Institutional Hearing:

The Health Sector

• ETHICS FOR HEALTH PROFESSIONALS

International ethical codes

1 Health professionals have an ethical obligation to place the well-being of their patients at the forefront of their professional commitments. From ancient times up until the present day, this has been codified in a number of oaths, codes of conduct and international declarations. In addition, since 1948, many ethical codes and international human rights instruments have been formulated concerning the treatment of patients, detainees, hunger strikers, mental health patients, and on the role of nurses and other related matters.[1]

2 The greatest drawback of these codes and oaths is the difficulty of monitoring and enforcing compliance with them. Responsibility for upholding these principles is left, by default, to professional organisations and statutory regulatory bodies in each country. This can be problematic if these institutions are themselves under the influence of the state or if they have colluded with or been complicit in violating human rights. The international health care community can help reinforce these standards by putting pressure on countries that violate them, and especially on professional organisations within those countries. However, it is often difficult for the international community to make a significant impact, except over extended periods.

Requirements in South Africa at the time of reporting

3 In South Africa, most doctors are expected to take the Hippocratic Oath or the Declaration of Geneva (the modern equivalent of the Hippocratic Oath) upon qualifying (see Appendices 1 and 2). However, some medical schools require their students to take other oaths or develop their own. There is thus no uniformity in the codes of conduct or ethical pledges taken by health professionals. These codes are intended to provide the fundamental principles of the physician's role as healer, including the obligation to maintain patient/doctor confidentiality and to undertake measures that are in the best interest of the patient. If different schools take different pledges, one cannot expect consistency within the profession.

4 Nurses take the 'Nurses' Pledge of Service' (a local adaptation of the Florence Nightingale Pledge) when they graduate. However, the submission of the Democratic Nurses Organisation of South Africa (DENOSA) noted that: "it was confirmed during interviews that an individual could, theoretically, decide not to say the pledge. Also, those who

are absent from the ceremony do not take the pledge." The same could obviously apply to graduating doctors. No system ensured or enforced the making of a commitment to ethical practice.

5 Mental health professionals are not required to take any sort of pledge or oath on qualifying or registering; their statutory obligations are outlined in the Mental Health Act.[2] Although the Psychology Board (a sub-section of the South African Medical and Dental Council or SAMDC) has a code of conduct, psychologists are only made aware of this (that is, sent a copy of it) when they register to practice.

6 Issues of ethics and human rights are not usually included in the teaching curriculum of psychology masters' degree students. Similarly, there are no uniform guidelines for the teaching of ethics in South African health science faculties. DENOSA had the following to say about the teaching of ethics to nursing students:

> *Ethics content has always been included in nursing curricula. However, it seems that educators largely did not succeed in teaching this subject so that it had everyday application.*
>
> *While provision is made for the teaching of ethics in the curriculum, nurses do not seem to identify it as significant to their professional role. In one particular study, it was found that 87 per cent of the research sample indicated that they did not regard the subject Ethos as necessary to their work as registered nurses.*
>
> *It also appeared from interviews that, in teaching the subject, more attention was given to the history of nursing and etiquette than to ethics and professional conduct, and that students perceived the subject as a list of 'do's and don'ts'.*

7 During the period under review, ethics was taught on an *ad hoc* basis and, for the most part, students were not examined on these topics. There was, therefore, no uniformity in the way in which health professionals were made aware of, or given guidance on, incorporating issues of medical ethics and human rights into daily practice.

8 The SAMDC is responsible for disciplinary action and has a code of conduct and guidelines for ethical practice. The Council does not, however, ensure that all registered health professionals are informed of these. Health professionals who are not interested or do not themselves take the initiative to familiarise themselves with the code of conduct and guidelines may not be aware of their obligations.

9 The value of oaths and professional declarations in ensuring a human rights consciousness in clinical practice has been questioned by a variety of sources. If oaths and declarations are merely repeated and signed at the end of a period of training or study, they are unlikely to have any meaningful impact on the life and practice of health professionals. Ethics and human rights need to be incorporated holistically into the overall curriculum to ensure that these principles govern the activities of health professionals.

• HEALTH WORKERS WITH DUAL OBLIGATIONS

10 Many health professionals find themselves in situations in which their primary obligations are not clear. This is particularly true when they are employed to provide health care services for a clientele, organisation or institution whose primary function is *not* the provision of health care. The difficulties and challenges faced by district surgeons illustrate this clearly.

District surgeons

11 Of all the health professionals in South Africa, district surgeons working under the apartheid government probably had one of the most difficult jobs in terms of upholding medical standards and human rights. On the one hand, they were under a statutory obligation to provide medical care for prisoners and detainees, to record information on the mental and physical health of inmates and to ensure that proper health conditions existed in terms of basic sanitation, food and general health care. On the other hand, there was (and perhaps still is) great pressure on them to support the police and prison authorities for 'national security' reasons.

12 One of the most infamous cases involving inappropriate and negligent care of a detainee by district surgeons was the death of Stephen Bantu Biko.

The death in detention of Mr Stephen Bantu Biko[3]

Stephen Biko was a prominent leader of the Black Consciousness Movement in the mid-1970s. He was detained by Eastern Cape security police in August 1977 and kept at Walmer police cells in Port Elizabeth. From there, he was taken regularly to security police headquarters for interrogation. The two district surgeons responsible for his medical care were Drs Benjamin Tucker and Ivor Lang.

On 7 September 1977, Stephen Biko sustained a head injury during interrogation, after which he acted strangely and was unco-operative. The doctors who examined him (naked, lying on a mat and manacled to a metal grille) initially disregarded overt signs of neurological injury. They also failed to record his external injuries or insist that he be kept in a more humane environment (at least that he be allowed to wear clothes). When a physician was finally consulted, a lumbar puncture revealing blood-stained cerebrospinal fluid (indicating possible brain damage) was reported as being 'normal', and Biko was returned to the police cells.

Finally, on 11 September 1977, Stephen Biko lapsed into semi-consciousness. Dr Tucker recommended his transfer to a hospital in Port Elizabeth, but the security police refused to allow this. Subsequently, Dr Tucker acquiesced to the police's wish to transfer Biko to Pretoria Central Prison. Stephen Biko was transported 1 200 km to Pretoria on the floor of a landrover. No medical personnel or records accompanied him. A few hours after he arrived in Pretoria, he was seen by district surgeon Dr A van Zyl, who administered a vitamin injection and asked for an intravenous drip to be started.

On 12 September, Stephen Biko died on the floor of a cell in Pretoria Central Prison, naked and alone. The post mortem *examination showed brain damage and necrosis, extensive head trauma, disseminated intra-vascular coagulation, renal failure and various external injuries. The medical treatment was subsequently*

described by a judge of the Supreme Court as having been "callous, lacking any element of compassion, care or humanity".

The magistrate referred the inquest findings to the SAMDC on the grounds that there was a prima facie *case of professional misconduct and/or negligence against the doctors involved. The SAMDC took two and a half years to respond. They initiated a preliminary inquiry in which it was found that the doctors had no case to answer. The full Council ratified this decision.*

Despite an outcry from doctors both locally and internationally, the SAMDC adhered to this decision. It was supported by the Medical Association of South Africa (MASA), which even went so far as to imply that those doctors calling for the case to be re-opened were politically motivated.

The reversal of the SAMDC decision took years and was the result of the committed efforts of Drs Ames, Veriava, Jenkins, Mzimane, Wilson and Tobias. These doctors took the issue to the Supreme Court, which ordered the SAMDC to re-examine the case against Drs Tucker and Lang. As a result of this, a disciplinary enquiry was held in 1985, eight years after Stephen Biko's death. Dr Tucker was found guilty of improper and disgraceful conduct on three counts and was struck off the role of medical practitioners (although he was reinstated some years later). Dr Lang was found guilty of improper conduct on five counts and was suspended for three months (ironically, this suspension was conditionally suspended for two years and so had no impact on Dr Lang's practice of medicine). Dr Lang continued to be employed as a district surgeon by the Department of Health and was, in fact, promoted to chief district surgeon in Port Elizabeth in Dr Tucker's place.

13 The evidence available to the Commission suggests that most district surgeons were not directly involved in committing gross violations of human rights during the period under review. Their most common offence was a failure to carry out their duties within internationally accepted guidelines of medical ethics and human rights. All these points are starkly illustrated by the Steve Biko story. The doctors failed to:

a maintain patient-doctor confidentiality norms;

b treat their patient with dignity and respect;

c examine the patient thoroughly;

d record and report injuries accurately;

e diagnose illnesses and prescribe appropriate medication;

f register complaints (particularly pertaining to assault and torture).

14 On many occasions, district surgeons examined patients with security officers or prison warders in the room, which may have inhibited patients from disclosing abuse or torture by the police. This practice also reinforced the belief of prisoners that district surgeons collaborated with the authorities. District surgeons breached patient-doctor confidentiality by allowing third parties (police or prison authorities) automatic access to patients' files without

informing the patients concerned or obtaining their consent. International standards require a doctor to inform the patient *before* he or she conducts an examination if the information in the medical records will be released. Finally, a number of deponents (generally detainees) told the Commission that they did not receive what they believed to be appropriate care from district surgeons.[4]

15 These circumstances were aggravated by the fact that most district surgeons were white, while the majority of the detainees were black. Because white and black people had for years been separated by apartheid policies, there was a strained relationship and a lack of mutual trust and understanding between doctor and patient.

16 Many district surgeons also claimed that they did not know they could override the orders or wishes of prison warders or police on medical matters - for example, by not releasing information or by insisting that warders leave the room during examinations.[5] Finally, where a district surgeon *did* take a stand to uphold the human rights of his or her patients, he or she received little or no official support from the profession or the Department of Health.

17 At the height of the state of emergency in the mid-1980s, there was a flood of detainees into the prisons. The increased workload pushed district surgeons into unprofessional medical practices – such as failing to examine detainees properly, failing to insist on private examinations and failing to investigate complaints by their patients. While a number of independent sources reported evidence of almost routine torture and assault of detainees, district surgeons, with only one exception, failed to report or speak out about these violations.

