Torture and the medical profession in South Africa - complicity or concern?

Detention in South Africa - a brief profile

Since 1963, approximately 65 persons have died in detention. The death in detention of a leading black political activist, Steve Biko, focussed widespread concern on the practice of torture in South Africa. There is now considerable evidence, given under oath in court proceedings and in studies, that incidents of torture, both physical and psychological, have taken place as part of the coercive treatment of security law detainees. The supreme court application by Dr Wendy Orr to prevent the security police in the Eastern Cape from assaulting detainees is a notable example.

Foster and Sandler, in a study of detention and torture in South Africa, reported that 83% of former detainees claimed to have been subjected to physical torture. Over half were also subjected to psychological forms of torture. NAMDA, at its 1987 conference, reported that 72% of 303 detainees who consulted health workers after their release, alleged that they had been physically assaulted. Blacks appeared to be more commonly abused than whites.

Solitary confinement

Solitary confinement had been experienced by 79% and 34% of the detainees in the two above-mentioned studies respectively. It is used as an important tool during interrogation. The effects of this form of inhumane and degrading treatment on the detainee have been described by Professor C Vorster as follows: "If confinement is kept up, the person loses contact with reality, he (she) becomes totally disorientated and he (she) exhibits symptoms you find in a person with psychosis - imbalance of the

Solitary confinement is inhumane and psychologically harmful

mind - such as high levels of anxiety, panic and delusions. He (she) hallucinates, hears voices. Everything is distorted in terms of distance and height ...".

Solitary confinement and mental torture

A vivid account of the torment experienced by a detainee is given in a note submitted as evidence in the Supreme Court matter of Ebrahim vs Minister of Law and Order. In the note, Ebrahim describes his detention at John Vorster Square, after his abduction at gunpoint from Swaziland, by the South African Police: ".. my interrogators promised to put me under heavy mental strain. W/O Deetlef said if I survived it I would not be a human being".

According to Ebrahim, he was put in a cell which had no visible ceiling and through which little air entered. For four days he was subjected to sharp and piercing noises that were at times continuous throughout the night, at other times intermittent. A visiting

Protesting deaths in detention - 67 people have died in detention over the last 25 years

inspector of detainees intervened and he was removed to another cell. After nine days, the treatment was repeated for seven more nights.

"It was like living in a 'hell'. It completely wrecked my nervous system. I couldn't sit or sleep. Had to walk the cell day and night."

Twenty days after his detention the doctor at the prison told Ebrahim that a hospital appointment would be booked for him. He was to be taken to hospital five days later.

"Presently my mental and nervous health is getting worse ... I need an independent check up or I shall not mentally survive this torture and what is due to come. There are many times I feel my mind is cracking."

Medical intervention under these circumstances may be seen to be beneficial to the detainee, but may also be seen as rendering the detainee mentally fit for continued solitary confinement and interrogation. The administration of tranquillizers or other forms of therapy to counter the medical consequences of solitary confinement without firm recommendations to remove the victim from the harmful situation, constitutes medical complicity in torture.

The Tokyo Declaration and medical ethics

The atrocities committed by Japanese and German doctors during the Second World War prompted international bodies to outlaw medical participation in torture. The World Medical Association's (WMA) Declaration of Tokyo, Article I, states: "The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such a procedure is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife".

Medical complicity or participation in torture is a violation of three fundamental tenets of medical ethics:

- no harm should be done without the expectation of benefit to the patient;
- an intervention should be made only with the consent of the patient in order to obtain some benefit for the patient;
- treatment should be rendered to people in medical need, regardless of their social status, economic resources or political beliefs.

Areas of conflict over medical ethics

Doctors working in prisons and the military are the ones who are most likely to find themselves in a conflict over the principles of medical ethics. These doctors may, in the course of their official duties be called on to:

- perform medical examinations of suspects before they are subjected to interrogation which may include torture;
- attend torture sessions in order to intervene when the victim's life is in danger;
- treat the physical effects of torture and attend superficially to a seriously injured torture victim, so that the interrogation can be continued;
- develop medical and psychological methods which assist or protect those responsible for interrogation and torture. As an example, doctors may be asked to issue a false medical or autopsy report so that allegations of torture cannot be substantiated.

