Johannes Wier Foundation

HEALTH PROFESSIONALS AND HUMAN RIGHTS IN SOUTH AFRICA

Report of a mission on health and human rights to the Republic of South Africa on behalf of the **Johannes Wier Foundation,** the Dutch Foundation for Health and Human Rights, from 2-15 April 1987

by

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and

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SUMMARY

The Johannes Wier Foundation, the Dutch Foundation for Health and Human Rigths, has commissioned a delegation consisting of Adriaan van Es, M.D. and Marijke van Gurp, S.R.N. to visit the Republic of South Africa and report on health related problems of detentions, especially detention of children, and the reaction of health professionals, and on violations and limitations of professional integrity and human rights related to health care.
The mission took place from 2 - 15 April 1987 at the invitation of the National Medical and Dental Association of South Africa. This professional organization is particularly concerned with health effects of apartheid, involved in monitoring human rights and in the examination and treatment of ex-detainees and victims of state violence.
During the mission the delegates attended and addressed NAMDA's 5th Annual Conference and visited a large numer of medical, dental and nursing professionals, lawyers, psychologists, university staffmembers and organizations concerned with (ex)detainees and health care. They had access to sometimes most confidential information and had extensive consultations with organizations and individuals.

The report contains 3 sections. Section I deals with the detrimental effects of apartheid regulations and the new constitution on health. During the mission the delegation as confronted with several obvious violations of medical ethics as a result of these regulations.
Section II focusses on detentions. The rapidly increasing number of detainees are very frequently exposed to mental and physical torture and abuse.
South African colleagues, lawyers and others related many distressing and appalling cases of torture. The devastating effects of detentions and torture on individuals and society became obvious.
Section III describes limitations and violations of professional integrity. Violence against and harassment, intimidation and de-

tention of individual health workers who care for ex-detainees and who defend and promote human rights, are in flagrant contradiction with international codes and declarations.
The conclusions are reviewed under these internationally accepted codes and declarations. The recommendations mainly focus on the recognition and defense of those health workers who defend and promote human rights and medical ethics. Strengthening of international contacts with these health workers, notably those organized in the National Medical and Dental Association is recommended.
The recommendations have been adopted by the Board of the Johannes Wier Foundation for publication and circulation.

INTRODUCTION

Human rights are being violated daily on a large scale in many countries of the world.
The medical, nursing and paramedical professions have a special responsibility towards the preservation and promotion of human rights.
The Neurenberg trials after World War Two have made us aware how far health professionals can become involved in the violations of human rights. Since then many treaties and international rules have been formulated and accepted to prevent such involvement and to give health professionals a tool for the promotion of - especially the medical aspects of - human rights.
Wherever human rights are violated, there are people who oppose these violations, among them health workers. They work individually, as groups or in an organization.
They frequently have to oppose strong forces, which are mostly connected to state or parastatal authorities.
The struggle these people fight need international support and recognition; they express the most precious aspects of medical ethics. The identification of these colleagues and the support they deserve and need, are some of the objectives of the Johannes Wier Foundation for Health and Human Rights, founded in 1986 by a group of Dutch health professionals who want to contribute to the responsibility of the medical, dental, nursing and paramedical professions for the preservation and promotion of human rights.
South Africa is one of the countries where human rights are violated on a large scale. The country is unique in maintaining a legal system of racial discrimination (apartheid) denying basic human rights to the majority of its population. The recent State of Emergency has still added to the situation of lawlessness, especially by detentions and other forms of organized violence.

Apartheid and detentions have penetrated deeply in health and health care. They have created repression, disparity and physical and mental suffering.

They have also generated resistance among health professionals. Individual health workers have since many years challenged apartheid and its effects on health. They conceive detentions as detrimental to health, as an institution itself and in its effects. Many of these health professionals have organized themselves since 1982 in the National Medical and Dental Association of South Africa (NAMDA). They felt the necessity to form a new professional organization because of dissatisfaction with the failure of the MASA (the Medical Association of South Africa) to denounce and challenge apartheid and the detention without charge. The formation of NAMDA was accelerated by MASA's failure to have the Biko doctors disciplined before the South African Medical and Dental Council.

Since its formation NAMDA has consistently opposed apartheid and detentions. NAMDA adheres to the World Health Organization's principles of equal health facilities for all, and strives for a non-racial and democratic South Africa.

NAMDA has made it easier to identify health workers who promote and protect human rights, sometimes under very difficult circumstances.

The Johannes Wier Foundation was invited by NAMDA to participate in its 4th Annual Conference and Annual General Meeting at the University of Western Cape, Cape Town, from 3 - 5 April 1987, and to undertake a tour of visits to major universities and institutions, organizations and individuals in South Africa.

The invitation was accepted. A delegation of two persons, Dr. Adriaan van Es, M.D., president of the Johannes Wier Foundation, and Ms. Marijke van Gurp, Senior Nurse, at the invitation of the Johannes Wier Foundation, undertook the mission to South Africa from 2 - 15 April 1987. The terms of reference, described in detail in the next chapter, were defined by the Board of the Johannes Wier Foundation in view of its deep concern about the - medical aspects of - detentions, the endangered professional integrity and the influence of apartheid on health, health care and health professionals.

During preparatory meetings with NAMDA delegates in Durban and Amsterdam and with the Board of the Johannes Wier Foundation, it was agreed that the mission would meet doctors, nurses, psychologists, lawyers, university staff, organization delegates, and would take as sources of information for this report the personal and professional information of these people and reports of research on human rights and detentions already available in South Africa.
Preparatory meetings were further held with international lawyers and health professionals.
The mission to South Africa was financed by the Johannes Wier Foundation and the Royal Dutch Medical Association.

During the stay in South Africa many places, institutions and people were visited, mostly in Cape Town, Durban and Johannesburg. Visits were made to universities, hospitals, clinics and townships. Meetings were held with delegations of Medical Faculties of the University of Natal and of the University of the Witwatersrand, Legal Resource Centres, Medical Students' Representative Council, Executive members of NAMDA, OASSSA, DPSC, MASA, Lawyers for Human Rights, Health Workers Association, Emergency Service Groups.
Discussions were held with Dr. LeRoex, chairman of the Federal Council of MASA, Dr. Mji, president of NAMDA, Prof. Arbickle, Prof. W. Loening, Prof. J. Coovadia, Prof. T. Jenkins, Prof. S. Browde, Dr. S. Karim, Dr. R. Dyer, Dr. M. Bhikoo, Dr. E. Buch, Dr. J. Gluckman, Dr. C. de Beer, Dr. T. Wilson, Dr. F. Randera, Dr. D. Rees, Dr. P. Vallabj, Dr. P. Davis, Mr. Nicholson, Mr. Kearny, Mr. M. Freeman, Mr. L. Vogelman, Mr. N. Manoïm, Mr. J. Browde, Dr. M. and Mrs. A. Coleman, Ms. S. Goldstein, Ms. Daphne, Ms. S. Manson, Ms. Schneider, Dr. Tlakula, Dr. Nair, Dr. Jinabhai, Dr. F. Meer, and many others, some of whom wish to remain anonymous.
Unsuccessful attempts to contact were made to the secretary general of the MASA and the secretary general of the SANA (South African Nurses Association).

The mission to South Africa was an inspiring and impressive event.

The conference, described by many as a landmark in NAMDA's history, was attended and the delegation members were both invited to deliver a speech. The papers presented at the conference were of high quality and most relevant for the cause of human rights. Among the approximately 500 attendants were 11 speakers from abroad.

The atmosphere of the conference was filled with discussions about the future health care in South Africa, and an aforeshadow of a free and democratic society that nobody doubted South Africa would become despite of the painful and often bitter transitional period it is going through.

The delegation of the Johannes Wier Foundation would like to express their feelings of gratitude for the hospitality with which they were received and for the trust they were given, since much of the information they received was most personal and confidential.

This introduction is followed by the terms of reference and a discription of the Johannes Wier Foundation. Three sections focus in detail on "health and apartheid" (Section I), "detentions" (Section II) and "professional integrity" (Section III), in which the role of various professional organizations is discussed as well.

The report continues with the conclusions and recommendations as adapted by the Board of the Johannes Wier Foundation and ends with a list of abbreviations, references and appendices with international codes and declarations.

The foundation hopes sincerely that this report will contribute to an increased understanding of the position of and an increased international support for those health workers in South Africa who work for the defence of human integrity, human rights and the implementation of an equitable and just health care.

TERMS OF REFERENCE

The Board of the Johannes Wier Foundation defined the following terms of reference.

1. To attend and address the Annual Meeting of the National Medical and Dental Association (NAMDA) in Cape Town, 2 - 6 April 1987;

2. To express the feelings of solidarity with health professionals in the Republic of South Africa who are confronted with violations of human rigths;

3. To assemble up-to-date information about the role of health professionals in the Republic of South Africa, paying special attention to the role of health professionals in the treatment of detainees, in particular children; to collect, moreover, information about the threats to the professional integrity of health workers, among others by way of intimidation of both health professionals and patients; to assemble finally information about the care given to victims of violations of human rights, and, if possible, about sexual harassment against children in detention centres;

4. To review the assembled information under internationally accepted norms relating to human rights and medical ethics;

5. To report on the collected factual information and to formulate opinions and considerations in this respect;

6. To indicate ways by which organizations of health professionals in the Netherlands, in particular the Johannes Wier Foundation, may express their feelings of solidarity and may undertake efforts to bring about an improvement in the position and responsibilities of health professionals in the Republic of South Africa.

THE JOHANNES WIER FOUNDATION

The "Johannes Wier Foundation", Dutch Foundation for Health and Human Rights, was founded in 1986. A group of doctors, nurses, dentists and paramedics decided that there was a need for an organization of health professionals with special concern for human rights.

The foundation intends to be a platform for the expression of specific professional responsibility towards human rights. It was felt that this responsibility could not sufficiently be expressed and carried out by existing organizations alone, like Amnesty International, which has a mandate too limited for the objectives of the foundation.

Human rigths lawyers also have emphasized the need of a professional organization, for the above mentioned reasons and for the provision of medical, dental, nursing and paramedical expertise when needed in human rights research and missions. The objectives of the Johannes Wier Foundation are partly similar to those of Amnesty International and there is cooperation where possible. The Foundation maintains close relations with the Royal Dutch Medical Association and the Geneva-based International Commission of Health Professionals.

The objectives of the Johannes Wier Foundation are as follows:

- the identification and exposure of cases in which health workers are actively involved in the violation of human rights, in order to take action as effective as possible;
- the identification and exposure of cases in which health workers are restricted or harassed in their professional duties in such a way that human rights are violated;
- the identification and exposure of cases in which health workers are or have been threatened, harassed or punished for their refusal to take part in the violations of human rights, or because of their struggle to promote the cause of human rights;
- the promotion of knowledge of human rights in connection with health, by means of education, information and publications;
- the enrolment of interested and dedicated specialists from re-

levant medical, nursing and paramedical sciences, to be involved in human rights missions, possibly together with other disciplines (notably lawyers);
- the expression of solidarity with colleagues who are harassed, persecuted or punished for their refusal to take part in the violation of human rights, or their furthering the cause of human rights;
- the cooperation with international organizations with similar objectives.

The funding of the Johannes Wier Foundation is by donations from organizations and private persons.

The board consists of the following persons:

R. Bakker, M.D., district surgeon; Ms. Dr. I. de Beaufort, Ph.D., inst. of bio-ethics, Maastricht, A. van Es, M.D., general practitioner, president; Prof. dr. C. Flinterman, dept. of international law, University of Limburg, E.W. Free, dental surgeon and forensic odontologist; Dr. H.A. van Geuns, deputy chief medical officer, dept. of health, vice-president; Prof. dr. E.L. Noach, former head of dept. pharmacology, University of Leiden; Ms. J.J. von Nordheim, chief nursing officer, dept. of health; Prof. A. Th. Schweizer, pediatrician, medical director University Hospital of Leiden; J.B. van Seters, physiotherapist, treasurer; Ms. Prof. dr. B.H.P. van der Werf-Messing, head of dept. of radiotherapy, Erasmus University of Rotterdam, vice-president; D.H. de Witte, lawyer, secretary

SECTION I: HEALTH AND APARTHEID

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In the 2,000 bed training and referral King Edward VIII hospital for non-whites in Durban, over 600,000 patients are treated per year. The wards are constantly overcrowded. The maternity ward has a bed occupancy rate of over 150% and there are always floor cases. In the huge 67 bed labour ward over 15,000 children are born annually. Mothers are sent home before completion of treatment, newborns are admitted to overcrowded nurseries, exposed to cross infections and accidental changing of babies. The children's ward, where many typical third world diseases (gastro/enteritis, dehydration, meningitis, tuberculosis, malnitrition) are seen is also constantly overcrowded.
The nearby Addington children's hospital for whites was recently closed for 50% because there were too few sick white children.

In Johannesburg, Baragwanath Hospital (for Africans), Hillbrow Hospital (for Indians) and Coronation Hospital (for Coloureds) are overcrowded, often with floor cases and early discharges. The Parktown and Strijdom Hospitals (for Whites) have many empty beds. An Indian patient may be refused at Coronation Hospital (because it is too full) and has to go to Hillbrow Hospital, right past the white Strijdom Hospital.

While working conditions for nurses in non-white hospitals are worse than in white hospitals and salaries usually lower, it happens that nursing staff is transferred from overcrowded non-white hospitals to white hospitals to serve white patients (in case the patients approve) because there is a shortage of white nurses, leaving non-white hospitals worse understaffed.

"A "white looking" woman was involved in a traffic accident and was transported to a nearby white hospital. She was treated in the emergency room and brought into a stable condition. It was then discovered - by her name - that she was "Indian".

She was subsequently transported to a hospital for Indians - still in a stable condition -. There the doctor in charge made an error of judgement and sent the woman home. Her condition deteriorated quickly and after readmission she died of internal bleeding.
A SAMDC Disciplinary Committee ruled that the Indian doctor had made an error of judgement and disciplined the doctor."
(Dr. J. Gluckman - personal remark).
The professionally irrational decision of transporting the patient to another hospital was not judged upon.

Contrary to tuberculosis and sexually transmitted diseases, malaria is a perfectly controlled disease in South Africa. An excellent disease control service operates throughout the country and meets all internatonal standards, also in remote areas. Why? The malaria mosquito is not subject to racial segregation and easily transgresses racial boundaries. 1).