18 While it is easy to criticise district surgeons, it must also be appreciated that the conditions under which they had to work made it difficult for them to uphold human rights. They were given no specific training for work in the prisons, no continuing medical education and no independent avenues to report abuses. They were generally isolated from the rest of the profession and sometimes actively ostracised. It is, thus, perhaps not surprising that they adopted the culture of the police and prison officials from whom they received affirmation and support. The Department of Health submission said:

> *[District Surgeons had] a firm belief that the detainees were the enemy of the State and that it was the right thing to do to assist the police in getting the information out of the detainees, as they were trying to overthrow the government. The country was fundamentally racist and this included many district surgeons. The ideology was such that it was regarded as completely normal not to give black people the same services as whites and to treat black people as second class citizens.*

Lack of support from institutional bodies

19 Institutional bodies such as the Department of Health, the SAMDC and the MASA contributed indirectly to breaches of ethics by district surgeons. None of them took responsibility for the inadequacies of the system in which these doctors operated. The Department of Health was responsible for ensuring that district surgeons (who were, after all, employees of the Department of Health) were aware of their rights and responsibilities within the prison and police systems. It should have provided practical guidelines for action by district surgeons faced with situations in which violations of ethical conduct seemed inevitable. The SAMDC was supposedly responsible for dealing with those guilty of professional misconduct and for educational guidelines and ethics. There are well-documented cases in which the

SAMDC failed to take proper action on professional misconduct. Both the SAMDC and the MASA gave little support to those who upheld human rights, thus discouraging health professionals from challenging the system. None of these organisations provided guidelines to assist district surgeons in dealing with adverse situations, in which it was almost impossible to treat detainees properly.

The death in detention of Ms Elda Bani[6]

Ms Elda Bani, a fifty-year-old political activist, was detained in 1986 in North End Prison, Port Elizabeth. She suffered from severe insulin-dependent diabetes, which she reported to the medical staff at the prison. Initially, she was able to treat herself with medication she had brought into prison but, when her medication supply ran out, she received no treatment from the district surgeon. In spite of her condition, she was made to eat normal prison food at inappropriate times (for example, supper at 16h30 with no further meals until breakfast the next morning). The district surgeon made no attempt to intervene, although it should have been obvious to a doctor that such long gaps between meals were quite inappropriate for a diabetic.

Inevitably, Ms Bani's condition deteriorated as her untreated diabetes worsened. She became confused and incontinent. Her cellmates reported this, and Ms Bani was taken away, they assumed, to hospital. When she returned, however, she reported that she had not been taken to hospital, but had been beaten by the police. Her cellmates saw blood on her clothes and injuries on her back. Her condition continued to deteriorate and she eventually lapsed into a hyperglycaemic coma. She died shortly afterwards of an entirely preventable and treatable condition.

Examples of misconduct among district surgeons

20 There are numerous accounts of district surgeons who failed to fulfil their moral and ethical duties as doctors. For example:

a A district surgeon declined to refer to a hospital a detainee with three gunshot wounds in his groin, or even to apply disinfectant or a dressing because she believed it was more important for the detainee to assist the police with their enquiries.

b A district surgeon did not ask a youth whose teeth had been broken or allegedly extracted by a security police officer how he had acquired this injury.

c A district surgeon found no marks or injuries on a former detainee, although another district surgeon had recorded extensive injuries when he examined the same detainee.

d A district surgeon was allegedly requested by the security police to advise them as to whether a detainee was fit to undergo further electric shock torture.

e A district surgeon asked the security police questions about the health of a detainee, instead of asking the detainee himself.

f A district surgeon performed perfunctory examinations or did not inquire into the cause of injuries suffered by detainees.

g A district surgeon was personally acquainted with members of the interrogation squad.

A doctor who exposed the system

In September 1985, Dr Wendy Orr lodged an urgent application with the Port Elizabeth Supreme Court for an interdict restraining the police from assaulting detainees. Since the declaration of the state of emergency, Dr Orr had documented 286 cases concerning detainees who complained of police assault during questioning. In her affidavit*, she reported that the police seemed to believe they were immune to proceedings against them and that none of the complaints of torture or assault was ever investigated. Dr Orr told the Court that she felt "morally and professionally bound"[7] to seek legal intervention. As a result of her action, the requested relief was granted. She was, however, barred from seeing detainees; her telephone calls were monitored; she felt ostracised by some of her office colleagues and her duties as a district surgeon were reduced to almost nil. She subsequently resigned and began work at the Alexandra Health Centre.*

It is interesting to note that the Security Branch of the South African Police (SAP) instituted strict security clearances for all district surgeons subsequent to Dr Orr's revelations – further evidence of the influence and involvement of the SAP in the work and conduct of district surgeons.[8]

21 Health professionals who are employed in situations in which they have dual loyalties are, because they do not enjoy full independence in making or implementing decisions, at risk of becoming involved in overt or covert abuses of the human rights of their patients. It is all too easy for health professionals who are not particularly vigilant or well-informed to assume the culture of the organisation for which they work, rather than maintaining independence and putting the needs and rights of patients above those of the organisation. Appropriate measures are needed to prevent or pre-empt the moral and ethical dilemmas that may arise for health professionals faced with the (often conflicting) needs of their patients and expectations of their employers. This issue needs careful consideration.

• HISTORICAL OVERVIEW OF HEALTH CARE IN SOUTH AFRICA

22 While the Act establishing the Commission directed it to examine the years 1960 to 1994, many of the events under scrutiny by the Commission can only be understood adequately within the context of the history and events leading up to this period.

23 Although the Union Constitution of 1910 gave control of the hospitals to the provinces, there were no specific provisions for the delivery of health services until the Public Health Act was passed in 1919[9]. The Act created a Department of Public Health, but left hospitals under provincial control. It also gave local authorities responsibility for the control of infectious diseases and environmental sanitation.[10] This led to a fragmented health system.

24 In 1942, the National Health Services Commission, headed by Dr Henry Gluckman, found that there were 2 000 active medical practitioners in South Africa. More than half of them (about 1 100) practised in urban areas where only

28.2 per cent of the population lived. The doctor to population ratios ranged from 1:5 000 in the rural areas (where mainly black people lived) to 1:380 for urban areas (where mainly white people lived). The infant mortality rate for whites was 50 per 1 000 live births; for Africans, it was estimated to have been between 150 and 600 per 1 000 live births (it was impossible to arrive at accurate figures due to inconsistencies in reporting).[11]

25 The Gluckman Commission report was published in 1945 and contained significant recommendations, including proposals that access to health care for all be considered a right rather than a privilege and that the state assume responsibility for the provision of health services.[12] Ironically, although none of these recommendations were implemented then, many constitute the core of the transformation of the health care system today.

26 It is important to note that racial discrimination and the lack of appropriate health care provision predated the National Party (NP) and formal apartheid. Indeed, the effective rejection of the recommendations of the Gluckman Commission took place before the NP was voted into power. However, during its first decade in power, the NP made no significant changes in the provision of public health care, except to reduce expenditure on public health on which mainly black people were dependent: expenditure was, for example, reduced by 8 per cent for the period 1950-55.[13] Hence, by 1960, the health care of black South Africans had been prejudiced by years of unequal allocation of resources – based on the assumption that 'natives' required less sophisticated health care than whites and a complete lack of coherence in or centralisation of health policy development.

27 The 1960s saw the replacement of apartheid rhetoric with concrete apartheid programmes aimed at enforcing racially separate development and the establishment of the homelands. Homeland health services were appalling. This is not always apparent from government-supplied health indicators, as homeland health figures were usually excluded from the statistics.[14] In fact, official statistics often gave the impression that the health situation was improving in South Africa. However, both in the homelands and in the Republic, segregated health care services seriously compromised the health of disadvantaged communities.

• STATE HEALTH ORGANISATIONS

The Department of Health[15]

28 The Department of Health was the arm of the national government responsible for public health services. It provided for care at the local, provincial and national levels, allocated state funds, drew up regulations and appointed senior officials to the hospitals. During the years under review, the Department's policies appear to have been driven by the political objectives of the national government, rather than a desire to ensure the well-being of all South Africans. The Department helped develop health care legislation that discriminated against people according to race. It enforced segregation of health care facilities and allocated funds in a racially biased way. These policies shaped, and continue to influence, health care delivery and the health of South Africans.

29 Inequities in health services can, to a significant degree, be attributed to the Department of Health as the body responsible for state-run hospitals. Most hospitals and ambulances were assigned exclusively to specific racial groups. Where hospitals served more than one group, separate wards were allocated to different racial groups.

Generally, the facilities available to whites were far superior to those available to blacks in terms of technology, sanitary conditions, supplies and the number of patients per health care worker. For example, at the King Edward VIII Hospital in Durban, which served African patients, conditions were appalling. At times, the obstetrics and gynaecology ward would operate at 200 per cent capacity. Women who had just given birth, or who were about to give birth, lay on mattresses on the floor and had to share five toilets with up to 140 other patients.[16]

30 The practice of segregating facilities was particularly serious in emergencies. If an ambulance of the 'wrong colour' arrived at the scene of an accident, the driver would leave, and another ambulance would have to be summoned. Even if a 'white' ambulance was closer to the scene of an accident in which a black person was injured, an ambulance from further away would be summoned – regardless of the seriousness of the emergency or the threat to the life of the patient.

31 Between 1960 and 1994, the Department of Health failed to use its resources to provide the best possible public health service. Probably the greatest problem in the health sector was the maldistribution of resources. Because of apartheid restrictions on where people could live and work, it was very easy for the Department to ensure that the distribution of resources favoured white people. By far the largest proportion of government funds was spent on the white population, despite the endemic poverty and socio-economic deprivation of the majority black population. In 1985, for example, annual *per capita* health expenditure according to race was R451 for white people, R249 for Indian people, R245 for coloured people and R115 for African people (see Figure 1). Since black hospitals were regularly overcrowded and white hospitals underutilised, the funding should have been redistributed to provide better overall care. The silence of the Department about the effects of socio-economic conditions on the general health of the population was deafening.

Figure 1

Source: Department of Health submission to the Truth and Reconciliation Commission.

32 According to the Department of Health today:

The exact effects of segregation and inequitable distribution of health resources based on race are impossible to calculate in terms of exact morbidity and mortality. However, this, together with the indignity of racially based services, resulted in abuse that cannot be allowed to be repeated.

33 The Department was also responsible for the regulations that governed conditions of service and the appointment of personnel in hospitals. Compensation for doctors varied by race, and salary differentials persisted into the 1980s. Even when parity in salaries was achieved, differences in total compensation remained, including medical aid packages, amount of leave, housing subsidies, and travel allowances.

34 The appointment of doctors to government hospitals had to be approved by the Department of Health. Often people were denied positions because of their political activities.[17] The Department appointed the hospital superintendent, who enforced the policies in that hospital. This was significant, as many of the racist provisions enforced by the superintendent were not part of any law, but simply reflected a desire to conform to the ideology of the state.

35 The Department did little to prevent police from obtaining medical records from hospitals or clinics without the consent of patients. The police used these files to identify 'anti-apartheid protesters', which made many people afraid to go to a government hospital to receive care, as they feared arrest. The Department did not take issue with inhumane practices, such as handcuffing or shackling patients to beds.

