introduction to the rules* available at https://www. icrc.org (accessed 6 September 2022).

234 *In Re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976). Landmark US decision in which life-sustaining medical treatment may be discontinued even if the patient is incapable of consenting.

235 The principles of the law of armed conflict would not be the applicable source in this matter as the prisoner is *hors de combat* and as such is entitled to all the protection offered under international humanitarian law contained in the Geneva Conventions and the Additional Protocols.

©University of Pretoria

The commentary offered by Annas is deemed more appropriate and arrives at a logical conclusion based on international law and the dual loyalty conflict the treating physician had to overcome. This commentary is applicable to the situation in a South African context. Annas states that battlefield bioethics is of a more intense type than bioethics in a civilian context but that the two dimensions are largely the same.[236] This statement is supported; correctly, Annas states that the prisoner no longer is a combatant and is entitled to the full protection of international law (including customary international law)[237] as contained in the third Geneva Convention and the Additional Protocols.[238] What this opinion highlights is the dual loyalty conflict that military healthcare professionals face. The specialist nephrologist reported the refusal of treatment to her military (non-medical) commanders. This reporting resulted in a military command being issued for the forced treatment of the prisoner. The Additional Protocols clearly stipulate that medical personnel practice in accordance with medical ethics.[239] Further, the specialist nephrologist is not obliged to release any information she gained about the prisoner and his refusal of treatment to her military commanders unless disclosure forms part of national legislation. South African law[240] and the ethical rules of conduct prescribed by statutorily-enacted regulating bodies clearly stipulate when information regarding the medical care and treatment of a patient may be released.[241] The specialist nephrologist breached medical confidentiality if she did not have the explicit consent of her patient to disclose his renal failure and his refusal of treatment. Had the nephrologist had the consent of the patient, the attending physician still is bound by ethical considerations to execute her patient's wish not to be treated. The obligation, as rightfully commented on, is that the physician periodically would revisit the patient in order to establish whether he had had a change of heart. Annas further describes that the treating physician will be court-martialled if she refused a command to execute the dialysis despite the prisoner's continued refusal. The ordering of the physician to execute an order that is unlawful/unethical requires the physician disobey such a command and, if tried, can raise the defence of the order

236 Fn 226 above.
237 Fn 233 above.
238 This includes the guarantees stipulated under the GC III in that prisoners of war may not be coerced into providing information other than their basic information and the provisions of the AP I in that surgical interventions may be refused.
239 Art 16(2) AP I.
240 National Health Act, 2003.
241 Secs 14 & 15 National Health Act, 2003.

©University of Pretoria

being unlawful and against international law.[242] Annas concludes by stating that this matter represents an example of a dual loyalty conflict that military physicians face as part of the practice of medicine in the military. Annas recommends that doctrine be developed to assist military healthcare professionals identify and manage dual loyalty conflicts and so place the best interests of their patients foremost.[243]

5.3 Application to South African law

Domestic law pertaining to the refusal of treatment is founded in the Constitution[244] and the National Health Act, 2003.[245] The refusal to treat is in line with the recognition of autonomous decision-making on the part of the competent patient. In the above situation, although we are told the prisoner of war refuses treatment because he does not wish to be a prisoner of the belligerent force, it is of no value to know this; any refusal of treatment need not be accompanied by a reason.[246] Informed consent is pointless as a principle if it does not protect the patient's right to refuse treatment and permits a doctor to override a patient's wish, believing it is foolish or illogical. An ordinary situation requires a doctor to probe into reasons why consent is refused to address any fears or misconceptions the patient may harbour, but enquiry is to be performed in a respectful manner without undue coercion, or forcing a decision on the patient.

The prisoner of war no longer is a combatant and his status as a protected person must be respected and upheld.[247] South Africa, as signatory to the Geneva Conventions and the Protocols has ratified and so incorporated these instruments into domestic law.[248] By South African standards the situation is simple; there is no justification to adopt forced treatment as in the case above. It is not suggested the military healthcare professional will not face overwhelming pressure to submit to the command of the military authorities. The military healthcare professional may well find herself isolated and without recourse in an operational situation, far from home and under combat stress and struggling with an overriding desire to "complete the mission".

---

242 Art 16 AP I & Art 10 AP II. Within a South African context the Implementation of the Geneva Conventions Act, 2012 would also find applicability.
243 Fn 226 above.
244 Sec 12(2)(b) Constitution, 1996.
245 Sec 7 NHA.
246 HPCSA *Guidelines for Ethical Treatment Booklet 4 Seeking Patients Informed Consent* (2016).
247 Fn 229 & 230 above.
248 Implementation of the Geneva Conventions Act, 2012.

©University of Pretoria

6. Conclusion

Healthcare professionals have to respect the autonomous decisions made by their patients even to the point that the decision taken may well result in an adverse outcome. The skills and competency of a healthcare professional must be in the service of informing the patient in a manner that is clear, unambiguous and alleviates any misconceptions or fears regarding the medical treatment before commencing with any intervention. The military patient is vulnerable due to the nature of the environment in which they serve, which exhibits obedience to commands, submission to authority and limited autonomous decision-making. The military healthcare professional acts unethically if they use these characteristics to coerce the patient into accepting treatment. Notwithstanding the ability of the soldier-patient to exercise autonomous decision-making in peace time, conditions on the battlefield severely limits the exercise of this right. In this situation "individualism" gives way to the collective interest and the success of the mission. The requirement that the soldier returns to the battlefield outweighs the right to refuse treatment. During armed conflict respect for autonomy and utility are terms which are redefined. The soldier-patient and the military healthcare professional need to be aware of this reality and accept that the extreme situation that is the battlefield cannot be compared to anything else. Prisoners of war are protected under international law and medical ethical rules apply to them, protecting their autonomous choice not to be subjected to forced medical treatment.

Below the concept of beneficence in military healthcare is examined more closely.

©University of Pretoria

CHAPTER 7

BENEFICENCE:
THE BEST INTERESTS OF THE SOLDIER OR OF THE STATE?

OUTLINE

1. Introduction
2. Defeating the best interests of the patient.
2.1 Introduction
2.2 Fighting fit
2.3 Penicillin and military necessity: favouring the mission over medical ethics
2.4 Medical record-keeping during military operations
2.5 Conclusion
3. Duty of care: Military vs. civilian practices
3.1 Introduction
3.2 Duty of care: The battlefield vs the metropolitan city
3.2.1 Strategic differences
3.2.2 Clinical differences
3.2.3 Environmental differences
3.3 Battlefield conditions: Different environment but the same duty of care
3.4 Conclusion
4. Battlefield triage
4.1 Introduction
4.2 Triage and the law
4.3 Principles and practice of triage: Benefiting the most
4.4 Battlefield triage: Salvage, save or assess?
4.4.1 Medical need
4.4.2 Salvage
4.4.3 Assessing the battlefield
5. Conclusion

©University of Pretoria

1. Introduction

Ethical actions are performed in a manner that adds to others' wellbeing, not only respecting the autonomy of others but also refraining from causing harm.[1] Benevolent actions are positive and are taken for the ultimate good of others and thus are morally superior to merely refraining from harmful behaviour.[2] To act benevolently is to act with a kindness that transcends obligation.[3] However, there is not always an obligation to act benevolently.[4] There is no moral obligation on the individual to act for the benefit of others even if the means to do so exists.[5] Thus, a distinction is made between obligatory (specific) beneficence and non-obligatory/ideal (general) beneficence.[6] Specific beneficence encompasses the special relationship that exists between a doctor and his patient.[7] As a guiding principle in the Hippocratic oath, beneficence is considered to capture the moral essence of the professional responsibilities of the healthcare professional.[8] The healthcare professional strives to bring the patient out of a state of health needs to a state of health benefit.[9] Beauchamp and Childress identify an implicit assumption of beneficence in the actions of healthcare professionals not only to promote the welfare of patients but to act in a positive way to prevent harm.[10]

The military healthcare professional, too, acts beneficently towards the patients entrusted to their care although cognisant of an issue of dual loyalty that is intrinsic to the practice of medicine in the armed forces. In contemporary medical practice a paternalistic attitude has been replaced by recognition of the right to autonomous decision-making on the part of the patient.[11] However, in the armed forces an autocratic and paternalistic environment persists[12] and the healthcare professional has to be vigilant not to violate the medical ethical obligation of beneficence while being cognisant of the limitation on autonomic decision-making on the part of military

1 TL Beauchamp & JF Childress *Principles of biomedical ethics* (6th ed) (2009) 197.
2 As above.
3 MA Dada & DJ McQuiod-Mason *Introduction to medico-legal practice* (2001) 36.
4 Beauchamp & Childress 198.
5 As above.
6 As above.
7 As above, 199.
8 As above.
9 As above.
10 As above, 205.
11 As above, 207.
12 DE Lounsbury & RF Bellamy (eds) *Military medical ethics (Vol 1)* (2003) 298.

©University of Pretoria

personnel.[13]

In a military environment absolute beneficence may conflict with the principle of justice where the practice of triage dictates that the less severely wounded are treated first so as to return them to the fight.[14] The military healthcare professional must act in a manner that subordinates the needs of the individual for the collective benefit of the group.[15] This chapter examines the dilemma a military healthcare professional encounters, including the following topics:

i. Subordinating the best interests of the patient and setting medical priorities for military purposes.

ii. Substandard or a complete lack of medical record-keeping that impacts continued care.

iii. Triage priorities governed by military necessity and the practice of battlefield triage.

iv. Failure of the duty of care principle.

2. Defeating the best interests of the patient

2.1 Introduction

The Defence Act, 2002 stipulates that the Minister of Defence and Military Veterans may promulgate regulations for the establishment of standards of physical measurement as well as medical and psychological conditions determined by a medical examination and may authorise compulsory immunisation for members of the SANDF.[16] As pointed out in chapter 6 above, the Surgeon General is the officer who is responsible for determining standards of fitness which assign a category of fitness to each member of the SANDF.[17] Chapter XV, Part I of the General Regulations to the Defence Act, describes in full the requirement of the Surgeon General (or his delegate)

---

[13] Beauchamp & Childress 207.

[14] E Andrews (ed) *US Military medical professionals ethical guidelines, Practices and issues* (2016) 31.

[15] As above.

[16] Sec 82(1)(i) Defence Act 42 of 2002.

[17] Reg 2 General Regulations to the Defence Act, 2002.

to determine the fitness for service of all members who wish to be employed or enrolled in the SANDF, as well as continuing medical evaluation by means of periodical compulsory health assessments. The regulations also describe the process and procedures for medical unfitness and discharge from service for psychological or medical reasons.[18]

The Surgeon General further is obliged to provide for the necessary hospital, rehabilitative, preventive and prophylactic treatment of members (and other authorised patients).[19] The provision of the above form of medical care is solely for the benefit of the patient and includes the provision of preventive, prophylactic or immunisation treatment that the Surgeon General deems necessary in the interests of the SANDF or the patient.[20] This specific regulation reinforces the paternalistic nature of military medicine in that the Surgeon General determines preventive, prophylactic and immunisation treatments for the benefit of the entire SANDF (the collective).[21]

The examination of members of the armed forces and their comprehensive care are to be compatible with the dictates of medical ethics and the discharge of the beneficence principle. The examination, continued assessment and primary/preventive[22] healthcare of members of the defence force are comparable to the obligations created under occupational health and safety legislation applicable to workers in civilian workplaces.[23] Occupational health and safety laws and regulations are aimed at assuring the health of workers in the workplace in the execution of duties using plant

18 Regs 3 & 6 Part I.

19 Reg 7(2) Part 2.

20 Reg 7 (2)(d).

21 During the COVID-19 pandemic the provision of vaccination against the disease was developed in a reasonably short period of time and made available to all persons in South Africa, either free of charge or under the specific rules of those belonging to medical aid schemes. The President of the Republic of South Africa reinforced in legislation and in the national media the principle that vaccinations were to be administered only with the informed consent of the patient. As Commander-In-Chief of the South African National Defence Force, the President’s statement applied equally to members of the SANDF. Vaccination against the Covid-19 virus remained voluntary.

22 In an IHL context, primary healthcare is described by the International Committee of the Red Cross and Red Crescent Societies as health services delivered directly to the population (immunisation, outpatient treatment, provision of drinking water, nutrition) with a view to maintaining health, preventing illness and dealing with common medical problems; see ICRC *Primary Health Care Services, Primary Level* May 2006, available at www.icrc.org (accessed 1 July 2022).

23 Occupational Health and Safety Act 85 of 1993; “medical surveillance” means a planned programme or periodic examination (which may include clinical examinations, biological monitoring or medical tests) of employees by an occupational health practitioner or, in prescribed cases, by an occupational medicine practitioner.

©University of Pretoria

and machinery and for their protection from workplace hazards.[24]

2.2 Fighting fit

The 2015 Defence Review describes the role of the South African Military Health Service (SAMHS) as being a comprehensive deployable military health protection capability for deployed forces utilising a layered military health support system to protracted operations over long distances, including both force health protection and force health sustainment.[25] Although force health protection is not defined, the Military Health Service is described as a combat support service to deployed elements of the combat services.[26] Force health sustainment includes the care of non-deployed members and their dependents.[27] South African military healthcare professionals have two distinct missions.[28] First, serving members are kept in a healthy state by means of preventive, prophylactic treatment and continuing medical assessment. Secondly, care given to the member (and his family/other authorised patients) in the event of illness or injury.[29] In contrast to the philosophy of the United States Armed Forces' medical department, which in its motto describes its mission "to conserve the fighting strength",[30] the South African Military Health Service functions in a supportive role to the rest of the defence force without an outright obligation to ensure "fighting strength". Sidel and Levy attack the militaristic undertone of military medicine's priority being that of ensuring the best possible health for soldiers in order successfully to complete the mission.[31] The authors argue that this priority subordinates the best interests of the (individual) patient to the good of the (collective) fighting force.[32] The point is expanded on in the following paragraph.

2.3 Penicillin and military necessity: Favouring the mission over medical ethics

In a situation of armed conflict the requirement for fit and able soldiers for the

---

24 As above (Preamble).
25 *South African Defence Review* (2015) vi.
26 As above 10-18.
27 As above.
28 As above.
29 As above.
30 Lounsbury & Bellamy "Conserve the fighting strength" (1988) *Mil Med* 185-187.
31 Lounsbury & Bellamy 296.
32 As above.

battlefield challenges the physician's obligation of beneficence and poses a dilemma.[33] Sidel, Levy, Messelken and Baer describe an instance during the Allied North African campaign of the Second World War.[34] A limited pharmaceutical (penicillin) resource meant the distribution of the medication would be administered to the sick and wounded who would make the quickest recovery (in order to return to service) rather than to the patients who had the most critical need.[35] Penicillin was administered to soldiers suffering from venereal disease rather than to wounded comrades whose medical need was far greater. The order that was given declared recovery from venereal disease would be quicker and would ensure adequate numbers for the on-going campaign. The outcome of the Allied campaign may not have been a decisive victory if there had not been sufficient fit men to fight. The assessment of the military need influenced the ethical distribution of a scarce medical resource and thus benefited only the soldiers who could return to duty in the shortest period as opposed to those who had the greater medical need.[36]

Sidel and Levy's argument is sound on medical and ethical grounds but overlooks an overriding consideration. In normal circumstances the primary concern of the physician is the best interests of the patient, but armed conflict which threatens the survival of a nation is not a normal circumstance. In the historical example presented men had not been abandoned nor were the wounded left unattended. At the outbreak of the Second World War penicillin was still in the process of development[37] and was known to be decisively effective only in the treatment of certain medical conditions, which included venereal diseases.[38] As it was in short supply, initially the Allied powers limited use only for military purposes. The Allied victory in North Africa and subsequent outbreak of particularly resistant strains of the gonococci bacteria amongst servicemen frequenting brothels in Algiers meant that the British Army faced a severe shortage of manpower for the planned invasion of Sicily and Italy.[39] There was

---

33 Lounsbury & Bellamy 96.

34 Lounsbury & Bellamy 297; ML Gross & D Carrick (eds) *Military medical ethics for the 21st century* (2013) 263.

35 As above.

36 Gross & Carrick 263.

37 G Shama (2015) "The Role of the Media in Influencing Public Attitudes to Penicillin during World War II" (2015) 35 *Dynamis* 131-152.

38 As above.

39 "Casbah curse for British WW2 troops" *The Guardian* 22 January 1980, available at www.theguardian.com (accessed on 23 August 2022).

©University of Pretoria

consultation at the highest levels and the British Prime Minister, Sir Winston Churchill, ordered the distribution and use of the medicine to treat those who could return to duty in the shortest period of time.[40] Known to be effective in the treatment of venereal diseases, penicillin was used to treat servicemen suffering from its effects.[41]

This historical incident offers a setting for establishing medical priorities for military purposes. The attending medical professionals were ordered to administer the antibiotic for the treatment of venereal disease, even if that priority was inimical to ethical considerations, to ensure a military success.

2.4 Medical record-keeping during military operations

Ordinarily, the recording of consultations and the subsequent maintaining of medical records in a health establishment are of paramount concern for the continuing care of patients. An obligation to maintain records on the part of management of a health establishment is promulgated in legislation.[42] An obligation to protect health records is also mandated[43] and controlled by statutory regulating bodies.[44] In an armed conflict the physical recording of medical interventions and the subsequent maintenance of records are subject to external threats such as the severe environment, damage/destruction due to enemy action and loss and poor recording.

The previous chapter has dealt extensively with the role of informed consent in the military and described the administration in the first Gulf War of an experimental prophylactic drug called pyridostigmine bromide (PB). A commission set up by President Bill Clinton investigated the effects of the administration of the drug on veterans of the war in relation to Gulf War Syndrome.[45] The findings of the commission recorded that the US Department of Defense (DOD) erred in that proper medical record-keeping in the operational theatre had failed in that it could not be

---

40 As above.
41 As above.
42 Sec 13 National Health Act 61 of 2003.
43 Sec 17.
44 Health Professions Council of South Africa *Booklet 9 Guidelines on the keeping of Patient Records* (2016) 2 Health Professions Council of South Africa. Ethical guidelines for good practice in the healthcare professions. Pretoria. Available at www.hpcsa.co.za (accessed 1 September 2020)
45 J Lashof *Presidential Advisory Committee on Gulf War Veteran's Illness* (1995) available at https://www.ncbi.nlm.gov/books/NBK230136 (accessed on 20 September 2022).

accurately disclosed how many servicemen had received the PB vaccine.[46] The unsubstantiated classification of the administration of the vaccine as "secret" created a further issue that affected record-keeping.[47] The DOD admitted to either losing these records or that the records were destroyed. The failure under these circumstances to record and to maintain records was prejudicial to the proper treatment of veterans who developed symptoms consistent with Gulf War Syndrome and had compromised their future medical care.[48]The commission recommended that the DOD develop a central computerised record-keeping system for all types of medical records.[49]

Subsequently, the instance of poor record-keeping in the First Gulf War has been rectified and the mistakes that were identified were corrected to prevent any reoccurrence.[50] For as much as the surgeon's scalpel excises the cancerous tumour, so too his pen records what he has done so that continued care is possible in other health facilities as well as under other practitioners. A failure to keep records undermines the continuum of care and is not in the best interest of the patient.

2.5 Conclusion

The elevation of military necessity above individual beneficence is a hallmark of divided choice in the administration of medical care to soldiers. The military healthcare professional faces this choice as a situation becomes more extreme as the conflict progresses. The shift in prioritising the beneficence of the individual to acting for the 'greater good' of the collective (and the military mission) is a condition the healthcare professional must be prepared to confront. The subordination of the best interests of the individual in support of the collective is examined in greater depth in relation to the principle of distributive justice.

3. Duty of care: Military vs civilian practitioners

3.1 Introduction

South African law determines the healthcare professional is not obliged to accept any

---

46 As above, 23.
47 As above.
48 As above.
49 As above, 24.
50 CDC "Surveillance for adverse events associated with anthrax vaccination US Department of Defense, 1998–2000" Report 2000 (49) 283 *JAMA* 2648–2649.

©University of Pretoria

patient but is guided in further practice by the doctor-patient relationship.[51] In private practice doctors are free to accept patients in their practice (barring the provision of emergency medical care)[52] and to set a fee for their service.[53] Doctors employed by the state are required to manage patients arriving at state facilities for treatment and do not have a choice as to who they treat, except in situations of triage or of referral because the patient cannot be managed by their level of training or the level of care capability of the medical officer/medical establishment concerned.[54] Military healthcare professionals employed by the Department of Defence may administer treatment only to serving members of the Department, their dependents and other authorised patients as stipulated in regulations.[55]

The provision of base or home medical support care is uncomplicated and military doctors have a designated patient population to care for.[56] It is during an armed conflict that the question whom to treat has the potential to raise a myriad of ethical dilemmas. The military healthcare professional has an obligation not only in relation to his own forces but under international humanitarian law (IHL) has a duty to manage soldiers of allied nations, prisoners of war and the civilian population.[57] The duty of care principle is influenced greatly by the ethical dilemmas that the military healthcare professional faces on the battlefield. In order to understand these dilemmas a comparison is drawn between civilian and military medical practice.

3.2 Duty of care: The battlefield versus the metropolitan city

Kelly[58] identifies a dual loyalty conflict military healthcare providers (MHCPs) face on the battlefield in circumstances in which an obligation to provide care to the wounded may conflict with a military order.[59] Soldiers are viewed as a commodity in that they are used in battle to win and must be kept fit for duty.[60] Their individual healthcare

---

[51] McQuoid-Mason "The medical profession and medical practice" in Joubert & Faris (eds) (2008) 17 *The Law of South Africa* (2nd ed) par 31.

[52] Dada & McQuiod-Mason 7; *Magwane v Minister of Health NO* 1981(4) SA 472 (Z) and sec 27(3) Constitution, 1996.

[53] As above.

[54] Dada & McQuiod-Mason 6.

[55] Reg 7 General Regulations to the Defence Act, 2002.

[56] As above.

[57] Art 27(3) GC I.

[58] J Kelly (2013) *Is medical ethics in armed conflict identical to medical ethics in times of peace?* (2013) 39.

[59] As above.

[60] As above.

©University of Pretoria

rights are subordinated to the collective needs of the military to prevail in battle and the primary objective of battlefield medicine is to return the wounded to the fight as efficiently and as speedily as possible.[61] Kelly identifies three aspects that challenge the duty of care a MHCP has to wounded soldiers on the battlefield, suggesting that the battlefield is "distinctly different to civilian medical care, even during an emergency"; in an armed conflict medical ethics trail the exigencies of war and because the environment is so different, the duty of care does not apply.[62] The differences between civilian and military healthcare practices are described as due to strategic, clinical and environmental criteria.[63]

3.2.1 Strategic differences

The main ethical difference in civilian and military healthcare practice is that on the battlefield military necessity dictates the provision of care to the wounded in order to return them to the fight.[64] This practice may be necessary to win the battle, but Gross comments on the fact that during the Second World War Germany deployed fewer healthcare personnel than the Americans.[65] German and American policy on the care of the wounded on the battlefield differed significantly; Germany's primary aim was to return to battle every soldier who could be salvaged whereas the Americans concentrated on saving lives rather than returning men to the battle.[66] Germany did not maintain forward surgical units as did the Americans and the end result is that both belligerents ultimately returned the same number of soldiers to the front.[67] Civilian medical care concentrates on saving lives in which the quality of life outcomes increasingly is a holistic consideration concentrating on the best possible restoration of function for the patient.[68]

3.2.2 Clinical differences

Gross contends soldiers have a limited autonomy in that they cannot refuse medical

---

61 As above.
62 As above.
63 As above.
64 As above, 46.
65 Gross, 73.
66 As above.
67 As above, 69 & 74.
68 AG Spagnolo "Quality of life and ethical decisions in medical practice" (2008) 6 *Journal of medicine and the person* 118-122. Quality of life may be inconsistent with the medical ethical principle of '*bonum onticum*' (supreme good). Quality of life encompasses freedom from emotional and physical discomfort.

©University of Pretoria

treatment lest they face military disciplinary action for malingering or for disobeying a lawful command.[69] Civilians may exercise autonomous decision-making and refuse treatment even if refusal leads to their death.[70] Kelly contests that the standard of care available on the battlefield is not in line with a civilian counterpart in that due to the tactical situation referrals to higher definitive care may be delayed.[71] On the battlefield the treatment protocols differ and are adapted to treat injuries associated with massive bleeding first instead of attending to the airway obstruction.[72] Battlefield evacuation and care under fire delay transfer to definitive care, but these difficulties are faced also by civilian medical establishments, especially due to limited resources available in public health facilities.[73] The adaptation of treatment protocols for trauma patients is revised in both military and civilian healthcare environments. Lessons from the battlefield are learned and transposed to civilian healthcare practice in situations where they are warranted.[74]

3.2.3 Environmental differences

Civilian health facilities enjoy a relatively safe environment whereas the battlefield is an extreme situation presenting the threat of injury, death, severe weather conditions, isolation, exposure to the elements and an unpredictable outcome.[75] The level of access to adequate medical diagnostic equipment and surgical/intensive care facilities is in stark contrast to what is available in a modern city hospital.[76]

3.3 Battlefield conditions: Different environment but the same duty of care

The differences between battlefield and civilian healthcare practice have been described above; however, the duty of care remains the same.[77] The military healthcare professional's task is to administer the best possible care to the wounded in accordance with domestic and international law and bioethical prescripts. It is a command decision how those who were wounded are utilised after care has been administered and the

---

69 Kelly 49.
70 As above.
71 Kelly 49-50.
72 As above 50.
73 C Merrick (ed) *ATLS® Advanced trauma life support: Student Course Manual* (10th ed) (2018) 242-245; *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape* [2015] ZACC 33.
74 Merrick 279-283.
75 Kelly 50.
76 As above.
77 As above 39.

fitness of a soldier to return to duty is only evaluated by the healthcare professional. Severely wounded soldiers incapable of further deployment will be evacuated to the rear but those with lesser wounds which require only routine or limited follow-up care can return to the front.

Kelly reveals a significant element of a dilemma existing in her description of the military healthcare provider (MHCP) and military discipline. It has been established that it is not contra-indicated to serve as a healthcare professional in the armed forces of a nation,[78] but the consequences of service are that the healthcare professional is subject to military law.[79] Military law dictates levelling severe sanction on transgressions that ordinarily are not considered critical in a civilian environment;[80] an example is disobeying a lawful command.

Kelly gives a description of a vignette in which a MHCP disobeys an instruction during a routine patrol not to leave the hard surface of the road due to the threat of landmines.[81] The order is disobeyed by the MHCP to fulfil an obligation to attend to a critically wounded serviceman who has been injured in the mine field.[82] Ordinarily, the healthcare professional would ensure that a rescue in these circumstances meets the requirements of basic life-saving procedures. It is common knowledge among health care professionals that prior to administering care, the scene or location of the wounded must be declared safe.[83] Naturally, it is futile for a MHCP to rush into a burning building to save an unconscious victim only to succumb to smoke inhalation or, similarly, to run across a busy highway to rescue a motor vehicle accident victim. The battlefield too precludes an unregulated medical response without consideration of the situation that it is safe to proceed lest the rescuer becomes another casualty.

In Kelly's vignette the MHCP will have risked his own life by approaching the soldier in order to administer care. Despite this act being extremely brave, it will expose the MHCP to military disciplinary action in that a lawful command had been transgressed

---

78 Ch XV of the General Regulations to the Defence Act: Definition of a "medical officer" means 'a person entitled to practise as a medical practitioner in terms of section 17 of the Health Professions Act 56 of 1974".

79 Including the Military Disciplinary Supplementary Measures Act 16 of 1999 and the Military Disciplinary Code.

80 Sec 19 Military Disciplinary Code.

81 Kelly 43.

82 As above.

83 ICRC *First Aid in armed conflict and other situations of violence* (2005) ch 5 "Situation management".

(not to leave the hard surface road).

The point Kelly is making is that MHCPs are soldiers first and are subject to command authority even in the execution of their primary role as healthcare professionals.[84] In this example the command that the MHCP is subject to is there for their safety and the safety of the collective.

3.4 Conclusion

Howe describes a situation in which a military command dictates behaviour that conflict with bioethical (and often international humanitarian law) prescripts.[85] His premise is that the military command, who are equipped with a greater knowledge of the military mission, is correct to set care and triage priorities for military doctors.[86] Returning the greatest number of lightly-wounded soldiers to service ensures the favourability of the tactical situation and leads to a greater chance of mission success. His premise appears to violate international humanitarian law, particularly the determinations of the First Geneva Convention;[87] however, Howe supports his supposition that during military operations the flow of information does not reach all echelons of soldiers, healthcare professionals included.[88] Soldiers execute orders as instructed by command and do not have the luxury of questioning or offering an input into the course of action.[89] Military healthcare professionals are not privy to the tactical situation as is the command structure. Howe proposes in order to create a better understanding of the military situation communication needs to be developed between command and healthcare professionals through which the healthcare professional and the commanders have a greater understanding of each's responsibilities.[90] In the circumstance of battlefield care the principle of beneficence is concerned not only with the wounded in need of medical intervention but with the prevention of a situation that may lead to greater casualty numbers and/or defeat in combat.

84 Kelly 48.
85 Lounsbury & Bellamy 313.
86 Kelly 48.
87 Art 12(3) GC I: "Only urgent medical reasons will authorize priority in the order of treatment to be administered".
88. Lounsbury & Bellamy 313.
89 Lounsbury & Bellamy 181-182.
90 Lounsbury & Bellamy 313.

©University of Pretoria

4. Triage on the battlefield

4.1 Introduction

The goal of combat medicine is the return of the greatest possible number of fighters to combat which will include the preservation of life, limb, and eyesight. The decision to withhold care from a casualty who in a less-overwhelming situation might be salvaged is a difficult one for a physician, nurse, or medic. Decisions of this nature are unusual, even in mass casualty situations. Nonetheless, the overarching goal of providing the greatest good to the greatest number guides these difficult decisions. The commitment of resources is decided based first on the mission and the immediate tactical situation and then on medical necessity, irrespective of a casualty's national or combatant status.[91]

The practice of assigning limited medical resources in the face of an overwhelming number of patients is known as triage (the sorting of patients based on resources required versus resources available).[92] First implemented on the battlefields during the Napoleonic wars, triage has become accepted practice on the battlefield and during mass casualty events for the effective management of multiple casualties.[93] In its purest form the principle requires that the most seriously injured receive treatment first.[94] On the battlefield multiple casualties are sorted into categories prior to the initiation of medical treatment.[95] The three categories of wounded consist of those who will die regardless of care, those who will live regardless of care, requiring only the minimum of care and those who will die without care.[96] This sorting of the wounded represents the least part of an ethical dilemma. Once a decision is made as to which category is the first to receive care, only then the ethical dilemma becomes central.[97] This dilemma is discussed below.

4.2 Triage and the law

91 MA Cubano & MK Lenhart (eds) *Emergency war surgery* (2013) 30.
92 Merrick 6.
93 ER Frykberg "Triage: principles and practice" (2005) 94 *Scandinavian Journal of Surgery* 272-278.
94 As above.
95 ML Gross *Bioethics and armed conflict* (2006) 137.
96 As above.
97 GC I Commentary (2016) 1423.

The Constitution states that no one may be refused emergency medical treatment.[98] This determination applies in peacetime or during an armed conflict. The Constitution does not define the category "emergency medical care" but the courts have described it as "a dramatic, sudden situation or event, which is of passing nature in terms of time".[99] Thus, it is not a chronic or a terminal illness.[100] The Constitution does not distinguish between nationality, social status, race, gender and so forth - the reference is inclusive.[101] The extreme nature of conditions on the battlefield presents the military healthcare professional with conflicting demands in terms of the Constitutional imperative; it seems human nature to care for one's own prior to treating enemy combatants or even civilians caught in the crossfire.[102]

Article 12(3) of the First Geneva Convention obliges treatment to be prioritised according to urgent medical need only. Article 12(3) mandates "urgent medical reasons" as the sole triage criterion permissible in the prioritisation of medical treatment. The military medical practitioner, on the other hand, may be faced with an intrinsic need to prioritise the wounded according to affiliation;[103] first own forces, followed by allies, civilians and then enemy combatants who have become *hors de combat.*[104] This order of priority was accorded United States military medical doctrine and represents a clear violation of the Geneva Conventions.[105] The strong camaraderie among soldiers is a predominant factor which leads them to assist their own and would require competent command and a respect for international humanitarian law to give effect to the prescripts of article 12(3).[106]

Article 15 of the First Geneva Convention places a dual obligation on belligerents; first, medical care should be provided and planned for and secondly, that care is

98 Sec 27(3) Constitution, 1996.

99 *Soobramoney v Minister of Health, KwaZulu Natal* 1998 (91) SA 765 (CC) 778.

100 As above.

101 Sec 9 Constitution, 1996.

102 Gross & Carrick 24. "Disturbingly, a survey of 360 physicians who deployed to Southwest Asia during the 1990–1991 Gulf War reported that more than a third disagreed with the tenet that medical necessity should be the sole determinant of care in a triage scenario. Many of the respondents had experienced such a scenario, as 80 per cent acknowledged having cared for coalition combat casualties, 38 per cent for allied coalition soldiers and most having also treated non-combatant civilians".

103 Lounsbury & Bellamy 302.

104 As above; KG Swan "Triage, the past revisited" (1996) 161 *Military medicine* 448.

105 As above; Lounsbury and Bellamy 302. Art 12(2) Geneva Convention I prohibits adverse distinction with regards to the care of the wounded based on nationality.

106 As above.

©University of Pretoria

provided before and during armed conflict.[107] The use of the word "adequate" to describe the care that has to be available takes cognisance of differing medical capability among belligerents but at the same time obliges nations to ensure the provision of medical care is in accordance with accepted international medical practices and ethics (such as those published by the World Medical Association).[108]

The Implementation of the Geneva Conventions Act 8 of 2012 provides for the prosecution of war crimes committed extraterritorially[109] by South Africans and allows for the prosecution of foreigners who are suspected of grave breaches of IHL.[110] The Act also provides that superiors[111] can be prosecuted for war crimes committed by their forces. The Act further imposes a positive duty to investigate and punish subordinates for breaches.[112] Healthcare professionals employed by the National Defence Force are under the command of military commanders (referred to as line officers or career soldiers) and under the functional (professional) command of senior military healthcare professionals. Thus a dual obligation exists in that military healthcare professionals are accountable not only for their acts or omissions as soldiers but for breaches committed in the execution of their professional medical functions. This applies *mutatis mutandis* in the situation where the healthcare professional has been placed in a position of authority over other soldiers and/or healthcare professionals. South African law enforcement agencies, professional bodies or civil society groups may recognise new avenues of prosecution for breaches of international human rights abuses committed prior to 2002.[113] Maintaining the Constitutional obligation of incorporating international treaties into domestic law,[114] the Act brings home the accountability of breaches of international humanitarian law. The Act places on military healthcare professionals who either commit an offence, omit to act when required to or fail to report a breach of the conventions additional accountability that could have sanction in court.

