CRITICAL HEALTH

number 13 august 1985

HEALTH CARE UNDER SIEGE

CRITICAL HEALTH

number 13 august 1985

CONTENTS

Editorial....................................2

Statement: NAMDA - Transvaal Regional Committee...4

Giving Legal Aid in the Crisis of Uitenhage.......7

Emergency Treatment of Unrest Victims
in the Eastern Cape-
- A General Practitioner Reports..................13
- A Doctor from an Eastern Cape Hospital Reports. 23

The Role of Doctors in the Uitenhage Unrest -
The Legal Perspective
by G. Marcus......................................32

Health Professionals and Victims of Civil Unrest
Memorandum. NAMDA Hillbrow Branch.................38

ACKNOWLEDGEMENTS

Thanks to NAMDA for permission to publish the papers presented at the NAMDA meeting on 29 May 1985

EDITORIAL

The last issue of Critical Health highlighted some of the health issues raised by township unrest. In the meantime, more evidence on the medical treatment of unrest victims has come to light.

On 11 June 1985, the findings of the Kannemeyer Commission of Inquiry into the Langa shootings were published. Judge Kannemeyer criticised the police for not having issued standard riot control equipment - teargas, birdshot, and rubber bullets. The judge found it "particularly disquieting" that 35 out of the 47 killed or injured people were shot from the rear. This means that most shots were fired from the two police casspirs after the crowd had turned to run away.

The response of the police to this indictment can be summed up as a tightening of police presence and control in the townships. Mr le Grange, Minister of Law and Order, said there would be continued planning and research into methods of crowd and unrest control. A memorandum, issued as the Government's official response, lists points of action. They include the following:

- Urgent steps in conjunction with the Railways Police and Defence Force were taken to augment manpower in troubled areas

- A 24-hour operational centre had been created in Pretoria so as to co-ordinate control of units

- Temporary police bases had been set up in riot-stricken areas. (Star, 12 June 1985)

At no point does the police response concern itself with the causes of unrest. Instead, the government's response culminated in the declaration of a state of emergency for 36 magisterial districts within the Republic of South Africa. It becomes clear from both the

memorandum and the declaration of a state of emergency, that the security forces are preparing for a permanent state of unrest by taking more repressive measures of control.

This control affects township residents in all aspects of their lives, including their right to appropriate health care. It also interferes with medical practitioners' rights and responsibilities towards their patients.

Before the publication of the report of the Kannemeyer Commission, the Eastern Cape branch of the National Medical and Dental Association (NAMDA) issued a statement about state interference in the treatment of unrest victims. The statement alleges that police interfered with doctor-patient relationships and confiscated medication given to injured at the Uitenhage and Livingstone Hospitals after the Langa shootings. The injured were under armed guard, creating fear and tension. (Star, 17 May 1985)

These claims are supported by medical practitioners in the Eastern Cape whose accounts are published in this issue of Critical Health. Their reports raise some critical questions for health workers, and for the medical profession as a whole.

But they also challenge organisations. As police and vigilante groups tighten their hold on the townships, and as incidents of unrest are increasing, civic associations are called to act on this situation. Critical Health No 13 would like to give some legal information, and add some suggestions to the discusssion.

CRITICAL HEALTH is published by an
editorial collective
P.O. Box 16250
Doornfontein
2028

STATEMENT RELEASED BY THE TRANSVAAL REGIONAL COMMITTEE OF THE NATIONAL MEDICAL AND DENTAL ASSOCIATION (NAMDA), 29.5.85

NAMDA rejects the recent statement by the Police Directorate of Public Relations that the police do not intervene when any person involved in an unrest area seeks medical aid, and that any person taken into custody receives the required medical treatment.