The South African Medical Services

36 The South African Medical Services (SAMS) was the medical service of the South African Defence Force (SADF) – now the South African National Defence Force (SANDF). The SAMS was formed in 1979 as a distinct and separate section of the SADF. It was responsible for providing health services to members of the SADF (army, navy and airforce) and some health services in the former homelands and parts of Namibia and Angola for certain periods.

37 The SAMS included doctors, nurses, psychologists and non-professional, military-trained 'medics'. These individuals were either conscripts or permanent members of the SADF and had to be trained and fully incorporated into the doctrine and standing operational procedures of the combat forces. This made the operation of the SAMS quite different from civilian care.

38 Military health professionals had a particularly difficult time in upholding international standards of medical ethics and human rights. While they were supposed to follow the same ethical codes as civilian medical workers, they were, at the same time, required to follow orders given by superiors. This created an atmosphere of dual loyalty for these individuals.

Experiences of a military medic[18]

Sean Callaghan had to choose the section of the military in which he wished to serve at the age of fifteen when he completed his papers for military conscription. At the time, he chose to be a military medic so he could "help people rather than kill them". Two years later, he found himself working as a medic in the townships and on the Namibian and Angolan border.

The first time that many of the medics performed any medical procedures was in black hospitals because "frankly it didn't matter if we made a mistake because they were black people". He very quickly learned that "the only way to cope with the situation was to switch off my emotions immediately, not to feel anything for anybody, not to try and fit into any kind of humane circumstance; but just to be a cold machine that did what I was trained to do."

In some camps, members of the SADF were given monetary incentives to carry out military objectives. At the Koevoet camp, they were paid for killing and recovering weapons from the enemy. This was a great motivating factor as the men could double or triple their incomes. In one instance, an officer became so frustrated when he could not find a firearm in a patient's possession (which would have meant extra money) that he shot the patient through the head while Sean was attending to the patient's wounds. John Deegan, the officer concerned, confirmed this in a statement to the Commission.

Torture was used during interrogation to extract information about the enemy and the whereabouts of arms caches, as such information could help increase the men's incomes. Some of the procedures used included electric shock around the genitals and pouring boiling water over the chest and genitals. Medics were expected to treat the resultant injuries.

Prisoners of war were shot at point blank range and buried once enough information had been extracted from them. Bodies were often tied to Casspirs[19]*, and the men would drive around with them for a week with their skin being ripped off. This was done to intimidate prisoners, and to coerce them into identifying the bodies and disclosing the position of the deceased in the command structure, or face being one of the next bodies to be dragged by the Casspir.*

There was virtually no psychological help for the men to deal with the tragedies that they witnessed. They often drank heavily or took drugs – one of the only ways to cope with the adverse circumstances. Suicides occurred frequently, as national servicemen could not take the pressures of constantly being in combat situations or so far away from their families. When Sean did go to the local psychiatrist for help, he was told to "grow up and carry on" because there was nothing wrong with him.

Once the men completed their military service, there was no debriefing or assistance to help them reintegrate into society. Although, according to the SAMS, Project Curamus was launched on 2 April 1990 to assist conscripts and permanent force members 'disabled' in the course of duty, the project seems to have focused primarily on physical disabilities, not psychological problems. After completing his military service, Sean suffered from post-traumatic stress disorder for ten years.

39 It is apparent from this account that military medics were forced to violate international and local standards of medical professional conduct and human rights and that many were personally traumatised by their experiences. Many of them have had great difficulty reintegrating into and becoming productive members of civilian society.

40 As yet, relatively little is known about the human rights violations committed by health professionals in the military. The SAMS submission to the Commission focused on the history, functions and administrative structure of the service, rather than considering any possible involvement in gross human rights violations. Many questions were deferred because they related to supposedly 'classified' (secret) operations. For example, the SAMS submission referred to three special projects undertaken by the Psychology Directorate. The reference was followed by the disclaimer: "As these projects have national strategic and security implications, they are not discussed in detail in this non-restricted document." However, the little information that the Commission does have on the violation of human rights by the SAMS suggests that military objectives often took precedence over medical objectives. In June and July 1998, a special hearing on the SADF's chemical and biological warfare programme uncovered new information about the extent of involvement by the medical profession in human rights violations.[20]

41 The Commission investigated a number of allegations. There were reports of a particular psychologist who used aversion therapy and electric shocks on homosexual military men as part of a treatment for their 'gayness'. Another doctor allegedly helped the military develop chemical weapons and truth serum to be used in questioning.

Experiences of a doctor conscripted to the SADF[21]

Before beginning his two years of National Service in the mid-1980s, a young conscript had qualified as a medical doctor. On entering the military, he applied to work in the department of psychiatry at a military hospital because he believed that he could use his time most productively there. He worked in psychiatry for six months and was subsequently sent to Oshakati for three months.

While in South West Africa, he observed many irregularities in the provision of medical care. When he arrived at Oshakati, he was treated differently to the other doctors and was accused of having been placed there as a 'government spy for the Surgeon-General'. Later, he discovered that the other three doctors had been 'handpicked' by the commandant, who said that "he did not want me in the camp and that if I ever breathed a word about anything I saw or caused any 'trouble', I would 'disappear without trace'".

He said that some of the obstacles and breaches in medical ethics he experienced included:

- a psychologist prescribing a schedule five anti-psychotic drug that only a medical doctor is permitted to prescribe;
- the commandant and his deputy changing scripts for medication and discharging patients without consulting the attending doctor;
- the commandant's refusal to supply the necessary medication to a patient;
- being prevented from treating patients who were members of the local community;
- disregard of his recommendations for treatment of a patient who had injuries that were thought to have been inflicted by security police. The patient subsequently disappeared;

- when diagnosing post-traumatic stress disorder, he was told that no such condition existed.

He wrote a report to the Surgeon-General describing these situations. The head of the Department of Psychiatry promised to give his report to the Surgeon-General but never did so.

42 The SAMS was directly and indirectly responsible for putting health workers in positions in which it was almost impossible to uphold international ethical and professional standards, as strategic needs were given priority over the health of the patients treated by military medical personnel. In addition, the SAMS did not acknowledge that the experience of combat situations could result in significant mental distress and did not provide adequate debriefing and counselling services for those of its members (either permanent force or conscripted) who were suffering in this way.

43 The panel to which the SAMS made its presentation felt strongly that its submission was evasive, that it failed to consider the very real ethical challenges faced by health professionals in the military and that it made no attempt to consider the possible involvement of health professionals in human rights abuses, either through acts of omission or commission. The quality of the SAMS responses to the very extensive and probing list of questions posed at the hearing merely entrenched this perception.

44 The Commission made special attempts to determine the involvement of the SAMS (and particularly health professionals employed by the SAMS) in the development of and research into weapons for use in biological and chemical warfare. The matter proved extremely difficult to investigate and was not covered in the SAMS submission. However, in an interview with *The Argus* newspaper dated 2 March 1995, General Knobel was quoted as saying that Project B, a research project on chemical warfare, began in the late 1970s under the leadership of Dr Wouter Basson (a medical doctor) of Seventh Medical Battalion. This project was allegedly closed down in 1993. The special hearing on chemical and biological warfare in June and July 1998 (referred to above) uncovered some of the activities of this project. At the time of the hearing, Dr Basson was facing charges of (amongst other things) conspiracy to commit murder, fraud involving millions of rands and dealing in the drug, 'ecstasy'. He was also still registered with the SAMDC as a cardiologist and a practitioner 'in good standing'.

45 The Commission traced the following allegations about the use of biological and chemical weapons by the SADF. It was assumed that these were developed under the auspices of Project B:

a A paralysing gas was allegedly used in May 1978 in the massacre at Kassinga, Angola.[22]

b The SADF allegedly used chemicals, napalm and defoliants in the Rustenburg area in August 1978 in an attempt to flush out a detachment of Umkhonto weSizwe (MK) guerrilla fighters.[23]

c In an attack on Frelimo troops near the South African border on 16 January 1992, a gas similar to teargas (causing pain and irritation) was allegedly sprayed from reconnaissance aeroplanes.[24]

• MISUSE OF MEDICAL AND SCIENTIFIC INFORMATION[25]

46 Medical expertise and information should be used to heal patients and develop new methods of prevention, treatment and cure. They can, however, be used against people in destructive ways. Many people view scientific data as 'fact', although, taken out of context or misrepresented, such data can be used for unethical purposes and have adverse outcomes.

47 Submissions and amnesty applications forwarded to the Commission, together with court evidence and secondary sources, gave numerous indications that health professionals were involved in committing human rights abuses and used their medical knowledge directly or indirectly to harm others. Some professionals were alleged to have participated in developing more effective methods of torture and interrogation, or to have given advice on how to use chemicals to make weapons or to poison people. Some also used their knowledge to design specialised weapons. Others, especially forensic specialists, used their expertise to falsify information or to disguise the cause of death in order to exonerate certain persons (often the Security Police) from blame.

Misuse of medical expertise

48 Doctors and mental health professionals were alleged to have advised torturers on how to identify potential victims, break down their resistance and exploit their vulnerabilities in order to achieve the goals of the state. It was also alleged that they helped assess the vulnerabilities of victims and prescribed drugs or psychological procedures to weaken detainees before torture was administered. They also recommended the kind of torture that would be most effective. In addition, some doctors were alleged to have advised torturers during interrogations as to when victims were near breaking point and how much more pain could be withstood.

49 Doctors are alleged to have given advice to police on lethal chemical formulas that were undetectable or difficult to trace, and on ways to disguise torture methods. In the case of Mr Siphiwe Mthimkulu, the victim became very ill after his release from detention. Upon further investigation, it was found that he had been poisoned with thallium, an odourless, tasteless poison whose effects are delayed after ingestion.[26] Siphiwe Mthimkulu disappeared in the year after he was released from prison. Many people believe that only a medical professional or chemical expert would have had the knowledge to advise the police to use such a poison.

50 Mr Amos Dyantyi told the Commission that he was severely tortured on the day of his detention in 1985. He almost suffocated when his torturers put a tube over his head. He was electrocuted by having electrodes inserted into his anus and suffered excruciating pain when a mechanical piece of equipment (like a jackhammer) was forcefully pushed into his stomach. The police were so concerned about his condition that a part-time district surgeon was called in to see him. Before he was taken to the hospital, the doctor allegedly told the Security Branch police to force porridge into his nose so that it would look as if he had suffocated on the porridge.

51 It is also believed that doctors advised interrogators how to administer electric shock. Initially, it was administered through clips or wires. However, the clips left marks that were detectable under a microscope. Professor Simpson, who worked extensively with detainees, reported that, once it became widely known that detection of electric shock was possible, there was a change in the way in which detainees described the administration of electric shock.