107 GC I Commentary (2016) 1502.
108 As above, 1503 & 1504.
109 Sec 5(1) Geneva Conventions Act 8 of 2012.
110 Sec 5(3).
111 Sec 6(1) and (4).
112 Sec 6(2).
113 Sec 7(4).
114 Sec 231(4) Constitution, 1996.

©University of Pretoria

4.3 Principles and practice of triage: Benefiting the most[115]

The principles of triage are well known to all experienced trauma medical responders. Briefly, the principles of triage are as follows:[116]

- Safety of the scene: It would be counter-intuitive to risk the lives of first responders if the mass casualty scene has not been declared safe by appropriately qualified personnel such as fire-fighters. On the battlefield, only the foolhardy forsake all precautions to risk his life in order to save a fallen comrade under fire.
- Do most good for most patients with the resources available: An acknowledging that having all the medical resources necessary to treat every eventuality and volume of wounded on the battlefield may not be feasible requires an effective plan to do the most good with the available resources.
- Timely decisions: This is essential during triage and making life or death decisions with limited information. The triage officer should not be involved in the treatment of the wounded, other than in the role of prioritising care and communicating the decision to fellow medical staff.
- Triage is an on-going practice: There are initial scene of insult triage, triage prior to medical evacuation and triage at the operating theatre.
- Knowledge of medical resources available: The triage officer must be familiar with the medical resources available to utilise the limited resources available effectively.
- Preparedness: Training and preparation ensure competent practice when the need arises.
- Apply universally accepted triage categories: International triage practice ranks patients according to the severity of their condition. The following universal demarcations are used:
  - Priority 1 (Red colour coded): most severe and will die if no medical treatment is administered within an hour or less.
  - Priority 2 (Yellow colour coded): Less severe but requires treatment within 24 hours otherwise death may result.
  - Priority 3 (Green colour coded): Walking wounded, require minimal medical intervention and are able to wait for definitive care.

115 Merrick 317-319.
116 As above.

©University of Pretoria

- Priority 4 (Black colour coded): Also known as "expectant patients". Will die regardless of the medical interventions performed. This category of patient usually is administered analgesics in order to provide comfort.

Triage has been examined above in the context of the return of soldiers to service and where medical priorities are set for military purposes.[117] Triage had its origins on the battlefield[118] and subsequently with advances in warfare has been widely adopted and developed. The Napoleonic battlefield surgeon, Baron Dominique-Jean Larrey, is accredited with developing a system of medical evacuation and care of the most severely wounded from the battlefield based solely on urgency of need.[119] The practice of triage was limited and was available only to Napoleon's elite troops;[120] regular troops were not afforded this privilege and as did their comrades who preceded them. They suffered a painful death on the battlefield due to lack of medical attention.[121] For this reason the ascription of the origin to Larrey cannot be viewed as supporting the discharge of the principle of beneficence. As the methods and means of warfare[122] advanced and created situations in which the number of wounded vastly outweighed available medical resources, military triage was adapted.[123] The application of triage principles changed in favour of treating the most urgent medical needs first and incorporated the advent of improved evacuation means such as aero-medical transportation, helicopters and dedicated field ambulances.[124] However, these improvements were achieved only by modern well-equipped military forces with organised and dedicated military healthcare services.[125]

4.4 Battlefield triage: Salvage, save or assess?

---

117 See para 2.3 above. The provision of penicillin to soldiers suffering venereal diseases as opposed to those with war wounds is not considered battlefield triage but rather setting military priorities for medical treatment. In this study battlefield triage is limited to the care and evacuation of the wounded from the battlefield under extreme conditions.

118 KV Iserson & JC Moskop "Triage in medicine (Part 1) Concept, history and types" (2007) 49 *Annals of Emergency Medicine* 275–281.

119 As above 277.

120 Gross & Carrick 144.

121 As above.

122 Iserson & Moskop 277. The advent of machine guns and chemical weapons during the First World War saw a staggering increase in casualties.

123 As above. The setting of medical priorities for military purposes saw the treatment of less severely wounded troops for the sole reason of returning them to the battlefield and in so doing maintain the military advantage.

124 Iserson & Moskop 277-278.

125 As above.

©University of Pretoria

As established above, triage applies only in extreme situations where medical resources are overwhelmed by the volume of those requiring care. Battlefield conditions represent an example of such a situation; the battlefield is noisy, chaotic and in constant flux;[126] resources are limited and resupply unpredictable.[127] The battlefield is considered a most difficult environment in which to set treatment priorities and to triage casualties.[128] Under these conditions Gross challenges the provisions in international humanitarian law regarding the neutrality of military healthcare professionals, the fair distribution of medical care based solely on medical need and the non-discrimination principle in providing care to either friend, foe or civilian.[129] He is of the view that on the battlefield merely removing the wounded may not be an option but that the military healthcare professional should include a further dimension to triaging, that is returning the soldier to the battlefield as soon as possible.[130] Gross cites US military doctrine to support his argument. The US Army medical doctrinal manual[131] (1985) reinforced the priority of maintaining a fighting force[132] and dictated that returning soldiers to service was the primary mission of the medical support services. A later version of the US Army's doctrine ranked treatment based on severity of wounds as the sole consideration for a healthcare professional,[133] aligning doctrine to international humanitarian law and medical ethics.[134]

4.4.1 Medical need

Medical need is the treatment the patient requires, first, to save his life and, secondly, to restore him to health to an acceptably recognised standard.[135] The Conventions advocate a medical need-based approach in that no distinction is drawn between friend, foe, officer, troop, civilian or ally.[136]

4.4.2 Salvage

---

126 Andrews 64.
127 As above.
128 As above.
129 Gross & Carrick 138.
130 As above.
131 US Dept of the Army "Planning for Health Service Support" (1985) 8-55: "Return to duty considerations during the cold war".
132 Lounsbury & Bellamy 374.
133 Gross & Carrick 148.
134 Art 12(3) GC I.
135 Gross & Carrick 142.
136 As above.

Gross identifies the rule of salvage that asserts a different twin-principled approach to the distribution of medical resources,[137] namely, utility that overrides medical need when distributing scarce resources and utilitarian triage that favours treatment priorities for own forces first.[138] Gross contends that triage salvage applies only to armed conflict where the needs of the collective (and mission) are prioritised over those of the individual.[139] Soldiers are but a part of a larger military machine and as such their purpose is to return to the front lines to win the battle.[140] Salvage in Gross's terms requires that the lightly-wounded friendly combatant is treated first rather than the severely-wounded non-combatant or enemy soldier.[141] Gross further contends that the autonomous decision-making of the soldier is limited in that the salvageable cannot refuse treatment because the goal is to return to the front, and the severely wounded cannot demand treatment as their lot depends on the needs of the collective.[142] Such an approach conflicts with the civilian medical ethical principle of beneficence.

4.4.3 Assessing the battlefield

A further application of military medical triage principles is described in conventional and mass casualty triage. Conventional triage is practiced in situations where, despite numerous casualties, resources are adequate and thus a needs-based assessment of the wounded occurs.[143] Those requiring immediate resuscitation are treated first, followed by those that can wait for surgery and finally the lightly wounded.[144] Mass casualty triage takes place when the wounded exceed the medical resources.[145] Mass casualty triage favours salvage and utility over need with the emphasis on returning soldiers to service.[146] Minor injuries and procedures that ordinarily require less recovery time are prioritised.[147] Thus, mass casualty triage is a reversal of practice in conventional triage. Military healthcare professionals are burdened not only with the treatment of their patients but must monitor medical resources and the progress of the battle[148] as this is

137 Gross & Carrick 138.
138 As above.
139 Gross & Carrick 142.
140 As above.
141 As above.
142 As above.
143 Gross & Carrick 144.
144 As above.
145 As above.
146 As above.
147 As above.
148 As above 148.

©University of Pretoria

essential in deciding which triage practice to apply, whether conventional or mass casualty.[149]

With these difficulties in mind, healthcare professionals do well to expend their efforts on treating whoever they can as best they can, with an eye towards saving as many as possible and in the hope that what they do will make a significant, if not efficient, contribution to their nation's war effort.[150]

5 Conclusion

In a time of armed conflict the beneficence principle of medical ethics is under severe threat that results in a recognised deviation from practices that in other circumstances are unethical.[151] The dilemma the military healthcare professional faces is to identify correctly a situation that warrants a medical ethical deviation from the beneficence principle due to recognised medical resource challenges as opposed to subservience to the overriding claim of military command of the authority to dictate military priorities.[152]

The International Committee of the Red Cross (ICRC) recognises the utilitarian approach under which triage is practiced to achieve the greatest benefit for the most casualties and optimally utilises the available resources.[153] It is argued that to practice triage under the principle of providing the most good for the most casualties under battlefield circumstances corresponds to article 12(3) of the First Geneva Convention if it is conducted exclusively on medical grounds.[154] Military necessity is not a justification for deviating from the principles in triaging casualties for other than urgent medical reasons.[155] Nevertheless, attention is drawn to the reality of the situation and unless the battlefield situation is considered resulting in a shift in triage practices aimed at winning the fight, the battle may be lost which is not beneficial to the collective.

---

149 As above.

150 As above.

151 B Domres *et al* "Ethics and triage" (2001) 16 *Prehospital and Disaster Medicine*: *The Official Journal of the National Association of EMS Physicians and the World Association for Emergency and Disaster Medicine in association with Acute Care Foundation 16(10 53-58.*

152 See para 6.1 above.

153 ICRC *First Aid in Armed Conflicts and Other Situations of Violence* (2010) 116.

154 GC I Commentary (2016) 1424.

155 As above 1425.

©University of Pretoria

Modern warfare exhibits the participation of non-conventional belligerents who have neither respect for international humanitarian law nor any medical support. Failure to dominate these forces on the battlefield may result in a greater casualty or death rate if the tactical situation is not taken into consideration.[156]

Below the principle of non-maleficence in the context of military healthcare is examined.

[156] Gross & Carrick 173.

©University of Pretoria

CHAPTER 8

NON-MALEFICENCE - FIRST DO HARM

OUTLINE

1. Introduction
2. Battlefield euthanasia
2.1 Introduction
2.1.1 Passive euthanasia
2.1.2 Active euthanasia (Battlefield euthanasia)
2.2 Legal principles
2.3 Bioethical principles in battlefield euthanasia
2.4 Dichotomies in battlefield euthanasia
2.4.1 Introduction
2.4.2 Battlefield euthanasia: requested by the mortally wounded
2.4.3 Battlefield euthanasia: military necessity
2.4.4 Battlefield euthanasia: the difficult choices
2.4.5 Ethical analysis of battlefield euthanasia options
2.4.6 Conclusion
3. Doctors: Combatant or non-combatant?
3.1 Introduction
3.2 Domestic and international humanitarian law
3.2.1 Combatants
3.2.2 Non-combatants
3.3 The doctor as combatant
3.4 Conclusion
4. Manufacturing harm: Military medical practitioners and weapons development
4.1 Introduction
4.2 The prosecution of Dr Wouter Basson
4.3 Professional conduct: Dr Wouter Basson and the HPCSA
4.3.1 The professional conduct inquiry
4.3.2 Defences raised on the professional conduct inquiry
4.4 Conclusion
5. Ethics abandoned: Doctors and torture

©University of Pretoria

5.1 Introduction
5.2 South Africa: Torture, cruel, inhumane, degrading treatment and punishment
5.2.1 Steve Biko
5.2.2 Domestic legislation and torture
5.3 Doctor and torturer: The dichotomy
5.3.1 Introduction
5.3.2 The psychology of the physician-torturer: Lessons from the 'Nazi doctors'
5.3.3 Why physicians torture: Post World War II and into the new millennium
5.3.4 A role for the doctor in torture?
5.4 Accountability for those who torture
5.5 Conclusion: The end of physician involvement in torture
6. Chapter conclusion

1. Introduction

Primum non nocere[1]

In the preceding chapter, beneficence relating to military medical ethics was examined. To behave beneficently towards others requires a positive act and is not merely to refrain from harmful acts.[2] The principle of non-maleficence is the commitment not to cause harm to others.[3] Distinguishing the principles of beneficence and non-maleficence in the context of military medical practice will emphasise important differences. Beauchamp and Childress support this division of principles so as not to obscure these differences.[4]

A commitment not to harm or kill is distinct from commitments to help, especially in armed conflict. This chapter examines the principle of non-maleficence in the context of dichotomies that may arise in military medical practice. Military doctors, as primary care-givers to their soldier-patient population, may face extreme situations where they either are called upon to abandon the principle of non-maleficence and cause harm or

---

1 TL Beauchamp & JF Childress *Principles of biomedical ethics* (6th ed) (2009) 149. From the Latin "above all (first) do no harm. Considered a fundamental principle of medical ethics, the maxim does not appear in the Hippocratic oath. The oath does elicit the commitment of non-maleficence and beneficence.

2 See Ch 7, Introduction.

3 Beauchamp and Childress 149.

4 As above, 150.

©University of Pretoria

be induced to act contrary to medical ethics and actively partake in armed conflict. The chapter examines the circumstance of the military doctor dealing with these situations; such as in the context of active euthanasia on the battlefield, participating in combatant roles, using his medical knowledge as a weapon and partaking in torture.

2. Battlefield euthanasia

2.1 Introduction

Battlefield triage and the legal and bioethical challenges that a military doctor may face during the extreme conditions of the battlefield were examined in chapter 7. Battlefield euthanasia is not akin to battlefield triage.[5] Triage was described as the sorting of the wounded into specific categories dependent on the severity of their wounds so as to ensure the greatest good is done for the greatest number of wounded.[6] Euthanasia is described as the "mercy killing" of hopelessly ill or injured patients in order to prevent further suffering.[7] The practice and principles of triage do not contain the element of actively causing the death of another but may involve inactively (passively) bringing about the death of another due to priorities of care, the limitation of resources or the unsalvageable nature of their injuries.[8] Active and passive euthanasia require further discussion in the context of military (battlefield) medicine.

2.1.1 Passive euthanasia

Passive euthanasia is described as the consented withholding or withdrawing of medical interventions due to an injury or illness' that has a limited prognosis for recovery.[9] Passive euthanasia is not considered unlawful (or akin to murder) as the prescribed medical interventions are ceased voluntarily either by a competent patient or a next of kin and, as such, nature is allowed to follow its course and the patient eventually dies.[10] "Allowing to die" as opposed to actively causing the death of another is the hallmark of passive euthanasia.

During the extreme situations experienced on the battlefield, triage principles may

---

5 S Neuhaus "Battlefield euthanasia: Courageous compassion or war crime?" (2011) 6 *MJA* 307.
6 C Merrick (ed) *ATLS® Advanced trauma life support: Student Course Manual* (10th ed) (2018) 6.
7 Dada MA & McQuiod-Mason DJ *Introduction to medico-legal practice* (2001) 26.
8 As above.
9 As above, 26.
10 As above and *Clarke v Hurst NO* 1992 (4) SA 630 (D).

©University of Pretoria

dictate that soldiers with a greater chance of survival (and depending on the tactical situation) are treated first and thus are able to return to duty or be evacuated to higher levels of care, whereas the mortally wounded are triaged as "expectant" and treatment is not initiated until resources become available.[11] The expectant-classed wounded are made comfortable by means most readily available, such as the administration of analgesia.[12]

2.1.2 Active euthanasia (battlefield euthanasia)

An act by a healthcare professional, family member or another that directly causes the death of a patient, even at the patient's request, is unlawful in South Africa.[13] Situations arise on the battlefield, due to extensive wounds from which clearly there is no chance of survival, let alone evacuation to definitive medical care, that lead soldiers to request or even beg that their lives are ended whether at the hands of fellow soldiers or the treating healthcare professionals. There have been situations that saw military command or medical decisions necessitate the non-voluntary/active euthanasia of the wounded to prevent capture, torture or a certain, prolonged and painful death.[14] Napoleon's physician, René-Nicolas Desgenettes, was ordered to administer lethal doses of poison to wounded soldiers in order to spare them capture and certain death at the hands of the advancing armies of the Mameluk.[15] Jewish physicians administered hydrogen cyanide to patients, causing their death, rather than surrender them to National Socialist Sonderkommando in 1940.[16] In this discussion, battlefield euthanasia will be restricted to the legal and ethical dichotomies faced by military healthcare professionals when confronted with actively ending the lives of soldiers as opposed to the soldier requesting another comrade in arms to end his life.

Jeremiah Gage and the Battle of Gettysburg

In order to describe the act of battlefield euthanasia reference is to the sheer hopelessness of the condition of the battlefield wounded, despite being under the care of a surgeon at an aid station away from the battlefield. No better example exists than in the recollection of Dr Joseph Holt, a Confederate surgeon serving in a field hospital

---

[11] Fn 6 above.
[12] As above.
[13] Dada & McQuoid-Mason 26; *S v Hartmann* 1975 (3) SA 532 (C).
[14] Neuhaus (fn 5 above) 307.
[15] As above.
[16] As above.

©University of Pretoria

during the Battle of Gettysburg in July of 1863:[17]

> "I turned to him and he pointed to his left arm. I quickly exposed it and found that a cannon ball had nearly torn it away between the elbow and the shoulder. I made some encouraging remark when he smiled and said 'Why, doctor, that is nothing; here is where I am really hurt,' and he laid back the blanket and exposed the lower abdomen torn from left to right by a cannon shot, largely carrying away the bladder, much intestine, and a third of the right half of the pelvis; but in both wounds so grinding and twisting the tissues that there was no hemorrhage…He asked: 'Doctor, how long have I to live?' 'A few hours', I replied. 'Doctor, I am in great agony, let me die easy, dear doctor; I would do the same for you.' His soul peered from the depths of his blue eyes in an appeal of anguish that cut me to the heart and I replied 'you dear, noble fellow, I shall see to it that you die easy …'"

Dr Holt, like many a surgeon treating the wounded of the American Civil War, had limited resources and certainly not the skills or medical technology to manage the wounds that had befallen Jeremiah Gage.[18] The conclusion to the tale is that Dr Holt, equipped with opiate drugs, administered a lethal dose to Jeremiah and as a result hastened death.

2.2 Legal principles

Murder is the unlawful and intentional causing of the death of another human being.[19] Despite active euthanasia or physician-assisted suicide being lawful in certain countries,[20] active euthanasia remains unlawful in South Africa.[21] Jeremiah Gage was gravely and mortally wounded, even by today's standards his recovery from such massive trauma may not be possible especially if it is applied to a situation of armed conflict. The triage of Jeremiah would have reflected a low treatment priority that may have consisted only of analgesia administered for comfort.[22] However, in this tale Dr

---

17 M Deese "Unbounded by time: Jeremiah Saunders Gage and the Battle of Gettyburg. The Gettysburg experience" (2010) available at www.thegettysburgexperience.com/past_issue_headlines/2010 (accessed on 26 September 2022).

18 DL Perry "Battlefield euthanasia: Should military mercy killings be allowed?" Presentation at conference of the International Society for Military Ethics, 27 January 2011.

19 CR Snyman *Criminal law* (5th Ed) (2008) 447.

20 Physician assisted suicide or assisted suicide is law under certain conditions in the Netherlands, Austria, Canada, Belgium, Spain, Switzerland, certain states in the United States, certain areas in Australia and Luxembourg.

21 DJ McQuoid-Mason "Assisted Suicide and assisted voluntary euthanasia: *Stransham-Ford* High Court case overruled by Appeal Court – but the door is left open" (2012) 107 *SAMJ* 381; *Minister of Justice and Correctional Services and Others v Estate Late Stransham-Ford (Doctors for Life International NPC and Others as Amici Curiae* 2017 (3) BCLR 364 (SCA).

22 See Ch 7, Beneficence.

©University of Pretoria

Holt actively administers a lethal dose of opioids and hastens the death of Jeremiah. Under South African law the definitional elements of the crime of murder would have been met and Dr Holt would have stood trial for murder.[23]

South Africa, as a signatory to the Geneva Conventions and the Additional Protocols, ratified and incorporated into domestic law the articles contained therein.[24] Ethical military medical practices are described in the articles and prescribe the obligations of healthcare professionals.[25] The Conventions and Protocols prohibit euthanasia.[26] South African military healthcare professionals are governed by domestic and military law while deployed within the borders of the country and by military law, international law and specifically the Implementation of the Geneva Conventions Act, 2012 when deployed on external military operations.[27] Thus, military healthcare professional are accountable for their actions and face either military or civilian courts for the transgression of laws in respect of intentionally causing the death of another human being.

South African law remains in limbo regarding whether active euthanasia will be legally acceptable.[28] Robert Stransham-Ford, an advocate, was affected by cancer and despite treatment faced death as the hope of recovery slipped away.[29] Stransham-Ford petitioned the High Court in an application that sought that his physician be permitted either to administer a lethal dose of medication or to provide him with medication for self-administration and in so doing end his suffering and his life.[30] Further, that his physician should not face any criminal sanction for assisting in ending his life.[31] The application was served on the Minister of Health and the Minister of Justice and

---

23 Dr Holt's intentional act of administering an unlawful lethal dose of opioids, to Jeremiah, another human being, resulted in the (hastened) death.

24 Implementation of the Geneva Conventions Act 8 of 2012.

25 JC Moskop "A moral analysis of military medicine" 1998 (163) *Milmed* 76-79.

26 Arts 12 & 15 GC I, Arts 12 & 18 GC II, Art 10 AP I and Art 7 AP II.

27 Sec 199(5) Constitution, 1996 & Secs 5 (1) & 6(1)(a) Implementation of the Geneva Conventions Act, 2012.

28 HJD Robertson "Still waiting for an answer; Physician assisted suicide in South Africa" *De Rebus* August 2020 DR14.Available at https://www.derebus.org.za/still-waiting-for-an-answer-physician-assisted-suicide-in-south-africa/ (accessed 30 September 2022).

29 *Minister of Justice and Correctional Services and Others v Estate Late Stransham-Ford* (Doctors for Life International NPC and Others as Amici Curiae 2017 (3) BCLR 364 (SCA).

30 *Robert James Stransham-Ford v Minister of Justice and Correctional Services and 3 Others* (4) SA 50 Case no. 27401/15 (GP) paras 2-4.

31 As above, para 4.

©University of Pretoria

Correctional Services.[32] Fabricius J granted Stransham-Ford's application, albeit hours after he had died a natural death.[33]

The Minister of Justice and Correctional Services, the Minister of Health, the National Director of Public Prosecutions and the Health Professions Council of South Africa (HPCSA) appealed the Stransham-Ford judgment before the Supreme Court of Appeal (SCA).[34] The SCA upheld the appeal, setting aside the court *a quo's* findings and concluded that Parliament is best suited to answer the question of physician-assisted suicide, and not the courts.[35] The South African Law Reform Commission (SALRC) also examined the issue of physician-assisted suicide but its recommendations to date have gone unattended.[36] Precedent in matters related to assisted suicide may offer some guidance as to how the courts have dealt with physician-assisted suicide.

Professor Sean Davison

New Zealand born microbiologist, Professor Sean Davison, was convicted of attempted murder in the death of his mother in New Zealand during 2010.[37] Pleading guilty to the crime of assisted suicide, Professor Davison was sentenced to five months' home detention in New Zealand.[38] After returning to South Africa, Professor Davison was convicted of assisting in ending the lives of three persons, each suffering terminal conditions.[39] Convicted in 2019, Davison served three years under house arrest.[40] Archbishop Desmond Tutu, an advocate of a person's right to be assisted to end his own life in the event of unbearable suffering, supported Professor Davison in both trials.[41] Professor Davison, however, was not a medical doctor nor was he involved in the care or treatment of the three deceased. The SALRC, prominent

32 As above.
33 As above.
34 As above.
35 As above.
36 South African Law Commission. Euthanasia and Artificial Preservation of Life. Project 86. (1997).
37 "Tutu help saak vir genadedood in SA" *Die Burger* 14 July 2014 1 as cited in A Strohwald "Dignity in death; A critical analysis of whether the right to human dignity serves as appropriate justification for the legalisation of assisted death" unpublished master's degree dissertation, University of Stellenbosch, 2014 52.
38 As above.
39 "Sean Davison's euthanasia trial carries a 44-year-old echo – and not much has changed" *Daily Maverick* July 2019 available at https://www.dailymaverick.co.za/article/2019-07-01 (accessed 27 September 2022); https://www.constitutionallyspeaking.co.za/the case of Professor Sean Davison and the right to die with dignity (accessed 27 September 2022).
40 As above.
41 As above.

©University of Pretoria

clerical and political opinions and recent court decisions, unfortunately have not convinced the legislature to enact laws that legalise active euthanasia or physician assisted suicide in South Africa.[42]

S v Hartmann 1975 (3) SA 532 (C)

Dr Hartmann, a physician, assisted in hastening the death of his terminally-ill father by administering analgesia and anaesthetic medication.[43] Charged and convicted of murder, the court exercised a great measure of mercy by handing down a suspended sentence of one year on the condition that Dr Hartmann not be found guilty of a charge of murder during the period of the sentence.[44] The predecessor to the HPCSA, the South African Medical and Dental Council, struck Dr Hartmann from the roll as a practicing physician. However, he was later reinstated.

On the battlefield the administration of copious quantities of analgesia to mortally wounded soldiers has been practiced for centuries.[45] The dual effect of both suppressing normal physiological functioning (such as the suppression of breathing with the administration of morphine sulphate, thus hastening death) and the amelioration of pain that accompanies opioid-type analgesia administration may well be the most common types of "active" euthanasia of the battlefield.[46] Despite the courts' lenient sentencing, of further application to physicians who assist others in ending their lives is the sanctioning of continued practice by the HPCSA on the basis of unprofessional conduct.

S v Smorenburg 1992 (2) SACR 289 (C)

In another matter involving a healthcare professional, the accused, a nurse, attempted to end the lives of two of her patients.[47] Despite failing to do so her motive was to end the suffering and "uselessness" of those who were terminally ill.[48] The court convicted her of attempted murder, but much the same as in *Hartmann*, imposed an extremely

42 Fn 28 above.
43 *S v Hartmann* 1975 (3) SA 532 (C) Headnote.
44 *S v Hartmann* 1975 (3) SA 532 (C) and Masters Dissertation, Strohwald (n 37 above) 46.
45 Fn 23 above.
46 DE Lounsbury & RF Bellamy *Military Medical Ethics (vol 1)* (2003) 300; J Masters *The Road past Mandalay* 253; RKD Peterson "Insects, disease and military history: The Napoleonic Campaigns and historical perspective" available at http://entomology.montana.edu/historybug/nepoleon/nepoleon.htm (accessed 26 September 2022); and Perry 7.
47 *S v Smorenburg* 1992 (2) SACR 289 (C) 390
48 As above, 391-392

©University of Pretoria

lenient sentence of three months' imprisonment, suspended for three months.[49] Extreme battlefield conditions, together with the feelings of hopelessness and the humane intentions of a military healthcare professional, may convince a court to impose a lenient sentence, much the same as was handed down in these cases involving civilian healthcare professionals.

Despite precedent and the SALRC's position on the matter of active euthanasia (or physician-assisted euthanasia) South African law remains clear: the active participation in terminating the life of another, albeit with extreme mitigating factors, still is unlawful until the legislature applies their minds and drafts a law supporting the right to die. On the battlefield, active euthanasia may have been more prevalent considering the extreme conditions under which physicians act.[50]

2.3 Bioethical principles in battlefield euthanasia

Perry contends that the moral status of soldiers during armed conflict is perplexing.[51] Soldiers are called upon to make the supreme sacrifice in defence of the state and are lawfully permitted to take the lives of enemy belligerents on the battlefield without facing prosecution.[52] When the soldier is wounded and lays down his arms, no longer actively participating in hostilities, the soldier becomes *hors de combat*, a non-combatant and protected by international humanitarian law.[53] He must be collected and cared for either by his own or by enemy medical personnel.[54] However, the situation on the ground, as graphically described by Dr Holt and his patient Jeremiah Gage, may not be so straightforward.[55]

A distinction must be drawn between the killing of a mortally wounded soldier by a fellow comrade and the active euthanasia of a mortally wounded soldier at the hands of a healthcare professional. The latter scenario is significant to this discussion. As examined above, the intentional causing of the death of another by acts or omissions is unlawful and criminal charges follow. The courts have pronounced judgment and handed down sentences in matters that have been decided as described above. There

---

49 As above, 391-392.
50 Fn 46 above.
51 Perry 3.
52 As above.
53 Art 12 GC I.
54 As above.
55 Fn 18 above.

©University of Pretoria

exists no reason the same would not befall the soldier physician when assisting a mortally wounded soldier end his life by medical intervention.

The military healthcare professional would be acting against the bioethical principle of non-maleficence in that he would be causing harm (death) by his actions. Arguably, the harm caused may be to the benefit of the soldier-patient in that intolerable pain and suffering are ameliorated. Secondly, abandonment to face capture and certain death or torture is avoided and, finally, the overall consideration of military necessity, that is predicated on the collective being superior to the individual (or the mission over the man) are dilemmas that burden not only the healthcare professional but also military commanders.[56] Would the soldier-physician act unethically by not discharging his obligation to first (above all else) do no harm? The answer to this question requires an analysis of the dichotomies facing the military healthcare professional in the situation of battlefield euthanasia.

2.4 Dichotomies in battlefield euthanasia

2.4.1 Introduction

Domestic law and international humanitarian law are clear on this question, actively ending the life of another is unlawful. No soldier, physician or combatant, may take the life of a comrade or foe once he has been wounded and has laid down his arms.[57]

The intention to act compassionately towards one's comrades in arms may well be the overriding justification for soldiers ending the lives of the mortally wounded.[58] However, when physicians are called upon to end the lives of the mortally wounded, the situation becomes less morally clear.[59]

During armed conflict, and more specifically the chaos of the battlefield, military healthcare professionals are faced with two distinct dichotomies regarding their ethical obligations in respect of non-maleficence and euthanasia. The first is the conflict that perplexes every physician in that the obligation to do no harm is weighed against a hopeless prognosis filled only with the pain and suffering of the mortally wounded.[60]

---

56 Perry 4-6.
57 Art 12 GC I.
58 Neuhaus 308.
59 As above.
60 The physician has the capacity to ameliorate suffering by euthanising the terminally-ill or wounded but is barred from doing so by law.

©University of Pretoria

The second is the duty to first do no harm and the order to abandon or hasten the death of gravely-wounded soldiers under the premise of military necessity.[61]

2.4.2 Battlefield euthanasia: Requested by the mortally wounded soldier

The soldier's right to life during armed conflict is a perplexing subject.[62] Soldiers may kill without facing prosecution provided that the killing is done in accordance with the law of war.[63] Death during armed conflict may not violate the right to life if it is in accordance with the rules of international humanitarian law.[64] Further, the right not to be killed is not absolute.[65] The use of deadly force may be justified in warding off an attacker, the right of soldiers not to be killed is qualified in armed conflict and patients may request active euthanasia if their nation's laws permit it.[66]

First, a speculation; active euthanasia is lawful in the state involved in armed conflict and is available to its soldiers. Countries such as Denmark, the Netherlands and Canada have strict regulations in place prior to euthanasia being granted,[67] these include prior consultations, waiting periods, informed written consent, written requests, next of kin involvement and medical investigations to exclude psychiatric conditions.[68] States that have legalised euthanasia differentiate between physician assisted euthanasia and the self-administration of prescribed medication that causes death. Regardless of which method is lawful, strict regulations exist that ensure the person in fact is totally in control of and informed of his choice.[69]

These pre-existing determinants to lawful euthanasia or physician-assisted suicide are moot to the often-immediate decision to actively cause the death of another on the battlefield due to pain, the futility of medical interventions, lack of resources, fear of capture, torture or delayed evacuation times. The specific medications routinely used in active euthanasia may not be readily available in the medical kit of physicians and

---

61 Ordered to forsake the gravely wounded under orders by military command thus knowing that delayed treatment will result in a certain death.

62 Perry 3.

63 As above.

64 E Wicks "The Right to Life in Times of War or Armed Conflict" (2010) *The Right to Life and Conflicting Interests* available at https://doi.org/10.1093/acprof:oso/9780199547395.003.0004 (accessed 10 Nov. 2022).

65 Perry 3.

66 As above.

67 Example of the legislated requirements from the United States (Oregon) available at www.oregon.gov/deathwithdignityact/documents (accessed on 10 November 2022).

68 As above.

69 As above.

©University of Pretoria

primary response medical personnel.[70] Emergency medication used for the alleviation of severe pain, such as morphine sulphate, has a side effect of suppressing breathing and hastening death (palliative/terminal sedation).[71] Palliative/terminal sedation is described as being part of palliative care, in that the object is the relief of pain in the terminally ill patient and not to cause his death, as is the case with euthanasia or physician assisted suicide.[72]

2.4.3 Battlefield euthanasia: Military necessity

Exploring the second dichotomy faced by military healthcare professionals, all too often means examining the principle of military necessity. History presents two known and well-documented situations where military physicians were ordered based on military necessity to end the lives of the wounded by military command. The first relates to the ordering of Napoleon's physician, René-Nicolas Desgenettes, to administer opiates to French soldiers wounded in Palestine (1799).[73] Desgenettes refused to obey the order but others ended the soldiers' lives.[74] John Masters, a British commander in Burma during the Second World War, ordered the administration of morphine to terminally ill and wounded soldiers rather than have them fall into the hands of the brutal advancing Japanese army.[75] His order was executed.[76]

Military healthcare professionals are obliged to disobey obviously unlawful commands such as an order to euthanase.[77] In that scenario the wounded had not expressed their informed consent to be killed. The First Geneva Convention dictate that medical personnel are ordered to remain with and provide care to the wounded if they are unable to be evacuated even in the wake of an enemy advance.[78] The First Geneva Convention however contain a caveat in that the provision of medical personnel and

---

70 S Dierickx *et al* "Drugs used for euthanasia: A repeated population-based mortality follow-back study in Flanders, Belgium 1998-2013" (2018) 56 *Journal of Pain and Symptom Management*. 551.

71 Perry 15; M Welgemoed & L Henry "Palliative care as a form of relief for the dying: A South African perspective (2020) 4 *Obiter* 348 -370 available at http://www.scielo.org.za/scielo (accessed on 10 November 2022).

72 As above.

73 Fn 15 above.

74 Perry 5.

75 Perry 8.

76 Perry 9.

77 Code of Conduct of Uniformed Members of the South African National Defence Force available at https://www.researchgate.net/figure/Code-of-Conduct-for-Uniformed-Members-of-the-SANDF (accessed 1 February 2021).

