The Legacy of Apartheid

The American Association for the Advancement of Science

and Physicians for Human Rights

IN CONJUNCTION WITH

The American Nurses Association

and the Committee for Health in Southern Africa
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American Association for the Advancement of Science

Since its founding in 1848, the American Association for the Advancement of Science (AAAS) has continually worked to advance science. From its early, specific aims concerned with communication and cooperation among scientists, the Association’s goals now encompass the broader purposes of “...furthering the work of scientists, facilitating cooperation among them, fostering scientific freedom and responsibility, improving the effectiveness of science in the advancement of human welfare, advancing education in science, and increasing the public understanding and appreciation of the importance of the methods of science in human progress.”

AAAS enrolls more than 145,000 scientists, engineers, science educators, policymakers, and others interested in science and technology who live in the United States and in many other countries throughout the world. AAAS is the world’s largest federation of scientific and engineering societies, with 280 organizations that cooperate with the Association on a variety of projects, including Annual Meeting symposia, fellowships, international programs, annual analyses of the federal research and development budget, equal opportunity activities, and science education.

A staff of nearly 300 people, headquartered in Washington, DC, handles the Association’s day-to-day activities, including editing and producing Science magazine and other publications in print and on the World Wide Web; planning and supporting the Annual Meeting and a variety of colloquia and other meetings; developing special programs in science education and human resources, international scientific cooperation, and science and public policy; managing a variety of fellowships, grants, and prizes; and disseminating information about these activities. In addition, twelve staff members are located in Cambridge, England, as part of the international office for Science magazine.

The Science and Human Rights Program is part of the AAAS Directorate for Science and Policy Programs, which furthers AAAS objectives in areas where science, government, and society intersect, and operates under the auspices of the AAAS Committee on Scientific Freedom and Responsibility.
Physicians for Human Rights (PHR) mobilizes the health professions and enlists support from the general public to protect and promote the human rights of all people. PHR believes that human rights are essential preconditions for the health and well-being of all members of the human family.

Since 1986, PHR members have worked to stop torture, disappearances, and political killings by governments and opposition groups; to improve health and sanitary conditions in prisons and detention centers; to investigate the physical and psychological consequences of violations of humanitarian law in internal and international conflicts; to defend medical neutrality and the right of civilians and combatants to receive medical care during times of war; to protect health professionals who are victims of violations of human rights; and to prevent medical complicity in torture and other abuses.

As one of the original steering committee members of the International Campaign to Ban Landmines, PHR shares the 1997 Nobel Peace Prize, awarded to the Campaign and its coordinator, Jody Williams. PHR currently serves as co-chair of the U.S. Campaign to Ban Landmines.

The President is Charles Clements, M.D.; Vice President is Carola Eisenberg, M.D. The Executive Director is Leonard S. Rubenstein, J.D.; Deputy Director is Susannah Sirkin; Advocacy Director is Holly Burkhalter; Senior Program Associate is Richard Sollom; Director of Communications is Barbara Ayotte; Director of Finance & Administration is Lori Maida; Development Coordinator is Steve Brown; Campaign and Education Coordinator is Gina Cummings; and Media Relations Coordinator is Caetiona Palmer. William Haglund, Ph.D., is Director of the International Forensic Program and Senior Medical Consultant is Vincent Iacopino, M.D., Ph.D.
American Nurses Association

Headquartered in Washington, DC, the American Nurses Association (ANA) is the only full-service, professional organization representing the nation's entire registered nurse population. From the halls of Congress and federal agencies to the board rooms, hospitals and other health care facilities, the ANA is the strongest voice for the nursing profession and for workplace advocacy.

The ANA represents the interests of the nation's 2.6 million registered nurses through its 53 constituent state and territorial associations and over 180,000 members. Dedicated to ensuring that an adequate supply of highly-skilled and well-trained nurses is available, the ANA is committed to meeting the needs of nurses as well as health care consumers. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the general public.
The Committee for Health in Southern Africa (CHISA) was formed in the early 1980s as the major voice of health professionals in the United States and Canada in support of the African National Congress and the anti-apartheid health sector in South Africa. Over the ensuing decade, CHISA helped to document and publicize the health effects of apartheid, support anti-apartheid physicians and other health workers imprisoned or exiled by the South African government, and enlisted the support of other U.S. and Canadian professional organizations. CHISA also organized biennial workshops, attended by South Africans in exile and others from Mozambique and Namibia, on issues of health and health care in southern Africa, and organized the 1990 Maputo Conference that brought together exiled health leaders and the ANC Health Secretariat for the first time. Since liberation, CHISA has worked to muster technical assistance and support for the government's efforts to reform and improve health care in South Africa.
Preface and Acknowledgments

The report was coordinated and edited by Audrey R. Chapman and Leonard S. Rubenstein and written by Audrey R. Chapman, Leonard S. Rubenstein, Vincent Iacopino, H. Jack Geiger, Gregg Bloche, John Hatch, Robert Lawrence, Barbara Nichols, and Marian Secundy. Affiliations are listed in Appendix A. Elena Nightingale, leader of the AAAS delegation to South Africa that wrote the 1989 AAAS report, *Apartheid Medicine*, and Barbara Ayotte of Physicians for Human Rights, carefully read a draft and made many helpful suggestions. Gretchen Richter provided tireless editorial and technical assistance. Elizabeth Gehman was responsible for the report’s design and layout. The American Nurses Association generously supported the printing of this report. The Conamira Foundation and Georgetown-Johns Hopkins Joint Program in Law and Public Health contributed research assistance.

Patrick Ball of AAAS and Vincent Iacopino of PHR traveled to South Africa in March 1997 to engage in preliminary research that helped structure the delegation’s work. Research assistance was provided by Jeremy Wood, Bertram Cooke, Eric Carlson, Aviva Poczter, and Kharm Singm. Ray Patterson and Jeanne Spurlock of the American Psychiatric Association, Diane Kuntz of the American Public Health Association, and Elena Nightingale contributed to the planning for the report.

Many people in South Africa helped the delegation in countless ways. We are grateful for the hospitality shown to us by members of the Truth and Reconciliation Commission, especially those who were responsible for organizing the health sector hearings. The comprehensive review of human rights violations in the health sector compiled by the Health and Human Rights Project was invaluable to our work.

Before, during, and after our visit in June 1997, literally hundreds of other South Africans—health professionals, government officials, community leaders, political activists, lawyers, members of Parliament, students, and academic leaders—patiently answered our questions, provided important insights into the problems of human rights in the health sector, and even opened their homes to us. They are too numerous to acknowledge, but we
thank them all. Finally, while the report is critical of the behavior of many health professionals who went along with the policy of apartheid, others acted with extraordinary courage, endured stigma, fear and sometimes detention, and thus provide the inspiration to believe that human rights can become a part of the culture of the health sector. To those people we owe the greatest acknowledgement.

The Truth and Reconciliation Commission (TRC) requested the Science and Human Rights Program of the American Association for the Advancement of Science, Physicians for Human Rights and other U.S.-based organizations to examine human rights violations in the health sector under apartheid and to make recommendations to build a culture of human rights in the health professions and the health sector as a whole. This report responds to that request. It is our belief that without concerted action, the racism that so deeply infected the health system will continue to cause pain and injury to South Africans.

Apartheid was a system fundamentally based on such deep racism that it deprived black people of all human dignity. This racism was manifested in every aspect of health: rigid segregation of health facilities; grossly disproportionate spending on the health of whites as compared to blacks, resulting in world-class medical care for whites while blacks were usually relegated to overcrowded and filthy facilities; public health policies that ignored diseases primarily affecting black people; and the denial of basic sanitation, clean water supply, and other components of public health to homelands and townships. Health services were deliberately fragmented to perpetuate discrimination. Race bias infected health research and even the keeping of health statistics. Even forensic evaluations were biased in favor of the police, controlled as they were by the very institutions who were responsible for human rights violations. Apartheid also exacerbated the denial of human rights of people with mental illness and mental retardation by locking them away in institutions, deprived of all semblance of human rights and due process of law, and denying them access to community-based programs that would enable them to recover.

The health consequences of apartheid extended beyond the practices within the health sector itself. Apartheid inflicted an enormous level of violence on black people, including indiscriminate killing in the townships and torture in detention facilities. Forced relocations and family breakups inflicted additional trauma.

Under apartheid, few blacks could become health professionals. Those who were trained were subjected to schools with inadequate resources
and, when admitted to white institutions, were demeaned by practices like prohibitions on black medical students learning anatomy on white cadavers or wearing white coats and stethoscopes in white hospitals. Black nurses were denied adequate training resources and the opportunity to use their skills in an appropriate manner.

White health professionals were deeply implicated in human rights abuses under apartheid. A few acted with great courage to uphold medical ethics in the face of demands for silence and complicity, and some medical educators fought for desegregated professional schools. But the large majority of white health professionals benefited from a discriminatory system and either embraced the values and practices of apartheid or went along with them in silence. Some physicians working in detention facilities as district surgeons wrote false medical reports to cover up the existence of torture; others testified falsely in support of security forces; others failed to provide adequate health care to detainees. Hospital personnel discharged men, women and children wounded by gunshots in political demonstrations and in need of medical attention to the police; the ethical duties of confidentiality and provision of emergency treatment were trumped by cooperation with security forces.

Health professionals who were not directly involved in abuses were also deeply compromised by apartheid. Clinicians tolerated segregated services, gross inequities in treatment resources, terribly overcrowded facilities for the black majority and other facets of a dual health care system as part of normal life. Most failed to take action to protest human rights violations by their colleagues.

The conduct of the leaders of health professional organizations was in many respects the most egregious of all. These individuals occupied positions of power and prestige and could more safely speak out in support of medical ethics and human rights. Instead, the white leadership of the health professions generally allied itself with the apartheid state and, until very late in the day, went out of its way to avoid challenging overt discrimination in health, forced relocations, and detention of children. When individual physicians committed violations of human rights, establishment health organizations chose the side of the state over the victims of abuse. They not only refused to support colleagues who spoke out but sought to discredit them. They demonstrated no interest in training health professionals in human rights or medical ethics and, indeed, the training of health professionals in South Africa has neglected human rights and medical ethics.

The behavior of the South African Medical and Dental Council is of special concern. It not only refused to take disciplinary action against physicians who were implicated in the death of Black Consciousness leader Steven Biko until compelled by a court to do so, but even now refuses to acknowledge its disgraceful behavior in that case and others.

After the end of apartheid some institutions of the health professions, including academic institutions and professional societies, have expressed regret at their past behavior and have pledged to work toward a society that respects human rights. It is not for us to judge the sincerity of these commitments. The question is whether they will be accompanied by concrete steps to address the legacy of apartheid, which continues to inflict injury on South Africans. Our recommendations are designed to help ameliorate that legacy and build a culture of human rights in the health sector in South Africa.

Recommendations

1. Elimination of racial discrimination in the health sector

The most fundamental step in overcoming the legacy of apartheid in the health sector is to eliminate racial discrimination and racial disparities in that sector. All vestiges of segregation of facilities and inequities in health funding based on race should end. Black people must gain both greater access to professional education in the health fields and greater access to education generally. Affirmative steps should be taken to bring blacks into positions of leadership in associations of health professionals and in the bodies that regulate the professions.

Legal reform is needed as well. The mandate of the South African constitution to create a non-discriminatory society should be fulfilled by enacting civil rights laws prohibiting discrimination in all institutions concerning health.

Health professionals must no longer have exclusive power to regulate themselves. Representatives of consumers of health services, human rights organizations, unions, and other sectors of society must participate
effectively in the promulgation of human rights standards and their enforcement.

2. Adoption of human rights standards for health professionals

A binding code of human rights standards should be promulgated for health professionals and enacted into law. The code should pay special attention to human rights violations committed by health professionals, including violations of confidentiality, mistreatment or cooperation in the mistreatment of prisoners and detainees, and discrimination on the basis of race in the clinical setting. There are many models for the content of these standards, including the model code promulgated by the Commonwealth Medical Association, the guidelines of the World Medical Association, and many others. The code should be written with significant input from stakeholders in the health system, including those who have suffered human rights violations. Compliance with the code should be a condition of licensure.

3. Reform of societies of health professionals

While most societies of health professionals have adopted policies embracing non-discrimination, and some have apologized for their conduct under apartheid, additional steps need to be taken to develop a professional culture supporting human rights. In the first place, the societies should affirmatively embrace certain reforms recommended here, including the promulgation of a legally binding code of conduct, reform of the professional disciplinary process, human rights training as a condition of licensure, and human rights monitoring in the health sector.

Second, professional societies should investigate human rights violations by their own members under apartheid. The TRC process, effective as it was, did not reach many health professionals who committed gross violations of human rights, and its mandate did not reach violations of complicity. The University of Witwatersrand has provided a useful model of an internal process to bring forward the facts of human rights violations by members of its medical faculty. The professional societies should do the same.

Third, the professional societies should incorporate human rights education and cross-cultural understanding in ongoing professional training.

Fourth, the leadership of the organizations should no longer be dominated by whites. The demographics of the professions are themselves products of apartheid and should not be used as an excuse to maintain the status quo.

Fifth, the professions should demonstrate a commitment to health equity for all South Africans.

Sixth, human rights should gain significant institutional stature within these organizations through high level committees, human rights presentations, and other means.

Finally, human rights should become a frequent subject of articles in professional journals.

4. Reform of professional regulation

The statutory Councils that uphold standards of professionalism can play a critical role in fostering and enforcing respect for human rights among health professionals. The behavior of the Councils under apartheid points to the need for thorough reform. To date, however, the interim Councils have shown little interest in or capacity to address human rights, either in the form of a review of violations in the past or in devising procedures and standards to investigate those that may occur in the future. Existing proposals for change we have reviewed are, we believe, inadequate to accomplish the essential task of reform.

Reform should begin with a thorough review of the Councils’ own records under apartheid. We especially urge such a review for the Interim Medical and Dental Council, which was far from forthcoming to the TRC even in discussing its most spectacular act of complicity, the case of the doctors who were in part responsible for the death of Steven Biko. Accordingly, all internal documents of the Council should be disgorged and reviewed by an independent authority. Reform should also include re-opening cases of alleged human rights violations from the apartheid past where the Councils failed to take appropriate disciplinary investigations or actions.
The composition of the Councils should change. Individuals who serve on the Councils as members or staff, who failed to investigate human rights abuses or who were complicit in covering up human rights violations, should be removed from their positions. More generally, representation on the Councils should change dramatically, so that they are no longer organs of the health “establishment” but include effective representation from community-based organizations and constituency groups concerned with health. Each major population group should be represented. Every member should demonstrate a commitment to human rights.

The investigative procedures of the Councils need to be completely overhauled so they can effectively investigate human rights abuses. The complaint-filing process should be made accessible to all members of the society and the Councils should have the authority to impose emergency disciplinary action where necessary to prevent imminent harm to individuals or groups of individuals.

The Councils should maintain an independent professional staff to investigate allegations of human rights violations by health professionals and prepare cases to present. These investigators must have the authority to engage in a full investigation of the allegations, including gaining access to relevant records, and to prepare cases to present before an independent panel of adjudicators. The adjudication process should be thorough, open, and fair to all concerned, including both the accused and the complainant, and should be subject to review by a court—including allowing an appeal for failure to prosecute. Decisions from the panel should include a statement of reasons. Sanctions for violations should include not only suspension, license revocation, probation and censure, but also barring individuals from certain positions, mandatory human rights training, fines, and periods of community service.

The Councils should keep and publish statistical data on their disciplinary investigations and activities.

5. Human rights education

All health professionals should receive training in human rights and bioethics, based on international human rights principles. The training should emphasize the responsibilities of health professionals to promote and protect human rights and should link these standards to concrete behavioral expectations. This training should take place at all levels: in the course of professional training, as part of continuing education programs, and at professional conferences. Completion of human rights training should be a condition of licensure.

The objectives of such training include the following: promoting understanding of the relationship between health and human rights, particularly in connection with a conception of health that looks beyond injury and disease to include concern for the well-being of the individual; promoting discussion of human rights concerns in the health sector, including physical and mental health consequences of human rights violations; and exploring the relationship between human rights and bioethics, particularly the limitations of an exclusively bioethics approach to the protection of human rights.

The health professions must restructure professional training to assure adequate consideration to human rights. The various health professional organizations should work closely with the Ministry of Health, academic institutions, community-based organizations, torture treatment centers, and other stakeholders to plan curricula; ensure adequate resources for training; establish concrete training objectives; develop educational materials; run pilot projects; and assess programs. Coordination and implementation should be supported by an infrastructure of professional support, including health and human rights committees; academic positions in the field; encouragement of writing and publication for professional journals; regular national, regional and local conferences; and monitoring of progress.

6. Human rights monitoring of the health sector

Monitoring of human rights is a widely respected and highly successful means of measuring compliance with human rights standards, fine-tuning public policies that affect human rights, and reinforcing respect for human rights. By monitoring, we mean systematic and comprehensive efforts to collect appropriate data to determine whether the performance of individuals and institutions conforms to international human rights standards. Monitoring should include regular reviews, based on established protocols, of human rights compliance by health institutions like hospitals, clinics, and other facilities where violations of human rights in health are
frequent, such as prisons and detention facilities, in addition to reviews of complaints of particular violations of human rights in health. Monitoring of access to health care should also be undertaken under Section 184(3) of the South African constitution.

Effective monitoring is proactive, scheduled at regular intervals, systematic, independent, based on well-articulated standards, and performed according to a uniform methodology. A baseline should be established so that progress can be measured. The standards should include those that apply exclusively to health professionals, those especially relevant to health institutions, and those time-related goals for systemic reforms that progressively realize the constitutional right of access to health care. It is also important to develop guidelines for monitoring the mandate of non-discrimination, not only as to race, but as to gender, age, social and economic status, and immigration and other statuses. It is also essential to include public and community involvement in the promulgation of monitoring standards. The public awareness campaign by the Progressive Primary Health Care Network is a good starting point.

Monitoring strategies can include a review of legislation and codes to assess conformity to international human rights standards; regular site visits to assess human rights compliance in particular localities or institutions (particularly those that have a history of human rights violations); self-assessments and written reports by institutions subject to monitoring; reviews of records; interviews with staff, professionals, and patients; and investigation of individual complaints. The monitoring body should have the legal authority to review records that might otherwise be considered confidential, as long as it does not further disclose the records.

Monitoring should also include regular reports, at least annually, to the nation on the human rights situation in the health sector. Reporting also provides an opportunity to synthesize data collected to provide a “report card” on human rights in the health sector.

Non-governmental organizations in South Africa have proposed a variety of monitoring systems. The Health and Human Rights Project has recommended a Commission on Health and Human Rights, consisting of professionals, human rights experts, consumer and community representatives, and legal experts. The Commission would monitor human rights in the health sector, provide advice on curriculum development in human rights education, receive and investigate individual complaints of human rights abuses in the health sector, create the position of “medical public prosecutor” or ombudsman, and review human rights and health concerns in the military. We understand that related proposals along similar lines are under discussion by a wide variety of stakeholders and we urge support for these efforts.

7. Addressing the legacy of apartheid: the need for mental health services

Our analysis and recommendations regarding mental health fall into two distinct areas. The first concerns the wholesale violation of the human rights of people with mental illness and mental retardation, including massive institutionalization and denial of their basic dignity. The second concerns the lasting trauma suffered by thousands of South Africans, including children, as a result of violence inflicted on them by the state and the unending deprivations and degradation to which they were subjected.

(a) Human rights, mental illness and mental retardation

South Africa’s mental health law needs to be rewritten to assure that the fundamental human rights of people with mental illness and mental retardation are respected. The law should protect, among other rights, the right to be treated with respect for the inherent dignity of the person, to be free from discrimination on the basis of disability, to have access to treatment in the community in which the person lives, to be protected from harm if institutionalized, and to be treated in accordance with due process of law. The Ministry of Health should also follow up the 1995 report on human rights violations in mental health facilities with an evaluation of current human rights conditions in institutions, along with recommendations for steps necessary to address them.

People with mental retardation should be recognized as having different needs from people with mental illness and their rights should be protected as well. There is special urgency in addressing allegations that involuntary sterilization is still widespread among people with mental retardation.

The solution to the human rights violations against people with mental illness and mental retardation must include development of a full range of community-based programs to serve their needs. Despite the severe re-
source constraints it faces, the Ministry of Health has begun this process, and it should be encouraged to continue. The Ministry should establish a national policy and plan to move toward a community-based system of services for people with mental illness and mental retardation. As part of this process, the Ministry of Health should provide support for participation by people with mental illness and mental retardation and their families in the planning and treatment process. This should include support for advocacy.

(b) The psychological legacy of apartheid

Apartheid took a tremendous psychological and emotional toll on people subject to laws that denied liberty and freedom, to forced relocations, to family separation, to arbitrary detention, to denial of educational opportunities, to the humiliations of daily life, and most of all to the infliction of violence against them. The trauma from those violations remains, and the legacy of violence continues to inflict harm on all South Africans.

Recommendations for healing these wounds is beyond the scope of this report, but we make particular note that respect for human rights calls for encouragement of treatment approaches to healing that span cultural divides. South Africa is a country where Western and non-Western approaches to healing have been separated not only by culture and language but by apartheid. Now is the time to reach across that divide and bring the resources of social workers, particularly those versed in traditional cultures, clergy, healers and diviners, and trauma centers experienced in melding Western and non-Western approaches, to the effort to bring healing to the hundreds of thousands of people suffering from the trauma of apartheid.

8. Medical documentation of torture and ill-treatment

Under apartheid, medical investigations of torture and abuse were entirely corrupted by physicians’ loyalty to the state at the expense of their patients and by structural arrangements that sought to and did compromise the independence of forensic investigations. The need for reform is made even more compelling because torture is still practiced by the police in many parts of the country, including Johannesburg. Moreover, district surgeons appear to have undergone little reflection about their roles in apartheid.

In 1996, the Ministry of Health circulated a document entitled “Proposed National Policy on the Medicolegal Services in South Africa,” which proposes a reorganization of post-mortem forensic services, particularly to assure the independence of post-mortem examinations. We endorse this proposal.

The Ministry plan includes proposals for changes in clinical forensic services, including evaluation of rape victims, but not health care for detainees. It recommends removing these duties from district surgeons, and decentralizing them to the same doctors and other health professionals who provide primary health care. The change seeks to avoid the possibility of complicity of district surgeons in human rights violations by entirely removing them from the process. We are concerned, though, that the proposal increases fragmentation of services and raises concerns about the quality of evaluations. We therefore recommend further dialogue on the question of restructuring of clinical forensic services. One possibility is a corps of clinical forensic specialists, specially trained and certified. Another is an alliance between forensic pathologists and primary health care physicians such that primary health care practitioners would be responsible for evaluations, but subject to the standards and quality assurance mechanisms of forensic pathology services.

Regardless of the approach taken, these services should all be under the supervision of the Ministry of Health—for establishment of standards, training, certification, clinical services, selection of practitioners, quality assurance, procedural safeguards, and accountability. Licensing and certification requirements for individuals engaged in clinical forensic services should be established in conjunction with representatives of health professional organizations, human rights organizations, and community organizations. Current district surgeons who wish to continue to provide clinical services should be subject to performance evaluations and a review of complaints of misconduct.

Further, the Ministry should address clinical evaluation of and health services for detainees. The first step is to remove control of prison health services from agencies that run prisons and transfer them to the Ministry of Health. Second, medical and procedural standards for medical evaluations of detainees should be written to assure the integrity of evaluations.
and the protection of the human rights of the detainees. Our detailed recommendations outline procedural safeguards and we provide an appendix containing model standards and procedures for evaluation of torture and ill-treatment of detainees.

Finally, professionalism in clinical forensic services should be encouraged and supported. In the past, district surgeons were very isolated from other health practitioners and stigmatized by their association with people and institutions that were themselves devalued. Practitioners in the field of clinical forensic services deserve and should receive professional support.

The legacy of apartheid for the health of all South Africans is deep and grim. There is an opportunity now to plan and implement a system of health care in South Africa that is fair, non-discriminatory and based on the commitment to and observance of basic principles of human rights. The protection and promotion of human rights also promote health and well-being. Such a system would not only serve South Africa, but could be a model for other nations worldwide as we celebrate the 50th anniversary of the United Nations Universal Declaration of Human Rights.

During apartheid, health professionals in South Africa had the unenviable challenge of working in a system that attempted to subordinate their ethical and human rights responsibilities to political decisions about appropriate health care for each legally defined racial group. While some health professionals acted with great courage and conviction to uphold

Introduction

This report, prepared at the request of the Truth and Reconciliation Commission in South Africa, examines the role that health professionals played in helping or hindering the promotion of human rights during the apartheid period and considers the legacy of apartheid for health care in South Africa. The report shows the variety of ways in which the culture and legal structure of apartheid continue to influence practices within the health sector and have left a system of institutions in the government and in the professions that are ill-equipped to prevent abuses. Accordingly, the report explores ways to develop a health system and assure professional standards of behavior in South Africa consistent with international human rights and ethical norms. It also recommends ways to nurture a culture that supports health and human rights within the health professions, official regulatory bodies, and community-based organizations. Additionally, the report considers how to hold perpetrators of violations accountable for their actions.

Under international human rights and humanitarian law, as well as codes of professional medical ethics, health professionals have a responsibility to protect and promote all human rights. Human rights violations have devastating health consequences, and protecting and promoting human rights also contribute to providing the conditions for health and well-being. Members of the health professions have considerable opportunities to fulfill these duties: they may be among the first witnesses of violence and human rights violations. They may care for persons injured during civil unrest. They may be called upon to provide medical care to victims of torture or to investigate suspicious deaths in custody. They themselves may experience violations of human rights because of their personal or professional beliefs or activities. And they may practice in health care institutions that systematically discriminate against people who are members of certain racial or ethnic groups.

During apartheid, health professionals in South Africa had the unenviable challenge of working in a system that attempted to subordinate their ethical and human rights responsibilities to political decisions about appropriate health care for each legally defined racial group. While some health professionals acted with great courage and conviction to uphold
ethical standards, the majority did not. Many health professionals acted to reinforce apartheid even when not legally required to do so.

A. Background of the Report

In late 1996, the South African Truth and Reconciliation Commission (TRC) invited the Science and Human Rights Program (the Program) of the American Association for the Advancement of Science (AAAS) to participate in their evaluation of human rights violations in the health care sector. The invitation reflected the TRC’s appreciation of earlier AAAS work on health and human rights in South Africa and ongoing collaboration between the Science and Human Rights Program and the TRC. In 1987, the Program sponsored the research and published a study entitled *Turning a Blind Eye? Medical Accountability and the Prevention of Torture in South Africa*, which documented the failure of district surgeons to protect the health of their detainee patients and prevent their being tortured and abused by prison authorities. In 1989, AAAS conducted a medical mission of inquiry to South Africa by sending a six-member delegation, representing four U.S. medical and scientific organizations, to examine health and human rights issues. The team’s report, *Apartheid Medicine: Health and Human Rights in South Africa*, examined how legal structures and the culture of apartheid resulted in massive human rights violations by individuals and institutions in the health care sector. Since January 1996, the Program has been providing scientific and professional assistance to the TRC Research Department.

To fulfill the TRC’s request, AAAS assembled a consultative team, including the U.S.-based non-governmental organization (NGO) Physicians for Human Rights (PHR), as co-sponsor. Other participating NGOs include the Committee for Health in Southern Africa (CHISA), and the American Nurses Association (ANA). Appendix A provides a list of the members of the consultative team and their affiliations.

The consultative team undertook the following tasks as contributions to the TRC medical sector review:

1. It suggested a series of themes to frame specific questions for those making submissions to the TRC health sector hearings; these themes were forwarded to the TRC in March 1997.
2. It prepared a preliminary submission for the TRC’s health sector hearings based on the research published in *Turning a Blind Eye?* and *Apartheid Medicine*, augmented by more recently published data. This submission specifically focused on international human rights and ethical standards and the failure of district surgeons to perform their duties in compliance with agreed-upon national and international codes of human rights law and professional ethics.
3. Members of the team attended the TRC health sector hearings in June 1997 and made a presentation based on their preliminary submission.
4. Staff of AAAS and PHR and members of the team conducted more than 100 interviews with health professionals, academics, government officials, representatives of community organizations and others, to be better able to develop recommendations to the TRC on overcoming the legacy of apartheid era abuses and fostering a human rights culture in the health care sector. In March 1997, staff members of AAAS and PHR visited South Africa to begin the interview process. Building on this initial work, ten members of the team each spent between ten days and six weeks in South Africa during June and July 1997 to undertake site visits, conduct interviews, and collect publications, unpublished papers, and documents.

This report represents the product of these efforts. It has seven chapters. The remainder of the introduction considers international human rights standards protecting health and the right to health and physicians’ responsibilities under international medical codes and South African law. The second chapter provides a brief overview of the nature of the apartheid system and its impact on the health sector. The third chapter examines patterns of apartheid era human rights abuses. The fourth chapter undertakes an analysis of various aspects of the health sector under the apartheid system, including professional associations, professional
regulatory bodies, the education and training of physicians, the role of district surgeons, forensic practices, and the military. The fifth chapter assesses the underlying causes of human rights violations in the health sector. The sixth chapter presents a series of recommendations on reforms relating to professional ethics, professional discipline, health system regulation, monitoring, the human rights component of professional education and training, the role of district surgeons, and forensic services. Recommendations for legislative changes are included. Finally, as a delegation from the United States, we thought it appropriate to examine the implications of our work for our own country, and the report concludes by doing so.

B. Health and Human Rights: The Role of Health Professionals

The TRC’s mandate is to determine “as complete a picture as possible of the causes, nature and extent of the gross violations of human rights...including the antecedents, circumstances, factors and contexts of such violations” and to compile “a report providing as comprehensive account as possible of the activities and findings...and which contains recommendations of measures to prevent the future violations of human rights.” In addition, the TRC must “make recommendations to the President with regard to the creation of institutions conducive to a stable and fair society and the institutional, administrative and legislative measures which should be taken or introduced in order to prevent the commission of violations of human rights.” Gross violations include killing, abduction, torture, and severe ill-treatment.

In order to understand the causes and nature of such gross violations of human rights, we believe that it is important to consider the manner in which the apartheid system affected all rights, both those rights categorized as civil and political rights and those labeled as economic, social and cultural rights. In considering the apartheid context in which health professionals functioned, it is relevant to take the following factors into account:

1. Gross violations are greatly facilitated by legal abridgments of the rights to free expression, association, movement and due process;

2. Grievous discrepancies in economic and social status, education, housing, work opportunities, access to health services, basic nutrition and public health programs in and of themselves constitute severe ill-treatment;

3. Systematic violations of economic, social and cultural rights represent a fundamental disregard for the inherent dignity of fellow members of the human family and thus may be antecedent causes of civil and political rights violations;

4. Enforcement of discrepancies in economic, social and cultural rights depends largely on abridgment of civil and political rights; and

5. Moral disengagement by perpetrators of violence often hinges on the view that their victims are somehow less human than they are because of the political culture under which they live.

Systematic disparities in economic, social and cultural rights represent a form of structural violence that had become so ingrained in South African society that the relationship between these human rights violations and more “gross violations” of human rights deserves special attention. The AAAS’s Apartheid Medicine report documents disparities in equity and access to health care, education, and health status, as well as segregation in medical education and the delivery of health services.

Throughout history, society has charged healers with the duty of understanding and alleviating causes of human suffering. In the past century, the world has witnessed ongoing epidemics of armed conflicts and violations of international human rights, epidemics that have devastated and continue to devastate the health and well-being of humanity. As we enter the twenty-first century, the nature and extent of human suffering has compelled health providers to redefine their understanding of health and the scope of their professional interests and responsibilities.

Health professionals have a responsibility to protect and promote all human rights. This is the case not only because human rights violations have devastating health consequences, but because protecting and promoting human rights (civil, political, economic, social and cultural) may be
the most effective means to providing the conditions for health and well-being.

However, health professionals throughout the world have been ill-equipped to address suffering caused by armed conflicts and human rights abuses. Medical and health concerns in the twentieth century have dealt almost exclusively with the diagnosis, treatment and prevention of disease. Traditional disease concerns often fail to recognize the physical, psychological and social health consequences of violations of human rights and humanitarian law. In contemporary medical practice, rational and empirical traditions that form the basis of scientific thought greatly reduce the complex phenomenon of suffering to the concern of disease: its diagnosis, treatment and prevention. By decontextualizing suffering and neglecting the social conditions that affect health and well-being, health providers marginalize their roles in society.

Furthermore, medical codes of ethics tend to focus narrowly on the provider-patient relationship, thereby neglecting the institutional context in which health professionals function. Principles of bioethics, such as beneficence, non-maleficence, confidentiality, autonomy and informed consent aim to regulate the conduct of physicians in their encounters with individual patients. They do not, however, generally address interference with health care and well-being by the state.

In South Africa, as in the United States and other countries, narrow conceptualizations of health and the ethical responsibilities of health professionals have contributed greatly to silence and inaction in the face of the suffering caused by human rights violations. Although some progressive health professionals in South Africa worked for the protection and promotion of human rights during apartheid, most did not.

Increasingly, health professionals are recognizing the importance of protecting and promoting human rights as necessary preconditions for individual and community health. When health is defined as “complete physical, mental and social well-being, and not just the absence of disease or infirmity,” health professionals recognize an ethical responsibility to protect and promote human rights in order to provide the conditions for health and well-being. In this regard, progressive health professionals in South Africa who have worked for the protection and promotion of human rights have made important contributions to establishing a culture of human rights in the health sector. However, human rights concerns have not yet been formally integrated into the curricular studies of health professionals.

Health professionals in South Africa and around the world face immense challenges in addressing human rights concerns and engaging in human rights education. The extent of human rights violations, the complexity of their causes, and enormity of their consequences make for extraordinarily difficult and emotionally challenging work. Despite such challenges, evolving international standards demand that health professionals adopt adherence to human rights as a fundamental component of health care.

C. Health and International Human Rights Law

Beginning with the Universal Declaration of Human Rights, adopted by the United Nations General Assembly in 1948, the international community has drafted a series of instruments that recognize the inherent dignity and the equal and inalienable rights of all members of the human family. The Universal Declaration, broadly considered to be a common standard of achievement for all peoples and nations, enumerates some two dozen specific rights to which all persons are entitled without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Two fundamental protections are the right to life, liberty and security of person (article 3) and the right to freedom from discrimination (article 7). Other civil and political rights that are articulated include freedom from torture and cruel, inhuman, or degrading punishment (article 5), freedom from arbitrary arrest and detention (article 9), and the right to a fair trial (article 10). In addition, the text of the Universal Declaration sets forth a series of social and economic rights, among them, that “everyone has a right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services” (article 25)."\n
The principles enumerated in the Universal Declaration are further developed in a series of human rights conventions. States that ratify these instruments and thereby become states parties are legally bound by their provisions. Well over 130 countries have ratified the two most important of these instruments: the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights.

Among its provisions, the International Covenant on Civil and Political Rights incorporates protections for the right to life, security of the person,
and freedom to seek, receive, and impart information, all of which are relevant to the health care sector. In addition, Article 7 of the International Covenant on Civil and Political Rights incorporates protections against torture and cruel, inhuman or degrading treatment or punishment. These latter provisions are further amplified in the Convention Against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment. Among its protections, Article 10 instructs states parties to ensure that education and information regarding the prohibition against torture are fully included in the training of medical personnel.

Of the major international human rights instruments, the International Covenant on Economic, Social and Cultural Rights provides the fullest and most definitive conception of the right to health. Article 12 of the International Covenant on Economic, Social and Cultural Rights "recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." To achieve this goal, it mandates states parties to undertake the following steps:

a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
b) The improvement of all aspects of environmental and industrial hygiene;
c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
d) The creation of conditions which would assure medical service and medical attention to all in the event of sickness.

Also relevant to the health sector, under the terms of the International Convention on the Elimination of All Forms of Racial Discrimination, states parties undertake to prohibit and eliminate racial discrimination in all its forms and to guarantee, without distinction as to race, color, national or ethnic origin, the enjoyment of the right to public health and medical care. The Convention on the Elimination of All Forms of Discrimination Against Women directs states parties to take all appropriate measures to eliminate discrimination against women in the field of health care and to ensure equality of access to health care services, including those related to family planning, pregnancy, confinement and the post-natal period, granting free services where necessary. Similarly, the Convention on the Rights of the Child extends provisions of the right to health enumerated in the International Covenant on Economic, Social and Cultural Rights to children and mandates that states parties take appropriate measures to diminish infant and child mortality; ensure the provision of necessary medical assistance and health care to all children, with emphasis on the development of primary care; combat disease and malnutrition; provide clean drinking water; and combat the dangers and risks of environmental pollution.

D. International Medical Codes of Ethics

International medical ethical principles unequivocally provide that physicians, nurses, and other health professionals have the professional duty of care to patients. This applies to the treatment of detainees regardless of whether a health professional has an obligation to a third party such as a state institution. This section reviews three aspects of medical ethics often violated under apartheid, especially in the care of detainees: health professionals’ duties regarding torture, the non-discriminatory provision of medical care, and confidentiality.

1. Physicians’ duties regarding torture

Under circumstances where doctors are employed by the government or a third party, they retain a duty (1) to provide care to the patients they examine or treat, (2) not to participate in torture in any way, and (3) to document acts of torture, and cruel, inhuman or degrading treatment. The Convention Against Torture, 1984, defines torture as:

...any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent
or acquiescence of a public official or other person acting in an official capacity.

The duties and obligations are clear: physicians must not collaborate in any way with state-sponsored torture.

The obligations of physicians treating prisoners and detainees are set forth under the Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment. These Principles specifically address the obligations of physicians under internationally accepted standards of medical ethics. The Principles are intended to prevent any direct or indirect participation by physicians in torture:

Principle 2: It is a gross contravention of medical ethics, as well as an offense under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment.

Principle 3: It is a gross contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not to solely evaluate, protect or improve their physical and mental health.

The Declaration of Tokyo not only prohibits physician complicity in torture, but also calls for complete clinical independence in caring for the person for whom the physician is responsible, and support for doctors who face threat of reprisals resulting from a refusal to condone the use of torture:

Article 1: The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures.

Article 2: The doctor shall not provide any premises, instruments, substances or knowledge to facilitate torture or other forms of cruel, inhuman, or degrading treatment.

The Standard Minimum Rules for the Treatment of Prisoners and Procedures for the Effective Implementation of the Standard Minimum Rules place many obligations upon physicians who come into contact with prisoners. The prison medical officer has the obligation to report to the director of the institution whenever he or she considers that a prisoner's physical or mental health has been or will be injured by continued imprisonment or by the conditions of imprisonment. He or she has the obligation also to report any cruel, inhuman or degrading punishments, as these are completely prohibited. It is further indicated that where it is beyond the competence of those in charge to alter the adverse conditions, the medical officer should then submit his or her own report to a higher
authority for action. Physicians who examine detainees are, for the purposes of the Declaration, considered to be prison medical officers.

Article 25 (2): The medical officer shall report to the director whenever he considers that a prisoner’s physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment.

2. Non-discriminatory provision of medical care

The fundamental principles of non-maleficence articulated in the Hippocratic Oath and similar pledges clearly establish the physician’s role as healer of human suffering and the professional responsibility to do no harm. These concepts are reinforced by the Declaration of Geneva, which states that: “I will maintain the utmost respect for human life from its beginning even under threat... I will not use my medical knowledge contrary to the laws of humanity...[and]... I will not permit considerations of religion, nationality, race, party politics, or social standing to intervene between my duty and my patient.”

Furthermore, the International Code of Medical Ethics provides that: “A physician shall give emergency care as a humanitarian duty...” The World Medical Association’s Regulations in Time of Armed Conflict states “The physician must never be prosecuted for observing professional secrecy.”

Breaches in medical confidentiality may be justified on the basis of compelling health concerns such as the spread of infectious disease or safety of the public. Codes of conduct for health professionals prescribe safeguards for confidentiality. The World Medical Association’s Regulation in Time of Armed Conflict states “The physician must never be prosecuted for observing professional secrecy.”

4. The nurse’s role in safeguarding human rights

The International Council of Nurses has adopted a number of statements to implement its endorsement of the Universal Declaration of Human Rights, the most comprehensive of which is “The Nurse’s Role in Safeguarding Human Rights,” which dates from 1983. It emphasizes the responsibility of nurses to safeguard human rights in normal work situations as well as in times of political upheaval and war. According to the text, whenever abuse of patients, nurses, or others is witnessed or suspected, “[N]urses have a responsibility in these situations to take action to safeguard the rights of those involved.” The statement advises that while nurses have an individual responsibility, they often can be more effective when they approach human rights issues corporately.