Torturers poured water over the victim and administered the current over a larger area of the body. Because the area through which the current penetrated was larger, this method left no marks. Again, it is believed that it was health professionals who advised torturers on this less detectable method of electric shock. Professor Simpson noted that, once it was discovered that electric shock could *still* be detected by a blood test, electric shock was used less frequently.

52 Doctors were also used by the SADF to develop weapons such as letter bombs and silencers for guns.[27] In a recent amnesty application, a perpetrator admitted to working for an SADF front company which, posing as a commercial chemical company, developed weapons such as letter bombs and special weapons that could deliver small amounts of lethal chemicals. This application named several medical doctors who were involved in this operation.[28]

Misrepresentation of forensic information

53 Forensic information was misused in various ways. Some forensic pathologists omitted crucial information or falsified *post mortem* reports to cover up the cause of death. There were many cases where doctors misrepresented forensic evidence and findings in court in order to absolve the state of allegations of abuse or criminal activity. This required the collusion of police, lawyers, forensic experts, district surgeons and other health professionals and magistrates and judges. The misuse and manipulation of specialised knowledge is illustrated in a number of case studies selected from submissions to the Commission.

Accidental or deliberate?

Ashley Kriel was shot in 1987 while allegedly resisting arrest and engaging in a scuffle with a security policeman. The police version of events was that, in the course of the arrest, Kriel produced a small .22 pistol. Captain Jeffrey Benzien, the senior police officer involved in the arrest, tried to take the gun away from him. A scuffle ensued during which Ashley Kriel was fatally injured by a bullet wound in the back, fired from his own pistol. The evidence presented by the state forensic experts supported this version of events.

On an examination of the facts, however, numerous inconsistencies are evident. These were not presented to the magistrate by the state witnesses, but were highlighted by the expert forensic witness testifying on behalf of Ashley Kriel's family. The two assessors sitting with the magistrate, both of whom were forensic experts, also failed to point out the inconsistencies or take them into consideration. The outcome of the inquest was a 'no blame' verdict.

Some of the inconsistencies were:

• The marks around both of Ashley's wrists indicated that he had been handcuffed before his death. If the handcuffs were removed, why was this done? If they were not, how could Ashley have engaged in a fight with Benzien, and how could he have shot himself in the back?

• The size and nature of the entrance wound in Ashley's back was consistent with a direct contact wound; in fact, stigmata around the entrance to the wound indicated that the muzzle of the revolver was held directly against the skin. However, the size and nature of the holes in the clothing that he was wearing at the time (a T-shirt and track suit top) were inconsistent with a contact shot.

54 There are some well-known examples of cases where doctors reported false causes of death. These include the numerous detainees who supposedly died from such causes as slipping on a bar of soap, dying of an epileptic seizure where no prior history of epilepsy existed, having a heart attack without a history of heart disease, choking on food or suffocating or committing suicide. In addition, doctors were known to give expert advice on the mental health of deceased prisoners, or to conclude that someone had committed suicide because of mental instability, without ever having met the person involved. This type of evidence was advanced at the inquest into the death of Neil Aggett.

55 Expert forensic evidence of gun shot wounds was also used to determine the distance between the victim and the killer.

Determining shooting distance

In 1986, seven young men were killed in a police ambush in Gugulethu. The police evidence was that all seven were shot from some distance. No contrary evidence was produced by the state experts. Independent forensic experts, however, found evidence of very close range 'finishing-off' shots on the bodies of many of the seven victims. One of the victims had, in fact, been shot in the jaw at such close range that there was almost no dispersal of the shotgun pellets, and the felt wad (which contains the pellets) was embedded in his brain. This evidence was presented at the second inquest into the deaths.

Hence, the police version that this person was shot from a distance of a few metres cannot be true. Again, however, a collusion of silence and a tacit agreement to turn a blind eye by lawyers, state forensic experts, police and the magistrate resulted in a 'no blame' verdict.

56 Professor Michael Simpson told the Commission that, on one occasion, a doctor gave evidence on the exact time of death of a detainee in order to help absolve a Security Police officer of suspicion; although, using the available technology, it would have been impossible to determine time of death with such precision. As it turned out, the expert had felt the victim's forehead and pronounced the time of death as having been exactly twenty minutes earlier. A professor of forensic medicine who was acting as an assessor in that case failed to comment on this unusual method of determining the time of death.

Mistake or complicity?[29]

April Makhwenkwe Tarliwe was killed in KwaZulu-Natal on 19 April 1992. The post mortem *was performed by a district surgeon, Dr A Nhlanhla, who reported the cause of death as "fractured base of skull" with mention of a "laceration on the upper lip". There was no indication in the* post mortem *report that the deceased had been shot. The district surgeon expressed the opinion that the deceased may have died in a motor car accident.*

Subsequently, a member of an Inkatha Freedom Party (IFP) hit squad who had been present at the incident (a 'drive-by' shooting) confessed to the Investigative Task Unit that Mr Tarliwe had been shot by a member of his squad. This new information and the post mortem *report were obviously contradictory, and the Investigative Task Unit arranged for an exhumation.*

At the second autopsy, a bullet entrance wound was found in the facial bones below the victim's nose, and the bullet was found still lodged in the victim's skull. Either the district surgeon made a mistake or he had been complicit in covering up a crime. If Dr Nhlanhla's evidence had simply been accepted, a gross miscarriage of justice might have ensued.[30]

57 These examples demonstrate some of ways in which medical and scientific information was misused or abused. It is difficult to determine the culpability of doctors in these situations, as the evidence may have been destroyed or the doctor could claim to have made a misdiagnosis or an honest mistake. However, there is enough evidence to indicate that these misrepresentations occurred frequently.[31]

• MEDICAL SCHOOLS

58 Medical schools played a significant role in perpetuating human rights abuses. Black people were systematically prevented from obtaining training in the health sciences and, even where this was allowed or provided for, received an inferior quality of education to that of white students. Medical schools failed to teach ethics and human rights. Professors in medical schools held dual appointments with both the state and the medical schools, leaving them vulnerable as health professionals with dual obligations. Finally, with a few exceptions, medical faculties did not speak out about the unethical nature of apartheid medicine and its adverse effects on training and patient care.

Admission for training in the health sciences

59 Opportunities for black South Africans to become health care professionals were extremely limited in the case of doctors and mental health professionals; although far less so for nurses. Before World War II, no black doctors were trained in South Africa. None of the medical schools in South Africa would admit black students and all black doctors received their training overseas. There does not appear to have been any statute preventing medical schools from accepting black students; it simply did not happen. Some of the schools claimed that it was because they did not have the facilities (such as separate residences) in which to accommodate black students.

60 The outbreak of World War II ended overseas training. From that time, a few black students were admitted to the University of Witwatersrand (Wits) and the University of Cape Town (UCT). However, very few black doctors were trained until 1951, when the University of Natal in Durban (UND) Medical School was opened exclusively for black students.

61 In 1959, the University Extension Act was passed, requiring black students to obtain ministerial consent before they could attend a white university. This made it very difficult for black students to enter any medical school other than UND and, in turn, for many aspiring medical students living outside Natal (as it was then) to attend medical school. UND was far from their homes and many did not have the financial resources to pay accommodation and travel expenses and academic fees. A small number were, however, able to attend white universities if they could convince the Education Ministry that extenuating circumstances prevented them from attending UND. The number of black medical students increased from the early 1980s, after the Medical University of Southern Africa (MEDUNSA) was

established. This was part of the apartheid plan to keep blacks (especially Africans) out of white universities, while at the same time ensuring a supply of black doctors to care for the black population.

62 The lost opportunities that resulted from the University Extension Act are impossible to quantify, although one can say with certainty that numerous black people were kept out of the medical profession. Between 1968 and 1977, for example, 86 per cent of all newly qualified doctors were white, while white people comprised less than 20 per cent of the population. By contrast, 3 per cent of the new doctors were African, while Africans constituted 71 per cent of the population (see Figure 2).[32]

Figure 2. Racial composition of doctors compared to the racial composition of the population

Note: Figures are the mean average percentages for 1968-1977.
Source: Data from the Health and Human Rights Project submission to the Commission, p87.

Disparities in the education of black and white medical students

63 Although the various South African medical schools were quite different from one another, they displayed strong similarities in their patterns of racism and the often overtly degrading treatment they inflicted on black medical students.[33] In general, black students were excluded from sports facilities and most social events. Accommodation was not usually offered to black students, which meant that they had to spend much time and money commuting. Where accommodation *was* made available, it was far inferior to that available to their fellow white students. Tearooms and changing rooms at hospitals were also segregated, and facilities for black students and professionals were inferior.

Personal experiences of Dr Ahmed Moosa at the University of Cape Town

There were no African students on the UCT Campus [when Dr Moosa attended medical school]. The only African people working there were people who were employed as labourers and as assistants maybe in some of the laboratories.

All the residences were closed [to black students]. You couldn't stay on the campus no matter where you lived. The clubs – all academic or social clubs – were closed … There were sports facilities, but those were segregated.

This lack of integration continued throughout our medical school years ... In anatomy, in the second year of study … all the black students were separated into a smaller lab.

In third year, the autopsies that we attended … they would only show black bodies if there was a mixed class. If there was a white corpse that had an interesting pathology, these corpses were eviscerated in an anteroom and the organs from these bodies were brought in and displayed to the class. You weren't even allowed to see a white corpse.

During our clinical years … the tutorial groups that we were in were separated along colour lines … We couldn't work in the white wards in the obstetrics wards … the white side of the hospital was a 'no-go' area for students of colour.

The separation of doctors continued throughout our internship years. There were separate residences. There were three or four white interns with us – they had a separate dining room. There was obviously the very sore point of differential salaries.

64 Even the training received by the few black students who were admitted to white medical schools was in some ways inferior to that of their white colleagues. While the lecture halls were not actually segregated, some of the practical training was. It is important to note that there was no legislation enforcing this discrimination; it simply became accepted practice at the medical schools. Black students could not attend *post mortems* on white cadavers and, at many medical schools, black students were not allowed to examine white patients. This changed in the mid-1980s when they were allowed to examine those patients who gave consent. Even after this, many hospitals maintained a policy preventing black students from examining white women in the obstetrics and gynaecology wards.

65 Black students had to do their clinical training in black hospitals, whereas white students could choose from any of the teaching hospitals. Since most of the training institutions are attached to white hospitals, black students had to travel long distances for their training. Heads of department usually chose to be based at the white hospitals, which limited the access of black students to the best and most experienced teachers. Since black hospitals lacked the resources of the white hospitals, many of the black students felt that they were deprived of the opportunity to use new technology or to see 'first world' diseases.