78 Art 12 GC I.

©University of Pretoria

material in such circumstances is discretionary.[79] Thus, the commander may decide not to leave any medical personnel or material behind when abandoning the wounded.[80] Article 12(5) contradicts the obligation contained in the opening paragraphs in that the use of the word "compelled to" makes it obligatory to care for the wounded and sick.[81] The 2016 Commentary to the First Geneva Convention states that the abandonment of the wounded was meant as a last resort and that despite there being no known state practice thereof in modern times, the article should not be interpreted as having fallen into disuse.[82]

The Conventions fail to address the situation where belligerents are non-state actors engaged in unconventional warfare. Where belligerents openly disregard international humanitarian law, such as by the armies of Japan during the Second World War and the Turks in the Napoleonic campaign in Egypt, abandoning the wounded would mean certain death, torture or the cruellest of treatment to maximise terror and demoralise the enemy.[83]

2.4.4 Battlefield euthanasia: Difficult choices

There exists no easy option for the military healthcare professional if he were to be confronted with such extreme situations on the battlefield; should he ameliorate the suffering of a mortally wounded soldier or end the life of the wounded because abandonment means certain torture and death? The doctor may opt to administer palliative or terminal sedation with the intention to ameliorate pain as intentionally causing the death, even hastening the death of another would be unlawful. However, if the physician were to be prosecuted for causing the death of the mortally wounded, the court may consider the mitigating factors as they have in the *Hartmann* and *Smorenburg* matters and hand down a lenient sentence.[84]

Enacting legislation that legalises euthanasia would have to consider its application on the battlefield or in the military environment. The potential for euthanasia to be abused in an authoritarian environment such as the military would be a primary concern.[85]

---

79 Art 12(5) GC I: "as far as military considerations permit".
80 GC I Commentary (2016) 1441.
81 As above, 1439.
82 As above, 1442.
83 Perry 15.
84 *S v Hartmann* 1975 (3) SA 532 (C); *S v Smorenburg* 1992 (2) SACR 289 (C).
85 TE Beam in Lounsbury & Bellamy 391.

©University of Pretoria

2.4.5 Ethical analysis of battlefield euthanasia options

Military medical practitioners require a pragmatic approach in dealing with the bioethical issues of battlefield euthanasia. Beam suggests addressing battlefield euthanasia using different ethical approaches.[86] The four-pronged principle-based ethical analysis of autonomy, beneficence, non-maleficence and distributive justice will be examined in order to present an understanding of the moral issues and, by so doing. equip the military healthcare professional to address the dichotomy. Beam rightfully summarises this approach by recognising that the military healthcare professional's first step in understanding this complex moral issue is to understand the dynamics before he is confronted with the extreme situation that exists on the battlefield.[87] Through prior preparation using hypothetical situations the physician will be better equipped to care for his patient in an actual crisis.[88]

The hypothetical situation used by Beam is from a paper written for the publication *Military Medicine* by Dr Steve Swann.[89] Swann describes a situation in Europe where Russian forces attack North Atlantic Treaty Organisation (NATO) positions in Germany. Due to the nature of the onslaught, NATO forces suffer a great number of casualties and are forced to withdraw from their positions. Their withdrawal necessitates the evacuation of the wounded in a forward field hospital. The situation for the lone surgeon at the hospital is dismal. The needs of the patients exceed capacities, medical staff have been depleted by enemy action, supplies are exhausted without any prospect of resupply, evacuation means are unavailable and intelligence reports state that Russian forces are executing the wounded that are abandoned.[90] The majority of the wounded admitted to the field hospital are triaged as expectant (unsalvageable due to the extreme nature of their wounds plus limited/no medical resources to care for them).[91] The surgeon is faced with the difficult choice either to abandon the expectant patients to a certain death or mercifully end their lives before evacuating the patients who can be saved.[92]

---

86 Lounsbury & Bellamy 389.
87 As above, 392.
88 As above.
89 Lounsbury & Bellamy 385; SW Swann "Euthanasia on the battlefield" (1987) 152 *Mil Med* 545–549.
90 As above.
91 As above.
92 As above.

©University of Pretoria

The principle of autonomy

Beam begins by questioning whether the expectant patient should be informed of the dire situation and whether a process of decision-making should commence. Further, he examines whether the soldier has full autonomous decision-making capabilities when he joins the military or whether medical autonomy is restricted.[93] Can a soldier demand that his wishes be fulfilled in that treatment is initiated?[94] The autonomous medical decision-making ability of the soldier was discussed in chapter 6 and the conclusion drawn that autonomous decision-making is restricted in military service. Beam reinforces this finding making use of an analogy in which soldiers are not consulted or even included in decisions that may cause their death or injury (for instance, soldiers are ordered to charge up a hill under machine-gun fire without gaining their consent to or having input in the decision).[95] The extreme situation faced in the scenario may preclude a physician from gaining such consent from his patient or even engaging his patient in the matter due to the greater chance it may cause further suffering and anxiety.[96]

The scenario continues in speculating that expectant patients have requested to be euthanased. Swann, as author of the scenario, contends that in war euthanasia is a justifiable method of treatment that is available to the physician and that it is morally permissible to do so.[97] Beam counters this conclusion by questioning whether the wounded should be granted all requested "treatment".[98] Without expressing an opinion about battlefield euthanasia, Beam comments that the physician remains responsible for the actions he takes, even in such extreme situations.[99]

However, Beam probes who should carry out the euthanasia and what means should be used.[100] As the scenario explained that medical resources were limited, would it not be irresponsible to use these valued assets to euthanase?[101] Additionally, would it be morally permissible for the physician to allow death by a rifle-shot when the physician

93 Lounsbury & Bellamy 389.
94 As above.
95 As above.
96 As above.
97 Swann 546.
98 Lounsbury & Bellamy 390.
99 As above.
100 As above.
101 As above.

©University of Pretoria

is in a doctor-patient relationship.[102] Beam argues that this decision, if affirmed, would be questionable as all the physician would be doing is morally distancing himself from the situation if a command decision is made to kill the wounded.[103]

Diving deeper down the rabbit hole, Beam questions the reality of a right to autonomous decision-making that an unconscious or incapable patient has.[104] He concludes that these incapable patients cannot be denied the right simply because they are unable to express their wishes. At this point, he contends, euthanasia becomes involuntary.[105]

Finally, Beam explores the international humanitarian law obligation contained in the First Geneva Convention at article 12(5) in that when the decision is made to abandon the wounded, medical staff should be left to continue with their care.[106] This matter was discussed above,[107] but Beam challenges the conventional view, arguing that intelligence reports of the alleged execution of the wounded are nothing more than propaganda and that the enemy may well honour the Geneva Conventions and care for those who are *hors de combat* and respect them and the medical personnel remaining behind to take care of them.[108]

Principle of Beneficence

In examining this principle, Beam questions whether it is always considered beneficial for the patient not to die.[109] In the scenario is it in the patient's best interest to continue to suffer in pain, waiting for capture and an uncertain future? Beam offers no opinion other than to question the truth of the reported enemy action of killing captives.[110]

Principle of Non-maleficence

Beam continues exploring the idea that allowing a patient to die or, under the principle of non-maleficence, assisting or hastening death is considered not to be in the best interests of the patient.[111] Referencing the text of the Hippocratic oath, Beam contends

---

102 As above.
103 As above.
104 As above.
105 As above.
106 As above.
107 Fn 78-82 above.
108 Lounsbury & Bellamy 391.
109 As above.
110 As above.
111 As above.

©University of Pretoria

that physicians are proscribed from causing harm or advising on how to cause harm in a manner that hastens death.[112] Allowing a patient to continue to suffer and to face capture is against the do no harm principle.[113] Beam again offers no solution to this dilemma.

The Principle of Distributive Justice

The principle of distributive justice will be examined in depth in the next chapter. However, Beam's analysis of distributive justice entails the balancing of competing claims on limited resources.[114] Set against the extreme situation of the Swann scenario, patients are competing for limited medical resources. Those triaged as expectant are in a lower priority for care than patients who have a fighting chance of survival and evacuation.[115] Further, the operational situation cannot be ignored in that the battle continues with a definite further influx of wounded into an already constrained medical support system.[116] Beam's analysis of the extreme situation in the scenario considers the international humanitarian law obligation under which the wounded are abandoned leaving medical personnel to care for them.[117] The application of the caveat explained above in the First Geneva Convention article 12(5) that places the military situation as a deciding factor in the quantity (if at all) of medical personnel to be left to care for the wounded is an example of the practical application of international humanitarian law obligations.[118]

2.4.6 Conclusion

Distinguishing between active euthanasia and the practice of triage on the battlefield is of primary importance to an understanding of the dilemma faced by military healthcare professionals on the battlefield. Allowing a wounded soldier to die on the battlefield because of unsalvageable injuries and lack of resources equates to passive euthanasia where nature is permitted to take its course. Actively causing the death of another remains unlawful in South Africa. Active euthanasia has been practiced on the battlefield for centuries as either a humane method of ending suffering or of avoiding

[112] As above.
[113] As above.
[114] As above.
[115] Lounsbury & Bellamy 392.
[116] As above.
[117] As above.
[118] Fn 78-82 above.

©University of Pretoria

capture and certain torture and death at the hands of the enemy. The sheer hopelessness of the condition of the wounded as described above places the military physician in an extreme situation. To this dilemma there exists no clear solution.

South African courts have considered mitigating factors when passing sentence on perpetrators of mercy killings and in all probability would show the same mercy to the military physician presented with the severe conditions faced in battle.

International humanitarian law does not specifically address euthanasia but maintains the obligation to provide care and protection for the ill, wounded and shipwrecked. No easy solution exists with reference to the topic, whether or not the situation's focus is the battlefield. Commentators such as Thomas Beam advocate preparedness by means of scenario-based training to provide the capacity for the physician to address such situations if he has the misfortune to be in such a position.

3. Doctors: Combatant or non-combatant?

3.1 Introduction

A healthcare professional may serve in the armed forces of South Africa.[119] He serves alongside his comrades in arms in the same uniform, on the same military base and under the same military laws and regulations.[120] However, is the military healthcare professional a combatant? When does his role as a healthcare professional begin? Is it only upon being called to medically manage another soldier? When executing functions not related to medical practice is he considered to be a soldier, a combatant that can be utilised in winning the battle? What if the military healthcare professional directly participates in military missions by engaging the enemy or assists in planning the attack?

3.2 Domestic and international humanitarian law

In order to establish whether a military Healthcare professional may act in a combatant role or if he is considered a non-combatant, the definitions and roles of combatant and

---

119 Ch XV of the General Regulations to the Defence Act: "Definition of a "medical officer" means 'a person entitled to practise as a medical practitioner in terms of sec17 Health Professions Act 56 of 1974)".

120 As above.

©University of Pretoria

a non-combatant must be examined.

3.2.1 Combatants

> Rule 3: All members of the armed forces of a party are combatants except medical and religious personnel.[121]

Combatants (war-fighters, soldiers, servicemen/women) are persons authorised to use force in situations of armed conflict under international humanitarian law and are legitimate military targets in times of armed conflict.[122] Their actions in causing the death or wounding of others and the destruction of property cannot be criminally prosecuted in so far as they act within the confines of the laws of armed conflict.[123] Combatants must be under the effective and lawful command of the nation's armed forces, must wear distinctive uniforms/markings, be distinguished from civilian populations and must openly display their arms (weapons).[124] The Protocols Additional to the Geneva Conventions relaxed some of the requirements for combatant status in that belligerents need not be in a distinctive uniform or wear identifying insignia.[125] The Protocols provide that combatants belong to an organised group, carry their arms openly and respect international law applicable to armed conflict.[126] When captured, combatants become prisons of war and are afforded the associated protection offered under international humanitarian law.[127]

3.2.2 Non-combatants

> Members of the armed forces of a Party to a conflict (other than medical personnel and chaplains covered by Article 33 of the Third Convention) are combatants, that is to say, they have the right to participate directly in hostilities.[128]

The status of a non-combatant is conferred upon persons who are not actively participating in an armed conflict and includes civilians, the sick, wounded and shipwrecked (who have laid down their weapons), prisoners of war, religious

121 J Henckaerts & L Doswald-Beck *Customary International Humanitarian Law* (2009) 11.
122 Art 43(2) AP I.
123 ICRC "How does law protect in war" available at https:// www.icrc.org (accessed 29 September 2022) ch 12 2.
124 Art 4 GC III, Art 44 AP I.
125 Art 44 AP I.
126 Arts 43 & 44 AP I.
127 As above and at Art 13 GC III.
128 Art 43(2) AP I.

©University of Pretoria

personnel and medical personnel[129] exclusively employed in the treatment, care, transport, and search of the wounded, sick or shipwrecked.[130] Members of the armed forces who are temporarily assigned to the care, treatment or search for the sick, wounded or ship-wrecked too are considered non-combatants during the execution of those duties.[131]

Though the term "non-combatant" is not defined in the Conventions or Protocols, the status of medical personnel not directly participating in armed conflict, the exclusive nature of their duty (treatment, search and transport of the sick, wounded and ship-wrecked) and their obligation to wear the prescribed protective symbols (red cross, crescent or diamond) exclude them from being classified combatants and as such medical personnel must be respected and protected at all times.[132] The protection afforded is lost if medical personnel commit acts harmful to the enemy.[133]

Medical personnel may not renounce their protective status[134] and also will not lose their protection if they carry arms for their protection and that of their patients.[135] Medical personnel do not become prisoners of war if captured but instead are retained exclusively on the basis for their need to continue to provide medical care.[136]

Under South African law the assignment of military healthcare professionals is addressed in the Implementation of the Geneva Conventions Act.[137] The South African National Defence Force includes a separate arm of service engaged in medical matters,

---

129 Art 8 AP I: "medical personnel" means those persons assigned, by a Party to the conflict, exclusively to the medical purposes enumerated under sub-paragraph e) or to the administration of medical units or to the operation or administration of medical transports. Such assignments may be either permanent or temporary. The term includes:
(i) medical personnel of a Party to the conflict, whether military or civilian, including those described in the First and Second Conventions, and those assigned to civil defence organizations;
(ii) medical personnel of national Red Cross (Red Crescent, Red Lion and Sun) Societies and other national voluntary aid societies duly recognized and authorized by a Party to the conflict;
(iii) medical personnel or medical units or medical transports described in Article 9, paragraph 2.

130 Art 24 GC I.

131 Art 25 GC I.

132 As above and Art 40 GC I.

133 Art 21 GC I.

134 Art 7 GC I.

135 Art 22 GC I.

136 Art 28 GC I.

137 Sec 17 Act 8 of 2012.

©University of Pretoria

the South African Military Health Service (SAMHS).[138] By virtue of their being a member of the SAMHS, its personnel are protected as contemplated under the Conventions[139] as long as the SAMHS member is engaged exclusively in the treatment, care, search, collection or preventive, administrative and evacuation tasks described in the Conventions.[140] By virtue of their protected status, confirmed by the protective symbol of the red cross and the compulsory carrying of an identity card displaying the red cross, no SAMHS member may be utilised in any capacity other than those mentioned in article 24 of the First Geneva Convention.[141] Nor may a SAMHS member revoke, whether partially, temporarily or in full, his status as a protected person.[142]

3.3 The doctor as combatant

The Knights Hospitalliers of St John of Jerusalem[143] were the first organised military medical officers. Their conduct during the 11th century Crusade was that of defenders of hospitals against enemies of the faith.[144] During the day the knights actively participated in combat and at night their role changed to dressing and caring for the wounded regardless of to which side in the battle they belonged.[145] In recognition of this the first military medical order, the SAMHS has as its emblem the Maltese cross used by the Knights of the Order of St John.

In recognition of the military service of medical doctors, the United States of America has bestowed upon three doctors their highest military decoration for valour in battle,

---

[138] Secs 4A(e) & 12(d) Defence Act, 2002 together with the General Regulations to the Defence Act at Ch XV, Medical Matters.

[139] Sec 17(1) Implementation of the Geneva Conventions Act, 2012. Note that the wearing of the Red Cross is for all "personnel" of the SAMHS (sec 17(2)) and not restricted to medical personnel. Support staff such as drivers, administrators, catering and so forth must comply with the provisions as well and are afforded the same protection (with the corresponding obligations) under international humanitarian law. Religious personnel also are specifically included.

[140] Art 24 GC I, Art 36 GC II, Art 33 GC III, Art 8(c) AP I and Art 9 AP II.

[141] Sec 17(2) Implementation of the Geneva Conventions Act, 2012:
"Personnel of the Military Health Services and religious personnel of the South African National Defence Force must wear armlets and carry identity cards issued by South African National Defence Force displaying the red cross".

[142] Art 7 GC I: "Wounded and sick, as well as members of the medical personnel and chaplains, may in no circumstances renounce in part or in entirety the rights secured to them by the present Convention, and by the special agreements referred to in the foregoing Article, if such there be."

[143] Latin: Ordo Fractrum Hospitalis Sancti Loannis Hierosolymitani

[144] H Nicholson *The Knights Hospitaller* (2001) 6.

[145] EA Vastyan "*Warfare: Medicine and war"*in WT Reich (ed) *Encyclopedia of Bioethics* (2nd ed) Vol) 4 1695-1699.

©University of Pretoria

the Medal of Honour. Dr Bernard JD Irwin, an assistant surgeon, took command of troops in an attack on indigenous American Indians in 1861; Jacob F Raud took part in repelling an offensive by enemy troops in the battle of Hatchers Run, Virginia in 1865; and Dr Leonard Wood, a Harvard medical school graduate and civilian contracted surgeon in the United States Army, carried dispatches while commanding troops in 1886. Dr Wood was later promoted to the rank of Major General and served not as a doctor but as a military commander.[146]

The above represent examples of a significant dichotomy military healthcare professionals face today. Although they pre-date modern international humanitarian law, the actions of these knights today would be unlawful.[147] Under modern law medical practitioners employed in the medical support role lose their protected status if they act in a combat role.[148] It has been established that if a military healthcare professional is assigned exclusively to the care, transport, treatment and search for the sick, wounded and shipwrecked, then renouncing that assignment is not permitted.[149] It remains an issue if the military healthcare professional at the onset of armed conflict is not assigned to the exclusive role described above or if a military medically qualified (and duly registered) professional is utilised as a combatant by the command elements of the military.

In the SANDF military healthcare professionals serve in a dedicated and separate arm of service, the SAMHS,[150] but that does not preclude a medically qualified and registered person voluntarily serving in another arm of service (Army, Navy or Air Force). However, then the member may not be utilised in a medical support capacity, whether directly or indirectly, and is considered a combatant and would have to change his SAMHS uniform for that of another arm of service.[151]

Two examples exist in South African military history where doctors have acted in combatant roles. The first is Lieutenant General (Dr) VJ Ramlakan, former Surgeon General of the SANDF and, second, Brigadier General (Dr) W Basson. General Ramlakan applied for amnesty for his combatant role against the armed forces of South

146 Lounsbury & Bellamy 303-304.
147 Art 7 GC I.
148 Art 43 AP I & Art 24 GC I.
149 Fn 134 above; Art 7 GC I.
150 Fn 138 above.
151 Fn 139 above.

©University of Pretoria

Africa during the 1980s. Ramlakan, as member of the African National Congress' Umkhonto WeSizwe, was directly involved in planning military actions against the South African government. The General was apprehended, prosecuted and was incarcerated on Robben Island until his release in the early 1990s. Ramlakan appeared before the Truth and Reconciliation Commission (TRC) and was granted amnesty for his actions that led to the destruction of property and injury to civilians under Operation Butterfly.[152]

Brigadier General (Dr) W Basson was the appointed head of the then South African Defence Force (SADF) Chemical/Biological research project under Project Coast.[153] Basson stood trial before the High Court on charges of murder, attempted murder, fraud, possession of narcotics and dealing in narcotics.[154] The charges emanated from Basson's time in the SADF under Project Coast. The trial lasted longer than 300 days and Basson was acquitted on all charges.[155] Basson was also brought before the Health Professions Council of South Africa (HPCSA) to face allegations of unprofessional conduct.[156] Following the HPCSA's ruling against Basson the matter was taken on review by counsel representing Basson and the HPCSA has yet to reinstate disciplinary proceedings. Basson's involvement in military research will be scrutinised later in this chapter.

The involvement of uniformed military healthcare professionals on opposite sides of the political spectrum and the resultant outcomes illustrate the consequences of forsaking medical ethics in favour of military objectives. Both practitioners were prosecuted, however only Basson suffered additional professional conduct procedures at the behest of the HPCSA.

3.4 Conclusion

The status that is conferred upon the healthcare professionals of an armed force together with the domestic law provisions contained in the Implementation of the

---

152 Truth and Reconciliation Commission Hearing 4 September 2000, matter LM77, available at www.justice.gov.za/trc/amntrans/2000/200904db.htm (accessed 30 September 2022).

153 C Gould & P Folb *Project Coast: Apartheid's chemical and biological warfare programme* (2002) 19.

154 *S v Basson* 2000 (4) SA 479 TPD.

155 *S v Basson* 2000 JDR 0059 (T), *S v Basson* 2000 (1) SACR 1(T) 17.

156 More than 40 doctors lay the charges against Basson in 2007 available at http://www.iol.co.za/news/politics/trc-evidence-at-basson-hearing (accessed 30 September 2022).

©University of Pretoria

Geneva Conventions Act of 2012 clearly intend a non-combatant role for members of the military health service, as may be seen from sections 17(1) and 17(2) The non-combatant role is perpetual throughout the exclusive direction of the healthcare professional in the service of the armed forces and this function commences once the doctor is appointed in the National Defence Force. The non-renouncement of medical duties precludes the military healthcare professional from partaking directly in actions that could be harmful to the enemy and the bioethical principle that obliges non-maleficence remains intact. As well as the Geneva Conventions conferring protection on medical practitioners exclusively tasked with the search, evacuation and care for the wounded, the Implementation of the Geneva Conventions Act requires all members of the SAMHS to don the protective red cross, whether in times of peace or armed conflict. The role as a military healthcare professional (including any support function executed by other SAMHS members), nevertheless, is by virtue of being a member of that arm of service (SAMHS).

Military healthcare professionals are utilised in the planning of military operations within the scope of providing medical support and all the consequences of such support on and beyond the battlefield. Utilising a healthcare professional in a combatant role would require the member to vacate their post within the Military Health Service and serve in another arm of service such as the Army, Navy or Air Force. Despite their being a qualified healthcare professional, their function would not be that of caring for the ill and wounded but rather a specific combatant role. Further, despite SAMHS personnel being protected by virtue of their appointment and protective insignia, direct participation in offensive actions has the effect of the loss of protection. Perfidious conduct carried out while under the protective insignia is considered a grave breach of international humanitarian law.[157]

4. Manufacturing harm: Military healthcare professionals and weapons development

4.1 Introduction

If the basis for ethical practice in medicine is to benefit those who seek medical care

[157] Art 85(3)(f) AP I.

©University of Pretoria

and to endeavour to not cause harm, it raises questions about the active participation of doctors in the development of weapons of war. Does a doctor owe a duty of non-maleficence to everyone or does the principle arise only upon entering the doctor-patient relationship? The following section examines a controversial aspect of military medical practice, that of direct participation in militarily useful research and development.

Sidel and Levy purport that due to healthcare professionals' ethical obligation to "do no harm", they should not be involved in the manufacture or development of weapon systems.[158] Further, the participation of healthcare professionals in the development of a defensive means to counter offensive weapons is to be undertaken only with the clear separation of their ultimate utility.[159] Withdrawal from such projects is permitted if the healthcare professional objects ethically to an often-arbitrary distinction between offensive and defensive weapon development.[160] An example of a notorious (and on-going) example of a physician actively participating in militarily useful research and development is found close to home.

Brigadier General (Dr) Wouter Basson is a practicing medical specialist in the fields of internal medicine and cardiology.[161] As former head of the then SADF chemical biological programme, Project Coast, Basson faced criminal prosecution and an unprofessional conduct inquiry by the HPCSA.[162] The inquiry at the time of drafting is on going.

4.2 Prosecution of Dr Wouter Basson

Basson's career as a military healthcare professional commenced in 1979. Later the young doctor was recruited into the SADF's chemical biological programme, Project Coast.[163] Basson completed postgraduate study in internal medicine as well as physiological chemistry.[164] These skills, together with Basson's considerable intellect,

[158] Lounsbury & Bellamy 305.
[159] As above.
[160] As above.
[161] Health Professions Council of South Africa *Register Dr Wouter Basson* available at https://www.hpcsa.co.za (accessed on the 15 October 2022).
[162] *S v Basson* 2000 (4) SA 479 (T).
[163] Gould *et al* 41. Project Coast was the SADF's chemical biological program, established to develop weaponised deterrents for use in the Namibian/Angola war and against so-called terrorists engaged in the popular uprising against the apartheid government.
[164] As above, 43.

©University of Pretoria

resulted in his meteoric rise in the SADF and culminated in him holding the rank of a Brigadier. Basson was in charge of medical staff operations and research in the then South African Medical Services (SAMS).[165] His military career ended in 1993 due to the closure of Project Coast but he was later reinstated, as a security measure, by the newly-established democratic government purportedly to "keep an eye on him".[166]

Basson was arrested on 29 January 1997 on charges of dealing in ecstasy tablets and being in possession of secret documents pertaining to the erstwhile chemical biological project.[167] The following year Basson testified at the Truth and Reconciliation Committee (TRC) regarding Project Coast.[168] The testimony, together with a multitude of additional evidence, lead the TRC to submit in their findings a vast range of violations of human rights and other crimes which ultimately resulted in the prosecution of Basson.[169]

Basson faced 67 charges, ranging from 229 counts of murder, attempted murder, fraud, assault with the intention to do grievous bodily harm, possession of ecstasy tablets and the distribution of narcotics.[170] After a lengthy trial, Basson was acquitted on all charges in April 2002.[171] The state took the matter on appeal to the Supreme Court of Appeal (SCA) where the appeal was dismissed and, in a later action in the Constitutional Court it was found that the trial court had erred in law in terms of section 18(2) of the Riotous Assemblies Act 17 of 1956, in that the court did not have the power to adjudicate on a conspiracy within South Africa to commit an offence beyond the borders. The SCA set aside the High Court judgment (which acquitted Basson on six charges of conspiracy to commit murder).[172] The other appeals were dismissed.

The criminal trial, significant as it is in South African jurisprudence and for the prosecution of crimes against humanity, will not be discussed but rather attention is paid to the appearance of Basson on charges of unprofessional conduct at the HPCSA.

---

165 As above.
166 Gould 210.
167 As above, 243; JA Singh "Project Coast: eugenics in apartheid South Africa" (2008) 32 *Endeavour* 5-9 available at https://www.sciencedirect.com (accessed 15 October 2022).
168 Singh 7.
169 As above.
170 *S v Basson* 2000 (4) SA 479 (T).
171 Singh 7 & Gould 240.
172 *S v Basson* 2003 (3) All SA 51 (SCA) and *S v Basson* 2005 (12) BCLR 1192 (CC) 1.

©University of Pretoria

4.3 Professional conduct: Dr Wouter Basson and the HPCSA

4.3.1 The professional conduct inquiry

The HPCSA is established as a juristic person by the Health Professions Act[173] to function (*inter alia*) to serve and protect the public in matters involving the rendering of services by those registered under the Act and to uphold and maintain professional and ethical standards in the health profession.[174] The HPCSA is charged with the investigation of complaints against members registered under the Act and with ensuring appropriate disciplinary action is taken against transgressors.[175] Matters decided as being unprofessional conduct[176] carry a sanction that ranges from a reprimand to removal from the respective professional board's roll.[177]

Complaints received by the HPCSA with reference to the professional conduct of Basson and his involvement in the SADF's chemical biological programme prompted investigation by the Council.[178] Basson was accused of unprofessional behaviour because, while registered as a medical practitioner with the HPCSA and its predecessor, the South African Medical and Dental Council (SAMDC), he led a process where chemical substances for warfare were manufactured, weaponised and provided for use in combat, kidnapping and suicide.[179] The charges were:

- During or about the period 1986 to 1988 and in 1992, as project officer of Delta G, Basson coordinated the production of the following drugs and teargases on a major scale:

  Methaqualone (mandrax) - a sedative drug;

  MDMA (Ecstacy) - a semi-synthetic entactogen of the phenethylamine family considered a recreational drug;

---

173 Sec 2 Health Professions Act, 1974.

174 Sec 3.

175 Sec 3(n).

176 The Health Professions Act's definition of unprofessional conduct: "means improper or disgraceful or dishonourable or unworthy conduct or conduct which, when regard is had to the profession of a person who is registered in terms of this Act, is improper or disgraceful or dishonourable or unworthy".

177 Sec 42 Health Professions Act, 1974.

178 GJ Annas "Medical ethics and human rights in wartime" (2015) 105 *South African Medical Journal* 240.

179 J Hugo "Dr Wouter Basson: The HPCSA's professional conduct committees ruling" Politicsweb 19 December 2013 available at https://www.politicsweb.co.za/documents/dr-wouter-basson-the-hpcsas-professional-conduct-c (accessed 17 October 2022).

©University of Pretoria

BZ - an incapacitating agent;

CS - a teargas, which causes the eyes to sting and water; and

CR - an eye irritant (teargas), more potent but less toxic than CS.

- During the 1980s as Project Officer of Project Coast and on the direct instructions of the Chief of the South African Defence Force, Basson was involved in weaponising thousands of 120 mm mortars with teargas; and supplying them to allies of the South African government.
- During or about 1983 to 1989 Basson on two to four occasions provided disorientation substances for over-the-border kidnapping (or "grab") operations, where the substances were used to tranquilise the person to be kidnapped.
- During 1982 to 1989 Basson made available cyanide capsules to special operational officers for distribution to members of specialised military units for suicidal usage.

Each of the charges was based on evidence provided under oath by Basson in his criminal trial. Exact pages and lines of this evidence were selected and agreed to before the inquiry. These facts are not in dispute. In the evidence led during the hearing of the inquiry, however, numerous factual disputes were debated.

Basson maintained his innocence throughout the proceedings.[180] The Professional Conduct Committee (PCC or Committee) heard evidence from expert witnesses that included medical ethics specialists, a former Surgeon-General and other medical experts.[181] The Committee pronounced on the evidence and arguments before it and delivered its findings in December 2013. The Committee considered that the breaches of medical ethics amounted to unprofessional conduct.[182] The Committee adjourned to consider an appropriate sentence. Counsel representing Basson learnt that two of the members of the PCC were also members of the South African Medical Association (SAMA), one of the complainants in the matter, and launched an urgent application for

180 As above.
181 As above.
182 As above.

©University of Pretoria

the recusal of these members.[183] The two members refused to recuse themselves and several court actions ensued initiated by Basson that accumulated in the SCA setting aside the findings of the High Court, which had denied a review application based on bias of the PCC.[184]

In March 2019 the High Court granted the relief sought by Basson.[185] Following the applications launched by Basson, a further comedy of errors was produced, which ultimately led to the High Court finding bias on the part of the PCC, and setting aside their findings with the effect that the HPCSA would have to reinstate proceedings for unprofessional conduct *de novo*.[186]

4.3.2 Defences raised in the professional conduct inquiry

Regardless of the challenges related to the irregularities experienced during the disciplinary hearing, the defences raised by Basson in response to the charges of unprofessional conduct are significantly important to understanding the dichotomies of ethical practice in service of the armed forces. Basson's opinion is that his actions were not unprofessional due to the following arguments raised in response to the charges.[187]

The alleged unprofessional conduct occurred during armed conflict

Basson described the armed conflict in the then South West Africa (SWA) and in Angola.[188] The use of chemical and biological warfare by enemy forces was attested to by the then Surgeon-General, Knobel.[189] In response, South Africa initiated Project Coast to counter the threat.[190] This argument is based on military necessity and was rejected by the PCC.[191] Basson relied on the testimony of Surgeon-General Knobel and the General, in turn, relied on the writings of Professor Michael Gross who maintains that medical ethics are different during times of war.[192] The PCC heard testimony from Professor Steven Miles who referred to the World Medical Association's (WMA)

---

183 Available at www.iol.co.za/news/south africa/gauteng/basson-uses-loophole-to-delay-sentencing 1865040 (accessed on 5 October 2022).
184 Hugo (fn 179).
185 *Basson v Hugo and Others* 2018 (1) All SA 621 (SCA) 27.
186 *Dr Wouter Basson v Professor JFM Hugo and two Others* (GP) Case no 29967/2015 (38); "HPCSA's comedy of errors in disciplinary pursuit of Dr Death" *Juta Medical Brief* 3 April 2019 available at www.medicalbrief.co.za (accessed 17 October 2022).
187 Hugo (fn 179).
188 As above.
189 As above.
190 As above.
191 As above.
192 ML Gross *Bioethics and armed conflict Moral dilemmas of medicine and war* (2006) 323-332.

Regulations in times of armed conflict.[193] The World Medical Association declared medical ethics in times of war to be the same as medical ethics in peacetime.[194] This declaration was repeated throughout the inquiry and formed the basis of the finding of unprofessional conduct by the PCC.[195]

Basson was under military instruction and supported by senior doctors

Basson argued that he was acting under the direct orders of his superiors, including senior doctors (Surgeon-General Nieuwoudt and Surgeon-General Knobel).[196] He claimed these generals were men of integrity that would not have ordered unlawful or unethical practices. Basson thus considered their instruction lawful and ethically sound. It is noteworthy that the defence of acting under orders was a defence used in the Nuremberg doctor's trial of the Nazi doctors.[197] The Nuremberg tribunal rejected this defence as did the HPCSA's PCC. The PCC concluded that the healthcare professional is responsible as an individual for his actions.[198] The PCC used the example of doctors who defied state medical protocols and prescribed anti-retroviral drugs to infants born to HIV positive mothers.[199] Further, the PCC had not heard evidence that Basson disagreed with his superiors and concluded that he had supported them.[200] It must be noted that the Surgeon Generals from whom Basson claimed to have received these orders also were medical doctors duly registered with the HPCSA (or their predecessor, the SAMDC). However, unprofessional conduct charges were not pursued against them, nor did the HPCSA add them as accused in the inquiry.[201]

Basson was acting in his capacity as a soldier and not as a medical doctor

Basson maintained throughout his testimony that he was acting as a soldier and not as

---

193 World Medical Association *Regulations in times of armed conflict and other situations of violence* (rev 63rd WMA Assembly, Thailand October 2012).
194 As above.
195 Hugo (fn 179).
196 As above.
197 E Shuster "Fifty years later: The significance of the Nuremberg Code" (1997) *New England Journal of Medicine* available at https://www.nejm.org/doi/full/10.1056/nejm199711133372006 (accessed 10 October 2021); Complete transcript of the Nuremberg Medical Trial: United States v. *Karl Brandt et al* (Case 1) Washington, DC National Archives, 21 November 1946 – 20 August 1947 (Microfilm publication M887).
198 Hugo (fn 180).
199 *Minister of Health and Others v Treatment Action Campaign and Others (*No 2) (CCT8/02) (2002) ZACC 15; 2002 (5) SA 721 (CC); 2002 (10) BCLR 1033 (CC) 5 July 2022.
200 Hugo (fn 179).
201 As above.

©University of Pretoria

a medical doctor.[202] This argument relates closely with the above in that orders given by senior or superior officers (doctors) were being followed. The argument addresses the crux of this thesis which is to examine the dichotomy whether military healthcare professionals are seen as soldiers first (thus discharging their obligation to the collective and to obeying orders) or doctors first (bioethical principles override military orders). The PCC noted that Basson had contradicted himself in that he claimed to have been acting as a military doctor.[203] The PCC stated that Basson would have had to deregister as a medical doctor in order to pursue his role as a soldier. Having medical doctors deregister as doctors to partake in combatant roles is a perversion of the profession. The question remains that after a deregistered doctor leaves the employ of the military would he be permitted to reregister and again begin practicing as a doctor? The PCC concluded that Basson was subject to medical ethics despite being a military doctor.