The World Medical Association has, in various codes of conduct for health professionals, stated the physician’s obligation to maintain confidentiality:

Introduc:ion 13

Regulations in Time of Armed Conflict: “A physician shall preserve absolute confidentiality on all he knows about his patient even after the patient has died.”

Declaration of Geneva: “I will respect the secrets which are confided in me, even after the patient has died.”

International Code of Medical Ethics: “A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences.”

The fulfillment of medical duties and responsibilities shall in no circumstance be considered an offense.”

3. Confidentiality

International standards of medical ethics uniformly call upon physicians to maintain confidentiality as a fundamental obligation to patients and to disclose information only with the patient’s consent. When a doctor is required by the state or another third party to release information, the patient must be informed before the examination.

The World Medical Association has, in various codes of conduct for health professionals, stated the physician’s obligation to maintain confidentiality:
the statement directs national nurses’ associations to participate in the development of health and social legislation relative to patients’ rights and all related topics.

5. Nurses and torture

A statement on nurses and torture was adopted at the meeting of the Council of National Representatives of the International Council of Nurses (ICN) in May 1989. Recognizing that violations of human rights have become more pervasive and that scientific discoveries have brought about more sophisticated forms of torture and methods of resuscitation, the text specifies that the nurse shall not countenance, condone, or voluntarily participate in:

- Any deliberate, systematic or wanton infliction of physical or mental suffering or any other form of cruel, inhuman or degrading procedure 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.
- Any treatment which denies to any person the respect which is his/her due as a human being.27

6. The nurse’s role in the care of detainees and prisoners

The International Council of Nurses Code for Nurses states that the fundamental responsibility of the nurse is to those people who require nursing care. To that end, it mandates the nurse to take appropriate action to safeguard the individual whose care is endangered by a co-worker or any other person.28

A directive on the “Nurse’s Role in the Care of Detainees and Prisoners” was adopted at a meeting of the Council of National Representatives of the International Council of Nurses in Singapore in August 1975.29 This statement condemns the use of interrogation procedures for detainees and prisoners of conscience that result in ill effects on the person’s mental and physical health. It directs that “[N]urses having knowledge of physical or mental ill-treatment of detainees and prisoners must take appropriate action including reporting the matter to appropriate national and/or international bodies.” The statement prohibits nurses employed in prison health services from assuming the functions of prison security personnel, such as body search procedures for security reasons. It also specifies that nurses only participate in clinical research carried out on prisoners if the freely given consent of the patient has been secured based on an explanation and full understanding of the nature and risk of the research.

NOTES

3 Promotion of National Unity and Reconciliation Act 1995, § 3(1)(d).
4 Promotion of National Unity and Reconciliation Act 1995, § 3(1)(d).
8 Id., Art. 10.
11 Ibid.
Historical Background

The system of apartheid ("apartness" in Afrikaans) was a cornerstone of South African economic development and political policies from 1948 until 1994. South Africa's political and legal system classified people by race and accorded (or denied) specific rights to the identified "race" groups. After World War II, when many countries moved away from colonialism and racial laws, South Africa moved to preserve and increase discrimination. Apartheid ensured that the white minority government, dominated by the primarily Afrikaner National Party, maintained economic, military, and political power over the resources and population of South Africa.

Discrimination against the African, Asian, and mixed race populations has characterized the region's history since the arrival of Europeans on the continent of Africa. In the seventeenth and eighteenth centuries, Dutch, German, and French settlers (later known as "Boers" or "Afrikaners") established a colony in the Cape area, subjugating the indigenous population and importing other slave labor. Once the British took control of the Cape area in the early nineteenth century, they began competing with the Afrikaners for control over the economic and human resources of the region. In the following decades, the British and Afrikaners moved north and east, establishing colonies that gave little or no political rights to Asians, people of mixed race, and Africans.

In 1910, British and Afrikaner settlers agreed to unite the previously independent states of Natal, Cape, Orange Free State, and the South African Republic (Transvaal) into the Union of South Africa. Racial discrimination became institutionalized at a national level. Legislation enacted by the all-white Parliament in 1913 and 1936 prohibited African land ownership in 86 percent of the country. "Native reserves" for Africans were set up in the remaining 14 percent of the land, although Africans comprised approximately three-fourths of the total population. Other restrictions limited where Africans could live and work in areas outside their "reserves."

After the electoral victory in Parliament of the National Party in 1948, the Party set the apartheid system in place. One of the principal
foundations of that system was the Population Registration Act, passed by Parliament in 1950, which legally (and often arbitrarily) classified every person in South Africa as a member of the "white," "colored" (mixed race), "Indian" (Asian), or "black" (African) "race" or ethnic group. The Group Areas Act of 1950, and its various amendments, defined separate areas that legally could be owned and occupied by white, African, mixed race, or Asian people in South Africa. Three years later, the Reservation of Separate Amenities Act of 1953 mandated the reservation of separate (but usually unequal) buildings, services, and conveniences for each racial group.

In order to enforce the Group Areas Act and sustain the "native reserves" or "homelands" system, the government forcibly relocated people, primarily Africans, Asians, and people of mixed race. The Surplus People Project estimates that between 1960 and 1983, about 3,522,900 people were forcibly relocated. Africans were sent to one of ten homelands, which were established according to official cultural and linguistic definitions, or forced to become citizens of their assigned homeland even if they lived in urban, "white" South Africa. By the late 1970s, some 53 percent of the total African population resided in the homelands, ten percent more than in 1950. The government also initiated policies to transform these reserved lands into politically autonomous African states. Four "independent" homelands, recognized as independent countries only by South Africa, and six "self-governing" homelands were created. Residents of the homelands were stripped of their South African citizenship.

A. Apartheid Structures that Affected Health Status

The apartheid policies of the South African government had a deleterious effect on the health of the majority of South Africans. When the government created the homelands and forcibly relocated people to these and other rural places, it did so with little concern for the capacity of these areas to sustain a population or to develop an economic base. The government frequently did not provide adequate housing, water, sanitation, schools, hospitals, and other public services.

Most blacks were not allowed to live near their urban workplaces, and many endured long commutes on public transportation (some up to three hours one way) to the cities from their homes. For those who left their homes to work as contract laborers, their housing consisted of single-sex hostels in urban areas and near mining camps where they lived for approximately eleven months out the year. Moreover, those Africans who remained in the homelands—mainly the elderly, women, and children—were forced to rely on income from migrant or commuter labor and pensions because there were few sources of employment there.

The repeal of the Pass Laws in 1986 eased legal restrictions on the migration from rural areas to the cities and townships by people searching for work. But the migration also caused a proliferation of "squatter" communities on the periphery of urban centers. Physical conditions in these overcrowded and ill-served townships and squatter communities, such as make-shift housing, lack of protected water, and the absence of sanitary facilities, threatened the health of residents and encouraged the spread of disease. In addition, police surveillance, and the lack of jobs, privacy, and designated and clean recreational sites created much mental and physical strain on the families living in these areas.

As an apartheid legacy, few people in townships and squatter areas have had access to safe and adequate water supplies. In some areas, outdoor water spigots serve large numbers of families. In 1989 members of the AAAS mission found that in an area near Durban there was only one water spigot for an estimated 15,000 to 20,000 persons. Women and children, often traveling substantial distances, are required to collect water in containers ranging from bottles and cans to huge plastic jugs weighing thirty pounds or more.

Sewage disposal has been another problem. Some townships have pit latrines; others have portable toilets, but often in inadequate numbers. Many residents use open buckets within their homes. The lack of adequate sewage disposal, combined with heavy rains, hot temperatures, and accidental spilling of these buckets, obviously creates enormous health problems—in particular, infectious diarrhea, other gastrointestinal disorders, and worm infestations. Flies and rodents are omnipresent vectors. Other sanitation problems arise in the disposal of garbage. Many open areas near houses serve as garbage dumps.

A household health survey conducted by the Community Agency for Social Enquiry (CASE) in 1994 of a nationally representative sample of 4,000 households in South Africa found that approximately two-thirds of the African population is affected by poor public health conditions.
overcrowding; lack of electricity, clean water, or sanitation. Only 20 percent of African households reported having a water tap inside the home, compared to nearly 100 percent of white and Indian households. Sixteen percent of African households have no toilet of any kind. Nearly 60 percent of African households lack electricity.

Poverty in South Africa was and continues to be a primary cause of many health problems. It creates financial obstacles for persons seeking health care and affects their living conditions. It is therefore significant that close to two-thirds of all African households (more than three-quarters in rural areas) have monthly incomes below the minimum living level of R900 and nearly one-fourth have a monthly income below R300. In comparison, in 1994, nearly two-thirds of white households reported a monthly income of more than R2000. Combined with the lack of education about health, those who are most in need of public health services (for example, immunizations, pre-natal care, tuberculosis testing and treatment) often do not receive medical care. Diseases such as tuberculosis, cholera, and measles, and widespread hunger and malnutrition are common among the economically deprived population groups. Many diseases that are preventable with good immunization programs, improved sanitation and water supply, and better nutrition, and that have been all but eliminated among the white population, continue to plague blacks in South Africa. The epidemiology of the HIV/AIDS epidemic also demonstrates the link between poverty, low status and vulnerability to infection.

B. Fragmentation, Privatization, and Access to Care

After the formation of the South African state in 1910, health services in South Africa were characterized by a multiplicity of authorities and systems responsible for providing health care, rather than a unified system. The South African health care system was divided according to race, geographic area, the public sector (further divided into local, provincial, and central health authorities), and the private sector. Each of the ten homelands had its own health department.

Significant inequalities in the provision of health care therefore emerged between blacks and whites, between rural and urban areas, between primary and tertiary health care programs and between the homelands and the rest of South Africa. The four "independent" homelands of Transkei, Ciskei, Venda and Bophuthatswana, for instance, were almost totally dependent on aid from the South African government, and were reported to have generally worse health statistics than the rest of South Africa.

The Second Carnegie Inquiry into Poverty and Development in Southern Africa characterized the South African Health Service as "not a federal arrangement with rational, clearly defined regional boundaries; [it] is an arrangement almost tailor-made to encourage the growth of a bureaucratic jungle whilst minimizing its efficiency." During apartheid, most physicians favored the replacement of the inefficient 14 separate health ministries and the hundreds of local health authorities with a more unified approach.

Most blacks in South Africa have not had easy access to health professionals and health care facilities. In 1990, there were approximately 22,000 doctors registered in South Africa, of whom only about 1,000 were black. At that time there were 3,581 dentists, of whom only 25 were black. Socio-economic factors induce most doctors to practice in the developed areas of South Africa where potential patients can afford the fees and where more patients are likely to be covered by medical aid schemes. Thus in 1990 the ratio of general practitioners to population was 1:900 in the urban areas as compared with 1:4100 in the rural areas.

Mobile clinics travel through some rural areas to provide health care, but these are too few for the large populations they serve. During apartheid, persons often did not have access to the hospital nearest to them because the hospital was designated for another race or was located in an area which did not serve them (for example, a person residing in one homeland could not be served by another homeland's clinic even if it was closer.)

Although there was a sliding scale of payment based on income for medical services at the public hospitals, many people still were unable to pay for health services, nor could they afford the transportation costs to a far-away health facility. The majority of blacks did not have health insurance of any kind. Private purchase of health insurance was far beyond their economic means, and many employers did not offer blacks health coverage as a work-related benefit. As a legacy of apartheid, most Africans continue to rely on the public health service, whereas whites and Indians utilize private health care.

The segregation of hospital care was one of the most visible manifestations of apartheid practices in health. Almost all public hospitals
in South Africa had segregated wards or were designated entirely for a specific “race” group.

Groote Schuur Hospital, an internationally renowned medical center affiliated with the University of Cape Town, was the only South African hospital that offered services to all races. The Hospital, which opened in the 1930s, originally had separate entrances and wards for black and white patients. The result was severe overcrowding in the black wards and empty beds in the white wards. In the mid-1980s, the hospital staff began to integrate its services without official permission. The construction of a new hospital complex led to considerable controversy over whether the facilities would be segregated. However, at the insistence of physicians, medical students, and administrators at the University and health organizations, desegregation occurred despite opposition from the provincial government.

C. Segregation in Medical Education

Formal education in South Africa during apartheid disproportionately benefited the white minority. The apartheid policy segregated students from elementary school on up, allocated resources unequally among the white, “colored,” Indian, and African populations, and offered better quality education to whites. State expenditure for white children in 1985 was estimated to be seven times higher per child than the expenditure for Indian, mixed race, and African children.11 Unrest and subsequent school disruptions and boycotts also contributed to the comparatively poorer education of blacks. The number of black students who were academically able (not to mention financially able) to pursue higher education was thus limited. As schools for the health professions began to lower the color bar, the paucity of adequately educated Africans emerged as a major barrier to expanding the ranks of African doctors, nurses, and other health care providers.

Segregation also prevented black medical students from attending to white patients on the same basis as white medical students. Only in the final years of apartheid were some black medical students allowed to attend to white patients at all, and even this varied from medical school to medical school.

The students at the University of Cape Town were the only students who had an essentially desegregated hospital as one of their major clinical settings. Medical students of all “races” at the English-language universities conducted their clinical rotations at both white and black hospitals. White medical students at the Afrikaans-speaking universities were allowed to rotate through both white and black hospital wards. However, the small number of black medical students (usually Asians) who attended these universities were not allowed to rotate through the white hospitals. Some medical students at several universities refused to rotate to hospitals that cared only for white patients, as a means of pressing for desegregation.

For many years, blacks had a difficult time gaining admission to medical schools. From 1959 to 1984, the Extension of University Education Act provided that anyone of color accepted by a medical school had to obtain individual ministerial consent from the ethnically relevant ministry in order to attend the university. Such consent was not readily given to all qualified applicants, and was disproportionately denied to Africans. The consent system was lifted for medical schools in 1986.12 But because apartheid still existed in education, blacks still had a limited number of schools to which they could apply.

The universities of the Witwatersrand, Cape Town, and Natal admitted any qualified student, regardless of race, to their medical schools. They designed premedical and medical school tutoring programs for those blacks who needed some educational assistance, often as a consequence of segregated and inadequate premedical education. These were of uneven quality. They also allowed blacks two years to complete their first year of medical school. The University of Natal Medical School, originally intended to provide medical education opportunities for Africans, had a primarily Asian student population. Even so, black students at these schools experienced severe forms of discrimination, both in access to education and in living conditions. Black medical students at Natal were not even permitted to wear clothes with the university insignia.

Generally the English-speaking medical schools enrolled more blacks than the Afrikaans-speaking medical schools. In 1989, only about 12 percent of Stellenbosch’s 600 medical students were black (i.e. mixed race, Asian, or African). One reason cited for this was that most Africans did not speak Afrikaans, the language of instruction there.
MEDUNSA, the Medical University of Southern Africa, was originally established in 1976 by Parliament through the University of Pretoria as a medical school for blacks. Admission preference was given to Africans. Africans from other African countries studied there as well. Because MEDUNSA was a creature of apartheid, some held it in disdain. During the apartheid era, few blacks held leadership posts at the school, and most of the faculty was white.

The loss of trained medical practitioners due to emigration was another serious problem. Physicians at the University of Witwatersrand estimated in 1989 that 50 percent of its medical graduates, white and black, left the country within ten years of graduation. A similar situation existed at the University of Cape Town. A considerable number of white male graduates left to avoid military service, which was mandatory. Those who emigrated tended to be English-speakers with the means to resettle elsewhere.

D. Political Detainees, Health, and Human Rights

Human rights organizations in South Africa estimate that between 1960 and 1989, some 73,000 detentions—the imprisonment of people without charge or trial—took place. Seventy percent of those, or approximately 51,000 detentions, occurred between 1984 and 1988. In the first two years of the national state of emergency (June 1986 through June 1988), an estimated 30,000 people were detained without trial under the emergency regulations, of whom up to 40 percent were believed to be children under the age of 18. Exact figures on the numbers of people detained in South Africa and the “independent” homelands are impossible to verify because the government refused to publish such information.

Under emergency legislation, people could be detained incommunicado and without charge or trial for a period up to 30 days, after which the Minister of Law and Order could authorize an extension of the period of detention. Any member of the security forces had the power to arrest and detain any person who, in the opinion of the security force officer, might pose a threat to the “safety of the public or the maintenance of public order” or to “the termination of the state of emergency.” The detainees might be held indefinitely during the declared emergency and without reconsideration of their individual cases as successive states of emergency were declared. Many emergency detainees were held continuously from June 1986 until early 1989 when, following a series of hunger strikes, the majority of those detainees were released. Lawyers and family members had no automatic right of access to the detainee or any official information about the detainee, unless the Minister of Law and Order or Commissioner of Police permitted it.

Detention could also occur under the Internal Security Act (ISA) No. 74 of 1982 (and its equivalents in the homelands) for purposes of interrogation, to serve as a witness, or as a “preventive” measure. Between 1986 and 1988, at least 5,700 persons were detained under this security legislation. Under Section 29, a frequently-used provision of the ISA, the detainee could be held indefinitely for purposes of interrogation, at the discretion of the arresting officer and the Minister of Law and Order. The other sections of the Act limited the initial time period for detention but allowed for renewal. The court had almost no jurisdiction over the circumstances of Section 29 detainees. The detainee could be held incommunicado and in solitary confinement, without any access to a lawyer. Persons held under Section 29 were at particularly great risk of torture. Only the Minister of Law and Order, the Commissioner of Police or their designated agents had direct access to information about these detainees.

In the final years of apartheid, the primary targets of detention were trade union leaders, educators, religious workers, students, health workers, lawyers, members of the media, and community organizers. Often relatives were not promptly informed of the detention of a family member until weeks or months later, despite prolonged and sometimes desperate attempts to learn the whereabouts and fate of the person or even to obtain assurances that the detainee was still alive. An overwhelming majority of those detained were eventually released without charge or trial. Of those charged, fewer than five percent were ever convicted of any offense.

E. Deaths in Detention

The Johannesburg-based Human Rights Commission, founded in 1988 by six legal, medical, religious and anti-apartheid organizations, reported in 1989 that at least 68 deaths in detention had occurred since 1963, when laws were first introduced allowing detention without trial. By law, any
unnatural death must be investigated by an inquest court, presided over by a magistrate (who is a civil servant) to determine the cause of death. The court may also rule, but rarely did, on the separate issue of responsibility for the death. The courts ruled, often without adequate evidence, that many of the deaths were suicides or accidents, and that others were due to natural causes. In some cases of death in detention, medical negligence was an important contributing factor.

Perhaps the most famous case where medical negligence contributed to the death of a detainee was that of Black Consciousness leader Steven Biko. On 12 September 1977, Mr. Biko died in a prison cell in Pretoria, six days after being interrogated by police. An inquest found that the likely cause of death was a “head injury with associated extensive brain injury, followed by contusion of the blood circulation, disseminated intravascular coagulation as well as renal failure with uremia.”18 In early 1978, an ombudsman with the South African Council of Churches submitted a complaint to the South African Medical and Dental Council (SAMDC), alleging indifferent and irresponsible medical care by the physicians who had attended Mr. Biko between the time of his assault and the time of his death—medical care that was exposed during the inquest proceedings. The SAMDC is the statutory body responsible for licensing physicians and investigating breaches of professional medical conduct.

In 1980, a SAMDC inquiry committee announced publicly that it had found no \textit{prima facie} evidence of improper or disgraceful conduct by the doctors who attended Mr. Biko, and the full Council confirmed the finding by a majority vote. Significant portions of the South African medical community, troubled by the failure of the SAMDC to investigate, asked the Medical Association of South Africa (MASA) to consider the matter. The MASA executive committee supported the decision of the SAMDC and criticized those who had brought the charges, asserting that the critics had relied on flawed newspaper reports. The \textit{South African Medical Journal} refused to publish letters representing views opposed to the leadership. Several prominent MASA members subsequently resigned in protest. A MASA member then persuaded the organization to set up a select committee to examine the ethical issues raised by the medical treatment of Mr. Biko. The committee’s findings disagreed with those of the SAMDC. Encouraged by this, several physicians lodged complaints with the SAMDC, but to no avail. The complainants then successfully petitioned the Supreme Court, which set aside the SAMDC’s initial findings and ordered the SAMDC to initiate a new inquiry. In July 1985, the SAMDC finally held disciplinary hearings against the doctors who had treated Biko. Two physicians were found guilty of improper behavior; one was eventually stripped of his medical qualifications, the other received a reprimand.19

\section*{NOTES}

1 The South African government classified all persons in South Africa according to race. The four main groups officially recognized were “white,” “Indian” (Asians), “colored” (mixed race) and “black” (black Africans). The term “black” was used by anti-apartheid organizations to refer to all persons who were disenfranchised or otherwise discriminated against under the apartheid system. As apartheid affected the Asian, mixed race, and African populations differently, it is necessary to distinguish people according to government race classifications of “Indian,” “colored,” and “black.” When South Africans used the term “black,” it was not always clear whether they meant “black” in the sense used by the anti-apartheid organizations or in specific reference to Africans. In this report, the term “black” is used inclusively to refer to all persons of color who were disenfranchised under apartheid.

2 In 1984, under the Group Areas Act, 451 of the 899 total group areas were set aside for whites (13.9% of the population) covering 83.6% of the total designated areas. \textit{South African 1986: A Permanent State of Emergency}. Washington DC: Lawyers’ Committee for Civil Rights Under Law, 1987, p. 7.

3 The U.S. Committee for Refugees estimates that 3,570,000 persons were internal refugees in South Africa in 1988. This figure includes persons forcibly relocated in government resettlement programs as a result of their race, religion, ethnicity, social group, or imputed political opinion. Clark, Lance. “Internal Refugees—The Hidden Half.” \textit{World Refugee Survey-1988 in Review}. Washington DC: U.S. Committee for Refugees, 1989.


6 That apartheid policies contributed to the poverty and poor nutrition of many in South Africa has been well documented by UNICEF reports on South Africa and the Second Carnegie Inquiry into Poverty and Development in South Africa. See, for example, \textit{Children on the Front Line: A Report for UNICEF}. New York, 1989.

7 The Community Agency for Social Enquiry, p. 11.

Patterns of Human Rights Violations

The Biko affair was perhaps the most public, controversial, and embarrassing incident of medical negligence in South Africa. Yet, unethical or neglectful medical treatment of detainees by physicians did not end with the Biko investigation.

The apartheid period was characterized by serious and pervasive human rights violations within the health sector. Some of these abuses were institutional in nature and others resulted from the behavior of individuals. Many of the violations reflected the institutionalized racism that was at the core of the apartheid system. Others were a by-product of an authoritarian political system that did not respect human rights. Some types of abuses appear to be a result of sheer neglect in instilling professional standards of conduct that incorporate fundamental ethical and human rights principles in health professionals.

Much of the available data about these infringements comes in the form of case studies. These are found in published documents and in various submissions to and testimonies at the Health Sector Hearings conducted by the Truth and Reconciliation Commission on 17 and 18 June 1997. This has complicated the process of assessing the patterns and extent of the human rights infractions. It has also prompted some health professionals to claim that the human rights violations documented represent aberrations and to argue that the majority of health professionals were well intentioned and acted morally.

To aid the process of understanding the systemic nature of the abuses in the health sector, this section integrates various data sources to show patterns of human rights violations. The data utilized come from a variety of sources: publications, submissions to the Truth and Reconciliation Commission, testimonies at the Health Sector Hearings, and interview notes of members of the AAAS health sector team. The descriptions of violations are not meant to be comprehensive. Nor are the listings, many in the form of vignettes or brief descriptions, intended to be more than illustrative examples of the types of violations taking place in the health sector during apartheid. The next chapter of this study will provide a more in-depth analytical treatment of several of the topics.
International human rights standards are used to determine what constitutes a violation. Here, it should be noted that the apartheid regime did not ratify any of the major international human rights instruments. Ironically, just as the rest of the world was affirming the standards outlined in the Universal Declaration of Human Rights, which was adopted without a dissenting vote by the member states represented in the United Nations General Assembly in 1948, South Africa was instituting a system that violated many of these fundamental rights. Because certain rights set forth in the Universal Declaration are now considered to be generally applicable under customary international law, it seems appropriate to judge the apartheid regime by these norms.

The other major international human rights instruments discussed below are multilateral treaties which are based on the Universal Declaration and elaborate on its provisions. The post-apartheid regime has signed several of them, including the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, and the Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment. Two of these treaties have also been ratified by South Africa: the Convention on the Elimination of All Forms of Discrimination Against Women and the Convention on the Rights of the Child. When states ratify a specific treaty they become legally bound to abide by its requirements.

Moreover, the new South African constitution recognizes and provides protection for human rights based on international standards. It states that "[C]ustomary international law is law in the Republic unless it is inconsistent with the Constitution or an Act of Parliament." There is now an embedded deference to international law. "When interpreting any legislation, every court must prefer any reasonable interpretation of the legislation that is consistent with international law over any alternative interpretation that is inconsistent with international law." As regards health care, provisions of the Constitution specify that "[E]veryone has the right to have access to health care services, including reproductive health care." Additionally, "[N]o one may be refused emergency medical treatment." Furthermore, "[E]veryone who is detained, including every sentenced prisoner, has the right...to conditions of detention that are consistent with human dignity, including at least exercise and the provision, at state expense, of adequate accommodation, nutrition, reading material and medical treatment.”

Following international human rights usage, the violations profile below distinguishes between three major types of violations: violations of commission (with a separate category for violations of commission related to discrimination), violations of the obligation to protect, and violations of omission. A separate category on the failure to respect women’s reproductive rights is also included. Each of these five categories is further divided into a variety of subtopics.

A. Violations of Commission

A violation of commission is a human rights violation resulting from initiatives by a state actor. It includes laws, policies, and actions that constitute or result in abuses of human rights.

Human rights instruments pertinent to such abusive government initiatives in the health sector include the International Covenant on Civil and Political Rights, the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and the International Convention on the Elimination of All Forms of Racial Discrimination. All of these international agreements mandate the norms of equality and nondiscrimination and the right to liberty and security of the person. The first two require that no one shall be arbitrarily deprived of life and that no one be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Many of the violations noted in the compilation below caused serious physical harm and health impairment to victims.

1. Legislation and government policies that resulted in the torture and maltreatment of prisoners

The Convention Against Torture requires that each State Party "take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction." The Convention further states that "[n]o exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other
public emergency, may be invoked as a justification of torture." Various of the apartheid-era governments’ legislative enactments violated this international understanding of State responsibility and proved to be the cloak of government support that afforded political cover for the practice of torture.

- Detention, arrest and incarceration without formal charges or trial, was a common mechanism of repression utilized in South Africa and the so-called independent homelands to isolate, silence, and intimidate suspected enemies of the state during apartheid. A network of laws was enacted to broaden the power of detentions, among them the antiterrorist acts, that defined terrorism very broadly and allowed for the arrest of anyone in South Africa suspected of terrorist activity or of having information about terrorist activity. Under Section 29 of the Internal Security Act 74, an individual could be detained indefinitely, explicitly outside the jurisdiction of the court, without access to a lawyer, family members, religious advisors, or a personal physician. Section 29 also allowed for a detainee to be held incommunicado and in solitary confinement. The lack of protections for detainees made them more vulnerable to torture and maltreatment.

- Between 1960 and 1990, it is estimated that some 73,000 detentions took place. It is now common knowledge that severe torture was commonplace; many people were temporarily or permanently injured (physically and psychologically) and a number of people died in detention.

- A study conducted by doctors affiliated with NAMDA (National Medical and Dental Association) practicing at a clinic near the center of Durban on detainees released between September 1987 and March 1990 indicated that 94 percent claimed either physical or mental abuse. The beating of detainees was widespread. Of the ex-detainees who alleged physical abuse, half showed evidence on physical examination. When their psychological status was assessed, 48 percent were found to have some degree of psychosocial dysfunction.

- In December 1982, the Minister of Law and Order issued a set of directives as safeguards for those detained under Section 29 of the Terrorist Act. Paragraph 15 states, “A detainee shall at all times be treated in a humane manner with proper regard to the rules of decency and shall not in any way be assaulted or otherwise ill-treated or subjected to any form of torture or inhuman or degrading treatment.” However, there is little evidence of the safeguarding of detainees’ human rights.

- While the courts were denied jurisdiction in cases of detainees, they indirectly “augmented and sanctioned the practice of interrogation and torture of detainees by accepting as evidence testimony obtained from detainees while in detention.”

- The May 1983 report of the Ad Hoc Committee of MASA (Medical Association of South Africa) published as a supplement to the South African Medical Journal stated that “[T]here are insufficient safeguards in the existing legislation to ensure that maltreatment of detainees does not occur. Persuasive evidence has been put before the Committee that where harsh methods are employed in the detention and interrogation of detainees, this may have extremely serious and possibly permanent effects on the physical and mental health of the detainee...The Committee has concluded that the circumstances relating to the detention of security law detainees in South Africa present potential hazards to their physical and mental health.”

- The Department of Health did not conduct its own investigations into the health care of detainees by district surgeons despite the number of complaints about torture that were being reported in the media and in court cases.

- Corporal punishment was sanctioned until 1994. In 1987 there were 35,000 whippings, in 1988 41,000. Doctors were required to be present to qualify victims for punishment and observe its effects.

- Many children were detained under the security and emergency regulations, which did not require that they be formally charged, rather than under the Criminal Procedure Act, where they would have to be charged and brought before a court of law. Up to 10,000 children, some very young, were arrested during 1986 and 1987 as the government attempted to crush widespread school boycotts. Many were placed in solitary confinement. Parents and/or relatives were generally not informed of the child’s detention or given visitation rights. Nor were there protections in place, such as the inspection of juvenile cells by persons independent of the system. Prisons were found to be very unsuitable places for detaining children; they were overcrowded,
had inappropriate feeding schedules, and little stimulation for growth and development. In a 1986 study conducted by the National Medical and Dental Association of 600 persons who had been recently released from detention, 40 percent were children. One third of these children were suffering from post-traumatic stress disorder.

- A representative of MASA cited the case where “a district surgeon...was allegedly requested by the security police to advise them whether a detainee was fit to undergo further electric shock torture.”

2. Government policies that resulted in the failure to provide appropriate health care to detainees

Contrary to international standards, the apartheid government interfered with the health care provided to detainees through the Department of Health. Under UN Standard Minimum Rules for the Treatment of Prisoners, a qualified medical officer “shall have the care of the physical and mental health of prisoners and should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is specially directed.” According to UN principles, “A proper medical examination shall be offered to a detained or imprisoned person as promptly as possible after his admission to the place of detention or imprisonment, and thereafter medical care and treatment shall be provided whenever necessary. This care and treatment shall be provided free of charge.”

- The submission of the Department of Health to the TRC acknowledges that “[T]he Health Department was in fact collaborating with the police services against the health interests of their patients. The Department was in fact allowing the professional integrity of its employees to be violated.”

- The Department of Health submission to the TRC states that “[I]t appears that medical negligence was a factor in the deaths of a number of people in detention.” It goes on to acknowledge that “[A]s the employer of District Surgeons, it is incumbent on the Department of Health to bear some responsibility.”

- Psychiatrists had to treat patients in detention, knowing that continued detention or solitary confinement was exacerbating the illness of their patients. When psychiatrists recommended release from detention as a way to prevent further deterioration of mental health, detainees were transferred to areas without such sympathetic psychiatrists.

3. Failure of district surgeons and other health professionals to protect the health of detainees

Virtually all medical codes of ethics emphasize that a medical professional’s primary responsibility is to his/her patient. Apartheid imposed a system of dual loyalties that compromised many medical professionals who allowed political considerations to override their professional obligations.

- “The current Premier of the North West, Popo Molefe, is reported to have been kept in leg irons while being treated for a lung infection.”

- In a 1987 study by the National Medical and Dental Association, 75 percent of the detainees interviewed had been assaulted, but less than half had received medical care.

- Mass detentions increased the workload of district surgeons making it difficult to provide adequate care to all their patients.

- Detainees were not told that under a 1985 policy they had access to independent doctors who were members of special panels. The detainees were thus limited to the health care provided by district surgeons.

- In a study of the medical care provided to 123 individuals who were in detention between 1986 and 1990, only 8 percent were informed that they had the right to see a doctor while in detention.

- In 1985, when district surgeon Wendy Orr reported evidence to the Department of Health that her patients were being tortured, the Department obstructed her efforts to protect those detainees. After she took the matter to the Supreme Court for the Eastern Cape, she was barred from seeing detainees. “Dr. Orr was in effect ‘pushed out’ of the district surgeon’s role.”

- The Department of Health instructed district surgeons not to testify to a MASA committee that was formed in May 1982 to investigate the reported medical controversy over the poor treatment of detainees and prisoners. Minister of Health and Welfare Dr. C. V. van der Merwe stated that “it is not practical for any civil servant to give evidence before a committee that makes inquiries about the activities of civil servants.”
The Department of Health acknowledges that district surgeons failed in their duty to report, treat and inquire about the torture of detainees. This is particularly unfortunate because they were “the only lawful source of access to medical care and a potential safeguard against abuse by the detaining authority.” With only minor exceptions, they were not prepared to take the necessary actions to protect patients.

Many district surgeons and other physicians filed false or misleading reports regarding injuries to detainees. In a case from the 1970s, a man was found comatose in police headquarters. He was examined by a district surgeon and then transferred to police headquarters in Pretoria. The Chief Pathologist filed a false affidavit saying there were no injuries. In 1985, Amos Dyanti received a diagnosis of epilepsy without a careful examination to exclude the possibility of head injury or inquiring from the detainee whether he had been assaulted or tortured. Mr. Dyanti further alleged that while he was being tortured, a doctor advised police to smear porridge around his nose, “so that in the event that he died during interrogation they could attribute his death to aspiration of food during an epileptic seizure.”

Some psychiatrists worked extensively with the security police providing expert testimony that denied that there was evidence of damage to, and abuse of, political detainees.

Doctors may have helped police modify electric shock torture to hide evidence of it. At first, electric shock was applied using clips and wires, but because of its detectability upon histological examination, the torture was changed to broaden the surface area of the charge, thus making evidence of torture less detectable.

Some psychiatrists prescribed drugs so detainees would be fit for torture, or to cover up evidence of torture.

According to the Department of Health, “many District Surgeons failed to put their medical and health obligations as their primary responsibility, and allowed themselves either by commission or omission to become accomplices to actions resulting in unnecessary illness, sufficiency and death.”

There were district surgeons who performed “perfunctory examinations or who did not inquire into the cause of injuries suffered by detainees.”

Psychologists, when called upon to examine a prisoner, would ask more questions of the guard in order to determine the condition of the prisoner than of the prisoner. Psychologists acted as “spy-chologists,” seeking to obtain information from prisoners useful to the state.

4. Results of coercive population policies

The apartheid-era government sought to control the location and limit the growth of the black population. These policies had devastating effects on the unity and health of black families because it forced many black men to leave their families in search of work and hindered a black family’s access to quality health care. The right to move around freely and have a family life are inherent in the International Covenant on Civil and Political Rights. With regard to migration, Article 12 provides that, “[e]veryone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement and freedom to choose his residence.” Article 23 of the Covenant covers family planning to some extent when it states that, “[t]he family is the natural and fundamental group unit of society and is entitled to protection by society and the State. . . The right of men and women of marriageable age to marry and to found a family shall be recognized.”

The population policies are also contrary to provisions of the International Covenant on Economic, Social and Cultural Rights. Article 12 requires States Parties to recognize “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” Achieving the full realization of this right involves “the creation of conditions which would assure to all medical service and medical attention in the event of sickness.”

The results of “confining more than 72 percent of the people [blacks] to 13 percent of the country in Bantustans and ghettoes; the serious underdevelopment of rural black areas; the migration of work seekers to the cities; the strict control of those searching for employment by migrant labor laws; the illegal squatter camps; the forced removals of upwards of three and one-half million Africans from settled communities to poorly served resettlement villages; the lack of sufficient and good quality housing and sewage disposal and sanitation in settled
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townships...all create circumstances which lead to frequent and infectious diseases and rampant malnutrition.  

- Because of apartheid policies that sought to contain and relocate blacks to distant homelands...Smith Mitchell facilities (psychiatric institutions now called Life Care) were located far from many black patients' homes. This made it difficult for patients' relatives to visit and maintain contact with them, thus contributing to the social isolation and “chronicity” of black patients.  

- The migrant labor system required men to live apart from their families for much of the year, often in overcrowded single-sex hostels with dormitory accommodation. Without the potentially stabilizing influence of family support, there was a high incidence of violence and widespread abuse of alcohol and drugs.  

5. Interference with the privacy and confidentiality of medical information  

Article 17 of the International Covenant on Civil and Political Rights states that “[n]o one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honor and reputation.” Hand in hand with the right to privacy is the expectation that there is confidentiality of medical information. Confidentiality is considered an essential component in the practice of medicine that helps to define the relationship between a doctor and her patient. It allows for a measure of trust that facilitates proper treatment. Threats to confidentiality are thus symptoms of a suspect medical system.  

- From 1978 to 1994 district surgeons were required to tell the police “about the medical condition of detainees, thereby creating a situation in which doctors handed their clinical files over to the very interrogators and torturers who would misuse such information.”  

- “The Department of Health did little to protect professional confidentiality and in fact collaborated with the police in producing information. There are numerous reported incidents in which doctors, nurses and administrative staff were forced to give information—often with threats against the health worker or their family.”  

- In 1986 at the Alexandria Clinic in Johannesburg, following a clash between the police and township residents, police requested patient files of patients with gunshot wounds. When doctors refused, the files were taken by force. The files were returned when the director of the clinic informed the police that they were obstructing proper medical care.  

- “The District Surgeons were particularly vulnerable to having to provide medical and other confidential information provided to them. S/he has a legal obligation to give confidential information upon court order. Moreover a full medical record had to accompany a detainee when being transferred.”  

- In 1982, one district surgeon stated, “the [district surgeon] is obliged by law to hand over his notes to the security police.” Another stated, “if district surgeons wished to have a detainee put in hospital it was first necessary to divulge all medical information to the security police.”  

- Ambulance workers would bring patients with gunshot wounds to state hospitals where security police had easier access to records, rather than bring them to clinics where doctors may have tried to protect the patients from the police.  

B. Violations Related to Discrimination  

Nondiscrimination is one of the most central human rights principles and as such it is enshrined in all of the international human rights instruments. Using language repeated in the text of other of the international conventions, Article 2 of the International Covenant on Civil and Political Rights requires each state party to the Covenant to respect and to ensure to all individuals within its territory the rights enumerated in the text “without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.” Article 1 of the International Convention on the Elimination of All Forms of Racial Discrimination defines racial discrimination as “any distinction, exclusion, restriction or preference based on race, color, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of
human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life."

1. Failure to grant true personhood and autonomy to blacks as patients and professionals

The Universal Declaration of Human Rights states that, "[a]ll human beings are born free and equal in dignity and human rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood."

The international conventions on human rights, likewise recognize the dignity of the individual. Listed below are just a few examples of direct assaults or the results thereof on this concept.

- Excerpts from South African Medical Journal articles during apartheid purport to document inherent differences in "races" and the inferiority of black "races" to European "races." One article from 1960 stated, "the most striking traits of the African are the recognition of the importance of physical needs (nutrition and sexuality), and a liveliness of the emotions counterbalanced by their short duration. The African essentially lives in the present (in a sense, like a child) and his behavior is largely motivated by influences and impulses of the moment."  

- Nursing councils created specifically for black nurses were established in the homelands without consulting the affected nurses. "This tended to undermine the professional status and international recognition of these nurses...These councils commenced without any financial support to assist them."

- The Medical Association of South Africa "probably was insensitive and indifferent to the lot of its black members such as when branch meetings were scheduled at venues where they were legally barred."

- "Despite equitable qualification between white and black personnel, for most of the period under review discriminatory salaries were paid to blacks. This includes nursing, medical and other professionals. In addition facilities and conditions were separate and unequal. Personnel working in the same facility and with the same qualification had separate toilets, separate tea rooms and separate accommodation. In such ways the Department of Health ensured that blacks 'knew their place' and whites maintained their superiority."

- The Democratic Nursing Organization of South Africa has stated that racial discrimination led to mistreatment of the nurse as a trained professional, with consequences for the quality of care to patients. For instance, when a nurse was instructed by a white doctor to remove an intravenous infusion from a dehydrated black man, or when a nurse was instructed by a pharmacist and doctor to ignore the recall of a batch of medicine that she located in a high-care nursery of a black community mission hospital.

- In the mining industry, "[e]mployees were regularly brought into a hall, en masse and naked, where they were systematically and publicly checked for any signs of [sexually transmitted diseases]."