66 Conditions in the black hospitals were often horrific, which in itself hampered proper ethical treatment of patients. As one former student told the Commission, "it's difficult to teach ethics in an unethical environment."[34]

Dr Solly Rataemane's personal experiences of post-graduate training at the University of the Witwatersrand

Our lectures and clinical work (in neurology) took place in the Wits Department of Neurology … One afternoon, Dr Rangaka and I were the only two post-graduate students who attended the clinical session. The senior specialist would not give us a patient to assess. We were told that she was protecting us against embarrassment, if the white patients were to refuse being examined by black doctors. It was clear that we were only allowed to examine these patients in the presence of our white colleagues, who would explain that we are also doctors.

I was allocated a rotation at … one of the white centres providing training in child and adolescent psychiatry. On the eve of my commencement at this centre, a senior member of the Department of Psychiatry phoned me to inform me that I would not be going to that centre, as the superintendent of the centre was white and racist and he was not happy to have black doctors interview white children and white families. My anger at the Department and the University was immeasurable.

Inadequate teaching of ethics and human rights

67 None of the health science faculties made the teaching of ethics and human rights a priority. Most often, courses on these subjects were optional and the students were not tested on the material, thus reducing their incentive to attend the lectures. The teaching institutions failed to integrate ethics and human rights into the curricula in a way that could have helped students understand their importance and practical applicability. In addition, students were not encouraged to question the *status quo* or to protest at the differences in the provision of health care by race. Professor Frances Ames told the Commission:

> *I think submission to authority and absolving oneself from blame by saying that one has to obey orders are widespread… I think all medical students should be taught about the research on submissiveness being a key etiological factor in the perpetuation of atrocities. They should be fully familiar with Milgram's work and reflect on Hannah Arendt's concept of the 'banality of evil'.*

Relationship between the state and medical school faculties[35]

68 One of the major points of confusion concerning the medical faculties was their relationship with the state. The hospital superintendent, who ran the hospital, was accountable *only* to the provincial authorities. Doctors in the public hospitals (which were often also teaching hospitals) were appointed by the province and were subject to provincial terms of employment. Professors were appointed jointly by the university and the state through a committee composed of medical faculty members, administrators and provincial representatives. The university paid only a small percentage of their salaries.

69 This arrangement may have made it more difficult for individual members of medical faculties to criticise state policies, as they may have believed that such criticism would have put their jobs in jeopardy. Professor Frances Ames related the following incident, which illustrates that this was not an unfounded fear:

> *[In] 1980 … I was pushed and shamed into action by UCT students. They invited me to join a panel to address a public meeting held at the Medical School to protest against the refusal of the South African Medical and Dental Council to discipline Drs Lang and Tucker, who had been accused of improper and disgraceful conduct during the public inquest into Biko's death.*
>
> *I accepted their invitation and was surprised when, some hours before the meeting, I was summoned by the superintendent of Groote Schuur Hospital. He told me that head office had 'phoned him to tell me that I was a provincial servant and forbidden to participate in political activities.*

70 Although many of the racist practices in the hospitals breached international medical ethical codes of conduct, medical faculties were subjected to triple loyalties: to their patients, to their students and to their employers (the state and the university). Criticism of the failure of health science faculties to act against apartheid medical practices must also be tempered by the acknowledgement that universities in general relied on the government for a large part of their funding and were not completely independent. Failure to conform made institutions vulnerable to funding cuts.

Complicity of the medical schools

71 While some medical schools did start to speak out against the inequities of apartheid medicine, especially in the latter part of the period under review, they were generally complicit in committing human rights abuses by helping to create and perpetuate the racist environment in which health professionals were trained. Greater efforts should have been made by the lecturers and administrators to provide equal educational opportunities for all students. The medical schools could have challenged more vociferously the issue of segregated facilities, hospital rules concerning the treatment of patients, the lack of promotion of black doctors and the unequal resource allocation to black and white teaching hospitals. In addition, they could have encouraged their students to question the validity of the system and taught them how to maintain their integrity as doctors by upholding international ethical standards for the profession. Finally, they could have been more vocal in encouraging the professional organisations to take a stand against apartheid medicine and the injustices within the profession that stemmed from the maldistribution of resources.

• THE ROLE OF THE NURSING PROFESSION

72 Nurses in South Africa form the largest body of health workers in the country and make a great impact on health care delivery. During the period under review, they were very often at the frontline when it came to treating patients who had been subjected to human rights abuses resulting in injuries.

73 Nurses working for the prison services were very often the first points of contact for prisoners or detainees with medical complaints arising from abuses. The role of nurses in preventing and reporting abuses could thus have been absolutely crucial, as they could have brought cases to the attention of the relevant authorities and the public at large. The fact that this seldom happened reflects the hierarchical relationship between nurses and doctors, the subordination of nurses, the lack of awareness of ethical rights and responsibilities and the failure of the South African Nursing Council (SANC) to support and encourage the observance of human rights. Rather, nurses were encouraged to support the political situation of the day:

> *If they [nurses] suspect that a person is involved in insurgent or terrorist activities, they are required to report this to the medical superintendent or the nearest police station or army unit. If they do not do so, they may themselves be charged under the Terrorism Act if there is evidence that they have given assistance to a 'terrorist'.*[36]

74 Submissions and statements received did not indicate that nurses actively participated in gross human rights violations, but they *did* suggest that acts of omission and 'turning a blind eye' were common. "I think we are all guilty, but we had blinkers on, so did not see it at the time."[37]

> **Experience of Ms Betty Ncanywa, a nurse at Livingstone Hospital (Port Elizabeth) in the 1980s**
>
> *Most of the cases that we attended were for gunshot wounds and tortured people and detainees with severe depression. Some died before they reached us. Some died on arrival. Some were taken before we could treat them. The Security Police would take them from the casualty department before we could even treat them.*

As nurses, we were given an instruction that we mustn't obstruct the work of the security force. We mustn't stand in the way of the police. The only thing we need to do is to just treat the patient. Even if we see people being tortured, we must just keep quiet. This was the instruction from the hospital management … I must try to refrain from politics, otherwise my future would be in jeopardy.

75 This testimony very starkly illustrates the dilemma in which nurses found themselves. On the one hand, their training inculcated a culture of adherence and obedience to the hierarchy (doctors, matrons, sisters, nurses) and to authority of any kind (for example, the police). On the other hand, those who were conscious of human rights and ethical issues found themselves having to lie (for example, to admit a patient with 'severe depression' when they knew this was not the diagnosis); discouraging patients from going to hospital when they knew hospital care was desirable, and performing procedures (for example, removing bullets) for which they knew they were not qualified.

76 The way in which nurses were perceived to collude with apartheid policies and, during unrest situations, to co-operate with police (even though this perception was not always accurate) undoubtedly had a negative impact on the delivery of health care by nurses to communities.

This touches individual lives and safety, the ability to function in one's professional capacity and a fundamental loss of trust between various sections of the community, leaving jagged wounds of a physical, psycho-emotional, social and spiritual nature, which may take a long time to heal.[38]

• THE ROLE OF MENTAL HEALTH PROFESSIONALS

77 The area of mental health has historically been neglected in South Africa. Very few psychologists and clinical social workers were trained, resource allocation was notoriously inadequate and very few attempts were made to provide culturally appropriate mental health care to all South Africans.

78 The training of clinical psychologists in South Africa has been criticised for producing mental health professionals who mirrored their (white) environment: urban-based, in private practice and focused on curative rather than preventive mental health care. In addition, the type of treatment modality taught was overwhelmingly that of one-on-one therapy. Although obviously effective in some settings, this kind of therapy was generally available only to the elite few who could access and afford it – that is, the white population.

79 The first black psychologist to qualify in South Africa did so in the early 1960s. By 1998, the Human Sciences Research Council estimated that there were 3 897 psychologists in South Africa, 3 587 (92 per cent) of whom were white. Mental health care for black people consisted largely of institutionalisation (even at the time of reporting). A number of inaccurate concepts about the mental health of black people included, for example, the notion that black people do not get depressed and that black people displaying symptoms of severe stress are suffering from 'Bantu hysteria', to be treated with medication. An entire language and terminology was built up around this issue. The effect was to deny the need for preventive and counselling services for black people. Instead, chronic stress and trauma were pathologised and prescription medication was used as treatment.

Involvement in human rights abuses

80 While it was extremely difficult to find any hard evidence of overt involvement in gross human rights violations by psychologists, the profession was undoubtedly involved in human rights abuses through acts of omission. It also displayed a general apathy in relation to issues such as the effects on mental health of endemic violence, detention, solitary confinement and torture. In addition, until very recently, the profession failed to draw attention to the incontrovertible link between apartheid and mental health or to comment on the destructive effect of apartheid policies on the mental health of those they oppressed. According to one submission:

> *All citizens have had their human dignity denied and degraded through the experiences of living through the apartheid years. Our humanity and common sensibilities have been stunted.*
>
> *It is evident that the predecessor of the South African Federation for Mental Health at the national level was supportive of the apartheid policies of the government and did little or nothing to oppose other human rights violations in the field of mental health. It even reprimanded committee members or staff who did so.*

81 Various submissions reported that individual psychologists were involved in human rights abuses and/or unethical conduct that may have led to abuses. Some of those named were psychologists EG Malherbe, RW Wilcocks and HF Verwoerd who, for example, advocated racist policies like job reservation and prohibition of sexual intercourse between the races. Others mentioned were psychologists like ML Fick and JA van Rensburg, who were amongst those who propagated ideas of black intellectual inferiority. These views bolstered segregationist policies that resulted in gross violations of human rights.

82 Similarly, there is evidence that at least some practitioners engaged by the prison service acted in collusion with the prison authorities:

> *Practitioners … tended to adopt an attitude that indicated their subservience to the requirements of the security police or the prison administration. Indeed, many of them …would rather gather information from the warders/jailers than myself. I often wondered who the actual patient was … I, the patient, became invisible…*
>
> *The psychologist who visited me at Victor Verster Prison … in Nov 1982, really interrogated us … His role was to ferret out exactly what we would do on our release. He actually told me that, if I became a psychologist, I would be dangerous to the state because of the insights I could bring to political organisations – that I would be able to decide who would be an asset and who a liability to the struggle, while sifting out agents!*[39]

83 Breyten Breytenbach described his encounters with prison psychologists thus:

> *These perverted practitioners of the spurious science of psychology do not have as their first priority to help the prisoner who may be in need of it. They are the lackeys of the system. Their task is very clearly to be the psychological component of the general strategy of unbalancing and disorientating the political prisoner.*

84 A former SAP psychologist admitted in an interview that work associated with the use of psychology in torture and interrogation was ‘contracted out’ to outside psychologists, so that the SAP could deny the involvement of their own staff in this type of unethical behaviour.