Military doctor ethics differs from civilian doctor ethics

In his argument Basson reiterates that as a military doctor his obligation is towards the South African citizen and not the "target".[204] Knobel testified that medical ethics is different in times of war from medical ethics in a civilian context. His reasoning again is based on the writings of Michael Gross. Knobel substantiated his argument by explaining that military personnel do not have autonomy in decision-making and that the prevailing circumstances caused bioethical principles to be overridden by military necessity.[205] The arguments used here largely mirror those used in the argument that Basson was acting in his capacity as a soldier and not as a doctor. The PCC rejected this argument and stated that medical ethics remain intact regardless of the prevailing situation. This view is based on the testimony of Steven Miles and the World Medical Association's Guidelines for Medical Ethics in Armed Conflict.[206] In order to practice medicine in the armed forces and particularly in the SANDF the medical officer has to

---

[202] As above.
[203] As above: "my concern, as a military doctor, is for South African citizens".
[204] As above. Basson uses the word "target" in describing enemy combatants and other persons who received the brunt of the developed weapons.
[205] As above.
[206] As above.

©University of Pretoria

register with the HPCSA.[207] By virtue of being registered with the HPCSA the medical officer is subject to the statutory regulator's prescripts.[208] No regulation (or ethical guideline) distinguishes between civilian and military doctors.

No doctor-patient relationship existed

Basson and Knobel claimed a lack of a doctor-patient relationship in that the "targets" of the weaponised chemicals were not his (Basson's) patients and Basson cannot be accountable for the consequences of the actions taken by the defence force.[209] The PCC quoted the WMA in the 1975 Tokyo Declaration[210] regarding the use of the term "victim" where the respondent uses the term "target". The declaration states:

> The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedure is suspected, accused or guilty, and whatever the victim's belief or motives, and in all situations including armed conflict and civil strife.

The PCC stated that when doctors are involved in decisions and actions that impact on the lives of people, responsibility cannot be denied simply on the basis that no direct doctor-patient relationship exists.[211]

These matters are central when considering when a doctor is bound by medical ethical principles. Doctors are functioning members of society and have lives and experiences outside of their profession. Is the doctor (or any healthcare professional) always "switched on" or "on duty"? When does the obligation to treat begin? When does the doctor-patient relationship begin entailing the application of the legal and ethical principles to which a doctor is bound?

Central to Basson's defence before the PCC was that no doctor-patient relationship existed between Basson and the "targets".[212] Basson contended that his involvement in developing weapons excluded the doctor-patient relationship and a breach of his duty

---

207 Ch XV of the General Regulations to the Defence Act, 2002: Definition of a "medical officer" means 'a person entitled to practise as a medical practitioner in terms of sec 17 Health Professions Act, 1974".

208 Sec 17 Health Professions Act, 1974.

209 Hugo (fn 179).

210 WMA *Declaration of Tokyo – Guidelines for physicians concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention or imprisonment* (1975).

211 Hugo (fn 179).

212 As above.

©University of Pretoria

of care was not applicable.[213]

In South Africa the doctor-patient relationship is one of consent, contract and the obligation to treat.[214] Consent is gained by way of the patient approaching the doctor and accepting treatment, either tacitly (conduct by action or verbal agreement) or expressly (in situations involving invasive procedures such as surgery).[215] There is no obligation on the private practice physician to accept a patient but once he has, the treatment must be completed.[216]

Military doctors are employed by the state and have less choice in the patients they treat.[217] The military doctor's patient base consists of employed members (soldiers), their dependants (family) and other authorised persons.[218] Additional to this patient population, the military doctor is obliged to treat the wounded, sick and shipwrecked of belligerent forces (friend or foe) encountered on the battlefield.[219]

Reliance on the argument that no doctor-patient relationship exists (at the least) is understandable, but the argument is flawed. Basson's actions, in fact, fall short of the ethical obligations that encompass the doctor-patient relationship in that no patients were accepted (or rather assigned) to him. His actions were aimed at developing weapons. His argument is further refuted by the ethical obligations created by the Declaration of Geneva[220] and the World Medical Association's Regulations in times of Armed Conflict.[221] It is of no consequence that a patient-doctor relationship was not in

---

213 As above.

214 M Slabbert & M Labuschaigne "Legal reflections on the doctor-patient relationship in preparation for South Africa's National Health Insurance" (2022) 15 *South African Journal of Bioethics and Law* 31.

215 As above.

216 As above. Treatment commenced can be terminated only if the patient is handed over to another doctor, the doctor instructs the patient on the treatment plan, the patient is discharged from care because he has been cured or the patient terminates the relationship by withdrawing consent.

217 As above.

218 Ch XV Part II General Regulations to the Defence Act, 2002.

219 Art 12 GC I; Art 12 GC II; Art 15 GC III; Art 10 AP I; and Art 7 AP II.

220 Physician's oath: "At the time of being admitted as member of the medical profession: I solemnly pledge myself to *consecrate my life to the service of humanity*… I will practice my profession with conscience and dignity… *I will maintain the utmost respect for human life* from the time of conception, even under threat. *I will not use my medical knowledge contrary to the laws of humanity*" adopted by the General Assembly of the World Medical Association, September 1948.

221 "Medical ethics in the time of armed conflict is identical to medical ethics in times of peace… The primary obligation of the physician is his professional duty; the physicians' supreme guide is his conscience; *the primary task of the medical profession is to preserve health and save lives*. *It is deemed unethical for physicians to: give advice or perform prophylactic, diagnostic*

©University of Pretoria

existence as the above ethical principles do not specifically require such a relationship to have been established.[222]

Whatever the ethical principles contained in these documents, South Africa was a signatory to the Convention on the Prohibition of the Development, Production and Stockpiling of Bacterial (Biological) and Toxin Weapons and on their Destruction.[223] The mere act of producing and stockpiling such weapons in breach of the instrument is prohibited.

Basson was a young doctor and thus not responsible

Basson argued that he was a "young" practitioner at the time of his involvement in the chemical weapons programme and as such could not be held responsible for his actions. This argument was dismissed by the PCC, which stated that at the time of Basson's involvement in the programme he held a postgraduate degree and was a registered medical specialist in internal medicine.[224] These characteristics hardly permit Basson to be categorised as "inexperienced" or "immature". The PCC concluded by stating that regardless of experience, healthcare professionals remain accountable for their actions.[225]

Basson was not aware of codes and conventions that barred chemical weapons manufacture and the use of medicine for non-therapeutic purposes

Basson and Knobel both claimed not to have knowledge of the conventions and ethical prescripts regarding chemical weapons. The PCC heard evidence from Professor Steven Miles, who concisely provided the relevant conventions and declarations that had regard to a physician's obligations and the development, stockpiling and use of chemical and biological weapons.[226] The PCC concluded that Basson, as a responsible practitioner involved in a specialised field of chemical biological warfare, should have familiarised himself with the applicable legislation, conventions and ethical

or therapeutic procedures that are not justifiable in the patients interest, weaken the physical or mental strength of a human being without therapeutic justification and employ scientific knowledge to imperil health or destroy life. Privileges and facilities afforded to the physician must never be used for other than professional purposes" World Medical Association *Regulations in times of Armed Conflict*, 1956 and 1983.

[222] As above.

[223] Of 1975.

[224] As above.

[225] As above.

[226] As above.

©University of Pretoria

prescripts.[227] Ignorance thus could not succeed as a defence.

Ethics of the 1980s were different from ethics today

Professor Benatar in support of this argument claimed that medical ethics (especially medical ethics in research) was not well known in the 1980s and had developed considerably since then.[228] Professor Benatar's testimony relied on the acquittal of Basson on the charges of unprofessional conduct with regard to his involvement in research and claimed that the same principle should be applied in respect of the other charges of unprofessional conduct.[229] The PCC did not support this claim and motioned that a healthcare professional ought to have knowledge of medical ethics in the Hippocratic Oath and in subsequent developments such as the WMA's Declaration of Geneva.[230] The PCC made use of the example of doctors who broke the law under apartheid policies in support of medical ethics by not declaring to the security forces the condition/status/identity of patients they treated and by circumventing military conscription.[231]

The chemical substances developed were non-lethal and were designed to protect life

Basson explained that substances that were developed were not intended to kill but rather to disorientate and weaken. By so doing, he claimed, lives were spared.[232] Professor Miles rebutted these claims by testifying that the substances produced did not correspond to a therapeutic purpose but rather aided military operations (such as sedatives to effect "grab" operations).[233] In the opinion of Miles, it resulted in Basson confounding the ethics of being a soldier with those of medicine while retaining his licence to practice medicine.[234] Miles testified that the substances produced (especially teargas and other agents) could be lethal if administered to persons in confined spaces or to individuals with pre-existing conditions such as respiratory conditions.[235] Despite these dangers, the substances developed by Basson were administered without consent

[227] As above.
[228] As above.
[229] As above.
[230] As above.
[231] As above.
[232] As above.
[233] As above.
[234] As above.
[235] As above.

©University of Pretoria

and for military purposes.[236]

The allegation that Basson supplied cyanide to special forces operators to ingest in the event of capture was lambasted by Miles as being not only unethical (Basson had no knowledge of the physical or psychological condition of the soldiers) but also misguided in the assumption that a quick death ensues.[237] The PCC dismissed this defence on the basis that although death may not have been contemplated, the maleficence nature of Basson's actions was contrary to bioethical principles.

4.4 Conclusion

The inquiry into the unprofessional conduct of Dr Basson addresses a controversial breach of ethical principles being, first (above all), do no harm. The maxim, not included in the original Hippocratic oath, was first observed in the 19th century in the writings of Thomas Inman.[238] Gillon claims the maxim's origin lies in the Hippocratic corpus, the *Epidemics,*[239] and a subsequent English translation: "As to diseases make a habit of two things, to help, or at least, to do no harm".[240] Omonzejele explains that the doctor-patient relationship is fiduciary in that the patient trusts that the doctor will apply his knowledge to the benefit of the patient.[241] The patient trusts that the doctor in the execution of his duty will bring no harm.[242] This uncomplicated description may well explain the unethical conduct of Basson in participating in research and development of military use. In the development of biochemical weapons, the supply of lethal and non-lethal medications and substances and the production of narcotics, Basson did not exercise the above in a pure doctor-patient relationship, however, using his medical and chemical knowledge and training he created a means that had military application.

5. Ethics abandoned: Doctors and torture

---

236 As above.
237 As above.
238 DK Sokol "'First do no harm' revisited" (2013) 347 *British Medical Journal* 23.
239 AR Jonsen "Do no harm: Axiom of medical ethics" in SF Spicker & HT Engelhardt (eds) *Philosophical medical ethics: its nature and significance* (1977) 27-41.
240 R Gillon "*Primum non nocere* and the principle of non maleficence" (1985) 291 *British Medical Journal* 130-131
241 PF Omonzejele "Obligation of non-maleficence: Moral dilemma in physician-patient relationship" (2005) 4 *Journal of Biomedical Sciences* 22-30.
242 As above.

©University of Pretoria

> The object of terrorism is terrorism. The object of oppression is oppression. The object of torture is torture. The object of murder is murder. The object of power is power. Now do you begin to understand me?[243]

5.1 Introduction

Michael Gross expresses the powerful dictum by Anthony Zwi[244] in his description of doctors who either perform or partake in torture.[245] Zwi considers the participation of healthcare professionals in torture as the "most explicit violation of the basis of medical practice".[246] Every dictum that forms the basis of their practice is contradicted; transforming care and ameliorating suffering to causing pain and suffering.[247] Gross concludes that Zwi's dictum on torture raises two arguments; first, for physicians to be involved is wrong and, secondly, torture in itself is always wrong.[248] Yet the ancient and modern history of man is rife with acts of torture, whether committed during armed conflict or not. The examination of torture, including cruel, inhumane, degrading treatment and punishment is worthy of its own study. In this section only the direct and indirect involvement of military healthcare professionals in torture (including cruel, inhumane, degrading treatment and punishment) as relating to the bioethical principle of non-maleficence will be discussed.

5.2 South Africa: Torture, cruel, inhumane, degrading treatment and punishment

5.2.1 Steve Biko

South Africa's history is stained with accounts of torture by the security forces and other parties but none is so infamous as the involvement of doctors in the torture and death of Steve Biko.[249] Biko, an anti-apartheid activist, was apprehended and taken into custody by South African security forces and subsequently died in detention in September 1977.[250] The district doctors who attended to Biko before his death were found to have falsified medical reports, failed to conduct a proper medical

243 George Orwell *1984* (1949).
244 ML Gross *Bioethics and Armed Conflict. Moral Dilemmas of Medicine and War* (2006) 211.
245 As above.
246 As above.
247 As above.
248 As above.
249 M Eide "Stephen Biko and the Torture Aesthetic",(2014) *Ufahamu: A Journal of African Studies* 38(1) 9-11.
250 As above.

examination, allowed the security forces to be present (and ultimately influence the findings of medical reports), failed to perform the appropriate tests regarding his condition and none of the doctors who had examined Biko reported that his injuries and condition were consistent with assault.[251] It was not until 1985, and after petitioning from medical doctors, that the South African Medical and Dental Council (predecessor to the HPCSA) reopened professional conduct investigations against the doctors involved in the treatment of Steve Biko while in detention.[252] Though they were not military healthcare professionals, the doctors were in the employ of the state and worked with the security forces (police and correctional services officials).

5.2.2 Domestic legislation and torture

The political upheavals in South Africa of the late 1980s and early 1990s brought in a new era for the protection of human rights that includes the prevention and combating of torture. The South African Constitution, 1996 provides the right neither to be tortured nor to be treated/punished in a cruel, inhumane or degrading way.[253]

The Prevention and Combatting of Torture of Persons Act 13 of 2013 gives effect to South Africa's international law obligation in respect of the United Nations Convention against Torture and other Cruel, Inhumane or Degrading Treatment or Punishment (CAT).[254] The Act recognises the "shameful" history of South Africa regarding human rights violations and criminalises the act of torture, and prescribes the sanctioning of transgressors.[255] The Act defines torture[256] and specifically excludes the defence of acting under the command of a superior official for any act of torture committed.[257] Further, no exceptional circumstances justify the use of torture, whether under the threat of war, during armed conflict, a state of national security, internal political instability or a state of emergency.[258] The statute of limitations for the prosecution of perpetrators was extended beyond 20 years in an amendment to the

---

251 L Baxter "Doctors on trial. Steve Biko, Medical ethics and the Courts" (1985) 1 *South African Journal on Human Rights* 137.
252 K Moodley "History of Medicine: Dual loyalties, human rights violations and physician complicity in apartheid South Africa" (2015) 17 *American Medical Association Journal of Ethics* 966-972.
253 Sec 12(d-e) Constitution, 1996.
254 Preamble, Prevention and Combatting of Torture of Persons Act 13 of 2013.
255 As above.
256 Sec 3 Prevention and Combatting of Torture of Persons Act, 2013.
257 Sec 4(3).
258 Sec 4(4).

©University of Pretoria

Criminal Procedure Act.[259]

The Implementation of the Geneva Conventions Act of 2012[260] makes it an offence to contravene the provisions in the Conventions and Protocols concerning torture. Not only does the Act describe sanction for the commission of acts of torture but also penalties for a superior military officer who fails to prevent breaches of the Conventions and Protocols.[261] Torture is considered a grave breach of the Conventions and Protocols and carries extra-territorial prosecution for South African perpetrators.[262]

5.2.3 International law and torture

Geneva Conventions and Additional Protocols

As discussed above torture, including cruel, inhumane and degrading treatment, is prohibited under the Conventions and the Protocols.[263] The obligation not to commit acts of cruel, inhumane, degrading treatment and torture rests on all belligerents, including medical personnel.[264]

Convention against Torture and other Cruel, Inhumane or Degrading Treatment or Punishment (CAT)[265]

The convention recognises the inherent right to dignity, freedom, justice and peace of all persons of the human family. It recognises the obligations created under the UN Charter, the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights. The Convention was signed by South Africa on 29 January 1993 and subsequently ratified in December 1998. In September 2006 South Africa signed the Optional Protocol to the Convention against Torture and other Cruel, Inhumane or Degrading Treatment or Punishment (the Optional Protocol strengthens the original CAT) and ratified it in March 2019. South Africa has accepted the functions of the Subcommittee for the Prevention of Torture in that states can be visited where detention centres are located to examine the treatment of persons held

---

259 Criminal Procedure Act 51 of 1977.
260 Implementation of the Geneva Conventions Act 8 of 2012.
261 Secs 5(3) & 6(1).
262 Sec 5(2).
263 Common Art 3 of the Geneva Conventions; Art 12 & 50 GC I; Art 51 GC II; Arts 17, 87, 130 GC III; Arts 32 & 147 GC IV; Art 75 API; Art 4 AP II.
264 As above.
265 Res 39/46, adopted 10 December 1984 and in force 26 June 1987.

©University of Pretoria

there.[266]

The prohibition of torture and other inhumane treatment is contained in numerous universal and regional human rights treaties including:

- African Charter on Human and Peoples' Rights at article 5.
- American Convention on Human Rights at article 5.
- American Declaration of the Rights and Duties of Man at article 27.
- Arab Charter on Human Rights at article 8.
- Cairo Declaration on Human Rights in Islam at articles 19 and 20.
- Convention on the Protection of the Rights of Migrant Workers and Members of their Families at article 10.
- Convention on the Rights of the Child at article 37.
- European Convention for the Prevention of Torture and Inhuman or Degrading Treatment
- European Convention for the Protection of Human Rights and Fundamental Freedoms at article 3.
- Inter-American Convention to Prevent and Punish Torture.
- International Covenant on Civil and Political Rights at articles 4, 7 and 10.
- United Nations Standard Minimum Rules for the Treatment of Prisoners at article 31.
- Universal Declaration of Human Rights at article 5.

A golden thread is weaved through all the above instruments regarding the right to freedom from torture and cruel, inhumane and degrading treatment. A part of it is the obligation on states to protect individuals from its own agents, the duty on states to prosecute offenders and the right of individuals not to be extradited (or repatriated) to states where they may be subject to torture.

Medical ethics and torture

The participation of healthcare professionals in acts of torture, cruel, inhumane, degrading treatment and punishment contradicts all bioethical principles, and none more than the principle of non-maleficence where the acts (or omissions) of the healthcare professional cause harm, whether that harm is of a temporary nature causing

266 General Assembly Resolution 57/199, 18 December 2002.

©University of Pretoria

intense pain or mildly uncomfortable, physical or psychological discord.

Medical ethics repeatedly bar healthcare professionals from participating in torture. The World Medical Association's 1975 Declaration of Tokyo,[267] the World Medical Association's International Code of Medical Ethics,[268] the United Nations 1982 Principles of Medical Ethics,[269] the International Council of Nurses', Nurses' Role in the Care of Detainees and Prisoners[270] and various international and domestic instruments proscribe this explicitly. The American Medical Association's (AMA) Code of Medical Ethics states: "physicians must not be present when torture is used or threatened".[271] Further, the Code states "physicians may treat prisoners or detainees if doing so is in their best interest, but physicians should not treat individuals to verify their health so that torture can begin or continue".[272] The WMA reinforces the above in its publication of Regulations in times of Armed Conflict and other situations of Violence.[273]

Additional soft law publications prescribe the bioethical obligations that military healthcare professionals have in relation to torture, or cruel, inhumane, degrading treatment and punishment.[274] South Africa's HPCSA publishes guideline booklets on ethical practice but, despite describing the ethical obligations intrinsic to all healthcare professionals, no specific guidelines are published for the practitioner faced with situations of torture, cruel, degrading and inhumane treatment.[275]

---

267 "The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife."

268 "A physician shall, in all types of medical practice, be dedicated to providing competent medical services in full technical and moral independence, with compassion and respect for human dignity."

269 "It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment."

270 "Nurses having knowledge of physical or mental ill-treatment of detainees and prisoners must take appropriate action including reporting the matter to appropriate national and/or

271 Available at www.ama-assn.org/delivering care/ethics (accessed 16 November 2022).

272 As above.

273 WMA *Regulations in times of armed conflict and other situations of violence* revised 63rd WMA Assembly, Thailand October 2012.

274 E Andrews *US Military medical professionals: Ethical guidelines practices and issues* (2016); ICRC *Handbook on international rules governing military operations* (2013); BMA *Ethical decision making for doctors in the Armed forces: A tool kit* (2012).

275 HPSA *HPCSA's Guidelines for Ethical Practice Booklets* (2016).

©University of Pretoria

5.3 Doctor and torturer: The dichotomy

5.3.1 Introduction

A clear contrast must exist between the doctor as an embodiment of a healer and the torturer as the inflictor of pain, suffering and even death. In depicting torturers, Hollywood seems to gravitate towards the white coat-attired doctor-villain, preparing surgical type instruments while a bound victim looks on in terror. Unfortunately, it is an example of art imitating life all too accurately, as history shows. From Josef Mengele[276] to Mahendra Chand,[277] from Hastings Banda[278] to Blagoje Simić,[279] these doctors exhibited in their actions the cruellest practices by torturing and killing.[280] The circumstances in which a doctor, trained as a healer, a conduit between sickness and health, betrays the ethics of medicine and forsakes the principle of not harming but actively (or passively) partakes in torture needs explaining. Michael Grodin and George Annas describe the psychological traits associated with torturers in an International Red Cross and Red Crescent publication.[281]

5.3.2 Psychology of the physician-torturer: Lessons from the "Nazi doctors"

Grobin and Annas examine the psychological characteristics of physicians who partake in torture in the context of social, political and cultural factors.[282] The authors use the situation as of 1933 in National Socialist Germany to describe how the German people, including educated persons such as healthcare professionals, identified with the ideology of the National Socialist German Workers Party.[283] Their analysis describes the psychology of the individual, the psychology of the group and finally the cultural and social contexts of torture perpetrators.

Individual psychological traits of the torturer

---

276 SH Miles *The Torture Doctors. Human Rights Crimes and the Road to Justice* (2020). Mengele was an Auschwitz Nazi doctor who performed inhumane experimentation on human subjects.

277 Miles xiii; Dr Chand was summoned by Guyana officials to attend to a young boy who had been tortured while being in detention. Chand provided the minimum treatment, neglecting the victim and failed to report the torture.

278 Miles 7; Banda was a US educated physician who tortured thousands in Malawi between 1961 to 1994.

279 Miles 8; Simić, a Serbian internist was convicted of torture, setting up concentration camps and other crimes against humanity in the former Yugoslavia.

280 Miles "Preface".

281 M Grodin & G Annas "Physicians and Torture: Lessons from the Nazi Doctors" (2007) 89 *International Review of the Red Cross* 635 – 653.

282 As above.

283 As above.

©University of Pretoria

Classic philosophical views of human reality dictate that everyone has the capacity to commit evil but we are constrained by order and tradition.[284] In the Romantic philosophical view, persons are intrinsically good but are spoilt by circumstance and culture.[285] Grobin and Annas conclude that people either are evil but constrained by society or moral beings corrupted to commit evil deeds by a social context.[286] They consider the tension between the Classical and Romantic views to be highly relevant in examining perpetrators of torture.[287] In addition, Grobin and Annas identify five psychological defence mechanisms that explain how the healer can act as the torturer or killer:

Dehumanisation: Of the self and others uses additional defence mechanisms (denial, repression, depersonalisation and compartmentalisation) and lets the perpetrator transcend emotions and commit heinous acts as if they are a part of normal life.[288] Dehumanisation makes the victim of torture less than human and dirty and justifies atrocious acts.[289] Grobin and Annas theorise that certain professions, such as medicine, law enforcement and the legal profession, teach a selective dehumanisation so that the professional can be detached from emotion in order to respond more efficiently to the task at hand.[290]

Splitting: A personality model that enables a person to deal with trauma by having the unconscious mind block incompatibilities with self-image and separating thought from emotions.[291] Lifton's interaction with the "Nazi doctors" describes how the dual/doubling of the self justified the actions of torturing and killing in the name of serving (or saving) the German race from the enemy.[292]

Numbing: In conjunction with splitting, numbing further removes the perpetrator from

---

[284] As above.
[285] As above.
[286] As above.
[287] As above.
[288] As above; V Bernard, P Ottenberg & F Redl ''Dehumanization: Aa composite psychological defense in relation to modern war'' in M Schwebel (ed) *Behavioral Science and Human Survival* (1965).
[289] Grobin & Annas 640.
[290] As above.
[291] As above and SW Jackson ''Aspects of culture in psychoanalytic theory and practice'' (1968) 16 *Journal of the American Psychoanalytic Association* 651–70.
[292] Grobin and Annas 641; R Lifton *The Nazi doctors: Medical killing and the psychology of genocide* (1986).

©University of Pretoria

his victim.[293] Numbing, in the manner of an anaesthetic drug, diminishes the ability to feel and in this psychological context the ability to repress emotion to the point of disavowing one's own perceptions.[294]

Omnipotence: The ideology of National Socialism reinforced one omnipotent social structure with which individual perpetrators of atrocities strongly identified.[295] Within the concentration camps, guards, executioners, torturers and doctors exhibited total control over life and death.[296]

Medicalisation: This abstraction saw the "Nazi doctors" use medical and technical skills to carry out their professional duties by convincing themselves that the use of these skills ultimately diminishes the pain and suffering of their victims by killing them.[297] The physicians became automated in their tasks, absorbed in the technical skills that efficiently caused the death of millions.[298]

Psychology of group perpetrators

Grobin and Annas approach the psychology of the group by referencing two social experiments conducted in the United States.[299] The first experiment, conducted by Stanley Milgram at Yale University, saw participants deliver electrical shocks to each other on the command of the investigator.[300] The object of the study was to show the reactions of the participants if someone else, an authority figure, instructed and took responsibility for the participants' (personal) actions even though the actions caused pain (electrocution).[301] Milgram theorised three outcomes to the obedient behaviour exhibited by his participants; the first is from learned object relations (such as the specific up-bringing of the participant at home or school), secondly, the binding feeling the participant exhibits when obeying authority and, finally, the discomfort experienced when commands are disobeyed.[302]

Philip Zimbardo's infamous prison experiment at Stanford University also described

---

[293] Grobin & Annas 641
[294] As above.
[295] As above.
[296] As above.
[297] As above, 642.
[298] As above.
[299] Grobin & Annas 642.
[300] S Milgram ''Behavioral study of obedience'' (1963) *Journal of Abnormal and Social Psychology* 371–378.
[301] As above.
[302] As above.

©University of Pretoria

how situational factors influence behaviour.[303] Students were divided into groups, either as prison guards or inmates. Zimbardo acted as research investigator and prison superintendent. The guards developed feelings of belonging, group cohesion and power. The blame for the sadistic abuse of the inmates was placed on the group and the researchers, and individual responsibility for the actions taken was lacking.[304]

Individual perpetrators of Holocaust crimes, just as the subjects of these two experiments, placed responsibility on those who had ordered them to kill or torture.[305]

Obedience to authority and the diffusion of responsibility were evident in the explanations of the 'Nazi doctors'. They did not accept individual responsibility for their actions and claimed they were obeying orders.[306] The doctors identified with belonging to a special group, an elite and being important persons in their function.[307]

The medical profession embraces both the individual and group personality traits in that for the efficient healing of the patient a dehumanised attitude is embraced so as not to be overwhelmed by emotion if the treatment outcome is not successful.[308] Splitting and numbing are coping mechanisms that are used to distance the doctor from his patient, to act scientifically, technically and, again, not to be overwhelmed by feelings in the event of regression or the death of the patient.[309] A tolerance or resilience is built up against the extreme situations faced on a daily basis. The healthcare profession, due to the control exercised over life and death situations, embraces the sensation of omnipotence.[310] This sense of power over others is a trait of the doctor.[311] This sense of omnipotence, however, must not be combined with a trait of sadism, as was the case in the actions of the "Nazi doctors".[312] The identification as a group (physicians) further encourages doctors to be vulnerable to compliance to unlawful or unethical practices out of a strong sense of belonging, as exhibited by the "Nazi doctors".[313] Grobin and Annas conclude that these defence mechanisms shifted to the extreme end

303 As above and C Haney, W Curtis Banks & PG Zimbardo ''Interpersonal dynamics in a simulated prison'' (1973) 1 *International Journal of Criminology and Penology* 69 – 97.
304 As above.
305 Grobin &Annas 644.
306 As above, 642.
307 As above.
308 Grobin & Annas 644.
309 As above.
310 As above.
311 As above.
312 As above.
313 As above, 647.

of the continuum in National Socialist ideology and caused the individual physician to be vulnerable and to identify with evil and act brutally.[314]

Cultural and social circumstances encouraging to perpetrators[315]

> anyone who wants to cure this era, which is inwardly sick and rotten, must first of all summon up the courage to make clear the cause of this disease

The wording in the writings of Adolf Hitler represents a medicalised approach in the ideology he propagated and is theorised by Grobin and Annas to represent a call to arms of medical professionals to be part of the racial purification of the German people at the moment of National Socialist political victory in 1933:[316]

> The white-coated doctor became the black-robed priest, a professional capable of leading the biological soldiers on a mission of medical purification, eradicating the impaired and incurable.[317]

The National Socialist government initially commenced its programme with legislation compelling the sterilization of individuals who were deemed capable of procreating, offspring inferior to the ideal person, with inflictions such as mental retardation, physical abnormalities, psychiatric conditions and alcoholism.[318] At the outbreak of the Second World War, the mass murder of physically and mentally-handicapped persons, deemed to be a burden on the state, took place.[319] Medicine adapted to fit National Socialist ideology and so doing caused many physicians to join the party and to identify with its medicalised philosophy.[320] The zealous National Socialist policies that overwhelmed German society made it difficult to challenge the new order;[321] those who did were forced to emigrate or were persecuted.[322]

5.3.3 Why physicians torture: Post Second World War and into the new millennium

The medical atrocities committed by the "Nazi doctors" were centred on a perversion of eugenics and biomedical experimentation. There is not a distinct border that

---

314 As above.
315 A Hitler *Mein Kampf* as cited in Grobin & Annas 648.
316 Grobin & Annas 648.
317 As above.
318 As above 649.
319 As above.
320 As above.
321 As above.
322 As above 650.

©University of Pretoria

distinguishes the pain and suffering of torture victims from that of victims of unethical medical experimentation, both equally are egregious. The question remains whether doctors are more or less complicit in the violation of their bioethical obligation of non-maleficence post Second World War.

Jesper Sonntag identifies two classes of physicians who are prone to be involved in torture.[323] First, high-risk doctors are physicians who may be involved in torture due to the nature of their work.[324] These include doctors employed by the military, correctional facilities, police, forensic departments or the state.[325] Secondly, Sonntag identifies doctors with dual loyalty conflicts.[326] These doctors also are employed in state departments such as the military, correctional facilities and forensic departments but are conflicted about to whom they owe their primary duty as physicians - the patient (detainee/prisoner) or the state.[327] The War on Terror is used as an example of such a dual loyalty conflict faced by healthcare professionals deployed at detainee centres in Iraq, Guantanamo Bay and Afghanistan.[328] Referencing studies done by Jerome Singh,[329] Sonntag identifies dual loyalty as being a conflict between the physician's duty to care for the detainee and responsibility to the state, in that abuse, poor detention conditions and well-being are weighed against a patriotic duty to protect the interests of the nation.[330]

Sonntag explains that doctors employed by the government in non-democratic states such as Iran have little choice in exercising freedom to practice due to draconian government policies (threats to families, compulsory work-back duties after state-funded studies)[331] whereas democratic states, such as the United States, enacted specific laws and policies that authorised detainee abuse that is indistinguishable from torture.[332] The United States military initiated Behavioral Science Consultation Teams

---

323 S Jesper "Doctors' involvement in torture" (2008) 1 *Torture* available at www.semanticscholar.org/paper/doctors involved in torture/jesper (accessed 8 November 2022).
324 As above.
325 As above.
326 As above.
327 As above.
328 As above.
329 JA Singh "American physicians and dual loyalty obligations in the 'war against terror'" (2003) *BMC Medical Ethics* 4 (accessed at https://doi.org/10.1186/1472-6939-4-4 on 23 January 2023).
330 Sonntag (fn 329 above) 164.
331 As above.
332 US Department of Defense "BSCT standard operation Procedures" available at

©University of Pretoria

(BSCT) at the Guantanamo Bay detention facilities in 2002 that consisted of healthcare professionals who devised various interrogation techniques, sleep deprivation, loud noise, stress positions and sensory deprivation.[333] These interrogation measures were authorised by the Secretary for Defence and drafted into policy.[334] The enacted policies never referenced torture but instead undermined the physician's duty of care by creating a distinction between clinical and non-clinical tasks, interpreting international law according to United States domestic law, thus bypassing acceptable ethical standards and circumventing medical confidentiality.[335]

Singh describes the rationale for the involvement of doctors in torture in a manner that resonates closely with reasons explored above in "Nazi doctor" complicity. Singh further identifies social circumstances and particular factors, including ideological totalism,[336] moral disengagement[337] and victim blame.[338]

The explanations presented by Sonntag and Singh for physician participation in torture and other cruel acts represent history repeating itself.

5.3.4 A role for the doctor in torture?

The doctor owes a duty of care to his individual patients (grounded in bioethics) and the military healthcare professional takes an oath of allegiance to the nation he serves.[339] Is there a dual loyalty conflict in the participation of healthcare professionals in acts of torture?

The unlawful nature of torture (including cruel, inhuman, degrading treatment and punishment), whether committed at the hands of a soldier or a military healthcare professional demands that instances are investigated and prosecuted. Any participation by a military healthcare professional in these acts must be viewed as an aggravating circumstance during sentencing in terms of the obligation the soldier-physician has to

---

http://www.aclu.org/files/projects/foiasearch/pdf/doddon000760.pdf (accessed on 20 October 2022).

333 Institute on Medicine as a Profession *Ethics abandoned: Medical professionalism and detainee abuse in the "War on terror"* (2013) xvii.

334 As above.

335 Sonntag 163.

336 Negative labelling and devaluing of a group by influential forces can breed a culture of ideological totalism (Singh (fn 335 above) 2003).

337 When subordinates of a labelling group regard the interests of the labelled group as less relevant because of the political culture under which they live (Singh 1-10).

338 A tendency to hold victims responsible for their own fate (Singh 1-10).

339 Sonntag 164.

©University of Pretoria

domestic law, military law, international humanitarian law and bioethical prescripts. The resolution of a dual loyalty conflict in this specific situation is purely academic in relation to legal and bioethical obligations against torture.