- In response to discriminatory salaries, some black nurses, in order to receive increased earnings, would have to try to pass as colored by straightening their hair, lightening their skin and modeling their speech.

- "Despite black health personnel sometimes having better qualifications and experience, white personnel were promoted above them. It was seen as unacceptable for blacks to have positions of authority over whites."

- There was little chance of advancement for black nurses. When serving black patients they functioned as nurses and when they served white patients they functioned as auxiliaries, "limited to caring for personal needs of patients (tea, bed-pan, etc.)." Many black nurses retired after a lifetime of service to the State, still in the most junior professional nurse's post.

- Black medical students were given strict rules to obey when entering "European" hospitals. They had to stay away from white patients, or dead white bodies, leave by separate exits and disguise the fact that they were medical students by not wearing doctors' coats or stethoscopes.

- "Doctors' [offices] had separate waiting areas and consulting areas. Whites had a waiting room which was usually fairly comfortable with chairs, magazines and possibly a potted plant. The black patients'
waiting area was usually more uncomfortable and inadequate—a verandah which may or may not be covered, with hard wooden benches.” While the white patients had a consulting room where there was privacy, the black consulting area was not private and “created a feeling of a depersonalized ‘production line.’”72

- The Nursing Act 69 of 1957, Section 49, made it a criminal offense for a white nurse to be put under the supervision of a nurse belonging to another race group.

- Nursing Amendment Act 69 of 1957 and Nursing Act 50 of 1978 prohibited black nurses from being on the board of the South African Nursing Association and the South African Nursing Council. This exclusion resulted in the failure of professional associations and regulatory bodies to investigate inconsistencies in health care provision, represent and defend black nurses; and provide leadership, guidance and protection.74

- It was a longstanding policy of the South African Medical and Dental Council that a practitioner be free to decide to whom he or she wanted to render a service in non-emergency situations. It was only in 1989 that the South African Medical and Dental Council expressly disapproved of the attitude of a practitioner in not rendering services to a particular “population group” and 1992 when it clarified that differentiation on a racial basis in the provision of waiting rooms for patients was wrong.75

2. Systematic differences in the provision of health care

Article 5 of the International Convention on the Elimination of All Forms of Racial Discrimination calls for the elimination of racial discrimination in all its forms, and specifies the “right of everyone, without distinction as to race, color, or national or ethnic origin,” to enjoy economic, social and cultural rights, among them “the right to public health, medical care, social security and social services.”76 A 1989 AAAS medical investigation to South Africa concluded that apartheid was “the prime cause of the unequal appropriation of funds for medical services; overcrowding in black hospitals and underutilization of white hospitals;...and poor or non-existent health care in the homelands and rural areas.”77

- About four times more was spent on health care for whites than for Africans by the government. The Department of Health has acknowledged that “[T]he allocation of inequitable resources is probably the most important factor for which the Department can be held responsible for past illness and death.” Per capita expenditure on health was as follows:

<table>
<thead>
<tr>
<th></th>
<th>1985</th>
<th>1987</th>
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<tbody>
<tr>
<td>Africans</td>
<td>R115</td>
<td>R137</td>
</tr>
<tr>
<td>Coloreds</td>
<td>R245</td>
<td>R340</td>
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<tr>
<td>Indians</td>
<td>R249</td>
<td>R356</td>
</tr>
<tr>
<td>Whites</td>
<td>R451</td>
<td>R597</td>
</tr>
</tbody>
</table>

- “Rather than allowing ‘health’ to be the driving force of its policies, [the Health Department] concentrated most of its efforts and resources on only part of the population, in line with the political objectives of the Apartheid State. The Department also became part of the oppressive apparatus of the State by not taking stands and intervening when medical ethics were being violated - even by their own employees.”79

- “Because admission to hospitals was racially based, patients were forced to go to hospitals which were not necessarily the nearest or most accessible. In terms of ambulances they were dispatched to emergency situations based on race. As a result, if an ambulance serving the black population was in use, a patient would have to wait rather than use an ambulance reserved for whites being dispatched.”80

- In April 1984, treatment was delayed to a colored television announcer who was injured in a car accident. He was denied treatment in the colored section of the hospital because he was thought to be Indian and was denied treatment in the Indian section because he was thought to be white. The delay in treatment contributed to his death.81

- In December 1984, treatment was delayed to an African-American dancer who was injured in an accident. He was left on the side of the road by the ambulance that took his companion to a hospital. When a black passerby took him to a “white” hospital he was refused treatment. After 24 hours he finally received treatment in the white section of another hospital, which admitted him as an “honorary white.” The delay in treatment resulted in paralysis of his arms and legs.82
No disciplinary action was taken by the South African Medical and Dental Council with regard to the differential health care provided by the separate hospital facilities established for each race.

The Medical Association of South Africa's "official stance was that doctors did have the 'right' to choose their patients for themselves... It was not until 1994 that the organization unequivocally made the policy statement that separate waiting rooms based on race as well as separation of State versus private patients is unethical."

According to an American Psychiatric Association report of 1979, government-funded private psychiatric facilities, such as Smith Mitchell (now called Life Care), provided racially segregated care on a per diem basis for chronic psychiatric patients transferred from state institutions. Racially disparate treatment by Smith Mitchell included refusing sheets to black patients, despite the fact that a significant number were incontinent; having a number of black patients sleep on the floor, citing overcrowding and the lack of beds, while white wards had extra beds; and providing inferior quality food to black patients on the grounds of cultural preference, despite the complaints made by black patients. Furthermore, black patients were civilly committed in the early stages of mental illness, when they were still treatable. Epileptics may have been unnecessarily confined.

Hospital bed availability differed quite markedly by race. According to data of the Department of Health (no date given) on the average bed availability in the major regions, there were 6.05 beds per 1,000 whites and 3.29 beds per 1,000 blacks. This is made more compelling with average bed occupancy rates of 54.75 percent for whites and 88.60 percent for blacks. In two regions, Transvaal and Cape, the bed occupancy for blacks was 103 percent while bed occupancy for whites never exceeded 60 percent in the five regions surveyed.

"[T]he number of white patients receiving dialysis in 1977 was one of the highest in the world - around 107 per million whereas the number of black South Africans was around 4 per million."

"There are still relatively few [specialists] in black hospitals, resulting in heavier clinical loads and less time for research and preparations for teaching duties. The pressure under which doctors were compelled to work at the hospitals for black patients must have resulted in less satisfactory care for the patients."

In 1987, the ratio of white dentists to the white population was 1:2,000. For blacks it was 1:2,000,000.

3. Race bias in health research

Accurate data are essential for health policymaking. Under apartheid, the type of data collected reflected political considerations and their quality was poor.

According to a World Health Organization report of 1981, "[N]o research was available looking at the effects of living under apartheid. Little was known of the consequences of the enforced breakup of families, of the migrant labor force system or the mass uprooting of millions of people under the Homelands policy."

Vital statistics, i.e. data on births, deaths, and population size and structure, are critical for public health planning. Under apartheid there was very little attempt to collect valid and reliable data on births and deaths for blacks.

Kwashiorkor, a disease that almost exclusively affected blacks, was delisted as a notifiable disease in 1968.

Since 1990, research in the Johannesburg hospital remains preoccupied with the affluent. This is because of constricted access to the Johannesburg hospital by working class patients and increased usage by the well-to-do.

4. Inadequate and discriminatory training of black health workers

Contrary to the right to education as recognized in Article 26 of the Universal Declaration of Human Rights and Article 13 of the International Covenant on Economic, Social and Cultural Rights, segregation at all levels of the educational system during the apartheid period made it difficult for black students to receive the requisite science background and to gain admission to medical schools. The small numbers of non-white medical students were then subjected to indignities and not allowed to rotate to hospitals for white patients. This system resulted in a serious imbalance in the number of blacks trained as health professionals relative to their numbers in the population.
Although whites made up approximately 17 percent of the population from 1968-73, they made up a mean annual percentage of 85 percent of medical school graduates. Blacks, on the other hand, during the same period made up approximately 70 percent of the population, but represented a mean annual percentage of 3 percent of medical school graduates.

In 1985, 83 percent of all doctors and 94 percent of all specialists were white.

In 1990, of the nearly 155,000 nurses in South Africa, slightly over half were African, a third white, and over 21,000 colored.

"Most training institutions were attached to white hospitals which refused black trainees from examining and treating white patients. Because most of the professorial units were situated at white hospitals, black students did not get the opportunity to attend professorial ward rounds. Also for many years black students at 'white universities' were not allowed to attend post-mortem examinations of white bodies."

The training at black hospitals was inadequate. The more skilled and experienced doctors taught at the white teaching hospitals. The black teaching hospitals were located farther away from the university. When Johannesburg Hospital began to provide a bus service in 1952 between the teaching hospitals, only whites were allowed to use the service.

In the mid-1970s around 93 percent of doctors were white. In 1978, 83 percent of Indian and 95 percent of colored applicants were granted the Ministerial permission required under the Extension of University Education Act. However, only 29 percent of black applicants were granted such permission.

Postgraduate training and academic advancement was limited for black doctors. "In order to become a cardiologist, black doctors in the sixties and seventies had to leave their province or the country to receive training in this subspecialty."

"Whereas white nurses were trained within well-equipped hospital schools and, later, nursing colleges, black nurses were exposed to harsher conditions within hospital settings and nursing homes and educational settings which were poorly resourced."

"Black nurses were limited or not able to pursue on-going education in a general or specialized field of courses as courses were not available to them."

Nursing education was Eurocentric, and nurses didn’t understand what remedies were available to rural patients. For instance, a nurse prescribed a high protein diet of eggs and cheese to a severely malnourished black child from a rural setting. The nurse was not trained to know that the prescribed diet was unavailable, unaffordable and culturally inappropriate.

As of 1990 it was estimated that there were only four black psychiatrists out of the total of 200 trained psychiatrists serving South Africa.

The Extension of University Education Act 45 of 1959, Proclamations 221 and 223, limited the universities that Bantus could enter. "[W]ith effect from 1 January 1960 no Bantu person or non-white person other than a Bantu person that was not registered as a student of a university established by Act of Parliament, other than the University of South Africa, on or before the said date, shall register with or attend any such university as student without the written consent of the Ministers of Bantu Education or of Education, Arts and Science, respectively: Provided that this Proclamation shall not apply to Bantu persons or non-white persons other than Bantu persons in respect of their registration and attendance as students at the medical school for Non-Europeans of the University of Natal.

5. Differential health outcomes

With regard to the Covenant on Civil and Political Rights, the UN’s Human Rights Committee issued a General Comment stating that the right to life, enunciated in article 6 of the Covenant is "the supreme right from which no derogation is permitted even in time of public emergency which threatens the life of the nation." The Committee further stated that "it would be desirable for States Parties to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics." Apartheid medicine had a deleterious effect on the health of the non-white majority. The following data provide some insight into the disparities in health outcomes.
The infant mortality rate is generally considered a useful indicator of the level of health in a country. "It is evident that the Infant Mortality Rate of Africans and coloreds is almost five times higher than whites. Rural Africans had [infant mortality rates] approximately 2.6 times higher than those living in urban areas." This means that African and "colored" children have been disadvantaged from birth.

From 1965-70, the life expectancy for black males was 51 and 60 for females. For whites, they were 65 and 72. In 1985, life expectancies for blacks were 55 and 61 for males and females respectively and 68 and 76 for whites.

Various regional and national studies conducted by the Department of Health in 1980 established that one third of non-white children were malnourished.

In 1989 there were 2.3 million people in South Africa who could be considered in need of nutritional assistance. Of these 87 percent were African and 2 percent white.

In 1978, typhoid fever was 48 times more common in blacks than whites; in 1971, deaths from diarrhea were 100 times more common among black children than white children.

As of 1983 it was estimated that there was a shortage of housing for rural and urban blacks in the amount of 724,000. The result was overcrowding and lack of ventilation, which facilitated the transmission of air-borne infections. Furthermore, the absence of proper sanitation and lack of clean water resulted in spread of enteric diseases.

In 1989, eleven times more measles were reported among blacks than whites.

In 1987, African women had 3.5 times higher rates of cervical cancer than whites.

The HIV epidemic has progressed rapidly in South Africa, with a doubling of infection every 11 to 13 months. While HIV affects all population groups, the infection is more common among Africans. In 1993 the prevalence was 0.52% among whites, 0.76% among coloreds, and 5.5% among Africans. The epidemic is at its most advanced stage in KwaZulu-Natal. Moreover, the epidemiology of HIV infection demonstrates the link between individual vulnerability to infection and the socio-economic context within which this occurs. The low status of women in society, economic pressures that result in the disruption of families and conjugal instability caused by men seeking employment away from their families have influenced the nature of the HIV/AIDS epidemic.

C. Violations of the Obligation to Protect

In contrast to the human rights abuses in the first two categories, violations of the obligation to protect are triggered by the actions of non-state actors. Under international human rights law, a government has the obligation to protect its citizens and to prevent individuals and groups from perpetrating human rights violations. In South Africa, the actions by non-state actors often reflected state policies. The violations described below deprived South Africans of basic civil and political rights outlined in the International Covenant on Civil and Political Rights as well as the rights to health and health care enumerated in the International Covenant on Economic, Social and Cultural Rights.

1. Failure to protect against non-state violence or prosecute perpetrators

- Members of progressive health organizations were often harassed, threatened, or even murdered.
- During the 1985/1986 political unrest, doctors "allegedly donned camouflage uniforms and went on nocturnal raids with vigilantes."
- "Alexandria Clinic had been the target of petrol bombs on several occasions in the mid-1980s. Many people believe that the clinic was targeted because it provided services to those in the community who protested the government’s policies. The individuals responsible for the petrol bombs were never apprehended; however, some employees at the clinic believe that the security police were behind the attacks. They came to this conclusion because witnesses had described the perpetrators as white at times when the township was sealed off by police, thus making it difficult for other whites to come and go freely without being noticed."
Doctors who treated detainees received death threats. For example, Ruth Benjamin, a clinical psychologist who spoke out about the treatment of detainees, reported that in 1991 individuals made threatening phone calls, broke into her car on one occasion and held her and her daughter at gunpoint on another.

Homosexuals and drug users in the military were coerced into undergoing experimental treatment. In one case, a homosexual victim was alleged to have been induced to receive aversion therapy in order to reprogram him in exchange for having to forego drug detoxification treatment. "The context was clearly one of being experimented upon, and consent appeared to have been obtained under circumstances of coercion."

The KTC clinic at the Xolani Center Crossroads was burned down by government supported Witdoek (a group of township men also known as the "Fathers") vigilantes in 1987.

"The Security Police took action against many people who opposed apartheid and apartheid health care. The Health Department did nothing to protect these individuals or protest their situation. Worse though is that people known by [the Health Department] to actively oppose apartheid, were discriminated against in terms of things such as intern placements and jobs within the State sector."

During periods of unrest, mobile police stations were set up outside hospitals. Sometimes hospitals were shut down.

During the State of Emergency, people who were injured as a result of clashes with the police were arrested when they went to seek treatment. In some instances, township residents were unable to get to hospitals in towns because the townships were sealed off by police. In other instances people were afraid to get into ambulances because of reports that they went to the police station rather than to the hospital.

NAMDA members were repeatedly harassed and threatened.

D. Violations of Omission: Failure to Fulfill Minimum Core Obligations

The International Covenant on Economic, Social and Cultural Rights recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. To that end, it mandates a series of steps be undertaken, one of which is the creation of conditions which ensure medical service and medical attention to all in the event of sickness. Other provisions call for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child; improvement of all aspects of environmental and industrial hygiene; and the prevention, treatment and control of epidemic, endemic, occupational, and other diseases.

A General Comment drafted by the United Nations Committee on Economic, Social and Cultural Rights, the body which oversees implementation of this instrument, declares that obligations to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights, are not alleviated by a lack of resources. The General Comment lists deprivation of essential primary health care among a substantial portion of the population as one of the grounds for a fundamental violation.

Moreover, lack of resources was not the primary reason that the South African government failed to make a serious effort to respond to the health needs of the black majority. The health sector afforded a standard of health care for the minority white population comparable to many developed European countries, including high technology interventions. Apartheid policy mandated an intentional maldistribution of resources to the benefit of the white population. The priorities of the Ministry of Health also encouraged its staff to ignore serious health problems if they did not affect whites.

1. Failure to respond to serious health problems

"The apartheid government...failed to give appropriate attention to combating preventable diseases, particularly those that affected the black population."
Until 1968, all cases of kwashiorkor had to be notified to the government. Presumably since it struck seven whites and almost 11,000 non-whites in 1967, the government deemed it a useless waste of money to keep track of cases. According to an article published in 1981, "[a] spokesman for the Department of Health rationalized the removal of kwashiorkor from the list of notifiable diseases by stating that 'notification was far too time consuming,' "figures too inaccurate," and that a "general idea" of the prevalence of kwashiorkor had been gained by that stage."

In 1978 at a conference convened by the New York Academy of Sciences, the presentation of research of two South African researchers linking asbestos-related diseases to workers in asbestos mines was "suppressed" by the Medical Research Council of South Africa. The instruction to withdraw the paper was allegedly issued "at the request of the asbestos mining companies in the Northern Cape who wanted to prevent evidence of a link between blue asbestos and cancer being disclosed." 

Disease patterns reflect major differences in access to health care and socio-economic conditions. "Amongst Africans and coloreds, diseases of the respiratory system such as tuberculosis, pneumonia, enteritis and other diarrheal diseases as well as hypertension are major causes of death. The health system was, however, geared towards the disease patterns of whites, who, for example, had higher levels of ischaemic heart disease."

Patterns of Health Care

In one year R400 million was allocated to the Pretoria academic hospital (primarily white), while R15 million was allocated to the Medical University of South Africa (MEDUNSA — primarily black).

Per capita expenditures on health care for white South Africans were four times greater than the expenditures for Africans.

The per capita expenditures on health care in the Homelands in 1983-84 ranged from R16 to R45. In the Provinces the expenditures for curative care ranged from R79 to R127 per capita. "Only 12 percent of public health expenditures went to the homelands where perhaps 40 percent of the population lived."

The government paid the Smith Mitchell organization (now called Life Care), a private organization that provides custodial care for the chronic mentally ill and mentally handicapped, three times more for white patients than for black patients.

Homeland hospitals received approximately half the funding that provincial hospitals of the same size received. Infrastructure support was erratic.

As of 1983, high technology tertiary care comprised 97 percent of the health budget, while most of the population was not receiving adequate primary health care.

The Separate Amenities Act required separate hospital accommodations for different racial groups. Under the Act, a quota of approximately 5 percent of beds in designated white facilities could be used for patients of another racial group.

Until the early 1970s the government was not even authorized to provide psychiatric services anywhere but in hospitals. To some extent, the government got around this restriction by funding NGOs for community services, but this money went overwhelmingly to services for whites.

3. Failure to provide basic health services

- Black "[p]atients died because they were not given timely treatment which they could have received had they been from a different race group."
- There was a shortage of doctors in the homelands. The Department of Health provided no incentives for South African doctors to practice in rural areas where the quality of life was poorer than that in the cities.
- Doctors from other countries were willing to work in the rural areas of South Africa, but the South African Medical and Dental Council had difficult and inconsistent procedures for registering foreign doctors that limited their ability to provide medical assistance.
- Accessibility to private general practitioners for black workers is limited due to the high cost of care, "physical geographic separation (since the general practitioner's [offices] are often located in the better parts..."
of town), and social and cultural (language) barriers (as 80 percent of all doctors are white, while 70 percent of the population is African) — [according to 1983 figures].

- The government provided no incentive for general practitioners to immunize children. As a result there was high morbidity and mortality from preventable illnesses like the measles, particularly among poor, black children.

4. Failure to respect women’s reproductive rights

The Convention on the Elimination of All Forms of Discrimination Against Women\(^1\) condemns discrimination against women in all its forms and requires governments to establish legal protection of the rights of women on an equal basis with men. Article 12 applies these principles to the field of health care, including access to health services and those related to family planning. It specifies that States Parties ensure appropriate services in connection with pregnancy, confinement and the post-natal period, including granting free services where necessary.

The violations noted below go beyond the failure of the South African government to respect women’s reproductive rights and are indicative of the lack of willingness to respect women’s basic human dignity, particularly non-white women. The threat of reprisals, unless non-whites accepted family planning measures, was part and parcel of the apartheid system’s efforts to reduce the size of the black population in relation to the number of whites. Both the Women’s Convention and the International Covenant on Economic, Social and Cultural Rights contain provisions to require paid maternity leave for women workers and protection of their jobs while they are on maternity leave.\(^2\)

- “Midwifery patients...were often discharged immediately after birth, day and night, to wait for the next bus home” because of bed shortages. \(^3\)

- In some clinics large groups of black women were subjected to vaginal examinations in full view of each other. This was validated by a practitioner in 1982, who stated: “there was nothing wrong with this behavior since these women were not upset as they were ‘black’ and that ‘natives’ were more communal and don’t mind...” \(^4\)

- Until the early 1970s public sector black nurses could only be hired as temporary employees, and thus had no maternity leave, so they had to resign from their posts and reapply after they gave birth.\(^5\)

- “As late as the early 1990s, no female public servants were entitled to paid maternity leave and they had to prove marriage. Even to date paid maternity leave (84 days) is granted” only for the first two pregnancies or adoptions.

- Black women were injected with the controversial contraceptive Depo Provera, often without their consent, counseling, or being given another birth control option. White women weren’t even told about Depo Provera. Factories coerced black women to be injected.\(^6\)

- “Much of the so-called family planning services of [the Department of Health] were directed at controlling the size of the black population. In 1981, the Director-General of this department warned that sterilization and abortion might have to be made compulsory unless ‘certain ethnic’ groups accepted family planning measures. While fortunately this was not enforced, this laid the foundation for the Department’s approach to family planning.” \(^7\)

NOTES

1. We would like particularly to acknowledge the comprehensiveness of one submission, the Health and Human Rights Projects document, “Professional Accountability in South Africa,” June 1997. [Hereinafter “HHRP”]
3. The declaration was adopted by the UN General Assembly on December 10, 1948. Forty-eight states voted in favor, none against, and eight abstained (including Saudi Arabia, South Africa, the U.S.S.R and Yugoslavia).
5. CESC.
CEDAW.


Barry E. Carter


Ibid, p. 3-5.

Ibid, p. 5.


Id., p. 10.


Id. at 8.


Department of Health, p. 13.

Department of Health, p. 7.

Society of Psychiatrists of South Africa, p. 9.

Department of Health, p. 15.

Id. p. 11.

AAAS, p. 18.

Department of Health, p. 12.

van Heerden, Judith. Submission to the Truth and Reconciliation Commission of Dr. J. van Heerden of the Department of Primary Health Care at the University of Cape Town, p. 4, May 1997.

Department of Health, p. 10-11.


Id., p. 7-8.


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Department of Health, p. 4

Department of Health, p. 23.

Ibid., p. 18.


Ibid., p. 7.

Ibid., p. 4.

Medical Association of South Africa, p. 42.


Department of Health, p. 6, table.

Id. p. 22.

University of Witwatersrand, p. 13.


Society of Psychiatrists of South Africa, p. 4.

HHRP, p. 47.

HHRP, p. 47.


Department of Health, p. 19.

University of Witwatersrand, p. 11.

Department of Health, p. 19.

HHRP. My Career in Apartheid Medicine, p. 8.

Democratic Nursing Organization of South Africa, p. 11.

Id. p. 11-12.

Id. p. 12.


University of Pretoria Faculty of Medicine. Submission to the Truth and Reconciliation Commission. June 1997, Section 1.1, paragraph 5. Hereinafter “University of Pretoria”.


Id. Comment 6, paragraph 5.

Department of Health, p. 3.

Id. p. 2.


Department of Health, p. 4.

Health and Human Rights Project, appendix, untitled – Dept of Medicine, p. 18, table 12.

Department of Health, p. 4.

Ibid.


Id.

CESCR. Article 12.

AAAS, p. 13.


University of Witwatersrand, p. 34.

Id. p. 38.

HHRP. Supra note 37, Involvement by Military Health Personnel…p. 45; para. 4-5.

Id. Health Professionals as Victims of HR Abuses; p. 5; para. 3.

Department of Health, p. 21.


Department of Health, p. 13.

CESCR. Article 12, paragraph 2.

Id. p. § 2 (a).

Id. p. § 2 (b).

Id. p. § 2 (c).


AAAS, p. 12.

HHRP. The Scientific Justification; Page 7, para. 1.

Id. p. 8, para. 4.

Id. p. 4.

Pretorius (Deputy Minister of Health) and Melvin Freeman (Director of Mental Health, Ministry of Health). Interview by M. Gregg Blechc., June 25, 1997, p. 17.

Department of Health, p. 4.

Id. p. 5.

Society of Psychiatrists of South Africa, p. 3.

Giddy and Reid, section 1.2

Id. appendix, untitled – Dept of Medicine, p. 23.

Society of Psychiatrists of South Africa, p. 25 (appendix).

Zwi, Ruth (Director of Mental Health, Gauteng Province). Interview by Len Rubenstein, June 1997.

Department of Health, p. 18.

Giddy and Reid, section 2.1.1.

Id. p. section 2.1.4.

HHRP. Appendix (untitled – Dept of Medicine), p. 22

Giddy and Reid, section 3.3.

CEDAW.
Sector Analyses

A. The Role of Professional Health Organizations

During the long decades of apartheid, and in the century or more of essentially colonial and racist governance that preceded it, many organizations, groups and individuals contributed to the massive violations of human rights in the health sector. Chief among these, of course, were the successive Departments of Health (later, ominously, renamed the Department of Health and Population Control) as the authors of the policies and regulations that legalized and furthered rigid segregation, gross inequity and neglect, and pervasive racial discrimination in every aspect of the provision of health services.

A wide variety of health professional organizations served as willing—even eager—handmaidens to these efforts, by actively defending the apartheid social order and its structures and policies in the health sector, ignoring or denying its consequences to the health of subject populations and refusing to acknowledge, until far too late in the day, its violations of fundamental principles of medical ethics and human rights. On an individual level, a cumulative total of hundreds of thousands of physicians, dentists, nurses, psychologists and other health workers in both the private and public sectors, in varying degrees, supported apartheid health care or acceded to it without complaint, maintained segregated offices, delivered racially inequitable care, and in numerous instances were directly complicit in human rights and medical ethics violations that resulted in injury and death. A subset of this number—some of the district surgeons responsible for the care of prisoners and detainees—acted as co-conspirators with security police in torture, denial or neglect of even minimal medical care, violation of physician-patient confidentiality, falsification of records and other abuses.

In sum, apartheid support and racist ideologies and practices were pervasive in the health professions and their professional organizations, a chilling indication of the case with which the basic commitments of
medicine and its allied professions can be co-opted by political ideology. By no means, however, was this surrender total.

Any analysis must also recognize that there were thousands of physicians and other health workers who openly and persistently opposed apartheid and its health practices, often at great personal risk, and formed professional organizations that actively conducted the struggle on both the national and international levels.

1. The Medical Association of South Africa

The Medical Association of South Africa (MASA) is the national organization of physicians in South Africa, representing well over 10,000 doctors. MASA’s decades of compliance with—and often active support of—apartheid’s human rights violations are well documented in detail in a multitude of formal submissions to the TRC, most notably and extensively that of the Health and Human Rights Project, *Professional Accountability in South Africa,* and, in fairness, by the candid release of numerous and sometimes damning internal documents and records in MASA’s own submission.

There is no need here to repeat that history, so amply documented from so many sources. A brief summary analysis of its major features might be presented as follows:

- MASA never opposed, nor acknowledged, the health consequences of the Group Areas Act, the forced relocation of millions of people of color, and the life-threatening conditions and lack of health care in the resulting “homelands;”
- MASA consistently ignored the disastrous health consequences of virtually all other apartheid policies;
- MASA published pseudoscientific racist articles in its journal and never questioned the false biological and social premises underlying apartheid’s racial policies and legislation;
- For most of its existence, until 1989, MASA did not oppose racial segregation and, more recently, attempted to justify it by suggesting that “separate but equal” was a satisfactory policy;
- MASA cooperated actively with the apartheid Department of Health, bestowed honors on senior apartheid leaders, and developed a culture of being entirely comfortable with repressive and discriminatory policies;
- In the Biko case, MASA effectively supported the decision of the preliminary inquiry that absolved the physicians of any misconduct, accepted and supported the same ruling by the full South African Medical and Dental Council, argued against any re-opening of the case, attacked criticisms of these decisions as “political,” and suppressed the publication of dissenting articles and letters (including many from its own members) in its journal;
- MASA refused to acknowledge or investigate the many subsequent and massively reported instances of torture, police brutality and other abuses of detainees, including those cases in which the participation of district surgeons in assistance, cover-up or neglect was reported, and refused to support district surgeons like Wendy Orr who brought detention abuses to light;
- In 1983, a MASA Ad Hoc Committee of Enquiry into the medical care of prisoners and detainees noting evidence of “physical as well as psychological coercion,” asserted that it had not been able to establish conclusively the truth of many of the allegations, admitted that “there have been cases of serious maltreatment of detainees...that may have extremely serious and possibly permanent effects on (their) physical and mental health,” and proposed rigorous standards for the prevention of torture and the independence of district surgeons—and then suggested that all this be overseen by committees jointly appointed by MASA and the government responsible for the violations;
- Especially in the 1980s, MASA ignored the litany of deaths in detention and unquestioningly accepted the assurances of government officials that there were no human rights violations, despite evidence of abandonment of ethical responsibilities at every level from physical examination through diagnosis and treatment, to autopsy reporting, and including violations of confidentiality and physician identification of patients with gunshot wounds;
- Instead, MASA actively attacked those of its members who protested these policies, collected and published systematic evidence of abuses, or sought court interdiction to prevent them, and vehemently opposed
or dismissed the efforts of NAMDA and other anti-apartheid health organizations, both domestic and international;

- During much of the 1980s, at least, MASA's ruling body, the Federal Council, was effectively controlled in turn by physician-members of the Broederbond, and on occasion the Council published blatantly political statements describing township violence as a "Soviet-inspired assault on South Africa" and "a Marxist-Leninist-inspired effort to bring political change by overthrowing the present South African government by any means." This faithfully echoed the rationale offered by the apartheid government: that a "total onslaught" justified the State of Emergency and all its attendant repressions.

No brief summary of this sort can adequately represent the thousands of pages of testimony about MASA's role that have been submitted to the TRC. Taken as a whole, they describe, for a significant majority of South Africa's white physicians and the professional organization that represented them, the effective abandonment of fundamental medical ethics and human rights commitments in defense of a political ideology and maintenance of a racist status quo. This history is hardly unique to South Africa: to a significant degree, it reprises the behavior of much of the medical profession and its organizations in Nazi Germany, the Soviet Union, and other totalitarian states in this century. The facility with which such commitments can be undermined, and the frequency with which this has occurred even after the Nuremberg trials and the formal adoption of international instruments defining the human rights obligations of health professionals, should be matters of grave concern.

Starting in about 1989, MASA started taking a very different posture than the one it had adopted in the past. It adopted the World Medical Association policy on hunger strikers, issued a statement deploring detention without trial, and called for a non-discriminatory society and the end of apartheid.

In its submission to the TRC, MASA highlighted these changes, contending that it has "assumed a role in social responsibility," begun to "develop a human rights initiative which has had a number of worthy successes," re-examined its principles and established a "law and ethics team" to offer practical assistance to doctors "faced with human rights dilemmas."

The centerpiece of the "new" MASA was its June 1995 public "apology" for its failure to oppose apartheid policies. It stated:

MASA has never embraced a race-based policy and its membership has always been open to all, irrespective of race, color or creed. However, the Association was perceived both at home and abroad, as an essentially white organization and a captive of the political status quo. In this respect, MASA remained silent about race-based public policies affecting the medical profession, the restriction of medical school admissions on race, segregation of hospitals and other health facilities, the maintenance of separate waiting rooms by members of the profession, the involvement of medical doctors in the treatment of prisoners and detainees, and there are others. Furthermore, the Association was perceived as, and probably was, insensitive and indifferent to the lot of its black members such as when branch meetings were scheduled at venues where they were legally barred. In the spirit of national reconciliation and to the extent that through these and possibly other acts of omission or commission, the Association may have caused offence or hurt to persons within and outside of the medical fraternity, MASA offers an unreserved apology. We are confident that our commitment to the MASA credo and the code of conduct will ensure that we can more explicitly and pro-actively address similar matters in future. This statement is a statement of intent and promise and we hope it will stand as a beacon of the completion of our transition.  

This formal apology was promptly questioned by critics as a self-declared and collective blanket amnesty, when many individual doctors had not disclosed their own involvement in human rights violations. In this view, the apology was a suspect and superficial transformation; it implicitly attempted to close the books on the past, and specifically to obviate the need for ongoing, case-by-case investigation to achieve professional accountability for the physicians involved, through active
participation, collusion, neglect or denial, in the tens of thousands of documented cases of torture and other gross violations reported to the TRC. Other critics called attention to MASA’s long acceptance of the “lesser” crimes of the apartheid medical establishment, such as the harshly restrictive and humiliating conditions of undergraduate and graduate medical training for non-whites.

The submission made by MASA to the Truth and Reconciliation Commission mirrors the apology; it is a mixture of forthright admissions and concessions on specific points of previously denied (but now documented) internal decisions and statements, on one hand, but half-truths, disingenuous and misleading qualifiers, euphemisms, internal contradictions and vague promises, on the other. In these respects it reflects the organization’s slow and grudging movement from a sordid human rights past toward an accommodation with the commitments of post-apartheid South Africa.

For example, in its introductory account of what it calls MASA’s “human rights development,” the submission concedes that from its inception in 1927, “MASA was relatively silent on human rights initiatives and was part of the apartheid system,” but adds that this was true only “until 1977 (the year in which Steve Biko died).” In fact, MASA did not declare its unqualified opposition to apartheid medicine and apartheid itself until 1989, and was a systematic and unwavering supporter of apartheid abuses throughout most of the intervening years. During this 1927-81 phase, the submission states, “there were one or two minor incidents of conflict with other medical associations at the World Medical Association...” These “minor conflicts” include, among others, MASA’s expulsion from the Commonwealth Medical Association and its effective expulsion (disguised as a voluntary resignation) from the World Medical Association in response to protests from outraged medical societies in many other nations.

In the next phase of its “human rights development,” the written submission suggests that from 1982-88 “MASA actively began to address its human rights role” and then adds, without apparent irony, that “the period started with justification and defense of apartheid medicine.” It goes on to claim that “MASA began a series of human rights initiatives surrounding children in detention and the care of prisoners and detainees, but these initiatives were not successful.” In fact, as its own documentation and the TRC submissions of other organizations make clear, during this period MASA never opposed the detention without trial, interrogation and imprisonment of children—as many as 30,000 children, by reliable estimates—but rather proposed terms and conditions to make such incarceration “acceptable.” Similarly, its only active intervention regarding the medical care of adult prisoners and detainees was to negotiate a deal with the apartheid government under which a panel of volunteer MASA members, subject to screening and approval by security forces, would be available to such prisoners for “second opinions” on their medical problems, if prisoners requested their help and could afford to pay their fees.

Some of these issues are discussed in the final sections of MASA’s formal submission to the TRC. These sections, particularly the one entitled “understanding the context,” include much more detailed and specific admissions of culpability than does the brief “MASA Apology” mentioned above.

Most notably, the submission refers to attempts to change the structure of MASA’s membership and governance by merger with “other doctor organizations”—its progressive opponents of the past. It calls for general human rights training within medical ethics education, special human rights training for district surgeons and forensic pathologists, and formation of a health and human rights organization to “provide a mechanism by which investigations into human rights violations may be conducted.” These commitments were accompanied by publication of previously suppressed letters concerning MASA’s behavior in the case of the Biko doctors in the June 1997 issue of its journal, the South African Medical Journal.

In our view, these are important initiatives and can be seen as hopeful signs of a new commitment to human rights. Paramount among them is the reported effort to form what would be in effect a truly new professional organization, combining MASA with the Progressive Doctors Group on terms that might, for the first time, give the interests of South Africa’s majority population a dominant voice in the organization’s leadership and policies. Of necessity, however, these are “top-down” initiatives. Any lasting transformation also requires “bottom-up” change—that is, the full acknowledgement of past error (and, where it has occurred, individual involvement in violations) by all of South Africa’s physicians, and the true incorporation of a human rights ethic into their daily practices.

At the same time, the leadership from the past must demonstrate its commitment over and over again not simply through statements of intent, but through action. The June issue of the South African Medical
Journal editorialized that, "[a]n examination of medicine in our country suggests that racism, which has pervaded every aspect of our society, is the underlying cause that has resulted in the gross violations for which we bear collective responsibility." MASA states that it wants to cleanse that racism. It has taken some steps in that direction. It must take many more.

2. The National Medical and Dental Association

The history of the National Medical and Dental Association (NAMDA) is testimony to the fact that compliance and complicity with apartheid and apartheid medicine did not uniformly characterize South Africa's physicians. Among their number were more than a thousand men and women of all racial groups who were willing to act openly and vehemently to oppose the abuses, and ethical and human rights violations of the apartheid system; to document its effects; and to campaign on both national and international levels for change. (There were undoubtedly thousands more who shared this opposition. Many elected to emigrate; others were silent or merely financial supporters rather than formal organization members.) In the process, they created an alternative to MASA—a professional organization that viewed apartheid medicine as intrinsically unethical, acted on that principle, and demanded professional accountability.

They did so at substantial risk. Members were harassed and sometimes arrested and detained without trial by security police. The homes of some NAMDA leaders were bombed, and many others received death threats. NAMDA offices were raided, probably by security police, and computer files and other documents were stolen. Members were effectively barred from employment in the health system's public sector, which was controlled by the government. Many medical student members had to flee into exile to avoid imprisonment.

NAMDA was formed by 52 physicians in December 1982, in concert with the creation of the Health Workers Association, which enlisted non-physician health workers in the same cause. During the ensuing decade it worked closely with its professional and lay counterparts, including the Organization for Appropriate Social Services for South Africa (OASSSA), the Detainees' Parents Support Committee, the South African Council of Churches, and a number of local ad hoc medical and dental committees. Although its base was strongest at academic medical centers, NAMDA's membership included doctors and dentists in private practice and in both urban and rural areas.

From 1982 to 1992, when it merged with other progressive organizations to form the South African Health and Social Services Organization (SAHSSO), NAMDA conducted seven major programs:

- Care of former political prisoners and detainees and their families. Jointly with OASSSA and the Detainees' Parents Support Committee, NAMDA established clinics for the physical and psychological examination of released detainees who had suffered trauma, and arranged for follow-up medical and psychological care and counseling.

- Provision of emergency medical care for victims of state violence. NAMDA sent doctors into townships after police assaults on peaceful demonstrators, since victims (often with gunshot wounds) were either blocked from access to hospitals or feared arrest if they were seen there. Doctors treated such patients in churches and other safe facilities. When this program was systematically hampered by police harassment of the physicians, NAMDA helped to form a National Emergency Services Groups Network, at seven regional bases across South Africa, to train local community residents as community health workers. Training committees of doctors, psychologists, and nurses provided materials and instruction in basic trauma and psycho-supportive first aid.

- Documentation of the standardized interviews with recently released detainees. NAMDA provided evidence that shocking percentages—from 75 to 96 percent—had been beaten, tortured with electrical shocks, subjected to partial suffocation, burned with acid, held in solitary confinement for long periods, or subjected to other abuses under detention. More than half of the respondents had never been seen by a district surgeon; of those who were, more than 65 percent believed the medical history and physical examination to be inadequate. The NAMDA survey, widely reported though denied official publication in South Africa, provided some of the strongest evidence to refute government denials of abuse.
Conduct of a national campaign to expose the effects of apartheid on health. NAMDA campaigned to end the segregation of hospitals by race, to open all hospital facilities to all races, and to achieve de facto integration of in-patient facilities.

Research and initiatives on health policy. NAMDA prepared and published detailed policy papers on a national health system for South Africa, health care financing, and medical education.

International campaigns. These were among the most important and effective of the organization's initiatives. NAMDA members published papers on the health effects of apartheid medicine, detention and other abuses in medical journals in the United States, the United Kingdom, the Scandinavian countries and elsewhere. The organization established contact with human rights organizations in the U.S., Europe and the Third World, and cooperated in the formation of NAMDA support organizations in those countries.