After requests from the Medical Faculty of Witwatersrand University to the Johannesburg municipality to allow black medical students and housemen to examine white patients, the request was granted on the condition that the patient gives permission and with the exception of gynaecology.
The limited granting of the request was not accepted by the faculty.

A doctor working in a Bloemfontein hospital testified that the hospital had facilities for kidney transplantation and haemodialysis. These facilities, however, are only available to whites in the segregated hospital. He had seen several early deaths from kidney failure of young non-white patients.

By virtue of the Group Areas Act, non-white medical and nursing students are frequently not allowed to live near their training institution. They have to travel considerable distances to poor lodgings. The negative effect on study results is a frequently heard complaint at universities and training institutions.

Introduction

South Africa holds a unique position in the world; racial segregation and discrimination are embedded in a legal system which pervades all sectors of society, including health and health services.

Although apartheid is a most prominent feature, it must be emphasized that the economic relations in the country are such that the means of production are owned by an industrial and landowning minority, which is largely South African and partly foreign.

Factors of race and colour lie at the very heart of the economic and political power relations.

Political power is completely in the hands of the whites. The majority of the people (80%) is black and has no political power. Since the National Party seized power in 1948 and has held it without interruption to date, the apartheid regulations and legislation have been perfected and adapted to the economic needs of the minority white class.

In 1983 the government introduced the so-called "tricameral" parliament. Separate parliaments for Indians and coloureds were added to the existing white one. In-built over-representation of whites preserves final white ruling power. The tricameral elections were heavily boycotted but the government is apparently carrying through its policy of "own affairs".

The main pillars of apartheid are the division of land by race, the division of population by race and the division of political representation by race.

The division of population by race means that at birth everyone is labelled as black, coloured, Indian or white. This determines largely the life one is going to live. The "race-tag" affects all sectors in life (for example the life expectancy, likelihood of certain disease patterns and the chance to have certain political rights like the right to vote or not).

By the inauguration of the tricameral system the government has marked an important step towards the perfection of the "divide and rule" system. Limited and subordinate administrative power is

allocated to the different racial groups with the result that representatives of non-white race groups become accomplices in the enforcement of apartheid rules, and that its execution gets a "darker face".

A most effective repressive measure is the division of land by race.

The Africans were dispossessed in 1913 by the introduction of the Land Act. They were forced to move into the Native Reserves, later named "Bantu homelands" or "bantustans".

Only 13% of the land, largely barren and frequently in scattered parcels, has been allocated to 71% of the population.

Since 1977 the South African Government has "granted independence" to 4 of the 10 "homelands": Transkei, Ciskei, Venda and Bophuthatswana. Those South Africans who were declared inhabitants of the "independent homelands" have become foreigners in South Africa according to South African law.

Poverty related problems and statistics, like high unemployment, high figures of tuberculosis and malnutrition, were automatically "exported" to the "homelands".

Cedric de Beer (Health Services Development Unit - University of Witwatersrand Medical School) states: "Should all ten bantustans be induced to accept independence, it will allow the state to claim that there are no African South Africans at all. All Africans resident in "white" South Africa will be regarded as foreign workers who do not have the rights of citizenship; a neat way indeed to solve the thorny problem of political rights for Africans. It also, of course, provides a strange sort of justification keeping people from the bantustans, now regarded as foreign countries out of South Africa. This is central to the state's current survival strategy." 2).

Since socio-economic conditions in the homelands are poor and family life is disrupted because of migrant labour, the effects on health are obvious.

Poverty related diseases like tuberculosis, malnutrition, gastro-enteritis are very high and the infant mortality rate is estimated close to 300 : 1,000.

Many authors have argued that these health problems cannot be solved by increasing hospital beds and doctors, but need a political and socio-economic change.

Urban Africans live in townships, where they are not entitled to possession of land (only 99 years leaseholds). Townships are usually located far away from urban centres with poor transport facilities. People living in townships have frequently been subjected to forced removals and "repatriations" to "homelands" or neighbouring states (25,000 in 1984). 3).

Townships are usually designed in such a way that control of movement and residency is very easy. They are surrounded by highways, railroads and open areas and only a few roads, usually with police or army barriers, give access to the townships. The delegation visited several townships. Extended families in small houses or shacks live in appalling squalor under poor hygienic conditions.

When the government induce material improvements, the basic structure of control of the township remains, but spontaneous community development is disrupted.

Statistics

The existence of both a "first world" and a "third world" in South Africa is reflected in the health statistics, which reveal two distinct patterns of diseases for white and black people.

White South Africans have a pattern similar to that of industrial countries; a low infant mortality rate and a long life expectancy. They form a rich community with a low birth rate and an aging population.

Black South Africans have a pattern similar to that of a developing country: a high infant mortality rate and a low life expectancy. They form a poor community with a high birth rate and a large under-five population.

Dr. Jacques Kriel of the Medical Faculty of the University of the Witwatersrand summarizes some differential statistics: 4).

- mean death rate among coloûreds is double the rate among whites;
- death rate from infection diseases among coloureds is 14 times higher than among whites;
- death rate from tuberculosis is 37 times higher among coloureds than among whites, and from measles 52 times higher;
- 50% of all deaths among Africans and coloureds occurs under 5 years. Among whites this figure is 7%;
- infant mortality rate (per 1,000 live births): whites 12, urban blacks 90, rural blacks exactly unknown but expert calculations up to 280 and over;
- although the non-white: white ratio in the country is about 6 : 1, the hospital bed ratio for non-whites : whites 2 : 1;
- expenditure per patient per day in Baragwanath Hostpital (Soweto) is R 46,60, in Johannesburg Hospital R 185,50 (1985).

Doctors and nurses

A huge disproportion of doctors exists in rural and urban areas. Prof. Gear, head of the department of community health at the University of the Witwatersrand, stated in 1985 that "the doctor to population ratio in rural areas was 1 : 25,000 whereas in urban areas it was 1 : 750. Most rural doctors are not South Africans." 5).

The effect of race in the doctor to population ratio is still stronger thant the urban-rural comparison: Among whites 1 : 330 and among Africans 1 : 91,000 (Indians and coloureds 1 : 730 and 1 : 1,200 resp.).

It follows that there is a relative oversupply of white and Indians doctors and an undersupply of coloured and African doctors. Nevertheless among the medical students at the severe medical faculties, most students are white, and no policy seems to be designed or carried out to undo this disproportion.

The newly created medical school in Bophutatswana (MEDUNSA) will possibly supply more African doctors.

According to the South African Nurses Association South Africa had 1.5 African, 1.8 coloured, 1.4 Indian and 6 white nurses for every 1.000 people (1983). 6).
The W.H.O. recommends 1 nurse to 500 people in developing countries.
Considering the future health care in South Africa where nurses have to play a major role in any primary health system, there is an undersupply of nurses.
The most severe problem at the moment, however, is the imbalanced provision of nursing care to the different racial divisions and the differences of working conditions and salaries between white and black nurses.

Health Management: fragmentation of services.

After the tricameral elections in 1984 the government has, in spite of the heavy boycotts, started with the implementation of the new constitution. Most health matters fall under "own affairs", the core of the constitution, which provides for the dismantling of the present health authorities and the re-allocation of responsibilities to the various ethnic authorities. Ultimately South Africa will have 14 health departments: one for each "homeland", and four in each so-called communal area: a white, Indian and coloured "own affairs" and a general health department.
This fragmentation of health services creates chaos. Multiplication of burocracies, different health policies, difficult communication, non-cooperation between different health departments and competition between services, are counter-productive for the delivery of efficient health services and cause irrational rules and effects. Fragmentation of health services is expensive too: the taxpayer has to take the burden of the salaries and allowances for all the new administrative and other staff.

Competition will be more probable than coordination and it follows that the racial identity of hospitals will be strenghtened.

One example of the irrational, chaotic and detrimentous decisions caused by "own affairs", by Cedric de Beer: "Shiluvane Hospital lies on land claimed by both Lebowa and Gazankulu. In 1976 the South African Government took over the hospital from the mission that had run it. There was uncertainty as to which bantustan should get the hospital but it was put under the administration of the Lebowa health department until a final decision could be made. In 1981 the hospital was taken away from Lebowa and handed over to the Gazankulu health authorities. One Friday, Gazankulu health officials arrived to take over the hospital. The next week the Lebowa government withdrew all Pedi-speaking staff members. Pedi-speaking patients were loaded into ambulances along with their files and their drips and taken to other hospitals in Lebowa. Thirty patients and 24 out of 38 staff members were moved". 7).

At the 1985 NAMDA Conference Cedric de Beer said that: "In the health sector, as elsewhere in society, the true meaning of the constitution is this: a growing identity of interest and coordination of action between the white rules and the political and economic elites of the other, non-african populations. This will be combined with attempts to increase control through division and fragmentation of the poorer sections of the coloured and indian communities and the african population and the sowing of seeds of discord between them." 8).

SECTION II: DETENTIONS

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The case of S.N.

The 20 year old black S.N. from KwaMashu Township, Natal, was detained on the 7th of August 1985 at the police cells in C.R. Swart Square Police Station, Durban. On August 19th 1985 he was fetched from his cell for interrogation. He was assaulted by police officers in the following ways: he was stamped on the toes with the heels of shoes, slapped in the face with an open hand, banged with his head against the wall; he was ordered "to stand as if riding a bicycle for at least half an hour, with pins under the heels"; he was punched in his stomach; then his hands were handcuffed at his back and a rubber bag was pulled over his head; he had difficulties in breathing for several minutes; he was threatened with repeated treatment until he admitted the accusation (participation of burning a house). Out of fear of further assaults he admitted.
His head was covered again with the rubber bag and he was asked to mention names: from fear he mentioned names of people which he did not know whether they were present at the alleged place or not.
The second assault took place on 29th August. He was blindfolded, slapped across the face and his head was banged against the wall several times. He was then tied to a table and made to lie flat on his back. His legs were tied with a damp cloth and he was handcuffed. During the ongoing interrogation he was electroshocked at intervals of about 10 minutes. He tried to scream but could not because he was experiencing excruciating pain. He was treated in this manner for a period of 3 hours. Then he was untied and led to his cell.
The medical history on 20th August reveals besides "painful testes" no abnormalities. The medical history of 21st August 1985: "tenderness over xyphisternum and complaints of flu-like symptoms; treated with panadol".
The medical history of 5th September: "painful legs; stiffness, for 5 days increasing in severity: painful testes;

injuries: none; on examination grossly exaggerated reflexes of legs; ankle clonus ; admitted to hospital".

A psychiatrist was consulted and he concluded that the patient had a "major depressive episode (DSM III)", the "psychomotor retardation was a manifestation of his loss of energy". He was given psychotherapy and neuroleptics.

On 14th October 1985, 3 weeks after release from detention, he was discharged from hospital.

In response to a request on 20th February 1986 from the lawyer of S.N., a specialist chemical pathologist, examined the reports of the results of blood tests on S.N. on 12th September 1985. This test showed a creatine kinase level far outside the normal range for an adult male (1196 U/L, normal range 0 - 110 U/L). The test was repeated on 20th February 1986, the CK was 157 U/L (normal range 22 - 269 U/L at that laboratory). It was concluded that "a highly abnormal result of this blood test in September was found, which has now returned to normal, and is fully consistent with the patient's account (being electrocuted), complaints and clinical signs and difficult to explain in any other way."

The lawyer had access to S.N. only after release from his detention. Medical personnel at the hospital was not prepared to cooperate or give information during the detention time on grounds of confidentiality. The counter-expertise of the chemical pathologist was needed by the lawyer to establish torture by electroshocks in court.

(Abstracts from S.N.'s lawyer's file).

Introduction

Over the recent years there has been a disquieting increase of detentions, including a high percentage of children.

Torture and abuses take frequently place during detention, and the sequelae of this organised violence against individuals constitute a serous health hazard.

Even if no torture and abuse is reported, the detention as such constitutes a considerable health threat, both physically and

mentally. Detentions without trial contradict international human rights, declarations and treaties.
Medical and psychological aspects of detention and treatment of detainees have been a continuous subject of discussion in the medical profession, and the profession's attitude towards detentions has frequently been reviewed.
This section will focus mainly on medical aspects of detentions and the role of health professionals both individually and organized.

Detention without trial has for several decades become a permanent feature of the legal system in South Africa. The Public Safety Act of 1953 provides for summary arrest and detention of persons under emergency regulations.
In 1982 the Internal Security Act (ISA) was introduced. This act superceded the old ISA, the Terrorism Act (section 6), and the General Law Amendment Act (section 22). The ISA contains several sections for detention of people considered by the security police to be a security danger to the state.
The State of Emergency (proclaimed on basis of the Public Safety Act), which currently prevails in South Africa, provides powers much wider than those under the ISA to "any member of a force", including the South African Police, the Railway Police, the South African Defence Force and the Prison Force, or a person nominated by them.
Under the State of Emergency the arrested or detained person is completely at the mercy of a security force officer to whom almost complete immunity is granted. This means that if a police officer finds it necessary for security reasons to kill a person, this decision goes unchallenged under the emergency regulations.
Detention without trial is an obvious instrument of repression and an organized form of violence. It is one element in the wide spectrum of the repression in South Africa, in which also predetention harassment, police violence in townships and informal violence should be regarded.

Detentions also affect the dependents and relatives of the detainee and have a disrupting and devastating influence on communities and organizations, which is the very aim of the instrument of detention.

Since the early eighties detentions on the other hand have become a major issue in organised resistance. The formation of the Detainees Parents Support Committee (DPSC) provides information to and support for the relatives of the detainees.
The DPSC's monitoring activities play a keyrole in the opposition against detentions. A number of other organizations align with DPSC and for some years DPSC has formed together with NAMDA and OASSSA (Organization for Appropriate Social Services in South Africa), individual health workers and lawyers the Detainee Service.
For health workers the Detainee Service constitutes challenging but sometimes straining, usually voluntary work in addition to their full-time job.
The responsibility they assume is embedded in the professional ethical codes, but in South Africa sometimes subject to strong pressure from the side of authorities.
They accept the responsibilities of their profession including the care of victims and the exposure of the causes of their suffering, even if this means that their personal freedom is endangered. Section III of this report describes the risks these colleagues run if they persist in maintaining professional secrecy.