85 Conditions in mental institutions were appalling and did nothing to foster mental health. Inmates were used as sources of income-producing labour and there are (unproved) allegations that black patients were used as ‘guinea pigs’ in research. Mental health professionals remained silent about this situation. The Department of Health acknowledges:

> *Conditions in a number of psychiatric institutions are still poor. Some of the worst wards and hospitals (for example, Westford in Gauteng) have been closed down. Many psychiatric hospitals are still faced with staff shortages.*

Abuse of diagnosis and treatment

86 The abuse of diagnostic tools by mental health professionals in collusion with the state must be regarded as a violation of human rights. Diagnosis was used to silence activists or opponents of the state, condemning them to institutions where they were under state control. This tendency increased the stigma attached to mental health institutions.

87 Health professionals also produced diagnoses that minimised illness or claimed that individuals were feigning illness, thus allowing the police to continue torturing and ill-treating political prisoners. Misdiagnosis also served to deny political prisoners and black people in general access to much needed mental health services. Yet, ironically, in an attempt to persuade the Commission’s Amnesty Committee to grant amnesty, a diagnosis of post-traumatic stress disorder was employed by security personnel.

88 The abuse of diagnosis is inextricably linked to that of treatment. Thus, individuals were given the wrong medication. As noted above, it was also claimed that detainees were used as guinea pigs to test new drugs.

Education, training and research

89 As with other health professionals, mental health professionals received very little under- or postgraduate training in ethics or human rights issues. At the time of reporting, psychologists were still not required to take an oath on graduation or registration and appeared to be acquiring knowledge about appropriate conduct by default rather than design.

90 Up until the time of the Commission, the training of mental health professionals adopted a largely Eurocentric paradigm, resulting in a style of mental health care that was inaccessible and inappropriate for many South Africans. While transformation was occurring in some academic sectors, change was still absent in others. Likewise, the types of psychometric tests used for assessment purposes (such as IQ tests) still tended to be appropriate only in a western culture. In South Africa, they were used as a way of excluding black candidates from, for example, educational institutions and employment opportunities.

91 In the same way, the types of research initiated and funded by tertiary academic institutions and organisations, such as the Human Sciences Research Council, remained esoteric and of little relevance to the mental health needs of the majority of South Africans.

Rural mental health

92 Most of the deponents who came from rural communities complained that they had no access to mental health services. Those who did experienced the services as alienating. They also spoke of the need for a culture that incorporated indigenous healing systems – for interventions informed both by the prevailing culture and by religious modes of healing.

The impact of trauma

93 At the time of the Commission, most South Africans were still experiencing the consequences of trauma. It was clear that mental health services were not yet geared to address this need. This point was discussed at a mental health workshop conducted by the Commission which dealt with the psychosocial and emotional needs of communities and individuals who had been identified by the Commission and other victim support agencies. The view was also expressed that mental health services historically received little or no resources and that the impact of poor mental health is far-reaching. In addition, the traditional paradigm used to understand trauma was Euro-American. The indigenous wisdom in South African cultures had been marginalised and its richness ignored. An aspect of trauma that also deserves attention is its impact on families and communities at a multigenerational level so that intervention strategies incorporate the family in its entirety.

> *Psychiatric patients remain a vulnerable group for discrimination and abuse of human rights. Both the mentally ill and the mentally handicapped are clearly stigmatised and thus discriminated against … In particular, there is a tendency to provide a differential level of care to different socio-economic groups, which is similar to the dehumanisation of other deprivations we have lived through.*[40]

94 The ‘sins’ of the mental health profession in South Africa were largely those of omission, although there is some evidence of more direct involvement in unethical conduct leading to human rights abuses. Unfortunately, because of the veil of secrecy surrounding the inner workings of the SADF and SAP and the invocation of the Official Secrets Act, it was not possible to perform an adequate assessment of the role that mental health professionals played in these institutions. Undoubtedly, like doctors and nurses with dual obligations, mental health professionals in these settings were vulnerable.

• THE ALLIED HEALTH PROFESSIONALS

95 The Commission received submissions from other sectors of the profession, including physiotherapists, pharmacists, dentists and complementary practitioners. The submission by physiotherapists pointed again to the hierarchical

nature of the health profession and the fact that some professionals were perceived as having a less important status. The submission of the physiotherapy profession complained that:

> *Certain individuals and institutions had been invited to make submissions [to the Commission]. However, the rehabilitation therapists had not been included in this group, which consisted of doctors (and psychiatrists), nurses and psychologists. This seemed to be a perpetuation of long-standing professional hierarchy/hegemony, which needs to be challenged as part of the health care sector hearings.*[41]

96 All submissions emphasised the lack of training in ethics as a major area of concern. In addition, the fact that other health professionals felt compelled to make submissions is indicative of the pervasiveness of abuses - either overt or covert - in the health sector and an acknowledgement of the fact that most health workers did not speak out enough, or at all, about these abuses.

• PROFESSIONAL HEALTH ORGANISATIONS

97 In his testimony, Dr Barry Kistnasamy noted:

> *The social consequences of apartheid were so gross, so thoroughly destructive and so widely acknowledged and abhorred by the international community that there could be no avoiding the intrusion into the professional lives of the medical men and women of this country.*

98 It was surely the task of the statutory and professional organisations to ensure that professionals were able to provide ethical and appropriate health care, regardless of the policies of the government in power. If, as Dr Kistnasamy states, those policies made this impossible, it was for the statutory and professional bodies to speak out against those policies.

The organised medical profession

99 History has shown that the two most powerful bodies with which doctors were associated - the SAMDC and the MASA - failed to speak out or take a stand for most of the period under review.

100 The SAMDC was a statutory body and, during the period under review, was responsible for the registration, education, maintenance and monitoring of professional standards of conduct as well as for disciplinary enquiries into allegations of misconduct of all health professionals except nurses and pharmacists.[42]

101 The successor body to the SAMDC, the Interim National Medical and Dental Council (INMDC), prepared a submission to the Commission on behalf of the earlier body. The submission made it clear that the SAMDC saw itself as an independent body:

> *Although created by statute originally in 1928, the SAMDC was not an organ of state. It was totally funded by the health care professionals falling within its jurisdiction. The majority of its membership was persons who were not appointed by the Minister.*

102 Yet, the SAMDC was viewed widely as an almost parastatal organisation, lacking in independence. Nothing highlighted this more that its initial failure to launch an investigation into the conduct of the district surgeons, Drs Tucker and Lang, after the death of Steve Biko. The following explanation was given as to why the SAMDC's first enquiry into the matter in 1980 differed so markedly from the second enquiry in 1985 (undertaken in large part in response to continued public outcry):

> *When eventually (the second) inquiry was held, that was a completely different body in a different Council. Remember the Council's terms of office stretch in five-year terms, or used to. So, that was one Council from 1980 to 1985 and then a new Council from 1985 onwards. So that when eventually this inquiry reached the stage where it came before Council, there was a completely new Council with new members, and that Council then came to the conclusion that the practitioners were in fact guilty.*

103 One might question this explanation. A body responsible for discipline and the maintenance of professional standards of conduct should display consistency in applying those standards.

104 The SAMDC, in contrast, displayed no hesitation in taking action against another of its members who was guilty - not of negligence in treating patients, but of resisting the apartheid regime. Dr Aubrey Mokhoape was a doctor convicted of terrorism in 1974. During his interrogation, he was put into solitary confinement, beaten and tortured. The Council did nothing to protest about this treatment and proceeded to use the criminal offence ('terrorism') as the basis for launching proceedings against him as a medical professional. It eventually dropped its charges against the doctor, but the case demonstrates that the SAMDC could take swift action when it deemed it appropriate.[43]

105 Another significant problem raised in the hearings was the fact that the SAMDC was only able to respond to complaints or submissions made to it. This inability to be proactive severely hampered its capacity to monitor and maintain professional and ethical conduct.

106 In a letter submitted to the Commission after the hearing, Mr Prinsloo, on behalf of the executive committee of the SAMDC, stated:

> *The Committee resolved that the [Truth and Reconciliation Commission] be informed … that the Executive Committee wished to state explicitly that it records an apology in respect of any acts of omission or commission on the part of the SAMDC in not taking firmer steps to negate the effects of an unacceptable social system.*[44]

107 The apparent collusion of some doctors with state security forces and the lack of response from professional bodies in relation to this led to deep divisions within the South African medical world. Therefore, two bodies came to represent the medical profession - MASA and the National Medical and Dental Association (NAMDA).

108 The older body, MASA, was a voluntary, independent, professional association for medical doctors. It was historically (at the time of reporting) the largest professional medical organisation in South Africa, with a membership of about 14 000. At the time of the hearings, it saw its role as "empower[ing] doctors to bring health to the nation"[45] by representing the collective interests of the profession and the patients it serves, as well as shaping health policy to meet the needs of the community.

109 MASA made a 104-page submission, the result of an extensive study of its records and archives. The submission noted that MASA had members that actively supported the apartheid government and members that actively opposed it. Rather than focusing on the activities of individuals, the document examined MASA's role as an association. It said, in this regard:

> *The Association in general was quite comfortable with the* status quo*, and its public reaction to any criticism of the inequity and the iniquities in society, particularly the inequities in health care delivery, was to dismiss that criticism as the work of enemies of the state and it defined all sorts of means to defend itself and the system.*

110 The submission also acknowledged the fact that MASA failed to respond appropriately to the health needs of the majority of South Africans.

> *MASA was always, without doubt, a part of the white establishment … and for the most part and in most contexts, shared the worldview and political beliefs of that establishment. Inescapably, it also shared the misdeeds and the sins for which the white establishment was responsible.*

111 Dr Hendrik Hanekom of MASA clearly acknowledged the organisation's past positioning in his response to a question at the hearing:

> *MASA was so wrapped up in its white, male, elitist, educated, professional world as individuals and as a collective organisation and as part of a broader society from which doctors were drawn, that it failed to see the need to treat all people as equal human beings. Perhaps the same could be said of other groupings in society. MASA allowed black and white people to be treated differently, and this is the form of human rights violations for which it stands disgraced.*

112 The written submission added, however, that the events surrounding the death of Steve Biko forced MASA to begin a long process of examining the ethics and morality of its actions.

> *This sad and disgraceful episode marked the beginning of a movement within the association, a movement of opposition to the actions and attitudes of the then leadership of the Association which, haltingly and with many setbacks and failures, finally grew powerful enough so that by 1989, it was quite clear that the Association had set its feet firmly on the road of renewal and transformation.*

113 NAMDA was an 'alternative' medical association, formed on 5 December 1982. In its submission to the Commission, the Progressive Doctors' Group (PDG), a core group of ex-NAMDA doctors formed to pursue discussions about a united medical association for South Africa, gave some of the reasons for the NAMDA breakaway from the MASA. These included:

a the conduct of the profession in respect of the medical conduct of those responsible for the death of Steve Biko;

b the devastating effects of apartheid on health and human rights, and

c the failure of existing medical organisations to respond cogently to these issues.