Medical care of detainees in South Africa

The key person in the medical care of South African detainees is the district surgeon or the prison medical officer. These doctors have a statutory obligation to visit and treat detainees. Criticism has been levelled against them for negligence, incompetence and for turning a blind eye to brutality. There are, however, district surgeons who claim to

be able to perform their duties according to the guidelines embodied in the Hippocratic Oath and the Declaration of Tokyo. This may be so, but if a doctor in the state's employ encounters evidence of physical and psychological abuse in patients and remains silent or fails to act effectively and continues service under these circumstances, it amounts to condoning torture.

Dr Orr is an example of a South African district surgeon who refused to condone the abuse of detainees. In an affidavit before the Supreme Court, she alleged that the police were responsible for systematically assaulting and torturing detainees. Out of 286 detainees who complained of having been assaulted, she found 153 had sustained injuries that could not have been inflicted lawfully. Of these, 60 had facial injuries, 8 had perforated ear drums and 26 had weals and blisters consistent with quirt blows. Physical abuse was particularly apparent after detainees had returned from interrogation sessions. After prison officials and Dr Ivor Lang, a doctor involved in the Biko case and one of her superiors, had failed to investigate her complaints, she was compelled to take the matter to court. As a result, the police were ordered to stop assaulting present and future detainees, but Dr Orr was relieved of her duties with respect to detainees.

South Africa

Guidelines against medical complicity in torture

Although in South Africa there is no evidence that any doctor assumes the role of torturer, there are indications of medical complicity in the process. This may occur when a detainee is examined and cared for in the immediate detention environment, usually by a district surgeon, or in a private or public hospital, usually by a specialist. In both these situations, medical collaboration can occur with the full knowledge and co-operation of the doctor. They may also be unwitting or reluctant accomplices duped and coerced by their belief that the circumstances are totally out of their control. Detainees are examined by a district surgeon soon after their arrest. This is necessary to evaluate the health needs of the detainee and could also ensure subsequent identification of injuries resulting from the prisoner's custody. However, the findings of the examination could also be used to establish the level of fitness and consequently the degree of torture a detainee is able to withstand. It may also identify weaknesses which might be exploited by the torturer. Medical information on individual detainees that is made available to the security police, is a major breach of confidentiality. The doctor has a responsibility to ensure that this does not occur. Under circumstances where the police have legal access to medical records, collective medical opposition is imperative in order to protect individual doctors from complicity.

Interrogation during detention can cause severe mental anguish

Biko's doctors admitted they would have behaved differently with another type of patient

Doctors in various states' employ are also called upon to attend to detainees who develop problems during detention. These may be unrelated to the circumstances of detention. They may, however, be the outcome of physical or mental abuse in which case medical intervention may amount to a "patch up" process rendering the detainee fit for further violation. It may, however, also be argued that medical intervention can prevent further suffering. Under these circumstances a doctor cannot withhold treatment in order to avoid being an accomplice to further interrogation and torture. The British Medical Association code of ethics provides a guideline to doctors confronted with this situation: "Whether or not a doctor should treat the effects of torture depends on whether the patient wants the doctor's help. The doctor must be prepared to use his or her skills to help the patient, whatever the cause of his or her injuries. But if the victim of torture prefers to die the doctor must respect the patient's wishes".

The doctor is also obliged to report the matter to his/her superiors, protest through official channels as well as solicit the support of colleagues. If these measures fail, the precedent set by Dr Orr, should be followed.

The Biko case

The difficulty in proving that individual doctors are accomplices to acts of torture is inherent in the provisions of the security laws. Strict secrecy often surrounds the circumstances and whereabouts of a detainee. There is, however, evidence from court or inquest proceedings reflecting behaviour verging on complicity or collusion.

The case of Steve Biko, a leading black political activist, who died in detention in 1977, is the best known example in this regard. According to security police evidence, Biko was involved in a scuffle with police the morning after he was detained. The inquest magistrate concluded that this was responsible for the head injury which ultimately led to his death. Dr Lang, a Port Elizabeth district surgeon, examined him that morning for a suspected "stroke" in the security police office and in the presence of Colonel Goosen, the officer in charge of the investigation. Biko lay on a mat tied to a metal grille. Although Dr Lang detected lacerations and bruising as well as neurological signs indicative of brain damage, he issued a false medical certificate stating: "I have found no evidence of any abnormality or pathology in the patient".