Statistics

Detentions under the Internal Security Act have increased over the recent years from approx. 500 in 1983 to 5,000 in 1986. These figures include detentions in the "homelands". Under the State of Emergency the number of detainees has increased to a total of 30,000 (25,000 under the State of Emergency, in April 1987; in August 1987 30,000 under the State of Emergency alone). These figures have been calculated by the Detainees Parents Support Committee (DPSC).

The most severely affected target group are community and political activists and trade union workers, UDF (United Democratic Front) and youth. As DPSC's Max Coleman describes: "The government is afraid of its youth, they are crucial in black organizations and most active in politicising the community".
An increasing number of children have been detained and are still under detention.
The target group is young people of 16 and 17 years old, frequently involved in community activities and school boycotts, but also younger children of 12 or 13 years old and even younger have been detained.

The DPSC issues quarterly and annual reports and statistical breakdowns on detention by area, by length of detention, by age and sex, by profession or activity under the different ISA-sections or emergency regulations. 9 - 12).
The figures are drawn from reports of regional DPSC offices, which directly receive information from ex-detainees, lawyers, doctors and members of organizations like Black Sash and DPSC itself.
Figures and data provided by DPSC are accurate, well documented and authoritative, but at times very conservative. In 1986 DPSC estimated that 2,300 detentions under the ISA took place. The Minister of Law and Order released official figures in Parliament : 4,132 security detentions 13).
Official statistics from the government give a limited picture of the detentions. Police statistics include only detentions of 30 days and over. Data concerning the State of Emergency are irregularly released and incomplete.
Statistics exclude informal repression, and repression by means, not provided for by ISA or State of Emergency. Examples of factors which decrease the figures of detention and abuse:

- Charging detainees with minor or frivolous charges; the advantage for the government is that overseas demands "charge or release" are met. In 1984 62% of the detainees were charged (in 1983 only 15%); of these 1.2% were convicted (in 1983 43%). Charged detainees can be held without bail for long times. This

tactic to use the courts was successfully applied to remove leading persons of opposition organizations from "circulation". 14).

- "Call-in cards" are used to intimidate activists. They receive a note from the police to report at a police station, where they are interrogated and held for a short period. No security legislation is used, so the cases do not appear in statistics.
- The same applies to the arresting of persons and interrogation and abuse or torture in police or army vehicles.
- Raiding of offices by the police and seizure of files; the recurrent but inconsistent character of this method puts a spell of prudence and sometimes secrecy on organizations. On several occasions many offices were raided simultaneously, especially in the first two months of the State of Emergency, including NAMDA offices.
- Many cases of abuse or torture are never recorded because the victims do not reach the detainees service.
- Cases of abuse or torture can be proven in court only if traces can be shown scientifically.
- Telephone tapping, surveillance of offices and individuals, prevention from hiring offices, meeting places or buses by organizations, distribution of fake pamphlets with wrong information; threats to individuals by telephone or mailing or actual physical assault or killing by a hit-squad.
  Coleman adds to this list: "informal repression was also aimed at individual activists. They received death and bomb threats. Bricks were hurled through their windows and their houses were broken into or fired at with shotguns. Their assailants sprayed paint onto cars, slashed, overinflated or deflated tyres, drained oil from the car sump, or removed the ignition. Dead pets, especially cats were left on the doorsteps or tied to the door handles of activists homes. Some attacks were believed to be perpetrated by police, others by unknown individuals who had access to unlisted telephone numbers and little-knowm addresses". 14).
- An increasing number of court cases against the police are set outside court. Apparently when the police fear loss of a case,

an out-of-court settlement is sought; the government's expenses for this purpose have grossly increased over the recent years. While in the period '69 - '73 R 42,916 were paid in settlements to 87 cases, in the period '83 - '85 R 6,068,328 were paid in 539 settlements. 15).

Medical care in detention: the district surgeon

Besides law enforcement personnel and the (district) magistrate, the district surgeon is the only person who has direct access to a detainee.
Major detention centres employ full-time district surgeons, smaller centres contract medical practitioners as part-time district surgeons. The district surgeon is an employee of the Ministry of Health and accountable to his/her superior in the Ministry of Health, but has to cooperate with the law enforcement personnel which is employed by the Prison Service or the South African Police.
The responsibility for the medical care of prisoners and detainees is entirely in the hands of the district surgeon. He or she has to monitor hygiene and health conditions of the prison, food and sanitation and to provide curative medical care. The decision whether or not to refer to a specialist is taken solely by the district surgeon. Another duty of the district surgeon is to record physical and mental signs of torture and abuse, and to report these to the health authorities for appropriate action. Since this duty clearly conflicts with the interests of law enforcement personnel, and largely depends on the professional and personal interest and courage of the district surgeon, this duty has become a major field of discussion and comment.

Trefor Jenkins, professor of Human Genetics at the Medical Faculty of the University of the Witwatersrand, about the role of the district surgeon: "The prison doctor (in South Africa: the district surgeon) occupies a pivotal position with respect to the care of detainees. Deprived of virtually all rights, denied visits from family members and friends, subjected to periods of

intense and harsh interrogation interspersed with prolonged stretches of sensory deprivation (solitary confinement), the detainee is very vulnerable and is at high suicide risk. The good district surgeon will be aware of these dangers and should be the first to detect any warning signals. Whether the police will heed his pleadings and permit him to remove the detainee to a less hostile environment depends entirely on the attitude of the police. In the Biko case, the security police refused, the doctors acquiesced, and the detainee died. In the more recent Post Elizabeth incident, Dr. Wendy Orr, a young district surgeon, tried to intervene on behalf of patients whom she believed had been abused by the police. She got little encouragement (perhaps even an obstructionist response) from her superiors, so she took her objection to the supreme court and was successful in the attempt. An interdict was issued restraining the police from assulting he detainees..... The response of the organised medical profession was disappointing. The MASA gave only cautious qualified support, advising that the outcome of an investigation should be awaited before committing itself .... It could be argued that even if the courts were to fail to establish that the police had in fact assaulted the detainees, the Association had the moral responsibility in the spirit of the Declaration of Tokyo, to support the colleagues' efforts to act in the interests of her patients." 16).

The MASA's attitude towards Dr. Wendy Orr was confirmed during the delegation's visit to Dr. LeRoex, MASA's Federal Council's Chairman. Only if the alleged cases would be established in court and if it was clear that there was no perjury on the side of Dr. Orr, MASA could come with an official statement of support. The Orr case fell away with the ending of the first State of Emergency on 7th March 1986; the police paid the costs of the initial hearing without admitting guilt.

Asked whether it was not unlikely that Wendy Orr's observations were not unique, Dr. LeRoex said that no cases have come to the notice of MASA and that the proper way of reporting suspected

abuse by the police is to the district surgeon's superiors in the Ministry of Health, where the complaint is communicated to the Department of Prison Services or to the South African Police for further action.

This formal approach, however, seems to be deficient. Saxe and Elsworht state that: "The follow-up of notification of injuries sustained while in police custody is not thoroughly persued. The notification could be discarded without further action being taken. These is an obvious gap in procedure". 17).

But Prof. Jenkins disagrees with Dr. LeRoex: "This is the feeling that doctors may not have done everything in their power to expose torture when it has occurred. It is unlikely that the experience of Dr. Wendy Orr was unique". 16).

Gilbert Marcus of the Centre for Applied legal Studies of the University of Witwaterstand writes about the duties of District Surgeons: "By virtue of the fact that they are employees of the state there is invariably a crisis of confidence between district surgeon and detainee. There are many instances of detainees deliberately not disclosing evidence of ill-treatment to district surgeons because they do not perceive the district surgeons to be independent, nor do they have the guarantee that such complaints are kept confidential. Indeed, reports of ill-treatment cannot be confidential." 18).

And the MASA also acknowledges that" as district surgeons are involved in the medical care of detainees who may be subjected to harsh methods of detention or interrogation, they (the district surgeons) are regarded by some persons as part of the apparatus of indefinite detention ...". 19).

Large sick parades of detainees-patients, especially during arrests and during the State of Emergency make it virtually impossible to properly examine every individual detainee, let alone monitor and record signs of abuse. In their report "Visits to prisons" (May 1986) Professor Norma Saxe and Dr. Margaret Elsworth remark that "when large numers of prisoners have to be seen, examination is likely to be cursory. Medical supervision,

already suspected of inadequacy, cannot suddenly be extended to overwhelming numbers; it is physically impossible for a medical officer properly to examen 80 prisoners in one day in addition to regular duties. At St. Albans Prison there were an extra 300 prisoners during September/October 1985. The importance of careful medical examination on every occasion of admission at discharge (this includes those who are sent to police headquarters or to the courts for trial) must be emphasized: the probability that injuries are sustained during arrest and police custody is high. It is recommended that doctors and medical personnel employed to care for the health of detainees ..... should refuse to be hustled by the pressure of work.". 17).
The NAMDA paper on the treatment of detainees (1987) reports that "of the 26% (of the detainees) who reported that they had asked to see a doctor, 63% alleged that this request was refused". 20).

The DPSC Health Subcommittee has issued an extensive protocol for the examination of detainees by district surgeons. The protocol was checked and agreed upon by university and independent medical and juridical experts. 21). Assistance for circulation to all district surgeon has so far been refused by the government and the South African Medical Journal.

An additional problem, especially in remote areas and smaller centres, is that of social identification. The part-time district surgeon who has an easy social contact with the magistrate and police officials, is unlikely to identify with a detainee who sustains an injury inflicted upon him or her by the police. This lack of identification is even greater if the doctor conceives the detainee as a security risk, or a "terrorist".

How far politics can penetrate in medical ethical discussions remembers Prof. Jenkins when a colleague of his, member of the SAMDC, said that a major part of the special meeting on June 17th 1980 of the council on the Biko-case, was spent on the "communist threat" and the "total attack" against South Africa. 22).

Detainee Services, lawyers and doctors have reported a lack of cooperation of district surgeons. Since they are the only doctors with direct access to the detainees, information largely depends on their willingness to cooperate. It was reported that only one of the district surgeons of Johannesburg was prepared to exchange information with Detainee Service doctors. The others even refused telephone contact.
Particularly lawyers depend on information from doctors and their proceeding can be severely paralysed by this lack of cooperation.

Free choice of doctor.

Following the Biko case, the MASA appointed an ad hoc committee to institute an inquiry into the medical care of prisoners and detainees.
The committee's findings were adopted by the MASA's Federal Council in 1983. 19). The committee describes the lack of legislative safeguards and the potential health hazards of detention ("the circumstances relating to the detention of security-law detainees in South Africa present potential hazards to their physical and mental health"). The committee recommends that "a detainee should under no circumstances be kept in prolonged isolation (in any event not exceeding 7 days) in the absence of regular physical and psychiatric assessment".
About the district surgeon "contact only with members of the authority detaining the individual is seen as threatening rather than supportive. The district surgeon as an employee of the state, may also be regarded in this same light by detainees, their relatives and sympathizers and may therefore not be acceptable on offering independent medical treatment, particularly of a psychiatric nature." The MASA committee recommends: "Should it be requested by a detainee, the opportunity should be created for a medical examination of him by an independent medical practitioner of his own choice and at his own expense".

The recommended panel of independent doctors has been seen as a step forward to the free choice of doctor. Strong criticism, however, has been voiced too.

The most fundamental criticism is that the MASA fails to challenge the system of detention as such as a health hazard, and accepts a 7 days period of solitary confinement, which contradicts the Tokyo Declaration, which holds that "the doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures whatever the offence".

The implementation of the panel is criticised for the consent needed by MASA and the government. This renders the independence futile and the real free choice absent.

The problem of independence and free choice was discussed with the MASA's Federal Council President Dr. LeRoex. He explained that the committees' recommendations had been achieved after a long period of negotiations with the government. MASA in this respect was helped by the WMA (World Medical Association). The achieved recommendations should be viewed as the best possible compromise. Asked whether MASA considered this compromise as a step-in-between in a strife for a real free choice of doctors, Dr. LeRoex, however, said that MASA considered the compromise as final and did not intend to open negotiations again. For the MASA, the political attainability apparently prevails over the tenacity of principle.

Many doctors and others working with ex-detainees considered that the panel lacked real independence.

One doctor was not accepted to sit on a panel; he is involved in detainees work. Another doctor was expected to be withdrawn because he was politically too outspoken.

Additional thresholds to apply for the service of a panel doctor is that the request has to pass the district surgeon and that the detainee has to pay the costs.

TORTURE AND ABUSE

During the mission to South Africa the delegation received many narrated and written accounts about torture and abuse in detention.

The distressing and dramatic personal reports of torture and the devastating effects it has on health and future life of the detainee and his/her relatives, are of course not fully reflected in figures and statistics, which already present a gloomy picture.

The long list of reported abuse and torture is consistent with other reports.

The authoritative study of Foster, Davis and Sandler reports that "only 17% of the cases claimed no form of physical torture; in other words 83% reported some form of physical torture during detention. 23).

Several studies by doctors on ex-detainees following their release, reveal that the findings during the physical examinations are remarkably consistent with the claims made by the ex-detainee. This finding contradicts the frequently heard commonplace of the "detainee's exaggerations" and confirms the need to take the claims of the detainee serious.

Professionals working with ex-detainees have to develop their own expertise, and a sensitivity to recognize certain effects and conditions after release from detention. Dr. Paul Davis, a Johannesburg general practitioner has worked for many years with ex-detainees: "in the beginning we did not recognize always conditions like the Post Traumatic Stress Syndrome; it took years before we had developed that sensitivity" (personal remark). A wide variety of methods of torture and abuse have been reported to the delegation by many health professionals and lawyers. They are summarized as follows:

Psychological methods:

- solitary confinement (almost always related to interrogation);
- enforced nakedness, verbal insults, humiliating language;
- threats with execution, threats with death of family or relatives, belied betrayal by friends, threats to families;
- sophisticated interrogation techniques (by one cruel and one "friendly" interrogator);
- continuous surveillance in cell by close circuit television monitoring;

- incommunicado detentions;
- withholding information about place of detention, expected duration, charge;
- pressure to make or sign false statements;
- interrogation at gunpoint;
- extremely long periods of interrogation by changing (teams of) interrogators;
- use of current fears: e.g. threats with necklacing, incarceration in dark cell with a human corps, or with a living snake;
- forced looking at and touching of a human corps in a mortuary: this method including threats "once to be like that" is especially applied to children;
- fake execution, fake necklacing.