At a meeting on 29.5.85, about 300 members of the medical profession heard accounts from medical and legal colleagues who had attended to victims of the unrest in the Eastern Cape. They stated that:

- injured people were arrested when seeking medical attention, while receiving treatment, or after discharge

- other injured people were afraid to seek medical attention for fear of immediate arrest

- information regarding injured and arrested victims was often not given by the hospital administration to family members, nor was access to them granted

- a number of medical practitioners were instructed by the police not to treat victims of the unrest and were harassed and prevented from doing so; in fact, a senior police officer threatened to arrest any doctor treating an injured patient on the grounds that they were obstructing the ends of justice

- a large and undisciplined police presence at the provincial hospitals in the Eastern Cape created an atmosphere of fear and tension among patients, staff, and visitors and this may have influenced their medical care

- some of the injured were released from the hospital into police custody by medical personnel while still critically ill

- there were accounts of at least two victims who were denied their usual medical treatment while in police custody

NAMDA wishes to draw the attention of all doctors and members of other health professions to the legal opinion expressed by Advocate Marcus that there is no general obligation in law for doctors to report any injury, including gunshot wounds, to the police. In addition, a medical practitioner is not under a general obligation to divulge information to a policeman who arrives at a hospital on a "fishing expedition" in search of people wounded in the unrest. It may well be that to disclose such information is unethical.

NAMDA calls on members of the health professions, whether in private or hospital practice, to take a strong personal and public stand on this issue and to absolutely reject any police interference with the proper treatment of their patients.

NAMDA calls on the provincial hospital authorities to issue a public statement and undertaking that:

- the patients attending hospitals and clinics will be safe from harassment and interference by the police

- families shall enjoy normal access to the patient and shall have the right to speedy confirmation of the presence of the patient in hospital as well as the condition of the patient

- doctors must compile a comprehensive medical report including details of the treatment required before allowing a patient to be handed over to the arresting authority who should be identified and instructed to give this report immediately to the district surgeon who should also be identified by name

- if the doctor is unhappy about the condition of his patient or has reason to fear that s/he might not receive the proper care in custody, the doctor should refuse to allow such a patient to be released.

NAMDA urges the SAMDC to take note of the judgement of the Supreme Court that if the SAMDC fails to deal properly with complaints of professional misconduct or improper or disgraceful conduct, one of the main and important objects of the South African Medical and Dental Council Act will be defeated and will be rendered nugatory and the medical profession and public interests, in so far as members of the public are affected by such conduct, will be unprotected.

GIVING LEGAL AID IN THE CRISIS OF UITENHAGE

A lawyer reports

Even before the 21st March 1985, the police had detained numerous residents of townships in Uitenhage. Among those arrested were a number of children who could not be located by their families. The families of these children approached the Black Sash for help.

I had gone to Port Elizabeth on 20 March to look into this problem when the shooting incident occurred the following day. Another Johannesburg attorney, Mr Halton Cheadle, went to Uitenhage on 22 March. When he arrived there, the Black Sash had already established a crisis centre where people could come for assistance. There were many people who did not know whether their relatives were in police custody, in hospital, or whether they were dead. Many of the missing people were minors under the age of 18.

Mr Cheadle organised a team of between five to seven advocates and attorneys to go to Uitenhage. He himself and an advocate attended the hearings of the Kannemeyer Commission of Inquiry, which started the following day. They were acting on behalf of the families of those killed and injured on the 21st March. The rest of the team, including myself, assisted at the crisis centre, organised bail, and found witnesses for the Commission.

I was mainly involved with helping in the crisis legal centre, which also included administrative work. Every day, people came to the centre with various problems. I worked at the centre for six and a half weeks until the 10th May. Our tasks involved the following:

Tracing missing people

When I arrived at Uitenage, there must have been at least 50 people still missing, and many of these were children. As attorneys we faced considerable antagonism

from the police and court officials. Sometimes, the police denied that they had someone when they did. Or they told us that a child was being held at a certain police station; but when the attorney got there, the child had been moved to other cells. Sometimes we were told that the person we were looking for was out with the investigating officer who was not in radio contact with the police station. Both the police and the court challenged our status as attorneys. Our search for an awaiting-trial prisoner usually started at the local police cells and hospital. The next step would be to enquire at Port Elizabeth hospitals, police cells, and jails. On one occasion, we were preparing to make an application to the Supreme Court in connection with a child whom we could not locate but believed to be in police custody. In the meantime, he had been released; he bore large marks on his back from having been beaten with a sjambok.

Bail applications

Once we had located a person and obtained all the relevant court details, we requisitioned that person to court for a bail application. We were not simply permitted to make applications on the remand date. The court officials presented us with new rules every day. At first, we were told that no bail would be granted. This was changed when we replied that we would then fight all bail applications.