Drs Lang and Tucker, the chief district surgeons, examined him the next day. Still lying manacled to a grille, on a mat which was now soaked in urine, additional clinical signs indicative of brain damage were detected and Biko complained of a headache. The doctors never once suggested he be taken off the mat, put to bed and observed and did not inquire of their patient or those in charge of him whether he had suffered any head injury or assault. A private physician examined Biko at Sydenham prison and found neurological abnormalities and blood in the cerebro-spinal fluid. A neurosurgeon was consulted telephonically and advised close supervision of Biko's clinical situation. In spite of all this, Dr Lang wrote in the bedletter: "Dr Hersch and myself can find no pathology".

Protesting against toture

Dr Lang arranged for Biko to be transferred to prison cells claiming that his condition had improved although this was not the case. He also admitted that there were no trained medical staff at the prison and he did not visit the patient until the next afternoon. At the police station Biko lay on a mat on the cement floor with a police warden occasionally looking in on him. Tucker was again called to attend to Biko who had collapsed and was glassy eyed, hyperventilating and frothing at the mouth. Tucker suggested that he be transferred to a provincial hospital in Port Elizabeth, but Colonel Goosen refused permission. Dr Tucker conceded and gave permission for Biko to be transported 1 200 kilometers to Pretoria. He was transported naked, semicomatose and handcuffed in the back of a landrover to Pretoria Central Prison. Dr Tucker, knowing the journey would be made without the presence of a medical attendant, made no attempt to insist on such attention nor to withold his consent for the journey. No medical report was sent with Biko.

At Pretoria prison, Biko was not taken to hospital but received an intravenous drip and a vitamin injection and left on a mat on the floor. He died on the 12 September 1977, almost a month after his original detention. Dr Lang visited the patient on five occasions but made no notes or reports on his findings until the day after the death of his patient. Dr Tucker actually admitted during the inquest that he would have acted differently with any other patient. Clearly, the interest of the patient was subordinated to the interest of the security police.

The case of Simon Mndawe

A similar situation was again encountered during the inquest into the death of detainee, Simon Mndawe. The district surgeon failed to detect and record serious injuries apparently sustained at the time of his arrest. Seven days before his death, Mndawe had made a statement to a government official about his injuries and general state of health. The doctor failed to inquire of Mndawe about assault and relied upon the version of events given to him by the security police who were present during the examination.

The case of Mcube

The case of an African National Congress member, Mncube, who was examined by a doctor to ascertain if he was fit for further interrogation, provides insight into another area of medical complicity. He had been captured in the Messina district having had no food or water for nine days. In court it was alleged that he had been severely assaulted by the security police on two occasions in January 1987. Mncube was examined by a military doctor at the security police offices at Messina on both days. He was examined in a seated position with his arms and legs in chains. He was dehydrated and had scratch marks and abrasions all over his body. The doctor did not

inquire about the origin of these injuries. In court, he explained that the injuries were the result of travelling through bush country and abrasions over his back were due to friction from a ruck sack. He admitted that he was not told by any person whether or not Mncube possessed a ruck sack which in fact he did not. He did not conduct an adequate neurological examination and, concluding that Mncube was relatively well, advised the police to provide him with food and water. The doctor acknowledged in court that he did not understand his role towards his patient to be one in which he could decide upon and provide treatment. Rather, he felt his purpose was primarily to establish whether Mncube could survive questioning. He also believed that he was specifically called upon because Mncube's detention was being kept a secret.