Deprivation

- deprivation of food and drinks;
- deprivation of sleep;
- continuous loudspeaking of high pitch noises in cells;
- delayed stay in too little space: in one case reported the detainee was kept in a "cell" of 60 cm width;
- not cleaning of bedsheet or clothes; one man had continuously one shirt during 2½ years without it being cleaned.

Physical

- physical assault; beating with fists, kicking with boots, knees; banging detainee's head to wall or floor; slapping in the face;
- beating with the sjambok (whip with metal flexible tip) or stick;
- use of teargas (CS) in confined room or vehicle, either by spraying in the face or by throwing in a teargas canister;
- forced standing in non-physiological position e.g. on toes (with pins under heels) and with bent knees;
- forced physical exercise;
- delayed standing and forbidding the use of the toilet,

resulting in loss of urine and excrements on the spot;
- heating cell to abnormally high temperature;
- forced drinking of contaminated water;
- near drowning e.g. in toiletpot;
- falanga: beating on the sole of the feet with a stick;
- beating on ears (causing perforated eardrums);
- hooding: a rubber or canvas hood is pulled over the detainee's head causing (near) suffocation;
- beating with wet paper rolls;
- pressing with burning cigarette on hands, feet, genitals and elsewhere;
- fixation of detainee under wet sheet on which he or she is beaten with a stick (reduces traces of abuse);
- helicopter (suspension at legs and arms);
- electric shocks: this widely used technique of torture is applied in various ways: in prison, police office and in vehicle. For sometimes short, sometimes protracted periods of time electric shocks are applied to fingers, toes and genitals;
- dogbites;
- poisoning: a case of thallium poisoning;
- drug abuse: some cases of intravenous injections were reported, invariably with the detainee being blindfolded. The person or profession giving the injection could not be identified;
- sexual abuse, rape. This was most frequently reported outside detention areas, in the townships.

In addition to these forms of physical and sexual assaults and abuses, forms of violence outside the detention centres are:

- Shotwounds: birdshots, buckshots, rubber bullitshots, sharp bullit shots, causing fractures, wounds and infections, damage to organs, death.
- Teargas , causing respiratory and ophthalmic damage and death.

Health related effects of detentions

Many studies, medical and psychological, have been carried out and published about the health related effects of detentions, many of which are a direct result of torture and abuse.

Most studies stress that the compiled data on health effects are incomplete, since only reported effects appear in the figures. This means that a lot of suffering remains unexposed.
If one considers the fact that only a minority of the ex-detainees is monitored by the detainee service and that no independent access to detainees during detention exists, one can only guess the extent of the results of organized violence.The secrecy in which detentions take place give rise to suspicion of more serious violence. As one doctor involved in detainee's work said that "Sometimes it is more expedient for security officers to kill a tortured detainee than to deal with the effects; and it happens".

On the data which are available, however, a lot of research has been done. The legal, medical and psychological reports that were produced from this research, present an overwhelming evidence of the detrimental effect of detentions and torture on physical and mental health.
Doctors and psychologists working in the detainee service invariably reported serious physical and psychiatric ailment following detention.
Torture sequelae may be direct, such as loss of function of a limb, or finger due to electric shocks, or problems in walking due to falanga, or impotence following genital abuse, or indirect such as problems due to poor living conditions, lack of stimulation or physical exercise, or due to exhaustion.

The most severe and the most common sequelae of torture are psychological. They are frequently persistent and may cause considerable stress after the events of torture; they may arise long time after release from detention.

The pychological sequelae have been described in terms of Post Traumatic Stress Disorder, depression and anxiety related symptoms, and expressed in problems of sleep disturbances, relation and marital problems, sexual problems (notably impotence), drugs or alcohol-addiction, obsessive promiscuity, irritability, concentration weakness, memory loss, anxiety states, hyperreactivity, passiveness, psychosomatic disorders.

Traces, scars and biochemical evidence are needed for legal action against tortures, but it may be difficult to find traces of torture applied some time ago. This places the lawyers and forensic doctors before a particularly difficult problem.
Dr. J. Gluckman, consultant pathologist and former president of the MASA's Southern Transvaal Branch knows by experience how difficult it is to obtain evidence in time. He remembers a fourteen year old boy who was tortured by means of electric shocks and was released very soon after the torture. He reached Dr. Gluckman's office within 48 hours after having been tortured. A histology could be taken proving that electric shocks were applied. In that respect the boy was "fortunate" because his court case had a good chance to be won, but, as Dr. Gluckman acknowledged, many more are not so "fortunate", and the traces have disappeared before release from detention. In some cases it is possible to establish visual evidence by a doctor, who cooperates with the detainee's lawyer.

Children

People are detained in South Africa without discrimination for age. State violence and the detentions do not exclude children. On the contrary, a large proportion of the detainees is, according to definitions in the law in South Africa, a child: over 40% (DPSC figures). The NAMDA report on treatment of detainees also reports that "40% of those seen were under 18 years". 20).

The extensive report "The war against children" of the Lawyers for Human Rights Committee has exposed the extensive suffering of

children. 24). Other reports also contain many statements and affidavits of children. 25, 26).

The Johannesburg DPSC office has compiled data of 2,300 torture cases, out of which 950 are children of 18 years and younger. The Durban DPSC office had counted in November 1986 a number of 865 detainees; 65% of those of whom the ages were knowm, were minors. On a list of detainees known to have been assaulted, compiled by Durban lawyers, 66 out of the 119 assaulted detainees were children (18 years and younger), some as young as 12 years. 27).

A particularly striking abuse of children is incarcerating them with criminals, which exposes them to additional physical, psychological and sexual abuse.

The MASA has recently issued a code, which was prepared for MASA by the South African Pediatric Association, on the treatment of children in detention. 28). The code which in detail recommends safeguards against maltreatment of children and for the protection of their development, was welcomed as a contribution to the improvement of the condition of children in prison, also by PDSC, NAMDA and OASSSA. These organisations, however, stated that the "goal is not to have children in detention at all" and that "detention of children could not be made acceptable by improving conditions in prisons" 29).

Parents and psychologists have for years continuously stressed the disastrous effects of detentions on children. The risk of a distorted mind, a debilitated mental health and stability provokes enormous problems for the future. 23, 24, 26, 30, 31, 32).

Sexual abuse

The proportional figures of sexual abuse is relatively low. The figure may, however, not be accurate, but an underestimation. Sexual abuse is not as openly discussed in South Africa as other forms of abuse. It is not specifically asked for by the DPSC and NAMDA workers. The absence of concrete and direct questions about sexual abuse in combination with the generally well-known self-censured silence of victims of sexual abuse, constitutes a bias for a low figure of sexual abuse.

While sexual abuse in detention is not reported frequently, it is mentioned as a form of informal violence outside detention, especially in townships.
In April 1987 a case was reported of an 18 year old detained girl, who was transported in a prison vehicle with 12 male criminals. During the transport she was raped several times and subsequently killed.
The MASA's code for the handling of children in detention 28), advises separation of sexes and from criminals and adults, for reasons of abuse, notably sexual abuse.

Detainee service

Detentions have become a major site of resistance. In the wake of the death in detention of Dr. Neil Aggett and the detentions of trade union workers and leaders in 1981/1982, the Detainee's Parent Support Committee was formed.
The DPSC compiles, describes and reports extensive data of individuals in detention and provides information for relatives about detainees. 9 - 12). The DPSC has established credibility nationally and internationally for its reliable information.
One of the activities of DPSC is the compilation of a comprehensive report on each individual detainee upon his or her release, provided that the detainee contacts the DPSC. The report comprises length and place of detention, legal aspects, charge (if present), complaints, medical and psychological aspects. The detainee is helped to find his or her way to a lawyer and a doctor. The doctor takes a detailed history and performs detailed physical examination. In addition, he makes a psychological assessment of the ex-detainee and, if necessary, refers him of her to a psychologist or psychiatrist for psychotherapy or counselling. NAMDA has developed a comprehensive protocol for the examination of ex-detainees. 33).

This network of committed voluntary and professional people is called the Detainee Service, and exists in a growing number of (major) centres. The Detainee Service is important in two dis-

tinct ways: the ex-detainee is helped in an optimum way, and the compiled data provide an impressive amount of documents that contribute to challenging the system of detentions.
The Detainee Service, however, is limited in resources and personnel. Those working in the Detainee Service usually have a full time job and are often overloaded with work.
The "offices" of the Detainee Service - DPSC, doctors, lawyers, psychologists - are often far away from places of detention or residences of ex-detainees. This means that an ex-detainee - e.g. a resident from a remote area in a "homeland" - may find it difficult to find funds, and motives to visit a faraway place and to tell in full detail the emotional story of his detention and the tortures he or she went through to subsequently a DPSC worker, a lawyer, a doctor and eventually a psychologist.
Large numbers of ex-detainees nevertheless find their way to the Detainee Services and receive the assistance they need and provide the service with up-to-date information on detentions.

Counselling

When the ex-detainee is examined by a doctor, the psychological assessment may indicate a need for psychological counselling. In that case the ex-detainee is referred to a psychologist or psychiatrist, often within the context of OASSSA (Organization of Appropriate Social Services in South Africa).
The objectives of the counselling or psychotherapy are described as follows: "alleviating feelings of guilt, fear and humiliation; and restoring the individual to his/her premorbid level of functioning". 34).
The first goal is to offer the ex-detainee an empathic atmosphere to relate his or her history of detention and to normalize his/her feelings. Sharing of experiences and fears in group sessions is considered beneficial.
Psychological counselling of ex-detainees in South Africa differ widely from counselling violence victims in other countries, where refugees seek and receive help far away in place or/and time in a friendly environment. In South Africa, however, psy-

chologic counselling usually is a short process (basically one session therapy) because the ex-detainees can never be certain to come again, for geographical or security reasons, or because they have been redetained or killed. As Lloyd Vogelman, head of OASSSA and a Clinical psychology and Community mental health care lecturer at the University of the Witwatersrand said: "torture rehabilitation centres in Europe removed survivors from the environment in which they had been persecuted. In South Africa, however, victims of state violence not only returned to townships virtually occupied by Security Forces, but often engaged in political activity which increased the threat of further persecution. 35).

An intriguing discussion is going on in NAMDA and OASSSA about the view and position of the ex-detainee.

On the one hand psychologists stress the need to expose the psychological damage to individuals, families and society by organized violence, and on the other hand they warn against individual victimization and decontextualisation. In other words: is every ex-detainee because of the suppression he or she went through, a psychiatric patient? The answer is negative: the many thousands of ex-detainees cannot be regarded as individual patients; the psychologic counselling some of them need, should be placed in the context of the sociopolitical reality of South Africa, and in the perspective of the liberation from repression. 31).

SECTION III:

SECTION III: PROFESSIONAL INTEGRITY

The case of Dr. K.

Dr. K. is a general practitioner in a black township. As an African he was trained at the open (multiracial) Medical Faculty of Natal University in Durban and worked there after graduation for 3 years. He remembers that violence victims could not safely be treated in the hospital he worked in. Some hospital staff voluntarily divulged names of unrest victims, especially when having gunshot wounds, to the police. The police sometimes intruded emergency wards in order to arrest patients after treatment.

Unrest victims often chose not to report at emergency rooms. It became necessary to develop a safe network for treatment of unrest victims. Dr. K. became one of those actively involved. Unrest victims were admitted through a hospital backdoor - after sometimes having been collected in the doctors' private cars. They were given fake names, and X-rays and laboratory tests were performed by Dr. K. himself. The treated person was dismissed under the same fake name. Now, working as a general practitioner in a township, Dr. K. faces similar problems when treating violence victims. During unrests he frequently experiences trouble caused by police or army. His secretary was asked for names, or the entrance of his practice was blocked by police trucks (casspirs) preventing patients to go in or out. Patients were sometimes harassed or arrested. Severely wounded patients were unable to leave the township in order to report at the hospital because the township was sealed off by police or army. Ambulances were at times not trusted because the driver was possibly a plain-clothes policeman. And Emergency Service Teams were prevented by the police to come into the township when they wanted to enter the township.

These experiences necessitated Dr. K. to take refuge in one of the townships' churches during unrest. The church is more difficult to be blocked by cars and police are less likely to come in.

It was necessary to develop safe facilities for transport of wounded people. Dr. K. now participates in First Aid programs for township inhabitants, in cooperation with the Emergency Services Group (personal account Dr. K.).

Introduction

As many other countries in South Africa the integrity of the medical and nursing profession is frequently impinged upon and violated.
Individual health workers and organizations or institutions have faced intolerable limitations of this professional integrity.
These limitations are of very different character: they may be individually imposed upon health workers, like detention or banning, or they may exist as a threat: to be expelled from medical practice, as informal violence, or as a state or self-imposed censorship.
In this report the different forms and extents of limitations and violations of professional integrity will be described.
The position of professional medical and nursing bodies and their reactions to structural or incidental violations of professional integrity will be discussed.
Professional integrity is defined as the freedom to perform the professional medical and nursing duties to patients entrusted to the care of doctors and nurses, in their full extent, according to the internationally accepted ethical standards.

For centuries doctors and nurses have been aware of their duty to be dedicated to the care of their patients, and of the duty to keep their secrets.
After the Second World War international organizations like the World Medical Association and the United Nations have been very specific about the preservation of professional integrity.
Not only does the text of the Declaration of Geneva (WMA 1948, 1968, 1983) read:
"The health of my patient will be my first consideration";
"I will not permit considerations of religions, nationality,

race, party politics or social standing to intervene between my duty and my patient",

but it is also specified in "Regulations in times of Armed Conflict" (WMA 1956, 1957, 1983) that:

"Medical Ethics in time of armed conflict is identical to medical ethics in time of peace";

"The members of medical and auxiliary professions must be granted the protection needed to carry out their professional activities freely .... Free passage should be granted whenever their assistance is required. They should be afforded complete professional independence";

"The fulfilment of medical duties and responsibilities shall in no circumstances be considered an offence. The physician must never be prosecuted for observing professional secrecy".

The United Nations' "Principles of Medical Ethics" (1982) state (Principle 1) that:

"Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease with the same quality and standard as is afforded to those who are not imprisoned or detained."