Unfortunately, the participation of military healthcare professionals in torture continues to taint the profession. Military physicians must be equipped to identify and resolve the pressures of this perceived dual loyalty conflict when confronted with an instance in military service. Sonntag refers to five studies[340] involving physicians and torture to classify three categories of physician involvement in torture.[341] Gross categorises physician involvement in torture under three distinct situations:[342]

Before torture commences: Certification as "fit for torture"

Medical support to detainees, prisoners, internees and retained persons is an obligation created by the Third Geneva Convention.[343] It is both legally and ethically sound to provide care if requested (informed consent) and if all bioethical principles of autonomy, confidentiality, beneficence and non-maleficence are adhered to. It is unlawful and unethical to provide the outcome of any intervention or examination to authorities without the express consent of the patient, particularly if information is used to plan specific torture methods to which the patient-detainee would be greatly susceptible.[344] Participation in these activities by military healthcare professionals represents a passive involvement in the torture process and is unlawful and unethical.[345] Certification of detainees for torture is a violation of the Convention Against Torture, Tokyo Declaration and the United Nations Principles of Medical Ethics.[346] Physicians are equipped with intrinsic medical knowledge whereby anatomically sensitive areas are known and methods that guarantee maximum pain

---

340 Office of the Surgeon General *Assessment of detainee medical operations for OEF, GTMO, and OIF* (2005) available at www.armymedicine.army.mil/ reports/detmedopsrprt/detmedopsrpt.pdf (accessed 21 October 2022); OV Rasmussen "Medical aspects of torture" (1990) 37 *Dan Med Bull* 1-88; K Smidt-Nielsen "The participation of health personnel in torture" (1998) 8 *Torture* 91-94; PB Vesti "Extreme man-made stress and antitherapy. Doctors as collaborators in torture" (1990) 7 *Dan Med Bull* 466-468; C Rei *et al* "Physician participation in human rights abuse in southern Iraq" (2004) 29 *JAMA* 1480-1486.

341 Sonntag 164.

342 Gross 230.

343 Art 14 GC I; Arts 13, 15, 17, 20, 30, 31, 46 & 108 GC III.

344 Fn 333 above.

345 Sonntag 171 & Gross 231.

346 Principles of medical ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment. United Nations General Assembly, 1982.

©University of Pretoria

without necessarily causing death or even leaving physical scars assist the torturer.[347] Similarly, the diagnosis and treatment of detainees with the intention to make them "fit" for interrogation or torture is neither lawful nor ethical.[348]

Participation during torture

Three practices are distinguished in the participation by doctors during torture. The first is the treatment and diagnosis of a detainee during active torture with the intention of enabling the torture to continue.[349] Secondly, supervising torture so as to intervene when necessary (such as in the case a detainee experiences a cardiac arrest or stops breathing).[350] Finally, where the torturer is the doctor.[351] The first two participations represent a passive involvement in torture and are unlawful and unethical and the third represents an active participation, similarly clearly unlawful and unethical.[352] Treatment provided under torture represents a maleficent intention in that the best interests of the patient-detainee are not served but rather the object is for the torture to continue.[353]

Physician participation during torture violates the essence of the Convention Against Torture, Tokyo Declaration[354] and the UN Principles of Medical Ethics[355] together with International Humanitarian Law.[356] Perpetrators face prosecution under the Implementation of the Geneva Conventions Act of 2012,[357] as well as professional

347 Sonntag 172
348 UNHR "Principles of medical ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment" available at https://www.ohchr.org/en/instruments-mechanisms/instruments/principles-medical-ethics-relevant-role-health-personnel (accessed 21 October 2022) & Sonntag 171.
349 Sonntag 171 & Gross 231.
350 As above.
351 As above.
352 As above.
353 Sonntag 172.
354 Art 1 "The physician shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offense of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife".
355 GA Res 37/194 Principle 2: "It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment".
356 Eg Common Art 3 of the Geneva Conventions; Art 12(2) GC I & Art 50 GC I (that describes torture as a grave breach).
357 Sec 5 Implementation of the Geneva Conventions Act, 2012.

©University of Pretoria

sanction from statutory regulating bodies.[358]

Examination and treatment after torture

Ordinarily this situation is the most common occurrence in which healthcare professionals become involved and when a truly ethical practitioner must step forward. Examination and subsequent treatment after torture has occurred are lawful and ethically sound.[359] The distinction between the lawful and ethical professional and the compromised professional lies in reporting suspected torture (based on medical evidence) to the appropriate authorities.[360] Further, the healthcare professional who falsifies medical reports or fails accurately to record all findings acts in violation of the Convention Against Torture, Tokyo Declaration and the UN Principles of Medical Ethics.[361] Healthcare professionals who withhold prescribed treatment, especially analgesia, under instruction from torturers also act with maleficence, unlawfully and unethically.[362] Criminal prosecution and professional sanction must follow such actions.

5.4 Accountability for those who torture

Accountability for transgressions by healthcare professionals of the law or bioethical principles is dealt with in separate disciplinary forums; unlawful conduct is referred to the municipal courts system; violations of professional duties in the form of unethical conduct is brought before the statutory professional council.[363] Military healthcare professionals face sanction under the military judicial system.[364] The involvement of doctors (passive or active) in torture and cruel, inhumane, degrading treatment and punishment means they face judgment in their respective forums.[365] The courts impose sentences of imprisonment or fines, whereas professional boards revoke or suspend licenses to practice or order other sanctions.[366] Courts may not have jurisdiction to sanction unethical conduct (as such conduct may not be unlawful) and professional

358 Health Professions Act 56 of 1974 definition of unprofessional conduct.
359 Sonntag 172.
360 Fn 249 above.
361 As above and Sonntag 172.
362 As above.
363 Sec 41 Health Professions Act, 1974.
364 Military Disciplinary Code, First Schedule to the Defence Act, 1957.
365 SH Miles "Medical Associations and Accountability for Physician Participation in Torture" (2015) 17 *American Medical Association Journal of Medical Ethics* 945-951.
366 Sec 41 Health Professions Act, 1974.

©University of Pretoria

boards may not impose sentences for criminal transgression; the two forums act in synergy with each other. Criminal conduct proceedings may yield a not guilty verdict, the doctor, nevertheless, may face an unprofessional conduct hearing before his respective Board.[367]

There is an advocate who stands out from all the others in pursuit of establishing accountability for doctors involved in torture, cruel, inhumane, degrading treatment and punishment. This advocate is Dr Stephen H Miles who has published numerous books and written for professional associations, universities and medical ethical publications. In his recent publication, *The Torture Doctors, Human Rights Crimes and the Road to Justice* (published in 2020), Miles names the torture doctors of numerous states, describes harrowing accounts of their acts, comprehensively describes torture and promotes accountability for transgressors.[368] His life-long dedication to the subject includes the Doctors who Torture Accountability Project, an internet-based site dedicated to show and to promote progress in encouraging physicians, courts, medical associations and regulating authorities to be active in ending torture.[369] Dr Miles was an expert witness called by the HPCSA in the professional conduct hearing of Dr Wouter Basson.[370]

Why should doctors be held accountable for torture if their government sanctions torture? It is argued that responsibility for these acts rests with political and judicial organs.[371] Miles' counter-argument is that the leadership and judicial organs of a torture state will be less than eager to act against individual torture physicians.[372]A lacklustre approach in imposing accountability violates public trust in various ways; doctors are not advocates for health and welfare, it offers impunity to transgressors and encourages practitioners to comply with state-sanctioned torture.[373] Statutory medical boards are seen to be complicit in such practices by the international community by aiding officials to cover up acts of torture by physicians.[374] Torture survivors and families of torture victims are denied recourse in law or even access to civil rights

---

367 *S v Basson* 2000 (4) SA 479 TPD.
368 Fn 276 above.
369 See www.doctorswhotorture.com.
370 Para 4.3 above.
371 ML Gross *Moral Dilemmas of modern war: Torture, assassination, and blackmail in an age of asymmetric conflict* (2010) 233-251.
372 Fn 365 above.
373 As above.
374 As above.

advocates.[375] The impunity with which states conceal torture and the acts of torture physicians undermine international solidarity and the much-needed support of protestors in other nations.[376]

Miles' final words on the matter resonate universally:[377]

> In its most fundament sense, accountability is less about punishment than about driving a wedge between torturing governments and the doctors whose help, fraud and silence they condone. Accountability for doctors' behaviour allows light to shine on a nation's darkest places.

5.5 End of physician involvement in torture

Interrogational torture, cruel, inhumane treatment and punishment test a doctor's moral compass in the relation of the duty towards the patient and the duty to the military organisation. Fidelity to principles of beneficence and non-maleficence are undermined when military objectives are used to influence the doctor to place the interests of the mission above those of his patient.

The practice of torture, whether at the hands of physicians, soldiers, police officials, government officials, contracted persons or anyone else, is a crime against humanity and a grave breach of international humanitarian law. Yet torture and cruel, inhumane, degrading treatment and punishment continue worldwide. Miles suggests ways in which torture physicians can be held accountable, but admits such action is dependent on the appetite for accountability that is invested by the state and state organs such as the judiciary and professional medical boards.[378] First, he petitions medical organisations to be proactive in holding to account physician torturers.[379] It is suggested that the World Medical Association (WMA), national medical associations and statutory regulating boards establish procedural guidelines for conducting hearings.[380] Secondly, the WMA is encouraged to maintain a reporting system by which medical associations, human rights groups and others can report physician torture involvement and, finally, a WMA registry stipulating outcomes and sanction of

---

375 As above.
376 As above.
377 As above.
378 SH Miles *The torture doctors. Human rights crimes and the road to justice* (2020) 125-127 and SH Miles "Medical Associations and Accountability for Physician Participation in Torture" (2015) 17 *American Medical Association Journal of Medical Ethics* 947-948.
379 As above.
380 As above.

criminal or professional bodies should be maintained and be accessible to national professional boards.[381]

6. Conclusion

Sokol[382] claims that the maxim *primum non nocere* requires revisiting. His opinion is based on the premise that the obligation to first, above all, do no harm is flawed.[383] Physicians routinely perform procedures that cause harm with the expectation that the benefit pursued outweighs the harm committed.[384] Sokol believes that if physicians were to be bound by first and above all not causing harm, they would not be able to do anything at all.[385] The author proposes, as a more apt, modern obligation under the non-maleficence principle, "First do no *net* harm".[386] The so-called harm-benefit analysis rests on the clinical facts but requires active decision-making on the part of the patient.[387] The autonomous decision-making capability of the individual would guide the physician in situations where the patient is able to make such decisions and, if available, an expression of an advanced life directive in situations where the patient is incapacitated.[388]

In a military environment such non-maleficent expressions would apply, *mutatis mutandis,* during peacetime. However, in the extreme and severe conditions of the battlefield where the individual expression of a soldier's will may be under pressure from the prevailing situation of military necessity, the situation is more complex. It is in these situations that the military healthcare professional is required to keep a steadfast approach to the bioethical principle to first, above all, do no (net) harm. The physician will encounter a duality of obedience when requested to actively euthanase a mortally wounded soldier, partake in weapons development, undertake combatant roles or participate in interrogatory investigations that involve cruel and inhumane acts that amount to torture.

---

381 As above.
382 Sokol 23.
383 As above.
384 As above. Eg, the surgeon's scalpel that incises and leaves a scar or the oncologists titrates that destroy both cancerous cells and healthy tissue.
385 As above.
386 As above.
387 As above.
388 As above.

©University of Pretoria

Maintaining a sound character, legal and ethical, in the face of external pressure exerted against the non-maleficence principle, is the greatest challenge to the duality of loyalty a military healthcare professional will face. Without prior exposure on how to manage these situations, consequent breaches of the law and of ethical principles will find the physician being held personally accountable, in court or before a regulatory body.

©University of Pretoria

CHAPTER 9

DISTRIBUTIVE JUSTICE: AN EQUAL SHARE AND THE BATTLEFIELD

OUTLINE

1. Introduction
2. The South African military health system
3. The distribution of resources on the battlefield
3.1 Introduction
3.2 Military necessity versus medical need
3.3 Distributive justice on the battlefield: Scenario-based evaluation
3.3.1 Principles of distributive justice
3.3.2 Distributive justice and international humanitarian law
3.3.3 Application of international humanitarian law to the scenario
3.3.4 Conclusion
4. Military medical neutrality: An unrealistic goal?
5. Conclusion

1. Introduction

The bioethical principle of justice relates to the obligation to treat everyone justly, to give each person what is their due, together with what is reasonable and fair.[1] Justice determines who is to receive benefits and who is to bear burdens.[2] The principle involves decision-making about the fair distribution of scarce (or limited) medical resources.[3] Distributive justice is the fair, equal and appropriate distribution that is determined by justified norms that structure the terms of social cooperation.[4] Broadly speaking, distributive justice is the distribution of all rights and responsibilities in

1 TL Beauchamp & JF Childress *Principles of biomedical ethics* (6th ed) (2009) 241.
2 MA Dada & DJ McQuoid-Mason *Introduction to medico-legal practice* (2001) 37.
3 AG Nienaber 'Ethics and Human Rights in HIV-related Clinical Trials in Africa with Specific Reference to Informed Consent in Preventative HIV Vaccine Efficacy Trials in South Africa' Unpublished LLD thesis, University of Pretoria, 2007 95.
4 Beauchamp & Childress 241.

©University of Pretoria

society.[5]

This chapter concentrates on the fair distribution of medical resources in a military context, especially the severe and extreme conditions faced on the battlefield during times of armed conflict. The premise will be that the armed forces of nations have military medical resources to support their soldiers on the battlefield and at home. These medical resources may differ as defence budgets of states differ from one to another. International humanitarian law obliges states to collect and care for the wounded but does not describe specifically the standard of care that each party must maintain.[6]

Military healthcare professionals face situations where they are conflicted as to the equal and fair distribution of medical resources among their comrades, their allies, enemy wounded and civilians encountered during armed conflict. In a situation of this type, the principle of medical neutrality in the care of the wounded and ill represents an issue of dual loyalty that military healthcare professionals should identify and manage lawfully and ethically.

2. South African military healthcare system

The Constitution of the Republic of South Africa, 1996 (Constitution) guarantees access to healthcare to everyone and declares that no person may be denied emergency medical care.[7] The Constitution requires the state to realize the rights under section 27 in reasonable legislation and within available resources.[8] The right to access health care is a basic human right.[9] The Constitution and the National Health Act 61 of 2003 (NHA) provide for a single healthcare system in South Africa; however, private health establishments also exist.[10] The state uses a means test to determine who qualifies for free health services and the Minister of Health from time to time may determine who is eligible for basic healthcare services.[11] In accordance with distributive justice principles, the right to access healthcare can be limited depending on the availability of

[5] As above.
[6] Common Art 3 of the Geneva Conventions.
[7] Sec 27 Constitution, 1996.
[8] Sec 27(2) Constitution, 1996 & sec 3 NHA.
[9] SAHRC "Access to health care" available at https://www.sahrc.org.za (accessed on 14 November 2022).
[10] As above.
[11] As above; sec 4 NHA.

©University of Pretoria

resources, but the right cannot be denied completely.[12]

The South African military healthcare system is unique in that it is under the control of the President as Commander-in-Chief of the Defence Force and the Minister of Defence and Military Veterans, not the Minister of Health.[13] Military healthcare, however, is regulated by the same legislation as public or private healthcare.[14] The provision of healthcare services in the National Defence Force is subject to the National Health Act and other legislation regulating healthcare in the Republic.[15]

Regulations to the Defence Act describe the mandate the Chief of the South African National Defence Force (CSANDF) and the Surgeon General have in the provision, management and control of medical services to serving and other authorised members of the Defence Force.[16] Their mandate extends to the setting of standards for fitness or unfitness to serve, arranging comprehensive medical care and authorising medical care outside of the military health system at either public or private health establishments.[17]

Access to healthcare in the South African National Defence Force is a service benefit.[18] Regulations 13 and 14 of Chapter XV of the General Regulations describe the medical benefits that can be accessed by serving members and their dependents;

---

12 As above.
13 Sec 1 (Definitions) NHA.
14 As above.
15 As above.
16 General Regulations to the Defence Act 42 of 2002, GN R631/2004 Ch XV Medical matters (Part II: Nature, extent and administration of medical treatment & Part III: Medical benefits).
17 As above.
18 As above at reg 13:
13. Defrayment of expenses
(1) The South African Medical Health Service must at all times be structured and funded at State cost to provide an all-inclusive multi-disciplinary health capability to the SANDF and its members: Provided that the cost of services to serving members shall be the liability of the State.
(2) The cost of any treatment, service or medical prosthesis or medical aid authorised in terms of this Chapter and provided to a patient is, apart from conditions to the contrary in this Chapter, defrayed from State funds, obtained for this purpose through the normal budget programme: Provided that -
(a) services rendered by private medical and dental practitioners and specialists must be paid from State funds;
(b) any patient to whom this Regulation is applicable, shall be accommodated in a general ward of the hospital concerned, unless -
(i) the patient's medical condition requires treatment in a private ward, or intensive or high care unit, in which case the extra cost is paid from State funds; and
(ii) the patient, for whatever reason, prefers to be receiving nursing care in a private ward, in which case such patient accepts prior responsibility for the additional costs and settles the difference directly with the relevant hospital authorities.

©University of Pretoria

Regulation 15 describes limited benefits to members of the Reserve Force.[19] Described as an all-inclusive multi-disciplinary service,[20] military health benefits allow members and their dependents to enjoy comprehensive medical care no matter where they find themselves in the Republic.[21]

During peacetime, the military healthcare system operates within the policies that govern the provision of health services to members and their families in much the same way as a medical aid or insurance scheme does for its contributors. The Medical Schemes Act 131 of 1998 does not regulate the military health system, as military medicine does not meet the requirements for a medical aid scheme as per section 20 of the Act.[22]

During armed conflict situations arise that present a challenge to the ethical principle of distributive justice. These challenges are discussed below.

3. Distribution of resources on the battlefield

3.1 Introduction

Medical necessity[23] and military necessity[24] are in conflict on the battlefield. Military healthcare professionals need to be aware of the conflict and the dual loyalty issues that arise in order to manage effectively their patients while supporting the military command in its purpose of winning the battle. The fair distribution of limited medical resources on the battlefield is not akin to the practice of battlefield triage. Battlefield triage, as discussed in chapter 7, applies when the medical support is overwhelmed by ill and wounded soldiers and treatment priorities are set.[25] Situations that warrant the triage of casualties are not applicable in all instances, especially when medical

---

[19] As above.

[20] As above, reg 13(1).

[21] As above.

[22] Sec 20 Medical Schemes Act 131 of 1998.

[23] ML Gross "Caring for Compatriots: Military Necessity before Medical Need?" (2015) 1 *Ethics and Armed Forces; Controversies in Peace Ethics and Security Policy* (available at www.ethikundmilitaer.de (accessed 10 November 2022). The principle of medical necessity mandates that care be provided on the basis of a national plan that balances lifesaving care with quality-of-life care.

[24] Military necessity was first described in the Liber Code of 1863 as the "necessity of those measures which are indispensable for securing the ends of the war and which are lawful according to the modern law and usages of war."

[25] MA Cubano & MK Lenhart (eds) *Emergency War Surgery* (2013) 30; C Merrick (ed) *ATLS® Advanced trauma life support: Student course manual* (10th ed) (2018) 6.

resources are adequate. The fair distribution of limited medical resources and the principle of distributive justice, on the other hand, apply all the time. This circumstance will be explained fully in the following paragraphs.

3.2 Military necessity versus medical need

Gross theorises that the relationship between military necessity and medical necessity is complex.[26] Military necessity concerns the collective, its foundation is in winning the battle and thus acting in the best interests of the state and its political will.[27] Medical necessity favours the individual and the best outcome available to that individual.[28] Military necessity, as does medical necessity, has the shared outcome to save lives.[29] Military necessity, however, may have the outcome the state sacrifices the lives of combatants (soldiers) to save the state and the citizens that make up the state.[30] Medical necessity does not require a sacrifice and makes no distinction among the lives it saves.[31] Medical and military necessity both strive to improve a quality of life albeit the quality of life that military necessity strives for is the political or collective life and medical necessity the individual life.[32] Gross examines the two concepts by applying to them international humanitarian law and armed conflict.[33] It is in this application that the bioethical principle of distributive justice is examined.

3.3 Distributive justice on the battlefield: Scenario-based evaluation

As stated above, the fair distribution of limited medical resources is not battlefield triage.[34] To illustrate the application of the bioethical principle of distributive justice use is made of the following scenario:

A field hospital deployed in a foreign state by allied forces is equipped with South African military healthcare professionals and resources. The field hospital has one surgeon and two intensive care beds available and evacuates the wounded and ill to

---

26 Gross 1.
27 As above.
28 As above.
29 As above.
30 As above.
31 As above.
32 As above.
33 As above.
34 Fn 25 above.

higher levels of care in South Africa. On a particular day four patients are admitted simultaneously.

Patient A is a South African infantry soldier with a gunshot wound to the shoulder sustained in battle. He requires surgery and most likely will be returned to the battlefield.

Patient B is a local allied infantry soldier, wounded in the same battle. He sustained multiple gunshot wounds including a head injury. His prognosis is limited and he requires specialised surgery not available at the field hospital.

Patient C is an enemy belligerent, captured during the battle. He sustained an abdominal gunshot wound that requires surgery and intensive care observation.

Patient D is a 9-year-old local girl, caught in the crossfire on the battlefield. She sustained chest and abdominal injuries that require surgery.

3.3.1 Principles of distributive justice

Both Beauchamp and Childress[35] and Cookson and Dolan[36] describe substantive principles of justice for making healthcare priority decisions.[37] Need principles dictate that healthcare resources are distributed based solely on the immediate need.[38] Beauchamp and Childress distinguish between needs and fundamental needs;[39] not all (health) needs can be satisfied owing (*inter alia*) to economic considerations, whereas fundamental needs are described as needs, which if not satisfied, result in harm or a detrimental outcome.[40] Maximising principles entail that the distribution of healthcare attain the maximum benefit.[41] Finally, egalitarian principles require that healthcare is distributed to reduce lifetime health inequality.[42]

3.3.2 Distributive justice and international humanitarian law

The provision of medical care on the battlefield receives considerable attention in

35 Beauchamp and Childress 242.
36 R Cookson & P Dolan "Principles of justice in health care rationing" (2000) 26 *Journal of medical ethics* 323-329.
37 Cookson & Dolan 323.
38 As above.
39 Beauchamp and Childress 242.
40 As above.
41 Cookson and Dolan 323.
42 As above.

©University of Pretoria

international humanitarian law, conventions and bioethical publications. The Geneva Conventions dictate the obligation on belligerents to provide medical care to the wounded, but the provision of care is not unlimited.[43] The Additional Protocols have the proviso that distribution of medical care is "to the fullest extent practicable".[44] Commentary to the First Additional Protocol stipulates a distributive justice principle in that signatories are obliged to do what is practically possible considering both the place and the time.[45] Article 10(2) of the First Additional Protocol is duplicated in Second Additional Protocol at article 7(2).

Customary international humanitarian law rules dictate distributive justice principles.[46] Medical personnel must be protected and are obliged to practice according to established medical ethical principles.[47] The World Medical Association (WMA) proclaims that medical ethics are the same in peacetime and during armed conflict.[48]

3.3.3 Application of international humanitarian law and bioethics to the scenario

Armed with the bioethical and international humanitarian law prescripts an analysis of the military medical practitioner's obligations to each of the four patients can be undertaken.

Patient A: *South African soldier, gunshot wound to shoulder, stable and expected to make a full recovery*

A distinct dual loyalty issue arises in the medical management of this patient. First, he is not in a critical condition yet requires surgery that most likely will enable his

43 GC I Commentary (2016) 1503: The Convention includes the word "adequate" care to the sick and wounded which has commentators accepting that medical care resources such as healthcare personnel and equipment differs from state to state. The obligation to collect and provide adequate care has been interpreted to mean that any medical care, even if administered by non-healthcare personnel must be undertaken. Naturally the optimal standard of care would be most beneficial but such optimal care may not be within the means of every state.

44 Art 10 AP I & Art 7 AP II.

45 Art 10(2) AP I & AP I Commentary (1987) 451 "no one is expected to do the impossible".

46 ICRC Customary International Humanitarian Law Rules (rule 109) available at https://www.icrc.org (accessed 22 November 2022): "Rule 109. Whenever circumstances permit, and particularly after an engagement, each party to the conflict must, without delay, take all possible measures to search for, collect and evacuate the wounded, sick and shipwrecked without adverse distinction".

47 Art 28 GC I; Art 16 AP I & Art 10 AP II.

48 WMA *Regulations in times of armed conflict and other situations of violence* (2012).

©University of Pretoria

returning to the battlefield. He is 'own' forces, thus a strong sense of camaraderie is present in urging to "treat one's own" before treating allies, prisoners of war or local civilians. This appeal also has an immense impact on the morale of South African soldiers and the belief that, if wounded, care will be immediate. Also, a military need exists to return the soldier to the battlefield and continue his contribution to winning the fight.

A physician faced with the four patients presented in the above scenario simultaneously in a busy city emergency department is not confronted with the same dilemma as is the military medical physician. Ordinarily, the civilian physician would distribute health care based on need and overall benefit (best outcome, compliance with treatment regime and follow-up visits).[49] Military physicians presented with a similar scenario unanimously state that the own forces' soldier should be given the primary attention of the medical staff due to affiliation.[50] A study conducted among physicians deployed during Operation Desert Storm (1991) showed that only two thirds believed medical need to be the sole criteria for evaluating health care distribution and 22% claimed to not treat prisoners of war before all coalition troops are treated.[51] Gross believes that the obligation to treat own forces before other wounded/ill finds a foothold on moral ground in associative obligations and the theory of ethics of care.[52]

Associative obligations (also political obligations, communal obligations or obligations of role) are those we do not choose but rather consist of the special relationships assigned by local practice to be part of a membership in a biological or social group such as a family, neighbours or colleagues.[53] Simmons considers the moral obligation that exists between members of a small closely-knit family or friend unit to care for each other above the obligation to care for strangers.[54] Commitments of mutual aid and the implied agreement to assist friends in times of need, together with good social reasons to assist family first, preserve these institutions of family and friendship that

---

49 ML Gross & D Carrick (eds) *Military medical ethics for the 21st Century* (2013) 77.

50 As above.

51 BS Carter "Ethical Concerns for Physicians Deployed to Operation Desert Storm" (1994) 159 *Military Medicine* 55-59, available at https://doi.org/10.1093/milmed/159.1.55 (assessed 22 November 2022).

52 Gross & Carrick 78.

53 R Dworkin *Law's Empire* (1986) 206 as cited in AJ Simmons "Associative political obligations" (1996) 106 *Ethics* 247.

54 As above & Gross & Carrick 78.

are essential for security and persistence.[55]

The ethics of care appeal to an emotive rather than a contractual bond; the appeal is for personal faithfulness, loyalty, attention, passion and an awareness of the unique quality of loved ones and their specific needs, interests and history.[56] Confronted by associative obligations and care ethics for those closely affiliated to you when having to apply an impartial distribution of health care resources, is a present condition on the battlefield and in the military medical care of the wounded. Gross comments that in order to understand the associative obligations and care ethics present in the military one must understand the bonds that exist between soldiers.[57]

Soldiers in small units (platoon size of 30-40 members) train, live, eat, deploy, interact and bond on a daily basis.[58] The identification with one another creates a strong associative obligation towards their welfare, loyalty, commitment and self-sacrifice that, in turn, nurtures a cohesive fighting unit.[59] These primary bonds cause the assigned medic in the platoon to associate strongly with his comrades and, consequently, he will afford them preferential care before any care is given to allies, the enemy or to civilians.[60] In this platoon, bonds of friendship create a moral relationship and develop duties of care that prescribe preferential treatment and undermine considerations of (impartial) justice and even international humanitarian law obligations.[61] Gross justifies this approach by stating that the survival of the small group or platoon is dependent on receiving medical support that will return soldiers to the fight and, secondly, that there is the "moral primacy" of the associative obligation of care among comrades in arms.[62]

Secondary bonding among soldiers occurs as the group becomes larger, that is, as the echelons of the military command structure expand and friendships and camaraderie weaken.[63] Gross describes a return to medical ethical principles that is less blurred by the closeness of the platoon level in the distribution of limited/scarce medical

55 Gross & Carrick 78.
56 V Held *The ethics of care* (2006) 10.
57 Gross & Carrick 79.
58 As above.
59 As above.
60 As above.
61 As above.
62 As above.
63 As above.

©University of Pretoria

resources.[64] The care and treatment at higher levels of medical care that is situated further from the battlefield is performed by physicians and nurses who may not present with such close bonds as displayed by the platoon-deployed field medic to *his* comrades.[65] Despite the weakening of the bond between higher echelon medics and their own 'comrade' wounded, the bond does not disappear in its entirety.[66] At this level of care other contributing factors may influence the impartial distribution of medical resources as will be discussed in the analysis of the remaining wounded.

Thus, patient A, despite requiring surgery to a wound that is non-life threatening, possibly would have to wait for attention to be paid to other more critical patients in his proximity to undergo stabilisation and surgery. The tactical situation, as dictated by military command, may warrant the soldier return to duty and is a consideration that the military medical physician must consider and advise on once the soldier has been stabilised. Secondly, the order from command may require that patient A be given treatment prior to the other wounded because of a strong sense of camaraderie or the military need to return many soldiers as soon as is possible to win the battle. The military medical practitioner should be aware of and in his actions reinforce the international humanitarian law principles of urgent medical need being the only determinant in the distribution and order of care to be received.[67]

Patient B: Local allied infantry soldier requiring specialized care and evacuation to higher levels of care.

This example is of a critically-wounded local soldier and an allied comrade who requires a level of care not available at the level of a field hospital. His injuries in all probability will not allow his return to the battlefield but rather he will need to undergo extensive care and rehabilitation elsewhere.

The Geneva Conventions are clear; medical need alone prescribes the order of medical care and there is no distinction made, *inter alia*, in respect of nationality.[68] The moral obligations that are present in relation to the care of the South African wounded soldier may not be present, despite being an ally, the wounded soldier may not enjoy

[64] As above.
[65] As above.
[66] Gross & Carrick 80.
[67] Art 12 GC I, Art 16 AP I & Art 10 AP II.
[68] Art 12 GC I.

©University of Pretoria

the same spirit of camaraderie or the care ethics and associated obligations in his treatment by allied comrades.[69]

The Geneva Conventions and international codes of medical ethics require the local allied soldier to receive medical care according to his need.[70] Unfortunately, as a local citizen, there may be a disparity in the level of care that exists between what the field hospital can deploy and locally available resources.[71] American and other European coalition medical facilities deployed in Afghanistan and Iraq over the past two decades had experience of a local medical infrastructure that was non-existent, poorly resourced or unable to manage complex medical conditions, which led often to the detriment of the condition of the wounded.[72] Once local allied soldiers had primary treatment in well-equipped and specialty-staffed field hospitals, they were discharged into the local health care system.[73] There is a question surrounding the obligation on the military medical practitioner to follow up on the allied soldier once he has been discharged to the local health care system. Ordinarily, the doctor-patient relationship ceases once the discharging physician is content that the treatment is complete, can be continued at home or the patient is transferred to further rehabilitative or specialised care.[74] However, if the wounded allied soldier does not receive the care and/or rehabilitation that would be reasonably expected he might regress and even die from avoidable secondary infections/complications. The care received and resources expended to stabilise the wounded ally would be for nothing if adverse consequences follow discharge to local care facilities. Medical resources of the deployed field hospital will be depleted if comprehensive definitive care were allocated to every allied soldier. Gross highlights the role of medical planning, in that partnership with local medical facilities should be created before the onset of such deployments to maximize recovery of local combatants and civilians.[75] The understanding of the local health care facilities will discharge the beneficence and non-maleficent obligation resting on all

[69] Fn 56 above.
[70] Fn 67 above.
[71] Gross & Carrick 24.
[72] As above.
[73] As above.
[74] On the doctor-patient relationship, see Ch 7 above and DJ McQuoid-Mason "The Medical Profession and Medical Practice" in WA Joubert & JA Faris (eds) *The Law of South Africa* vol 17 part 2 (2nd ed) (2008) para 31.
[75] Gross & Carrick 25.

©University of Pretoria

medical practitioners in the field.[76] Gross further recommends the involvement of non-governmental aid organisations (NGOs) such as Medecins Sans Frontiers (MSF), the United Nations' World Health Organisation and the local ICRC.[77] The coordination with local and NGO health care providers will assist the military field hospital in distributing the burden of care of local allied and local population wounded and ill.

Patient C: Prisoner of war, gunshot to abdomen requiring surgery and post-operative intensive care.

This critically wounded patient requires immediate care and the field hospital has the capacity to treat his wounds, but treatment comes at great expense of resources. International humanitarian law prescripts dictate that only urgent medical need is to be considered and no determinations according to race, gender, nationality, etcetera, are to be considered when medical care is prescribed.[78] An additional obligation is to be considered in that the patient no longer is a combatant[79] and has a protected status of that of a prisoner of war under the Third Geneva Convention.[80] Treatment, stabilisation and eventual discharge to a prisoner of war camp or medical repatriation to his country of origin are options that should be considered.

Patient D: Local minor child, multiple gunshot wounds requiring surgery and postoperative care.

In Article 3(2) of the First Geneva Convention an obligation is established by humanitarian law to treat civilian casualties.[81] The child requires surgery to stabilize, but definitive care would be the responsibility of local health care facilities. The definitive care and the ultimate outcome for this patient thus is dependent on local health care resources. In this situation, coordination and cooperation with local and NGO health care providers will assist in attaining the best possible outcome

[76] As above.
[77] As above.
[78] Fn 67 above.
[79] Art 3(1) GC I.
[80] Art 4A GC III.
[81] Art 3(2) GC I. The wounded and sick shall be collected and cared for. An impartial humanitarian body, such as the International Committee of the Red Cross, may offer its services to the parties to the conflict. The parties to the conflict should further endeavour to bring into force, by means of special agreements, all or part of the other provisions of the present Convention. The application of the preceding provisions shall not affect the legal status of the Parties to the conflict.

©University of Pretoria

considering the limited resources available.[82]

3.3.4 Conclusion

The allocation and distribution of scarce medical resources remain a primary concern of military medical practitioners in discharging their legal and ethical obligations to care for those on the battlefield. A conflict of dual loyalty arises when the military medical practitioner discharges the obligations of international humanitarian law and medical ethics in the context of supporting the military command and the requirement to win the battle.[83] Once these dual loyalties are identified, the military physician can manage the situation effectively using skills that were taught prior to deployment.

The Geneva Conventions require medical care based solely on needs, however, maximizing the return of the soldier to the battlefield ranks as the foremost aim of military medicine in the task of maintaining a combat ready force able to win the battle.[84] Needs-based and maximizing principles are both recognised in distributing limited medical recourses.[85] Egalitarian principles of distributive justice may not feature as prominently in battlefield medical ethics as they do in the civilian sector. However, it is in the equal distribution of medical resources among allied soldiers where the greatest injustices may occur.[86] Local allied soldiers, having received initially care in military facilities, are returned to a local health care system that may not be as well-resourced as the military counterpart.[87] Experience in Iraq and Afghanistan is evidence of unequal treatment of the war wounded. Coalition (United States and Western allied) wounded are evacuated to specialised fully-equipped medical centres in Europe and mainland United States, Iraqi and Afghan wounded are handed over to a local health care system ill-equipped to provide equal care to that given to their allied comrades.[88]

The proposed outcome of the four patients presented in the scenario will see the South African soldier wait for surgery until the allied soldier is stabilised and transferred to

---

82 Fn 75 above.
83 ML Gross *Bioethics and Armed Conflict. Moral Dilemmas of Medicine and War* (2006) 175.
84 As above.
85 As above.
86 ML Gross "Military medical ethics in war and peace" in G Lucas (ed) *Routledge handbook of military ethics* (2015) available at http:/www.taylorfrancis.com/chapters/edit/10.4324 (assessed 9 November 2017).
87 As above.
88 As above.