114 With the increased repression of the 1980s, it became important to work at making health facilities safe or providing alternative services. NAMDA, together with other professional organisations, such as the Organisation for Appropriate Social Services in South Africa (OASSSA), took on this responsibility.

115 NAMDA disbanded in the early 1990s when it became evident that South Africa was moving towards a new democratic dispensation in which the Department of Health would (it was believed) take on the issues that had triggered its creation.

116 The PDG highlighted a number of other concerns in its submission: The first was the harassment of NAMDA and its members, which manifested itself in various ways. Second, was the concern that so few health professionals came forward at the time to testify about human rights abuses in the profession. “It seems that many more health professionals were aware of problems or were involved in problematic practices than they were prepared to acknowledge.” A third concern was the way in which certain research was conducted, particularly in the area of occupational health: for example, heat acclimatisation chambers set up to ‘customise’ workers to the work place. Last was the fact that, at the time when NAMDA was supporting the ‘Free the Children’ campaign, MASA was involved in drawing up, ‘Children in places of detention: a code for their handling’. In other words, while NAMDA abhorred the very concept of detaining children, MASA was trying to find ways to make it more acceptable.

South African Nursing Council (SANC)

117 Similarly, it is evident that nurses did not feel that their statutory body, the SANC, or their professional organisation (then the South African Nursing Association) offered appropriate or adequate guidance and support for nurses who found themselves in situations where human rights were abused.

118 The SANC admitted in its submission:

> *We further acknowledge and accept without justification that Council was influenced by the policies of the government of the day. This could have resulted in both a conscious and unconscious perpetuation of those discriminatory policies and legislation, leading to gross violations of human rights.*
>
> *We are aware that Council was all the time morally bound to adhere to a strict professional approach to matters of nursing, without allowing itself to be used as a tool of the apartheid machinery.*
>
> *We appreciate that Council could at times have exercised a free discretion on some of the issues.*
>
> *We therefore wish to apologise unreservedly both for conscious and unconscious activities that could have had the effect of undermining human rights from time to time.*

119 According to the DENOSA submission, there was, over the years, no accountability within the profession to pledges or other codes studied by nurses. This is underscored, for example, by the long-standing acceptance of section 49 of the Nursing Act (no 69 of 1957), which made it an offence for white nurses to be subordinate to black nurses.

120 Other ‘failures’, raised by the SANC include:

a Only white persons could serve on the Council.

b While the SANC was aware that there was segregation in health treatment along race lines, which vitiated the nurses’ pledge, it apparently made no effort to protest against this.

c Where victims of accidents were denied emergency treatment on the scene because of their race, the SANC made no efforts to confront this situation.

d The SANC failed to react to gross inequities in the provision of training facilities for the various population groups.

e When former political prisoners and detainees made allegations against nurses in prisons and other hospitals, the SANC failed to conduct proper investigations.

f Appointments of staff in the categories of typist/clerk and upwards were almost exclusively limited to whites. There was no effort on the part of SANC to empower members of the disadvantaged communities.

121 These admissions on the part of the SANC make it unsurprising that nurses failed to respond more vigorously to the human rights abuses with which they were confronted. Where leadership failed to lead on issues of human rights and, at times, was seen to sanction and support apartheid policies and practices, those in subordinate positions would have needed unusual courage to protest, particularly when threatened, as was Ms Betty Ncanywa, with loss of employment.

Mental health organisations in South Africa

122 The South African Psychological Association (SAPA) was founded in 1948, with a membership of thirty-four. In 1962, following the admission of a black member, a new association, the Psychological Institute of the Republic of South Africa (PIRSA), was established exclusively for whites. The two organisations merged in 1983 to form the Psychological Association of South Africa (PASA). Black professionals were permitted as members but, because of the racist history of PIRSA, many chose to join the Black Psychologists' Association instead.

123 OASSSA was formed in 1985. It included psychologists and social service workers, and attempted to provide social services (largely counselling) to communities and individuals that did not generally have access to them.

124 Finally, in 1994, the Psychological Society of South Africa (PsySSA) was formed. This organisation represented the professional interests of South African psychologists and was attempting, at the time of reporting, to bring about transformation in the field of mental health care.

125 The Society of Psychiatrists of South Africa (SPSA) is a sub-group of the MASA and was formed in 1966. About half of the approximately 300 registered psychiatrists in South Africa are members. Commenting on its activities over the previous thirty years, the SPSA said:

> *That the SPSA had to be prodded into adopting a more distinct role, that of lobbying the government for equal and adequate facilities for all the country's mentally ill, regardless of race, is evident … Much of the Society's concern with respect to apartheid was generated in response to external pressures and reports since 1977.*

126 In other words, the SPSA was a largely reactive body that did not play a proactive role in ensuring that the human rights of mentally ill people were upheld.

127 In addition to the professional organisations mentioned, a number of societies working in the area of mental health were formed over the years. In 1920, the South African National Council for Mental Hygiene and the Care of the Feebleminded was formed in an attempt to facilitate communication and formalise the relationship between the government and these societies. This Council was originally structured in such a way that at least half of the members of the policy making board were government psychiatrists. In addition, the Broederbond managed to influence policy significantly.

> *The Board of the SA National Council for Mental Health was, therefore, at least until the early 1980s, heavily influenced by two power groups not representative of civil society, namely government psychiatrists who sought to protect government mental health services from criticism and reform, and the Afrikaner Broederbond, which oversaw the implementation and maintenance of a Christian National Philosophy, which is today recognised as being a euphemism for apartheid.*
>
> *In 1966, the Department of Social Welfare and Pensions issued its notorious Consolidated Circular no 29 [Appendix 4], according to which welfare organisations were no longer allowed to have racially mixed memberships … The National Council for Mental Health complied with the circular by excluding all black persons from its meetings and membership.*

128 This was in direct contravention of the constitution of the World Federation for Mental Health (of which the National Council for Mental Health was a member), which affirmed non-discrimination on racial grounds as a major principle. The World Federation failed to act against its South African affiliate, however.

129 During the 1980s, the Council began a gradual process of transformation, starting with racial integration. Eventually, after wide consultation, the South African Federation for Mental Health (SAFMH) was formed in 1992.

130 Some would argue that, because the profession was so small, any intervention or declarations would have had little effect. In addition, the fact that psychology was low in the hierarchy of health care has been put forward as a reason for the profession's failure to act on issues which should have drawn rigorous condemnation. These arguments,

however, appear more as attempts at self-justification than as valid reasons for the profession's failure to respond to human rights abuses. For instance, in July 1987, the SPSA issued the following statement:

> *The implementation of section 29 of the Internal Security Act 74 of 1982 and other Emergency Regulations involves a type of detention such as isolation, solitary confinement, immoderate interrogation, etc., that in our opinion may damage the mental health of many persons so detained.*
>
> *We accept that it is our bounden duty to effectively treat and prevent relapse in the mentally disordered. We wish to express unequivocally our opposition to practices that lead to mental breakdown.*
>
> *While we accept that justice must be done and that security must be maintained, we believe that this should not be achieved in a manner that diminishes the dignity of the individual or the integrity of his or her mind and body.*

131 This mild (and somewhat euphemistic) statement could surely have been issued much earlier than mid-1987. Incontrovertible evidence of the mentally deleterious effects of detention, solitary confinement and torture existed decades before this. The SAFMH submission reflected on this:

> *The Board members and staff of the SAFMH acknowledge that the Board of the National Council for Mental Health was guilty of activities contrary to the promotion of good mental health, by actively and tacitly supporting the apartheid policies of the previous government and failing to support those within its ranks who protested against apartheid atrocities and human rights violations in the field of mental health. They are also conscious of many acts of omission during the apartheid era and that, instead of campaigning actively against the mental illness of apartheid, they remained silent … They express their sincere regret for the Federation's action in this respect …They will in future strive towards the social welfare of all South Africa's people, with special recognition of those who have been previously disadvantaged.*

• RESISTANCE TO ABUSES

132 The Commission acknowledged that it was difficult for health professionals, particularly those with dual loyalties, to fight against the systemic human rights abuses that apartheid so deeply entrenched in the health sector. There were, however, many instances where people protested quietly or vociferously, and a few who put their careers and lives at risk in protest against violations of human rights. Many of the people who protested about the conditions under which health services were delivered or did not co-operate with state authorities were victimised in various ways. Some were fired from their jobs; others ruined their chances of promotion; some faced personal violence.[46]

133 Many unknown and nameless health workers offered health care to injured 'protesters' in their own homes in the townships. Injury during an unrest situation meant automatic arrest and people who went to hospital, particularly with gunshot injuries, were often handed over to the police. These health workers placed themselves and their families at risk and, although the Commission was unable to name them, they deserve acknowledgement. They saved many lives and prevented many inappropriate arrests.

134 Although one can cite many such cases, the health profession as a whole was not outspoken enough in its protests against abuses.

Raids for medical files

135 During the period of unrest in the mid-1980s, Dr Tim Wilson,[47] who was the Chief Medical Officer at Alexandra Health Centre in Alexandra township outside Johannesburg, tried to prevent police from identifying so-called 'terrorists' (anti-apartheid protesters) through the seizure of patients' medical files. On many occasions, he refused to turn over the records. He also advised his staff that, while they could not obstruct police activities, they were under no obligation to help them. He told patients that, if they gave false names or addresses, nobody in the clinic would attempt to verify them, thus making it safer for people to obtain medical treatment with less fear of subsequent detention.[48]

Baragwanath doctors

136 A letter signed by 101 doctors from Baragwanath Hospital (historically an African hospital) was published in the South African Medical Journal (SAMJ) of 5 September 1987, protesting the appalling conditions in the hospital:

(T)he facilities are completely inadequate. Many patients have no beds and sleep on the floor at night and sit on chairs during the day. The overcrowding is horrendous. Nurses are allocated according to the number of beds, and not to the number of patients.[49]

137 The Transvaal Provincial Authority (TPA) claimed that the doctors' statement was inaccurate and demanded an apology from them. Most doctors signed the letter of apology, later published in the *SAMJ*, because they believed that they could face personal victimisation if they did not do so. Six doctors, however, refused to sign the apology because they did not believe that they had made inaccurate statements. They were subsequently denied their previously approved posts at the hospital. One of the six doctors, Dr Beverly Traub, brought the matter to the Supreme Court and was later reinstated.

