Article

Dual loyalties: How to resolve ethical conflict

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Health professionals frequently find themselves in dual loyalty situations, where their commitment to the well-being of their patients is challenged by the demands of other individuals or groups. This article describes the nature and extent of dual loyalty conflicts in health care and offers suggestions for their prevention and management.

Not long ago, when the term 'dual loyalties of health professionals' was mentioned, many listeners thought immediately of South Africa. The widespread publicity given to the actions of individual physicians and the South African medical profession in general in the Steve Biko case and subsequently[1] raised the issue of dual loyalty conflicts in their starkest form. The 2002 report of the International Dual Loyalty Working Group[2] built on the South African experience and set it in a broader international context. Since then, revelations about the complicity of medical personnel in gross violations of human rights in Iraq and elsewhere[3] have shown that dual loyalty continues to be an issue of global proportions, for which guidance is urgently needed.

The purpose of this article is to offer such guidance. It will begin with an analysis of the term 'dual loyalties', followed by a review of dual loyalty conflicts in health care. It will then suggest ways in which such conflicts can be either prevented or managed.

Dual loyalties and conflicts of interests

Dual loyalties, also known as 'divided loyalties'[4] or 'double agency',[5] need to be distinguished from conflicts of interests, to which they bear some resemblance. 'Conflict of interests' is a more familiar term and is the subject of an extensive literature in ethics, law, business and elsewhere. It has many different definitions, but for the purpose of this article, the following one will do: 'The 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.'[6]

Dual loyalties also involve conflict. But whereas conflicts of interests are usually between one's own interests and those of another individual, institution or group, dual loyalties are conflicts between two external accountabilities that are incompatible. For example, when physicians provide unnecessary services solely for financial gain, they are clearly in a conflict of interests – their own versus their patients or insurance providers. Conversely, when they assess a patient's fitness to drive an automobile, they usually have nothing personal to gain from the outcome but they may have to decide which of two loyalties should prevail – the patient who wants a driver's licence or society as represented by the licensing agency, which needs to keep unsafe drivers off the road.

Although health professionals may at times have more than two conflicting loyalties, for example to a patient, the patient's family and the hospital, for the sake of simplicity the term 'dual loyalties' will be used throughout this article to include all such conflicts.

Dual loyalties in health care

Although dual loyalty conflicts arise in many professional and occupational settings, they are particularly acute in health care, for three reasons: a perennial shortage of resources, family dynamics and a clash of cultures.

The shortage of health care resources gives rise to many dual loyalty conflicts. Physicians may have to decide who among their patients is most in need of a surgical procedure for which there is a waiting list, or an expensive drug of which the hospital has a limited supply. They want to do what is best for each patient, but they are forced to decide who should benefit when not all can.

Health professionals are often faced with conflicts between patients and their families. Sometimes the patient orders the physician or nurse not to tell the family about their diagnosis or prognosis. In other situations the family implores the physician or nurse not to give the patient 'bad news', for example that the patient is terminally ill. The health professional feels a loyalty to both patient and family. The former goes without saying but the latter is important, too, because the patient's situation affects the health and well-being of other family members. They often need to know the diagnosis and prognosis in order to care for the patient. The health professional has to decide which loyalty should prevail if they cannot be reconciled.

Health professionals, particularly physicians but also nurses, pharmacists and others, value their clinical independence. They are trained to make judgements about what is best for their patients, and their professional ethics requires that they put the interests of their patients above all others.[7] At the same time they often find themselves working in a setting with a very different culture. Many organisations, including the military, police, prisons, governments and commercial enterprises, place a higher value on obedience than on independent thinking. As necessary as this may be to accomplish their goals, obedience to the policies of the organisation and the decisions of its officials can conflict with a health professional's judgement of what is best for a patient who is an inmate or employee of the organisation.