Secondly, the amounts set for bail were ridiculously high considering the financial position of most of the people concerned. Many of the bail applicants were children, and most of the families concerned were affected by unemployment. So applications had to be made to have the amounts reduced.

We were told to liaise with the investigating officers before bail would be granted. This is traditionally done by the prosecutors. The court officials saved themselves a lot of time by making that our task.

The CID were most unco-operative and always difficult to contact. This improved after we complained. Bail was refused in certain cases and appeals are being made to the Supreme Court.

It was interesting to find out that the magistrates were relying on certain unreported cases that appear to differ substantially from elsewhere in the country. No opposed applications were heard on Thursdays and Fridays. The courts seldom sat after 3 p.m., and certainly made no effort to deal with the increase in cases. As a result, the urgent nature of bail applications was ignored. In one case, it took us a week to get a twelve year-old before the court to be released into his parents' custody.

Bail funds

Money was donated to us for the pupose of bailing people out. Without it, many people would not have been able to afford their bail. Most families contributed something to their bail. Money was donated by NAAWU, the Uitenhage Catholic sisters, and the SACC.

Aid Office in Uitenhage

Case referrals

Each case was referred to a local attorney for representation once we had obtained bail for the person concerned. On the day before I left Uitenhage, 66 cases were withdrawn.

Problems with the court and other officials

Many of the people arrested alleged that they had been assaulted by the police while in custody. Others were not brought to court within the stipulated 48 hours. Sometimes I managed to trace people before their first court appearance, and to have an attorney at court to ask for bail, only to be told at court that they would not be appearing. Some cases, however, would be brought to court later during the same morning, once we had left.

Parents were not advised of their minor children's court appearances despite the provisions of the Criminal Procedure Act. A few parents complained that they were not allowed into the court. Certain court orderlies and magistrates were extremely rude to blacks in their courts. Many people complained of the way they were treated at police stations. At every police station that we dealt with, police officials tried to deny awaiting-trial prisoners their visiting rights.

Assistance to neighbouring towns

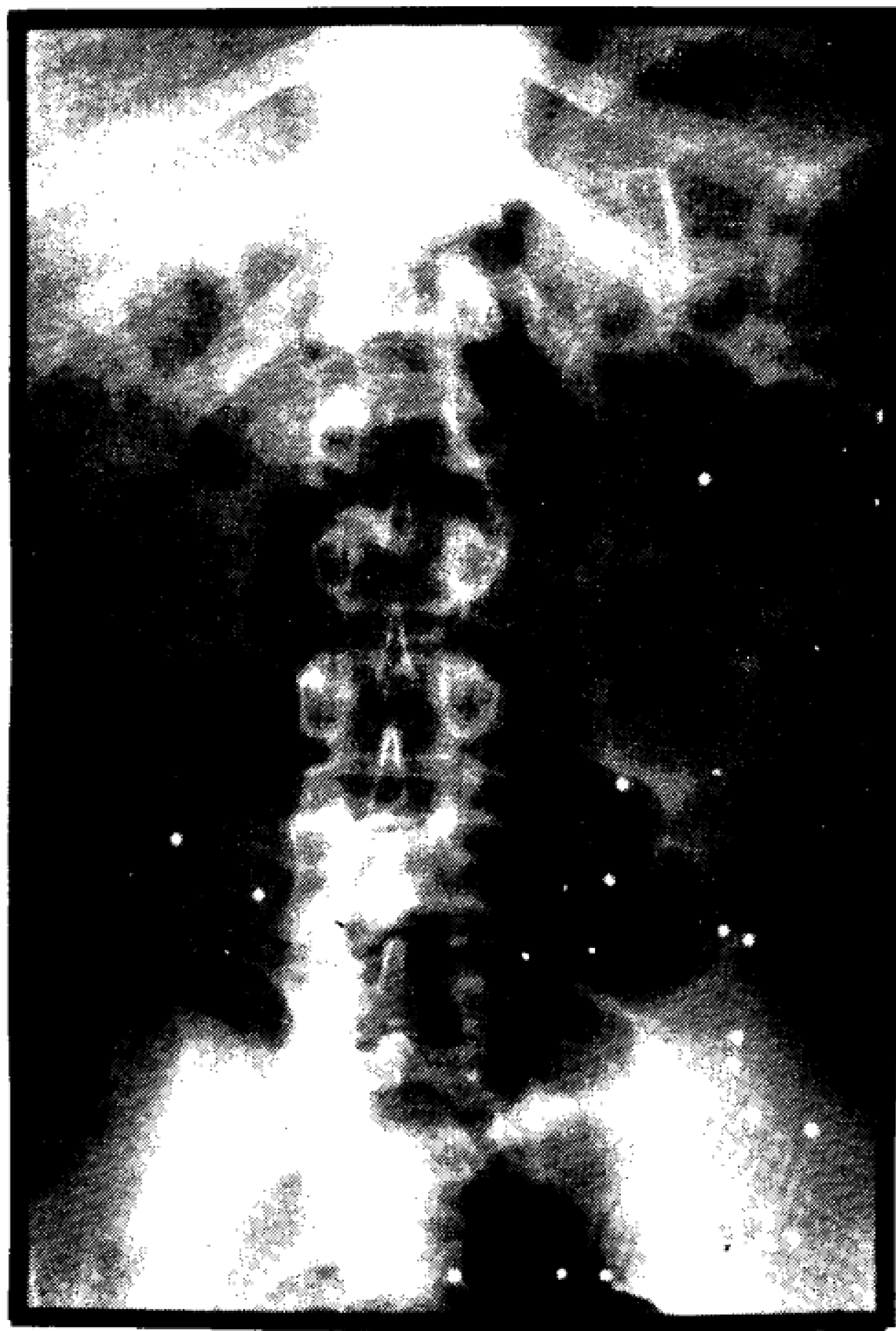
We were approached by people from all over the Eastern Cape: Kirkwood, Port Alfred, Somerset East, Grahamstown, Pearston, Adelaide, Jansenville, and several other towns. We arranged representation for them in those areas.