NAMDA officers and members made international speaking tours (when they were able to obtain permits to travel outside South Africa). Directly and indirectly, NAMDA made repeated and effective appeals to international and national professional medical associations to exclude MASA and similar South African professional organizations from participation. To deepen the international pressure that was being applied to South Africa, NAMDA called for an academic boycott to limit outside professional contact and visits to MASA, DASA, South African government agencies and academic centers that supported apartheid. As a corollary, NAMDA engaged international agencies to provide support to enable black South Africans to receive health professional training abroad.

Special programs. NAMDA physicians served as volunteer observers at post-mortem examinations of victims of apartheid state violence, provided funds for the funerals of such victims, assisted trade unions with health and safety programs, and, later, assisted with the health needs of returning South African exiles.

In many of these respects, NAMDA was thus a diametrically opposed image of MASA, and a signal that even under the most oppressive conditions there will be physicians who recognize social responsibilities and struggle to maintain ethical and human rights standards.

In 1992, NAMDA merged with other progressive organizations to form the South African Health and Social Services Organization (SAHSSO). Following the elections in 1994, many NAMDA leaders and members assumed senior positions in government service. A core group of former NAMDA doctors rallying around the umbrella of the Progressive Doctors' Group began discussions with MASA in 1995 about forming a united medical association and agreed to merge in October 1997. The future of the South African medical profession's commitment to human rights may well depend on the success of the former NAMDA members in influencing both the governance and the values of MASA members. The veterans of NAMDA's decade of work should be an important resource for the ongoing restructuring of South Africa's health care system, for provision of medical care to address the continuing physical and emotional needs of former detainees, and for the accomplishment of ethical and human rights training for the entire health work force.

3. Psychology

The profession of psychology in South Africa promulgated and reinforced many of the racist ideas underlying apartheid. By the 1920s, theories of black inferiority were becoming part of the "scholarship" of psychology in South Africa. Psychologists proposed legislation to limit job opportunities for blacks and severely penalize sexual relationships between the races. This tradition continued throughout most of the 20th century: theories of black inferiority flourished while little attention was paid to the problems of the effects of racism and oppression on the black majority in the country.

One of the profession's architects was Dr. Hendrik F. Verwoed, a professor of psychology at Stellenbosch, who later became prime minister. Verwoed embraced psychiatric genetics, which theorized that blacks are genetically inferior and suitable only for manual labor. He saw the future of South Africa at great risk if blacks were permitted to improve their skills and draw better wages. As the profession of psychology evolved, additional theories of black inferiority emerged. When he became prime minister, leading psychologists approached him to extend the Group Areas Act to ban meetings between blacks and whites.
The behavior of professional associations reflected this stance. In 1957, a black person applied for membership in the South African Psychological Association, fueling a debate that lasted for years. In 1962, blacks were finally admitted to the Association, which in turn triggered a walkout by whites who formed the explicitly pro-apartheid Psychological Institute of South Africa. The two organizations finally merged in 1983 to form the Psychological Association of South Africa (PASA), which had no racially exclusive clauses. However, as the Health and Human Rights Project points out, this merger did not amount to a political statement against apartheid and did not end control by conservative forces within the profession. On the contrary, race-based psychological theories remained tolerated and even encouraged within the Association. PASA did not take positions against apartheid, or even against pervasive use of torture.

Despite this stance by the institutions of the profession, psychology, like the other health professions, also included those who sought to fight apartheid. Some of these individuals joined with other social service workers to form the progressive Organization of Appropriate Social Services in South Africa (OASSSA). In 1987, the Institute for Clinical Psychology called for removal of apartheid structures, an end to indefinite detention without trial and solitary confinement, unconditional cessation of the detention of children, the reinstatement of freedom of speech and removal of restrictions on the media, and the lifting of the state of emergency.

Individual psychologists played an important role in human rights abuses under apartheid, particularly in the prisons. Some psychologists became agents of the security forces by seeking information from political prisoners and detainees. Others participated in torture.

When apartheid ended, the Psychological Association of South Africa dissolved, and a non-discriminatory organization, the Psychological Society of South Africa, now represents psychologists in South Africa. The society is still dominated by the 85-90 percent of members who are white. Of the few black psychologists in the profession, only a handful speak African languages.

With the end of apartheid, there is an enormous need for skilled professionals who can help people cope with trauma or post-traumatic stress. But psychology has remained focused as an academic field with little attention to the needs of the population as a whole. Efforts are underway to organize black psychologists and to encourage them to be responsive to the needs of South Africans.

4. Nursing

The apartheid state went to great lengths to maintain segregation within the nursing profession. Laws enacted in 1957 and 1978 kept black nurses off the boards of the South African Nursing Association and the South African Nursing Council. Later, black nurses were excluded from the South African Nursing Association entirely. Registers segregated by race perpetuated separate and unequal professional standards. By 1973, the International Council of Nurses sanctioned the South African organization for its racist composition and policies.

Black nurses were especially ill-treated. Their education was inferior to that of white nurses, as they were forced to train in badly equipped hospitals and, later, nursing colleges. Their schools had far more limited resources than those of their white counterparts. Inferior education was matched by extraordinarily difficult working conditions, characterized by long hours, jobs at locations far from their homes, and degrading treatment by white superiors. They were routinely deprived of their dignity on the job. For example, no black nurse could supervise a more junior and less experienced white nurse. Black nurses on white wards were often relegated to menial tasks like emptying bedpans or serving tea. One result of these policies was to put patient health at risk, since the skills of black nurses were ignored even when they were essential for the well-being of patients. The black nurse was trained, most of all, to play a subservient role. Those who dared to speak out were labeled as troublemakers, dissidents, or even enemies of the state.

Nursing, however, was one of the first of the health professions to make a commitment to end discrimination within the profession. In 1978, the South African Nursing Association sought to end the policy allowing only whites to be represented on the Nursing Council. Still, its commitment to an anti-apartheid stance was not thoroughgoing: when, in 1985, black nurses engaged in a strike against apartheid and its denial of equal pay and working conditions, the Association condemned them for bringing the profession into disrepute by engaging in a prohibited strike.

Beginning in 1992, nursing organizations worked toward unifying the profession under principles of non-discrimination, finally resulting in the
establishment of the Democratic Nursing Organization of South Africa (DENOSA) in 1995, which replaced the South African Nursing Association and associations from the homelands. The formation of the DENOSA is an important step toward the development of a culture of human rights among nursing professionals and a means of assuring that human rights are sustained in South Africa's health care system.

The challenges facing the nursing profession are daunting. Training institutions still tend to be separated: while formerly white institutions have brought black students in, formerly black institutions have remained largely black, principally as a result of their location in former homelands, poor infrastructure, and lack of adequate housing. The nurses' strike of 1995 illustrates the problems on the ground. It concerned working conditions including patient load (including as many as three patients to a bed), inadequate facilities, and a shortage of supplies.

B. Health Professional Regulatory Bodies

Under apartheid, the South African Medical and Dental Council (SAMDC) and the regulatory bodies of other health professions reinforced the institutions of apartheid and abdicated responsibility for disciplining health practitioners for human rights violations. Submissions to the health sector hearings of the Truth and Reconciliation Commission and our own interviews demonstrate the existence of a disciplinary apparatus that shielded individuals from accountability for human rights violations they committed. These violations included deprivation of medical care to individuals in detention, breach of confidentiality for political reasons, racial discrimination in health services, and filing of false or incomplete reports of injuries or torture of detainees.

Since apartheid ended, the Interim Councils have not taken steps that demonstrate their capacity to protect human rights against violations by health professionals within their jurisdiction. We believe that current proposals for changes do not go nearly far enough in restructuring the disciplinary process to vigorously protect human rights in the health sector.

1. The Medical and Dental Council

(a) The Council and apartheid

The South African Medical and Dental Council is the quasi-governmental professional organization charged, among other responsibilities, with investigating alleged breaches of medical ethics, including neglect or abandonment of medical responsibilities, falsification of medical records, violations of confidentiality, and other violations. It also advises the government on certain health policy questions, licenses physicians and makes recommendations on medical education. Its more recent successor, the Interim National Medical and Dental Council [Interim Council] has the same responsibilities and is essentially the same organization, now incorporating representatives from the former puppet government homelands of Ciskei and Transkei. Much of its senior staff is unchanged; its Registrar, Mr. N. M. Prinsloo, submitted both written and oral testimony to the TRC.

Under the apartheid regime, the Council not only failed to address human rights abuses committed by health professionals, but by both acts of commission and by silence and inaction, it in effect encouraged such violations. Its submission to the TRC, in our view, constituted an appalling defense of the old SAMDC's dismal failures to require professional accountability for violations, and its repeated demonstrations of support for the apartheid regime without regard for fundamental medical ethics.

The Council's submission to the Truth and Reconciliation Commission acknowledges that the Council was part of the apparatus of apartheid in the sense that those who were members of the Council occupied leadership positions in government and apartheid society and believed in and sought to implement the policies of apartheid. As the Interim Council's submission to the TRC states:

...the SAMDC functioned in a society of which virtually every member of the politically-dominant class was steeped in doctrine and propaganda. The SAMDC did not act the way it did because of direct state involvement, since governmentally appointed members were in the distinct minority. The Council acted as it did because of the milieu in which it functioned.
The Council never saw a conflict between the goals and policies of the apartheid regime and the imperatives of medical ethics and human rights. For example, in many cases, notwithstanding the principle of confidentiality between physicians and patients, the Council adopted a position that alleged “terrorists” who sought urgent treatment should be reported by providers to the police. Similarly, it refused to take a position on whether people who received gunshot wounds should be reported to the police. The Council took no action on the operation of separate medical facilities segregated by race or the Separate University Education bill, which separated medical schools by race, and acknowledges even now that no consideration of the human rights violations manifested by such policies was ever given. It was not until 1989 that the Council even “disapproved” of the practice of refusing to treat persons of a particular race. But even then it took no further action. It took until 1992 to “disapprove” of separate waiting rooms.

The Council’s submissions to the TRC also refrain from discussing its role in the cases of other individual physicians alleged to have committed serious human rights violations. Instead it consists mainly of generalizations, and even omits discussion of the disposition of complaints against physicians concerning such violations as complicity in torture, failure to provide medical care to detainees, and obvious breaches of confidentiality.

The Council also professes ignorance. The Council’s submission indeed states that “[T]he members of the Interim Council who were members of the SAMDC state that they are unaware of decisions taken by the SAMDC or its predecessors...in order to willfully effect discrimination on the basis of race, gender, culture, religion or any other consideration...” Of course, the Council had no need to vote to “willfully effect discrimination,” since state policy already did that; the ethical failure was the Council’s refusal to oppose discrimination in health care and to decline to discipline physicians who engaged in human rights violations.

In short, the Council has demonstrated a willful failure to come to terms with its past. Information about the Council’s response to complaints of discrimination and its complicity in human rights violations, however, is not hard to find in human rights reports and elsewhere. Lawyers who represented detainees informed us of numerous instances in which physicians—usually district surgeons—covered up the existence of torture by the security police or even filed false reports involving the medical condition of detainees, but discipline was imposed by the Council in only a
handful of cases. And when discipline was imposed, it was far lighter
than the infraction would warrant. A Dr. Niemann, for example, who
falsely claimed that a detainee’s injuries were the result of smoking, not
torture, was suspended for only 6 months. Other physicians who were
alleged to have committed violations appear never to have been investi-
gated at all even after the cases were brought to the Council’s attention.18

The violations that warranted investigation fall into many categories.
Many involved people jailed or imprisoned. The violators include physi-
cians who filed false reports, covered up assaults by security police ot
prison officials, refused to provide medical care to detainees or provided
them with grossly inadequate care, breached confidentiality by providing
information about intimate medical details to security officials, or exam-
ined detainees for the purpose of assuring their suitability for torture.19
Other human rights violations warranting investigation include turning over
or reporting individuals wounded in political violence (or in peaceful dem-
onstrations, attacked by the security forces) to the police, breaching pa-
tient confidentiality in political cases, refusing to treat black South Africans
in need of medical attention, shackling patients to hospital beds, discharg-
ing individuals who remained in need of hospitalization to the police, and
denying access by family members to hospitalized patients.

We are not aware of any plan by the Council to review these past
violations now or in the near future. The submission says that the Interim
Council will not grant amnesty “in respect of professional conduct of reg-
istered health practitioners” but urges “voluntary reporting of instances
of questionable conduct” so that these can be “taken into account as a miti-
gating factor.” There is thus no explicit commitment to an ongoing inves-
tigation of apartheid-era violations, despite the fact that thousands of
submissions to the TRC by victims of abuse have involved district sur-
guere and other physicians, the vast majority of whom are apparently still
in practice and have neither offered testimony nor been called to account.
We have been informed by physicians, lawyers, human rights groups and
others that many of the individuals who are alleged to have committed
violations still remain in practice and, in a significant number of cases,
continue employment as district surgeons or hold positions of responsibil-
ity in universities, government, and elsewhere.

We have little confidence that the Interim Council will have either the
political will or the investigative resources to carry out its mission, and—
above all—to function with community participation and statutory public
oversight, rather than—as in the past—as a mechanism for exclusively
self-protective professional self-regulation. These questions are critical to
the goal of securing and maintaining ethical principles, eliminating racism
and protecting human rights in the health sector.

(b) Human rights standards for the medical profession

The Council has promulgated no standards of ethics or human rights
for physicians and other health professionals to follow. It has no institu-
tional knowledge of or even concern for human rights. Indeed, it does not
appear to conceive of itself as having responsibilities in the area of human
rights. In its disciplinary work, its staff informed us that the Council only
uses the statutory standard of unprofessional conduct, and it is up to the
individual investigating committees to decide what that means in a par-
ticular context. There are no standards for treatment of prisoners, for
respect for confidentiality, or even for protection against discrimination.
Indeed, Council staff informed us that it does not discipline a physician or
other professional within its jurisdiction for engaging in racially discrimina-
tory conduct. This state of affairs is unacceptable.

(c) The Council’s disciplinary procedures

As applied to human rights violations, the Council’s procedures are
problematic and appear to serve the interests of doctors who commit vio-
lations rather than the victims of human rights violations. The Council is
an unwieldy disciplinary body. It is very large, with 53 members, and yet
has only a skeleton professional staff in the disciplinary section. Their
duties are principally administrative, and not the investigation or prosecu-
tion of cases.

The Council has little capacity to engage in a thorough and impartial
investigation of human rights violations. Developing a case of a human
rights violation against a professional is a complex process, involving int-
erviewing witnesses, gaining and examining records, assessing evidence,
and managing the investigation. Often it involves non-medical as well as
medical witnesses and questions to investigate. But the Council has no
investigative staff of its own and relies on a group of practitioners (and one
non-physician) appointed as a committee to engage in the initial
investigation of a complaint. These physicians are not specially trained in
disciplinary investigations, much less in human rights. The lack of professional staff, trained and experienced in investigations of professional misconduct related to human rights, means that investigations are slow and often lack thoroughness. The Council sometimes has difficulty gaining records from those under investigation.

Other elements of the basic investigation procedures, which have not changed since apartheid ended, impede investigation of human rights cases. In the typical case of any allegation of professional misconduct (including one that involves human rights violations), when a complaint is received, it is sent to the accused doctor, who is given a chance to respond. There is no public access to the content of the complaint. Neither is there an emergency discipline or suspension procedure that could be used in the case of physicians who pose an imminent risk to the public.

There are no time limits set for the health professional to respond to the allegations. It is not uncommon for the physician to request and receive three or more months for a preliminary response. Complaints can also be delayed while other proceedings against the doctor are pending.

Most complaints end at this preliminary investigation stage. Only a small percentage of all complaints go to a formal, public hearing, and no record is kept of the reasons why complaints are not pursued. Neither the complainant nor the public is provided information about these cases. We have no data on complaints filed by race, and it is unclear what relevant to a determination of its full role in apartheid are kept.

When hearings are held before members of the Council, there are often difficulties regarding appropriate rules of procedure and evidence. The public has no role in the entire process. Complainants are not kept informed of the disposition of complaints and are given little opportunity to participate in the hearings. When discipline is imposed, there is no written decision or explanation of reasons for the decision.

We express no views on whether these procedures are adequate to address cases of professional misconduct like malpractice or other violations of duty not involving human rights violations. They have been demonstrated to be inadequate, however, to address professional misconduct involving human rights violations.

2. South African Nursing Council

The South African Nursing Council's (SANC) role in apartheid was similar to that of the Medical Council; it was an arm of the apartheid state. If anything, the Council was employed even more explicitly to support the policies of apartheid than the Medical and Dental Council.

Starting in 1957, the law prevented black nurses from serving on the Council and required separate registers of nurses by population group. Although black nurses were subject to the Council's jurisdiction, they had no right to vote. In 1978, the Council composition was designated as five white nurses, three black nurses, and one colored and one Indian nurse.

The law reached deeply even into day-to-day clinical practice. Section 49 of the Nursing Act of 1957 made it a criminal offense to place a white nurse under the supervision of a black nurse.

This legal structure, combined with the leadership role the Council was expected to play in society, led to a role very similar to that of the Medical and Dental Council. For example, like the Medical and Dental Council, the Nursing Council was perfectly well aware of segregation in health treatment, but accommodated it instead of protesting against it. And like the Medical and Dental Council, it remained a cog in the apartheid state rather than a defender of the ethics of a profession. In its submission to the TRC, the Interim Nursing Council acknowledges that it was far less concerned with health or professional standards than with the maintenance of power and privilege. For example, the Council admits that it:

- Ignored the denial of treatment, even for emergency care, on the basis of race.
- Accepted without protest gross inequalities in nurses' training by race.
- Failed to take any steps to improve health care facilities for blacks.

Its record in investigating gross human rights violations is as appalling as that of the Medical and Dental Council. It concedes that it failed to engage in proper inquiries when former political prisoners or detainees alleged violations of human rights by nurses in prison or jail hospitals.

Some episodes go unmentioned in its submission to the TRC, however. In 1985, 800 black nurses went on strike to protest discrimination in
pay and working conditions as compared to white nurses and to demand an end to apartheid health policies. The strike was prohibited under the 1978 Nursing Act. In response, over a period of two and a half years, more than 800 nurses appeared before the Nursing Council and many were disciplined for “disgraceful conduct.”

There is, however, one major difference between the posture of the Nursing Council and that of the Medical and Dental Council as apartheid neared its end. By the end of the 1980s, the nursing profession, under severe international pressure, began to move toward non-racial policies. In 1988, the Council issued a statement on medical neutrality in treating prisoners, including political prisoners. The policy required nurses to provide care in saving lives and relieving pain and suffering regardless of the political beliefs of the patient, to refrain from restraining a prisoner on other than medical grounds, and forbade nurses from participating in torture.

In 1989, the Council petitioned to remove all racial references from the Nursing Act. This change did not take place until 1992.

Finally, the Interim Council states in its submission to the TRC: “We therefore wish to apologize unreservedly both for the conscious and unconscious activities that could have had the effect of undermining human rights from time to time.”

It commits itself to a future course of action to advocate and protect the human rights of all nurses and patients and, importantly, advocates reparations for victims of violations by the former Council.

Welcome as the Council’s commitment is, it does not go far enough. It must establish procedures that assure that human rights violations will be adequately investigated and decided, and make a commitment to reopen cases from the past so that nurses who violated human rights can be held accountable by their professional regulatory body. Moreover, its composition must better reflect the racial composition of the nation.

C. Education and Training in the Health Sector

Health education has far-reaching and long-lasting effects for health personnel and their health practices. It has a formative effect on conceptualizations of health and human suffering, and consequently the scope of professional interests in society. Furthermore, educators provide role models which students often emulate, and ideas about questioning authority and one’s role in relation to the state.

In South Africa, education and training in the health sector played an important role supporting the racist ideology of apartheid. Support of the political aims of apartheid is evident in years of highly discriminatory selection processes of medical and other health professional students and discriminatory and demeaning treatment of students of color. Such discrimination served to establish and maintain a health care system that primarily served the health interests of white South Africans.

Under the University Extension Act of 1959, “non-white” students were accepted into universities only with ministerial permission. The University Extension Act and the Bantu education system effectively excluded most Africans from being educated as health practitioners. Indian, colored and Chinese students were generally given approval for admission into medical school, but Africans were usually refused ministerial consent. According to the Ministry of Health, in 1978, 83 percent of Indian and 95 percent of colored applicants were granted permission, compared to only 29 percent of African applicants. Between 1968 and 1977, 88 percent of all new doctors were white (whose percentage of the population was less than 20 percent) and 3 percent were African (who comprised about 70 percent of the population).

Discrimination in the selection of health professional students has had profound effects on the composition and geographical distribution of health care providers in South Africa. According to Kale, more than 25,000 doctors are registered in South Africa to serve a population of about 40 million. The number of doctors who are actually in practice is probably lower because of emigration. Between 1975 and 1981, as many as 30 percent of graduates from the English-speaking universities left South Africa. In 1985, 94 percent of specialists and 83 percent of all doctors were white. The number of non-white students admitted to medical colleges has increased in recent years. The distribution of doctors is skewed in favor of urban areas and the Western Cape province, which has nine times more doctors than the northern Transvaal. More than half of South Africa’s doctors are in the private sector, which serves only 20 percent of the population. In 1990, of the nearly 155,000 nurses in South Africa, over half were Africans, a third were white and over 21,000 were colored. The distribution of nurses is also skewed. The Western Cape area has three and a half times as many nurses as the northern Transvaal.
Dentists, pharmacists, and other supplementary health professionals are also maldistributed. Most of the 2,900 community pharmacists are concentrated in urban areas. One pharmacy serves 616 white people, whereas black people have only one pharmacy to every 232,992 people. Fewer than 4,000 dentists serve South Africa's 40 million people and most are in private practice. Those who are not in the private sector do little more than pull teeth. The dentist to population ratio in the northern Transvaal region is 1:50,000, and is even lower in the former homelands.25

During apartheid, the government developed educational programs in the health sector specifically for black students. Many believe that the founding of Medical University of Southern Africa (MEDUNSA) in 1976 was part of the “grand apartheid” plan, which was aimed at having fewer black doctors trained at “white” universities. Increasing the number of black doctors and other health professionals also served to maintain the health of the black labor force and to prevent the spread of diseases from black migrant laborers and domestic workers to white communities. MEDUNSA has produced more African doctors than any other medical school in South Africa. Some consider health education at MEDUNSA to be racist and second class, while others see it as affirmative action for those denied access to white institutions due to the inadequacy of Bantu education.

During the apartheid years, students in the health sector experienced discriminatory and demeaning treatment. In many cases, health educators served as models of supporting extreme discrimination. Most training institutions that were attached to white hospitals prohibited black trainees from examining and treating white patients. White students, on the other hand, were able to examine and treat all patients. When black students were allowed into the “European” hospitals, they were often not allowed to wear their white coats or stethoscopes. Black students generally were not allowed to attend professorial ward rounds since they were conducted in white hospitals. In the 1980s, black students were permitted to examine white patients, but not those who had obstetric or gynecological problems. For many years, black students were not allowed to attend post-mortem examinations of white bodies. Because of the Group Areas Act, black students trained at “white” universities were not allowed to stay at any of the official university residences for many years. This meant that students had to find their own accommodations and finance their daily commute to the medical school and health facilities. Personnel working in the same facility and with the same qualifications had separate toilets and separate tea rooms. At the University of Natal, black students were not allowed to use the sports facilities or library on the main campus. In fact, black students were not allowed to wear the blazer with the emblem of the University. Such discriminatory conditions persisted after graduation in the form of less pay for equal work and being bypassed for promotion and appointments to administrative positions. Marked differences in resources and funding of health facilities which served people of color had a major influence on the quality of education for non-white students in the health professions.26

After 1986, health professional schools were permitted to admit black students to the student body. Affirmative action programs developed at a number of institutions. From 1986 until 1990, the University of Cape Town Medical School admitted into its six-year MBChB program the top African applicants who were eligible (by virtue of completing some college), irrespective of these students’ competitiveness with applicants of other races. This affirmative action program proved unsuccessful in the absence of academic support programs; only 46 percent of these students passed the first year on the first attempt, and by the fourth year, only 15 percent were still on track and 36 percent had been excluded from the school.27

In 1991, the University of Cape Town Medical School instituted the Medical Academic Support Program (MEDASP) and African students achieved greater success. The program enabled the students to complete the first three pre-clinical years of the regular program over four years, and sought to enhance the students’ study and language skills and to supplement their backgrounds in physics and chemistry. Students then entered their clinical training on an equal footing with the regular program colleagues. Forty-five percent of students in their fourth MEDSAP year were still on track (having reached the third year of the regular program) and, while 23 percent had been excluded, these exclusions mostly occurred at the end of the first year. In 1994, Africans accounted for 24 percent of admittees, whites made up 45.3 percent and 30.7 percent were from other minority groups.28 Academic support programs achieved similar results at other institutions. A number of medical schools have now committed to increasing black enrollment.
During apartheid, health education failed to include human rights and bioethics concerns in virtually all health institutions. Health education and practice in South Africa focused primarily on tertiary medical care. Historically, health educators have provided students with disease-based conceptualizations of health and human suffering which neglected the importance of social determinants of health. National regulatory bodies such as the SAMDC and SANC are responsible for setting standards in health education. In 1986, the SAMDC required only one hour of "medical ethics" training among undergraduate medical students. Consequently, most students in the health sector have received little or no formal training in bioethics. Despite the lack of leadership among national health regulatory bodies, traditional bioethics training has developed at the University of Cape Town and Witwatersrand medical schools in recent years through considerable efforts of individual health educators at these institutions.

The importance of including human rights concerns in education is only just beginning to be recognized in the health sector. Unfortunately, bioethics training in South Africa has focused primarily on codes of conduct which regulate clinical encounters with individual patients. Such codes of conduct have not been applied to the health consequences of human rights violations; nor have they been interpreted as a mandate to protect and promote rights as a means of promoting the conditions for health and well-being. Bioethicists and individual health educators are increasingly recognizing the importance of human rights education for health practitioners. Over the past few years, several elective courses in health and human rights have been offered, particularly at the University of Cape Town School of Medicine. Such courses represent important steps in understanding the relationship between health and human rights and actively engaging health practitioners in the protection and promotion of human rights.

In the future, systematic inclusion of human rights concerns in health education will depend largely on leadership from national health regulatory bodies and health professional organizations. Given the intimate relationship between these organizations and the apartheid state in the past, it is not surprising that human rights concerns were excluded from health education. What is perhaps more disturbing is the persistent lack of concern for human rights education among these organizations today. The health sector hearings demonstrated that these organizations have not embraced the notion that health promotion requires health practitioners to protect and promote human rights nor recognized their responsibility to provide effective leadership to this end. The TRC's health sector recommendations hopefully will serve as a wake-up call for the effective inclusion of human rights education in the health sector.

D. District Surgeons and Prison Medicine

District health services, which employed the district surgeons, were local agencies administered by provincial and municipal health authorities and overseen by the national Department of Health. Among their responsibilities, district surgeons cared for prison inmates and other detainees, and performed forensic examinations on those who died or were injured while in prison or police custody. The district surgeon was usually a detainee's only health care provider and often the only connection to the outside world. Thus, the district surgeon occupied a particularly important position, and had a unique opportunity and responsibility.

1. District surgeons and South African law

The only specific regulation which deals with the medical care of detainees states that a detainee shall be examined medically by the medical officer as soon as practicable after his or her arrest or detention and as shortly as possible before his or her release from detention. The regulation also provides that the head of a prison shall ensure that any medical or dental treatment for a detainee prescribed by the medical officer be carried out promptly. Finally, medical or dental treatment by a medical practitioner who is not the medical officer may be provided only on the recommendation of the medical officer.

In practice, there are no prison medical officers and the medical care of detainees has fallen to district surgeons. The district surgeon has a statutory duty to treat patients entrusted to his or her care. The common law also imposes upon the district surgeon an affirmative obligation to care for injured or ailing detainees of whose condition he or she is aware.

Notably, unlike the security police, district surgeons enjoy no special immunity by reason only of their statutory obligations. In other words, a district surgeon cannot defend him- or herself against the charge that he
or she actively participated in torture or otherwise failed to satisfy his or her responsibilities to a detainee patient, by asserting that his or her doing so was part of a good faith effort to advance domestic security.  

District surgeons (and prison medical officers) are employed by the Department of Health and Population Development. Yet, it is the view of a leading authority on medical law that, in their work with detainees and prisoners, these physicians fall under the control of the Commissioner of Prisons. Regardless, the responsibilities that these doctors have to their patients are independent of the employment hierarchy in which they physician operate.

2. District surgeons' behavior during apartheid

While there was considerable variation in district surgeons' attitudes toward their patients and in the quality of care they provided, district surgeons did, in the main, accommodate themselves to the dehumanizing system in which they were operating. District surgeons commonly participated in abuses by failing to record and investigate apparent signs of abuse, by not providing or insisting on appropriate treatment, and by not respecting doctor-patient confidentiality.

While failing to record and investigate apparent signs of abuse and not insisting on appropriate treatment are obviously violations of professional responsibility, breaching doctor-patient confidentiality is also quite serious as it further erodes the quality of care; as detainee-patients observed the frequent presence of security personnel during medical consultations and as they learned of the common release of medical records (which are the property of the health service) to prison authorities without their consent, they understandably reacted by withholding important information about the nature and origin of their injuries.

While it appears that district surgeons did not generally participate actively in torture, they rarely spoke out against inhumane practices, and more than a few either submitted false evidence to cover up abuse or torture or failed to report any relevant findings at all. While there were a few bright spots, those few who spoke out against the abuses received little support from their colleagues, suggesting that the problem was not limited to a few 'bad apples.' It must also be acknowledged that the variation in district surgeons' performance also went in the opposite, less positive direction.

More than 70 political detainees died in detention between 1960 and 1990. And, in some cases, medical negligence was an important contributing factor. Further, it should be noted that the district surgeons' silent complicity worsened the problems toward which they turned blind eyes. By overlooking the medical evidence of torture, district surgeons contributed to the myth that the government cared for those in prison. Thus, the South African problem mirrored that in the Soviet Union, where mental health professionals abused medicine and patients by saying that those individuals had diseases which, in fact, they did not, so that they could be confined to mental hospitals. South Africa's district surgeons supported the regime by abusing medicine in ways that allowed the regime to continue to abuse its citizens.

3. Factors contributing to district surgeons' inadequate performance

Internationally, the prevailing wisdom is that medical professionals who become involved in torture are typically unexceptional, and that situational factors are quite important. Regardless of the physicians' eagerness, district surgeons' actions took place within a particular context, and context can either make it relatively easy for a physician to fulfill his or her responsibilities to his or her patient, or extraordinarily difficult for a physician to avoid culpability. Accordingly, we review below various aspects of the context within which district surgeons operated and consider the way in which these aspects contributed to gross violations of human rights. Many are discussed elsewhere in this report and we summarize them here.

(a) Dual responsibilities

The relationship of health professionals in a prison system to their detainee-patients is a difficult one in any society because the health professionals' medical and ethical responsibilities to their patients may conflict with their perceived responsibilities to the prison system which controls and directs their work. This conflict was especially pronounced for those charged with treating detainees. District surgeons operated in an environment of indefinite, incommunicado detention in which courts accepted confessions obtained via torture, and security forces were immune from prosecution for their role in human rights abuses as long as they...
acted in good faith. Such a desensitizing, authoritarian context fosters disrespect for human rights.\(^45\)

Further, South Africa’s detention took place within the context of the apartheid system. The psychological distance that apartheid succeeded in placing between the white world of the district surgeons and the black world of the detainees fostered disrespect and human rights abuses.\(^46\) The force of this factor is augmented by the fact that the government justified detention by telling its white supporters that detainees posed a threat to order. In fact, it seems that district surgeons were often fearful of their patients and sympathetic to the goals of the security police; it is far from clear that most doctors involved in human rights abuses felt that they were doing anything other than their patriotic duty.\(^47\)

(b) Workloads

Mass detentions dramatically increased the workload of already overworked district surgeons.\(^48\) This burden encouraged them to focus less on providing adequate care and more on getting through the patient load. Although district surgeons responsible for detainee care were not unique among physicians in facing excessive patient loads, the workload encouraged district surgeons to adopt practices (such as cursory group examinations) that conveyed a lack of caring, undermined the doctor-patient relationship, and made it less likely that a detainee would disclose his injuries and discuss their origins. Thus, we believe that, in the detention context, the patient-load hardened district surgeons’ attitudes and made it easier for them to fail to see or to overlook the evidence of torture.

(c) Isolation

District surgeons operated alone in this inhospitable environment,\(^49\) and a ban on publicizing alleged abuses increased their psychological isolation. Specifically, the State of Emergency regulations prohibited the unauthorized publication of conditions in detention, the names of detainees or their whereabouts. Publishing allegations from an unconcluded judicial proceeding about detainee treatment could lead to a ten-year prison sentence.\(^50\) Thus, a district surgeon recognizing human rights abuses likely did so alone and without knowing that the problem was widespread and was being judicially contested.

(d) Medical education

Partly as a result of segregated and unequal pre-medical and medical education, the overwhelming majority of South Africa’s physicians are white. Second, training in medical ethics and human rights was inadequate. Taken together, these aspects contributed to the social distance between district surgeons and their detainee-patients, increased the physicians’ sympathy for the apartheid regime, decreased physicians’ understanding of their responsibilities, and contributed to a medical culture that tolerated gross violations of human rights. Thus, these two aspects of medical education contributed to district surgeons’ inadequate performance with respect to detainees.

(e) Ignorance of national and international law

While the district surgeons’ responsibilities under international and South African law are quite clear to us, they were, apparently, less clear to many district surgeons. For example, district surgeons apparently did not know that they could override wardens on medical matters.\(^51\) In fact, it seems that district surgeons’ source of understanding of their role was often gleaned in passing from the police.\(^52\) Of course, there is a clear conflict of interest and genuine education is unlikely when the police are the district surgeons’ source of information on his or her responsibilities to his or her patients and his or her authority to insist on treatment over the police’s objections.

District surgeons’ ignorance was, in another way, the product of governmental policy: the District General of the Department of Health, for example, issued an order preventing doctors from attending a lecture on medical ethics.\(^53\)

(f) Lack of enforced codes of behavior

While they are important guideposts, international standards are too often enforced late, or not at all. Accordingly, we look to national disciplinary bodies to set standards, investigate complaints, and exclude from professional activity those who compromise codes of conduct. As noted above, the South African Medical and Dental Council’s rule-making and disciplinary procedures proved wholly inadequate to regulate district surgeons’ treatment of detainees.
(g) The fallacy of neutrality

District surgeons’ sympathy for the security police’s goals, their ignorance of the law, the lack of clear, public mechanisms for accountability for their conduct, and their fear of reprisals encouraged district surgeons to accept the notion that they were merely neutral. Rather than being neutral, physicians have the obligation to protect their patients.

(h) Lack of peer leadership—the role of medical associations

It is very important that doctors receive institutional support to stand against the pressure to participate in abuse. Yet, South African medical organizations did not support physicians when they were at risk of becoming compromised in unethical practices. Until the 1980s, MASA took the view that, because the SAMDC bore responsibility for regulation and because MASA was a private organization, it had no medico-ethical responsibilities. Accordingly, MASA’s official journal, the South African Medical Journal, curtailed publication of critical comment and documentation on detention.

Further, while MASA did remind district surgeons of their duties to patients, it did not provide clear guidelines as to the specific course of action they should follow if faced by evidence of torture or other forms of abuse of detainees, and it declined to criticize the practice of indefinite, incommunicado detention, asserting that this was a political question beyond its sphere of authority. Yet, neutrality did not block MASA from asserting that “to date no conclusive evidence has been submitted that any assault in fact took place against Steve Biko,” and that “the use of violence, from whatever source, cannot be condoned but it must be realized that the police have a duty to perform, frequently under very difficult circumstances.”

While using its purported neutrality to justify its not condemning the practice of indefinite, incommunicado detention, MASA urged reform of the detainee health care system. But even here its effort was underwhelming. For example, in 1983, MASA’s Ad Hoc Committee to Institute an Inquiry into the Medical Care of Prisoners and Detainees issued a report calling for a legislative guarantee of prison doctors’ clinical independence; criminalization of police interference with a district surgeon’s access to a detainee; an active program for peer review of the medical treatment district surgeons gave to detainees; and allowing detainees the right to an examination by an independent practitioner. Yet, the report did not give district surgeons specific guidance as to what steps they should take to protect their detainee patients, and the report did not pledge the organization’s support to a district surgeon who encountered difficulties in his or her efforts to fulfill his or her obligations. Further, nothing came of the report for two and a half years. Then, when the government’s only concession was to allow detainees to request medical care from alternate doctors who had been approved by MASA and the security police, MASA hailed this as a “major breakthrough” which would prevent incidents like the one involving Steve Biko. MASA did little when it was clear that detainees were reluctant to use doctors who had been approved by the security police as a prerequisite to their eligibility. Further, in 1985 and 1986, the Association did little to support district surgeon Wendy Orr when she sought to protect her patients against from torture.

(i) Persecution of outspoken health care workers

In any society where violations of human rights are prevalent, complaints to the police of mistreatment of detainees may endanger the very people the health professionals are trying to protect. In addition, health professionals may fear that the complaint will not be considered seriously or without bias by the investigating body. The experience of then-district surgeon Wendy Orr, who was victimized for her efforts to protect detainees, points to the validity of these fears. Further, health professionals may themselves be at risk if they report violations of human rights. In fact, members of the health professions did not escape the general suppression of dissent in apartheid South Africa; health professionals have suffered harassment for offering medical treatment to former detainees and victims of violence and for speaking out on behalf of human rights. They themselves were banned, restricted, detained without trial, tortured, and murdered.

E. Mental Health

Apartheid systematically and explicitly denied the human rights of people with mental retardation and mental illness. Racially segregated hospitals housed tens of thousands of people, and the facilities for the black majority received only a third of the funds available to whites.
Community-based programs have enabled people with mental disabilities throughout the world to escape stultifying custodial confinement, but in South Africa their availability was constrained by legal limitations, academic indifference, and a government interested principally in custodial confinement. Many of the most basic rights of people with mental disabilities were not—and still are not—recognized in law.

Apartheid inflicted pain and psychological trauma on millions of black South Africans, from the violence the regime inflicted on the young to the denial of human dignity embodied in the apartheid laws and their implementation. The impressive work of trauma centers in South Africa does not meet the enormous and continuing need for treatment and rehabilitation.

1. Human rights, mental illness and mental retardation

People with mental illness and mental retardation are especially vulnerable to discrimination and abuse in many parts of the world. In South Africa, apartheid greatly exacerbated this problem since black people with mental illness and mental retardation were doubly stigmatized and systematically subject to discrimination on the basis of both race and disability. During the past twenty years, many reports have demonstrated the effect of apartheid on people with mental disabilities. A 1977 World Health Organization (WHO) report found "gross inequalities" in mental health care. It also expressed grave concern about the institutionalization of thousands of South Africans in private facilities (then known as Smith Mitchell facilities) that provided only custodial care for people with chronic mental illness and mental retardation.

Reimbursement for patients in these facilities, WHO found, was three times greater for institutions housing white patients than for those housing blacks. Two years later, an American Psychiatric Association inspection of Smith Mitchell facilities found grossly inferior conditions for blacks as compared to those for whites, needless deaths in institutions, unacceptable medical practices, physical abuse, and inadequate hygiene, housing, and clothing. It also reported on the destructive impact of apartheid on black individuals and families. In 1981, another WHO report focused on the lack of data on psychiatric morbidity or research into the impact on black individuals and families of apartheid practices such as the forced breakup of families and forced migrations.

As part of its 1989 report, Apartheid Medicine, the American Association for the Advancement of Science examined mental health services under apartheid. It noted the tiny number of blacks trained in Western mental health professions and the lack of incorporation of aspects of traditional healing into therapy. It reported on the continuing fragmentation of services by race, particularly in efforts to develop community-based services. In the area of mental retardation, AAAS noted that, in addition to other factors, urbanization and the disruption of the African family impeded the development of adequate support services. Institutional conditions had improved in the Smith Mitchell facility AAAS visited, but the quality of acute psychiatric care in three public hospitals was highly variable. Overall, AAAS found that apartheid prevented the rational allocation of mental health resources and made continuity of care extremely difficult.

In February 1995, Dr. Diamini-Zuma, Minister of Health for South Africa, appointed a Mental Health and Substance Abuse Committee to address issues relating to the provision of mental health services. The Committee was chaired by Professor T.B. Pretorious, and included representatives of universities, the Department of Health, the Medical Association of South Africa, Lawyers for Human Rights and others. In November 1995, the Committee issued its report, entitled "Human Rights Violations and Alleged Malpractices in Psychiatric Institutions.