©University of Pretoria

local medical care facilities. The prisoner of war and the child have equal need for surgery and it is decision of the attending surgeon to ascertain who receives admission to the next available surgical ward, based only on the most urgent medical need.

4. Military medical neutrality: An unrealistic goal?

The question that needs attention is whether military medical practitioners truly can be neutral in decisions about providing care to all battlefield casualties. Doctors serve in the armed forces of a state.[89] They pledge their allegiance to the country they serve and the political head or party of the state.[90] Their primary task in the defence force is the amelioration of the suffering of those wounded or ill due to the services they perform, whether in peacetime of during an armed conflict.[91] Doctors have an additional obligation in that combat ready, fit for service men and women are either maintained or are restored to health after injury or illness to ensure an effective military force capable of defending the state.[92] Gross maintains that the neutrality of military doctors is a near impossibility as they care for their own first before expending time and resources on allies, the enemy or on civilians.[93] Thus the fair distribution of medical resources primarily favours one's own force first.[94]

Gross views medical neutrality as consisting of two elements; impunity and impartiality.[95] Impunity or the protection offered to medical personnel exclusively involved in the search for, care and treatment of the ill and wounded has been discussed previously.[96] Impartiality is the international humanitarian law obligation to treat all wounded and ill without regard to nationality, age, gender, and allegiance, the only consideration being the severity of the illness or wounds.[97]

Impartiality relates closely to the fair distribution of scarce or limited medical

---

89 Ch XV of the General Regulations to the Defence Act: Definition of a "medical officer" means 'a person entitled to practise as a medical practitioner in terms of section 17 of the Health Professions Act, 1974 (Act 56 of 1974).

90 Code of Conduct for Uniformed Members of the South African National Defence Force available at https://www.researchgate.net/figure/Code-of-Conduct-for-Uniformed-Members-of-the-SANDF (accessed 1 February 2021); further see Ch 3 above.

91 Arts 24 & 25 GC I.

92 Ch XV of the General Regulations to the Defence Act, 2002; Part 1 Medical fitness.

93 Gross 175.

94 As above.

95 As above.

96 As above & Art 12 GC I.

97 As above.

©University of Pretoria

resources in a time of armed conflict.[98] Unless acting in a truly impartial way, military medical practitioners behave akin to a mechanic and are tasked to ensure the maximum utility derives from his acts to support the war effort. Henry Dunant's ideal was for neutral medical volunteers to attend to the casualties of war.[99] Despite the establishment of the ICRC, military forces employ medical personnel to fulfil the function of caring for the ill and wounded.[100] Non-government relief, medical and aid organisations maintain impartiality during armed conflict as they do not represent a specific state or have any interests in the outcome of the conflict.[101]

Gross does not offer a solution to the dichotomy faced by the military medical practitioner in his duty to remain impartial when treating the wounded from other armies or civilians.[102] He maintains that as a natural consequence, a situation likened to that of a mother having a primary obligation towards her own child who will forsake other children in need,[103] the sympathies of the military medical practitioner naturally gravitate towards their own soldiers first.[104] With the associative obligations and an overriding care ethics approach to treating one's own first, military medicine may always present a negative response to the obligation of an equal and fair distribution of medical resources to the individual, regardless of affiliation or who has the greatest need.[105]

At most the expectation is the equal distribution of medical resources will be applied only to one's own military force and maintain a fair distribution among those who have the greatest need. In this circumstance the ideal outcome is represented by a distribution of care based not on a military need (return to service) but rather on urgent need and maximising prognosis.[106] However, strong external influences, such as

98 Gross 177.
99 H Dunant "A memory of Solferino" International Committee of the Red Cross (1959).
100 DE Lounsbury & RF Bellamy (eds) (2003) 1 *Military Medical Ethics* 295-296.
101 Non-governmental organisations (NGOs) such as doctors without borders (MSF) have no defined international status as a subject in international law but they should be regulated by international law because they must be protected and respected in the execution of their humanitarian tasks. Their independence must be preserved in that their activities may not be influenced by a state. Such organisations are established under municipal law. The Geneva Conventions make provision for the respect and protection of these agencies during times of armed conflict, Arts 26-28 GC I.
102 Gross 178 & 179.
103 As above.
104 As above.
105 Fn 52 above.
106 Gross 177.

©University of Pretoria

military authority, are a challenge to the medical ethical principle of fair distribution of resources by the demand for a fit military force prioritizing a return to the battlefield.[107]

5. Conclusion

Distributive justice in respect of scarce or limited medical resources in a military context is situated inside a closed circuit; the immediate care and treatment of competing actors on the battlefield only and not in relation to society at large. Military medicine is responsible only to the population it serves, the uniformed men and women, as well as international humanitarian law obligations such as wounded enemy belligerents and civilians caught in the crossfire. The doctor must pay attention to the international humanitarian law prescripts as well as to the bioethical obligation of need in deciding who gets what share of the resources.

The doctor's decision is heavily influenced by his duty to care for his own first, together with orders to treat and return to service 'own' forces at the commands of higher authority. These orders, although manifestly unlawful and having no force of obligation, nonetheless will be obeyed to satisfy the associative obligations to one's own people above the needs of others.

The solution to the dilemma the compliance to international humanitarian law and bioethical requirements demands rests on medical resources so plentiful that a decision to distribute resources is not an issue. Unfortunately, even the best equipped armies are unable to maintain such a commitment and a military medical practitioner is faced with this dilemma regardless of individual choice.

The next chapter concludes the thesis and offers recommendations.

[107] As above.

©University of Pretoria

CHAPTER 10

CONCLUSIONS AND RECOMMENDATIONS

OUTLINE

1. Introduction

2. Overview of chapter findings

2.1 Regulation and differentiation: Military medicine law and ethics

2.2 Dual loyalties: Between doctoring and soldiering

2.3 Dual loyalties and the four-principles approach of bioethics

3. Conclusions

3.1 Domestic legislation, international humanitarian law and medical ethics

3.2 Dual loyalty conflicts

3.2.1 Conflicts of maintaining confidentiality against military necessity

3.2.2 Autonomous medical decision-making and military service

3.2.3 Failing to care: Conflicts to benevolent actions

3.2.4 First (above all) do no harm: Duality in the principle of non-maleficence

3.2.5 Dichotomies and dual loyalty dilemmas in distributive justice

3.3 Training the military healthcare professional

4. Recommendations

4.1 Introduction

4.2 Recommendations regarding the drafting of legislation, ethical guidelines and internal military policies addressing medical law and ethics

4.3 Recommendations regarding the status of healthcare professionals in the South African National Defence Force

4.4 Recommendations regarding training of military healthcare professionals and soldiers in aspects of military medical law, ethics and IHL

©University of Pretoria

4.4.1 Initial or basic training for all military members
4.4.2 Specifics in military medical law and ethics training for military healthcare professionals
4.4.3 Mission-specific training prior to the deployment of military healthcare professionals
4.4.4 Continued Professional Development
4.5 Identification of dual loyalty dilemmas and ethical decision-making
4.6 Doctor or soldier first
5. Closing remarks

> Military medical personnel, especially in a time of war, are faced with the most ethically difficult dual loyalty of doing what is in the best interest of their patient and doing what is in the best interest of their government and fellow soldiers. This conflict has existed for as long as we have fought wars. It is the most difficult because it is the state or the military exerting the pressure on the medical professional.[1]

1. Introduction

This chapter concludes the study and having done so makes recommendations. This goal is approached by presenting an overview of the chapter findings and consolidating the findings into a comprehensive conclusion and, lastly, offering recommendations. The research questions that were investigated are revisited:

1) What are the systems of law and medical ethics governing the conduct of healthcare professionals in the military?

2) Does the regulation of military medicine differ from the regulation of civilian health care practice?

3) Which specific ethical and legal challenges are presented by the practice of military medicine and how do these challenges lead to dual loyalty obligations?

4) What is the extent of additional or special military medical training required for serving as a military healthcare professional?

[1] PA Clark "Medical ethics at Guantanamo Bay and Abu Ghraib: The problem of dual loyalty" (2006) *The Journal of Law, Medicine & Ethics* 571.

©University of Pretoria

5) When faced with dual loyalty conflicts which is the better course of action a military doctor should choose (in terms of ethics and law)?

6) What methods may be devised to resolve the dichotomies experienced?

7) What role does the law have to play in solving these dichotomies?

2. Overview of the chapter findings

2.1 Regulation and differentiation: Military medicine, law and ethics

Following upon chapter 1 which set out the object and scope of the thesis, chapter 2 listed and examined domestic legislation applicable to healthcare professionals employed by the state and the private sector. International humanitarian law (IHL) and international human rights law were included in the chapter to show their application to the practice of healthcare professionals in peacetime and during armed conflict.

Chapter 3 briefly introduced the foundations of medical ethical theories (biomedical ethical theories). Civilian medical ethics were examined to explain its similarities (and differences) with military medical ethics. As the thesis examined the dichotomies and dual loyalty conflicts present in military medical practice, the four principles-approach of Beauchamp and Childress was introduced to assist in the process. These principles were examined individually in the successive chapters to show the dichotomies and dual loyalty conflicts that military healthcare professionals face in caring for their patients in a military environment. Military ethics and the conduct of those engaged in armed conflict were introduced and the rules, developed over centuries of armed conflict, were described.

The chapter introduced, arguably, the greatest dichotomy military healthcare professionals face - the obligation to care for the sick and wounded as counterbalanced by the obligation to support the state in securing military dominance over the enemy. The dual loyalty conflict represented by service to the individual (patient) versus the service to the collective (the state or military complex) was described and a basis was set down for the in-depth analysis of these conflicts in the forthcoming chapters.

To conclude chapter 3 attention was drawn to the examination of IHL and military medical ethics. Obligations created under IHL were listed and described to explain the triad of issues that exists as a dominant theme in the thesis; the interplay between

lawful medical practice, bioethical principles and IHL in the conduct of military healthcare professionals.

2.2 Dual loyalties: Between doctoring and soldiering

Chapter 4 commenced by examining the profession of arms and the healthcare profession. The seemingly opposite purposes of the two careers were explored, first to show that a military career equates to following a profession and displays the attributes which categorise professionals and, secondly, how the healthcare profession developed to accommodate doctors in uniform.

The chapter began by defining a dual loyalty conflict and indicated that it is considered not unique to the military environment. The conflicts and the polarisation of opinion among researchers on the issue were examined. The age-old question of whether a doctor serving in the armed forces of a state is first (and identifies as) a soldier or a doctor was introduced and was the basis for further examination in relation to the bioethical principles of autonomy, beneficence, non-maleficence and justice.

The chapter concludes by describing two unique approaches to resolving dual loyalty conflicts that will be used to recommend action to be taken by the military healthcare professional in resolving such dilemmas later in this chapter.

2.3 Dual loyalties and the four-principles approach of bioethics

Chapters 5 through 9 studied the four-principles approach of autonomy, beneficence, non-maleficence and justice in relation to the dichotomies and dual loyalty conflicts that a military healthcare professional experiences during his career. This approach was selected so that bioethical principles form the medico-legal and international humanitarian law basis for the conduct of the military healthcare professional.

The four-principles approach was addressed in the conventional order, that is, first autonomy and then beneficence, non-maleficence and justice. This convention does not imply that there is a ranking or order of importance placing one principle above another.

Chapter 5 addresses medical confidentiality separately from the autonomy principle due to the increased threat of breaches inherent to organisations with strict hierarchical

structures and restricted autonomous decision-making such as in military service. One scenario and two historical examples were used to apply the legal and ethical obligations that a doctor has with regard to maintaining confidentiality. The domestic legal and ethical principles were discussed and the application of medical confidentiality to international humanitarian law was assessed because of its application during armed conflict. The chapter offered a management solution to the dual loyalty conflicts that may arise in medical confidentiality obligations.

The dichotomy of autonomous decision-making and service in the armed forces was the focus of chapter 6. The exercising of medical autonomous decision-making is a right of the patient. Without understanding this as a right a doctor will not be effective in managing their patients. The autonomy pendulum was shown to swing from a freedom to choose the path of treatment in exercising uncompelled decisions regardless of the basis for the choice, to submission to medical treatment due to coercion by a third party. In examining a soldier's freedom to choose their own medical path, reference is to the unconsented use of medicinal agents to counter chemical and biological weapons in the First Gulf War. Autonomous decision-making coexists with informed consent. Informed consent and the accompanying autonomous decision-making of soldiers were further examined through practical situations, such as waiving consent, refusing treatment, autonomy on the battlefield and the care of prisoners of war. The exhaustive topic of the use of soldiers as research participants was addressed briefly in the chapter.

Benevolent actions require a positive action that transcends merely refraining from doing harm. Chapter 7 examined the bioethical principle of beneficence and the healthcare profession's core value of ameliorating suffering caused by illness and injury. Within a military environment the military healthcare professional clearly acts in response only to illness or injury caused by the nature of being a soldier in service in peacetime or during an armed conflict. However, military medicine has an additional function in that servicemen and woman must be maintained in a condition that makes them fit for service. The chapter examined an extreme form of a dual loyalty conflict faced by doctors in which the need of the military service to have ill or wounded soldiers return to the battlefield overrides following the benevolent care prescribed by the healthcare professional.

©University of Pretoria

The obligation to execute the principle of beneficence towards the soldier-patient was described in the duty of care obligation and the application of triage principles on the battlefield.

A commitment not to harm or kill is distinct from commitments to help, especially during armed conflict. The principle of non-maleficence is challenged in the military environment and chapter 8 tackles important legal and ethical obligations that the military healthcare professional will encounter. Unfortunately, history is rife with examples of doctors who commit heinous acts in the guise of the good of the military and state order. Chapter 8 commenced with euthanasia and specifically the ending of life on the battlefield by means of either physician-assisted suicide or the action of military healthcare professionals under orders from superior officers.

The chapter examined the dark recesses of unethical and unlawful medical practice, the active participation of healthcare professionals in weapons development and torture. Accountability, not only by the healthcare professional personally but of those in positions of authority, was fully described in the chapter. A South African example in Dr Wouter Basson is presented of a doctor who used medical knowledge to develop the means of warfare and was supported by a military command. Accounts of torture and the examples of doctor's involvement under misguided authority and government-sanctioned methods are shown to involve even democratic states. An identification with the policies of governments and a strong patriotic sense were highlighted as being the root causes for this practice. An attempt to make sense of these dangerous actions by educated persons resonated throughout the chapter.

Chapter 9 concluded the application of the four-principles approach by examining the principle of distributive justice in a military context. Ordinarily, distributive justice is the disseminating of scarce or limited medical resources in order to benefit the greatest number of persons in need of medical care. The principle just may be the most controversial and taxing to apply in difficult life or death situations. The military environment during armed conflict exhibits these difficult situations. The chapter examined distributive justice in the microcosm of the battlefield where scarce medical resources are shared among competing players. The obligations created by international humanitarian law add to the dual loyalty dilemmas faced by military healthcare professionals in doing the greatest good for the largest number of sick and

wounded. The chapter concluded by addressing medical neutrality in a chaotic situation where brotherhood and camaraderie feature as intrinsic characteristics of a military order that often results in the abandonment of neutrality in providing medical care.

3. Conclusions

3.1 Domestic legislation, international humanitarian law and medical ethics

The initial research question was to establish the systems of law and medical ethical principles governing the conduct of healthcare professionals in the military. Secondly, to indicate how the regulation of military medicine differs from the regulation of civilian healthcare practice.

The Constitution, 1996, as the supreme law of the Republic, is central to the development and implementation of health law and policies. It establishes that government has a positive duty to take all reasonable legislative measures within its available resources to achieve the progressive realisation of the right to access healthcare. It was concluded in chapter 2[2] that the rights protected and listed in the Bill of Rights have a significant impact on medical care. These rights include the right to access healthcare,[3] the freedom and security of the person (to protect against medical experimentation and non- consent to medical treatment),[4] the right to dignity (protecting confidential medical information),[5] privacy[6] and the further protection of information.[7] The rights of vulnerable persons such as children and prisoners, two classes of persons requiring special protection during armed conflict, and their right to access healthcare are included.

The Constitution, 1996 addresses security forces and the role of the South African National Defence Force (SANDF).[8] The lawful deployment of the National Defence Force in protecting state sovereignty and actions in accordance with international law remain the core function of the SANDF. In extreme situations such as a state of

2 Sec 27 Constitution, 1996.
3 Sec 27(1)(a) Constitution, 1996.
4 Sec 12(2)(c) Constitution, 1996.
5 Sec 10 Constitution, 1996.
6 Sec 14 Constitution, 1996.
7 Secs 14 & 32 Constitution, 1996.
8 Sec 200 Constitution, 1996.

©University of Pretoria

national defence or a state of emergency, where the lawful derogation of certain human rights is necessary, the Constitution lists non-derogable rights that may not be infringed.[9] These non-derogable rights apply to and reinforce healthcare rights in that human dignity, life, freedom and security of the person, equality, children and arrested and detained persons feature in the provision of lawful and ethical medical treatment. The Constitution, 1996 applies to all persons in the borders of the Republic, including members of the National Defence Force and, at times of external deployment, the extra-territorial application of certain domestic legislation applies to soldiers.[10]

The South African Military Health Service (SAMHS) as the military healthcare provider executes its mandate in accordance with constitutional provisions and must apply international law in situations where the National Defence Force is deployed regardless of the mission.

The National Health Act of 2003 defines military medical establishments and provides for their control by the President, as Commander in Chief of the SANDF and vests the executive authority in the person of the Minister of Defence and Military Veterans and not the Minister of Health.[11] The Surgeon General, as head of the SAMHS, has a seat at the National Health Council of the Health Professions Council of South Africa (HPCSA).[12] Measures which regulate the health professions include the Health Professions Act 56 of 1974,[13] the Nursing Act of 33 of 2005,[14] Pharmacy Act 53 of 1974[15] and the Allied Health Professions Act 63 of 1982.[16] Regulations to the Defence Act 42 of 2002 provide that a medical officer is one that is registered with the HPCSA.[17] As the above Acts regulate each of their respective professions, no person may practice in the Republic without being duly qualified and registered with the

[9] Table of non-derogable rights: Sec 37 Constitution, 1996 includes the rights of children, right not to be subjected to servitude or slavery, rights not to be treated unequally, the right to life, human dignity and freedom and security of the person. The rights of detained and accused person is further protected.

[10] Implementation of the Geneva Conventions Act 8 of 2012 & Military Disciplinary Supplementary Measures Act 1 of 1999.

[11] Sec 1 National Health Act, 2003 (Definitions).

[12] Sec 22.

[13] See para 3.3 Ch 2 above.

[14] As above para 3.4.

[15] As above.

[16] As above.

[17] Reg 17 General Regulations to the Defence Act, 2002.

©University of Pretoria

applicable regulation authority.[18] Military healthcare professionals are not excluded from the provision and may not practice without registration.

The Defence Act provides for the defence of the Republic and all matters incidental to it.[19] The composition, limitation of rights, training, employment, deployment and administration of SANDF members and employees encompass healthcare professionals serving in uniform.[20] The General Regulations to the Defence Act describe in greater detail the functioning of the military medical healthcare system and the obligations of the Surgeon General in the maintenance of military health and the provision of medical support to members, dependents and other authorised persons.[21] Neither the Defence Act nor the General Regulations describe the conduct of military healthcare professionals in the execution of their medical practice in the SANDF. Military healthcare professionals must reference the guidelines for professional practice from their respective statutory regulating authorities in order to maintain ethical conduct.[22] Unfortunately, guidelines issued by the various statutory regulators do not address ethical guidelines for professionals who have dual loyalty obligations such as those who are employed by the state (forensic services, correctional services and the military), insurance companies and sports teams.

The distinction between civilian and military healthcare professionals lies in the application of military disciplinary legislation contained in the Military Disciplinary Supplementary Measures Act 16 of 1999 (MDSMA) and the Military Disciplinary Code (MDC).[23] The MDSMA creates a system of military courts which exercise jurisdiction over certain crimes and disciplinary offences committed by members of the SANDF.[24] The MDC describes offences and prescribes sanctions for each offence.[25] The military healthcare professional is subject to disciplinary offences that

---

[18] Sec 34 Health Professions Act, 1974; Sec 31 Nursing Act, 2005; Sec 13(1) Pharmacy Act, 1974; Sec 15 Allied Health Professions Act, 1982. See Ch 2 paras 3.3-3.5 above.
[19] Preamble, Defence Act, 2002.
[20] Secs 5, 18, 50, 52 & 53 Defence Act, 2002. See Ch 2 para 3.5 above.
[21] Ch XV General Regulations to the Defence Act, 2002. See Ch 2 para 3.5.1 above for full reference.
[22] HPCSA Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act, 1974 BN 26 G. 36183.
[23] See para 4.2.1 Ch 2 above.
[24] As above and Sec 6 MDSMA, 1999.
[25] First Schedule to the Defence Act, 1957 from sec 5 and see para 4.2.1 Ch 2 above.

©University of Pretoria

carry serious sanction to which the civilian healthcare professional is not subject.[26] In addition, the professional boards of their respective profession bind military healthcare professionals and may also enact sanction if their regulations are transgressed. A dual responsibility to maintain military disciplinary codes as well as statutory health regulatory prescripts rests on the military healthcare professional.[27]

The Implementation of the Geneva Conventions Act 8 of 2012 is described as important domestic legislation for the military healthcare professional as it incorporates international humanitarian law (Geneva Conventions and the Additional Protocols) into South African legislation and provides for the sanction of transgressions of IHL.[28] Military healthcare professionals and members of the SAMHS are obliged to wear protective symbols and by so doing may be utilised exclusively as non-combatants in the roles of searching, care, administration and treatment of those who are *hors de combat*.[29]

The binding nature of conventions such as the Hague Convention, the Geneva Conventions and their Additional Protocols and the United Nations Charter on military healthcare professionals during times of armed conflict has been clarified.[30] International human rights conventions are shown to play an important part in the conduct of military healthcare professionals who in their careers are placed in situations to which these conventions apply.[31] Knowledge of and compliance with the various conventions listed not only will ensure lawful practice but also ethical conduct.[32] During military operations, which include armed conflict, operations other than war and peace support operations under regional organisations or the United Nations, a military healthcare professional's conduct is prescribed by international humanitarian law instruments such as the Geneva Conventions, the Additional Protocols and Law of The Hague.[33] Basic military training introduces the military healthcare professional to the fundamental principles of IHL, however, the complex dilemmas that arise as a result of the dual obligation they encounter to the individual

[26] As above.
[27] See para 4.3 Ch 2 above.
[28] Preamble Implementation of the Geneva Conventions Act, 2012 & Ch 2 para 3.6 above.
[29] Sec 17(1) Implementation of the Geneva Conventions Act, 2012.
[30] See paras 5.2-5.3 Ch 2 above.
[31] See paras 5.4 – 5.9 Ch 2 above.
[32] See para 5.10 Ch 2 above.
[33] See para 5.2.1 Ch 2 above.

©University of Pretoria

patient as opposed to the collective interests of the military mission are not addressed in any training currently offered in the SANDF.[34] If the military healthcare professional is unable to identify dual loyalty conflicts, they will be exposed to breaches of IHL and medical ethics for which the professional may personally be liable.[35]

The military healthcare professional is subject to the same legislative regulation as his civilian counterpart.[36] The exception to this statement is that military discipline also prescribes regulation and sanction applicable only to the uniformed member.[37] Military healthcare professionals are required to be registered and maintain their registration at their respective statutory authorities, thus, they are subject to the same professional conduct rules as their civilian counterparts.[38] The civilian healthcare professional is subject to IHL in armed conflict, however, their military counterpart to a greater extent is commanded by regulation created by the Law of Geneva and the Law of The Hague by virtue of his exposure to battlefield conditions.[39] As uniformed members the sanction for transgression may be much harsher as military professionals are measured against their obligation to be disciplined members of the SANDF.[40] Military healthcare professionals are required to undergo additional military training and while serving are subject to the same limitation of rights as their combatant comrades.[41]

Additionally, it was established that the military healthcare professional is bound not only by their professional code of ethics but by the oath they take to serve their country as a uniformed member of the armed forces. An understanding of military ethics complements compliance with medical ethics and is amalgamated as military medical ethics.[42]

---

34 Sec 20(11) Defence Act, 2002; see para 5.1 Ch 2 above.
35 Secs 5 & 6 Implementation of the Geneva Conventions Act, 2012.
36 Preamble and definition of military health establishment under the National Health Act, 1974 and see para 3.7 Ch 2 above.
37 Sec 4(5) First Schedule to the Defence Act, 1957 (MDC) and see para 3.5 Ch 2 above.
38 Fn 18 above & see para 3.3 Ch 2 above.
39 See para 3.6 Ch 2 above.
40 Sec 200 Constitution, 1996.
41 Fn 34 above.
42 See para 2 Ch 3 above.

©University of Pretoria

3.2 Dual loyalty conflicts

In answering which specific ethical and legal challenges are presented by the practice of military medicine and how these challenges lead to dual loyalties conflicts, the following was concluded.

Dual loyalties were defined as a clinical role conflict between professional duties to a patient and obligations, whether explicit or implied, real or perceived, to the interests of a third party such as an employer, insurer or the state.[43] Such conflicts have the potential to erode the trust relationship between the doctor and patient if the doctor identifies with the needs of the organisation and neglects the patient's individual medical needs. For example, a patient will be apprehensive to fully disclose sensitive information if there exists a chance for disclosure to an unauthorised third party.[44] The following dual loyalty conflicts were identified.

3.2.1 Conflicts of maintaining confidentiality against military necessity

Healthcare and the associative obligation of confidentiality are the fiduciary responsibility of the healthcare professional.[45] The consequence of not having trust in the healthcare professional who has been consulted will be that the medical condition either worsens to the detriment of the patient or that a greater risk to public health might emerge.[46] The above applies correspondingly in the context of the soldier-patient. The question arises whether a soldier, merely by serving in the armed forces, relinquishes their right to medical confidentiality or if a military healthcare professional is obliged to breach patient confidentiality at the command of a superior officer.[47]

Confidentiality is not an absolute right and in certain situations the doctor has ethical and legal obligations to breach that trust.[48] Maintaining confidentiality between soldier-patients and their military healthcare professional represents a major legal and ethical dilemma faced in the ranks of the armed forces as military commanders often

[43] See para 4.1 Ch 4 above.
[44] See paras 1 & 3.2 Ch 5 above.
[45] As above and ML Gross *Bioethics and armed conflict. Moral dilemmas of medicine and war* (2006) 117.
[46] R Bennett & CA Erin (eds) *HIV and AIDS: Testing, screening and confidentiality* (1999) 146.
[47] See sec 2 & 4, para 3.4 Ch 5 above.
[48] See para 3.4 Ch 5 above & Sec 14(2) National Health Act, 2003.

©University of Pretoria

demand information from military healthcare professionals about those they command under a generalised guise of military necessity or superior orders.[49] The right to privacy is entrenched in the Constitution, as is medical confidentiality in legislation and in ethical rules.[50] Breaches of the right may elicit sanction against the healthcare professional and the state.[51]

Despite there being limitations to confidentiality, service in the SANDF does not represent such a limitation.[52] Military necessity may not be used nor may obedience to a superior officer's orders as these exclusions are not described in law or in medical ethics as an acceptable exception permitting a breach of confidentiality without the informed consent of the patient.[53] There are mechanisms employed by the SANDF to manage the effective deployment of the soldier and in the ambit of a medical classification which dispenses with a need to disclose medical information unnecessarily.[54] International law prescripts protect the healthcare professional from being ordered to act in a manner contrary to medical ethical practices.[55] When there is a need to breach medical confidentiality the military healthcare professional must inform the patient, limit the breach to a specific person or persons and disclose only that which is absolutely necessary.[56]

3.2.2 Autonomous medical decision-making and military service

The right to freedom and security over oneself is constitutionally entrenched and in chapter 6 the questions examined are whether a soldier can exercise full medical autonomous decision-making and the consequential management on the part of the military healthcare professional. Service in the military does not preclude the right of a soldier-patient to active participation in medical decisions that affect their health.[57] These decisions may well affect continuing service in the armed forces if the soldier is

---

49 See sec 4 Ch 5 above.
50 Sec 14 Constitution, 1996; Sec 14 National Health Act, 2003 & HPCSA's *Booklet 5: Confidentiality; Protecting and Providing Information* (2016).
51 See para 4.2 Ch 5 above.
52 See para 3.4 Ch 5 above.
53 See paras 3.4 & 4.2 Ch 5 above.
54 Reg 3(2) General Regulations to the Defence Act, 2002.
55 Art 28 GC I, Art 16 AP I and Art 10 AP II.
56 See para 4.5 Ch 5 above.
57 See para 2 Ch 6 above.

©University of Pretoria

found to be unfit for further military service.[58] South African citizens voluntarily enter the SANDF with the understanding that a limitation exists on certain entrenched freedoms.[59] The healthcare professional enlisting in the armed forces makes the same choice to accept the limitation on autonomous decision-making within a traditionally autocratic military environment.[60]

The expression of autonomous decision-making corresponds to the legal prescription of informed consent. Informed consent is described in the Constitution, the National Health Act, the HPCSA's guidelines for ethical practice and case law.[61] The emphasis today is on a fully informed patient who is capable of exercising their decision free from a paternalistic, "doctor knows best", attitude.[62] A failure to have the informed consent of the patient to any procedure results in delictual liability and the possibility of a practitioner facing a criminal penalty.[63]

Healthcare professionals must respect the autonomous decisions made by their patients, even if these decisions are self-harming or lead to the eventual death of the patient.[64] The skills and competency of a healthcare professional must be honed to inform the patient in a medical manner that is clear, unambiguous and alleviates any misconceptions or fears regarding the prescribed medical treatment.[65] The military patient has been identified as a vulnerable person due to the authoritative and hierarchical environment in which he serves, which exhibits obedience to commands, submission to authority and limited autonomous decision-making.[66] The military healthcare professional as a rank-carrying member of the service is perceived not only as a healthcare professional but as an officer by the soldier-patient.[67] Healthcare professionals act unethically if they use military rank or authority to coerce patients

---

58 As above.
59 Sec 50 Defence Act, 2002. Restrictions on freedoms such as movement, communications, freedom to dress as one likes or to have grooming standards that are prescribed and so forth.
60 As above and Ch 5 para 3.4 above.
61 Sec 12(2)(c) Constitution, 1996; Secs 6-9 National Health Act, 2003; Health Professions Council of South Africa; and *Castell v De Greef* [1994] 4 All SA 63 (C).
62 TL Beauchamp & JF Childress *Principles of biomedical ethics* (6th ed) (2009) 208, TE Beam in DE Lounsbury & RF Bellamy *Military Medical Ethics* (2003) 379 and see para 3.1 Ch 6 above.
63 *Castell v De Greef* [1994] 4 All SA 63 (C). The court found that the failure of the physician to comprehensively inform a patient of all the material risks associated with a medical procedure constituted assault and not negligence.
64 See sec 4 Ch 6 above.
65 See sec 6 & para 5.3 Ch 6 above.
66 See sec 6 & paras 3.3.2, 3.3.3 Ch 6 above.
67 See para 4.3.1 Ch 6 above.

©University of Pretoria

into accepting treatment against their will and for the sake of military necessity.[68] Procedures for gaining the consent in situations where the soldier-patient is unable to consent are the same as in civilian medical practice; the exception is under the extreme conditions of the battlefield that preclude the express consent of the wounded, then treatment dependent on the situation is justified on the grounds of necessity.[69]

Notwithstanding the ability of the soldier-patient to exercise autonomous decision-making in peacetime, extreme conditions on the battlefield severely limit the exercise of this right.[70] In this situation individual rights are subordinated to the collective interest and the success of the military mission.[71] The requirement that the soldier return to the battlefield outweighs the right to refuse treatment or request an additional opinion or demand a specific treatment regime.[72] It is concluded that a dual loyalty conflict will arise as a result of comprehensive medical care as ordered by the healthcare professional not being delivered by a military command ordering the return to service of a soldier-patient. In this situation the decision of continued care is superseded by military necessity and may indemnify the military healthcare professional from any liability that may rise due to unresolved/unfinished medical treatment regimes.[73]

IHL provides that prisoners of war are safeguarded and that medical ethical rules apply equally to them, thus, their autonomous choice not to be subjected to forced medical treatment is protected.[74]

The use of military service members in clinical research studies is permitted with additional precautions that are accepted by the research community as applying to vulnerable populations.[75] Proper informed consent, use of researchers not in the line of command of the soldier, voluntary withdrawal, the availability of an impartial third party to consult, the exclusion of reward for participation and research specific to a

---

68 As above.

69 See para 4.2 Ch 6 above & MA Dada & DJ McQuiod-Mason *Introduction to medico-legal practice* (2001) 16.

70 TE Beam in Lounsbury & RF Bellamy *Military Medical Ethics* (2003) 379.

71 As above and fn 69 above.

72 ML Gross & D Carrick (eds) *Military medical ethics for the 21st Century* (2013) 202 and see para 4.2 Ch 6 above.

73 See para 4.2 Ch 6 above.

74 D Zupan *et al* "Dialysis for a prisoner of war" (2004) 1 *Hastings Cent Report* 11 and see Ch 6 para 5 above.

75 See para 3.3 Ch 6 above and reg 4.4 National Health Act, 2003 Regulations Relating to Research with Human Participants R719, 19 September 2014.

©University of Pretoria

military environment is considered fundamental in legal and ethical medical research.[76] An adherence to domestic legislation, international instruments and ethical codes of conduct in medical research conducted in the military will ensure research that is both lawful and ethical.[77]

3.2.3 Failing to care: Conflicts to benevolent actions

Benevolent actions are positive and are taken for the ultimate good of others and thus are viewed as morally superior to merely refraining from harmful behaviour.[78] As a guiding principle in the Hippocratic Oath, beneficence is considered to capture the moral essence of the professional responsibilities of the healthcare professional.[79] Dual loyalty dilemmas that a military healthcare professional encounters in discharging the beneficence principle includes subordinating the best interests of the patient to the greater military good, substandard medical record keeping, setting military priorities in triage decision-making and failing in the duty to care for the individual patient.[80]

In execution of the duty of care obligation, military healthcare professionals are responsible for two aspects of the soldiers' health and welfare. The first is a responsibility to ensure a fit for service soldier who is capable of deployment and, secondly, treatment and care after illness or injury has occurred.[81] The duality in these obligations exists in the priority that a military assigns to its medical support. The motto of the SAMHS is *"Audecas Servamus"* (we serve the brave). In comparison, the motto of the United States Medical Corp is "conserving the fighting force". The United States military's motto places fitness for service as a priority, whereas the SAMHS' promises a broader and encompassing service to the soldier as its priority.[82]

The above example demonstrates the pressure that can be exerted on military healthcare professionals to return soldiers to the battlefield as opposed to providing a benevolent and comprehensive care that may require a soldier's withdrawal from fighting and rehabilitation at home.