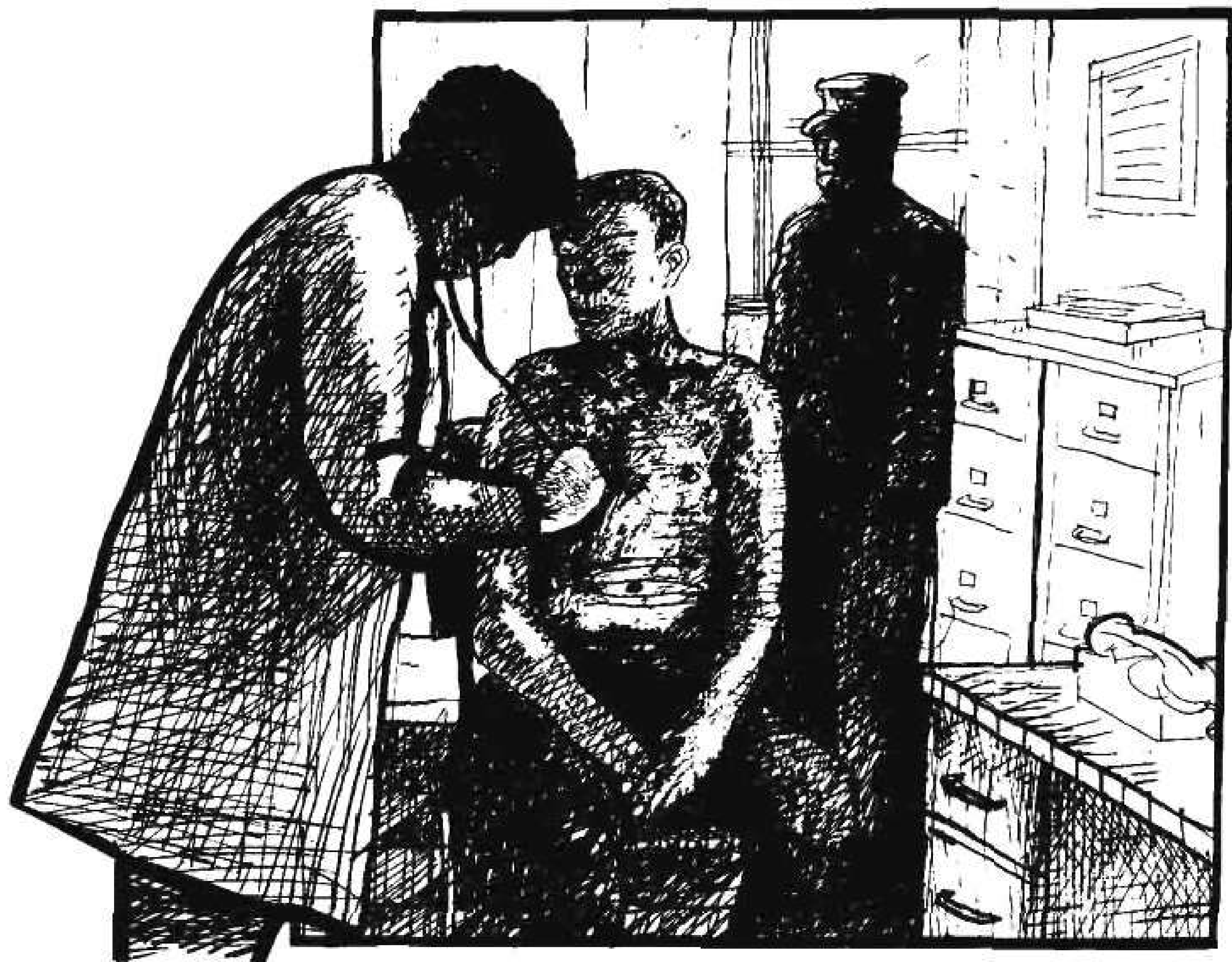
A sum of omissions, deficiencies and failures

These three examples reveal a number of common features:
- shortcomings in the medical examination, with a failure to detect important clinical signs of physical abuse;
- attempts to account for clinical signs of physical abuse detected in a manner which will not implicate the police;
- failure to obtain adequate histories relating to injuries sustained;
- conducting examinations under suboptimal conditions in the secrecy of the security police offices and in the presence of the police;
- a lack of clinical independance in deciding on the care of the detainee;
- subordinating the interests of the patient to those of "security";
- absent, inadequate or inaccurate clinical records;
- apparent disregard for the welfare and dignity of the patient;
- issuing false medical or autopsy reports.

Detainees' specialist care needs: the example of Soni

Detainees requiring specialist care are often referred to either a state or a private hospital. Attending doctors, although appearing to have clinical independence in deciding upon appropriate care, are limited by various provisions of the security act pertaining to the detainee in that they may not be able to make a recommendation in the best interest of the patient. This is illustrated in the matter of Marajee vs Minister of Law and Order and others (1985).

Shirish Soni's mental and physical condition at the time of his detention was normal. After about one month in detention the chief district surgeon, concerned about



Doctors should not examine detainees in the secrecy of police offices and the presence of police guards may make it hard for the detainee to be open

the mental health of Soni, consulted Dr A Valjee, a psychiatrist. Another psychiatrist had already recommended hospitalisation. Dr Valjee treated Soni and later discharged him as he had responded to treatment. Soni was redetained soon after and was brought back to Dr Valjee who reported to the district surgeon that he had found his patient "extremely regressed, depressed and a totally broken man in less than two weeks". He stated that Soni had been in solitary confinement, interrogated and starved. He found Soni to be suicidal and arranged for readmission to hospital. Dr Valjee concluded by stating: "In relation to what I understand to be the purpose of the patient's detention, I must stress that he is in no condition to answer any questions which may form part of an interrogation. No answer that he might give in his condition can be relied upon. I am able to state that for medical reasons, interrogating the patient would be a pointless exercise. It's only consequence would be to worsen his condition .... further interrogation will most likely result in permanent mental damage of the patient .... the further detention of the patient, even without interrogation, is likely to have the same consequence. The patient is no longer in a condition to cope with deprivation of personal liberty which is a necessary consequence of his detention. This is why his surroundings, even in hospital, must be normalised as much as possible immediately".