The lengthy report was based on visits to dozens of public and private psychiatric institutions and addressed concerns ranging from basic living conditions to staff training to due process and human rights. The report identified major human rights violations, particularly in formerly black hospitals and formerly black sections of hospitals. Although the report has been criticized for methodological flaws, the raw observations of the Committee show how thoroughly and deeply institutions housing thousands of South Africans violate their human rights. These violations include gross inadequacies in housing, basic sanitation and nutrition; sexual abuse; racial discrimination; abuses in the use of physical restraints and denial of medical treatment; over-medication; lack of complaint systems; lack of privacy; and assaults on patients by staff. Some of the facilities were filthy. To our knowledge, no follow-up has taken place to the investigation and report.
In the fall of 1996, the American Psychiatric Association (APA) sent a delegation of thirteen professionals, led by its former president, Mary Jane England, to South Africa to assess the state of mental health services in South Africa. The delegation visited four medical school departments of psychiatry and met with government officials, TRC members and business leaders. It found major personnel shortages, dependence on an institutional model of services, lack of family or consumer participation and, among white professionals at least, a sense of paralysis regarding hopes for change. The report did not specifically address human rights, particularly among institutionalized people, nor mental retardation services.

The APA team recommended technical assistance to nurses, social workers, families and consumers, and psychiatrists regarding multi-disciplinary community-based systems of mental health care, de-institutionalization, support for families and consumers, and guidelines and treatment protocols.

The submission of the Society of Psychiatrists of South Africa to the TRC summarized the circumstances of people with mental illness and mental retardation in South Africa succinctly: “Psychiatric patients remain a vulnerable group for discrimination and abuse of Human Rights. Both the mentally ill and the mentally handicapped [retarded] are clearly stigmatized and thus discriminated against.”

During the apartheid period, however, the Society failed to provide significant leadership in addressing these abuses. As a tiny organization whose membership ranged from 100 to 150 members over the years, the Society felt under siege from the stream of reports attacking apartheid and psychiatrists' role in it. In 1984, a call was made to expel the Society from the World Psychiatric Association. Though this movement and similar efforts later in the decade failed, the Society acted defensively rather than taking the initiative to promote human rights.

In 1985 the Society took the position that it would strive for the elimination of all forms of discrimination that harm mental health, but it fell short of calling for an end to apartheid, and many of its statements were equivocal at best. For example, in 1986, it issued a statement on the mental health effects of criminal detention. The statement notes vaguely that “detention in isolation, solitary confinement and immoderate interrogation may, in our opinion, damage the mental health of many persons so detained.” It noted, however, that “justice must be done and security maintained,” and advised that “this should not be done in a manner that diminishes the dignity of the individual or the integrity of his or her mind and body.” It did not call for any specific actions to release political prisoners, stop torture, or otherwise protect human rights. As in the other professional societies, it was left to courageous individuals to speak up strongly against apartheid and its policies.

The leadership of the Ministry of Health is acutely aware of the staggering problem of mental health services in South Africa. The Ministry has reached out internationally to gain technical assistance in the area of mental health services, particularly to develop strategies to develop a training and service infrastructure for community-based mental health programs. In addition, the TRC has requested the National Institute of Mental Health in the United States to make recommendations concerning the impact of torture trauma on South Africans, and what can be done to address it.

Our visit focused exclusively on human rights, not on the state of mental health and mental retardation services in South Africa. It is impossible, however, to ignore the human rights implications of the organization of services, including widespread custodial institutionalization, denial of opportunities to live decent, independent lives, and blatant and rampant discrimination on the basis of mental disability.

We note the limitations of our inquiry. We visited only one psychiatric hospital and met with only a few individuals in government, NGOs and universities. We did not visit any forensic unit. The individuals we did meet with, however, have a great deal of knowledge about the system and included responsible officials in the Ministry of Health and Gauteng Province. We also reviewed the South African Mental Health Act, which deeply affects the human rights of people subject to it. Our findings and recommendations thus constitute an outline of a human rights evaluation in mental health and mental retardation, rather than firm conclusions.

We found the following human rights violations against people with mental disabilities (the term encompasses people with mental retardation and mental illness):
(a) There is inadequate recognition in law and in the culture that people with mental health problems or mental retardation have human rights

The very first step in assuring respect for rights is to recognize that they exist. For people with mental illness and mental retardation, these rights include the right to be treated with dignity and equality as a human being, to have treatment in one’s own community in a manner that is responsive to one’s needs, and to be treated in accordance with basic notions of due process. Despite the existence both of constitutional provisions stating that all people enjoy equal rights and forbidding discrimination on the basis of disability, and of international standards, there is very little recognition of the fundamental human rights of a person with mental illness or mental retardation. Similarly, in accordance with international standards, consumers and families should have a right to participate in planning and carrying out treatment.

The South African Mental Health Act does contain some protection for certain personal and property rights, but this is insufficient and, in any event, lacks mechanisms to assure that individuals are aware of these rights and can enforce them.

i. The law does not provide that people with mental illness and mental retardation have the civil, political, economic, social, and cultural rights other citizens enjoy. Nor does it provide that no inference should be drawn in the absence of an adjudication of incompetency regarding a person’s lack of competence to exercise such rights.

ii. It does not provide for non-discrimination in services.

iii. It does not recognize a person’s right to live and work in a community. On the contrary, the law is entirely based on an institutional model of services.

iv. It does not recognize the right to treatment suited to a person’s cultural background.

v. It does not recognize the right to treatment in the least restrictive environment appropriate to the individual’s health status.

vi. It contains no definable standard for involuntary civil commitment. Instead, a person may be hospitalized under a circular rule, that the person has “mental illness to such a degree that he should be committed to an institution.”

vii. It provides for no due process in civil commitment proceedings. Under the law, a magistrate receives reports from one or two medical practitioners about the person’s condition, which is the basis for an order by the magistrate. The person subject to such an order has no right to notice of the content of the evaluations nor a hearing to contest them. The law contains no provisions for lawyers to represent individuals subjected to these proceedings, much less at state expense. Hearings are entirely at the discretion of magistrates. When proceedings are held at all, they are held in private.

viii. It does not recognize the right of institutionalized people to confidentiality, to visitors, to mail, to decent living conditions, or to treatment in accordance with professional standards.

ix. It does not provide adequate safeguards with respect to the deprivation of control over property or medical decision-making for a person with a mental disability. Magistrates are empowered to make inquiry as they deem necessary, including summoning the person to a hearing regarding an allegation that the person is incapable of handling property or funds. But the person is not entitled to a hearing, nor to representation by counsel before his or her decision-making power is removed.

x. It does not recognize or protect the right to consent to treatment.

xi. Although the law takes some account of the existence of mechanical restraints and seclusion, it does not provide adequate substantive standards or procedural safeguards regarding their use.

xii. It does not provide for resources or mechanisms for patient advocacy. On the contrary, the law makes it a criminal offense to make false reports without taking reasonable steps to verify information about conditions in facilities, with the burden on the person accused to prove that reasonable attempts were made to verify the information. A consequence has been to stifle outside reviews.

xiii. It does not provide patients with safeguards as potential research subjects.
It does not distinguish individuals with mental retardation from people with mental illness. The consequence is that people with mental retardation are often placed in psychiatric institutions where they do not belong and which have no programs designed to meet their needs.

To its credit, the Ministry of Health is in the process of developing a new mental health law. It plans to involve stakeholders in the process.

(b) A continuing legacy of racial segregation in institutions

The government has ended official segregation, and the public psychiatric facility we visited in Pretoria was indeed integrated. The problem is that many custodial institutions have such a low turnover of residents and such long lengths of stay that they remain substantially segregated and will remain so unless people are released.

Historically, white institutions have had a far higher reimbursement rate than black institutions. Elements of this disparity remain today. Funding levels among historically black facilities remain lower in many instances than those facilities that were historically white.

(c) A legacy of an institutional model of services long after the model had been abandoned in the mental health and mental retardation fields

In the past three decades, the fields of mental health and mental retardation services have undergone a virtual transformation, in part due to the recognition that individuals with mental disabilities have human rights. One of the most fundamental of these is the right not to be locked up in an institution simply by virtue of carrying a diagnosis of mental illness or mental retardation.

This transformation has been a product, too, of the emergence of interventions to promote the human rights of people with mental disabilities, such as education and support of children with disabilities and training in independent living. The world over, people with mental illness and mental retardation are being treated in the community and trained in the skills of daily living, work, and independent or quasi-independent living. Children with mental retardation and serious emotional problems attend public schools. As a result, large facilities that once housed people with mental illness and mental retardation for life, and thus denied them an opportunity to participate in community life, are closing, replaced by normal housing with supports.

In South Africa, until the 1970s, the law actually prohibited the government from operating community-based mental health services. Today 90 percent of state funds remain committed to institutions. A few NGOs have established community-based programs, and they have a good record. But they are few in number. The imbalance in types of services has also impeded the emergence of professionals skilled in community-based services for people with serious mental illness. In particular, social workers, who play a central role in organizing and providing these services, have virtually no role in service provision to this population.

People with mental retardation are not even recognized by the government as a group with a separate and distinct set of needs from people with mental illness. They are housed in the same hospitals, despite the fact that hospitalization is almost never appropriate for a person with mental retardation not otherwise in need of medical care. Community-based training and housing programs are rare.

The Ministry of Health is seeking ways both to develop community mental health programs and to integrate mental health treatment into general health services. The obstacles to this effort are serious and include the need for professional training and development (particularly in the field of social work), the lack of any tradition of community psychiatry for people with severe mental illness within the field of psychiatry, the severe shortage of funds for developing community resources, lack of a strong advocacy movement, the need to avoid discharges when there are no community programs in place, and resistance to change among staff working in institutions. The Ministry of Health has sought international assistance for a transition to a community-based, integrated model of services, and some model programs are under development, but the challenges remain staggering.

(d) To the extent that community-based programs were established at all, they were designed primarily for whites

The legacy of apartheid is also evident in community-based services, where blacks were systematically starved of programs and funds. The scope of the problem was illustrated by a paper written by Dr. Ruth Zwi, Director of Mental Health services for Guateng Province at the time of
to the bucket that substituted for a toilet or latrine. The door of the room contained nothing but a slotted opening. Their clothing consisted of a “uniform” of striped pajamas.

(f) Reports of involuntary sterilization of people with mental retardation

In the past, it was state policy to sterilize young women at state institutions and homes operated by NGOs. We received multiple reports that this policy is largely unchanged, and that large numbers of people with mental retardation were and continue to be sterilized involuntarily. We were unable to confirm whether this practice takes place or, if it does, how widespread it is, but believe it warrants investigation as a major human rights violation.

In any event, the law does not require informed consent to sterilization.

(g) Lack of advocacy or legal support under current law for people with mental disabilities

In other countries, the protection of human rights of people with mental illness and mental retardation has been a product of a strong and well-organized movement involving consumers and their families. Despite the strength of civil society in South Africa, people with mental illness and mental retardation and their families lack strong organizations compared to those that exist in many other parts of the world and there are few resources and little training in human rights and how to protect them.

As a result, not only do people with mental disabilities have few rights, but there are exceedingly few advocacy resources available to them. Institutionalized people especially have very little access to assistance from advocates for problems that arise in institutions, with concerns regarding their treatment, or with civil matters outside the institution. There is a pressing need for support of the development of consumer and family advocacy organizations.

2. The psychological legacy of apartheid

The turbulence caused by physical dislocation and the social stress stemming from apartheid has produced an exceedingly large number of
social and psychological problems for individuals and the society. The impact of prolonged and intensive institutionalized state sanctioned oppression permeates every facet of national life and has affected hundreds of thousands of people.

Forced removal of some three to four million African people eroded social and personal relationships. Tens of thousands of people, overwhelmingly persons of color, and including women and children, have endured detention, torture, a persistent atmosphere of generalized violence and bereavement and the constant oppression of living under apartheid. The extent of violence against children under apartheid was extraordinary, high, and well documented. Unemployment still remains at 35-40 percent. It is those among the ranks of the oppressed, disproportionately black, powerless and poor, who are in greater need of help. Emotional damage is compounded by time and neglect. If not addressed it will cause dysfunction in society most likely to express itself in mental illness, dependency and violent behavior.

Even today, South Africa is a violent society, and this is perhaps one of apartheid's most insidious legacies. The violence of apartheid begot violence in the form of crime, child abuse, and violence against women. In the Eastern Cape Province, for example, we were told that there has been an explosion in cases of child abuse and in the number of children under the age of five diagnosed with sexually transmitted diseases. Violence even takes place in the examining room of clinics, so much so that studies are underway to document the extent of violence against patients seeking obstetrical care. Many adolescents who may once have channeled their anger, sense of dislocation and hopelessness, and disconnection from social institutions into a political vanguard are now drawn to violent crime.

The suffering from the violence and degradation experienced by people under apartheid, combined with the extent of violence today, is one of South Africa's major social problems. Trust among neighbors essential to a sense of personal safety and security is compromised through proliferation of random acts of violence and disregard for human rights and personal property. Unrest and insecurity have had a corroding impact on family life and psychological well-being at all levels of society.

The process of healing is complicated by the cultural divides within South African society. This is a daunting task even in situations where therapist and client draw upon a common cultural base to guide the process of thinking, perception, comprehension, memory and reasoning. In South Africa, where practitioners and patients are of profoundly different cultures, speak and/or think in different languages, and hold different beliefs about the purpose of life, God, disease, death and the hereafter, the ability to provide meaningful therapy is severely compromised.

In South Africa the obstacles to reciprocal understanding across cultural boundaries are profound. The majority population is African while the dominant models of practice within the mainstream are grounded in European thought and culture. These models are overwhelmingly controlled by professionals of European descent who are poorly prepared for cross-cultural practice.

Mental health resources within the formal sector are unequal to the task as the majority of those in need of treatment occupy worlds of thinking, perception, comprehension and reasoning outside the field of knowledge of the majority of practitioners. Western-grounded practitioners often are not trained in communication with ancestors whose participation is often perceived as essential to restoration of wholeness. The barriers of language and culture are formidable, even among black professionals. Very few black psychologists, for example, speak African languages.

There are, however, sources of strength to address these barriers. There are existing pools of traditional professionals such as healers and diviners as well as Africans trained in Western systems who are able to contribute powerfully toward overcoming barriers to care within the domain of formally recognized mental health workers.

Social Workers. About 20 percent of South African social workers are members of ethnic communities of color. Most of these professionals speak African languages and understand traditional African norms and values and were excluded from providing staff services for treatment programs that were based on a medical model. In 1993, the South African Association of Black Social Workers (SAABS) Conference on Violence and the Consequences of Violence on Families and Communities recommended that community cultural systems treatment in addition to individually focused treatment and prevention be urgently implemented. As many black social workers themselves live within neighborhoods and communities experiencing extreme stress, the readiness to act and resolve to commit were high. The Association of Social Workers
recognized the need for additional training, to enable practitioners to work more effectively in assessing needs and planning strategies to design and promote culturally appropriate models for treatment and prevention.

During our visit in June 1997, we revisited several of the organizers to assess their movement toward objectives identified in the 1993 conference. They faced the major obstacle that the hoped-for funding from government and international agencies had not materialized. Private agencies that previously provided funding have shifted resources to support of government agencies, which are perceived as less able to carry forward the mission of healing begun by NGOs during apartheid. Likewise, community programs focused on building trust and capacity lacked funding notwithstanding their demonstrated success. Still, these workers remain committed and many are directly involved in counseling abused persons on a volunteer basis. Several told of personal hardship in carrying out this role as their salaries were small. They are not paid for treating the victims of violence.

Reactivation of SAABSW’s resolve to treat victims of violence is a strong potential resource as many have grounding in both traditional and Western cultures. Black social workers are an underutilized resource in efforts to treat trauma and provide the balm needed to build new relationships across ethnic and racial barriers. Professor Mazibuko of Natal University School of Social Work, the immediate past president of SAABSW, spoke eloquently and powerfully of the need to construct healing and treatment within a context of coherence for African peoples. She told of efforts to develop self-help support group methodologies that would be maintained by victims of disorders related to torture and dislocation. A study group commissioned by SAABSW proposed short- to intermediate-term training of a cadre of lay counselors who would then organize and facilitate support group activities for social workers who are themselves in need of intensive training in work with post-traumatic stress and related disorders. Professor Mazibuko believes this strategy to be the most promising of those considered to meet the urgent needs of the majority of people with mild to moderate dysfunction.

The Clergy. Pastoral counseling is a vital task for the clergy. Many clergy occupy positions of respect and trust within the communities they serve. Encouragement and perhaps an invitation to take courses to enhance understanding of common disorders and mechanisms for referral will enable them to improve and expand services to their communities.

Faith structures within the framework of ecumenical world bodies of Muslims, Christians, Jews, Hindus, Buddhists and others might be asked for help in designing appropriate curricula. The World Council of Churches in Geneva is well situated to provide leadership in this type of effort.

Healers and Diviners. The vast majority of South Africans suffering post-traumatic disorders seek help within the framework of traditional African mental health systems. They do not perceive Western practitioners as offering treatment responsive to their needs. For example, Western practitioners may not recognize the symbolism of dress and color important in traditional societies in the treatment process. Many African peoples distinguish between African illness and European illness. By the same token, visions, dreams and prophetic revelation as evil-cleansing forces are not well understood by most Western-trained providers.

When powerful cultures meet, syncretism or integration of world view is often the better pathway. Both African and Western patterns of treatment have much to offer. There are, within South African society, persons familiar with more than one cultural perspective. There are models of successful integration in various societies. The health of the Chinese people improved under a system able to integrate traditional and modern treatment systems. Indeed, the World Health Organization has called for dialogue toward integrating health care. One of the fastest-growing and most influential religious movements in South Africa, the Zionist Church, owes much of its appeal to the coherence it lends to those who must live in both European and African societies.

With its rich, culturally-grounded systems of healing, South Africa too may find this strategy key to provision of urgently needed care for its wounded. For example, Professor Mthobeli Guma of the University of Western Cape, trained in his youth as a diviner, also holds degrees in public health and anthropology. Such persons should be called upon to help build pathways to broadened understanding and cooperation across philosophical barriers. Work carried out by WHO should inform those charged with this task in South Africa. At the same time, the discussion of licensing healers and diviners is complex. Not every person who claims to be a traditional healer is such. The challenge of integration is daunting.

Trauma Centers. These centers, like the Center for the Study of Violence and Reconciliation and the Trauma Center for Victims of Violence and Torture, provide high-quality services for victims of trauma and violence that combine Western and traditional methods. The Trauma
Center for Victims of Violence and Torture, for example, runs programs for returned exiles, refugees, torture survivors, former political prisoners, and victims of rural and urban violence. The Center for the Study of Violence and Reconciliation offers clinical treatment, outreach services, women’s and children’s services, and services for perpetrators and caregivers. At present, more than half of its caseload consists of victims of domestic violence and sexual assault.

Both centers use methods that combine Western and African modalities, especially in groups. The programs include family support for victims of violence. The overwhelming problem is that the demand for trauma center services astronomically exceeds the supply.

F. Military Medicine in South Africa

Unlike virtually every other military medical service in the world, South Africa’s military forces physicians and other health professionals have been organized since 1979 as an entirely separate armed services branch. A three-star general with a medical degree commands the South African Medical Service (SAMS), which provides care to army, navy, and air force personnel, but is constituted as a distinct, administratively co-equal military organization. The SAMS has included doctors, nurses, psychologists, and non-professional, military-trained medics. In theory, this unique administrative structure might be expected to nurture a separate medical culture within the military, respectful of the profession’s ethical tradition, including the Hippocratic commitment to keeping faith with patients. In practice, SAMS conceived of its organizational role differently. As the SAMS commander, Major General Neil Knobel, told the TRC’s health sector hearings, SAMS’ priorities were “firstly, to insure a healthy security environment and secondly, to insure a secure health environment.”

In theory and in practice, SAMS conflated its health and state security functions, engaging in a wide range of clinical, research, and other activities in support of the apartheid regime’s campaign against its opponents.

Like military doctors in other countries, SAMS personnel provided care to soldiers wherever they went. However, this meant that SAMS personnel accompanied South African troops on incursions into Angola and Namibia that violated international law, and on domestic operations against the regime’s opponents. In this role, SAMS physicians were almost uniquely well situated to learn of injuries to civilians and combatants suggestive of torture or other abuses. Neither the TRC hearings nor our own inquiries yielded direct evidence that SAMS personnel participated in atrocities during these missions or in other ways breached the duties of medical personnel in armed conflict under the relevant Geneva conventions and protocols. Neither, however, did we turn up evidence that SAMS personnel ever reported medical evidence of human rights or humanitarian law violations to anyone outside the military command system.

SAMS personnel played a more active state security role through the primary health care they provided to black civilians in some areas, including within the former homelands. During the 1980s, the security forces shut down private medical clinics in some townships and rural areas in an effort to forestall the development of community institutions into centers of resistance to the regime. SAMS filled the gap, becoming the main provider of health services to blacks in many rural areas as part of the state’s effort to prevent its opponents from gaining local footholds through the development of non-governmental social welfare institutions. This civilian health care program served as both a means for winning rural “hearts and minds” and a window into local community concerns. As SAMS commanders freely concede, these health services did not nearly approach the technological intensity or quality of medical care available to the white population. SAMS also provided medical care to civilians in Angola and Namibia in conjunction with South Africa’s military campaigns in these countries. We were unable to ascertain whether these services were merely incident to military operations in these countries or were part of a larger effort to discourage local civilians from giving safe harbor to the anti-apartheid resistance.

There is evidence that SAMS physicians and psychologists performed biological and chemical weapons research, but the exact extent of the chemical and biological programs and whether they included weapons of mass destruction is unclear. There are also various accounts alleging that SAMS personnel administered drugs and aversive electric shocks to gay conscripts without their consent in an effort to change their sexual orientation and assisted in the interrogation of detainees. The South African military may have used chemical weapons in Mozambique and herbicides in Namibia a decade ago. The former apartheid government apparently investigated the possibility of developing a bacteria that would selective kill or injure black people while leaving white people unharmed.
General Wouter Basson, a cardiologist in the military who was once the personal doctor to the former President, P.W. Botha, appears to have headed a special military program that operated covert laboratories and set up front companies. This unit conducted research and produced both recreational drugs, like Ecstasy, that were sold to make money and a variety of gadgets that gave the apartheid regime undetectable ways of murdering political opponents. The implements included screwdrivers with poison-filled cylinders, rings with spring-loaded compartments hiding deadly powders, vials of whisky laced with the toxic herbicide paraquat, and peppermints spiked with botulin.

At the time of our mission General Basson was still on active duty and registered with the SAMDC as a cardiologist and a practitioner in good standing.

In an interview with our team, General Knobel acknowledged that SAMS personnel had done research with biological weapons and poison gas but insisted that the work had been purely defensive. General Knobel said SAMS had begun a “command investigation” of the charges concerning the gay conscripts and that court-martial proceedings could follow. He denied that SAMS psychologists or other personnel had ever been “involved in interrogation under the command of the Surgeon General” [the SAMS commander]. He did say though that “certainly psychologists were involved” in training South African special forces “in how to resist special interrogation techniques.”

SAMS physicians and other health professionals, in sum, actively supported the apartheid state’s struggle to remain in power and understood this to be an important part of their mission. SAMS personnel rendered such support not only by providing medical services to the military but also by operating health care programs for civilians in contested rural areas and putting their technical skills to direct military use, e.g. in the country’s chemical and biological weapons programs. SAMS commanders’ non-responsiveness to the TRC’s detailed inquiries about these activities has made thorough scrutiny of them difficult thus far. We have therefore been unable to ascertain the full extent to which SAMS personnel acted contrary to international human rights and humanitarian law standards, as well as international medical ethics norms, in pursuit of their state security mission. We register our concern, however, that SAMS’ expansive conception of its state security mission is at odds with the more limited role of military medicine in most other nations’ armed forces. Like the district surgeons, medical personnel in SAMS confronted a situation where their dual loyalties put them at ongoing high risk for complicity in violations of human rights and humanitarian law.

G. Civilian Health Services for the Poor: District Surgeons and Public Hospitals

The vast majority of South Africans receive their medical care from government-run clinics and hospitals. Throughout the apartheid era, black people were relegated to grossly inferior facilities within this segregated system, while the mostly middle and upper class white population had access to an elite sphere of private practitioners and hospitals. Large differences by race in wealth and income enforced clinical apartheid.

Within the elite, private sphere, white (and some Indian and “colored”) South Africans could obtain care from physicians as committed to Hippocratic ideals of fidelity to patients as private practitioners in the U.S. or Europe. To be sure, these private physicians participated in apartheid culture and obeyed apartheid laws. Those who saw non-white patients tended both to have separate, less desirable waiting and consulting rooms and to admit them to non-white hospitals. Merely by following the norms of apartheid culture and obeying the segregation laws, they functioned, to some degree, as agents of the state and of white society at their non-white patients’ expense, in violation of the ideal of undivided commitment to patients. Yet these private practitioners were far removed from the culture and lines of authority of the military, police, prisons, and other state security organs. They conceived of themselves as devoted exclusively to their patients and beyond the reach of the state’s apparatus of repression.

By contrast, the physicians who served the black poor in state-run settings were pushed in myriad ways toward an understanding of their role that entailed balancing the state’s and patients’ needs. Severe budgetary limitations, large numbers of patients, overcrowded facilities, and limited access to tertiary care compelled virtually all who cared for poor blacks in the townships and rural areas to engage in ongoing triage. Their employment relation to the apartheid state invited a measure of loyalty to its policies and perceived needs.

The typical state-employed clinician could satisfy this loyalty passively, by practicing within the framework of the system’s racially discriminatory rules. Toleration of gross inequities in medical resource allocation,
adherence to clinical practice patterns that took these inequities as givens, and compliance with the rules of racial separation were necessities for "getting by," day by day, without colliding with administrators or government authorities. Physicians in leadership roles within this system collaborated more actively, by participating in resource allocation decisions that explicitly disfavored blacks and developing practice guidelines that made access to many expensive clinical interventions effectively contingent on race.59

The divided clinical loyalties of government physicians also led some to become collaborators in the apartheid regime's repression of opponents. The District Health System, in particular, functioned as a spawning ground for active and passive medical complicity in the torture and murder of apartheid opponents. Separate district health services, staffed by so-called district surgeons (actually general practitioners and internists, for the most part), provided medical care in many townships and rural areas to people unable to pay for private care. The district surgeons provided much of the care available to the country's black and "colored" populations and cared for prison inmates and other detainees.

District health services, which employed the district surgeons, were local agencies administered by provincial and municipal health authorities and overseen by the national Department of Health. National statutory and administrative law prescribed the district surgeons' care-giving and forensic duties but left daily management of their work to the provincial and municipal health authorities. In theory, this administrative scheme should have ensured the ethical and clinical independence of the district surgeons from prison, police, and military authorities. In practice, the low prestige and professional isolation associated with medical employment in black and "colored" townships and rural areas made the role of district surgeon ethically vulnerable.

South African medical graduates tended to view district surgeons' work as much less desirable than private practice and other career options, and the ranks of the district surgeons included many with weak credentials and few professional alternatives. In rural and township clinics, moreover, many had little or no regular contact with physician colleagues—and regular contact with police and prison officials who brought them clinical and forensic work. Indifferent local health authorities tended to pay little attention to district surgeons' performance. In such environments, physicians received little reinforcement from peers or supervisors for the quality of their work or for their adherence to the ethical standards of the profession. Notwithstanding their separate lines of authority to local health bureaucrats, they often developed closer ties to the prison and police officials with whom they worked regularly. Even in such environments, many district surgeons performed competently and ethically, providing the best care they could within resource constraints imposed by others, acting as advocates for their patients and thoroughly documenting medical evidence of abuse by the security authorities. Others, however, came to identify more with the purposes of the prison and police officials than with the distinct ethical role of the medical profession.

NOTES

1 HHRP, June 1997.
2 Most of the data in this section are drawn from Third Draft of the Submission by MASA to the Truth and Reconciliation Commission, June 1997.
3 Id., p. 5-14.
4 Id., p.51. See also discussion on page 61 of this report.
5 Id., p. 30.
7 Most of the material in this section is drawn from the "Submission to the Truth and Reconciliation Commission on Behalf of the Progressive Doctors' Group (PDG) in respect of the National Medical and Dental Association," May 1997.
9 HHRP, Chapter 3, Section 6.
11 References to the Council refer to the Interim National Medical and Dental Council or the former South African Medical and Dental Council, as is appropriate in the context.
12 In providing an overview of SAMDC conduct, we caution that we had no access to the minutes of Council meetings, internal memoranda, or other documents that would reveal the entire record of the Council with respect to wholesale violations of the right to confidentiality, participation of health professionals in torture (or in complicity in abuses) or other human rights violations. We did, however, speak to people knowledgeable about the Council's work, and to staff of the
Council, as well as review submissions made to the TRC. We believe the information to which we did have access provides a sufficient basis for our analysis and recommendations.


Id.

Id.

Id.


HHRP, p. 31.

These types of violations are described in great detail in the submission of the HHRP to the TRC, §3.11.


This section is drawn from several sources, including the South African Interim Nursing Council’s Submission to the Truth and Reconciliation Commission, May 1997, and interviews conducted by the AAAS/PHR team.


Id., p. 2.

Department of Health.


Ibid.

In 1995, Kale (p. 1397-9) reported that 75% of the health budget was spent on hospitals and academic institutions.


Id., p. 457.

Id., p. 456-7.

Jenkins, p. 2.

AAAS, p. 77. Also see van Heerden. Prison Health Care in South Africa: A Case Study Of Prison Conditions, Health Care And Medical Accountability For The Care Of Prisoners, 1996, p. 103-4 for an illustration.

Apartheid Medicine; van Heerden; Terence L. Dowdall, “Repression, Health Care and Ethics Under Apartheid.” Journal of Medical Ethics, 1991; Michael A. Simpson, “What Went Wrong?: Diagnostic and Ethical Problems in Dealing with the Effects of Torture and Repression in South Africa.” In Beyond Trauma: Cultural and Societal Dynamics. Rolf J. Kleber, Charles R. Figley, and Berthold P. R. Gersons (Eds.). 1995; South Africa interviews #9 and #18.
into MASA's filtering of complaints and SAMDC's enforcement record would advance the Truth and Reconciliation Commission's goal of establishing the origin and nature of gross violations of human rights.

AAAS, p. 77. Also see Silove, 1990.

Rayner, p. 77-79.

Id., p. 76-77. See also Silove.

Rayner, pp. 63-64.


"Submission to Health Sector of Truth and Reconciliation Committee by the Society of Psychiatrists of South Africa," p. 9.


Zwi.

Don Foster and Sally Swartz note that in the 1970s there were gradual shifts "from incarceration to out-patient and community intervention" but that "apartheid policy saw it that white persons were the main beneficiaries." Foster and Swartz. "Policy Considerations," in Mental Health Policy for South Africa, ed. D. Foster, M. Freeman, and Y. Pillay. Medical Association of South Africa. 1997.


The Abortion and Sterilization Act of 1975 authorized sterilization of persons with mental retardation.


81 Transcript of the Truth and Reconciliation Commission's Health Sector Hearings, June 17, 1997, p. 191.

82 There have been multiple allegations that SAMS personnel neglected the medical needs of injured civilians and prisoners of war taken during these military operations. Interviews by Laurel Baldwin-Ragaven, June, 1997. The Geneva Conventions and Protocols governing both international and intra-national armed conflict require medical personnel to prioritize and treat sick and wounded soldiers and civilians on the basis of clinical need, without regard for combatant status and national, racial, ethnic, or other affiliation.

83 To our knowledge, the TRC has received no reports along these lines from SAMS personnel.

84 Submissions to the TRC from both SAMS and its critics reported qualitatively on the service's role in providing health care to civilians in rural areas, but we were unable to ascertain, from these submissions, the size and scope of this role.


86 "Truth Panel is Told of Bacterial Warfare," The Washington Post, June 12, 1998, A22


88 Id. General Knobel said that SAMS personnel had experimented with CS gas and other chemical and biological agents only for the purpose of developing masks, protective clothing, and other defensive equipment and strategies. He acknowledged that SAMS General Wouter Basson, M.D., who ran this research program, was still on active duty, but he said President Mandela had personally instructed SAMS to retain Basson in order to discourage him from selling biological and chemical weapons technology to Libya and other countries.

89 Ironically, some racial mixing of patients occurred at South Africa's premier hospitals, the academic medical centers of the University of Cape Town (UCT) and the University of the Witwatersrand. These publicly-supported tertiary care centers received referrals from both the elite, whites-only private health system and the largely black (and "colored") government-run clinics and hospitals. In the 1980s, UCT's Grootte Schuur Hospital took the then-radical step of integrating its wards despite opposition from the provincial administration.

90 Neither the TRC's investigation nor our own inquiries yielded evidence that clinical practice protocols expressly conditioned access to services on race. Rather, such discrimination was effected through the channeling of blacks and "coloreds" to separate facilities, with varying practice protocols that reflected sharply different levels of resources.
Underlying Causes of Human Rights Violations

The mandate of the TRC includes determining causes of gross violations of human rights. Identifying these causes is essential for ending the cycle of abuses and to pointing the way to effective reforms. While the truth-telling function of the TRC is a critical step, prospects for reconciliation seem remote without the progressive realization of all human rights for all South Africans. In that regard, it is important to recognize that the acts of omission and commission which violated the inherent rights and dignity of South Africans were not limited to "gross" violations of human rights. Moreover, many of the same factors related to violations of civil and political rights also resulted in violations of social, economic, and cultural rights.

This chapter seeks to provide insight into the complex problem of the causes of human rights violations. It specifically addresses how members of the healing professions became an integral part of the apartheid system which deliberately inflicted sustained and untold suffering based on a racist ideology. In our analysis of causes of human rights violations, it is important to bear in mind that the suffering generated by apartheid was not limited only to the oppressed, as Allister Sparks points out; it undermined the humanity of the oppressors as well:

Slavery debases master as well as slave. The warden becomes a prisoner in his own jail; he is never free from the business of oppression and confinement. So, too, in Apartheid South Africa where white and black had been bound together in a web of mutual destructiveness. Apartheid, brutalizing the whites as it destroyed the self-esteem of the blacks, robbed both of their humanity.

A. The Primary Cause: Racism in the Society

The primary and defining cause of the human rights violations in South Africa's health sector is clear. It is a profound and pervasive racism: the belief that whole populations are "inferior," less than human, and there-
fore not entitled to the most fundamental rights and protections of the human condition. This racism was embodied in an authoritarian political system and expressed in law and in the structures and policies of every institution in South African society. It was enforced by violence; torture, extrajudicial executions and massacres, detentions, disposessions, the destruction of whole communities, and systematic humiliation comprise only part of the arsenal of oppression. Racism served as the immoral rationale for a massive system of political disenfranchisement and economic exploitation that approached (and sometimes included) outright slavery. Over decades, it cost hundreds of thousands of lives and stifled the potential of millions. Its cost to the human spirit is incalculable.

Racism was not and is not unique to South Africa. What is unique, at least among industrialized nations in the second half of the twentieth century, is the organization of an entire society on the principle of selective separation and inequity on the grounds of race. Apartheid was more than a state policy and more than a political economy. It was a culture, a system of beliefs and actions that profoundly affected every person in the nation—including the ruling caste of whites, variously moved to savagery and denial in defense of racial privilege.

Three aspects of this culture of apartheid are of particular concern to the protection of health and human rights. The first is the devastating effect of the South African apartheid system on the health of subject populations, primarily through the systematic and deliberate denial of adequate housing, food, sanitation, and environmental and occupational protection in contravention of every international standard. The second is the deliberate construction of a racially organized and caste-biased health care system that offered grossly inferior care to millions of South Africa's people of color and effectively accomplished the outright denial of care to millions more. The third is the extent to which the culture of apartheid poisoned the integrity of so many health professionals, so that—at best—they saw no conflict between the dictates of racism and the egalitarian commitments of medicine, and—at worst—they used their skills in active support of oppression and in violation of every ethical code relevant to their professions. These failures are more than individual. They reflect the extent to which a culture of racism can structure the social, environmental and political determinants of health and infect the core institutions of health care, including its professional schools and disciplinary bodies.

All these aspects are documented over and over again in the submissions to the Truth and Reconciliation Commission. It is this cumulative record that informs our analyses and recommendations. We recognize the profound and fundamental changes that have occurred in South African society, and the commitments of a new and democratic government. But we also know that the legacy of apartheid is manifest in the present in multiple ways, including health care and the determinants of health, and that it casts a long shadow on the future. Our own experience in the United States teaches the bitter lesson that racism dies hard, and slowly, but it is the purging of this primary cause that is the recommendation—and the task—that underlies all others.

B. Racism in the Health Care System

Health practitioners, of course, have a unique responsibility in society, as healers, to understand and alleviate causes of human suffering, and to promote health.8 Although internationally recognized principles of bioethics should have prevented, or at least greatly mitigated, health practitioners' complicity in human rights violations, by and large they did not. The triumph of racism over ethical responsibilities was built into the structures and characteristics of the health sector and the health professions. It is useful, we believe, to describe how racism played itself out in practice in the health sector so that health professionals could participate without a great deal of thought in a system of intentional discrimination and the deliberate infliction of harm on the majority in South Africa.

Bureaucratic fragmentation fostered the development of pervasive racial discrimination in health care. The separation of South African medical services into myriad bureaucratic entities, administered or overseen by different levels of government and responsible for providing care to different racial groups, meant that practitioners within each clinical setting saw relatively homogeneous populations of patients. However widely the standards of care and the norms of respect for patients varied among clinical settings, practitioners in any one clinical setting tended to apply the same or similar standards to the patients they treated in that setting. Racial discrimination operated for the most part at a higher level, through large differences in the per capita resources deployed to different clinical settings, as well as through differences in the mechanisms of governance.
The typical practitioner, working in a single professional setting, did not encounter these differences up close, on a daily basis.

The individual practitioner, to be sure, made the system of racial discrimination work, day in and day out, by adhering to protocols and rules that were race-biased in both effect and design. When patients of different races came to the same facility, they were often sent to separate waiting rooms, seen in separate areas, and given different priorities, according to race. But practitioners within a given setting more commonly saw patients of only one race and did not personally face the ethical and human rights affront of different clinical protocols and rules for patients of different races. This made it easier for clinicians to go along with the system without experiencing themselves as active perpetrators of racism. So long as they turned a blind eye toward the larger, race-biased context of their clinical work, they could see their own conduct as consonant with their ethical duty to treat patients without regard to race. This enabled large numbers of physicians who were not proponents of apartheid to rationalize the crucial support they lent to the system by practicing within its rules.

Bureaucratic fragmentation also fostered medical apartheid by giving legislative and administrative policy-makers the economic and budgeting tools to maintain patterns of racial discrimination. South Africa’s huge black-white disparity in economic status enabled markets to do much of the work of medical apartheid, by setting prices for private health services and insurance sufficiently high to deny almost all blacks access to private sector care. Public subsidies could have empowered black South Africans to gain access to private health services, thereby achieving a measure of racial integration through the marketplace, but the national and provincial health departments eschewed any such approach in favor of a separate, government-run system for the largely non-white poor.

The importance of this foundational policy decision cannot be overstated. Had the South African government either introduced subsidies sufficient to give all poor people access to private sector care or created a public system of health care provision sufficiently attractive to draw substantial numbers of middle class whites, it could have achieved considerable racial integration in the health sphere. To say the least, either approach would have made medical apartheid more difficult to impose. Public subsidies sufficient to give blacks access to private services would have required the state to be more heavy-handed in order to maintain racial segregation in the private sector. Public financing or provision of care good enough to attract many whites would also have required the apartheid state to more aggressively impose segregation in the medical sphere.

Within South Africa’s state-run health services, bureaucratic fragmentation facilitated budgeting practices that helped to maintain medical apartheid. The separation of government authority over medical matters into separate departments of health for the nation as a whole, the provinces, and the so-called black “homelands,” and the 1983 division of provincial health departments into black, “colored,” and Indian “own affairs” sections, enabled legislative and administrative policy-makers to budget grossly unequal per capita resources to programs serving members of different racial groups. These budgetary decisions, made by officials committed to apartheid ideology and remote from public clinics, hospitals, and the suffering people they served, translated into large racial differences in access to care within the public system. Residents of the virtually all-black “homelands” were particularly hard hit by low per capita allocations from the national government.