The principle of professional integrity is also laid down in the United Nations "Code of Conduct for Law Enforcement Officials" (article 6):

"Law enforcement officials shall ensure the full protection of the health of persons in their custody and, in particular, shall take immediate action to secure medical attention whenever required."

The importance of professional integrity is also stressed in the report of the Special Rapporteur to the United Nations Commission on Human Rights. 36).

It is laid down in internationally accepted codes of medical practice that the protection of professional integrity is the responsibility of the international community.

Paragraph 6 of the WMA Declaration of Tokyo (1975) states that: "The WMA will support and should encourage the international community, the national medical associations and fellow doctors to support the doctor and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of crual, inhuman or degrading treatment".
And the British Medical Association also believes that: "The medical profession has a responsibility to support any practitioner who refuses to keep silent about abuses of human rights" and that "doctors having knowledge of any activity covered by the Tokyo Declaration have a positive obligation to make those activities publicly known."

The above mentioned quotations of international codes and declarations make it clear that violations and limitations of professional integrity should be taken seriously and exposed to the international professional and lay community.

Limitations and violations of professional integrity

During the visit to South Africa a considerable number of limitations of professional integrity of various kinds have been reported to the delegation. The major part of information was received from health professionals themselves who had been or still were exposed to these limitations.

Physical and situational limitations

Although the most obvious violation of professional integrity occurs during unrest, it should be mentioned that health workers in South Africa have to "live" with daily limitations of professional integrity following apartheid regulations.
The Group Areas Act prevents e.g. black doctors to practise in white designated areas, black nurses and students are not allowed to have accommodation near the hospital where they work if the hospital is located in a white designated area; they are forced to travel considerable distances to their townships.

Apartheid regulations force health workers to take decisions, which have no medical or nursing grounds e.g. transport of patients to a racially designated hospital. These decisions are irrational and at times dangerous (delay in time) and have even resulted in casualties.

In times of unrest practices of private doctors and emergency rooms of hospitals have become part of the public area of confrontation between citizens and police or army.

In several places the police have forced their way into emergency rooms to arrest suspects and wounded victims. Actual prevention of medical care took place by blocking the entrances of health care premises by vehicles and police or army personnel.

Especially during the State of Emergency medical treatment has on several places physically been prevented by policemen. In 1986 two doctors in Chamdor near Krugersdorp had policemen in their surgery threatening them not to treat gunshot victims: the families of the doctors were also threatened. These kinds of incidences happen regularly and have at times led to tense relationships between health workers and police.

Other ways of preventing medical care are: arrests of suspects in surgery, in waiting rooms, announcing arrest as soon as first-aid treatment is finished, and harassment of patients in hospitals (e.g. by handcuffing them to a bed). Some sources had the impression that there was at times a special strategy of arresting suspects: by shooting them it was more "convenient" to arrest them in a hospital or clinic, than outside on the street.

The fear of "unsafe" hospitals has caused many unrest victims to stay away and not to attend hospitals, resulting in disease, disability and even death.

South African black townships have been designed in such a way that it is very easy to seal them off. The few roads to and from the township, with roadblocks for police and army control, make this possible. In times of political violence or civil war the townships are sealed off and ambulances and doctors cannot get in. Official health services collapse and community based health services, which are being developed by community (women, youth, trade union) groups are of increasing value.

It is estimated that several thousands people received gunshot injuries in Crossroads and NTC squatter camps (Cape Town) during the 1986 unrests.

Violation of professional secrecy

Violation of professional secrecy is a frequently heard complaint.
Besides suspected or established telephone tapping, history taking is overheard by plain-clothes policemen in overcrowded emergency rooms where privacy is absent. Doctors, nurses and administrative staff are asked for names of victims, and if "non-cooperative" they are forced to give information, usually by threats of violence against the health worker or his/her family. If they are prepared or forced to cooperate with the police, they give the police a copy of the daily emergency room admission register.
Generally nurses and clerks are, because of lower social status, more likely to suffer from police pressure to give information.

One of the most notorious breaches of professional secrecy was the incident at Alexandra Clinic in Johannesburg in 1986.
After a manifestation in Alexandra Township where a crowd was shot at by the police using shotguns, the police requested patients files, especially of those with shot wounds. The clinic's medical director turned down the request on grounds of professional secrecy. The police then seized the patient files by force. Only after the medical director informed the police that they were actually obstructing proper medical care, the files were returned. The incident caused a national and international outcry.
Less known is the remark of Dr. F.P. Retief, Director-General of the Department of National Health, that Alexandra Clinic "was the only clinic on the Reef which had refused to cooperate with the police". "This", according to Alexandra Clinic's medical director Dr. T.M. Wilson, "was meant to be an insult, but I regarded it as a compliment". It was rather sad to learn that other clinics apparently lend the police easier access to confidential information."

The district surgeon's duties towards professional secrecy are particularly difficult. In several places the doctor's notes are directly accessible to prison authorities.
The fact that the district surgeon has a legal obligation to give confidential information upon court order (security legislation makes this provision easy) and that a detainee must be accompanied by his full medical record when being transferred, the professional secrecy of the district surgeon and the confidentiality of the detainee's information is a utopia.

At the time of the 5th NAMDA Conference (april '87) a newspaper reporter was subpoenaed to divulge the names of the doctors who did research on the sequelae of detentions and torture. The reporter had published the outcome of the research.
The doctors might subsequently be subpoenaed to divulge the names of their informers, i.e. their ex-detainee patients. If, then, the doctors maintain their professional secrecy and refuse to give their patients' names, they are liable to serve prison sentence for up to 5 years. If they give the names, they violate their professional duty and spoil the trust of ex-detainees.

Detentions, imprisonments and bannings

Several members of the medical and nursing professions have been detained without trial. In these cases no charge is known, but political activity or reasons following professional ethical attitude can safely be assumed. Some have been imprisoned for political reasons, some have been banned. Among those who have been in detention are:
Dr. Essop Jassat, Dr. Zola Dabula, Dr. Vuyisile Madikizela, Dr. Aubrey Mokoape, Dr. Mamphele Ramphele (detained and banished upon release), Dr. R. Saloojee, Ms. Albertina Sisulu, S.R.N., Dr. Mvuyo Tom, Dr. Deliza Mji, Dr. Farook Meer, Dr. Joe Phaahla, Dr. Zweli Mkhize, Dr. Riedman Pillay, Dr. Vijay Ramlakan, Dr. Maxwell Dhlomo, Dr. Mike Nazo, Dr. Motala, Dr. U. Chetty, Dr. Frances Hlahla, Dr. Abubaker Asvat, Saths Cooper (psychologist) and the medical students Percival Mahlati, Lulamile Xate, Pumeza Nxiweni, Arleta Ngobese. 37, 38)..

Deaths in detention

The DPSC has listed 65 deaths in detention since detention without trial was introduced in 1963, and 26 persons who died while being held in police custody since 1984. Among the victims are the following health workers:
Dr. Nanaoth Ntshuntsha (died 8-1-1977), Dr. Hoosen Mia Haffejee (died 3-8-1977), Steven Bantu Biko (died 12-9-1977), Dr. Neil Aggett (died 5-2-1982), Dr. Batanda Ndondo (died 24-9-1985). All showed traces indicating torture.

Informal violence

Anonymous threats by letter or by telephone are regularly received by health workers associated with progressive or human rights organizations.
During the mission to South Africa one of the hosts of this delegation received a sophisticated postcard with rubber toy tire and a text suggesting threat with necklacing.
Dr. Fabian Ribeiro, a Mamelodi (near Pretoria) general practitioner, and his wife were murdered in their house by a death squad. Newspaper reporters and witnesses could trace the car used by the murderers to a police officer. The case has never been satisfactorily dealt with.

Suspension of duty

Some health workers have been prevented to do their duty for obvious political reasons.
A matron in an Unlazi hospital (near Durban) disciplined a nurse who was campaigning for Inkatha (the political movement of chief Buthelezi). The matron was subsequently suspended and transferred, and her disciplinary action was overruled.

Kwazulu's Chief Minister Gatsha Buthelezi demands of all people in the Kwazulu Government Service that they sign an oath of allegiance. Many health workers have refused to sign the oath, and

have come in trouble. Some doctors have been dismissed from, others were not employed, because of their refusal, in Prince Myshiyeni Hospital in Umlazi township near Durban.

Dr. Wendy Orr, after she had exposed torture cases in detention, was suspended from her duties as prison doctor: she was not allowed to contact detainee-patients. Curious detail is that her superior who issued the suspension, was Dr. I. Lang, one of the disciplined Biko-doctors.

Censure

Different kinds of censure can be regarded as limitations of professional freedom or integrity. A considerable degree of self or imposed (informal) censure occurs in many clinics, where "health talks" are organized for clinic attendants.
Various health related, sometimes highly topical subjects like poverty related diseases, waterborne diseases, housing and sanitation in relation to health, occupational diseases and disability (following a mine-disaster), malnutition, and health effects of forced removals, are relevant health issues, but also political issues. Clinic authorities sometimes collide with local or municipal authorities and the "health talk" is formally or informally forbidden, for obvious political reasons.

Expatriate doctors and nurses have a position which forces them to be very cautious for the risk of being expelled from the country. Particularly in community based primary health care projects when political issues are at stake, an outspoken point of view may collide with authorities with risk of expulsion.

One expatriate (Polish) doctor gave evidence in court in a torture case against the police.. Fear of problems afterwards made him to flee the country soon after having given evidence.

Disciplining the profession: the SAMDC

The official body to discipline the medical and dental profession in the South African Medical and Dental Council (SAMDC). The SAMDC holds a register of all medical and dental practitioners and has the task to discipline doctors and dentists when necessary. The SAMDC is a statutory body, composed of 3 sections: only one third exists of elected members of the medical and dental profession, the others are state appointed and ex officio members.

Although the purpose of disciplining the profession is the preservation of professional standards some remarks can be made.

Apartheid regulations may lead to decisions or actions which are medically irrational and occasionally this has led to casualties. Since the SAMDC is a government body, it has not challenged the apartheid regulations where this would be necessary from a medical point of view.

The SAMDC has consistently refused to conduct a full investigation into the alleged involvement of doctors in the death of Steven Biko, now ten years ago. Steve Biko, a black conscious movement leader and medical student, was tortured in detention, and after having been transported from Port Elizabeth to Pretoria, died on 12th September 1977 on a Pretoria prison floor. The doctors who saw Biko ignored the signs of the brain damage he showed, and had agreed to the 700 miles transport by road. Although already in december 1977 a complaint was lodged with the SAMDC against the responsible doctors (Tucker and Lang), it took over 2 years before, during a special meeting of the council of April 1980, the committee of preliminary inquiry concluded that "there was no prima facie evidence of improper conduct on the part of the practitioners. The committee thus therefore resolved that no further action be taken in the matter". 39).
In reaction to the widespread criticism with the decision, the President of the SAMDC said after a special meeting on June 17th

1980 that "the matter was thoroughly debated and is now closed" 40).

One member of the council told Prof. Jenkins later that that special meeting was devoted partly to a discussion on the "communist threat" and the "total attack" on South Africa. 22).

The MASA's executive council "was satisfied that the decision of the council was in no way subject to extraneous influences and that the integrity and motivation of the members of the council with regard to this matter are beyond question." 22).

Many medical professionals were critical about the SAMDC's ruling and MASA's attitude, and privately or in public disagreed strongly. 41).

It was through the persistent action of a group of concerned individual doctors (Prof. Tobias, Prof. Ames and Prof. Jenkins) that finally the Transvaal Supreme Court early in 1985 ordered the SAMDC to hold an inquiry into the conduct of the doctors concerned. Dr. Tucker was eventually removed from the register and Dr. Lang was suspended.

The Biko case is the most notorious case in which the political preference over medical ethics became clear.

Complaints against district surgeons about ill- or non-treatment have been lodged with the SAMDC (e.g. on behalf of Mbonjeni Bentley in 1980 and Marcus Motaung in 1982, both alleged ANC-members). The council has not investigated the complaints.

On the other hand the SAMDC has used its disciplinary powers against politically active doctors. In December 1985 doctors who supported nurses and other hospital workers who undertook trade union actions in Baragwanath Hospital in Soweto, and doctors who had protested against military presence in townships, were rebuked. 37).

In 1985 Dr. Aubrey Mokoape received a letter from the SAMDC in 1985 ordening him to appear before a disciplinary committee for holding a criminal record. In 1977 Aubrey Mokoape - then a medical student - had peacefully rallied for Frelimo in Durban and

was arrested for political reasons. He was found guilty under the Terrorism Act and subsequently sent to Robben Island where he served a 5 years prison sentence. Upon release he finished medical school and started a private practice in Durban.
He appeared before the disciplinary committee; the case was eventually dismissed over a technicality (there was no complainant).

In his opening address to the 12th meeting of the SAMDC in April 1986, the President, Prof. F.G. Geldenhuys, said: "... practitioners should act within the law. If a practitioner is convicted in a court of Law Council must consider the matter. In the case of an offence, whether it be politically or criminally inspired, Council would in my view, take disciplinary steps if the practitioner concerned, and that includes all persons registered with the Council, participated in any action which caused injury or damage to a person. Such action cannot be reconciled with the tradition of the profession", and "Council must strive to enhance the health of the population. It follows that council cannot condone any action which is aimed at impeding the promotion of health, such as for instance calls on overseas practitioners not to come to South Africa to render assistance to local practitioners and patients". 42).

Since South African law and especially security legislation and provisions under the State of Emergency make it extremely easy to identify any opposition or political action as criminal, it follows that those practitioners concerned are not only threatened by law but also by disciplinary action from the SAMDC. The "offences" include maintaining professional secrecy, political opposition, and advocating an academic boycot.

The above mentioned examples illustrate that the SAMDC is not an impartial body to protect only the medical and dental standards but also has shown political preferences: allegations that the SAMDC have been a part of state repression seems to have ground. 38).