Chapter 7 examined battlefield triage and the principles of care for the wounded in

---

76 As above.
77 As above.
78 As above.
79 As above.
80 See sec 1 Ch 7 above.
81 See paras 2.1 & 2.2 Ch 7 above.
82 As above.

©University of Pretoria

situations where priorities must be set in the order of treatment so that the best outcome can be attained for the greatest number.[83] Military healthcare professionals may undermine their obligation to the duty of care principle by returning wounded soldiers to the battlefield where ordinarily they will refer the wounded to definitive home-based care. The same lack of principle will apply in situations where military healthcare professionals treat own forces first regardless of the severity of their wounds and neglect the enemy wounded and civilians contrary to the prescripts of IHL.[84] IHL dictates that the only priority of care is the severity of the illness or wounds.[85]

The situation may arise that military command dictates behaviour in conflict with bioethical (and often IHL) prescripts.[86] Military command, equipped with a greater knowledge of the military mission, however, may be correct in its terms in setting care and triage priorities for military doctors,[87] by which the treatment of the greatest number of lightly wounded soldiers to return to service ensures a favourable outcome to the tactical situation and leads to a greater chance of mission success. During military operations the flow of information does not reach all echelons of soldiers, including military healthcare professionals.[88] Soldiers execute orders as instructed by command and do not enjoy a luxury of questioning or offering an input into the course of action.[89] Military healthcare professionals are not privy to the overall tactical situation. In the circumstance of battlefield care the principle of beneficence is bound up not only with the wounded in need of medical intervention, but with the prevention of a situation that may lead to greater casualty numbers due to defeat in combat.[90]

Triaging casualties, whether on the battlefield or in mass casualty situations, involves making difficult decisions that ultimately will determine who lives and who dies. On the battlefield the loss of life and limb is inevitable. The duty to care for the largest number of wounded and being cognisant of the overall tactical situation (winning the battle) is the difficult task of the military healthcare professional. The additional

83 See sec 4 & paras 2.3 Ch 7 above.
84 See para 4.2 Ch 7 above & Art 27(3) GC I.
85 Art 12(3) GCI Art 12(3): "Only urgent medical reasons will authorize priority in the order of treatment to be administered".
86 See para 4.4.2 Ch 7 above & Lounsbury & Bellamy 313.
87 J Kelly (2013) *Is medical ethics in armed conflict identical to medical ethics in times of peace?* (2013) 48.
88. Lounsbury & Bellamy 313.
89 Lounsbury & Bellamy 181-182.
90 See para 3.4 Ch 7 above.

©University of Pretoria

burden placed on the military healthcare professional of understanding the military situation and recognising the role of the military command in the aim to save lives by ensuring dominance on the battlefield sets military medical practice apart from civilian healthcare.[91]

For the military healthcare professional to act in the interests of his patients he needs to take account of the overall tactical situation; as a result saving the lives of the ill and wounded is not the only concern but also supporting command by ensuring the fitness of the fighting force able to win the battle. In considering this additional responsibility the healthcare professional may have a role in preventing a greater number of casualties, that is, by escaping interment in a prisoner of war camp, by preventing unlawful killings if surrender is contemplated, as well as abuse and torture of soldiers by a belligerent determined to cause maximum physical and psychological harm in delinquent behaviour in regard to IHL.[92]

A collective benevolent ethic applies in military medicine, that is, the collective or the overall duty to care for the military force may be shifted from an obligation of individual beneficence and instead is based on possible defeat on the battlefield by a merciless belligerent. The above scenario represents an extreme situation, nonetheless a critical element to the military medical support is an understanding of battlefield dynamics.[93]

3.2.4 First (above all) do no harm: Duality in the principle of non-maleficence

The commitment not to cause harm at first glance is the overriding obligation of those who choose medicine as a career.[94] On further inspection the obligation is compromised; surgeons cut into flesh, remove diseased organs, amputate limbs and prescribe medication which may have side-effects that are dangerous and other medical interventions may cause pain and discomfort when performed. Thus, it is questionable to say the healthcare professional first (above all) does no harm. In performing medical procedures that "harm", the end is to improve health and not to have the procedure cause further insult to the person.[95]

91 See sec 5 Ch 7 above.
92 As above.
93 As above.
94 See Ch 8 fn 1 above.
95 See sec 6 Ch 8 above.

©University of Pretoria

Healthcare professionals who intentionally disregard this bioethical principle, *prima facie* act unethically and must be held accountable by the properly constituted professional conduct committees of their respective professional boards.[96] Chapter 8 examined extreme situations in which military healthcare professionals face a dilemma in that their lawful and ethical obligation to heal is in conflict with military orders. Four situations that test the legal and ethical character of the military healthcare professional were presented.

First, it was concluded that ample legal precedent exists in domestic law and IHL which defines the healthcare professional as a non-combatant.[97] Utilisation of healthcare professionals in a combatant role is a grave breach of international law for which personal accountability applies not only to the doctor but also the commander who issues the order.[98] Secondly, the involvement of healthcare professionals in the development of offensive weapons is prohibited.[99] The findings of the HPCSA in the *Basson* matter reaffirm IHL in that healthcare professionals can be held accountable for direct participation in the development of the means and methods of warfare.[100] Physicians must distance themselves when requested to partake in weapons development and understand that orders to develop weapons manifestly are unlawful and are to be disobeyed.[101]

The involvement of healthcare professionals in any aspect of torture, cruel inhumane and degrading treatment and punishment is unlawful and unethical. There can be no argument that exonerates or condones the physician being associated with such practices, the sole response is a report to the applicable authorities.[102]

The ethical quagmire that exists in the debate surrounding physician-assisted ending of life where all attempts have been exhausted to save the patient, during armed conflict or in peacetime, represents one of the greatest challenges a healthcare professional may face in their career. It was concluded that no pre-determinable action or guidelines exist that assist the physician in managing end-of-life decisions on the battlefield.[103]

---

96 As above.
97 See sec 3 Ch 8 above.
98 See para 3.3 Ch 8 above.
99 See para 4.4 Ch 8 above.
100 As above.
101 As above.
102 See para 5.5 Ch 8 above.
103 See paras 2.4.5 & 2.4.6 Ch 8 above.

©University of Pretoria

Domestic law maintains the illegality of actively assisting in ending the life of another despite heart-wrenching requests by the patient.[104] IHL does not specifically address physician-assisted suicide, active or passive euthanasia, other than the overall obligation of collecting and caring for the ill, shipwrecked and injured. The conclusion drawn by Beam is supported in that the best means to prepare for these situations is scenario-based training.[105]

3.2.5 Dichotomies and dual loyalty dilemmas in distributive justice

Unlike the situation in which difficult decisions plague public healthcare distribution, the SANDF is obliged to provide healthcare services to members, dependants, veterans and other authorised persons in a closed military healthcare system.[106] The fair and equitable distribution of medical resources is determined by internal policy and budgetary constraints.[107]

It was concluded that the bioethical principle of distributive justice as an obligation on the military healthcare professional could be tested during armed conflict as external pressure may force the abandonment of IHL prescripts for the provision of healthcare based solely on medical need and not on affiliation, age, gender, race and so forth.[108] Military healthcare professionals are best equipped to manage a fair distribution of medical resources among the wounded of their own forces, allied forces, enemy prisoners of war and civilians caught in the crossfire if there is an adequate supply that overwhelms restricted distributive issues, however, even the best equipped military forces of the wealthiest states may not be able to provide this abundance.[109]

3.3 Training the military healthcare professional

What is the extent of additional or special military medical training required for serving as a military medical practitioner? It was concluded in chapter 2 that to serve in the SANDF as a healthcare professional all statutory requirements are to be complied with, which includes holding the appropriate tertiary qualification and

104 See para 2.3 Ch 8 above.
105 See para 2.4.5 Ch 8 above & TE Beam in Lounsbury and Bellamy 391.
106 See para 2 Ch 8 above; General Regulations to the Defence Act Ch XV.
107 As above.
108 See paras 3.3.3 & 3.3.4 Ch 9 above.
109 See para 3.3.2 Ch 9; Art 10 AP I & Art 7 AP II.

©University of Pretoria

registration with a statutory regulating health professions council.[110] Graduates with the respective healthcare certificate, diploma or degree may voluntarily serve in the SANDF either on a full-time or a part-time (reserve force) capacity. The SANDF has numerous study opportunities where selected members are granted authority to pursue, on a full-time or part-time basis, undergraduate or post-graduate studies in a healthcare field such as medicine, nursing, emergency medical care, ancillary healthcare and psychology. The statutory regulated basic and post-graduate qualifications form only the basis for further specialised medical training.[111]

The SANDF is obliged to maintain training institutions offering general military training as well as service unique training such as motor vehicle maintenance, culinary arts, logistical support and basic emergency medical care.[112] These examples of service specific training may be pursued with registered providers and endorsed by legislation or is in-house training suited exclusively to the military environment. It is in this category of military specific training that many of the basic military emergency care courses are categorised, equipping all soldiers with rudimentary first aid skills to be applied in the field if the need arises. These introductory courses form the initiation into medicine for the undergraduate military healthcare professional.[113]

After graduating from tertiary medical schools and universities specific military medical fields of training may be applied for in preparing the healthcare professional to fulfil the role and function of a military healthcare professional. These learning opportunities are usually presented in-house at the SAMHS School for Military Health Training.[114] Courses are focused on primary care such as preventive medicine and trauma care. Specialised courses equip the military healthcare professional to function on-board SA Navy vessels, on aeromedical evacuation missions or in severe conditions such as extremes of temperature and environment. Biological and chemical warfare detection and decontamination are considered fundamental to any military force and the SANDF conducts in-house specialised training at units within the SAMHS.[115]

---

110 Fn 18 above.
111 Sec 63(4) Defence Act, 2002.
112 Sec 63 Defence Act, 2002.
113 As above.
114 As above.
115 As above.

©University of Pretoria

Military healthcare professionals will also be exposed to unique military training that their civilian counterparts may never experience. This training includes working in a mobile field hospital with surgical capabilities, the isolation of patients who have been exposed to biological, chemical or infectious agents, search and rescue missions involving helicopters and advanced trauma courses such as the Battlefield Advanced Trauma Life Support/Battlefield Advance Resuscitation Techniques course (BATLS/BARTS).[116]

Apart from formal medical training the military healthcare professional is obliged to attend military specific courses concentrating on military aspects such as command and control, military drills, deployment of the SANDF, weapon systems employed by the services and military law. Instruction in international humanitarian law is provided at all levels of military training.[117] A discussion of military medical law, ethics and IHL will be addressed in the following section when making recommendations.

This additional military-specific training that is not available to civilian healthcare professionals forms the backbone of the skills exercised by every military healthcare professional. Military healthcare professionals attend post-graduate programmes that will benefit the National Defence Force; these include specialist training in the predominantly surgical disciplines such as general surgery, plastic and reconstructive surgery, maxilla-facial surgery, trauma and critical care. Nursing officers complete post-basic courses in primary healthcare, trauma, critical care nursing and occupational health and safety.

4. Recommendations

4.1 Introduction

To address the research questions and based on the conclusions drawn recommendations are made in this section. The primary question asked is whether the military healthcare professional is a doctor or a soldier first. I return to this quandary at the end of the recommendations. The recommendations plot the way forward in

[116] Battlefield Advance Trauma Life Support (BATLS) 2000 146 *Journal of the Royal Army Medical Corp* 110-114. Following the attendance of Dr Ian Haywood, a British military surgeon to an American Advance Trauma Life Support (ATLS) course, the need was identified to develop a military version of the programme.

[117] Sec 199(5) Constitution, 1996.

©University of Pretoria

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

equipping the conduct of military healthcare professionals to be in legal and ethical parameters and in the best interest of the patient and, at the same time, be able to withstand the external pressures brought on by an authoritative military structure.

4.2 Recommendations regarding the drafting of legislation, ethical guidelines and internal military policies addressing military medical law and ethics

South Africa is a signatory to the most important IHL and human rights instruments.[118] The Republic has one of the most progressive and liberal constitutions in the world. Our transition from an oppressive regime to constitutional democracy without civil war has been lauded internationally. Yet, our past (and our developing present) displays transgressions of IHL that are examples of what to avoid. The Implementation of the Geneva Conventions Act 8 of 2012 together with the Implementation of the Rome Statute of the International Criminal Court Act 27 of 2002 are important pieces of legislation concerning conduct under and accountability for breaches of IHL. However, these instruments remain impotent if they are not taught, discussed and incorporated into the cultural values of the South African National Defence Force.

The SANDF is one of a handful of military services that has a military health service separated from the traditional military branches such as the navy, army and air force.[119] The South African Military Health Service is tasked with the provision of and maintenance of everything medically-related in the National Defence Force and the Service is guided by Regulations adopted in terms of the Defence Act.[120] The four-part chapter XV of the Regulations describes in detail the medical level of fitness for service, medical benefits and continued healthcare after retirement age, but does not address the legal or ethical obligations of military healthcare professionals. Regulations defining the conduct of military healthcare professionals in peacetime and during armed conflict should be included in the Regulations to complement IHL. The Health Professions Act, the Nursing Act, Pharmacy Act, Allied Health Professions Act do not address the legal and ethical conduct of healthcare professionals who carry the burden of managing the dilemma of dual loyalty.

---

[118] See sec 5 Ch 2 above.
[119] Sec 4A Defence Act, 2002.
[120] General Regulations to the Defence Act Ch XV.

©University of Pretoria

Ethical guidelines promulgated by the Health Professions Council dedicate a single paragraph to dual loyalty issues without offering any concrete guidelines on their management.[121]

The 2002 International Dual Loyalty Working Group drafted the most comprehensive account of dual loyalty dilemmas encountered in South Africa and internationally. However, the working group's recommendations have not been incorporated into SANDF policy. Further, no military healthcare professional in the SANDF was part of the working group, which may have contributed to the recommendations not being adopted by the military.

It is recommended that unambiguous and comprehensive guidelines should be drafted for inclusion in the Health Professions Council of South Africa's Guidelines for Ethical Conduct and should address dual loyalty dilemmas and their management based on the recommendations of the International Dual Loyalty Working Group. A section of the guidelines must be dedicated to military healthcare practice with recommendations for addressing dual loyalty conflicts on the home front and in a deployed area. The First Schedule to the Defence Act, 1957, the Military Disciplinary Code must be amended to remove any sanction imposed on soldiers who disobey the instructions of military healthcare professionals where such instruction is purely of a medical nature constituting advice on health-related issues that would undermine autonomous medical decision-making.

The United States Military Defence Health Board publishes a compendium titled "Ethical Guidelines and Practices for US Military Medical Professionals".[122] The compendium was drafted in response to questions regarding the ethical practice of US military healthcare professionals in discharging their responsibilities in dual loyalty conflicts. The publication addresses topics such as principles of military and medical ethics, ethical issues and military medical and ethical training. The British Medical Association publishes a "toolkit" titled "Ethical decision-making for doctors in the

---

[121] HPCSA *Guidelines for good practice in healthcare professions. Confidentiality Booklet 5 Protecting and providing information* 6.

[122] Office of the Assistant Secretary of Defense Health Affairs, March 2015.

©University of Pretoria

armed forces".[123] This toolkit is a user-friendly summary for military healthcare professionals in the British Armed Forces and covers topics such as medical and ethical principles, managing dual loyalties, detainee treatment and provides further sources for specific challenges. There is no similar publication for the South African military healthcare professional. By having regulations and ethical guidelines, the military healthcare professional will gain clarity regarding his conduct in situations that may conflict with his wearing a uniform of the National Defence Force. Military commanders and soldiers too will be made aware of the legal and ethical obligations of their healthcare professional comrades.

4.3 Recommendations regarding the status of healthcare professionals in the South African National Defence Force

It is lawful for a healthcare professional to serve in the armed services of a state and the situation in South Africa is not exceptional.[124] As registered healthcare professionals, uniformed members serve in a separate arm of service, the SAMHS. Service in the military requires wearing the prescribed uniform and the rank insignia designated for the specific seniority level of the soldiers' mustering. Healthcare professionals wear the same rank insignia as their soldier comrades. Lawful orders and instructions issued by superior officers must be obeyed and only clearly unlawful orders disregarded.[125] There is a real risk that orders or instructions that are not obviously unlawful may not be clear to all those who serve in the National Defence Force. New recruits or naïve serving members may not be aware that the orders issued to them by superiors manifestly are unlawful and believe that disobeying an order will result in military disciplinary action before a military court. Military history is saturated with accounts of subordinates who maintain their conduct was in line with following orders from superior officers only to be held personally accountable for unlawful acts committed under those orders.[126] This scenario applies to the defence

[123] BMA *Ethical decision-making for doctors in the armed forces: A tool kit. Guidance from the BMA Ethics Committee and Armed Forces Committee* (2012).

[124] See para 3.5 Ch 2.

[125] Available at https://www.researchgate.net/figure/Code-of-Conduct-for-Uniformed-Membersof-the-SANDF (accessed 1 February 2021).

[126] See para 4.3.2 Ch 8 above.

©University of Pretoria

relied on by 'Nazi doctors' during their trial for crimes against humanity after the Second World War.[127]

Military chaplains (religious personnel) do not wear the applicable rank insignia as promulgated in Regulations to the Defence Act.[128] Military chaplains instead have the religious symbol of their respective religious faith in the place of a military rank insignia. Chaplains are also addressed by their respective religious title (such as Father, Rabbi, Imam) or often colloquially as "chaplain".[129] Military chaplains are afforded a rank status of that of a colonel.[130] Chaplains must be respected and are protected under IHL in much the same way as healthcare professionals if they are exclusively executing their functions and not actively engaging with the enemy.[131]

Chaplains serve in the SANDF wearing the same uniform as regular soldiers and functioning under their professional qualification. However, they are not burdened with a military rank system that requires an authoritative hierarchy and unquestionable obedience regardless of the mustering of the ordering superior officer. A chaplain's status as that of a colonel (a senior officer) ensures that the military respect attributed to their function is part of military culture. Chaplains are respected for the service they offer to the members of the National Defence Force and through their service are seen as an integral part of the military.

Military healthcare professionals share in service the following characteristics as their chaplain comrades:

- Professionally qualified.
- Accountable under a specific professional code of conduct enforced by a regulating authority.
- Specific service rendered whether in peacetime or during armed conflict.
- Protection under IHL.

---

127 E Shuster "Fifty years later: The significance of the Nuremberg Code" (1997) *New England Journal of Medicine* available at https://www.nejm.org/doi/full/10.1056/nejm199711133372006 (accessed 10 October 2021); Complete transcript of the Nuremberg Medical Trial: United States v. *Karl Brandt et al* (Case 1) Washington, DC National Archives, 21 November 1946 – 20 August 1947 (Microfilm publication M887).

128 Reg 1 Ch III General Regulations to the Defence Act, 2002.

129 Reg 2 Ch III General Regulations to the Defence Act, 2002.

130 As above.

131 Art 24 GC I.

©University of Pretoria

- Professional titles such as doctor, sister, nurse, etcetera.

To align the status of military healthcare professionals to that of the military chaplaincy services it is recommended that the formal military rank be done away with. In consequence, the status afforded military healthcare professionals will be based on their professional capacity and not on a military rank. Military healthcare professionals still will serve in the same uniform as other soldiers but have "rank" insignia which corresponds (as for their chaplain counterparts) to the respective medical symbol of their profession; traditionally the caduceus emblem is indicative of the medical profession with variations thereof applied to different healthcare professions. Orders or instructions issued to military healthcare professionals in this circumstance will not contradict the obligation towards their patients and their primary purpose of being a healthcare professional. Professional practice will dictate the execution of medical orders in the care and treatment of patients.

It is further recommended that the SAMHS remains a separate arm of service within the SANDF; it is in line with domestic legislation and will reinforce obligations under IHL.[132] It was the intention of Henry Dunant to have neutral medical personnel care for the ill and wounded on the battlefield, thus the SAMHS will exhibit, as a separate arm of service, a symbolic "step away" from a combatant arm of service such as the army. In addition, SAMHS members identify colloquially as "medics" independent from their combatant comrades. SAMHS members will continue to regulate and develop themselves with the focus on providing medical support to the SANDF. The Surgeon General is the advisor on all matters pertaining to the medical care and support to soldiers, their families, veterans and other authorised clients.[133] The advice disseminated will remain objective and be scientifically based. The Chief of the SANDF or any of the other combatant services who acts contrary to the medical advice of the Surgeon General thus will not have the Surgeon General (or their healthcare professionals) made liable for adverse health outcomes that are due to a commander's decisions or orders.

Maintaining a professional medical identity is recommended in the SAMHS. A focus on all things related to medical practice in the military through affiliation to

[132] Ch XV General Regulations to the Defence Act, 2002.
[133] As above.

international military medical organisations such as the International Committee on Military Medicine (ICMM)[134] will ensure the continuing evolving of military medical practice and military medical ethics. Regional (Southern African Development Community) and international military medical cooperation by means of military skills-sharing exercises is recommended. Knowledge transfers, research, conferences and other programmes will encourage the professional military medical status and pride in military healthcare professionals.

It is recommended that the above conceptualising of the important status of the military healthcare professional deployed within the SANDF will strengthen the understanding and commitment to ameliorating the suffering caused during armed conflict. Pride in the status of a professional military doctor, nurse, medic or any other healthcare professional will reinforce the adoption of a non-combatant status under IHL and ensure that a humanitarian function is the primary mission.

4.4 Recommendations regarding training of military healthcare professionals and soldiers in aspects of military medical law, ethics and IHL

The obligation to teach members of the security services about the Constitution, law, customary international law and international agreements binding on the Republic is clear in section 199(5) of the Constitution. The further obligation exists that security service members must act in accordance with the above. The Defence Act too incorporates training of members of the SANDF at both tertiary educational institutions and training units under the command and control of the Minister of Defence and Military Veterans. The First Protocol Additional to the Geneva Conventions (article 6) places an obligation on the high contracting parties to train its members in the Conventions.

As the Constitution, domestic law and IHL prescribe training *inter alia* in IHL, the most important recommendation in this study is to equip members of the SANDF in military medical law, ethics and IHL to ensure knowledge of and compliance with their regulation in peacetime and during armed conflict. Military healthcare professionals require post-basic instruction concentrating on the specific aspects of medical law, ethics and IHL with the end state being a competent military healthcare professional

[134] Established after the First World War, this international and intergovernmental organisation's goal is for cooperation in the fields of military medicine.

©University of Pretoria

capable of acting lawfully and ethically in dual loyalty dilemmas and the dichotomies of service in the armed forces. It is recommended that training be facilitated in the following ways:

4.4.1 Initial or basic training for all military members

All recruits into the SANDF must be instructed in the basic principles of IHL that include the medical legal and ethical boundaries to which military healthcare professionals are subject to ensure that all military service members have a basic understanding so not to cause situations where command interventions in medical tasks have a potential to create dual loyalty situations for the military healthcare professional.

4.4.2 Specific military medical law and ethics training for military healthcare professionals

All military healthcare professionals undergo basic military training and further military specific training throughout their careers. During this military specific training emphasis on aspects of landward conventional warfare dominates the curriculum in the SAMHS. It is recommended that the curriculum for these military courses is reevaluated and military medical, ethical and IHL training is the primary objective for healthcare professionals. Formal residential classes with evaluations will ensure that military healthcare professionals are declared competent in these fields prior to graduating.

4.4.3 Mission-specific training prior to the deployment of military healthcare professionals

Military healthcare professionals provide medical support to all deployments and training exercises embarked on by the SANDF. Prior to deployments to missions that may include peace support operations (such as the United Nations Mission in the Democratic Republic of the Congo), regional peace support operations (such as the Southern African Development Community Mission in Mozambique) or any service/joint exercises, members of the SANDF undergo mission specific training. Military healthcare professionals must receive training in specific aspects of the mission they are to support with an understanding of the military mission and the possible dichotomies and dual loyalty conflicts that may rise from the mission. In such

©University of Pretoria

operations and exercises, lessons learned, and experiences must form part of a mission debrief in order to prepare for future deployments and to prevent a repetition of incidents that may provoke breaches of IHL, medical law and ethical conduct.

4.4.4 Continued Professional Development

The Health Professions Act of 1974 requires healthcare professions registered at the respective professional boards to maintain competencies in their respective fields by completing annual accredited continued professional development (CPD) assignments.[135] These assignments may be determined by the professional boards but usually consists of structure presentations, questionnaires about medical articles, lecturing on courses and so forth. CPD points are earned for participation in such assignments together with ethics points for attending opportunities specifically addressing bioethical issues. A certain number of points must be accrued throughout the year in order to maintain registration. The various medical directorates in the SAMHS undertake the in-house presentation of continued professional development. It is recommended that military medical, ethical and IHL topics are presented at as many opportunities as possible, so doing a broader audience will be reached in the formal training of military medical law, ethics and IHL. Healthcare professionals would not have to spend time and money pursuing CPD assignments outside the workplace and contemporary topics can be presented specific to military medical practice.

4.5 Identification of dual loyalty dilemmas and ethical decision-making

It is of little use to enact IHL in domestic legislation if that law is not disseminated, understood, practiced and taught to the persons to whom it applies. The conduct of belligerents during armed conflict as described in IHL and international law devotes considerable articles to the conduct of military healthcare professionals and other persons involved in the care, search and evacuation of the ill and wounded. Teaching the obligations created under IHL to healthcare professionals would be fruitless if dual loyalty conflicts are not identified. The management of dual loyalty conflicts together with ethical decision-making represents the end state that all military healthcare professions need to master.

[135] Sec 26 Health Professions Act, 1974.

©University of Pretoria

Scholars and authors cited throughout the thesis have their respective views on the topic. The shared conclusion is that civilian medical ethical practice is not the same as the practice of medicine and medical ethics in the military. From Sidel to Gross, Levy and Messelken, Howe, Pellegrino and Kelly, Miles and Beam, these commentators describe the differing approaches to solving dual loyalty conflicts. All agree that conflicts arise when the military healthcare professional is placed in a situation where he must choose between his medical ethical obligations towards his patient versus the interests of the state, usually presented on a foundation of military necessity. Howe and Beam conclude in Military Medical Ethics: Textbooks of Military Medicine[136] by offering an oversimplified algorithm for military medical ethical decision-making. The algorithm predominantly supports military necessity decisions trumping soldier-patient autonomy. This explanation is too simplistic and is rejected.

In consideration of the various approaches that were examined the following recommendations as applied to the South African military situation in the management of dual loyalty conflicts are offered:

1. The practice of the skills necessary to treat and care for the ill and wounded is non-negotiable. Professional, scientific-based procedures and protocols must not be compromised in the care of the ill and wounded.
2. Individual or personality characteristics differ from person to person. Knowledge of the self is paramount to understand what type of healthcare professional you are and what type your colleague is. Character under extreme pressures as experienced on the battlefield can reveal a person's true self and in reaction to battlefield stressors can illuminate true character. Healthcare professionals either predominantly identify with the needs of the military or consider the patients' need as the only consideration in their actions. Identifying overtly with military necessity may cause a physician to neglect an individual obligation to his patient's needs and in so doing breach the law, bioethics and IHL.
3. A sound knowledge of bioethics and IHL must be intrinsic to the practice of every military healthcare professional.

---

[136] Lounsbury and Bellamy 855.

©University of Pretoria

4. The ability to identify a dual loyalty conflict is the first step in its management. This skill will be achieved only through comprehensive training including actual examples from history and scenario-based exercises.
5. The patient remains the primary concern of the military healthcare professional with emphasis on the amelioration of the condition of the ill and wounded.
6. It is vital to understand the tactical (military situation) by engaging with command, as well as reinforcing the recognition among commanders of legal and ethical obligations set by professional medical practice and IHL.
7. The military healthcare professional never should stop advocating the best interests of the patient.
8. Accept that the tactical or military situation involves decisions as difficult as in medical practice where life or death decisions are the order of the day. The command may make decisions contrary to medical orders or advice based on military necessity.
9. The military healthcare professional must suggest alternatives to military command decisions that may be to the detriment of the ill and wounded. Military command is at liberty to accept or reject advice.
10. Maintain comprehensive records of all events that transpire even if the records are created at the earliest time after the fact.
11. The military healthcare practitioner will evaluate every situation on its own merits to keep the patient informed of and part of the treatment plan or will decide to apply the opinion of therapeutic privilege by withholding information detrimental to the well-being of the patient.
12. The military healthcare professional must be actively involved in the planning of military operations to ensure that adequate medical support is available. In situations where a lack of medical resources is experienced, the military command must be informed to amend the course of action or ensure an adequate supply.
13. Referral systems must be in place that all military healthcare professionals have access either to senior colleagues or to specialist medical legal counsel if consultation or advice is sought.
14. In the approach to dual loyalty conflicts, the military healthcare professional must accept that the burden of protecting the sovereignty of a state may come

©University of Pretoria

with inherent risks such as loss of life. Society, in turn, and the political and military command have an obligation to ensure that those who place themselves in harm's way are afforded every opportunity to survive. The healthcare professional is well-versed in understanding when the interests of the collective supersede the obligations to the individual (such as reporting abuse, torture, communicable disease). Situations will be encountered where military necessity supersedes bioethics and the military healthcare professional may forsake autonomous decision-making of the soldier-patient or not act benevolently either by not initiating treatment or by abandoning a duty to continue with care. Commentators agree that although the instances of military necessity overriding bioethics are rare such situations must be understood and planned for.

15. Lastly, preparing the military healthcare professional to act in such situations is advocated; however, preparing the soldier to understand the limits of bioethics in extreme situations also will address the necessity that there might be conflict should the situation arise.

4.6 Doctor or soldier first?

Doctors can be soldiers.[137] This is concluded in that domestic law and IHL both allow for all manner of healthcare professionals to serve in the armed forces of a state. However, unlike in the past, military forces do not consist only of the foot soldier. Modern military structures employ professionals that support the combat soldier. From accountants to human resource practitioners, logisticians to lawyers, the modern military's organisational structure displays traits common to a business or company. But the primary function of the military is to defend the territorial sovereignty of the state, the only such organisation lawfully permitted to do so in South Africa.[138] Protecting state sovereignty translates to the lawful use of deadly force to take lives and destroy property during armed conflict. As contrasted with the doctor's obligation to prevent death by healing the ill and injured, this dichotomy of professional obligations seems not to belong in the same organisation.

In reaching a definitive conclusion to whether a doctor in military service is primarily a

137 Fn 124 above.
138 Sec 199(1) & sec 200(2) Constitution, 1996.

soldier or primarily a doctor the following is offered:

First, does the military healthcare professional primarily identify with a soldier status or do they primarily identify as a healthcare professional? If they identify as a soldier first the risk may be that the doctor may always consider military need over the individual patient's need. Orders that relate to medical matters that are unlawful or unethical may be executed as this type of physician will consider the orders in accordance with the mission or military necessity. In that case there may be breaches of medical law, bioethics and IHL for which the physician will be held personally liable.

Secondly, the healthcare professional who primarily identifies as a doctor would consider their patient's needs above those of the military mission. In such a situation there will be conflict arising from an external pressure placed on the physician and them being ostracised from the military "team". In turn the relationship of trust that military command has in the doctor will be eroded if the doctor disobeys a military order and military disciplinary charges may follow.

A healthcare professional who maintains legal and ethical practice in extreme situations they encounter in military service, who can identify the dual loyalty dilemma and has the skills to manage the situation, represents the physician who has mastered their primary responsibility as a military healthcare professional. The military healthcare professional knows primarily they are a doctor and is charged with filling the needs of their patient, a role that their comrades in arms expect of them, a role they have trained for and role they understand carries consequences if transgressed. The healthcare professional acknowledges that military medical practice will present situations where obligations to the individual patient will be challenged by an obligation to the collective military. When this dual loyalty creates conflict the military healthcare professional will maintain their primary function as doctor but acknowledge that military authority may override their treatment decisions. It does not mean the military healthcare professional abandons their professional obligations but they will continue to advocate for the best interests of their patient in line with the tenets of bioethical principles. The military healthcare professional understands that as healthcare professionals they will not be called upon to make military or command decisions nor should they be ordered to function in a combatant role.

To summarise; the military healthcare professional spends years in tertiary medical training to attain a qualification for which they must register and maintain an annual registration with a statutory regulating authority in order to seek employment and practice lawfully. Service in the SANDF as in the case of any other employer requires this obligation. A deviation from established professional conduct will result in sanctions imposed by the regulating bodies that may cause the healthcare practitioner to forfeit continued registration and thus will not be able to continue with their employment. The regulations to the Defence Act require registration as a prerequisite to practice in the SANDF.

IHL provides that persons exclusively engaged in the search, treatment and care of the ill and wounded are afforded a protected status and may not be targeted provided they do not engage in offensive military operations. The incorporation of IHL, specifically the Geneva Conventions, into South African domestic legislation describes severe sanction for breaches of IHL.

Domestic law and IHL clearly intend a healthcare professional primarily to discharge their function as a healthcare professional.

Military doctors are doctor's first and military officers second.

5. Closing remarks

From the beginning, the first professional military healthcare providers, the Knights of the Order of St John, continuing with the initial battlefield care provided by surgeons in the Napoleonic armies and culminating in the published observations of a Swiss banker on the battlefields of Europe, medical care for the sick and wounded in battle has evolved into the modern practice that has reduced death due to battlefield wounds or disease to a single digit percentage. The greatest advances in modern medicine have their origin on the battlefield. Yet the history of the conduct of healthcare professionals practicing in the military has left much to be desired. The record in South Africa unfortunately shows how identification with the political ideals of a state influences adhering to bioethical principles and leads to unlawful and unethical medical practice.

The thesis opens with an extract from Henry Dunant's book, *A memory of Solferino*, in which he lays the basis for compiling his painful experiences of the conditions in

which the wounded were left after a battle. Dunant's hope was that his words would encourage improvements on the current situation; in this his objective has been gained many times over. The subsequent codification of the amelioration of the condition of the sick, wounded and shipwrecked together with the treatment of those no longer engaged in battle remains the most important text for conduct on the battlefield. The humanitarian response to arguably humankind's darkest manner of resolving conflict, armed conflict, rests with those committed to the ideals of Henry Dunant.

Healthcare professionals and those charged with caring for the sick, wounded and shipwrecked have no other business but the interests of those placed under their care. The accepted bioethical principles of autonomy, beneficence, non-maleficence and justice may not be deviated from on the premise of military necessity. If extreme situations occur during armed conflict that challenge these principles, the military healthcare professional must be equipped to resolve a dual loyalty dilemma and put the interests of the patient first on an understanding that the resolution of the conflict does not rest in their hands.