Post-mortems

Second post-mortems were arranged for all those people killed on the 21st March, as well as for a few others shot subsequently.

Medical assistance

Those people who were shot on the 21st, or at any other time, and who were not arrested by the police, usually had to receive medical attention. Many came to us for help. They were terrified of going to private doctors and the hospitals; they said they would be handed to the police. Some alleged that the police waited outside the casualty doors in their hippos. One boy apparently died of gunshot wounds as he refused to go to hospital. Others tried to remove the pellets themselves. Two boys came to us from Kirkwood. They had been shot a day or two previously and had sustained abdominal wounds.



X-Ray of abdomen showing birdshot under skin

We arranged for doctors to come to the crisis centre in the evenings. Later, we were assisted by a few sympathetic doctors in Uitenhage's coloured townships. Those people who needed surgery, we tried to get admitted to a private hospital in Port Elizabeth, or to another hospital in the Eastern Cape.

Many of the people whom we bailed out of detention needed medication.Some families even brought in their relatives who had been shot in the townships, before they took them to the mortuaries.

Miscellaneous problems

We dealt with numerous other problems, such as teargassing of people and their homes. People were harassed by the police in their homes; the police just kicked in their doors. Several deaths from teargas exposure were reported. People were being arrested all the time, and so the reports of assaults and court appearances continued.

We tried to deal with each problem as best we could.

EMERGENCY TREATMENT OF UNREST VICTIMS IN THE EASTERN CAPE

A general practitioner reports

I am a General Practitioner in Port Elizabeth who got involved in treating people who were wounded during and after the Langa shootings.

I would like to relate some of the problems which I and other helpers experienced during those weeks. In this way, I hope we can help people and health workers who may find themselves in a similar situation.

The first bit of information on what was going on in the townships I got from one of the workers at the Black Sash Advice Office. This person was on duty on Thursday morning, the 21 March, in the Black Sash Advice Office in Uitenhage.

She phoned me at about lunchtime and told me that there had been terrible shootings in Uitenhage. Together, we decided to go there and see what we could do to help people. That is how I got involved.