PROFESSIONAL ORGANIZATIONS

Health professionals in South Africa deal in many different ways with lawlessness, apartheid, violation of human rights and professional integrity. As in any other country, health professionals are partly a product of their society.
However, both individually and organized, the health professions have produced strong advocates of human rights and strong opponents of apartheid, detentions and violations of human rights and professional integrity.
Some do so on a strictly private basis, others take initiatives which are very instrumental in the struggle for justice and human rights.
Individual doctors took the initiative to force the SAMDC to discipline the "Biko-doctors".
The Faculty of Medicine of the University of the Witwatersrand resolved on June 27, 1980, to publicly dissociate itself from the decision of the SAMDC.
Trefor Jenkins, head of the ethical committee of the same faculty, recommended a modified Hippocratec Oath, since many students felt that the Hippocratic Oath could not be taken in present-day South Africa. 43).

The Medical Association of South Africa (MASA)

MASA is the largest medical professional organization in South Africa, with membership of the majority of all South African doctors. It is a non-statutory body serving and promoting the interests of its members and the quality of medical care.
Dentists in South Africa are organized in a similar association: DASA (Dental Association of South Africa).
"MASA wants to be a home for all doctors", says Dr. LeRoex, chairman of the Federal Council of the MASA "and stays out of politics". Portraying NAMDA as an organization of political activists rather than health professionals, he confirms that the MASA regards subjects like apartheid, the new constitution, and detentions as political affairs on which MASA will not make any statements.

The imposed independence of the "homelands" of South Africa was formally underlined by MASA by its support of the formation of the Transkei Medical Association.

Although many individual MASA members have expressed their concern and reject detentions, the MASA has not officially denounced detentions.

Dr. LeRoex considered the role of MASA in the Biko case as "unfortunate". MASA issued a "Report on Medical Care of Prisoners and Detainees" on 21st May 1983, advocating safeguards for proper medical care and independence of the district surgeon.

The report, however, does not denounce detentions as such and accept a period of 7 days of solitary confinement, which is in contradiction with the declaration of Tokyo of the World Medical Association, which the MASA as a member of the WMA is supposed to endorse.

South African Medical Journal (SAMJ)

The SAMJ is the official organ of the MASA, and in South Africa the most widely circulated forum of information and discussion for the medical profession.

Individual practitioners have access to the correspondence columns of the SAMJ. The Federal Council of MASA has decided, however, that letters or articles from NAMDA "should not to be published in the SAMJ".

Censuring NAMDA from SAMJ has made it difficult for NAMDA to defend itself against allegations from colleagues that it is advocating an academic boycott. This "hot issue" has been discussed at the 1986 AGM of NAMDA, but never reached a stage beyond "proposal". The motion has not been accepted. 44).

The exclusion of NAMDA from SAMJ has necessitated NAMDA to publish in foreign medical papers.

It seems that the SAMJ has no real editorial independence and has unfortunately disqualified itself as a freely accessible forum for discussions on health care and policy.

World Medical Association

Following the refusal of Japan to grant visas to MASA delegates to attend the WMA meeting in 1976 in Japan, the MASA withdrew from the WMA.
Secretary General of the WMA, Dr. André Wynen, has been instrumental in the readmission of MASA to the WMA in October 1981. During a visit to South Africa in February 1980 Dr. Wynen stated that "South Africa's medical service is amongst the best in the world and we would like to have her back in the family".
MASA's readmission caused a large numer of members to leave the WMA. Medical associations of black African Countries have subsequently established the Confederation of African Medical Associations and Societies (CAMAS).
The WMA planned to have its 1981 annual congress in Cape Town, but after strong domestic and foreign protest the WMA council decided to switch the venue to Brussels. At the same time the council decided to send an investigative team to see what the conditions in medicine truly are in South Africa.

The secretary of the British Medical Association, Dr. John Havard wrote to the secretary general of the WMA, Dr. André Wynen:
"I have been asked by the representatives of the national medical associations of Denmark, Finland, Ireland, the Netherlands, Norway, Sweden and the United Kingdom, meeting in London on 15-16 February 1985 to convey to the council of the World Medical Association in the strongest terms their disapproval of the decision to hold the 37th World Medical Assembly in the Republic of South Africa. This decision, together with the fact that the Transkei Medical Association will be participating in the meeting as a national medical association, is bound to be interpreted as an endorsement by the WMA of the apartheid policy in South Africa", 45).

During a visit of WMA's Council chairman Dr. L.L. Wilson to South Africa in 1984, he apparentely was satisfied with "MASA's policy

that there should not be discrimination between the services rendered to individuals on the basis of race or colour.". 46). Dr. Wilson's visit has been instrumental in establishing the "independent doctors panels" as recommended by the MASA. According to Dr. LeRoex, the visit made the government to accept the achieved compromise. The WMA has not commented on the contradiction between the WMA Declaration of Tokyo and the retention of isolation and the whole process of detention, in MASA's report "Medical Care of of Prisoners and Detainees".

The South African Nurses Association (SANA)

The South African Nurses Association is the largest association of health professionals in South Africa. The association is closely linked with the South African Nurses Council (SANC), a statutory body which holds a register of all nurses and maintains the quality and discipline of the profession.

In 1983 the SANC had registered approximately 60,000 nurses. 6). Registration is on racial basis.

The SANA has reinforced the government's homeland policy by creating "independent" nurses associations in "independent homelands".

Membership of the SANC and SANA is obligatory and membership dues are deducted at source. Apartheid has penetrated strongly in the SANA. The Executive Council consists of 5 white members (for 30,000 white nurses), 2 African members (for 24,000 African nurses), 1 Indian member (for 1,000 Indian Nurses) and 1 coloured member (for 5,000 coloured nurses).

This strictly unequal representation guarantees white domination.

The SANA is not a member of the International Nurses Council because of its racial discriminatory organization.

The SANA does not challenge apartheid. Especially by African nurses, the SANA is experienced as an instrument of repression rather than a body of representation.

As SANA membership is obligatory and strike is forbidden, an alternative means of organization is very difficult. For South Af-

rican nurses it is virtually impossible to organize themselves in a democratic way. Another reason is that nurses work in a fairly hierarchic structure with strong vertical control, and have no alternative but government or corporation service. Unlike doctors, nurses cannot "go private".
While nurses have a pivotal position in health care, are largest in number, and are considered by many to be the stronghold of South Africa's health care, they have a most vulnerable position. Failure to represent or support nurses by SANA was demonstrated during the incident of Baragwanath Hospital (Soweto) in 1986. Over 2,000 hospital workers, including 1,000 student nurses were summarily dismissed over a stay-away action following alleged failure of hospital authorities to hear grievances of working conditions. Trade unions and progressive organizations like the Health Workers Association supported the student nurses, but the SANA said that "These students have ruined their position in the nursing profession and damaged public trust in the profession". 47).

The feasibility of an alternative (democratic) nurses organization has been discussed thoroughly, i.a. within NAMDA. Although the importance of such an organization is recognized by NAMDA, it was decided on the 1987 AGM of NAMDA that nurses could only be associate members.

National Medical and Dental Association (NAMDA)

This is a professional organization of doctors and dentists as full members, and medical and dental students and other paramedics as non-voting associate members.
NAMDA has over 1,000 members (since early 1987 fast growing), with branches in every major centre and most of the countryside of South Africa.
The organization was founded in 1982, by doctors and dentists, who were desillusioned in the way in which the existing medical organization MASA (Medical Association of South Africa) had failed to challenge the effects of apartheid on health and had failed to urge the South African Medical and Dental Council to di-

scipline the doctors who were responsible for Steve Biko when he died. It was felt that MASA had only cautiously commented on violations of human rights by the detentions and other forms of organized violence.

The professional responsibility for the implementation of a health policy is expressed in the preamble of the constitution of NAMDA 48). ; we

- Accept the WHO definition of health as a state of complete physical, mental and social wellbeing and not merely as the absence of disease or infirmity.
- Believe that the right to health is a basic human need which should be assured to all people irrespective of sex, race, colour, political belief, economic or social condition.
- Commit ourselves to create the conditions for optimum health in South Africa which can only exist in a free and democratic society.

NAMDA's program of activities can be divided into 3 areas.

1. Health policy; challenging the government on the effects of apartheid on health, challenging the effects of fragmentation of health services, and the development of alternatives for health policies in a free South Africa.
   On many occasions NAMDA has challenged effects of apartheid; in many studies and analyses the ill effects were substantiated and alternatives were offered. 49, 50, 51)
   An extensive program of primary health care projects has been initiated 52).

2. Health under repression: detentions and emergency services.
   The effects of detentions are documented. NAMDA provides medical services to ex-detainees. Together with other organizations like DPSC, OASSSA and LRC's, NAMDA constitutes a detainee service.
   Emergency services are related to police activities in the townships. Teams for emergency service are offered in time of unrest or expected confrontation, and community members from the townships are trained in first aid and health care orga-

nization. NAMDA participates in the organization of Emergency Services Groups; presently over 900 first aiders from community, youth and women organizations have been trained and provided with essential materials.

NAMDA has researched and reported on the effects and use of teargas (CS), especially in confined spaces, issued recommendations, 50) and about ballistics and wounds caused by different types of bullets 50).

Research is done and reports are published about the medical care of detainees, about the effects of torture. 20).

3. Mobilizing the medical and dental professions to play a meaningful role in changing South Africa into a free and non-racial society.

The Association has established many international contacts, and visited international congresses. NAMDA's president Dr. Diliza Mji received this year the Samuel Reuben Peace and Justice Award (USA).

The fourth annual conference of NAMDA was a milestone; according to the executive council of NAMDA it was the most successful conference and marked the increased momentum that NAMDA gained. The conference was attended by over 500 delegates, including eleven overseas guests, and was widely covered by the press. The conference theme was "Towards a National Health Service", papers presented included a historical view of National Health Service, analyses of facilities, manpower and education, papers on privatisation and fragmentation.

A major part of the conference was dedicated to "health under repression". In this section papers were presented about the effects of repression on children, the treatment of detainees, patient care under repression and emergency service.

During this part of the conference the delegates of the Johannes Wier Foundation have delivered their speeches.

The impression one got of the conference is probably best described in terms of dedication and inspiration. The large lec-

ture hall of the University of Western Cape contained the hundreds of dedicated members from all parts of South Africa, from faraway corners of the rural areas to universities and research institutions, from various backgrounds and "colours". It impressed as an aforeshadow of post-apartheid South Africa. The sincere and high-level discussions of experts on the effects of various health systems and the quality of the analyses of the present situation marked the collective conviction of the need of change in South Africa. The question was not "if" but "when" and "how".

CONCLUSIONS

APARTHEID

1. The racial segregation policies of the government of South Africa strongly reinforce socio-economic inequality in South Africa, and has to a large extent an impact on the health determinators and accessibility of health facilities of the various race-groups in South Africa.

2. Independence imposed by the South African government on the so called "homelands", has resulted in a concentration of unemployment, undernourishment, high infant mortality and low life expectancy for inhabitants of the "homelands".

3. Medical and nursing decisions are sometimes irrational and even fatal because they are not solely made on medical or nursing grounds but also in the framework of the existing apartheid policies.

4. Fragmentation of health services for the various race groups following the introduction of the new constitution in 1983 increases medical irrational behaviour and management; it deepens the interracial gaps and creates a burocratic elite in the non-white groups, which has an interest in maintaining apartheid.

5. Disciplinary supervision of the medical profession operates within the context of the apartheid regulations. These are irrational from medical and nursing point of view and are incompatible with international ethical standards.

6. Professional bodies:
   a. The South African Nurses Association (SANA) is a racially structured body. The majority of non-white nurses is "represented" by a statutory white majority in the executive council. Membership is obligatory for all nurses. Many

nurses regard SANA as an instrument of repression rather than as a representative body.
SANA has stimulated the "homelands" to create their "own" nurses associations. SANA is not a member of the International Council of Nurses, because of its racial structure.

b. The Medical Association of South Africa (MASA) is a non-racial, white dominated organization representing the majority of South African doctors.
Although many individual members have challenged apartheid, the MASA has not done so as an organization.
The MASA has not sufficiently been able and willing to accommodate professional opposition against apartheid and detentions as oppressive policies.
The MASA has supported homeland policy by the creation of the Transkei Medical Association.

c. The National Medical and Dental Association (NAMDA) is a national non-racial organization of medical and dental practitioners, representing a minority of doctors and dentists. The members of this association have individually and as an organization committed themselves to a democratic and non-racial society and system of health care in South Africa.
They consistently monitor and expose health effects of apartheid, detentions and violations of human rights. NAMDA doctors participate in the detainee service and regularly publish about the effects on the health of persons subjected to detention or torture.
NAMDA participates increasingly in international conferences.
NAMDA offices have been raided at least 3 times by South African police. Executives and members of NAMDA have been the victims of harassment, detention and abuse by security forces and informal violence or threats.

DETENTIONS

1. Being the most obvious aspect of a wide range of repressive methods, detentions constitute a serious threat to the mental and physical health, both during and after detention of the detainee and a considerable stress to his or her relatives and social support system.

2. Torture and other forms of cruel, inhuman or degrading treatment, both of phisical and psychological nature, are applied to large numbers of detainees.
   Various forms of physical and psychological ways of torture have been reported.
   Alleged assaults are remarkably consistent with the findings of examining doctors. Physical sequelae may sometimes be visible and disability may follow. Post detention psychiatric syndromes frequently occur, especially the Post Traumatic Stress Disorder, and Major Depressive Episode (DSM III).

3. About 40% of the detainees are children (persons of 18 years and below). Children are and have been tortured and maltreated to the same extent as adults.
   Children are exposed to additional violence since they are frequently incarcerated with adults and at times with convicted criminals who abuse them sexually too.

4. Sexual abuse is relatively unfrequently reported. The reported incidence is probably low because of the taboo connected with this subject in South Africa. Ex-detainees are not interviewed specifically about sexual abuse (contrary to other forms of physical abuse) by the detainee service.

5. The Medical Association of South Africa has produced a report on the treatment of detainees and prisoners. The recommendations of the report are considered as a positive step, but too limited in scope, and concessive to political pressure from the government.

The MASA does not per se denounce detentions as detrimental to health. It accepts a limited (7 days) period of solitary confinement.
MASA considers its report as the best achievable; however, the contents partly contradict the Declaration of Tokyo (1975). One of the recommendations provides for the establishement of a panel of independent doctors. The conditions upon which a doctor may sit on the panel and may be consulted by a detainee do not guarantee a free choice of doctor.

6. Medical care and safeguards for adequate medical care in detention by the district surgeon are insufficient. Several reports reveal the physical impossibility of examining huge numbers of detainees following political unrest. In a considerable number of cases a request by a detainee for medical attendance is either denied or ignored. Surveillance and reporting signs of torture and abuse in detention is insufficient.