©University of Pretoria

TABLE OF AUTHORITIES

Cases

South Africa case law

Basson v Hugo 2019 JDR 0707 (GP)

Basson v Hugo and Others 2018 (1) All SA 621 (SCA) 27

Carmichele v Minister of Safety & Security 2001 (4) SA 938 (CC)

Castell v De Greef [1994] 4 All SA 63 (C)

Doe v Sullivan 938F. 2d 1370 US App DC 111 decided July 16 1991

Dr Wouter Basson v Professor JFM Hugo & 2 others ase number 29967/2015 (GP)

Dwenga and four others v Surgeon General of the South African Military Health Service 40844/2013

Harksen v Lane NO 1998 (1) SA 300 (CC)

Khumalo v Holomisa 2002 (5) SA 401 (CC)

Magwane v Minister of Health NO 1981(4) SA 472 (Z)

Minister of Defence v Potsane and Legal Soldier (Pty) Ltd and others v Minster of Defence and others, Case CCT 14/01

Minister of Health and Others v Treatment Action Campaign and Others (No 2) (CCT8/02) (2002) ZACC 15; 2002 (5) SA 721 (CC); 2002 (10) BCLR 1033 (CC) 5 July 2022

Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape [2015] ZACC 33

S v Basson 2000 (1) All SA 430 (T)

S v Basson 2000 (3) All SA 59 (T)

S v Basson 2004 (1) SA 246 (HHA)

S v Basson 2005 (12) BCLR 1192 (CC)

S v Hartmann 1975 (3) SA 532 (C)

Soobramoney v Minister of Health (Kwa-Zulu Natal) 1998 (1) SA 765 (CC)

South African Security Forces Union v Surgeon General AO Case No. 18683/07 (2008)

Spendiff v East London Despatch Ltd 1929 EDL 113

Stransham-Ford v Minister of Justice and Correctional Services and Others 2015 (4) SA 50 (GP)

©University of Pretoria

Foreign case law

In Re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976)

John Doe and Jane Doe vs Louis Sullivan and Richard Cheney USDC, District of Columbia, 756F Supp 12 January 31 1991

United States of America v Karl Brandt et al (case 1) 20 August 1947 United States Military Tribunal

United States v Levy. CMR. 1968; 39

Legislative instruments

South African Legislation

Allied Health Professions Act 63 of 1982

Constitution of the Republic of South Africa, 1996

Children's Act 38 of 2005

Defence Act 44 of 1957

Defence Act 42 of 2002

Defence Act 42 of 2002: General Regulations for the South African Defence Force and the Reserve

Disaster Management Act 57 of 2002

First Schedule to the Defence Act 44 of 1957 The Military Disciplinary Code

Health Professions Act 56 of 1974

Implementation of the Geneva Conventions Act 8 of 2012

Implementation of the Rome Statute of the International Criminal Court Act 27 of 2002

Interim Constitution of the Republic of South Africa: Act 200 of 1993

Medical Research Council Act 17 of 2002

Medical Schemes Act 131 of 1998

Military Discipline Supplementary Measures Act 16 of 1999

©University of Pretoria

National Environmental Management Act 107 of 1998

National Health Act 61 of 2003

Nursing Act 33 of 2005

Occupational Health and Safety Act 85 of 1993

Pharmacy Act 53 of 1974

Promotion of Access to Information Act 2 of 2000

Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000

Protection of Personal Information Act 4 of 2013

State Liability Act 20 of 1957

South African Medicines and Related Substances Control Act 101 of 1965

Water Services Act 108 of 1997

International Law

Treaties, Conventions, Charters and Declarations

African Charter on Human and Peoples' Rights. Adopted 27 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982) entered into force 21 October 1986

American Convention on Human Rights, Nov. 22, 1969, 1144 U.N.T.S. 123

Charter of the International Military Tribunal at Nuremburg, August 8, 1945, 59 Stat. 1546, 82 U.N.T.S. 279

Charter of the United Nations, 24 October 1945, 1 U.N.T.S. XVI

Convention on the Rights of the Child, adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989 entry into force 2 September 1990, in accordance with article 49

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment New York 10 December 1984

©University of Pretoria

Convention for the Protection of Cultural Property in the Event of Armed Conflict, opened for signature 14 May 1954, 249 U.N.T.S. 240 (entered into force 7 August 1956)

Convention on Certain Conventional Weapons and the 1997 Ottawa Convention on Anti-Personnel Mines

Convention on or Restrictions on the Use of Certain Conventional Weapons which may be Deemed to be Excessively Injurious or have Indiscriminate Effects, Oct. 10, 1980, 1342 U.N.T.S. 137, 19 I.L.M. 1524

Declaration of Minimum Humanitarian Standards, reprinted in Report of the Sub-Committee on Prevention of Discrimination and Protection of Minorities on its Forty-sixth Session, Commission on Human Rights, 51st Sess, Provincial Agenda Item 19, 4, UN Doc. E/CN.4/1995/116 (1995)

Draft Convention for the Protection of Civilian Populations Against New Engines of War adopted by the International Law Association, 29 August – 2 September 1938 (not opened for signature) (ILA Draft Convention), reproduced in Schindler and Toman

Draft Rules for the Limitation of the Dangers Incurred by the Civilian Population in Time of War, approved by the International Conference of the red Cross, 1956 (no entry into force) (1956 Draft Rules)

European Convention for the Protection of Human Rights and Fundamental Freedoms, Sept 3, 1953, 213 U.N.T.S.

General Convention for the Amelioration of the Condition of the Wounded and the Sick in Armed Forces in the Field, opened for signature on 12 August 1949, 75 U.N.T.S. 31 (entered into force 21 October 1950)

General Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea, opened for signature on 12 August 1949, 75 U.N.T.S. 85 (entered into force 21 October 1950)

Geneva Convention Relative to the Treatment of Prisoners of War, opened for signature on 12 August 1949, 75 U.N.T.S. 287 (entered into force 21 October 1950)

©University of Pretoria

Geneva Convention for the Relative to the Treatment of Civilian Persons in Time of War, opened for signature on 12 August 1949, 75 U.N.T.S. 135 (entered into force 21 October 1950)

Hague Convention (II) with respect to the Laws and Customs of War on Land, 32 Stat. 1803, opened for signature 29 July 1899 (entered into force 4 September 1900) (1899 Hague Convention) and its Annex, Regulations Respecting the Laws and Customs of War on Land (1899 Hague Regulations)

Hague Convention (IV) Respecting the Laws and Customs of War on Land, 1910 UKTS 9, opened for signature 18 October 1907 (entered into force 26 January 1910) (1907 Hague Convention), and its Annex, Regulations Respecting the Laws and Customs of War on Land (1907 Hague Regulations)

International Covenant on Civil and Political Rights, 19 December 1966, 999 U.N.T.S. 17, 6 I.L.M. 368 (entered into force 23 March 1976)

International Treaty for the Renunciation of War as an Instrument of National Policy signed in Paris, 27 August 1928, 94 L.N.T.S, 57, 46 Stat 2343. T.S. No. 796

Legality of the Threat or Use of Nuclear Weapons 1996 ICJ Reports 226, 257

Montevideo Convention on the Rights and Duties of States, 1933

Protocol Addition to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts, 1125 U.N.T.S. 3

Protocol Addition to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflicts 1125 U.N.T.S. 609

Rome Statute of the International Criminal Court, U.N. Doc. A/CONF. 183/9 37 I.L.M. 999 (July 17, 1998)

Statute of the International Court of Justice, June 26, 1945, 59 stat. 1055, 33 U.N.T.S. 993

World Medical Association Declaration of Tokyo – Guidelines for Physicians concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in relation to Detention and Imprisonment. Adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975 and revised by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

©University of Pretoria

Universal Declaration of Human Rights, GA Res. 217A (III), U.N. Doc A/810 at 71 (1948)

United Nations Convention on Rights of Persons with Disabilities (A/RES/61/106)

World Medical Association Regulations in times of armed conflict and other situations of violence, 10th World Medical Assembly, Havana Cuba October 1956 and revised by the 63rd WMA General Assembly, Bangkok, Thailand, October 2012.

Vienna Convention on the Law of Treaties, opened for signature May 23, 1969, 1155 U.N.T.S. 331 (entered into force Jan 27, 1980)

Ethical Guidelines

South African ethical guidelines

Health Professions Council of South Africa Guidelines for Good Practice in Health Care Professions: Booklets (2016) Pretoria South Africa BN 26, G (1 March 2013)

Medical Research Council Guidelines on Ethics for Medical Research (Pretoria 4th ed) (2004)

Guidelines on Ethics for Medical Research: General Principles (Book 1), South African Medical Research Council (2000)

Foreign ethical guidelines

Defense Health Board: Ethical Guidelines and Practices for U.S. Military Medical Professions Office of the Assistant Secretary of Defense Health Affairs Falls Church Virginia (2015)

Ethical decision making for doctors in the Armed forces: a tool kit. Guidance from the BMA Medical Ethics Committee and Armed Forces Committee. British Medical Association

U.S. Military Medical Professionals: Ethical Guidelines Practices and Issues. Nova Publishers New York (2016)

International ethical guidelines

Council for International Organisations of Medical Sciences (CIOMS) International Ethical Guidelines for Biomedical Research involving Human Subjects World Health Organisation Press Geneva Switzerland (1982)

Declaration of Geneva World Medical Association Handbook of Declarations. Geneva: World Medical Association (1997)

Handbook on International Rules Governing Military Operations. Geneva Switzerland (2013)

Health Care in Detention: A Practical Guide International Committee of the Red Cross Geneva Switzerland (2017)

Principles of medical ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment. United Nations General Assembly, 1982

Summary of the Geneva Conventions of 12 August 1949 and their Additional Protocols: Geneva Switzerland (2012)

The Fundamental Principles of the International Red Cross and Red Crescent Movement: Ethics and Tools for Humanitarian Action Geneva Switzerland (2012)

The National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research "The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research" (1979)

The Nuremberg Code: Charter of the International Tribunal at Nuremburg, August 8, 1945, 59 Stat 1546, 82 U.N.T.S. 279

World Medical Association Declaration of Helsinki: Recommendations Guiding Medical Doctors in Biomedical Research Involving Human Subjects (Adopted on the 18th World Medical Assembly, Helsinki, Finland, 1964, and as revised by the 29th World Medical Assembly, Tokyo, Japan, 1975)

Miscellaneous sources

©University of Pretoria

Health Care in Danger: Making the Case International Committee of the Red Cross Geneva Switzerland (2011)

Health Care in Danger: Meeting the Challenges International Committee of the Red Cross Geneva Switzerland (2015)

Health Care in Danger: The Responsibilities of Health Care Personnel Working in Armed Conflicts and other Emergencies Geneva Switzerland (2012)

Hugo J. Dr Wouter Basson: The HPCSA's professional conduct committees ruling, 19 December 2013

ICRC *First Aid in Armed Conflicts and Other Situations of Violence* ICRC, Geneva, 2010

Safeguarding the Provision of Health Care: Operational Practices and Relevant International Humanitarian Law Concerning Armed Groups Geneva Switzerland (2015)

Secretary-General's Bulletin ST/SGB/1999/13 dated 6 August 1999, Observance by United Nations forces of international humanitarian law

South African Defence Review Department of Defence (2015) Parliamentary Monitoring Group, Pretoria South Africa

©University of Pretoria

BIBLIOGRAPHY

Books

Baccino-Astrada, A *A Manual of the rights and duties of medical personnel in armed conflict* (ICRC: Geneva 1982)

Beauchamp, TL & Childress, JF *Principles of biomedical ethics* 6th ed (Oxford University Press: Oxford 2009)

Bellamy, C *The State of the World's Children* (Oxford University Press: New York 1996)

Bloom, H & Bay, M (eds) *A practical guide to mental health, capacity and consent law of Ontario* (Monarchy books: Ontario 1996)

Bulger RJ, (ed) *Hippocrates revisited: A search for meaning*. (Medcom Press: New York 1973)

Carr, C *Unlocking medical law and ethics* (Hodder Education: Oxon 2012)

Carstens, PA & Pearmin, D *Foundational principles of South African medical law* (LexisNexis: Durban 2007).

Cook, P *A Profession Like no Other* (Routledge Handbook of military ethics: Routledge 2015)

Cubano, MA & Lenhart, MK (eds) *Emergency war surgery* (US Army Borden Institute 2013)

Dada, MA & McQuoid-Mason, DJ *Introduction to medico-legal practice* (Butterworths: Durban 2001)

Dhai, A & McQuoid-Mason, DJ *Bioethics, human rights and health law: Principles and practice* (Juta: Cape Town 2011)

Dugard, J *International law: A South African perspective* 4th ed (Juta: Cape Town 2013)

Dunant, H *A memory of Solferino* (International Committee of the Red Cross: Switzerland 1959)

Fisher, D *Morality and war* (Oxford University Press: Oxford 2011)

© University of Pretoria

Gabriel, RA *Between flesh and steel, A history of military medicine from the middle ages to the war in Afghanistan* (Potomac Books: Washington DC 2013)

Giannou, C & Baldan, M *War Surgery: Working with limited resources in armed conflict* Vol 1 (ICRC: Geneva Switzerland 2010).

Ginbar, Y *Why not torture terrorists* (Oxford University Press: Oxford 2008)

Greenberg, KJ & Dratel, JL *The torture papers: The road to Abu Ghraib* (Cambridge University Press: New York 2005)

Giesen, D *International medical malpractice law* (Marthinus Nijhoff: Dordrecht 1988)

Gould, C and Folb, P *Project Coast: Apartheid's chemical and biological warfare programme* (United Nations Institute for disarmament research [UNIDIR] United Nations 2002)

Gross, ML *Military medical ethics in war and peace* (Routledge: Oxon 2015)

Gross, ML *Bioethics and armed conflict. Moral dilemmas of medicine and war* (MIT Press 2006)

Gross, ML *Moral dilemmas of modern war. Torture, assassination and blackmail in an age of asymmetrical conflict* (Cambridge University Press: Cambridge 2010)

Gross, ML & Carrick, D *Military medical ethics for the 21st century*: (Ashgate: Surrey 2013)

Hall, MA *et al Health care law and ethics in a nutshell* 2nd ed (West Publishing Company: Minnesota 1999).

Hassim, H *et al The National Health Act 61 of 2003; A Guide* (Section 27 2008)

Held, V *The ethics of care: Personal, political, and global* (Oxford University Press: Oxford 2006)

Henckaerts, J & Doswald-Beck, *L Customary International Humanitarian Law Volume 1: Rules* (ICRC Cambridge University Press: Cambridge 2009)

Herring, J *Medical law and ethics* (Oxford University Press: Oxford 2010)

Hitler, A *Mein Kampf (*Houghton Mifflin: Boston 1943)

© University of Pretoria

Huntington, SF *The Soldier and the state.* (Harvard University Press: Cambridge 1959).

Joly, Y & Knoppers, BM *Routledge handbook of medical law and ethics* (Routledge: Oxon 2015)

Kelly, J Is *Medical ethics in armed conflict identical to medical ethics in times of peace?* (Cambridge Scholars Publishing: Newcastle 2013)

Kochi, T *The other's war. Recognition and the violence of ethics* (Birkbeck Law Press: New York 2009)

Lounsbury, DE & Bellamy, RF (eds) *Military medical ethics* (Office of the Surgeon General: United States Army 2003)

Mack, M *Increasing Respect for international humanitarian law in non-international armed conflicts* (International Committee of the Red Cross Geneva Switzerland 2008)

Mason, JK & McCall-Smith, RA *Law and medical ethics*, 5th ed (Butterworths: London 1999).

McCallum, JE *Military Medicine, From Ancient Times to the 21st Century*. (ABC Clio Inc: USA 2008)

Melzer, N *International humanitarian law, A comprehensive introduction* (International Committee of the Red Cross: Geneva 2016).

Merrick, C (ed) *ATLS® Advanced trauma life support: Student course manual* 10th ed (American College of Surgeons: United States of America 2018).

Miles, SH *The Torture doctors: Human rights crimes and the road to justice* (Georgetown University Press: Washington DC 2020)

Millett, AR *Military professionalism and officership in America* (The Mershon Center of The Ohio State University: Columbus Ohio 1977)

Moodley, K (ed) *Medical ethics, law and human rights: A South African perspective* (Van Schaik Publishers: Pretoria 2011)

Moore, DA et al (eds) *Conflicts of interest: Challenges and solutions in business, law, medicine and public policy* (Cambridge University Press: New York 2005)

© University of Pretoria

Moskos CC *Institutional and Occupational Trends in Armed Forces. The Military: More Than Just a Job?* (McLean, Virginia: Pergamon-Brassey 1988)

Nicholson, H *The Knights Hospitaller* (The Boydell Press: Suffolk 2001)

Orwell, G *1984* (Secker & Warburg 1949)

Ramlakan, VJ *Mandela's Last Years* (Penguin Random House Cape Town 2017)

Rettig, RA *Military use of drugs not yet approved by the FDA for CW/BW defense. Lessons from the Gulf Wa*r (RAND 1999)

Robinson, F *The ethics of care: A feminist approach to human security* (Temple University Press: Philadelphia 2011)

Roberts, A & Guelff, R (eds) *Documents on the Laws of War* (Oxford University Press: Oxford 2000)

Snyman, CR *Criminal law* 5th ed (Lexis Nexis: Durban 2008)

Stauch, M & Wheat, K *Text, cases and materials on medical law* (Routledge-Cavendish: New York 2006)

Stapleton, TJ *A Military History of South Africa. From the Dutch Koi Wars to the End of Apartheid* (Praeger: Santa Barbara 2010)

Steiner, HJ & Alston, P (eds) *International human rights in context* (Clarendon Press: Michigan 2000)

Temkin, O *Hippocrates in a World of Pagans and Christians*. (Johns Hopkins University Press: Baltimore 1991)

Veatch, RM *Cross Cultural Perspectives in Medical Ethics* (Jones and Bartlett Publishers 2000)

Wicks, E *The Right to Life in Times of War or Armed Conflict. The Right to Life and Conflicting Interests* (Oxford Academia: Oxford 2010)

Chapters in Books

Beam, TE "Medical ethics on the battlefield: The crucible of military medical ethics" in DE Lounsbury & RF Bellamy *Military Medical Ethics, Vol 2* (Office of the Surgeon General Department of the Army, United States of America 2003)

Bernard, V *et al* "Dehumanization: a composite psychological defense in relation to modern war" in Milton Schwebel (ed) *Behavioral science and human survival* (Behavioral Science Press: Palo Alto, Cal 1965)

Jonsen, AR "Do no harm: axiom of medical ethics" in: Spicker, SF & Engelhardt, HT eds *Philosophical medtcal ethics: its nature and significance* (Reidel: Dordrecht 1977)

Olsthoorn, P *et al* "Dual loyalties in military medical care – Between Ethics and Effectiveness" in Amersfoort *et al* (eds) *Moral responsibility & military effectiveness* (TMC Asser Press: Netherlands 2013)

Vastyan, EA "Warfare: Medicine and war" in Reich, WT (ed) *Encyclopedia of Bioethics* 2nd ed. Vol. 4 (Ney York Macmillan 1978)

Journal articles

Annas, GJ "Medical ethics and human rights in wartime" (2015) 105 (94) *South African Medical Journal*

Annas, G & Grodin, MA "Commentary on 'Treating the Troops '"(1999) 1 *The Hastings Center Report* (as cited in RA Rettig *Military use of drugs not yet approved by the FDA for CW/BW defense. Lessons from the Gulf War*

Benatar, SR & Upshur, REG "Dual Loyalty of Physicians in the Military and in Civilian Life" (2008) *American Journal of Public Health* 2161-2167

Clark, PA "Medical Ethics at Guantanamo Bay and Abu Ghraib: The Problem of Dual Loyalty" (2006) *Journal of Law, Medicine and Ethics* 570-580

Cookson, R & Dolan, P "Principles of justice in health care rationing" (2000) 26 *Journal of medical ethics* 323-329

DeWitt, C "Medical Ethics and the Law: The Conflict between Dual Allegiances" (1954) *Case Western Reserve Journal of International Law* 5

© University of Pretoria

Dierickx *et al* “Drugs used for euthanasia: A repeated population-based mortality follow-back study in Flanders, Belgium 1998-2013” (2018) *Journal of Pain and Symptom Management*

Domres, B *et al* “Ethics and triage” (2001) 16 *Prehospital and Disaster Medicine*: *The Official Journal of the National Association of EMS Physicians and the World Association for Emergency and Disaster Medicine in association with Acute Care Foundation*

Du Preez, M “The Geneva Conventions and South African Law” (2013) *Institute for Security Studies Policy Brief*

Dworkin, R “Law’s Empire” (1986) 206 as cited in AJ Simmons “Associative political obligations” 106 *Ethics* 247

Eckenwiler, L *et al* “Counterterrorism policies and practices: Health and values at stake” (2015) 10 *Bulletin of the World Health Organization* 93

Eide, M “Stephen Biko and the Torture Aesthetic” (2014) 38(1) *Ufahamu: A Journal of African Studies*

Enabulele, AO & Imoedemhe, CO “Unification of the Application of International Law in the Municipal Realm: A challenge for contemporary international law” (2008) 12 *Electronic Journal of Comparative Law (EJCL)* 7

Frykberg, ER “Triage: principles and practice” (2005) 94 *Scandinavian Journal of Surgery*

Fujio, CC “Dual Loyalties: The Challenges of Providing Professional Health Care to Immigration Detainees” (2011) *Physicians for Human Rights*

Gasser, HP “Acts of Terror, ‘Terrorism’ and International Humanitarian Law” (2002) 184 *IRRC* 847

Gillon, R “Primum non nocere and the principle of non maleficence” (1985) 291 *British Medical Journal*

Grodin, M & Annas, G “Physicians and Torture: Lessons from the Nazi Doctors” (2007) 867 *International Review of the Red Cross*

© University of Pretoria

Gross, ML "Bioethics and Defence, Military Medical Ethics, A Review of the Literature and a Call to Arms" (2013) *Cambridge Quarterly of Health Care Ethics Cambridge University Press*

Gunn, MJ & McCoubrey, H "Medical Ethics and Laws of Armed Conflicts" (1998) *Journal of conflict and security law*

Henckaerts, JM & Doswald-Beck, L "Customary International Humanitarian Law Rules" (2005) *Cambridge University Press*

Hills, SL "Dual Loyalty Conflict: The Ethical Ramifications of Medical Professionals' Participation in Torture" (2015) *School of Public Ethics Saint Paul University*

Howe, EG "When, if Ever, Should Military Physicians Violate a Military Order to Give Medical Obligations Higher Priority?" (2015) *Military Medicine* 180

Howe, EG & Martin, ED "Treating the Troops" (1991) *Hastings Center Report* (as cited in Rettig 55)

Iserson, KV & Moskop, JC "Triage in medicine (Part 1) Concept, history and types" (2007) 49 *Annals of Emergency Medicine*

Jackson, SW ''Aspects of culture in psychoanalytic theory and practice'' (1968) *Journal of the American Psychoanalytic Association*

James, BV "Canadian Military Criminal Law: An examination of military justice" (1975) 23 *Chitty's Law Journal* 120 & 123

Johnson, WB "Multiple-role Dilemmas for Military Mental Health Care Providers" (2006) *Military Medicine* 171

Langer, E "The Court-Martial of Captain Levy: Medical Ethics vs. Military Law" (1967) *Science* 153

Le, T *et al* "The COVID-19 vaccine development landscape." (2020) 19.5 *Nat Rev Drug Discov* 305-306

Leland, A "American War and Military Operations Casualties" (2010) *Congressional Research Service Lists and Statistics*

Levie, HS "Prisoners of War under the 1977 Protocol I" (1989) *Akron Law Review* 23

© University of Pretoria

Lifton, RJ "Doctors and torture" (2004) *The New England Journal of Medicine*
London *et al,* "Dual Loyalty among Military Health Professionals: Human Rights and Ethics in Times of Armed Conflict" (2006) *Cambridge Quarterly of Healthcare Ethics Cambridge University Press*

McQuoid-Mason, DJ "Assisted Suicide and assisted voluntary euthanasia: Stransham-Ford High Court case overruled by Appeal Court – but the door is left open" (2017) *South African Medical Journal*

Messelken, D "Conflict of Roles and Duties – Why Military Doctors are Doctors" (2015) *Zurich Open Repository and Archive University of Zurich*

Messelken, D "Humanity in the Midst of Armed Conflict: Military Doctors Ethical Obligations" (2017). *Open Repository and Archive University of Zurich*

Messelken, D "Physicians at War: Betraying a Pacifist Medical Ethos?" (2013) *Open Repository and Archive University of Zurich*

Miles, SH "Medical Associations and Accountability for Physician Participation in Torture" (2015) *American Medical Association Journal of Ethics* 17

Miles, SH "Abu Gharib: Its legacy for military medicine" (2004) *The Lancet*

Milgram, S ''Behavioral study of obedience'' (1963) *Journal of Abnormal and Social Psychology* 371–8

Moodley, K "History of Medicine: Dual loyalties, human rights violations and physician complicity in apartheid South Africa" (2015) *American Medical Association Journal of Ethics*

Moran, P "A Military Exception to 'Informed Consent'. Doe v Sullivan" (2012) *St John's Law Review*

Moskop JC "A moral analysis of military medicine" (1998) 163 *Milmed*
Neuhaus, S "Battlefield euthanasia: Courageous compassion or war crime?" (2011) *MJA* 6
Nienaber, A & Bailey KN "The right to physical integrity and informed refusal: Just how far does a patient's right to refuse medical treatment go?" (2016) *South African Journal of Bioethics Law*

© University of Pretoria

Nwobegahay, J *et al,* "Ethical guidelines for military-based health research: An unmet need in Africa" (2015) *South African Journal of Bioethics and Law* 11-15

Omonzejele, PF "Obligation of non-maleficence: moral dilemma in physician-patient relationship" (2005) *Journal of Biomedical Sciences* 22-30

Parasidis, E "Emerging Military Technologies and National Security" (2015) *Case Western Reserve Journal of International Law*

Perry, DL "Battlefield Euthanasia: Should Military Mercy-killings be allowed?" (2011) *International Society of Military Ethics*

Rascona, DA "A Moral Obligation for Military Medical Service in the United States" (2007) *Virtual Mentor American Medical Association Journal of Ethics* 722-724

Rasmussen OV "Medical aspects of torture" (1990) 37 *Dan Med Bull* 1-88

Reis C *et al* "Doctors as collaborators in torture. Physician participation in human rights abuse in southern Iraq" (2004) *JAMA* 1480-6

Robertson, HJD "Still waiting for an answer; Physician assisted suicide in South Africa" (2020) *De Rebus*

Rubenstein, L *et al* "Coercive US interrogation policies: A challenge for medical ethics" (2005) *Journal of the American Medical Association*

Shama, G "The Role of the Media in Influencing Public Attitudes to Penicillin during World War II" (2015) 35(1) *Dynamis*

Shuster, E "Fifty years later: The significance of the Nuremberg Code" (1997) *New England Journal of Medicine*

Singh, JA "American physicians and dual loyalty obligations in the 'war against terror'" (2003) *BMC Medical Ethics*

Slabbert, M & Labuschaigne, M "Legal reflections on the doctor-patient relationship in preparation for South Africa's National Health Insurance" (2002) 15 *South African Journal of Bioethics and Law*

Sokol, DK "First do no harm revisited" (2013) *British Medical Journal*

Spagnolo, AG "Quality of life and ethical decisions in medical practice" (2008) 6 *Journal of medicine and the person*

© University of Pretoria

Strassfeld, RN "Vietnam War on Trial: the Court-Martial of Dr Howard B. Levy" (1994) *Case Western Reserve University Faculty Publications*

Swan, KG "Triage, the past revisited" (1996) 161 *Military medicine*

Taitz, JL *"The rule of medical confidentiality v the moral duty to warn an endangered third party"* (1990) 78 *South African Medical Journal* 29

Van Dokkum N "Should doctor-patient communications be privileged" (1996) *De Rebus* 748

Williams-Jones *et al* 'Ethics in the Field: The Experiences of Canadian Military Health Care Professionals' (2015) *Ethics and Armed Forces*

Williams JR "Dual Loyalties and how to resolve ethical conflict" (2009) *South African Journal of Bioethics and Law* 8

Williams JR 'Dual Loyalties: How to Resolve Ethical Conflict' (2009) *South African Journal of Bioethics and Law* 8

Zupan, D *et al* "Dialysis for a prisoner of war" (2004) 1; 34(6) *Hastings Cent Report* 11

Theses and Dissertations

A Barit "The Doctrine of informed consent in South African medical law" unpublished dissertation, University of Pretoria, 2017

AG Nienaber "Ethics and human rights in HIV-related clinical trials in Africa with specific reference to informed consent in preventative HIV vaccine efficacy trials in South Africa" unpublished LLD thesis, University of Pretoria, 2007

A Strohwald "Dignity in death; A critical analysis of whether the right to human dignity serves as appropriate justification for the legalisation of assisted death". unpublished Masters degree dissertation, University of Stellenbosch, 2014

EC Meyer "An Analysis of the duty of care concept from a pragmatic medical malpractice perspective" unpublished M.Phil dissertation, University of Pretoria, 2017

© University of Pretoria

JL Nell "Aspects of confidentiality in medical law" unpublished LLM dissertation, University of Pretoria, 2006

PM Britz "Medical record keeping in South Africa: A medico-legal perspective" unpublished M.Phil dissertation, University of Pretoria, 2018

Newspaper articles

"Casbah curse for British WW2 troops" *The Guardian* 22 January 1980

"Graca Machel threat to sue over Mandela book" *The Mercury* 24 July 2017 3

"Mandela Book pulled off shelves by Penguin" *The Mercury* 25 July 2017 1

"Ramaphosa mobilises SANDF in one of the country's biggest deployments in history" *News24* 21 April 2020 www.news24.com/news24/southafrica/news/sandf

"SANDF defends acquisition of Interferon drug from Cuba" *Defence Web* 29 January 2021. www.defenceweb.co.za/wpcontent/uploads/security/humansecurity/Heberon

"Sean Davison's euthanasia trial carries a 44-year-old echo – and not much has changed" *Daily Maverick* July 2019 www.dailymaverick.co.za/article/2019-07-01 27 September 2022

"Tutu help saak vir genadedood in SA" *Die Burger* 14 July 2014 1

Reports

"Assessment of detainee medical operations for OEF, GITMO and OIF" 2005 Office of the Surgeon General wwwarmymedicine.army.mil/reports/detmedopsrprt/pdf

"Ethics Abandoned: Medical professionalism and detainee abuse in the 'War on Terror'" 2013 Task force report funded by IMAP/OSF

"Legality of the Threat or Use of Nuclear Weapons", Advisory Opinion, ICJ GL No 95, (1996) ICJ Rep 226, ICGJ 205 (ICJ 1996), 8th July 1996, United Nations; International Court of Justice (ICJ)

"Presidential Advisory Committee on Gulf Veteran's illness Interim Report" 1996 Washington DC US Government Printing Office

© University of Pretoria

Smidt- Nielsen K "The participation of health personnel in torture" (1998) Torture 1998; 8:91-4, Vesti PB

Internet Sources

Baxter I "Doctors on trial. Steve Biko, Medical ethics and the Courts" *South African Journal on Human Rights, cases and comments.* http://www.core.ac.uk/download/pdf/62563405 (31 October 2022)

Carter BS "Ethical Concerns for Physicians Deployed to Operation Desert Storm" (1994) 159 *Military Medicine* 55-59, https://doi.org/10.1093/milmed/159.1.55

Casebook ICRC: "How does law protect in war" ICRC Geneva. www.icrc.org (29 September 2022)

Code of Conduct for Uniformed Members of the South African National Defence Force https://www.researchgate.net/figure/Code-of-Conduct-for-Uniformed-Members-of-the-SANDF (1 February 2021)

Deese M "Unbounded by time: Jeremiah Saunders Gage and the Battle of Gettyburg. The Gettysburg experience" (2010) www.thegettysburgexperience.com/past_issue_headlines/2010

Du Preez M "The Geneva Conventions and South African Law" (2013) Institute for Security Studies Policy Brief www.issafrica.org (11 May 2020)

Edelstein L "The Hippocratic oath: Text, translation and interpretation" (1943) John Hopkins Press http:/philpapers.org. (15 January 2019)

Gross ML "Caring for Compatriots: Military Necessity before Medical Need?" (2015) 1 *Ethics and Armed Forces; Controversies in Peace Ethics and Security Policy* (available at www.ethikundmilitaer.de)

Gross ML "Military medical ethics in war and peace" in G Lucas (ed) *Routledge handbook of military ethics* (2015) available at http:/www.taylorfrancis.com/chapters/edit/10.4324 (9 November 2017).

https://www.merriam-webster.com/dictionary/discipline (15 April 2020)

"Human rights in the administration of justice: A manual on human rights for judges, prosecutors and lawyers 'The administration of justice during states of emergency'" (2002) http://hei.unige.ch/humanrts/monitoring/adminchap16.html (12 January 2021)

ICRC databases; Introduction to the rules, available at https://www. icrc.org

ICRC databases; "*Primary Health Care Services, Primary Level"* May 2006, www.icrc.org

"Legal Protection of Children in Armed Conflict" (2003) ICRC Advisory Service on International Humanitarian Law www.icrc.org (26 November 2022)

Lippi D "*A Short History of Medicine"* (2015) CLUEB: http://search-ebscohost.com uplib.idm.oclc.org

"Minimum data sets for human resources for health and the surgical workforce in South Africa's health system" (2015) African Institute for health and leadership developmentwww.who.int/workforcealliance/031616south_africa_case_studiesweb.pdf (16 November 2020)

Moll FH Krischel M & Fangerau H "Nazi Medical Crimes and the Nuremburg Doctors' Trial" (2012) https://www.researchgate.net/publication/294419257 (25 November 2020)

Overseas Territories: The Ministry of Defence's Contribution. https://assets.publishing.service.gov.uk,(accessed 26 April 2022).

Rochon C "Dilemmas in Military Medical Ethics: A Call for Conceptual Clarity" (2015) *Bioethique online* 4. 10.7202/1035513ar (15 January 2019)

"Physicians for Human Rights, School of Public Health and Primary Health Care" University of Cape Town. http://physiciansforhumanrights.org/ library/documents/reports/report-2002-duelloyalty.pdf.

SAHRC "Access to health care" https://www.sahrc.org.za

Singh JA "Project Coast: eugenics in apartheid South Africa" *ScienceDirect Endeavour* Vol. 32 No. www.sciencedirect.com (15 October 2022)

© University of Pretoria

Sonntag J "Doctors involved in torture" (2008) *Semantic Scholar, Torture* Vol 18 www.semanticscholar.org/paper/doctors (8 November 2022)

The 1987 Commentary to the First Protocol of the Geneva Conventions of 12 August 1949 www.ihl-databases.icrc.org/applic/ihl/ihl.nsf/Comment

The 2016 Commentary to the First Geneva Convention of 12 August 1949 www.ihl-databases.icrc.org/applic/ihl/ihl.nsf/Comment

The Presidential Handbook, The Presidency, Republic of South Africa

https://www.gov.za

United Nations. Security Council Resolution 2286 (2016), Strongly Condemning Attacks against Medical Facilities, Personnel in Conflict Situations. http://www.un.org/press/en/2016/sc12347.doc.

U.S. Department of Defense, JTF GTMO, "BSCT standard operation Procedures" (11 November2002) http://www.aclu.org/files/projects/foiasearch/pdf/doddon000760.pdf.

Welgemoed, M LERM, Dr Henry "Palliative care as a form of relief for the dying: a South African perspective" (2020) Obiter, Port Elizabeth v.4, n. 2, 348-370. http://www.scielo.org.za/scielo.

© University of Pretoria