Examples of dual loyalties involving organisations are legion. What follows is a partial listing:

- A patient versus the police or prison. This is probably the best known and most analysed type of dual loyalty conflict.[1-3,8] Despite this, it continues to defy resolution in many countries.
- A patient versus the army. Military physicians are often required to determine when an individual is fit to enter or return to active duty. They may encounter great pressure from military authorities to use minimal criteria for making such determinations, for example the physical condition of the individual, and to ignore psychological and other factors. As military personnel, such physicians have loyalties and obligations to their superiors as well as to their patients, and these can directly conflict.
- A patient versus a hospital. Although health professionals are expected to consider the needs of their own patients first, hospitals and other health care institutions have to meet the needs of all patients. In doing so they develop policies and make decisions that result in the denial of optimal treatment to many. Physicians and other health professionals working in the institution are expected to implement these policies and decisions even though their own patients are disadvantaged as a result. They have to decide whether to advocate for special treatment for their patients at the expense of other patients or institutional sustainability.
- A patient versus an insurer. In order to get coverage for life, health or travel insurance, individuals often have to undergo a medical examination. In such cases the examining physicians are accountable to the insurance company to give an accurate report, even if it means that the patients are denied coverage as a result. Physicians need to determine how they can best fulfil their loyalty to their patients in these circumstances.
- A patient versus an employer. Occupational health professionals are subject to some of the same pressures as their military counterparts to consider first the well-being of the company rather than the employees they examine and treat.[9] For example, they may be reluctant to attribute employee illness or disability to unsafe working conditions for which the company is responsible. If the health professionals are in the employ of the company, they risk dismissal if their loyalty to their patients is seen to outweigh their allegiance to the employer.
- A patient versus a sports team. Team physicians have the responsibility to determine whether an injured athlete is fit to resume competition. Their concern for the best interests of the athlete can conflict with the desires of the team officials, the other players and sometimes even the injured athlete to get back into the match for the good of the team.
- A patient versus the public. Recent epidemics of infectious diseases such as severe acute respiratory syndrome (SARS) and swine flu as well as the ongoing HIV/AIDS challenge have highlighted the conflict between individual rights and those of the public. Here again health professionals face dual loyalty conflicts. In the interests of public health they may have to restrict individual liberties, for example by imposing quarantine on infectious individuals or by revealing confidential information about patients' health status to public health authorities or sexual partners.[10]

There is clearly no shortage of dual loyalty conflicts in health care. To recognise them is relatively easy; to prevent or resolve them is often difficult. Fortunately there is a rapidly expanding literature on the topic from which a strategy for dealing with conflicts can be devised.

Preventing and managing dual loyalty conflicts

The first thing to note about dual loyalty conflicts is that some of them are easy to resolve: those in which the patient clearly must come first, e.g. when authorities request participation in torture or other serious violations of human rights; and those in which the other party must prevail, e.g. mandatory reporting of certain infectious diseases or of suspected child abuse. In between is a large grey area that requires ethical decision-making and behaviour.

Many health professional organisations and individual scholars have identified ethical principles and guidelines for dealing with dual loyalty conflicts. The World Medical Association (WMA) has been especially active in this area, as is evident from the following excerpts from WMA policy statements:[11]

- **Declaration of Geneva:** 'The health of my patient will be my first consideration'; 'I will not use my medical knowledge to violate human rights and civil liberties, even under threat.'
- **International Code of Medical Ethics:** 'A physician shall be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity. … A physician shall respect a patient's right to confidentiality. It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can be only removed by a breach of confidentiality. … A physician shall, in situations when he/she is acting for a third party, ensure that the patient has full knowledge of that situation.'
- **Declaration of Tokyo:** '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.'
- **Regulations in Times of Armed Conflict:** 'Medical ethics in times of armed conflict is identical to medical ethics in times of peace, as stated in the International Code of Medical Ethics of the WMA. If, in performing their professional duty, physicians have conflicting loyalties, their primary obligation is to their patients; in all their professional activities, physicians should adhere to international conventions on human rights, international humanitarian law and WMA declarations on medical ethics.'

Although these statements require physicians to consider first their loyalty to their patients, they also recognise that in rare situations the needs of others will prevail over those of their patients. When this happens, physicians must take all appropriate measures to mitigate any harm to the patients.

The report of the International Dual Loyalty Working Group contains numerous general guidelines for health professionals and specific ones on the following topics: prison, detention and other custodial settings; health care for refugees and immigrants; the workplace; forensic evaluations; and military health care. The report also includes recommendations for institutional mechanisms to deal with dual loyalty situations.