Confronted with these racial inequalities, physicians and other health professionals who worked in public settings made do with what they had. They can be fairly faulted for making do without demurring—for not protesting the fact that clinical settings frequented by people of different races brought vastly different per capita resources to bear on the same medical problems and followed very different practice protocols as a result. But bureaucratic fragmentation made such protest less likely, by making these inequities less conspicuous to practitioners. Engaged, for the most part, within one or a few institutional settings, practitioners were simultaneously well situated to see the clinical impact of their own resource constraints but poorly positioned to discern system-wide resource disparities and consequent inequities in clinical practice and results. These system-wide inequities tended to remain out of sight and out of mind, at least as a matter of daily clinical experience. This inattention and inaction was of a piece with the general tendency of people working in bureaucratic settings to accept and even justify role constraints rather than resisting them, and to evolve institutional norms to fit these constraints. The larger South African cultural context of race-based hierarchy and contempt eased the way for health professionals to do so, and the fragmentation of the health sector lessened the power of the ethical tradition of medicine as a counterweight.
C. Other Factors

Like other countries, there were other factors in South Africa that contributed to human rights violations in the health sector. Unlike most other countries, however, these structural, educational, and behavioral problems interacted with the underlying racism both manifesting and compounding its effect.

1. Limited conceptualizations of health and human suffering

Principles of bioethics have evolved within a limited disease-based and patient-centered conceptualization of health and human suffering and have usually not been applied to broader health concerns, nor particularly to matters of state interference with health or health practice. The codes of conduct usually regulate clinical encounters with individual patients and do not attempt to define health and well-being or address interference with health by the state. By tending to focus on suffering almost exclusively in the context of the physician offering treatment for injury or disease, these codes do not attend to the relation of health to the protection of human rights, nor to the physical, psychological and social health consequences of violations of human rights and humanitarian law. Consequently, they marginalize their role in society.

When conceptualizations of health and human suffering are devoid of human rights concerns, health personnel easily avoid coming to terms with the role they may be asked to play in a highly politicized environment, and thus can become willing and unwilling participants in human rights violations which serve the partisan interests of the state and other actors. In South Africa (and elsewhere), health professionals were ill equipped to respond to suffering caused by armed conflicts and human rights abuses and were more likely to focus narrowly on their own practices and turn away from even obvious violations of human rights.

Some health practitioners are quick to point out that there is a difference between active participation in human rights violations and “standing by.” The assertion by MASA that standing by in the face of human rights violations constituted “complacency” rather than “complicity” deserves further attention. The assertion implies that doctors did not have a professional duty to intervene in the suffering caused by apartheid. Was this the case? After all, a concern for human rights in the conceptualization of health and human suffering is a relatively recent development.

Having said this, it is also true that internationally recognized principles have evolved that provided ample justification for physicians to respond to the suffering caused by apartheid. For example, the World Medical Association’s “Declaration of Geneva” includes the pledge to serve humanity, to practice with conscience and dignity, to make patient health one’s first consideration, to maintain the utmost respect for human life even under threat, and not to use medical knowledge contrary to the laws of humanity. Furthermore, bioethical principles of beneficence, justice and fidelity provide a firm foundation to confer on health professionals the responsibility for protecting and promoting human rights and humanitarian law. Given these principles, it is more accurate to describe the inaction and silence of health personnel as complicity rather than complacency. Such complicity constituted a failure of professional duty, and served to legitimize state abuses and the active participation of health practitioners in these abuses.

In sum, South African health personnel either knew or should have known that the discriminatory practices of apartheid would cause significant harm to black South Africans. Silence and inaction in the face of human rights violations represented moral choices of health practitioners. Such choices, in combination with a limited conceptualization of health and human suffering, were a prescription for complicity in human rights violations.

The truth and reconciliation process represents a critical opportunity for those in the health sector to re-examine their definitions of health and the scope of their professional responsibilities. Health practitioners do have a responsibility to protect and promote all human rights not only because human rights violations have devastating health consequences, but because protecting and promoting human rights (civil, political, economic, social and cultural) may be the most effective means to provide the conditions for health and well-being in a global civil society.

2. Ineffective leadership of health sector organizations

Although some progressive health professionals in South Africa worked for the protection and promotion of human rights during apartheid, most
did not. A significant factor in the widespread disregard for human rights concerns was the lack of leadership within the health sector, including professional organizations, regulatory health councils, the Department of Health, health facilities and academic and research institutions. Such leaders were often an integral part of white South African society. Their failure to confront the health consequences of human rights violations legitimized the ruthless social engineering policies of apartheid and contributed greatly to the systematic dehumanization and disenfranchisement of generations of black South Africans.

Leadership is a critical factor in the determination of health policy and also serves as an example for health practice. Leaders within the health sector not only failed to recognize the relevance of human rights in health; they neglected to develop comprehensive codes of ethics or to enforce established codes of ethical conduct, and they failed to support and protect health personnel who took considerable risks in supporting human rights.

Many leaders within the health sector have provided the TRC with unqualified apologies for the conduct of health personnel during the era of "complacency," but how is one to believe that such conduct will change without evidence that the leadership within the health sector has also changed. The health sector hearings of the TRC clearly demonstrated little evidence of such a transformation on either level. Apologies and talk of building a "culture of human rights" are likely to become the instruments of surviving "transformation" intact, rather than promoting the health and human dignity of all South Africans. Furthermore, not one leader of a health professional organization or health regulatory body, nor SAMS, nor the Department of Health has offered a strategy to include human rights in health education. Without effective reform of the leadership that was responsible for the health sector's shameful silence and inaction under apartheid, the health sector's stunning opportunity for transformation may simply evaporate.

The effect of lack of leadership in promoting health and human rights in the health sector is compounded by efforts to maintain the status quo. Privatization of health care delivery has already become a major theme in the unity talks between MASA and the black physician organizations. Such interests in maintaining present reimbursement schemes and control over practice patterns appear to demonstrate MASA's preoccupation with the financial interests of its members, rather than the health and well-being of black South Africans.

3. Power without adequate accountability

Health professionals, particularly physicians, have a great deal of power in their relationship to patients. This asymmetry in power stems from differences in knowledge and language, and places health practitioners at an advantage in their clinical encounters and roles in society. Although many practitioners care greatly for their patients, their power needs to be held in check by the formal requirements of promoting health in society.

Because medical encounters are often characterized by an asymmetry in power, doctors and other health professionals have the potential to abuse that power. When health concerns are limited to the objective of curing disease, the likelihood increases that health professionals will not relate in a holistic manner to issues relating to the human worth and dignity of their patients. Such moral disengagement may be a critical factor in abusive behavior. Under such conditions, the body becomes the medium for doctors to achieve power, control and personal gain. Moreover, the fact that this power asymmetry is not formally recognized in health education suggests that it serves health providers rather than members of the community.

Structural mechanisms for accountability in the health sector generally consist of licensing and regulatory councils that function to prevent the abuse of individual patients. Their importance cannot be overstated, especially in the apartheid state. But there was no accountability, licensing or disciplinary system that valued ethics and human rights over the policies of apartheid.

4. Lack of independence in the health sector

South African physicians and other health workers under apartheid were widely expected to put the security and other interests of the state ahead of their ethical commitments to patient well-being. To some degree, medical institutions and professionals in all societies serve security-related and other non-therapeutic purposes—e.g., by performing forensic evaluations and treating members of the armed forces to maintain their combat-readiness. In apartheid-era South Africa, however, this non-therapeutic role was greatly magnified. The armed forces, police and prison officials, and the national and provincial departments of health looked to physicians to function as both active agents and passive adjuncts of the apartheid state's efforts to repress opposition, cover up torture and mur-
under, and sustain the systematic practice of race-based hierarchy. South African physicians, for the most part, went along with these expectations.

Independence in the health sector is essential to ethical health practices and health policies because third party interests almost always compromise efforts to provide effective care and to promote health. In South Africa, lack of clinical independence was most pronounced in situations that the state perceived as threatening, i.e. medicolegal medicine, custodial care, and health services in the South African military service. Similarly, the lack of independence of institutions that were responsible for health policy greatly facilitated their permeation by the racist ideology of the state. Acts of omission and commission by statutory regulatory bodies such as the SAMDC and SANC, as well as the Department of Health, academic and research institutions, and health care facilities, clearly contributed to violations of human rights.

That the state so extensively compromised the independence of the health sector should not come as a surprise. Such structural relationships develop because they serve the interests of the state and the health sector both. Under apartheid, what was at stake for the state was not simply winning a conflict, but the very legitimacy of its power to govern. The involvement of health professionals in human rights violations, and their pervasive acquiescence to such violations, served to legitimate the actions of the state. The apartheid government imposed its ideological claims to the detriment of the credibility of health practitioners. The intimate relation between the apartheid state and the health sector also served the interests of health practitioners. Apartheid policies provided practitioners with the means to realize the interests of physicians and other health professionals, at the expense of the health and well-being of black South Africans.

Clinicians employed in settings linked to institutions of state security tended to serve and even identify with these institutions’ missions. Military physicians did so openly, putting their skills to use not only to keep armed services personnel combat-ready but also to campaign for the allegiance of civilians in contested rural areas and even to develop weapons technologies. The isolation of military physicians from South African medicine promoted their development of a distinct identity and culture, less patient-oriented and more responsive to the perceived security needs of the apartheid state. Although South Africa’s district sur-

geneons did not formally report to police or prison authorities, the professional isolation of many in the townships and rural areas weakened their self-perceived constraints on identification and alliance with these authorities when called upon to attend people in detention.

5. Lack of adequate human rights and bioethics education

Education has far-reaching and long-lasting effects for health personnel and health practices. The educational process has a formative effect on conceptualizations of health and human suffering, and thus on the scope of professional interests in society. It provides role models which students often emulate, as well as ideas about questioning authority and one’s role in relation to the state.

Health education under apartheid clearly contributed to causes of human rights violations in the health sector. Under apartheid, health educators failed to include human rights and bioethics concerns and thereby contributed to the neglect of the health consequences of human rights violations. Health educators provided students with limited, disease-based conceptualizations of health and human suffering which disregarded the importance of social determinants of health. Furthermore, health educators served as models for the support of extreme discrimination in the delivery of health services and in health education. Student selection by health educators contributed to the institutionalization of racism in the health sector. The selection of privileged white students, combined with insufficient exposure to primary care experiences in black communities, reinforced the isolation of students from the health needs of the majority of South Africans. In addition, health educators have been criticized for discouraging students from questioning authority. This may have been a significant factor in the health sector’s history of obedience to authority.

NOTES


2. Health is defined as “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.” World Health Organization,
Physicians whom we interviewed generally expressed the belief that during the apartheid period, they were ethically obligated to provide the same technical quality of care to their patients of all races. However, the Medical and Dental Council took the position that racial discrimination by itself did not merit professional discipline, so long as the patients discriminated against were not "treated unacceptably." Interview with R. J. Fimlalter, M.D., Assistant Registrar for Professional Misconduct, Interim Medical and Dental Council. Many who said physicians were ethically obliged to provide the same technical quality of care regardless of race said they viewed segregation of health care facilities as ethically tolerable during the apartheid era.

The Medicaid program in the U.S. illustrates this possibility, albeit incompletely. Medicaid provides a combined federal and state subsidy to some poor people for the purchase of some medical care (less than that covered by comprehensive private insurance plans) in the private marketplace. The German system more completely subsidizes poor people's purchase of private insurance and medical care (while relying on private entities known as "sick funds" to pool middle class resources for the purchase of private care).

Great Britain's National Health Service, well-known to South Africans, is one example of a government-administered health care delivery system high enough in quality to attract most middle-class citizens. South African health care reformers have from time to time, without success, urged the creation of a British-style health service.

As district health system employees, they reported to provincial and local health agencies.


A. Elimination of Racial Discrimination and Disparities

Development of a unitary, post-apartheid health system, accessible to the poorest South Africans yet appealing to middle and upper class whites and non-whites as well, should be a high human rights priority. The International Convention on the Prevention of All Forms of Racial Discrimination requires states to eliminate policies that are discriminatory in impact as well as intent. To comply with the Convention, which constitutes the most authoritative statement of international law bearing on state-sanctioned racial discrimination, South Africa will need to transform its public medical services system to greatly reduce racial disparities in access and resource allocation. Incorporation of patients from diverse spheres of South African life within a single health system, funded equitably and administered with an eye toward coordination and consistency in clinical practice, would do much to reduce racial disparities in access to care. To be sure, the wealthiest South Africans, like the most privileged in any society, will be able to buy out of a medical system designed to distribute care equitably to the many. But inclusion of substantial numbers of people from all backgrounds within a single health system would build mass support for a floor below which the quality of care could not fall—and would foster a more integrated medical culture, with less racial and regional variation in clinical practice protocols.

Such reform is achievable through a variety of market-oriented and/or government mechanisms, depending on political and ideological preferences. A single, British-style, state-run National Health Service, well enough funded to attract the middle class, would accomplish this, as would reliance on private markets for insurance and/or provision of care, so long as public subsidies give the poor enough medical buying power to obtain care from private providers now accessible only to whites. Inevitably, reduction of South Africa's huge racial disparities in public medical spending will require retrenchment, particularly in taxpayer support for the tertiary services now provided disproportionately to whites by
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academic medical centers. The nation will have to strike some difficult balances between pursuit of racial equity and the costs of cutting support for these high technology centers, which have brought a measure of international prestige and economic benefit to South Africa. These and other hard choices about the reallocation of health care resources should be made through mechanisms that insure the participation of knowledgeable representatives of all of South Africa’s major racial and ethnic groups.

National and provincial legislation can define budgetary priorities in general terms, but the complexity of the decisions to be made will require administrative regulators and managers to fill in crucial details. The current South African state bureaucracy, staffed largely by holdovers from the apartheid era, is ill equipped to perform this task in a manner responsive to the country’s multiracial composition. Creative efforts to involve representatives of diverse racial and community groups in local resource allocation decisions will be necessary. In addition to developing substantive guidelines for the distribution of medical resources in the new South Africa, Parliament should specify mechanisms for administrative and regulatory decision-making that mandate the participation of representatives of the country’s diverse constituencies.

In addition to the institutional restructuring urged above, South African law ought to clearly proscribe racial disparities in the allocation of public funds to health services and make discriminatory treatment of patients by hospitals, physicians, and other providers clear cause for professional discipline and other sanctions. Such sanctions should be triggered by segregation of waiting rooms, treatment facilities, etc.; disparities in technical quality of care (e.g. race-linked differences in practice protocols or treatment actually provided); and expressions of race-related disrespect or contempt.

To address the enormous disparity between the racial distribution of South Africa’s population and its medical community, robust affirmative action efforts are essential. Affirmative action in clinic, hospital and academic medical hiring, as well as medical school admissions, and academic, emotional, and financial support for black students, is essential. On the other hand, no amount of affirmative action at the level of professional education and hiring can substitute for a national commitment to upgrade early childhood, primary, and secondary school education in black areas, with emphasis on education of girls whose education is essential for family health. The tragic legacy of the “Bantu education” philosophy, which led to gross underfunding and to curricula that emphasized rote training over the critical thinking essential to the preparation of students for higher education, could cast a decades-long shadow over black professional and career development.

B. Adoption of Human Rights Standards for Health Professionals

Given the record of health professionals under apartheid, a binding and enforceable code of conduct for health professionals that incorporates obligations respecting human rights is essential. The code of conduct should be enforceable both in professional disciplinary proceedings and through private actions against health professionals.

The code of conduct can build on the ethics of the health profession that have evolved since the time of the Greek physician Hippocrates. These standards represent the profession’s acceptance of the responsibility and trust with which it has been invested by society’s grant of a license to practice. Upon entering a profession, each practitioner inherits a measure of that responsibility and trust and the corresponding obligation to adhere to standards of ethical practice and conduct as set by the profession.

In the post-apartheid era, however, the professions alone should not be exclusively responsible for drafting such a code. Despite the commitments of professional organizations to the protection of human rights, the record of violations is so pervasive and clear that self-regulation alone is not appropriate. Indeed, in the post-apartheid era the health professions have yet to adopt comprehensive policies or codes of ethics designed to protect the human rights of South Africans. Nor are the professional regulatory councils the appropriate bodies to promulgate such codes. Their record on human rights is even poorer than that of the professional organizations, and the Interim Medical and Dental Council shows not the slightest inclination or ability to promulgate such standards. The Council seems, even today, perfectly satisfied with its case-by-case system for deciding what counts as unprofessional conduct, and compliant with respect to the exclusion of discriminatory practices from its concept of professional misconduct.
It is, rather, for the society as a whole, expressed through Parliament or an agency designated by Parliament, to design such a code. The code should be developed with the participation of all stakeholders in the health system. This does not mean that associations of health professionals should not have a say in their own code of ethical and human rights standards, but it does suggest including groups representing the victims of human rights violations.

Regardless of the entity or entities that adopt the code, certain fundamental principles of human rights should be respected. There are a number of possible sources and models for human rights standards in health. The Commonwealth Medical Association, for example, has adopted standards that address ethical as well as human rights concerns, and may well provide an appropriate model for South Africa. Other sources include the Chilean Medical Association, the Haitian Medical Association, the International Council of Nurses' statements on the Nurse's Role in Safeguarding Human Rights, on Torture, and on Care of Detainees and Prisoners. The World Medical Association has also issued statements on human rights in medical practice.

While it is not for us to draft such a code, we believe it useful to outline elements that should be included in an ethical code that includes respect for human rights. The standards should apply to both public and private facilities since human rights violations by health professionals take place in private practice and in private institutions as well as in government facilities. Given the record of the past, it is essential to assure that violations in the private sector are included. Because all elements are essential, the code should be both comprehensive and selective. These elements are:

1. The health professional must provide health care that promotes the dignity and human rights of the individual, endeavoring to treat the individual with both compassion and respect.
2. The health professional must provide health care unrestricted by considerations of nationality, race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. The individual professional should adhere to this principle of nondiscriminatory health care and should respect the worth and dignity of the individual human being throughout the entire life cycle, from birth to death.
3. The health professional must safeguard the individual's right to privacy by protecting information of a confidential nature, sharing only information that is relevant to care. The client/patient relationship is built on trust. This relationship will be destroyed and the patient's welfare jeopardized by disclosure of confidential information without the individual's consent.
4. The health professional must be concerned first and foremost with the health of the patient. In the case of prisoners and detainees, the health professional must meet the health needs of the individual and refuse to withhold health interventions in order to serve the interests of state officials. The health professional must honestly report medical findings, regardless whether those findings implicate officials in wrongdoing. Detailed standards concerning the responsibilities of health professionals to prisoners and detainees should be written. Associations of professionals must endeavor to support colleagues who comply with these obligations.
5. The health professional should comply with the provisions of the Declaration of Tokyo of the World Medical Association not to condone, participate in, facilitate, or use medical skills to further the practice of torture or other forms of cruel, inhuman or degrading procedures. Health professionals who are in a position to examine persons who may be victims of torture must obtain competence in performing such examinations and submit reports that are accurate and forthcoming. Health professionals should assist victims of torture and provide support to organizations that come to the aid of such victims.
6. The health professional who participates in research activities must ensure that the rights of individuals subjects are protected. This principle was established firmly in the Nuremberg Code a half-century ago.
Professionals who undertake a research project need to protect the subject’s rights to privacy and self-determination to ensure that fully informed consent has been obtained from the subject, and that the subject is free to leave the experiment at any time. The same obligations should apply with respect to members of the military service.

7. The health professional should work with members of other health professions and citizens in promoting efforts to meet the health needs of the public, including the establishment of a health care system that is equitable, fair, and consistent with the provisions on health care of the South African Constitution. It is increasingly recognized that the needs of all members of society for comprehensive health services can be met only through a broad and intensive effort on the part of both the community and the health professions.

8. The health professional must maintain individual competence in practice. This knowledge includes ethical and human rights standards. The nature of professional practice is such that inadequate or incompetent practice could result in the loss of health or even the life of the patient. The health professional must, therefore, be aware of the need for continuous updating and expansion of the body of knowledge on which the practice is based and must keep such knowledge and skills current.

The health professional should use individual competence, including knowledge of human rights, as a criterion in accepting delegated responsibilities and assigning activities to others. This, too, includes competence in human rights. Because of the increased complexity of health care and changing patterns in the delivery of health services, it is important that health professionals exercise judgment in accepting responsibilities as well as in assigning responsibilities to others. It should be noted that medical and nursing practice acts are usually expressed in broad and general terms and provide minimal guidance, direction or protection to the health professional in relation to acceptance or performance of specific delegated functions.

9. The health professional should participate in the efforts of the profession to define and upgrade standards of conduct as they relate to practice and education, including the role of human rights in health practice. These standards represent not only professional goals, but also a means of ensuring a standard of care for the public.

10. The health professional acting within the professional association should participate in establishing and maintaining conditions of employment, including a prohibition on discrimination. The health professional must be concerned with conditions of employment in health care.

11. The health professional should act to safeguard the patient when his or her care and safety are affected by the incompetent, unethical, or illegal conduct of any person, including conduct that violates an individual’s human rights. Inasmuch as the health professional’s primary commitment is to the patient’s care and safety, the professional must be alert to and take appropriate action regarding any incidents of incompetent, unethical, or illegal practice by any member of the health care team or any action on the part of others that is prejudicial to the patient’s best interest. When incompetent, unethical, or illegal practice on the part of anyone concerned with the patient’s care is not corrected by health professionals themselves it continues to jeopardize the patient’s care and safety.

12. Health professionals and their associations must have an affirmative obligation to protect and defend colleagues who stand up for the protection of human rights. This obligation is as critical as the need to prevent those who violate human rights from practicing.
13. Health professionals have a responsibility to protect and promote human rights.

C. Professional Societies

Since the end of apartheid, most organizations representing the health professions have restructured themselves to move toward multi-racial, democratically run associations. With varying degrees of candor and depth, they have disclosed their behavior during apartheid, particularly in undermining professional ethics through allegiance to the policies and practices of apartheid. Some of them have issued formal apologies for their conduct during apartheid. Virtually all have committed themselves to becoming organizations that respect the human rights of all members of their profession and of the people they are supposed to serve.

It is for South Africans, not us, to assess the sincerity of these commitments and the depth of the apologies. Motives, however, may be less important than taking the concrete steps necessary for professional organizations to develop a commitment to human rights within the professions. Some of these steps may require giving up some of their autonomy or power of self-regulation. The willingness to do so in the name of human rights is, we believe, another measure of their commitment.

1. Support legislation to assure the protection of human rights in the health professions

One of the key steps that organizations of health professionals can take is to support legislation designed to bring human rights to South African health professionals. The Medical Association of South Africa (MASA), the Democratic Nurses Association of South Africa (DENOSA), Psychological Society of South Africa (PSSA) and other organizations should support all the following initiatives:

(a) The promulgation of legally binding human rights standards for health practice, violation of which will subject the professional to disciplinary sanctions.

(b) Reform of the Councils' disciplinary processes to assure that allegations of human rights violations are thoroughly and independently examined by a well-trained professional staff and to guarantee inclusion of community and consumer representation in these processes.

(c) Requiring human rights training as a condition of licensure.

(d) Monitoring human rights in the health sector, both public and private, including the health professions, on an ongoing basis by non-governmental or academic organizations not employed by or associated with a professional medical association. (See Recommendation F.)

2. Investigate abuses committed by individual practitioners in the past

Despite their commitment to a new human rights era, the professional organizations by and large have resisted recommendations to conduct their own inquiries into human rights violations by members of their associations. The TRC hardly scratched the surface of violations of human rights by health professionals during apartheid. Both disciplinary bodies and professional societies should reopen cases from the past.

3. Incorporate human rights education and cross-cultural understanding to professional training

A program of training in human rights must begin during professional training and continue throughout the professional's career. While medical schools and other health professional schools will be expanding bioethics teaching and initiating human rights training in their curricula, that does not reach the overwhelming majority of physicians in practice, some of whom were complicit in violations and almost all of whom practiced when apartheid was the dominant culture. We recommend the following steps:

(a) In conjunction with the statutory councils, organizations of health professionals, e.g., MASA, DENOSA, and PSSA, should initiate a national continuing medical education program on human rights and professional accountability, involving every chapter for several sessions and including expert presentations and case discussions.

(b) Human rights training should be planned with the advice of existing South African human rights organizations and both domestic and international bioethics and human rights authorities. The training should
also address the relationship between the health professional and the patient, with the goal of diminishing the power differences between the two parties to the relationship. Further, white health professionals were educated in a system that deliberately and systematically devalued the worth of black South Africans. They were provided no tools to understand cultural differences, much less to seek to bridge the gaps between cultures. The education process should therefore incorporate cross-cultural understanding and be structured to involve presentations from all racial groups. The participation of patients who have suffered violations should be considered for case presentations.

The participation of the National Progressive Primary Health Care Network, which has mounted a major campaign to inform patients of their rights in health care, could provide helpful guidance in this process. Health professional societies should also support the efforts to the Health Systems Trust to train health workers at all levels in human rights.

(c) Specialty medical societies, e.g., pediatricians, psychiatrists, obstetricians/gynecologists, surgeons, and forensic pathologists, should regularly include substantive presentations on human rights and professional accountability at their annual meetings.

4. Undertake affirmative efforts to alter the leadership structure of the organizations

Despite restructuring, most of the leadership positions in the professional organizations are still held by many of the same whites. This is a product of the demographics and histories of the organizations. Affirmative steps need to be taken to assure that qualified blacks who were previously excluded from leadership, or who formed their own organizations out of protest, assume leadership positions in these organizations. One test of MASA's commitment to human rights, for example, will be the extent to which it integrates former NAMDA members into positions of leadership within MASA.

5. Demonstrate commitment to health equity

Professional organizations are guilds, and support what they believe to be in their economic interest. For many in the health professional organizations today, that means supporting moves toward privatization. That course threatens equity in South Africa's health care system, particularly the vibrancy of its private sector. The organizations should demonstrate, in concrete ways, how they propose to assure adequate health care for the majority of South Africans.

6. Elevate human rights concerns within the organizations

Human rights committees can easily become backwaters within professional associations. The associations should demonstrate their commitment to human rights by assuring that human rights receive attention at the highest levels of the organization. Human rights presentations and discussions should be incorporated into the day-to-day work of the organizations.

Organizational leaders should also make consistent and concerted efforts to raise awareness of human rights within the organization's membership, because many members continue to identify with the old order.

7. Incorporate human rights into professional journals

The South African Medical Journal and other professional publications should establish regular sections on bioethics and human rights. These sections should include the texts of formal papers presented at the meetings described above as well as news reports and other items concerning ethics and human rights issues in health care around the world, to make clear that these are not uniquely South African concerns.

D. Professional Regulation

The abysmal record of the statutory councils under apartheid, their refusal or inability to investigate or come to terms with the past, the absence of human rights standards, and the lack of structures for individual accountability for human rights violations committed by practicing health
professionals are all factors pointing to the need for structural reform of the mechanisms for disciplining health professionals in the area of human rights. The fact that institutions that were supposed to protect the integrity of health practice in South Africa instead became instruments of apartheid and shields against accountability for human rights violations is all the more reason now to reform the process of health professional discipline regarding human rights.

The reform of the disciplinary process for health professionals is, we believe, but one step toward the development of a culture of human rights among health professionals and a means of assuring that human rights are protected in South Africa’s health care system. It is, however, an essential one. Without it, the public can have no faith and no guarantee that individuals with the enormous authority of health professionals will respect human rights and, if they engage in violations, be held accountable for them. With such a step, human rights values in health can become established and reinforced time and again.

Our recommendations for reform of the disciplinary process are designed exclusively to address human rights violations by health professionals. They do not address procedures and standards for professional discipline unrelated to human rights and we express no view on those standards and procedures.

In our view, the keys to reform are to assign an independent professional staff to investigate and prosecute complaints of human rights violations against health professionals before disciplinary bodies, assure the existence of articulate human rights standards by which to judge cases, establish procedures for the effective and fair presentation of cases, and establish appropriate sanctions. We also believe it important now to investigate cases that arose during apartheid. By enacting such reforms, moreover, South Africa can provide a model for the world of how health professionals can be held accountable for the human rights violations they commit.

In addressing these concerns, it may be necessary to break new ground since few countries have had to address human rights violations by health professionals on the scale that occurred in South Africa. On the other hand, South Africa also has the opportunity to become a model for human rights enforcement in the health sector. We believe that current proposals for reform do not sufficiently address the structural problems in health professional discipline that have impeded accountability for human rights violations. Increasing public participation is a worthwhile goal, but it must be accomplished in a manner that will be effective. Similarly, decentralization of discipline will have no impact if the procedures under which discipline is performed, particularly for human rights violations, are not improved. Indeed, decentralization could impede accountability for human rights violations if each decentralized board lacks the resources for independent investigators and the procedures needed for effective action.

We therefore make the following recommendations for reform, which should be considered as a package:

1. **The record of the Councils must be thoroughly and independently examined**

   The search for truth can never be completed without a full exploration of the Councils’ past records. Unlike some other entities, the Councils have not made or presented to the public a serious review of their record in cases with human rights dimensions.

   We therefore recommend a review of the record of the Councils, based on their minutes, internal memoranda, and other documents that will reveal the full role the Councils played in apartheid. This review of the Councils’ records should be undertaken by an independent body and published, so that the truth can truly emerge. The report should be a thorough, well-documented, public report that covers the Councils’ role in the maintenance of an oppressive system, their complicity in apartheid policies, and their role in covering up wrongdoing. The report should not be confined to the gross violations that are the TRC’s concerns, but should also include the Councils’ failures to protect and promote human rights.

2. **Members of the Councils who advanced the policies of apartheid should be replaced and all members should receive training in human rights**

   Individuals, whether Council members or staff, who took actions to advance the interests of the apartheid state through the work of the Councils, for example, failing to investigate charges against physicians who
were complicit in or covered up the existence of torture by security forces, should no longer serve on the Councils or their successors.

In addition, because human rights education is so essential to fostering humane values in the medical profession, and because the Councils play such an important role in reinforcing medical values, human rights education should be mandatory for all members and staff of the Councils.

3. Legislation should be enacted to increase community participation in the work of health professional regulatory bodies and assure the Council's commitment to human rights

The Councils are currently structured to be an organ of the "establishment," with representation from universities, government agencies, medical societies and the like. There is very little representation of the public or of constituency groups that are broadly representative of the South African community. Restructured Councils should include representatives of labor unions, social welfare agencies and others with strong ties to community-based organizations. They should also include representatives of each major population group. These representatives should be able to speak as the consumers of health services, and have as great a stake in the profession as the professionals themselves. They should be more than tokens, and must be included in a manner to make their voices effective.

Legislation should also establish criteria for membership on the Councils that include a demonstrated commitment to human rights.

4. Legislation should be enacted to create special procedures for the investigation and prosecution of human rights violations by health professionals

As explained above, the Councils are not presently structured to be effective in disciplining professionals within their jurisdiction for human rights violations. Special investigatory procedures should be established for complaints of human rights violations committed by health professionals and a special unit to engage in such investigations. We believe this separation is essential, first, because human rights violations may differ in many respects from traditional ethical violations. Second, as our interviews have demonstrated, those in the business of enforcing traditional standards lack familiarity with human rights even to the point of not recognizing when a human rights violation takes place. Third, establishing a special procedure for investigation of human rights violations sends a very important signal to the nation that human rights violations in the health sector will be taken very seriously. Finally, separating human rights enforcement from other issues in professional discipline avoids becoming embroiled in a debate about the proper methods of professional discipline in general.

The following recommendations thus apply only to allegations of human rights violations by physicians and other health professionals. This approach, of course, means that rules must be established to distinguish more typical matters of professional misconduct, such as malpractice, from human rights violations. Legislation should therefore define human rights violations in professional behavior, so the professional and the public alike can understand which conduct falls into each category.

We recommend statutory change to create a special unit to engage in the investigation and prosecution of human rights violations by health professionals and to establish procedures for human rights violations.

(a) The first and most critical procedural recommendation is to establish a staff of independent professionals with the training and resources to investigate human rights violations

Investigators would work full-time and, to maintain independence, would not report directly to the members of the Boards or other entity that would ultimately adjudicate cases. The investigators' duty would be to investigate, develop and prosecute cases of alleged human rights violations before the members of Boards or other entity designated to hear cases.

We believe that existing proposals for change, which allocate professional discipline to each board, could make this process quite difficult, since they would require duplication of functions in each board. An alternative would be to establish one body to handle all complaints of human rights violations by health professionals.
(b) The investigators should have the authority to engage in a full investigation of allegations of human rights violations among health professionals.

(c) The complaint-filing process should be made accessible

Community-based organizations, clinics, churches and other local institutions should be informed about the role of the Councils and encouraged to assist members of their communities in filing complaints. Posters and other communication devices should be made available to help communicate the role of the Councils.

The Councils should encourage the filing of complaints in languages other than English or Afrikaans.

The process of filing a complaint should be made relatively simple and straightforward.

(d) The investigation branch would present cases to adjudication panels consisting of a designated number of members of the Council, health board or other designated entity as provided in law (for example, the law might provide for a panel of three members, including a physician, a lawyer, and a community member). The panel should have the assistance of a professional hearing officer.

Diversity of background is critical because human rights in health is not an exclusively medical question. While members of this unit should gain familiarity with medical issues, the emphasis should be placed on representatives of the greater South African community judging whether a human rights violation has taken place. Racial diversity in the panels should also be assured.

Professional hearing officers should be provided because conducting a hearing is a complex task, requiring ruling on evidence, maintaining an appropriate pace for the hearing, protecting witnesses, and other judge-like functions that require training and experience.

(e) In such proceedings, the health professional subject to investigation should be entitled to counsel and due process of law.

(f) The complainant should be entitled to receive notice of and be given the opportunity to participate in the proceedings before the panel.

The complainant may have critically important information and in any event deserves to be treated with respect. The complainant thus should be informed of the progress of the investigation and be encouraged to participate if he or she wishes. The panel should also protect the complainant from reprisal.

(g) Once the investigation staff has made a preliminary assessment to determine whether the complaint has a sufficient basis in fact, it should be made available to the public.

This would at once protect health professionals from a public airing of frivolous complaints and assure that serious allegations of human rights violations are known. Proceedings of the disciplinary entity would be a matter of public record. Only a full, public record of these allegations can assure that the complainant as well as the physician is treated fairly, that the process is not biased in favor of the physician, and that a cover-up becomes impossible.

(h) The adjudication panel should state reasons for its decisions and publish the names of and findings relating to people who are found culpable.

(i) Except in extraordinary cases, such as when it would interfere with a criminal prosecution, disciplinary actions involving human rights should not be deferred pending the resolution of other proceedings.
(j) The unit should have the authority to engage in emergency discipline pending the outcome of the adjudication when the action is necessary to prevent imminent harm to individuals or groups of individuals

Standards for emergency discipline, such as immediate suspension, should be established.

(k) The decisions of the unit should be reviewable in court, including appeals by the physician or the complainant

The latter should encompass the right to appeal a failure to prosecute. The law should establish standards for such appeals.

5. Legislation should establish effective sanctions for human rights violations by health professionals

There must be effective sanctions in addition to license revocation, probation, suspension and censure. Sometimes a person’s actions should preclude him or her from working in a particular setting, e.g., as a district surgeon, or from exercising certain responsibilities. These intermediate sanctions can be extremely effective in enabling the community to protect its human rights norms.

The sanctions available to the disciplinary unit could include the following:

(a) Barring from positions

The disciplinary entity could have the power to strip individuals found culpable from positions in government and from certain kinds of medical jobs, e.g., working with prisoners. This sanction should be tailored to the type of violation found.

(b) Human rights training

The disciplinary entity could have the power to require individuals found culpable to engage in rehabilitation by attending educational programs tailored to address the human rights

6. Human rights violations of the past that the Councils failed to address must be addressed now

It was apparent to our delegation that the desire for human rights accountability of health professionals is strong and compelling. Individuals who are supposed to be concerned with an individual’s health and well-being, and who continue to hold themselves out as committed to those values, should not escape responsibility for the human rights abuses they committed—and for the deep sense of violation among those who are victims of these abuses—because the Councils condoned or ignored these violations. We learned that almost without exception, individuals concerned with the future of health and human rights in South Africa believe it necessary to ensure that physicians who committed human rights violations during apartheid be held accountable for them.

Accountability of health professionals who engaged in human rights abuses can be had through a reformed disciplinary process, as described above. It should be permanent, appropriately staffed, and charged to engage in precisely the sort of investigation needed to address such violations. Thus, we recommend that legislation establishing a reformed disciplinary process for human rights violations include a directive to investigate human rights abuses of the past.

violations they committed, with monitoring of their performance thereafter.

(c) Fines

The disciplinary entity could have the power to impose fines on individuals found culpable. Legislation could provide that a portion of the fines be used as restitution for victims.

(d) Period of community service

The disciplinary entity could have the power to require a period of charitable or community service in health.
7. **Data collection procedures should assure an accurate record of the work of the Councils or their successor organizations**

The Councils or their successors should keep complete and accurate records of 1) complaints filed, at least including source of the complaint, geographical location, type of health professional against whom filed, and nature of the violation; 2) disposition of complaints; 3) disciplinary actions taken. The Councils should file an annual report to Parliament and to the public containing relevant statistical data as well as highlights of the Council's work for the year.

**E. Human Rights Education in the Health Sector**

One of the most important recommendations that has come out of the health sector hearings of the Truth and Reconciliation Commission is the need for educational reforms for health professionals. Many health sector submissions to the TRC include recommendations for such reforms, including the incorporation of human rights and ethics training for health professionals in the curriculum.

Recommendations for the integration of human rights concerns into health education should have special significance for the TRC. Human rights education represents a long-term strategy for developing a civil society that respects and nurtures human dignity. Conversely, the protection and promotion of human rights is perhaps one of the most effective means of promoting health and human well-being.

However, it is clear from our interviews with health professionals in South Africa, and review of health sector submissions to the TRC, that conceptualizations of human rights and its relationship to health are quite variable and often limited in scope. For example, health professionals often equate human rights with traditional bioethics concerns, the rights of patients, or the rights of health professionals themselves. Such conceptualizations are not well founded in international human rights law or contemporary human rights discourse.

1. **General recommendations**

All health professionals should receive training in human rights and relevant bioethics principles. The conception of human rights imparted should be based on international human rights principles. This training should be an integral and required component of their professional education. To underscore the importance of human rights, it should be a subject on which students are examined.

The training in human rights may be divided into several courses over time, and the content geared toward specific educational levels. For example, in the case of medical training, students could receive the following sequence of courses: (1) a comprehensive, semester-long course on health and human rights during one of the pre-clinical years, (2) a semester-long course on bioethics during one of the pre-clinical years, (3) a course on clinically relevant human rights and bioethics issues during one of the clinical years, (4) exposure to human rights and bioethics issues in other pre-clinical courses and during clinical training, and (5) special elective courses on clinical forensic medicine.

Most importantly, medical faculty should be only those who are role models in care of patients with respect to protection and promotion of human rights. Courses designed for various health professionals should, at a minimum, define human rights, articulate the relationship between human rights and health, and discuss the role of health professionals in promoting health by protecting and promoting human rights. It will be helpful for the courses to give students the opportunity for substantive discussions on the significance of human rights and the relationship between human rights and bioethics concerns. The courses should be both informed by international human rights understandings and relevant to the South African situation. Whenever possible, case study material should be included. It would be helpful for human rights courses to include outcome evaluations by students and colleagues.

To compensate for the deficiencies in the past training of health professionals, we recommend that continuing education human rights courses be developed and instituted for current health professionals. This could best be done by instituting a system, comparable to that of the United States and many other countries, that links maintaining certification to requirements for ongoing continuing education. The need for such instruction in human rights is made all the greater by the fact that most of these
professionals have practiced in a health care system with pervasive human rights violations and an inadequate sense of the responsibilities of health professionals. Beyond instruction in human rights and ethical norms, it will be important for such courses to examine patterns of human rights violations in the health sector during the apartheid era and the factors contributing to these abuses. The courses should emphasize the responsibilities of health professionals to promote and protect human rights and should link these obligations to concrete standards of behavior.

A central authority for human rights and ethics education should be established and assigned the responsibilities for developing resources, establishing educational guidelines, disseminating successful pilot initiatives, and monitoring progress. It would be preferable for this authority to take a “bottom up” rather than a “top down” approach so as to benefit from a variety of contributions and to engage health educators.

2. Incorporate specific objectives into human rights education

There are a number of objectives that should be kept in mind in when integrating human rights and bioethics concerns into the education of health professionals:

(a) Promote understanding of the relationship between health and human rights

With few exceptions, human rights have not been the expressed concern of the medical or other health professions in South Africa, as is the case in most countries. Although the World Medical Association and the United Nations have established codes of conduct for medical practitioners, neither these codes nor international principles of medical ethics address the relationship between the protection and promotion of human rights and the promotion of the conditions for health and well-being in the world. By promoting understanding of the relationship between health and human rights, South African health professionals have an opportunity to demonstrate leadership in health promotion in civil society.