Access to a radio, reading material and to family members and a priest was advised. It was also stressed that he not be visited by the police who had interrogated him in the past. Dr Valjee added that since these measures were vital in the treatment of his patient holistically, he would have no option but to withdraw psychiatric services if these recommendations were not met. He did state, however, that he was concerned that such action would be another stress upon his patient.

Dr Lasich, a senior lecturer in the Department of Psychiatry, University of Natal, agreed in essence with Dr Valjee, concluding: "The patient cannot under any circumstances be returned to detention which has been the direct cause of his illness. The environment of the police cells that incorporates and represents isolation, interrogation, manipulation of daily existence and pathological relationships with captors can never be considered as acceptable in the effective treatment of detention related psychiatric illnesses".

An affidavit submitted by Dr Porten, a private psychiatrist, on behalf of the Minister of Law and Order disagreed on psychiatric grounds, with the way in which the patient was managed. Porten stated that he would have approached the problem as follows: "Without any fuss, calmly, objectively, I will elicit the patient's complaints. I will point out to him his symptoms, although stressful, are inevitable normal consequences of the situation he put himself in. I would show him alternatives and urge him to make his choice as soon as possible. I might put him even on some mild tranquillisation, if I would feel his anxiety exceeding bearable levels. I would not hospitalise him. I would encourage his interrogators to complete their work as soon as possible and either to charge him or let him go".

He therefore saw his role as assisting the patient to cope with detention and to facilitate the interrogation process. This approach is, in essence, a breach of the obligations demanded by the Declaration of Tokyo. Because of conflicting medical evidence, the matter was referred for oral evidence. Soni was not released initially but concessions were made for "normalising" his immediate surroundings. Soni was released before the oral evidence could be heard.

Guidelines on mental health care

A number of important features emerge from this case. First, it is clear that detention can cause psychiatric disturbances. It also shows that in a recovered patient who returns to detention, psychiatric problems may return. This introduces a serious ethical dilemma for the attending physician. Should the doctor discharge the patient back to detention to the harmful circumstances which originally caused the patient's illness? An action that could be taken by a district surgeon or by a doctor working in a private or state hospital, would be, with the patient's permission, to inform the family, and

through them the detainee's legal representative, of the situation. The family could then take the matter further. The doctor should support any application that is made in the medical interests of the patient. A doctor may also decide to make a supreme court application on behalf of the patient (although such action has not as yet been taken).

What are the reasons for breaches in medical ethics

The resolution of these dilemmas is at present a matter of the doctor's own conscience. What then are the reasons that could be given to explain deviant ethical behaviour by a doctor? The British Medical group of Amnesty International suggest the following:

Ideological support for the regime

Doctors who see the political programme of the government as essential for the overall good of society may easily be persuaded that torture is necessary in order to maintain the security of the state. In South African society where the medical profession is dominated by members of the privileged white minority, the political loyalties of the medical profession generally reflect the interests of and the prejudices prevailing in this group. Political opponents are seen as "terrorists" or "communists" and a threat to the security or status of white supremacy.

In South Africa, the political loyalties of the medical profession often reflect the interests of the privileged white minority

Sense of duty

Where ultimate responsibility lies with others, some doctors absolve themselves of personal responsibility for their own actions.

Overt fear of repercussions

Future security may be at risk if a doctor fails to comply. This may apply to job security or even one's own personal security. In South Africa, for example, Dr Wendy Orr was relieved of her duties in respect of detainees for taking the matter of detainee abuse to court.

Humanitarian reasons

Torture must be a highly traumatic experience which some doctors may see as requiring their intervention to minimise the consequences of the practice.

Conclusion

In South Africa, however, there is an ignorance relating to ethical issues and responsibilities that arise under these circumstances. Many doctors do not have adequate training in or have failed to keep up with developments in medical ethics. The Tokyo Declaration was accepted relatively recently, long after the completion of training of many doctors. Clearly there is an urgent need for the medical profession to discuss the dilemmas raised by the issue of detention in South Africa.

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