7. Legal representatives have no access to detainees. Many district surgeons consider it a breach of confidentiality to give medical information to the lawyer of a detainee. Since the lawyer has no access to the detainee, he or she cannot communicate with the detainee about permission to ask medical information from the district surgeon. Legal procedures as to the protection of detainees can be seriously blocked by this vicious circle.

8. An extensive network of lawyers, doctors, psychologists and other professionals, either as individuals or within organizations like the Detainees Parents Support Committee (DPSC), NAMDA, the Organization for Appropriate Social Services in South Africa (OASSSA) and the Legal Resource Centres (LRC), constitute the detainee service. Although the service rendered to detainees is insufficient to reach all ex-detainees, especially in remote areas, the work done, in very difficult circumstances by highly motivated and committed people, is not

only important for the detainee but forms also a platform of protest against detentions and serves as a source of reliable information.

PROFESSIONAL INTEGRITY

1. Failing safeguards for medical and nursing care and for the professional integrity of health professionals - physical safety, professional secrecy, free access to places where needed - especially in times of political unrest or civil war, are serious violations of internationally accepted codes and declarations.
   The sealing off of townships, the prevention of medical and nursing care and of transport of unrest victims, the seizure of medical records and personal data of patients, and the arrests made in health care premises and the prevention of access to such premises, are a serious contradiction to international codes.

2. Violence against and harassment of individual health workers and organizations have been reported. Several health workers have died in detention, some have been banished. An important number of health workers has been in detention.
   Informal violence, varying from written or telephone threats to murder, are directed against committed and political active health workers.
   The NAMDA offices have been raided several times by the police.

3. Doctors in the Detainee Service who, according to international ethical codes, are obliged to make the findings of their examination publicly known, may face prison sentence, in cases in which a court rules that the names of detainees should be divulged, but those doctors decide to remain silent. For the protection of detainees and the preservation of the trust of their present and future detainee-patients, it is, however, of the utmost importance that they remain silent.

4. Health professionals - doctors, nurses, dentists, paramedics - who have identified themselves as protectors of human rights, who struggle for the integrity of their professions according

to internationally accepted declarations and codes of conduct, and who - with risk of harassment or inprisonment - maintain the prevalence of professional ethics over apartheid regulations and security legislation, are not protected and at times obstructed by the organizations of professional establishment, notably the SANA, the SAMDC and the MASA.

The formation of NAMDA has changed this situation and provided a platform for those health workers who have committed themselves to the promotion of human rights, medical ethics and the defence of professional integrity.

RECOMMENDATIONS

The Board of the Johannes Wier Foundation,

taking notice of the report of the mission of its delegation to the Republic of South Africa,

bearing in mind the relevant international codes concerning human rights and medical ethics, especially the U.N. Principles of Medical Ethics (1982) the U.N. Declaration against Torture (1975), the U.N. Standard Minimum Rules for the Treatment of Prisoners (1977), the U.N. Code of Conduct for Law Enforcement Officials (1979), the ICN Statement of the Nurse's Role in Safeguarding Human Rights (1983), the ICN Role of the Nurse in the care of detainees and prisoners (1975), the WMA Declaration of Tokyo (1975), the WMA Declaration of Geneva (1983) and the WMA Regulations in time of armed conflict (1983),

concerned about the violations of human rights as a result of the existence and application of apartheid regulations, the detentions and the health effects of detentions and the limitations and violations of professional integrity,

encouraged by the reported efforts and achievements of several individual and organized health workers who are committed to the struggle for human rights and a just health care and to the preservation and promotion of medical and nursing ethics,

considering its own objectives, which include i.a. the identification and exposure of cases in which human rights relating to health care are violated, the identification and support of those health workers who have become victims of human rights violations, and support of those health workers who have committed themselves to the protection and promotion of human rights,

adopts the following recommendations, presented by the authors of the present report:

1. It has sufficiently been established that the National Medical and Dental Association, (NAMDA) is a solid organization which

provides a platform for health workers committed to the protection and promotion of human rights, to the plight of detainees, and to a critical monitoring, opposing and challenging of apartheid regulations, detentions and torture, particularly in the light of the health effects of these policies and practices.

NAMDA as an organization and its representatives should, therefore, be strongly supported by the international professional communities. Support should be given to the establishment of formal contacts between NAMDA and foreign medical associations, international medical organizations and other non-governmental organizations.

2. Participation of NAMDA in international conferences and meetings on such matters as health care, health policy, and treatment and rehabilitation of detainees, should be encouraged.

3. Support should be given to South African initiatives to establish a non-racial, free and democratic nurses' organization.

4. The establishment of contacts between NAMDA and overseas donor agencies should be supported.

5. All measures of support of and all contacts with South African health professionals should be aimed at the furthering of human rights and the strengthening of the Rule of Law in the Republic of South Africa. Other contacts should be discouraged.

6. Provision of funds and personnel to institutions, projects and agencies in South Africa as well as overseas training of South African health personnel should be carefully monitored as to the places and purposes of such institutions, projects and agencies.

7. The establishment of a special working group on South Africa within the Johannes Wier Foundation with the task to monitor developments and to maintain contacts with appropriate partners in South Africa, is recommended.

8. The MASA should be urgently insisted upon to reopen negotiations with the South African government in order to achieve a real free choice of doctor for the detainee, to publicly denounce the policy of detaining opponents of the apartheid regime as harmful to the mental and physical health of the detainees, and to denounce openly the use of any solitary confinement as a violation of the WMA Declaration of Tokyo.

9. The Federal Council of the MASA and the Chief Editor of the South African Medical Journal should be insisted upon to open the columns of the SAMJ for contributions from NAMDA so as to gain credibility as a genuine open platform for discussion on matters of health policy.

10. The MASA should be urgently requested to study closely the problem of confidentiality of medical information in cases in which lawyers do not have direct access to their clients, as in the case of detainees under security legislation - which is by itself a clear violation of a basic human right of the detainee - and in particular to consider the adoption of a rule that in such cases the provision of medical information to the lawyer of a detainee does not amount to a breach of confidentiality.

11. The Board of the Johannes Wier Foundation should express its deep concern to the government of the Republic of South Africa about the effects of the apartheid policies and the new constitution on health and health care, about the existence of detentions as a health damaging repressive measure, and about the violation and limitation of professional integrity by security forces.

The Board of the Johannes Wier Foundation considers the implementation of these recommendations to form an important aspect of its program of activities. The Board will, in this respect, make all possible efforts to involve the support of other organizations of health professionals in the Netherlands.

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List of Abbreviations

CAMAS	Confederation of African Medical Associations and Societies
DASA	Dental Association of South Africa
DPSC	Detainees Parents Support Committee
ESG	Emergency Services Group
HWA	Health Workers Association
ICHP	International Commission of Health Professionals
LRC	Legal Resource Centre
MASA	Medical Association of South Africa
NAMDA	International Medical and Dental Association
OASSSA	Organization for Appropriate Social Service in South Africa
SANDC	South African Medical and Dental Council
SAMJ	South African Medical Journal
SANA	South African Nurses Association
SANC	South African Nurses Council
WHO	World Health Organization
WMA	World Medical Association

THE DECLARATION OF GENEVA

(World Medical Association, 1948, 1968, 1983)

The World Medical Association was formed in 1947. High on its initial list of priorities was the formulation of a modern equivalent of the Hippocratic Oath. First adopted by the Second World Medical Assembly in 1948, the Declaration of Geneva was amended by the 22nd Assembly of the WMA meeting in Sydney, Australia in 1968 and again by the 35th World Medical Assembly meeting in Venice, Italy in 1983.

The text, as amended, reads as follows:

DECLARATION OF GENEVA

AT THE TIME OF BEING ADMITTED AS A MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE myself to consecrate my life to the service of humanity;

I WILL GIVE to my teachers the respect and gratitude which is their due;

I WILL PRACTICE my profession with conscience and dignity;

THE HEALTH OF MY PATIENT will by my first consideration;

I WILL RESPECT the secrets which are confided in me, even after the patient has died;

I WILL MAINTAIN by all means in my power, the honor and the noble traditions of the medical profession;

MY COLLEAGUES will be my brothers;

I WILL NOT PERMIT considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;

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

I MAKE THESE PROMISES solemnly, freely and upon my honor.

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STANDARD MINIMUM RULES FOR THE TREATMENT OF PRISONERS AND RELATED RECOMMENDATIONS

(United Nations, 1955, 1977) (abstracts)

8. The different categories of prisoners shall be kept in separate institutions or parts of institutions taking account of their sex, age, criminal record, the legal reason for their detention and the necessities of their treatment. Thus,

   (a) Men and women shall so far as possible be detained in separate institutions; in an institution which receives both men and women the whole of the premises allocated to women shall be entirely separate;

   (b) Untried prisoners shall be kept separate from convicted prisoners;

   (c) Persons imprisoned for debt and other civil prisoners shall be kept separate from persons imprisoned by reason of a criminal offence;

   (d) Young prisoners shall be kept separate from adults.

24. The medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as necessary, with a view particularly to the discovery of physical or mental illness and the taking of all necessary measures; the segregation of prisoners suspected of infectious or contagious conditions; the noting of physical or mental defects which might hamper rehabilitation, and the determination of the physical capacity of every prisoner for work.

25. (1) The medical officer shall have the care of the physical and mental health of the prisoners and should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is specially directed.

(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.

31. Corporal punishment, punishment by placing in a dark cell, and all cruel, inhuman or degrading punishments shall be completely prohibited as punishments for disciplinary offences.

INTERNATIONAL CODE OF MEDICAL ETHICS

(WMA, 1949, 1968, 1983)

Drawing on the Declaration of Geneva, the WMA formulated a more detailed code of ethics which was approved by the Third Assembly of the WMA meeting in London in 1949. The International Code of Medical Ethics was subsequently amended in 1968 by the 22nd Assembly in Sydney and again in 1983 by the 35th Assembly of the WMA at Venice.

The text, as amended, reads as follows:

INTERNATIONAL CODE OF MEDICAL ETHICS

Duties of Physicians in General

A PHYSICIAN SHALL always maintain the highest standards of professional conduct.

A PHYSICIAN SHALL not permit motives of profit to influence the free and independent exercise of professional judgment on behalf of patients.

A PHYSICIAN SHALL, in all types of medical practice, be dedicated to providing competent medical service in full technical and moral independence, with compassion and respect for human dignity.

A PHYSICIAN SHALL deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

The following practices are deemed to be unethical conduct:

a) Self advertising by physicians, unless permitted by the laws of the country and the Code of Ethics of the National Medical Association.

b) Paying or receiving any fee or any other consideration solely to procure the referral of a patient or for prescribing or referring a patient to any source.

A PHYSICIAN SHALL respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences.

A PHYSICIAN SHALL act only in the patient's interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient.

A PHYSICIAN SHALL use great caution in divulging discoveries or new techniques or treatment through non-professional channels.

A PHYSICIAN SHALL certify only that which he has personally verified.

Duties of Physicians to the Sick

A PHYSICIAN SHALL always bear in mind the obligation of preserving human life.

A PHYSICIAN SHALL owe his patients complete loyalty and all the resources of his science. Whenever an examination or treatment is beyond the physician's capacity he should summon another physician who has the necessary ability.

A PHYSICIAN SHALL preserve absolute confidentiality on all he knows about his patient even after the patient has died.

A PHYSICIAN SHALL give emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care.

Duties of Physicians to each other

A PHYSICIAN SHALL behave towards his colleagues as he would have them behave towards him.

A PHYSICIAN SHALL NOT entice patients from his colleagues.

A PHYSICIAN SHALL observe the principles of the "Declaration of Geneva" approved by the World Medical Association.

REGULATIONS IN TIME OF ARMED CONFLICT

(WMA, 1956, 1957, 1983)

These regulations or guidelines set out the WMA's standards on the medical ethical position of the physician during a period of war or other armed conflict. The statement was approved by the 10th World Medical Assembly in Havana in 1956, was edited by the 11th Assembly meeting in Istanbul the following year and was amended by the 35th World Medical Assembly in 1983.

The amended text reads as follows:

REGULATIONS IN TIME OF ARMED CONFLICT

1. Medical Ethics in time of armed conflict is identical to medical ethics in time of peace, as established in the International Code of Medical Ethics of the World Medical Association. The primary obligation of the physician is his professional duty; in performing his professional duty, the physician's supreme guide is his conscience.

2. The primary task of the medical profession is to preserve health and save life. Hence it is deemed unethical for physicians to:

   A. Give advice or perform prophylactic, diagnostic or therapeutic procedures that are not justifiable in the patient's interest.

   B. Weaken the physical or mental strength of a human being without therapeutic justification.

   C. Employ scientific knowledge to imperil health or destroy life.

3. Human experimentation in time of armed conflict is governed by the same code as in time of peace; it is strictly forbidden on all persons deprived of their liberty, especially civilian and military prisoners and the population of occupied countries.

4. In emergencies, the physician must always give the required care impartially and without consideration of sex, race, nationality, religion, political affiliation or any other similar criterion. Such medical assistance must be continued for as long as necessary and practicable.

5. Medical confidentiality must be preserved by the physician in the practice of his profession.

6. Privileges and facilities afforded the physician must never be used for other than professional purposes.

Rules governing the care of sick and wounded, particularly in time of conflict

A. 1. Under all circumstances, every person, military or civilian must receive promptly the care he needs without consideration of sex, race, nationality, religion, political affiliation or any other similar criterion.

2. Any procedure detrimental to the health, physical or mental integrity of a human being is forbidden unless therapeutically justifiable.

B. 1. In emergencies, physicians and associated medical personnel are required to render immediate service to the best of their ability. No distinction shall be made between patients except those justified by medical urgency.

2. The members of medical and auxiliary professions must be granted the protection needed to carry out their professional activities freely. The assistance necessary should be given to them in fulfilling their responsibilities. Free passage should be granted whenever their assistance is required. They should be afforded complete professional independence.

3. The fulfillment of medical duties and responsibilities shall in no circumstances be considered an offence. The physician must never be prosecuted for observing professional secrecy.

4. In fulfilling their professional duties, the medical and auxiliary professions will be identified by the distinctive emblem of a red serpent and staff on a white field. The use of this emblem is governed by special regulation.