Health professionals should recognize that contemporary human rights discourse is dynamic. Historically, the principal actors in human rights discourse have been states and legal experts. Increasingly, non-governmental human rights organizations have contributed to, and influenced, the course of human rights discourse. Over the past fifty years, international human rights law has grown from a handful of articles in the Universal Declaration of Human Rights in 1948 to more that fifty declarations, covenants, and conventions. Recently, there has been substantial debate over the issues of universal application of human rights, accountability of human rights violators, the priority of certain rights relative to others, and concepts of truth, justice and reconciliation. In addition, concepts of the right to economic and social development, peace, health, a balanced environment, and humanitarian disaster relief are under consideration. Because protecting and promoting human rights has direct bearing on the health of individuals and communities, health professionals should be active participants in debates on these and other human rights issues.

Health professionals should understand that human rights are interdependent and indivisible. The spectrum of human rights violations that may potentially affect health includes a broad range of possibilities: civil, political, economic, social, cultural and others. Efforts to focus exclusively on a select group of rights is not justifiable from a health promotion perspective, and should raise suspicions of either an inadequate understanding of health and human rights, or the possibility of an alternative agenda. Health professionals with a selective human rights focus may actually undermine efforts to promote health.

(b) Promote discourse on human rights in the health sector

Before any strategy of implementing human rights concerns may be realized in South Africa, human rights must first become an issue of concern. The development of human rights concerns among health professionals in the years ahead will depend largely on the degree to which health professionals recognize the health consequences of human rights violations and conceptualize the relationship between health and human rights. Meaningful
dialogue within the health sector will ultimately guide the development and expression of human rights concerns in medicine and health care.

Ultimately, health professionals will need to question and redefine their definitions of health and human suffering; they will need to study and articulate the relationship between health and human rights and learn to improve their responses to human rights problems. Academic discourse on human rights may be facilitated by undergraduate and graduate courses in the health sciences, fellowship and graduate research programs in human rights, and greater emphasis on primary health care experiences. Educational training for clinicians may be initiated through continuing medical and health education courses and symposia. Publication of original research, books, and news articles relevant to human rights would increase awareness and understanding of human rights issues.

Also, the degree to which human rights concerns are actively supported by health educators will have far-reaching and long-lasting effects on students' conceptualizations of health and human suffering, and thus on the scope of their professional interests in society. Health educators provide role models which students often emulate, and ideas about questioning authority and one's role in relation to the state.

Human rights discourse should involve a wide range of participants, including stakeholders in the health sector, government representatives, consumers of health services, and other individuals in the public domain. The credibility and legitimacy of any consensus in human rights discourse will turn on the degree of representation achieved.

(c) Reconcile human rights and bioethics agendas

In the course of the progressive inclusion of human rights and bioethics concerns in the educational curricula, it is important that the similarities and difference between these fields be well understood. Human rights are social claims or values, which simultaneously impose limits on the power of the state (i.e. civil and political rights) and require the state to use its power to promote equity (i.e. economic, social and cultural rights). Human rights norms are rooted in the dignity and worth of all human beings and as such are universally applicable. Human rights principles place a great deal of emphasis on protections against discrimination and on the equality of all persons. The realization of such claims or rights are, in effect, a means of achieving the conditions for health and well-being in a democratic civil society.

Bioethical principles such as beneficence, non-maleficence, confidentiality, autonomy, equity, and informed consent are principles of conduct which regulate the clinical encounters of health professionals with individual patients. These principles do not attempt to define health and well-being, nor do they indicate possible causes of human suffering. In fact, it is fair to state that the discipline of bioethics was born of the misconduct of physicians and other health personnel. Historically, bioethicists have limited their concerns to within the disease paradigm; the discipline has evolved more in response to increasing ethical dilemmas that arise from disease-based medicine, than it has from an active agenda for health promotion. Only recently have bioethicists begun to examine the relationship between health and human rights.

Educational initiatives on human rights and bioethics should be complementary, and by no means should one preclude the other. Proposals for education on human rights and bioethics should be carefully examined to assess whether one discipline is, in fact, being subsumed by the other.

One example that needs careful scrutiny is the MASA proposal to the TRC for "general human rights training within medical ethics education." This proposal was supported by an eleven-page appendix that mentioned the words "human rights" only once, and in the following context: "The student will become more aware of current human rights issues." While the document appears to be a fine start for the inclusion of traditional bioethics concerns in the medical curriculum, it does not constitute a serious effort to integrate human rights concerns in the medical curriculum.
3. Human rights education campaigns

Health professionals also have the responsibility of advocating for health and human dignity. Human rights educational campaigns are critical not only because they are essential to raising awareness, but because they are essential to overcoming the tremendous resistance inherent in confronting painful issues. Advocating for health is both a political and a professional responsibility; it calls attention to the physical and psychological consequences of deliberate and systematic acts of violence which aim to destroy individuals and communities. However, advocacy to prevent and alleviate suffering must remain non-partisan to be credible and effective.

Those who suffer human rights violations often lack the means and/or capacity to represent their own interests. Health practitioners, as advocates of health and human dignity, have a duty to speak to the health and human rights concerns of vulnerable populations and should work to develop self-agency among those for whom they advocate.

4. Structural considerations

(a) Coordinate planning activities on human rights and ethics education in the health sector

Promoting understanding of the relationship between health and human rights, and promoting human rights discourse will require a central coordinating organization and interaction between various stakeholders. Organizations such as the Department of Health, professional and regulatory bodies, treatment centers for survivors of torture, the Health and Human Rights Project, the Progressive Primary Health Care Network, academicians, clinicians, human rights experts, consumers of health services, and others should participate in meetings and conferences on the subject of human rights and ethics education. Consensus on a strategic plan is likely to emerge through an iterative process.

The formation of a Committee on Health and Human Rights should facilitate the coordination of planning activities. In addition, individual organizations within the health sector should consider establishing an institutional task force or equivalent structure, to participate in human rights and bioethics education planning.

The need for diverse representation, including government representatives and statutory councils in the health sector, health professional organizations, members of the health professions, academicians, human rights experts, and others, cannot be overstated. These representatives should reflect geographic and racial diversity as well.

(b) Ensure adequate resource allocation

Implementing effective human rights and ethics education in the health sector will depend on adequate resource allocation. A formal accounting process should be undertaken prior to implementation and/or legislation of any costly education reform measures. In addition, human rights and ethics educators should be compensated at a fair wage for their services.

5. Curricular reforms and training in human rights and bioethics in the health sector

(a) Establish objectives for human rights and bioethics education

The objectives and goals of human rights and bioethics education should be clearly articulated prior to widespread implementation. These objectives may include the following: (1) providing improved conditions for health by protecting and promoting human rights; (2) understanding, alleviating and preventing human suffering; (3) ensuring respect for dignity and autonomy in clinical encounters; (4) promoting equity and access in the delivery of health services; and (5) promoting the concept of human dignity as the foundation for peace, freedom and justice in the world.
(b) **Assess educational initiatives in South Africa and abroad**

The Committee on Health and Human Rights, or an equivalent entity, should conduct an assessment of educational initiatives in South Africa and abroad to inform its strategic planning process. This is particularly important in human rights education for health professionals, as this is a relatively new area of study. Such assessments may be facilitated by meetings with national and international human rights and bioethics educators. The assessment will most likely aid in development of educational resource materials and pilot initiatives.

(c) **Develop educational resource materials**

Materials should be gathered from a diverse sample of human rights and bioethics educators and reviewed for possible inclusion in curricular studies in South Africa. Such materials may also serve as useful library references for instructors and students. Eventually, the materials gathered should be modified and consolidated for the purpose of specific human rights and ethics training in South Africa.

(d) **Develop and evaluate pilot initiatives**

Pilot initiatives should be identified and/or developed for various health professional target groups and evaluated for outcome. Teaching methods and the format of curricular studies should be periodically re-evaluated to assess their effectiveness.

(e) **Consider elements of effective human rights and bioethics education**

Human rights and bioethics education should be based on a coherent and comprehensive understanding of the relationship between health and human rights and bioethics. Since these areas of study cross many disciplines, educators must first educate themselves on a variety of new subjects. Also, collaboration from colleagues in disciplines such as law, philosophy, anthropology, history, women’s studies, etc., are important components of effective education.

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Educational initiatives should be grounded in real issues. Educators should make deliberate efforts to bridge abstract learning in the academy with practical human rights problems and ethical dilemmas. Examples of practical problems should draw on South African experiences and be related to international experiences when appropriate. Establishing bridges between the academy and the “real world” may be enhanced by providing students with opportunities for human rights experiences, encouraging colleagues to engage in socially relevant issues, and providing advocates with opportunities for reflection and analysis within the academy.

Teaching methods should be varied and stimulate interest among students. In addition to didactic seminars, other possibilities may include: student presentations, small group discussions, role play, visits by special guests such as survivors of torture, the use of film and audiotapes, and field trips. Student activities, for example, research internships and informal social events, offer additional opportunities for learning. Methods for teaching human rights and ethics, particularly for those who have completed their health education, may include conferences, workshops, roundtable sessions, training courses, and publications in professional journals, books, and the media, among others.

Course material should be diverse, culturally sensitive, complementary and stimulating. Readings may consist of scientific articles, analytical reflections, human rights reports, and literature.

(f) **Identify target groups**

As mentioned earlier, target groups for human rights education should include all people, and at many levels of education, including graduate and professional school students (i.e. law, humanities, arts, sciences), as well as training for those in law enforcement and government service. Human rights education for health professionals alone will not be sufficient for the values of human rights to take hold in society.
6. Professional support for human rights and bioethics educators

The quality and effectiveness of human rights and medical ethics training in the future may benefit greatly from efforts to provide professional support for educators in the health sector. Some suggestions include the following: (1) establishing a health and human rights society; (2) holding annual national, and possibly regional, human rights and health meetings; (3) soliciting by medical journals in South Africa manuscripts on the subject of human rights and ethics; (4) creating academic posts for human rights and ethics educators; (5) encouraging research in human rights and ethics through increased availability of grants.

7. Monitoring implementation of human rights and bioethics education

The central authority for human rights and ethics education in the health sector, or an equivalent entity, should be responsible for ensuring the progressive implementation of human rights education in the health sector. This authority may consider establishing an independent, non-governmental review board for the purpose of monitoring progress in human rights and bioethics education. Whatever entity assumes this responsibility, it is important that stakeholders within and outside the health sector be adequately represented.

8. Licensing linked to human rights and bioethics education

As noted above, the Councils should establish human rights and bioethics education criteria for the licensing of health professionals. In addition, human rights and bioethics education requirements should be established for continuing medical education for recertification purposes. These criteria for licensing and certification should be established in close association with representatives of medical professional organizations, non-governmental health and human rights organizations, and representatives in government.

F. Monitoring and Reporting on Health and Human Rights in South Africa

The apartheid period bequeathed a legacy of pervasive violations of human rights in the health sector. Moreover, the commitment to democracy and human rights of the current regime does not automatically eliminate these problems. South Africa has only just begun the long and complex process of institutional and educational reform to promote a culture of respect for human rights in the health sector, and human rights violations in the health sector are likely to continue for the foreseeable future.

It is therefore essential to monitor the behavior of both individuals and institutions in the health sector to assess their conformity with human rights standards and to identify serious problems. By monitoring, we mean systematic and relatively comprehensive efforts to collect appropriate data to determine whether the performance of individuals and institutions conforms to international human rights standards. Systematic monitoring serves a variety of functions. The primary aim of a monitoring procedure is to assist the state in protecting enumerated rights, not to criticize the inadequate performance of the state or particular professional sectors. By enabling the state and human rights monitors to evaluate progress or lack thereof, monitoring is indispensable in identifying human rights problems that may exist and helping to determine appropriate remedies. As such, it is a necessary input for the work of regulatory bodies and the formulation of public policy. The preparation and circulation of periodic reports enhances the accountability both of the individuals and institutions that are being analyzed, as well as of the government, which is ultimately accountable for the promotion and protection of human rights.

Monitoring and reporting are necessary in all political systems, even those with long traditions of respect for the rule of law and commitment to human rights and dignity. No country is free of problems or the need to improve its performance, and monitoring can help identify ways to better protect and promote human rights. For this reason each of the major international human rights instruments establishes a treaty monitoring body, functioning under the auspices of the United Nations, to receive and evaluate reports from the countries that have ratified these documents.
Monitoring is especially helpful in periods of transition, as in South Africa. In countries in which a change in regime is accompanied by a greater commitment to human rights, the government, as well as various institutions in the civil society, requires regular “report cards” as to the progress in overcoming the legacy of lack of respect for human rights. There is also a need to fine-tune public policy on an ongoing basis so as to reduce continuing human rights violations and encourage respect for human rights. Moreover, knowledge that monitoring will take place may in itself provide incentives to comply with human rights norms. Information from monitoring can also provide valuable input for professional oversight bodies, policy makers, educators, and administrators as they work to instill a culture of human rights.

Given the legacy of pervasive human rights abuses in the health sector in South Africa, it will be important to undertake three different levels of monitoring. The first is the individual behavior of health professionals. The second type of monitoring that we are recommending is the evaluation of the institutional practices of hospitals, prisons, and teaching facilities. Additionally, to assess whether the health care system is overcoming the legacy of apartheid, it will be important to monitor structural patterns relative to the distribution of resources, public policy priorities, educational curriculum, and licensing and professional oversight in the health sector. This third dimension of monitoring is required under section 184(3) of the South African Constitution, which mandates regular reporting by organs of state in respect of the realization of the rights enumerated in the Bill of Rights, one provision of which is access to health care.

Effective monitoring has many requirements. To begin with, it is proactive rather than reactive. This means taking the initiative to investigate performance at regular intervals rather than solely responding to reports of violations. It cannot be assumed that specific human rights are being respected just because complaints of violations have not been received unless regular monitoring occurs.

Effective monitoring is systematic. The data collected need to be representative of the most important indicators of compliance with relevant human rights standards. Monitoring is best done at regular time intervals, utilizing carefully designed strategies and instruments. To be able to assess trends over time, it is necessary to collect the same data in a similar way so that the various data sets can be compared. If large amounts of data are being collected, an information system for input, analysis, and retrieval will be required. Given the complexities of the task, it is important to use scientific methodologies that will provide reliable and accurate data.

Another requirement for effective monitoring is to have independent mechanisms with sufficient legal provision, knowledge of and commitment to human rights, adequate resources, professional standing, and skills to undertake the data collection and analysis. It will be particularly important for some monitoring mechanisms to have the statutory authority to go into institutions and examine records that might otherwise be confidential, subject to nondisclosure protections.

Another prerequisite is the existence of clear human rights standards that can provide a baseline against which to evaluate performance. We call elsewhere in the report for the adoption of a binding and enforceable code of conduct for health professionals that incorporates obligations respecting human rights. To be the basis for effective monitoring, the code should be translated or “operationalized” as to what each of its provisions requires and how conduct relevant to that provision should be monitored. In developing monitoring regimes, it is particularly helpful to anticipate the kinds of violations that may occur and collect appropriate data regarding these potential problems.

The code for health professionals should be augmented by two other sets of standards. The first is the development of binding norms that incorporate human rights criteria applicable to the conduct of institutions. In addition, there should also be specific time-related goals for systemic reforms to progressively realize the constitutional right of access to health care. As in the case of monitoring professional conduct, to be useful as the basis for monitoring, it would be important to translate these norms into specific guidelines to be checked.

It will be particularly important for these human rights codes of conduct to deal with implementation of the principle of nondiscrimination. Despite changes in the law, the legacy of unequal treatment of persons depending on racial origins continues to be reflected in individual relationships, the operation of institutions, and access to health care. It is therefore particularly important to define what it means to treat individuals—patients, health professionals, other staff of health facilities, and students—in a manner consistent with international human rights norms of nondiscrimination. It may be useful to build on the U.S. experience, legislation, and professional codes as they have addressed this issue.
Institutional codes of conduct also need to set forth detailed expectations that go beyond non-discrimination and embody the full range of international human rights principles. Many of the human right abuses noted in the submissions to the TRC’s health sector hearings described human rights violations that went beyond discrimination based on racial background. For example, there appeared to be a pattern of lack of respect for women’s dignity and autonomy that affected women of all races, although some of these violations, such as violence in clinical settings, were more likely to be directed at black women. Patients’ rights also appears to be an almost completely undeveloped area of work in South Africa.

Effective monitoring also requires community participation and commitment to human rights. Human rights are not entitlements that can be successfully conferred “from above” by benevolent governments. To be more than theoretical guarantees, human rights need to be supported, perhaps even demanded, and protected “from below” by citizens intent that the rights be realized. For this reason human rights education that reaches potential patients, as well as health care providers, is critical. The various public awareness campaigns and grassroots initiatives conducted by the Progressive Primary Health Care Network are an important beginning. These efforts need to be given sufficient resources so as to reach out to all areas of the country on an ongoing basis.

Monitoring can and should use a variety of approaches and strategies. These include the following:

- **Conducting a review of relevant legislation, regulations, and codes of various types to assess their conformity with international human rights standards.** Whether the international standards are reflected in domestic law and professional codes of practice or whether there are laws or regulations that contravene standards. In the case of South Africa, there are still many apartheid-era laws and regulations in place in the health sector that are inconsistent with a transition to a culture of human rights.

- **Undertaking regular site visits to assess human rights compliance in particular localities or institutions, especially those that have a history of human rights problems.** Given the pervasive problems in the past, police stations and prisons constitute obvious foci for monitoring to assess whether prisoners’ rights are being respected and to evaluate whether prisoners are being subjected to torture or denied appropriate medical care. Custodial and mental health institutions are another priority site requiring regular inspections. The situation in the military health service is another. It would also be important to visit a sample of other hospitals, medical facilities, and even practitioners’ offices to observe whether apartheid abuses are being repeated or corrected.

- **Requiring and evaluating written reports.** Many national human rights monitoring bodies require institutions to submit regular self-reports utilizing a specified format as the basis for assessing their compliance with relevant human rights standards. Some of the issues to monitor within the medical sector are whether: the institution has adopted an ethical or human rights code of conduct, personnel are receiving some form of training in respect for human rights, patients are being made aware of their rights and safeguards, or the institution has some form of a complaints procedure, and if so, the number and types of complaints that have been received.

- **Reviewing records.** Financial auditors regularly spot-check the records of institutions for which they have jurisdiction. In some locales, educational officials appear unannounced to review the records of schools. With necessary legal authorization, human rights monitors could also audit the records of providers, insurers, and regulatory bodies.

- **Interviewing practitioners and patients.** Like social science researchers, human rights monitors can develop formal interview protocols, identify representative samples, and conduct research to evaluate the current status of respect for human rights in the health sector. These methods can also be used on a more informal and less systematic basis.

- **Analyzing complaints and allegations of human rights violations.** Some institutions and medical societies have an ombudsperson or procedure through which victims can submit formal complaints and requests for remedies. Where such mechanisms exist, it is possible to set up an information system that would keep the complainants’ identities confidential but provide demographic information as well as data on the nature of the alleged violation, the circumstances, and the site at which it took place. Researchers could then analyze the data to ascertain the nature, source, frequency, and seriousness of the problems that are reported.
Finally, monitoring has a public reporting dimension that reinforces the accountability of health care professionals and the health sector as a whole. It is essential that the data collected through monitoring be analyzed and the results shared through the publication of periodic reports at specified intervals, usually on an annual basis. The reports enable the public to scrutinize the record and evaluate the extent of progress. This is essential if health care professionals and the health sector as a whole are to remain accountable for their conduct.

All too often primary emphasis is given to data collection without sufficient sensitivity to the importance of analysis and reporting. However, the collection of data is not an end in itself. Data collection is a means to assess the status of what is being studied, in this case progress in developing a health sector whose institutions and professionals operate in a manner consistent with human rights principles. Reporting provides a kind of report card on how far the health care system has progressed and where significant problems still remain.

Non-governmental organizations have made proposals for several types of monitoring mechanisms in South Africa. We understand that the Truth and Reconciliation Commission is considering a recommendation that a Commission on Health and Human Rights be established, consisting of health professionals, human rights experts, consumer representatives and legal experts. We consider the establishment of such an institution an important step forward. The proposed responsibilities of this Commission are:

- implementing the recommendations related to the health sector adopted by Parliament in response to the TRC report;
- monitoring institutional health care;
- advising on educational curricula on health and human rights;
- receiving and dealing with reports and complaints about human rights abuses in the health profession;
- creating the position and overseeing the work of a "medical public protector" or ombudsman; and
- undertaking an inquiry into the legal, ethical and professional position of health personnel in the military,

with the development of clear guidelines to avoid conflict between military law and professional ethics.

It is also important that an independent health complaints mechanism be established, possibly within the Commission on Health and Human Rights. This would allow for ongoing confidential reporting of human rights abuses by health professionals.

The TRC's recommendations run parallel to a proposal by the Health and Human Rights Project to establish a national health and human rights "watchdog" body to promote and monitor health and human rights among South Africans. A task force of South African health professionals is establishing a process of national consultations culminating in a national meeting to be held later in 1998. The initiative provides a unique opportunity for health professionals to build on the momentum generated by the TRC's health sector hearings and operationalize their stated commitment to reorient the health professions toward a greater focus on human rights. This process is very important because stakeholder involvement is likely to be key to the success of efforts to establish monitoring mechanisms.

Whatever form such national monitoring mechanisms assume, however, there will be a need for continued monitoring at many levels of the health sector. The effectiveness of a Commission on Health and Human Rights and/or an independent "watchdog" body will be dependent on the quality and type of data it receives.

G. Mental Health

1. Human rights and mental health

The problems in transforming mental health and mental retardation services are daunting. They require enormous resources for training, community-based services, advocacy, and research. Those efforts will take years, even decades. The difficulty of those transformations, however, should not delay the commitment to protect the basic human rights of people who find themselves in psychiatric institutions or discriminated against as a result of their disability. We therefore have the following recommendations:
(a) Recognize and protect the rights of people with mental illness

The most important step to take is to ensure that people with mental illness and mental retardation have a legally recognized right to dignity, to treatment in the community, to participation in their treatment, to non-discrimination, and to due process of law. These rights must be recognized in law. While the right to community-based services is aspirational at this time in history, it still needs to be recognized.

The law should protect the rights recognized by the international standards, and South African law should be rewritten not only to articulate them but to implement and devise procedures to protect them. These standards are summarized below:

- The right to be treated with respect for the inherent dignity of the person.
- The right to be free from discrimination on the grounds of mental illness.
- The right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights and other international declarations and covenants.
- The right to have the best available mental health treatment, in the community in which the person lives and suited to his or her cultural background. The treatment should include vocational and social skills training.
- The right to treatment in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the person’s needs and behavior toward others.
- The right to retain legal capacity to make decisions. When this is not possible, the right to a fair procedure in which the person is represented by counsel.
- The right to consent to treatment and refuse treatment offered unless specific standards and procedures are in place.
- For people in residential facilities, the right to privacy, to communicate with others, to be protected from harm, the right to be free from physical restraints (except when essential to prevent imminent harm), and the right to retain the rights of those not in facilities.
- The right to definable standards and procedural safeguards, including notice, the right to be heard before an impartial body, and to representation by counsel, before involuntary hospitalization.
- The right to access to advocates.
- The right to confidentiality.
- The right not to be used as a research subject without full safeguards.

These rights must be respected in fact. Professionals and other facility staff who work with people with mental illness and mental retardation should be provided with extensive training in human rights and with guidance in how to protect and respect those rights.

(b) Recognize and protect the rights of people with mental retardation

People with mental retardation and with mental illness are entitled to protection of their rights. People with mental retardation have all the rights listed above.

A law should be enacted to protect the rights of persons with mental retardation. The law should define mental retardation according to international standards and, in addition to the rights applicable to persons with mental illness specified above, should protect the following rights:

- The right to training in life skills, including self-care and vocational skills, to enable those who can to live, with supports, in the community.
- The right not to be institutionalized on account of mental retardation alone.
- For children, the right to an education.

People with mental retardation and no psychiatric condition should not be placed in psychiatric hospitals which can offer no
training to them. A plan should be developed to place people with mental retardation who are now in psychiatric hospitals in a more appropriate environment in communities, with appropriate supports.

(c) Training in human rights

Consumers, families and professionals should all be trained in the human rights of people with mental illness and mental retardation.

(d) Investigation of sterilization

The Ministry of Health should conduct an investigation of sterilization of persons with disabilities in South Africa. The investigation should include a comprehensive review of the extent of involuntary sterilization, particularly among people with disabilities, in institutions and in communities in South Africa.

A law should be enacted to protect individuals against involuntary sterilization with enforcement and reporting mechanisms designed to assure that people are not being sterilized.

(e) Facility standards and investigation

The Ministry of Health should establish standards for all facilities, public or private (including Life Care), including provincial facilities. These standards should be designed to assure appropriate and safe living conditions and the protection of the human rights of residents.

The Ministry of Health, or an entity it designates, should regularly investigate all facilities to assure they meet standards and protect human rights. The reports should address basic living conditions, the protection of patients from harm, and the nature and extent of therapies provided, and should review practices regarding medication, physical restraints, seclusion, and other physical interventions. The report should include specific action steps to bring human rights violations in facilities to an end. Reports of investigations should be made public.

(f) Advocacy support

The Ministry of Health should develop a plan to support the development of advocacy organizations representing people with mental illness and mental retardation and their families. The support should include assistance in organizing and communicating with individuals throughout the country and in traveling to meetings.

(g) End differential funding rates of institutions

Funding disparities for Life Care facilities based on the race of the population in the facility should be brought to an end.

(h) Plan for community-based services

Consistent with the changes in law recommended in (a) above, the Ministry of Health should establish, as national policy, a commitment to provide services in the community for people with mental illness and mental retardation. We recognize that this is an enormously challenging undertaking, requiring financial, human and technical resources. We urge that the process of development continue.

The Ministry of Health should continue its initiatives to develop mental health services in primary care and community-based services for people with mental illness and to take advantage of opportunities for training and technical assistance from the international community. These services must be well designed so that discharged individuals do not become homeless.

In a similar vein, the Ministry of Health should initiate a plan to develop community-based services for people with mental retardation and bring institutionalization of persons with mental retardation to an end. It should particularly take advantage of community resources for such a transition.

These processes should include participation by people with disabilities and their families.
(i) **Repeal of prohibition on institutional investigations**

Provisions of law that render it a criminal offense to make false statements about institutional conditions should be repealed.

2. **The psychological legacy of apartheid**

The legacy of violence and trauma from apartheid is one of the most difficult tasks South Africa faces. Some of the challenges, particularly to reduce the level of violence in society, are far beyond the scope of this report.

(a) **Promote understanding of the scope of the injury**

The ability to function at levels sufficient to fulfill personal, family, and community expectations requires appropriate management of grief, joy, rage, fear, a sense of security, hostility and spontaneity. Membership in civil society should assure a sense of belonging to a moral order grounded in broadly held values of right and wrong. To the extent that this has been compromised, it should be recognized and addressed. The TRC can provide a service to the nation simply by recognizing the enormous scope of the injuries to so many hundreds of thousands, perhaps millions of people.

(b) **Promote multicultural interventions for trauma**

One of the challenges facing a multicultural society such as South Africa is to include methodologies for treatment of trauma beyond those traditional to Western practitioners. An example is the success the Zionist Church has had in restoring wholeness and strengthening communities, due in part to its grounding in prophetic revelation congruent with Xhosa and other African peoples’ theological notions of cleansing and the casting out of evil forces.

Strategies for fostering a multicultural approach to trauma and the experience of violence must be developed. Earlier in the report, we discussed several possible pathways to expand multicultural resources for those suffering from torture, state sanctioned uprooting and human rights violations. These include taking advantage of the skills and talents of black social workers, clergy, traditional healers and trauma centers. These resources should be further developed.

(c) **Professional training and commitment**

Mental health professionals trained in Western methods have paid little attention to the trauma experienced by blacks during apartheid. Language and cultural barriers are reinforced by focus on private practitioners serving white patients. These professionals can themselves enlarge their cultural vision and contribute to healing and relief from suffering, but they must learn multicultural skills and, equally important, commit themselves to working with all the people of South Africa.

H. **Military Medicine**

The South African Medical Service (SAMS) should limit itself to providing medical care, and forensic services when needed for purposes of military administration, to members of the armed services and their dependents. In the event of armed conflict, it is legitimate, indeed required by medical ethics and international humanitarian law, for military doctors to treat sick and injured civilians and members of opposing forces. Absent such conditions, SAMS should not function as a civilian health services provider. The role conflict problems inherent in military medicine, which were demonstrated with particular force by SAMS’ performance during the apartheid era, weigh heavily in favor of these limits on the role of military medicine. The responsibilities in this area that SAMS currently exercises should be turned over to civilian medical institutions. Moreover, SAMS should be clearly proscribed by statute from participating in any manner in the development of biological or other weapons technologies that draw upon medical knowledge.

I. **Medical Documentation of Torture and Ill-Treatment**

Reforms that provide for the effective documentation of torture and human rights abuses are essential in the process of reconciliation and in restoring trust in the medical profession in South Africa. Although some
district surgeons, such as Dr. Wendy Orr, acted courageously and in the best interests of their patients under apartheid, most district surgeons did not.

Reforms in the medical documentation of torture and ill-treatment take on additional significance, as torture in detention is still practiced in South Africa. Moreover, it appears that district surgeons have failed to engage in the reflective process of the health sector hearings. A single submission by several district surgeons to the TRC offered little more than self-congratulations for a job well done under difficult circumstances. The magnitude of these problems calls for no less than a fundamental transformation of the present system.

In September 1996, the Ministry of Health drafted a document entitled “Proposed National Policy on the Medicolegal Services in South Africa.” The document is an excellent strategic plan for reform of forensic post-mortem services in South Africa. We support the recommendations which pertain to forensic post-mortem services, including legislative reforms regarding forensic post-mortem services, transfer of medicolegal mortuary services to the health sector, improvements in resource allocation and laboratory services, centralization of post-mortem services, restructuring of personnel, establishment of quality control measures, and improved training in forensic medicine.

The Ministry of Health proposal only briefly addresses the need for reform in clinical forensic medical services. It refers primarily to victims of rape, child abuse and assault, but does not specifically mention the evaluation and care of detainees. The proposal calls for decentralization of services from district surgeons to “the same doctors who render primary health care services.” It emphasizes the need for these medical practitioners to have special training in assessing and caring for such victims of violence and recommends a team approach, consisting of doctors, nurses, social workers, rape crisis workers, psychologists, and the like. The proposal also includes a warning that decentralization of clinical forensic medical services will, most probably, lower the current standard of service, and that it will take years of service for primary health care practitioners to develop the expertise that most district surgeons already have.

The prevalence of complicity among district surgeons, or equivalent personnel, in past and present human rights abuses has created an imperative to dismantle the present system of clinical forensic medical services. The Department of Health proposal effectively accomplishes this by transferring the responsibilities of district surgeons to all primary health care practitioners. However, this plan not only will be fraught with the problems of establishing and maintaining clinical standards and quality of care, it will increase the degree of fragmentation of services and render service providers even more isolated and vulnerable to coercion by perpetrators of human rights violations. In addition, displacement of clinical forensic medical services from district surgeons to all primary health care providers may indirectly compromise the delivery of primary health care services and create a disincentive for physicians to choose to work in this field. Given the need for frequent evaluations of detainees while in custody and following detention, it seems unlikely that these services will be effectively rendered by primary care providers.

Strategic planning for clinical forensic services would benefit from additional dialogue within the health sector. Such dialogue may aid in producing an extensive and coherent plan like that proposed for post-mortem forensic services.

Further dialogue on forensic clinical services in South Africa may be enhanced by the recommendations which follow. Although some of these recommendations may be specific, they are also intended to serve as points for further discussion.

(a) Reassign responsibilities for clinical forensic services

One possibility may involve replacement of district surgeons by a corps of clinical forensic specialists. These practitioners may work full-time, part-time, or on a sessional basis. However, each practitioner must be certified, or licensed, to practice clinical forensic medicine. This includes present district surgeons who may wish to participate in these services. The certification process may consist of an initial training course, followed by a proficiency examination (didactic and practical) and an oath pertaining to human rights and ethics. Clinical forensic specialists should be required to maintain their skills through continuing medical education requirements established in conjunction with the SAMDC.
Their activities would be monitored by an independent health and human rights commission, or similar entity.

Alternatively, restructuring of clinical forensic services in South Africa may involve joint responsibility by forensic pathologists and primary health care physicians. This restructuring plan would be similar to that proposed by the Ministry of Health, but would also include provisions to improve centralization, standardization and quality control of services, as well as professional organization and solidarity. In this plan, primary health care practitioners would assume the responsibility for clinical forensic services. However, the responsibilities for training, certification, selection of practitioners, establishment of clinical standards, and assessment of quality of service would fall under provincial forensic pathology services. Such a plan would require administrative links and coordination between forensic pathology services in all provinces, and within the Ministry of Health. It would also place significant demands on forensic pathologists, whose work already suffers from staffing shortages.

Another possible way of restructuring clinical forensic services in South Africa would involve transferring the custodial responsibilities of district surgeons to prison health services. Under these circumstances, non-custodial clinical forensic services (sexual assault, child abuse, motor vehicle accidents, and the like) might be best handled by clinical teams located in primary health care centers, as proposed by the Ministry of Health. Responsibility for training, certification, selection of practitioners, establishment of clinical standards, and assessment of quality of service could be assumed either by prison health services or provincial forensic pathology services. In either case, control of prison health services should be transferred from the Ministry of Correctional Services to the Ministry of Health.

(b) Establish a central authority for forensic services in the Department of Health

Regardless of whether the responsibilities of district surgeons are assumed by clinical forensic specialists, primary health care practitioners, prison doctors, or some other health professionals, a central authority should be established within the Ministry of Health for all forensic services. This authority should be concerned with assuring adequate standards for forensic training, certification, selection of practitioners, clinical services, quality assurance, procedural safeguards, and accountability. The central authority should work closely with health professional organizations, statutory medical councils, forensic medicine specialists, medical academicians, provincial health officials, health and human rights organizations, and torture treatment organizations, as well as the Departments of Education and Justice.

The authority should be responsible for providing official annual reports which contain information on forensic services and the activities of the forensic authority. The authority also would be responsible for providing access to information such as autopsy reports, medical examinations of detainees, and clinical records when indicated by allegations of misconduct. Under such circumstances, measures would need to be taken to preserve the confidentiality of the patient-physician relationship.

The authority should establish an independent review board to ensure that human rights and bioethics standards are strictly maintained in forensic services (see below).

(c) Establish procedural safeguards for medical evaluations of detainees

Forensic medical evaluations of detainees should be conducted at regular intervals and in response to official written requests by a public prosecutor or an appropriate judicial official. Requests for medical evaluations by law enforcement officials should be considered invalid unless they are acting on the written orders of a public prosecutor or an appropriate judicial official.

Detainees ideally should be examined at the time of detention, after interrogations, periodically during detention, and at the end of detention.

Official forensic personnel should have unequivocal access to those in detention. In addition, physicians who provide alternative medical evaluations at the request of a detainee should be guaranteed access to the detainee.
Detainees have the right to obtain a second, or alternative, medical evaluation by a qualified physician of their choice during and after the period of detention.

Each detainee must be examined in private. Police or other law enforcement officials may not be present in the examination room. This safeguard may only be precluded when the detainee poses a serious risk to the safety of health personnel. There must be strong evidence on which to base any omission of this safeguard.

Medical evaluations of detainees should be conducted at official medical facilities whenever possible. When examinations are conducted at a police station or other place of detention, forensic practitioners must be given access to adequate examination facilities. The presence of police in the examination room, for whatever reason, should be noted in the physician’s official medical report. Notation of police presence during the examination may be grounds for disregarding a “negative” medical report in court.

Medicolegal evaluations of detainees should include the use of a standardized forensic medical report form. An example is provided in Appendix B of this report.

A standardized forensic medical report form should be provided by the examining physician. The original completed evaluation should be transmitted directly to the public prosecutor and copies of each medical report should be retained by the examining physician and sent directly to an independent review committee (see below). Under no circumstance should a copy of the medical report be transferred to law enforcement officials.

When forensic medical examinations are conducted at the end of the period of detention, the detainee should not be returned to the place of detention, but rather should appear before the prosecutor or judge in a proceeding to determine the detainee’s legal disposition. This will reduce the possibility that torture or ill-treatment will take place after such medical examinations.

(d) **Legislate structural changes in forensic services**

Structural changes in forensic services should be drafted into legislation. These changes should include: (1) establishing the role and responsibilities of a forensic authority within the Department of Health; (2) reassigning responsibilities for clinical forensic services; (3) establishing procedural safeguards for medical evaluations of detainees and post-mortem examinations; (4) revising the Forensic Medical Service Postmortem Act as advised in the Proposed National Policy on the Medicolegal Services in South Africa, drafted by the Department of Health in September 1996; (5) requiring policy and procedural manuals for clinical forensic specialists and forensic medical examiners; (6) establishing regulations for law enforcement officials and security forces which ensure independent and effective forensic and clinical services for detainees; (7) requiring the South African Medical and Dental Council to improve licensing criteria for clinical forensic services and forensic pathology; and (8) establishing a legally-binding code of conduct for health professionals. (See Recommendation B.)

(e) **Monitor for potential complicity in torture and ill-treatment**

The monitoring authority discussed in Recommendation F should be responsible for ensuring that human rights and bioethics standards are strictly maintained in forensic services. This authority may consider establishing an independent, non-governmental review board for the purpose of monitoring human rights and ethics. In either case, monitoring may include: (1) periodic review of performance evaluations; (2) announced and/or unannounced site visits to examination facilities, including places of detention; such visits may include interviews with staff and examination of forensic documentation; (3) preliminary inquiries into reports of misconduct and referral of appropriate cases to the SAMDC; and (4) periodic quality assessments of random samples of forensic reports.
(f) **Establish criteria for licensing and certification of forensic practitioners**

Criteria for licensing physicians who provide forensic services, whether these services are in clinical or postmortem settings, should be established. In addition, requirements should be established for continuing medical education for recertification purposes. These criteria for licensing and certification should be established in close consultation with representatives of medical professional organizations, non-governmental health and human rights organizations, and representatives in government.

(g) **Undertake administrative reform among district surgeons**

District surgeons who are currently active and wish to continue providing clinical forensic services should undergo a personnel audit. This may involve review of performance evaluations, clinical service records, and complaints of any misconduct.

(h) **Ensure adequate resource allocation for restructuring of forensic services**

Recommendations which aim to provide effective documentation of torture and ill-treatment depend on adequate resource allocation. A formal accounting process should be rendered prior to implementation and/or legislation of any costly reform measures. In addition, clinical forensic services should be compensated at a fair level.

(i) **Provide professional support for practitioners of forensic clinical services**

In the past, district surgeons were very isolated from other health practitioners in the course of their daily work. The status of district surgeons in the health sector was stigmatized partly because of the nature of their work, but also because of the perception that district surgeons often engaged unsavory practices such as remuneration fraud (i.e. billing multiple payers for the same service). In addition to reassigning the responsibilities of district surgeons and making other structural changes in forensic clinical services, it is important to provide professional support for practitioners of forensic clinical services. To some extent, the absence of professional support in the past probably contributed to the problem of complicity of the district surgeons in human rights abuses and ethical misconduct.

The quality and effectiveness of forensic clinical services in the future may benefit greatly from efforts to incorporate forensic specialists into the mainstream of the health sector. Some suggestions include the following: (1) establish a forensic medical society; (2) hold annual national, and possibly regional, forensic meetings; (3) include clinical forensic specialists in medical education seminars on human rights and ethics; (4) encourage South African medical journals to solicit manuscripts from clinical forensic specialists; (5) create academic posts for clinical forensic specialists; and (6) encourage research in clinical forensic medicine through increased availability of grants.

Normative expectations of clinical forensic specialists should not tolerate complicity in abuses of human rights or ethical misconduct. These expectations should be voiced from all corners of the health sector.