• CONCLUSION (IN THE WORDS OF OTHERS)

A Worker's Speech to a Doctor

We know what makes us ill.
When we are ill we are told
That it's you who will heal us.
For ten years, we are told
You learned healing in fine schools
Built at the people's expense
And to get your knowledge
Spent a fortune.
So you must be able to heal.

Are you able to heal?
When we come to you
Our rags are torn off us
And you listen all over our naked body.
As to the cause of our illness
One glance at our rags would
Tell you more. It is the same cause that wears out
Our bodies and our clothes.
The pain in your shoulder comes
You say, from the damp; and this is also the reason
For the stain on the wall of our flat.
So tell us:
Where does the damp come from?
Too much work and too little food
Make us feeble and thin.
Your prescription says:
Put on more weight.
You might as well tell a bullrush
Not to get wet.
How much time can you give us?
We see: one carpet in your flat costs
The fees you earn from
Five thousand consultations.
You'll no doubt say
You are innocent. The damp patch
On the wall of our flats
Tells the same story.[50]

> *Apartheid was a process of dehumanisation. It reduced the majority of our people to objects or physical entities. Imperceptibly, medicine also became dehumanised. The focus was on the disease and not the person, their family and community. South Africa is politically free; however, our people need to be healed spiritually, mentally and physically if we are to create the type of society and country that we all desire. Doctors, medical schools and their teaching staff, and medical students can become important instruments for this change. The most important step in this process is to re-humanise medicine… In short, change is not merely desirable, it is essential. The narrow outlook of the past can no longer be justified.*
>
> PROFESSOR B. MAHARAJ

• FINDINGS ARISING OUT OF HEALTH SECTOR HEARINGS

138 Health professionals who were named in submissions as having contravened ethics or acted unprofessionally will be referred to the appropriate disciplinary body, together with as much information as is available, for further

investigation and suitable action. The Commission has neither the resources nor the time to conclude investigations to the point where individual findings can be made.

The Commission finds that

139 The South African Medical and Dental Council (SAMDC) failed to exercise its statutory obligations by neglecting to investigate the conduct of Drs Tucker and Lang pertaining to the death of Stephen Bantu Biko until ordered to do so by the Supreme Court.

140 The Medical Association of South Africa (MASA), its standing committees and its special interest groups failed to fulfil their stated aim of protecting the health of patients, by neglecting to draw attention, amongst others things, to:

a the effects of the socio-economic consequences of apartheid on the health of black South Africans;

b the fact that segregated health care facilities were detrimental to the provision of health care in quantitative and qualitative terms;

c the negative impact on the health of millions of South Africans of unequal budgetary allocations for the health care of different 'racial' groups;

d the fact that solitary confinement is a form of torture;

e the severe impact of detention on the health of children.

141 Academic institutions, even those that did admit black medical students, failed to provide equal educational opportunities to black and white students.[51]

142 Education in respect of human rights for all health professionals failed to address crucial patient-care issues.

143 The former government, and more specifically the Department of Health, failed to provide adequate health care facilities to black South Africans. Health care resources were thus unequally distributed and inappropriately allocated and used. Certain aspects of health care provision have been particularly under-resourced – for example, mental health care and primary health care.

144 District surgeons, with few exceptions, failed to record complaints and evidence of torture and abuse and, where such recording did take place, failed to take any steps to report or halt such abuse. Some district surgeons, in turn, either withheld pertinent medical information or reported such information incorrectly.

145 The South African Nursing Council (SANC) and the SAMDC, as the statutory bodies governing health professionals in South Africa during the period under review, failed to:

a speak out against segregation of health care along colour lines, thus compromising ethical pledges taken by doctors and nurses and failing to advocate adequate care for patients;

b confront local authorities who refused to allow emergency services designated for white patients to offer emergency care to black patients at the scenes of accidents;

c react to gross inequalities in the provision of training facilities for various population groups;

d draw attention to the lack of facilities and resources in institutions providing health care to black patients;

e conduct proper investigations into allegations of misconduct by doctors and nurses against political prisoners and detainees.

146 The SANC established surrogate nursing councils in the 'homelands' without due consultation with the nurses working in those areas. This undermined the professional status and the international recognition of those nurses.

147 The South African Medical Services (SAMS) of the South African Defence Force (SADF) failed to provide adequate mental health support for SADF members, particularly conscripts exposed to violence.

148 Members of SAMS, under the leadership of the Surgeon-General, were directly involved in the development of chemical and biological weapons to be used against individuals and in unrest and combat situations.

149 The Department of Health, the SADF and the South African Police and Prisons failed to provide adequate training, support and ethical guidance to those health professionals in their employ, who were working in environments in which there was a conflict of interests between employer and the patient. The interests of the patient/client were thus frequently subjugated to those of the state.

• APPENDIX 1: THE HIPPOCRATIC OATH[51]

I swear by Apollo the Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfil according to my ability and judgement this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art - if they desire to learn it - without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgement; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favour of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about.

If I fulfil this oath and do not violate it, may it be granted to me to enjoy life and art, being honoured with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

• APPENDIX 2: THE DECLARATION OF GENEVA[52]

At the time of being admitted as a member of the medical profession:

I solemnly pledge myself *to consecrate my life to the service of humanity;*

I will give *to my teachers the respect and gratitude which is their due;*

I will practice *my profession with conscience and dignity;*

The health of my patient *will be my first consideration;*

I will respect *the secrets which are confided in me, even after the patient has died;*

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

My colleagues *will be my brothers;*

I will not permit *considerations of religion, nationality, race, party politics, or social standing to intervene between my duty and my patient;*

I will maintain *the utmost respect for human life from its beginning even under threat and I will not use my medical knowledge contrary to the laws of humanity;*

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

• APPENDIX 3: THE DECLARATION OF TOKYO

Preamble

It is the privilege of the medical doctor to practice medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity.

For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

1 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.

2 The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.

3 The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment is used or threatened.

4 A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive, whether personal, collective or political shall prevail against this higher purpose.

5 Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgement concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgement should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner.

6 The World Medical Association will support, and should encourage the international community, the national medical associations and fellow doctors, to support the doctor and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

• APPENDIX 4: DEPARTMENT OF SOCIAL WELFARE AND PENSIONS CIRCULAR

DEPARTMENT OF SOCIAL WELFARE AND PENSIONS, 21 JUNE 1966
CONSOLIDATED CIRCULAR NO 29

a) To all national and provincial welfare organisations
b) To all offices of the department (for information)

CO-ORDINATION OF WHITE AND NON-WHITE WELFARE WORK IN NATIONAL AND LOCAL WELFARE ORGANISATIONS

1) The Government's policy on welfare organisations is based on the principle that each population group should serve its own community in the sphere of welfare.

2) The practice of certain welfare organisations of maintaining multi-racial organisations and having representatives of different races at council and committee meetings, is not only contrary to this policy, but also presents other problems:

   a) Meetings of White bodies are held in White areas, usually at well-known venues where non-Whites do not normally go, and there is every likelihood that this will give rise to talk, criticism, friction and so on. The social side, as regards meeting at tea-breaks and meals, also presents problems.

   b) Experience has shown that one or two non-Whites at a meeting of Whites are far less effective than when the position is reversed, because the non-Whites, being the minority group, are over-shadowed and therefore do not make a contribution unconstrainedly.

   c) In the case of some non-Whites, we have to a certain extent to deal with their need for recognition of status and encouragement towards independence, a need which is not gratified when non-White delegates, as outsiders, have to act in a larger White group.

3) For the implementation of Government policy non-White welfare societies should be established for the various racial groups and be given the opportunity to develop side by side with the corresponding White societies, and should be encouraged under the guidance and with the advice of White societies to unite, by affiliation, into fully independent national welfare organisation for each racial group separately. In this way non-White societies could enjoy the benefit of White guidance and advice, without coming into conflict with Government policy which is opposed to multi-racial organisations founded on joint membership of White and non-White. When matters affecting non-White societies come under consideration, one or two members of the White executive committee of the main body could, if so requested, attend meetings of the executive committee of the non-White body, to effect liaison between the two committees and to acquaint the White committee with the views of the non-White committee.

4) If the procedure described in the previous paragraph should prove impracticable in an exceptional case, one or more members of the non-White body could be designated to attend meetings of the White executive committee in an advisory capacity to represent the interests of non-Whites when the affairs of the non-White body are being

discussed. However, this alternative is considered less effective and should not be encouraged, since each of the various non-White racial groups has its own method of, and approach to, discussion, and in an atmosphere peculiar to such a group the guidance of Whites carries more weight than when it is passed on at second hand by a non-White to the non-White committee.

5) The policy of the Government as regards welfare organisations may therefore be summed up briefly as follows:

a) It is intended that non-White welfare organisations for the various racial groups should exist and develop alongside of White organisations. In the course of time, they will advance to a level of complete independence when they will be quite capable of managing their own affairs. Eventually, no White guidance and advice will be required, but what will be necessary is liaison in and consultation on matters of common interest. *Ad hoc* consultation will be possible and it would not be necessary to establish a committee for this purpose. Channels will be provided not only for exchanging views, but also for bringing to the attention of non-White organisations any information that has come to light at meetings of the White body.

b) As an interim measure, such non-White welfare organisations for the various racial groups may be helped and encouraged, under the auspices and guidance of White societies and national bodies with which they may be affiliated, to continue to develop separately and in due course to be linked together by means of affiliation in their own national organisations.

c) It goes without saying that in the process of helping and training non-Whites towards independence, White members of the national body and of the local committee will be able to attend the meetings of the non-White body or local committee as advisors and not as members, in order to give the necessary advice and guidance on policy, administration, control etc.

d) National councils and their executive committees, as well as local White welfare organisations and their committees, must consist of Whites only, and their annual meetings must be attended by White persons only. If it is necessary for the non-White organisations to be represented at an annual meeting as well (in cases where their own national organisation has not yet been established), they will have to be represented by Whites.

e) The executive committee of a national or local body may, however, invite a representative or member of a non-White organisation to attend a meeting of the executive committee when a matter specifically affecting the non-White organisation is being dealt with.

6) The intention is that officers of Government departments will attend meetings of a body or its executive committee (White or non-White) only if effect is given to the Government's policy as outlined above.

7) I should be pleased to learn -

a) whether your Council and/or any of its affiliated societies or branches has non-White members;

b) whether such non-Whites may serve on the executive committee of the society or on your Council;

c) what steps your Council has in mind to give effect to the policy of the Government as set out in paragraph 5 of this circular.

8) National or provincial welfare bodies experiencing any problems in carrying out the policy of the Government as indicated above are invited to discuss such problems with the Department.

9) This circular is issued with concurrence of the Departments of Education, Arts and Science, Bantu Administration and Development, Coloured Affairs, Indian Affairs, Health and Labour.

Signed:
Secretary