THE DECLARATION OF TOKYO

(WMA, 1975)

The Declaration of Tokyo has, since its adoption in 1975, been the most comprehensive statement produced by the medical profession on the question of the torture and cruel, inhuman or degrading treatment of detainees. It was adopted by the 29th World Medical Assembly, Tokyo, Japan.

The text is as follows:

DECLARATION OF TOKYO

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

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

1. The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.

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

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

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

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

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

CODE OF CONDUCT FOR LAW ENFORCEMENT OFFICIALS

adopted by the United Nations General Assembly 17 December 1979

(abstracts)

Article 5

No law enforcement official may inflict, instigate or tolerate any act of torture or other cruel, inhuman or degrading treatment or punishment, nor may any law enforcement official invoke superior orders or exceptional circumstances such as a state of war or a threat of war, a threat to national security, internal political instability or any other public emergency as a justification of torture or other cruel, inhuman or degrading treatment or punishment.

Article 6

Law enforcement officials shall ensure the full protection of the health of persons in their custody and, in particular, shall take immediate action to secure medical attention whenever required.

Commentary:

(a) "Medical attention", which refers to services rendered by any medical personnel, including certified medical practitioners and paramedics, shall be secured when needed or requested.

(b) While the medical personel are likely to be attached to the law enforcement operation, law enforcement officials must take into account the judgement of such personnel when they recommend providing the person in custody with appropriate treatment through, or in consultation with, medical personnel from outside the law enforcement operation.

(c) It is understood that law enforcement officials shall also secure medical attention for victims of violations of law or of accidents occurring in the course of violations of law.

DECLARATION AGAINST TORTURE

(United Nations, 1975)

The Declaration on the Protection of all Persons from Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (Declaration against Torture) was adopted without a vote by the United Nations General Assembly on 9 December 1975. It calls upon states to take effective measures to prevent torture and lists some of the most important safeguards and remedies to be provided. It is one of the most important international documents on torture.

DECLARATION ON THE PROTECTION OF ALL PERSONS FROM TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

The United Nations General Assembly adopted on 9 December 1975 a Declaration condemning any act of torture or other cruel, inhuman or degrading treatment as "an offence to human dignity". Under its terms, no State may permit or tolerate torture or other inhuman or degrading treatment, and each State is requested to take effective measures to prevent such treatment from being practised within its jurisdiction.

The Declaration was first adopted and referred to the Assembly by the Fifth United Nations Congress on the Prevention of Crime and Treatment of Offenders, held in Geneva in September 1975. In adopting the Declaration without a vote, the Assembly noted that the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights provide that no one may be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

The Assembly has recommended that the Declaration serve as a guideline for all States and other entities exercising effective power.

The text of the Declaration follows:

Article 1

1. For the purpose of this Declaration, torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted by or at the instigation of a public official on a person for such purposes as obtaining from him or a third person information or confession, punishing him for an act he has committed or is suspected of having committed, or intimidating him or other persons. It does not include pain or suffering arising only from , inherent in or incidental to, lawful sanctions to the extent consistent with the Standard Minimum Rules for the Treatment of Prisoners.

2. Torture constitutes an aggravated and deliberate form of cruel, inhuman or degrading treatment or punishment.

Article 2

Any act of torture or other cruel, inhuman or degrading treatment or punishment is an offence to human dignity and shall be condemned as a denial of the purposes of the Charter of the United Nations and as a violation of the human rights and fundamental freedoms proclaimed in the Universal Declaration of Human Rights.

Article 3

No State may permit or tolerate torture or other cruel, inhuman or degrading treatment or punishment. Exceptional circumstances such as a state of war or a threat of war, internal political instability or any other public emergency may not be invoked as a justification of torture or other cruel, inhuman or degrading treatment or punishment.

Article 4

Each State shall, in accordance with the provisions of this Declaration, take effective measures to prevent torture and other cruel, inhuman or degrading treatment or punishment from being practised within its jurisdiction.

Article 5

The training of law enforcement personnel and of other public officials who may be responsible for persons deprived of their liberty shall ensure that full account is taken of the prohibition against torture and other cruel, inhuman or degrading treatment or punishment. This prohibition shall also, where appropriate, be included in such general rules or instructions as are issued in regard to the duties and functions of anyone who may be involved in the custody or treatment of such persons.

Article 6

Each State shall keep under systematic review interrogation methods and practices as well as arrangements for the custody and treatment of persons deprived of their liberty in its territory, with a view to preventing any cases of torture or other cruel, inhuman or degrading treatment or punishment.

Article 7

Each State shall ensure that all acts of torture as defined in article 1 are offences under its criminal law. The same shall apply in regard to acts which constitute participation in, complicity in, incitement to or an attempt to commit torture.

Article 8

Any person who alleges that he has been subjected to torture or other cruel, inhuman or degrading treatment or punishment by or at the instigation of a public official shall have the right to complain to, and to have his case impartially examined by, the competent authorities of the State concerned.

Article 9

Wherever there is reasonable ground to believe that an act of torture as defined in article 1 has been committed, the competent authorities of the State concerned shall promptly proceed to an impartial investigation even if there has been no formal complaint.

Article 10

If an investigation under article 8 or article 9 establishes that an act of torture as defined in article 1 appears to have been committed, criminal proceedings shall be instituted against the alleged offender or offenders in accordance with national law. If an allegation of other forms of cruel, inhuman or degrading treatment or punishment is considered to be well founded, the alleged offender or offenders shall be subject to criminal, disciplinary or other appropriate proceedings.

Article 11

Where it is proved that an act of torture or other cruel, inhuman or degrading treatment or punishment has been committed by or at the instigation of a public official, the victim shall be afforded redress and compensation in accordance with national law.

Article 12

Any statement which is established to have been made as a result of torture or other cruel, inhuman or degrading treatment may not be invoked as evidence against the person concerned or against any other person in any proceedings.

PRINCIPLES OF MEDICAL ETHICS

(United Nations, 1982)

The principles are elaborated within the text of Resolution 37/194 adopted by the United Nations General Assembly, 18 December 1982.

PRINCIPLES OF MEDICAL ETHICS*

The General Assembly...

DESIROUS of setting further standards in this field which ought to be implemented by health personnel, particularly physicians, and by Government officials,

1. *ADOPTS 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 set forth in the annex to the present resolution;*

2. CALLS UPON all Governments to give the Principles of Medical Ethics, together with the present resolution, the widest possible distribution, in particular among medical and paramedical associations and institutions of detention or imprisonment in an official language of the State;

3. INVITES all relevant inter-governmental organizations, in particular the World Health Organization, and non-governmental organizations concerned to bring the Principles of Medical Ethics to the attention of the widest possible group of individuals, especially those active in the medical and paramedical field.

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

Principle 1

Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

Principle 2

It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment.[1]

Principle 3

It is a 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 solely to evaluate, protect or improve their physical and mental health.

Principle 4

It is a contravention of medical ethics for health personnel, particularly physicians:

a) to apply their knowledge and skills in order to assist in the interrogation of prisoners and detainees in a manner that may adversely affect the physical or mental health or condition of such prisoners or detainees and which is not in accordance with the relevant international instruments;[2]

b) To certify, or to participate in the certification of, the fitness of prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health and which is not in accordance with the relevant international instruments, or to participate in any way in the infliction of any such treatment or punishment which is not in accordance with the relevant international instruments.

Principle 5

It is a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself, or his fellow prisoners or detainees, or of his guardians, and presents no hazard to his physical or mental health.

Principle 6

There may be no derogation from the foregoing principles on any grounds whatsoever, including public emergency.

ROLE OF THE NURSE IN THE CARE OF DETAINEES AND PRISONERS

(International Council of Nurses, 1975)

At the meeting of the Council of National Representatives of the International Council of Nurses in Singapore in August 1975, the following statement was adopted:

ROLE OF THE NURSE IN THE CARE OF DETAINEES AND PRISONERS

WHEREAS the ICN Code for Nurses specifically states that:

1. *"The fundamental responsibility of the nurse is fourfold: to promote health, to prevent illness, to restore health and to alleviate suffering.*

2. *"The nurse's primary responsibility is to those people who require nursing care.*

3. *"The nurse when acting in a professional capacity should at all times maintain standards of personal conduct which reflect credit upon the profession.*

4. *"The nurse takes appropriate action to safeguard the individual when his care is endangered by a co-worker or any other person."*

and

WHEREAS in 1973 ICN reaffirmed support for the Red Cross Rights and Duties of Nurses under the Geneva Conventions of 1949, which specifically state that, in case of armed conflict of international as well as national character (i.e. internal disorders, civil wars, armed rebellions):

1. *Members of the armed forces, prisoners and persons taking no active part in the hostilities*
   a) shall be entitled to protection and care if wounded or sick,
   b) shall be treated humanely, that is:
   - *they may not be subjected to physical mutilation or to medical or scientific experiments of any kind which are not justified by the medical, dental or hospital treatment of the prisoner concerned and carried out in his interest,*
   - *they shall not be wilfully left without medical assistance and care, nor shall conditions exposing them to contagion or infection be created,*
   - *they shall be treated humanely and cared for by the Party in conflict in whose power they may be, without adverse distinction founded on sex, race, nationality, religion, political opinion, or any other similar criteria.*

2. *The following acts are and shall remain prohibited at any time and in any place whatsoever with respect to the above-mentioned persons:*
   a) violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture;
   b) outrages upon personal dignity, in particular humiliating and degrading treatment.

WHEREAS in 1971 ICN endorsed the United Nations Universal Declaration of Human Rights and, hence, accepted that:

1. *"Everyone is entitled to all the rights and freedoms, set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status (Art.2),*

2. *"No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment (Art.5)"; and*

WHEREAS in relation to detainees and prisoners of conscience, interrogation procedures are increasingly being employed which result in ill effects, often permanent, on the person's mental and physical health;

THEREFORE BE IT RESOLVED that ICN condemns the use of all such procedures harmful to the mental and physical health of prisoners and detainees; and

FURTHER BE IT RESOLVED that nurses having knowledge of physical or mental ill-treatment of detainees and prisoners take appropriate action including reporting the matter to appropriate national and/or international bodies; and

FURTHER BE IT RESOLVED that nurses participate in clinical research carried out on prisoners, only if the freely given consent of the patient has been secured after a complete explanation and understanding by the patient of the nature and risk of the research; and

FINALLY BE IT RESOLVED that the nurse's first responsibility is towards her patients, notwithstanding considerations of national security and interest.

STATEMENT ON THE NURSE'S ROLE IN SAFEGUARDING HUMAN RIGHTS

(ICN, 1983)

Responding to requests from national member associations for guidance on the protection of human rights of both nurses and those for whom they care, the Council of National Representatives of the International Council of Nurses adopted the statement given below at its meeting in Brasilia in June 1983.

STATEMENT ON THE NURSE'S ROLE IN SAFEGUARDING HUMAN RIGHTS

This document has been developed in response to the requests of national nurses associations for guidance in assisting nurses to safeguard their own human rights and those for whom they have professional responsibility. It is meant to be used in conjunction with the ICN Code for Nurses and resolutions relevant to human rights. Nurses should also be familiar with the Geneva Conventions and the additional protocols as they relate to the responsibilities of nurses.

The current world situation is such that there are innumerable circumstances in which a nurse may become involved that require action on her/his part to safeguard human rights. Nurses are accountable for their own professional actions and must therefore be clear as to what is expected of them in such situations.

Also conflict situations have increased in number and often include internal political upheaval, and strife, or international war. The nature of war is changing. Increasingly nurses find themselves having to act or respond in complex situations to which there seems to be no clear cut solution.

Changes in the field of communications also have increased the awareness and sensitivity of all groups to those conflict situations.

The need for nursing actions to safeguard human rights is not restricted to times of political upheaval and war. It can also arise in prisons or in the normal work situation of any nurse where abuse of patients, nurses, or others is witnessed or suspected. Nurses have a responsibility in each of these situations to take action to safeguard the rights of those involved. Physical abuse and mental abuse are equally of concern to the nurse. Over or under treatment is another area to be watched. There may be pressures applied to use one's knowledge and skills in ways that are not beneficial to patients or others.

Scientific discoveries have brought about more sophisticated forms of torture and methods of resuscitation so that those being tortured can be kept alive for repeated sessions. It is in such circumstances that nurses must be clear about what actions they must take as in no way can they participate in such torture, or torture techniques.

Nurses have individual responsibility but often they can be more effective if they approach human rights issues as a group. The national nurses associations need to ensure that their structure provides a realistic mechanism through which nurses can seek confidential advice, counsel, support and assistance in dealing with these difficult situations. Verification of the facts reported will be an important first step in any particular situation.

At times it will be appropriate for the NNA to become a spokesman for the nurses involved. They may also be required to negotiate for them. It is essential that confidentiality be maintained. In rare cases the personal judgment of the nurse may be such that other actions seem more appropriate than approaching the association.

The nurse initiating the actions requires knowledge of her own and others' human rights, moral courage, a well thought through plan of action and a commitment and determination to see that the necessary follow-up does occur. Personal risk is a factor that has to be considered and each person must use her/his best judgment in the situation.

Rights of those in need of care

- Health care is a right of all individuals. Everyone should have access to health care regardless of financial, political, geographic, racial or religious considerations. The nurse should seek to ensure such impartial treatment.
- Nurses must ensure that adequate treatment is provided - within available resources - and in accord with nursing ethics (ICN Code) to all those in need of care.
- A patient/prisoner has the right to refuse to eat or to refuse treatments. The nurse may need to verify that the patient/prisoner understands the implications of such action but she should not participate in the administration of food or medications to such patients.

Rights and duties of nurses

- When considering the rights and duties of nursing personnel it needs to be remembered that both action and lack of action can have a detrimental effect and the nursing personnel must be considered accountable on both counts.
- Nurses have a right to practise within the Code of ethics and nursing legislation of the country in which they practise. Personal safety - freedom from abuse, threats or intimidation - are the rights of every nurse.
- National nurses associations have a responsibility to participate in development of health and social legislation relative to patients' rights and all related topics.
- It is a duty to have informed consent of patients relative to having research done on them and in receiving treatments such as blood transfusions, anesthesia, grafts etc. Such informed consent is a patient's right and must be ensured.