Apartheid medicine violated fundamental human rights and failed to provide adequate health care to a majority of South Africans. The new South African Constitution enshrines the rights of all people in the country and affirms democratic values of human dignity, equality, and freedom. Its Bill of Rights recognizes the right to have access to health care services, including reproductive health care. Realization of these goals, however, will require overcoming the legacy of apartheid in the health sector through undertaking the reforms outlined in this report. If South Africa is able to institute a culture of human rights, it will serve the people of South Africa and provide a model for the rest of the world.
NOTES

2. The South African Ministry of Health’s current plan for reorganizing the nation’s health services envisions increased reliance on “contracting out” to private sector providers as part of an effort to develop a higher quality public medical system. Department of Health. White Paper for the Transformation of the Health System in South Africa. Government Gazette, vol. 382, no. 17910. Pretoria, April 16, 1997. For this plan to succeed over the long term, it is essential that quality be raised sufficiently to attract large numbers of middle class South Africans—enough to create a political constituency for preservation of the public system as something more than a separate, inferior program for the poor.
3. Such decisions will include budget allocations between and within government departments and health care institutions, siting of new facilities, salary scales, payment levels and mechanisms for services “contracted out” to the private sector, spending on clinical and basic research, and even allocation of human organs for transplantation.
4. Such a prohibition should be phased in over time, perhaps several years, given the enormity of current disparities and the desirability of limiting the institutional disruption that reallocation of public resources will inevitably entail.

Concluding Postscript: Implications for the United States

The South African Truth and Reconciliation Commission’s investigation of the health sector under apartheid has laid bare the long record of pervasive and institutionalized racism, segregation, limitation or outright denial of access to medical care, gross violations of human rights and willful abandonment of the ethical commitments of medicine. No industrialized nation in the last half century has so deliberately initiated and so long sustained a system with such massive effects on the health and life expectancy of its own population. But the scale, intensity and rigidity of the apartheid system should not obscure the fact that health sector racism and its attendant human rights violations are not unique to South Africa. Few nations are immune. To examine many aspects of the South African record is, for example, to find striking parallels to the health sector record in the United States—and not merely in the distant past. In many ways, the South African and American experiences illuminate each other, and such comparisons carry implications for both societies. It seems appropriate, therefore, for the American participants in this joint venture with the Truth and Reconciliation Commission to offer a brief review of their own national experience of human rights in health care, and to consider it in the light of South Africa’s current efforts at transformation.

Most such reviews begin with a reference to the federally sponsored Tuskegee Syphilis Study, in which for 40 years some 399 black men in Alabama were deliberately and secretly denied effective treatment in order to “document the natural history of the disease.” (The natural history of syphilis infection had already been thoroughly established; the underlying—and false—racist premise was that blacks were biologically different; and so the natural history might be altered). In the twenty-five years since its public disclosure, as medical historian Vanessa Gamble notes, the Tuskegee study “has moved from being a singular historical event to a powerful metaphor. It has come to symbolize racism in medicine, misconduct in human research, the arrogance of physicians, and government abuse of black people.”

As Gamble and many other historians of medicine have shown, however, Tuskegee merely extended a legacy of race-based human rights
violations in medicine that began more than two centuries earlier with the use of slaves for often brutal medical and surgical experimentation. (One physician described "research" in which he performed a total of thirty surgical procedures on a slave woman—without anesthesia). 2 Antebellum medical journals, especially but not only in the southern United States, published numerous pseudoscientific articles containing the usual derogatory stereotypes of blacks as biologically different, intellectually inferior, and emotionally labile; these implicitly justified slavery as a necessary and essentially benign institution. 3 Not even death afforded an end to abuse. The bodies of many blacks (often stolen from graves) were shipped to medical schools for use in anatomy demonstrations and dissections. 4

The Civil War and the Emancipation Proclamation ended the total dehumanization of blacks in the South, but the political freedom of the brief Reconstruction period was rapidly replaced by disenfranchisement in the South and by pervasive de jure and de facto racial segregation—including the health sector—in both North and South. In health care as in education, housing, urban and rural infrastructures and other areas, facilities and resources were separate and unequal; in the southern states, Jim Crow laws and vigilante terrorism by organizations such as the Ku Klux Klan maintained a social order strikingly similar to that of apartheid. Slavery was succeeded by the sharecropper system, a form of economic peonage; in the north, people of color were excluded from most skilled occupations.

Most hospitals in the United States either refused admission to blacks or admitted them only to segregated and inferior wards, often in the basement. No blacks were admitted to medical schools in the South, and only a handful in the North. Nor was the racism of the last half of the nineteenth century directed only at people of African descent; in a striking precursor of South Africa's forcible relocations and the creation of artificial homelands, the Native American population was decimated and confined to reservations. In the West, harsh restrictions on immigration and systematic discrimination were directed against Chinese and other Asians.

There was, nevertheless, some progress in the health sector. Several medical schools were established to train black physicians. A small network of separate black hospitals developed, although it was not until 1891 that the first black-controlled institution, Provident Hospital in Chicago, opened. Since many state medical societies refused membership to black physicians—thus effectively denying them hospital staff privileges as well as membership in the American Medical Association—minority physicians formed the interracial (but overwhelmingly black) National Medical Association, formed for some of the same purposes that were to inspire South Africa's NAMDA decades later.

Well into the twentieth century, discrimination and segregation by race remained characteristic of the health sector. The American eugenics movement in the 1920s and 1930s produced a new burst of pseudoscientific racism, and engendered eugenics laws enabling forced sterilization—carried out primarily though not exclusively against blacks—that remained on the books of some states well into the 1970s. After World War II, a massive government-funded program to build hospitals, the Hill-Burton legislation, permitted (though did not require) the construction of separate white and black facilities.

As late as the early 1950s, one survey found that while 83 percent of general hospitals in the North offered patient care on an integrated basis, only 6 percent of Southern hospitals admitted African-Americans without restriction; of the remaining 94 percent, 33 percent did not admit any African-American patients, 50 percent had segregated wards, and the remainder had modifications of segregated patterns. In the South, only 6 percent of hospitals offered internships and residencies, and only 25 percent provided medical staff privileges, to African-American physicians, usually restricting their work to the segregated wards for black patients. In these institutions, racial segregation required separate blood banks, lines, bathrooms, cafeterias and waiting rooms. The situation was little better in the North, where only 10 percent of surveyed hospitals accepted African-Americans as interns and residents, and only 20 percent offered staff privileges. 5

Forces for change in the health sector were gathering, however: interracial organizations such as the Association of Interns and Medical Students (AIMS) and Physicians Forum supported efforts by the National Association for the Advancement of Colored People (NAACP), the National Medical Association, the National Urban League, and the Congress of Racial Equality (CORE) to end segregation and discrimination in hospitals. But it was not until the great direct-action civil rights movement began in the 1960s, with nonviolent sit-ins, freedom rides, marches, boycotts and mass protests under the leadership of the Student Non-Violent
Coordinating Committee (SNCC) and the Southern Christian Leadership Conference headed by Martin Luther King, Jr., that massive change occurred. One result was congressional passage of the Civil Rights Act of 1964, which established a national priority against discrimination in the use of federal funds and provided for enforcement by withholding funds or "by any other means authorized by law." An intensive campaign involving the government's judicial, legislative and executive branches, using the threat of cutting off Medicare certification and all other federal funds to noncompliant hospitals and clinics, that was supported by the American Hospital Association and other professional organizations, effectively ended most formal racial segregation and discrimination in health sector facilities, although powerful differences in access to care, because of economic and geographic disparities, continued.

The civil rights movement (and the passage of the Voting Rights Act in 1965, which tempered but did not totally end the South's strategy of "massive resistance" to integration) focused national attention on the problems of hunger and poverty, disproportionately affecting (but not limited to) people of color. The resulting governmental "War on Poverty" implicitly recognized that the health status of America's minority populations, characterized by huge differences in infant mortality rates, burdens of acute and chronic disease, and life expectancy, could not be altered by health care change alone but required the reduction of inequity in incomes, education and economic opportunity and protection against dangerous social, biological and physical environments. Over the next thirty years, despite assaults by conservative forces on these measures and on "affirmative action" programs, the African-American middle class quadrupled in size; at the same time, the increasing urban segregation of poor people of color limited health progress. One study in the 1990s demonstrated that life expectancy for adult males in central Harlem was lower than in Bangladesh. While infant mortality rates for both blacks and whites steadily improved, the gap between them remained as great as ever. And although African-Americans comprise approximately eleven percent of the U.S. population, their number includes only three percent of the nation's physicians.

Racism aside, and despite the worldwide attention to the crimes of Nazi doctors and the publication of the Nuremberg Code in 1948, major attention to problems of medical ethics, accountability in research and treatment, and human rights in the health sector did not surface until the mid-1960s. Even then abuses like the Tuskegee study and the testing of contraceptive and other drugs primarily on third-world populations did not end immediately. Today they are secure aspects of medical and other professional education, and there are careful and institutionalized mechanisms for the oversight of research; nevertheless, racial and gender disparities in the allocation of resources for diagnosis and treatment continue to occur.

South Africans will recognize in this account the many parallels to their own experience, as well as some crucial differences. Change in the U.S. followed a slow curve over more than two centuries; change in South Africa has been far more abrupt. In the United States, there was an existing egalitarian and democratic social contract—the Constitution, including the Bill of Rights—and the struggle was, and is, to apply it fully to an oppressed minority. In South Africa, a majority was brutally repressed by a small minority wielding the social contract called apartheid. But some implications seem clear. Real change in South Africa's health sector will require intensive and continuous effort by every branch of government, spurred by an informed and demanding population. Human rights protection and professional accountability require secure and institutionalized mechanisms, and cannot be left to the health professionals alone, even with systematic improvements in their training in medical ethics. Racism is persistent and deeply entrenched, but not insuperable. Major improvements in health status do require health system reform, but more importantly they flow from improvements in housing, nutrition, education and the environment. And these, in turn, require not only the assumption of political power by the majority but also significant redistribution of income and economic opportunity.

One other aspect of the parallels between the American and South African struggles must be mentioned. As Robert Kinloch Massie argues in the recently published book, Loosing the Bonds: The United States and South Africa in the Apartheid Years, the South African struggle for liberty and justice was a direct continuation of the long American struggle for civil rights. There is another—and darker—side of that parallel: the same conservatives who opposed civil rights in the U.S. were apologists for apartheid and defenders of the South African government's oppressive actions. And that effort included the American Medical Association.
The record of conservative American leaders and their publications has recently been reviewed in detail by Jacob Hellbrunn in a liberal journal, *The American Prospect*. He notes:

During the first stage, in the 1960s, conservatives depicted blacks as racially inferior to whites and praised the homelands policy of South Africa. In the second stage, in the 1970s, conservatives painted apartheid as a necessary evil; the Soviet threat required the United States to support South Africa. In the final stage, in the 1980s, the right decried the move toward divestment and sanctions, argued that capitalism would save the country, and portrayed Nelson Mandela and the African National Congress as pawns of the Kremlin.6

In the 1960s, for example, the conservative *National Review* argued that, “the whites are entitled, we believe, to pre-eminence in South Africa.” Its editor, William F. Buckley, after traveling through South Africa for several weeks, wrote, “there has never been any reason to doubt Verwoerd’s own sincerity. He means to help the blacks.” In 1965, the conservative leader Russell Kirk echoed South African propaganda that blacks were not fit to govern themselves, that black enfranchisement “would bring anarchy and the collapse of civilization,” and “Bantu political domination would be domination by witch doctors.” And in the 1980s, during the height of the Reagan administration’s support of the apartheid regime, in a policy called “constructive engagement,” its architect, Chester Crocker, Undersecretary of State for African Affairs, told a South African reporter that, “all Reagan knows about southern Africa is that he’s on the side of the whites.” During this period, the American Medical Association consistently supported the South African Medical Association, fought for its inclusion in the World Medical Association and against its international isolation, and in 1989, sent a delegation to South Africa to hold a press conference and declare that there was no evidence of discrimination. Ironically, this group was in South Africa at the same time that a human rights mission of the American Association for the Advancement of Science was gathering evidence for a review of the devastating effects of apartheid on health. Much has changed since then in the U.S. and, most obviously, in South Africa, but a final parallel continues: in both societies, there is much more yet to be done. The work of the Truth and Reconciliation Commission, and the participation of the American Association for the Advancement of Science, Physicians for Human Rights, the Committee for Health in South Africa, the American Psychiatric Association, and the American Nurses Association, are steps in that ongoing process.

NOTES


Appendix A

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Standards for the Effective Documentation of Torture and Ill-Treatment

The following recommendations are intended to serve as possible guidelines for the effective documentation of torture and ill-treatment among detainees. Please note that the following recommendations are based largely on material contained in a publication entitled, “Torture in Turkey & Its Unwilling Accomplices.”

General comments

Medical evaluations of detainees for legal purposes should be conducted with objectivity and impartiality. The evaluations should be based on the physician’s clinical expertise and professional experience. The physician’s ethical obligation of beneficence demands uncompromising accuracy and impartiality in order to establish and maintain professional credibility.

Doctors who conduct evaluations of detainees should have specific training in forensic documentation of torture and other forms of physical and psychological abuse. They should have knowledge of prison conditions and torture methods used in their particular region and their common after-effects.

The medical report should be factual and carefully worded. Medical jargon should be avoided. All medical terminology should be defined so that it is understandable to lay persons.

The doctor should not assume that the official requesting a medical-legal evaluation has related all the material facts. It is the doctor’s responsibility to discover and report upon any material findings which he or she considers relevant, even if they may be considered irrelevant or adverse to the case of the party requesting the medical examination. Findings that are consistent with torture or other forms of ill-treatment must not be excluded from a medical-legal report under any circumstance, including the omission of the possibility of torture by the requesting official.
Purpose of inquiry, examination and documentation

- To assess for possible injuries and abuse of detainees, even in the absence of specific allegations by detainees, or law enforcement and judicial officials.
- To document physical and psychological evidence of injuries and abuse.
- To correlate the degree of consistency between examination findings and specific allegations of abuse by the detainee.
- To correlate the degree of consistency between examination findings of an individual detainee with the knowledge of torture methods and their common after-effects used in a particular region.
- To render expert interpretations of the findings in medical-legal evaluations and provide expert opinions regarding possible causes of abuse. The purpose is to provide expert opinions on the degree to which one's findings correlate with the detainee's allegation of abuse.
- To effectively communicate the physician's medical findings and interpretations to the judiciary. In addition, medical testimony often serves to educate the judiciary on the physical and psychological sequelae of torture.

Interview considerations

Physicians must ensure that patients understand the potential benefits and adverse consequences of an evaluation, to form the basis of informed consent. Physicians have a duty to maintain confidentiality of information and to disclose information only with the detainee's consent. Each detainee should be examined individually, in privacy. The detainee has the right to refuse the examination.

The location of the interview and examination should be as safe and comfortable as possible, including access to toilet facilities. Sufficient time should be allotted to conduct a detailed interview and examination.

Establish the identity of the detainee. The physician should provide his or her name and explain his or her role in conducting the evaluation.

Proceed only with an official request by a legal authority, such as a public prosecutor.

Notify police that they must leave the room. Note police presence if they refuse to leave.

Explain to the detainee the need to ask specific and detailed questions. Acknowledge the detainee's ability to take a break if needed or to choose not to respond to any question he or she may not wish to.

Trust is an essential component of eliciting an accurate account of abuse. Earning the trust of one who has experienced torture and other forms of abuse requires active listening, meticulous communication, courtesy, genuine empathy and honesty.

Translation: Interpreters should have professional training. The physician should be aware that various characteristics of the interpreter may affect the translation process, such as differences in gender, ethnicity, economic status, ideology, cultural sensitivity, professional experience, and development of rapport with the detainee.

Transference and Countertransference Issues: Clinicians who conduct medical evaluations of detainees should be familiar with common transference reactions (i.e., mistrust, fear, shame, rage and guilt) that victims of trauma experience and the potential impact of such reactions on the evaluation process.

In addition, the clinician's responses to working with victims of torture and other forms of abuse (countertransference) may compromise the effectiveness of the medical evaluation. Common countertransference issues include: disillusionment, avoidance, withdrawal, helplessness, hopelessness, over-identification, idealization, anger and guilt. Clinicians may experience symptoms of "vicarious traumatization" such as nightmares, anxiety, and fearfulness over hearing the experiences told to them. Effective documentation of torture and other forms of ill-treatment requires significant understanding of the motivations for working in this area. It is important that a clinician not use the population to work out unresolved issues in himself/herself, as these issues can clearly get in the way of effectiveness.
Medical history

Obtain a complete medical history, including prior medical and psychiatric problems. Be sure to document any history of injuries before the period of detention and any possible after-effects.

Avoid leading questions. Structure inquiries to elicit an open-ended, chronological account of the events experienced. Specific historical information may be useful in correlating regional practices of torture with individual allegations of abuse. Examples of useful information include: descriptions of torture devices, body positions and methods of restraint, descriptions of acute and chronic wounds and disabilities, and identifying information about perpetrators and the place of detention.

Pursuit of Information. Torture victims may have difficulty recounting past events because of: 1) blindfolding, 2) disorientation, 3) lapses in consciousness, 4) organic brain damage, 5) psychological sequelae of abuse, 6) fear of placing oneself or others at risk, and 7) lack of trust of the examining physician. Clarify any inconsistencies as they may have bearing on the detainee’s credibility.

General Information. Name, age, residence, education, occupation, family history, political activity, duration of the interview, name of translator.

Psychosocial History, Pre-arrest. daily life, relations with friends and family, work/school, entertainment, future plans, political activities, beliefs and opinions regarding the conflict, knowledge of torture, prior psychiatric history, use of alcohol and drugs.

Summary of Arrest(s) and Abuse. Before obtaining a detailed account of events, elicit summary information, including dates, places, duration of detention, frequency and duration of torture sessions. A summary will help to make effective use of time. In some cases where survivors have been tortured on multiple occasions, they may be able to recall what happened to them, but perhaps not recall exactly where and when it happened. In such circumstances, it is advisable to elicit the historical account by methods of abuse rather than as a series of events during specific arrests.

Arrest(s). Consider the following questions: What time was it? Where were you? What were you doing? Who was there? Describe appearances, whether they wore uniforms and carried weapons. What was said? Any witnesses? Was violence used, threats spoken? Was there any interaction with family members? Note the use of restraints or blindfold, means of transportation, destination, and names of officials.

Prison Conditions. Including access to and descriptions of food and drink, toilet facilities, lighting, temperature, ventilation. Also, document any contact with family or health professionals, and conditions of crowding or solitary confinement.

Consider the following questions: What happened first? Where were you taken? Identification process (personal information recorded, fingerprints, photographs). Were you asked to sign anything? Describe the conditions of the cell/room (note size, others present, light, ventilation, temperature, presence of insects, rodents, bedding, access to food, water and toilet). What did you hear, see and smell? Any contact with people outside or access to medical care? What was the physical layout of the place where you were detained?

Methods of Torture and Ill Treatment. In obtaining historical information on torture it is important to avoid suggesting forms of abuse that the detainee may not have been subjected to. This may help to separate potential embellishments from valid experiences. Questions should be designed to elicit a coherent narrative account.

Consider the following questions: Where did the abuse take place, when and for how long? Were you blindfolded? Before discussing forms of abuse, note who was present (give names, positions). Describe the room/place. What objects did you observe? Describe each instrument of torture in detail. Note clothing/disrobing. Record quotations of what was said during “interrogation,” insults to one’s identity. What was said among them? For each form of abuse, note: body position/restraint, nature of contact, including duration, frequency, anatomical location, and the area of the body affected. Note any bleeding, head trauma, or loss of consciousness. Was the loss of consciousness associated with head trauma, asphyxiation, or vaso-vagal tone related to pain? Note sexual violations. Elicit what was said during the torture. For example, during electric shock torture to the genitals, perpetrators often tell their victims that they will no longer have normal sexual functions, or something similar.

Review of Torture Methods. After eliciting a detailed narrative account of events, it is advisable to review other possible torture methods. Reviewing different forms of torture is especially helpful when:
psychological symptoms cloud recollections, the trauma was associated with impaired sensory capabilities (i.e., blindfolding, extreme fear and anxiety, sleep deprivation, loud noises, intense lights or the use of psychotropic drugs), when there is possible organic brain damage, or when there are mitigating educational and cultural factors. It is important to learn about regional practices of torture and modify the Review of Torture Methods accordingly.

Physical Abuse (partial list of general categories):

- Blunt trauma: punch, kick, slap, whips, wires, truncheons, falling down
- Suspension/stretching limbs apart
- Burns: electric shock, cigarettes, heated instrument, chemical
- Asphyxiation: wet and dry methods
- Crush injuries:smashing fingers, heavy roller to thighs/back
- Penetrating injuries: stab and gunshot wounds, wires under nails
- Sexual: humiliations, molestation, instrumentation, rape
- Exposure to extremes of temperature
- Prolonged constraint of movement
- Chemical exposures: salt, chili, gasoline (in wounds, body cavities)
- Traumatic removal of appendages and organs: hair, digits, limbs, kidneys, etc.

Psychological Abuse (partial list of general categories):

- Deprivation of normal sensory stimulation (sound, light, sense of time via hoooding, isolation, and manipulating lightness of cell); physiological needs (sleep, food, water, toilet facilities, bathing, motor activities, medical care); social contacts (isolation within prison, loss of contact with outside world). Such deprivations often result in disorientation of time and space; they may induce exhaustion and debility, difficulty concentrating, decreased memory, hallucinations/other psychotic reactions, depression, hopelessness, and despair.
- Humiliations: including verbal abuse, denial of privacy (e.g., toileting), prevention of personal hygiene, detailed set of regulations and rules over insignificant issues, overcrowding of cell, forced nakedness, filth in food, infected surroundings (lice, rats), being forced to perform humiliating acts, and sexual abuse. (Note: sexual assault is grossly underreported.)
- Threats: of death, harm to family, further torture, mock executions, or witnessing torture of others.
- Various psychological techniques designed to create an illusion of betrayal and to break down the individual. For example, forcing individuals to make impossible choices, to act against their ethics or ideology; inducing helplessness, confusion, mistrust and intense fear. This may be achieved by forcing individuals to witness or participate in the torture of others, by revealing certain information, mock executions, or by continuing the torture whether or not the individual cooperates.
- Pharmacology: Pharmaceutical agents may be used to create profound anxiety and disorientation. For example, sedatives and neuroleptics may be used to blunt and distort the senses. Curare and other paralytics may be used to cause near or complete suffocation.
- Post-release: Those who survive torture and remain in their country may experience intense fear and suspicion about being re-arrested. They are often forced to go “underground” to avoid being arrested again. Those who are exiled or are refugees may leave behind their native language, culture, families, friends, work and everything that is familiar to them.

Symptoms and Disabilities Following Trauma:

Acute and chronic symptoms and disabilities associated with specific forms of abuse and the subsequent healing processes should be documented.

- Acute symptoms: The detainee should be asked to describe any injuries that may have resulted from the specific methods of abuse alleged. For example, bleeding, bruising, swelling, open wounds, pain, numbness, and marks on the skin, difficulties with movement, vomiting, etc. The intensity, frequency and duration of each symptom should be noted. Note that the detainee’s ability to make such observations may have been
compromised by the torture itself or its after-effects and should be documented.

- Chronic symptoms: Elicit information about physical ailments that the detainee believes are associated with torture or ill-treatment. Note the severity, frequency and duration of each symptom and any associated disability or need for medical and/or psychological care.
- Psychological symptoms: review symptoms that constitute post-traumatic stress disorder (PTSD), anxiety and depression.

Physical examination

Conduct a thorough physical examination noting pertinent positive and negative findings. Although the physical manifestations of torture may involve all organ systems, there should be special attention to the possibility of the following findings:

**Skin:** dermatologic evidence of abrasions; contusions; lacerations; puncture wounds; burns from electric shock, cigarettes or heated instruments; alopecia; and nail removal.

**Musculoskeletal:** mobility of the joints, spine and the extremities; pain with range of motion; contractures; fibrositis; compartment syndrome; healed fractures with or without deformities; ostitis; periostitis; fibrosis in muscles, fascia, and connective tissue; injury to tendons and ligaments; and osteoarthritis.

**Neurologic:** mental status changes; plexopathies; radiculopathies; neuropathies; cranial nerve deficits; hyperalgesia; parasthesias; hyperesthesia; change in position and temperature sensation, motor function, gait and coordination.

**HEENT:** tympanic membrane rupture, sensorineural hearing loss, tinnitus, conjunctivitis, dental and mandibular trauma.

**Gynecological:** injuries to external genitalia and breasts, pain on internal pelvic and rectal examinations, pregnancy, and sexually transmitted diseases.

**Other:** examination of the pulmonary, cardiovascular, gastrointestinal, and genitourinary systems should follow a standard medical examination.

Psychological examination

The examiner needs to be qualified. Non-therapists need to develop qualifications to assess psychological evidence.

Assess for PTSD, depression, anxiety, suicidal ideation, and other DSM categories.

Assess specificity of psychological symptoms in the context of the traumatic experience. Is the overall picture consistent?

Clinicians need to educate lawyers, prosecutors, adjudicators and governmental representatives about the importance and validity of psychological consequences of torture.

Interrelate psychological and medical testimony.

Photographic evidence

Photographs are crucial for thorough documentation of visible physical findings of torture. Photographs should be in color, in focus, adequately illuminated, and taken by a professional or good quality camera. Each photograph should contain a ruled reference scale, an identifying case name or number, and a sample of standard gray.

Supplement photographs with distant and/or immediate range photographs to permit orientation and identification of the close-up photographs.

Photographs should be comprehensive in scope and must confirm the presence of all demonstrable signs of injury or disease commented upon in the medical report.

Diagnostic tests

Consider the indications and utility of any test before obtaining it. Some diagnostic studies that may be useful in establishing evidence of torture, among others, include: X-rays, CAT scan, MRI, bone scan (scintigraphy), testicular perfusion scan, skin biopsy for evaluation of electromyogram for nerve injuries; blood tests (such as a complete blood count; creatine phosphokinase; serologic tests to evaluate renal, hepatic and thyroid function; tests for pregnancy and sexually transmitted diseases), neuropsychiatric testing.
Indications for referral

**Specialists:** Referrals should be requested as indicated by individual diagnostic limitations. Referrals to psychology/psychiatry, neurology, orthopedics, and gynecology, are quite common.

**Rehabilitation Services:** In the course of documenting medical evidence of torture and ill treatment, physicians are not absolved of their ethical obligations. Those who appear to be in need of further medical or psychological care should be referred to appropriate services.

Interpretations of findings and conclusions

**General Comments.**

a) Individual variation

- Physical manifestations of torture may vary according to the intensity, frequency and duration of abuse, the victim's ability to protect himself/herself, the accuracy of the account of events, and the physical condition of the detainee prior to the torture.

- Psychological manifestations of torture also may vary according to the intensity, frequency, and duration of the abuse. However, psychological sequelae of torture typically vary according to the meaning or psychological impact of the torture for an individual. The personality or identity of the individual detainee must be assessed in conjunction with the presenting psychological symptoms.

b) Scars

- Scars associated with torture: review of scars commonly associated with beating, suspension, burns, electric shock, lacerations, penetrating injuries, contusions, abrasions, and lacerations, dating of scars.

- “Innocent” scars: stretch marks, ritual practices

c) Physical evidence

- A particular method of torture, its severity and the anatomical location of the injury often indicate the likelihood of specific physical findings. For example, beating the soles of the feet (*falaka*) may result in subcutaneous fibrosis and a compartment syndrome of the feet; the use of electricity and various methods of burning may also leave highly characteristic skin changes; whipping may also produce a highly characteristic pattern of scars; different forms of body suspension and stretching of limbs may result in characteristic musculoskeletal and nerve injuries.

- Other forms of torture may not produce physical findings, but are strongly associated with other conditions. Beatings to the head that result in loss of consciousness are particularly important to the clinical diagnosis of organic brain dysfunction. Trauma to the genitals is often associated with subsequent sexual dysfunction.

- It is important to realize that torturers may attempt to conceal their acts. To avoid physical evidence of beating, torture is often performed with wide, blunt objects, and victims are sometimes covered by a rug, or shoes in the case of *falaka*, to distribute the force of individual blows. Stretching, crushing injuries and asphyxiation are also form of torture which have the intent of producing maximal pain and suffering with minimal evidence. For the same reason, wet towels may be used with electric shocks.
Standard Medical Report Form

Date: 
Translator (Yes / No) Name: 
Case ID #: 
Detainee Name: 

Source of Request for Medical Report: 
Name: 
Position: 
Request type: Written / Verbal 

Reason For Request: 
Signs of Injury / Violence 
# of days off from work 
No request 
Other: 

Detainee accompanied by: 
Name: 
Police: Yes / No 
Security Forces: Yes / No 
Other: 

Present During Examination: 
Detainee: Yes / No 
Doctor: Yes / No 
Other Detainees: Yes / No (#___) 

Medical Report Transferred to Prosecutor Via: 
Police 
Soldier 
Mail 
Other: 

Review of Prior Medical Reports: 

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EXAMINATION

1. Complaints 
2. Alleged Methods of Injuries (give approximated dates of injuries) 
3. Examination Findings 
4. Assessment of correlation between physical findings and alleged methods of injury. 

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<tr>
<th>Alleged Method of Injury</th>
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* NC = not consistent with; PC = possibly consistent with; C = consistent with; HC = highly consistent with; DO = diagnostic of. 

Referrals: 
Diagnostic Tests / Studies Requested: 

Physician's Name: 
Signature: 
Written and verbal testimony

Medical reports and verbal testimony must be objective and impartial. All information presented in the medical testimony should be relevant and defensible in court. Do not include irrelevant information. Do not overstate the client's degree of certainty regarding exact dates or the precise sequence of events. The inclusion of "hearsay" information may undermine the credibility of the clinician's testimony and conflict with the detainee's account of the events.

Present various sources of evidence: physical, psychological and historical and interrelate them. The testimony should reflect the entirety of one's experience and individual reactions to it.

The quality of medical testimony, whether written or oral, can only be as good as the quality of the interview and examination that were conducted and the degree of adherence to procedural safeguards.

Components of the Testimony:

1. Qualifications
   - Medical education and clinical training (provide curriculum vitae)
   - Psychological training
   - Regional human rights expertise
   - Relevant publications, presentations, courses
   - Experience in documenting evidence of torture: specific knowledge and training regarding methods, physical and psychological consequences of torture, and relevant human rights conditions: i.e. course study, conferences, reading, experience.

2. Statement regarding the veracity of testimony: For example, "I personally know the facts recited below, except as to those stated on information and belief, which I believe to be true. I would be prepared to testify to the above statements based on my personal knowledge and belief."

3. Background information
   - Name, age, gender, family, education, work, political activity

4. Medical History
   - General Information
   - Psychosocial History
   - Summary of arrest(s) and/or abuse
   - Arrest(s)
   - Prison conditions
   - Methods of torture and/or ill-treatment
   - Review of torture methods
   - Physical abuse
   - Psychological abuse

5. Symptoms and disabilities following trauma:
   - Acute symptoms
   - Chronic symptoms

6. Physical examination

7. Psychological examination

8. Photographic evidence

9. Diagnostic tests

10. Referrals

11. Interpretations of findings and conclusions

12. Statement of truthfulness: For example; "I declare under penalty of perjury, pursuant to the laws of (Country), that the foregoing is true and correct and that this affidavit was executed on X/X/X at (City), (State or Province)."

13. Signature, date, place

Note: You have the opportunity and the responsibility to educate judicial officials and attorneys. Explain variability of sequelae of torture so adjudicators do not anticipate the presence or absence of a particular finding in every case that may appear similar.
Appendix C

The findings and recommendations in this appendix are taken from the *Truth and Reconciliation Commission of South Africa Report*, Volume 5, Chapter 8, pages 334-40.

**Findings and Recommendations of the TRC on the Health Sector**

Millions of South Africans were denied access to appropriate, affordable health care during the period under review. Health care workers, through acts of commission and omission, ignorance, fear and failure to exercise clinical independence, subjected many individuals and groups to further abuse. Fundamental reforms in the health care delivery system, legislative controls, monitoring and accountability mechanisms, and the training of health professionals are required.

**Legislation**

The Commission recommends that:

All legislation pertaining to health care focus on primary health.

Present health care legislation be reviewed, and future legislation developed, taking into account the need for transparency, evaluation and monitoring, the rights of service users and the primacy of confidentiality.

**Professional standards of conduct**

The Commission recommends that:

A uniform code of conduct for health professionals be developed, implemented, and taught in all health science faculties.

The statutory councils ensure that all health professionals registered with those councils are familiar with the professional standards to which they must adhere. Health professionals must be held accountable if they violate these standards.
Health professionals engage in “self-audits” of their professional conduct by meeting regularly in small facilitated groups to discuss ethical and human rights dilemmas.

**Training**

The Commission recommends that:

Health science faculties establish programs aimed at increasing the number of black under- and post-graduate students. This may require bridging programs, financial assistance, tutors, mentoring, etc.

Training in human rights be a fundamental and integral aspect of all curricula for health professionals. This training should address factors affecting human rights practice, such as knowledge, skills, attitudes, and ethical research practices. Knowledge of and competence and proficiency in the standards (both national and international) to which doctors will be held accountable should be a requirement for qualification and registration.

The content of the oaths pertaining to health care and the ethical principles embodied in them be taught as part of undergraduate training from the earliest opportunity possible. This facilitates an interaction with the principles espoused and an opportunity to question and implement them during the training period.

Continuing Medical Education programs include a review of human rights and ethical issues and developments.

**Safeguards for vulnerable health professionals**

In order to ensure that health professionals who work in situations in which they have dual loyalties are not complicit in committing human rights abuses, the Commission recommends that:

Appropriate ongoing training in institutional health care and human rights be mandatory for all health professionals working in public facilities.

Training be developed for non-medical prison staff, SANDF members and police, to facilitate a mutual understanding of the duties and obligations of health professionals working in those environments. This will support professional and ethical health practices.

Standards and norms that uphold human rights be developed for institutional health care. These need to be put into operation via regular independent audits.

The Department of Health assume de jure and de facto control of prison and detainee health care, military health care, state mortuaries and forensic services. (Those responsible for forensic services should not also be responsible for providing health care to prisoners and detainees, as is presently the case.) In other words, health professionals working in these environments must be employed by, report to and be professionally accountable to the Department of Health.

**Health care services in prisons**

The Commission recommends that:

The role, responsibilities and obligations of individuals responsible for the health care of prisoners and detainees, both in prisons and police cells, be clearly defined and accepted by all police and prison staff.

An audit of district surgeons currently employed by the Department of Health be carried out, to ensure that those who participated in or colluded with human rights violations in the past are no longer in a position to offer treatment to detainees and prisoners. (Note: this is not a recommendation that such people should no longer be allowed to practice, only that they be removed from situations in which they might be vulnerable to collusion.)

The medical records of prisoners and detainees be inaccessible to non-medical prison staff and/or police, unless the health professional in charge deems such access to be in the interests of the patient.

Medical examinations of prisoners and detainees take place in private, unless the patient or the health professional performing the examination requests otherwise.

Regular independent reviews of health care in prisons and other places of incarceration, military installations and mental institutions be conducted.

An independent line of authority be established to advise, guide and support district surgeons and other prison health care personnel facing controversial ethical decisions.

Compulsory refresher courses for prison health care workers focus on ethics, mental health issues, human rights and the specific health needs of prisoners.
The format of documentation completed by health professionals providing health care for prisoners and detainees specifically include sections on allegations of torture or abuse, evidence of such abuse and how the allegations are being investigated. All allegations of abuse must be reported to an independent monitoring body. Failure to report abuse should be a disciplinary offense.

**Medico-legal services**

The Commission recommends that:

There be uniform standards of training for all staff required to perform postmortems or other forensic examinations.

Custodial care and forensic services be separated. To prevent a conflict of interest, professionals who provide health care to prisoners and to others incarcerated or detained should not have forensic responsibility.

The legislation governing forensic psychiatry be revised, the secrecy clause related to forensic psychiatry be lifted, and forensic psychiatry services be reviewed.

The state fund an independent forensic service for the use of the family of anyone who dies in custody. The families be informed of their right to have an independent forensic pathologist present at a postmortem.

There be regular independent audits of the police mortuaries and forensic pathology laboratories.

Police mortuaries and forensic laboratories be adequately equipped. The absence of X-ray facilities, for instance, in the majority of mortuaries is noted with concern.

**Mental health**

The Commission recommends that:

Mental health be given priority as a national concern and be brought into the primary health care system.

Mental health services be accessible to all South Africans, with particular emphasis on the rural areas.

The focus of mental health services be shifted from the almost exclusively one-on-one therapy model, to become community based. Different care and therapy modalities be explored and instituted, particularly traditional and indigenous modes of treatment. Community counselors and family members be involved in care provision. Service users be included in decisions about service provision.

The quality and type of care provided in mental institutions be monitored by an independent body.

Psychometric tests which are culturally appropriate in all aspects be developed and appropriately applied.

Appropriate models for trauma counseling in the South African context be developed and implemented.

Mental health issues be taken into consideration by all appropriate ministries, for example Housing, Correctional Services, Education, and Safety and Security, in their planning processes.

Mental health services have a developmental focus.

There be increased research into the consequences of trauma related to the experience of violence. The growing body of research on post-traumatic stress disorder (PTSD) needs to be more widely shared and practically applied in social settings. Knowledge and awareness of PTSD should be encouraged in institutions, communities and the family.

**The organized medical profession**

The Commission recommends that:

The Statutory Councils governing the health professions be proactive in promoting human rights.

The Statutory Councils be given a proactive capacity to investigate unethical/unprofessional conduct, without having to depend on the submission of a formal complaint.

The composition of the Councils represent society in terms of gender, race, etc., and that the Councils include community representatives and members of other professions. This will ensure that the system of self-regulation, which has failed so obviously in the past, is not perpetuated.
The appointment of Council members should be a transparent process which ensures the political independence of the Councils.

The disciplinary "arms" of the Councils be bodies whose members have a core of appropriate knowledge and experience; disciplinary measures and sanctions be implemented in a consistent, fair manner; and the full Councils have the power to review outcomes of disciplinary inquiries and the sanction(s) imposed.

Political and functional autonomy and independence of statutory Councils be entrenched.

The Councils ensure that no legislation or policies violate the rights or dignity of patients, clients or health care professionals.

Health care professionals who oppose or draw attention to human rights abuses be actively supported and protected by statutory councils and professional organizations.

**Checks and balances for state-run organizations**

The Commission recommends that:

A body on health and human rights be established, consisting of health care professionals, human rights experts, consumer representatives and legal experts. This body could be appropriately located within the Human Rights Commission. It should be independent of government, professional organizations and statutory councils, but would obviously work in cooperation with these.

This body be responsible, among other things, for:

- implementing health sector-related recommendations adopted by Parliament as a result of this Commission’s report;
- monitoring institutional health care;
- advising on curricula in health and human rights education;
- receiving and dealing with reports and complaints about human rights abuses in the health professions;
- creating the position of and overseeing the work of a “medical public protector” or ombudsperson;
- implementing an inquiry into the legal, ethical and professional position of health personnel in the military, and developing clear guidelines to avoid conflict between military law and professional ethics.

This body have a mechanism to allow for ongoing confidential reporting of human rights abuses by health professionals.

**Service users**

The Commission recommends that:

Current efforts to create a Patients’ Rights Charter be encouraged. The Department of Health, statutory councils and professional organizations be required to engage in ongoing programs to inform users of health services of their rights and of ways in which complaints can be lodged.

**State health organizations (Department of Health and South African Medical Services)**

The Commission recommends that:

The disparities in health care resource allocation be redressed, with a special focus on the disparities between the urban areas and townships, as well as between urban and rural areas. This could be accomplished through a once-off tax, or slowly over time.

All employees of state-run institutions be made aware of their duties, obligations and rights.

Health care professionals exercise the privilege and responsibility of having final authority regarding decisions affecting the health of patients. This is particularly important in situations where the patient is incarcerated.

The SANDF provide appropriate mental and physical health care for those suffering from the effects of SADF actions or participation in them. Similarly, services are needed for those who participated in and suffered the results of other state-sponsored or liberation movement violence.
All health care facilities have policies that protect and promote:

- doctor–patient confidentiality
- clinical independence
- institutional independence
- patient advocacy.

**Research and publications**

The Commission recommends that:

The professional bodies, Statutory Councils, and the health and human rights body (referred to above) monitor research practices, especially among vulnerable populations whose members may be unaware of their rights.

There be a prohibition against research into scientific methods of interrogation and torture.

South Africa adhere rigorously to all the stipulations of the International Conventions on Chemical and Biological Weapons, particularly those pertaining to research and development.

The *South African Medical Journal (SAMJ)* have editorial independence from any interest group such as the state, the Medical Association of South Africa (MASA), etc.

The editorial board of the *SAMJ* be broadly representative and include community representatives.

**Responsibility for developing and implementing these recommendations, and for monitoring their implementation, rests primarily with:**

- The Department of Health – national and provincial;
- The statutory councils;
- Professional organizations;
- The SANDF;
- Health science faculties;
- The Human Rights Commission;
- NGOs involved in health.