Since dual loyalty conflicts are ethical as well as human rights issues, their resolution can profit from the tools of ethical analysis.[12] One such tool is the following process for ethical decision making:

- Recognition of dual loyalty situations. This requires health professionals to know when more than one individual or institution has a legitimate claim on their loyalty. They cannot simply assume that they have only one loyalty in any particular situation.
- Knowledge of applicable principles and guidelines. They should not base their decision on which loyalty should prevail on their feelings or intuition, but should be aware of relevant ethical principles and professional guidelines. This is especially important for health professionals working in environments where dual loyalties are endemic.
- Consideration of all relevant facts. Principles and guidelines have to be applied in particular situations, which often differ one from another. This requires knowledge of the medical and other related circumstances of the dual loyalty conflict and prudential judgement about the correct course of action. For example, whether infectious individuals should be quarantined during a pandemic will depend on many specific factors related to the nature and extent of the pandemic. Dealing with uncertainty is central to such decision making.
- Consultation with colleagues. When it is unclear which loyalty should prevail, it is wise to consult with colleagues who are or have been faced with the same dilemma. This is especially important when there is a conflict between professional ethics and institutional policies; the latter are difficult to resist on one's own but easier if done collectively.
- Independent judgement. Although health professionals often agree with restrictions on the treatment of their patients that result from hospital policies, sometimes these policies seem to be entirely inappropriate and opposed not only to the needs but also to the rights of the patients. In such situations health professionals should do everything in their power to advocate for their patients.
- Explaining and justifying their decision. In situations where loyalty to the patient must give way to another loyalty, health professionals should so inform their patients and tell them why, preferably before the decision is implemented so that the patients can make alternative arrangements.
- Minimising harm to patients. Health professionals should do everything in their power to protect patients from further disadvantage when loyalty to a third party prevails, for example, by providing the same level of care to prisoners as to other patients.
- Resisting pressure to change decisions. When health professionals decide to support patients against an institution, they may be subject to great pressure from the institution to change their decisions. Although they should always be prepared to review their actions and admit mistakes, they should maintain their professional independence and not allow their judgement to be subverted by outside influences.

By following these steps, health professionals can deal with dual loyalty situations when they arise. However, since prevention is usually better than cure, individual health professionals and their associations should consider strategies for lessening the prevalence of dual loyalty situations. These include the following:

- Defence of professional independence. Health professional associations and their members should be vigilant against attempts to curtail their ability to put the interests of their patients first, whether these come from governments or institutions such as hospitals, managed care organisations and insurers.
- Advocacy for patients. Defence of professional independence should not be, or be seen to be, simply a matter of self-interest but should be a means of promoting the interests of patients against the financial and bureaucratic interests of other parties.
- Employment contracts that recognise professional responsibilities to patients. These are best negotiated collectively, since individuals are relatively powerless when dealing with large institutions.
- Explicit procedures for dealing with public health emergencies. The curtailment of individual patient interests for the good of public health should be done according to an ethically justifiable process rather than in an arbitrary or *ad hoc* manner.[13]
- Informing patients about relevant professional obligations to third parties. Both individual health professionals and institutions should ensure that patients are well informed about any limits to their interests and needs that may be imposed when they access health care, for example required breaches of confidentiality or restrictions on treatment because of limited resources.

These and other such measures can limit the extent of dual loyalty situations and mitigate the harm to patients in situations where the health professional's first loyalty is not to the patient.

Conclusion

The reputation of physicians was severely marred by revelations of unethical behaviour before and during World War II, when many physicians in Nazi Germany and elsewhere were loyal to the state at the expense of their patients. As noted above, dual loyalty challenges still exist for health professionals. It is evident that much wrongdoing has occurred recently, either from ignorance of professional responsibilities or from a failure to live up to these responsibilities.

It is both possible and necessary to learn from such mistakes. The relevant principles and guidelines are readily available; the tasks ahead are to publicise, teach and learn how to interpret and apply them. The challenges should not be underestimated; there are powerful ideological, commercial and bureaucratic interests opposed to health professionals acting in the best interests of their patients. Progress is not inevitable; constant vigilance is required to ensure that the complicity of health professionals in the violation of their patients' human rights will no longer occur.

References

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