Police action before 21 March

Members of the Black Sash had been going to Uitenhage previously to take statements from people who had been maltreated by the police. There were many people who came to make statements. There were some very alarming statements about abuse and wrongful imprisonment of children.

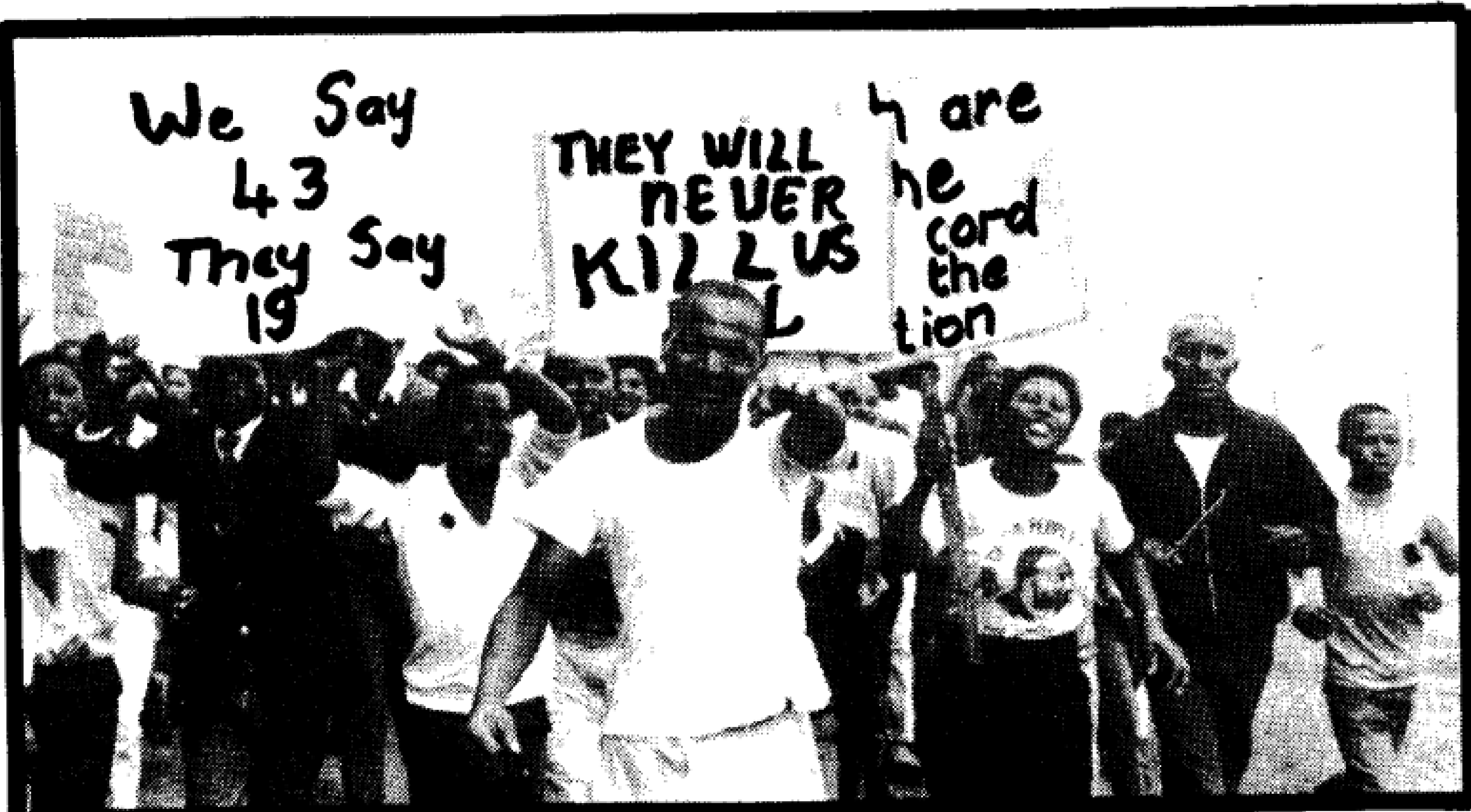
One example of police harassment and ill-treatment was the case of a twelve year-old boy who was standing in the front garden of his parents' house when he was shot in the eyes with buckshot. He lost consciousness. He was taken to one of the black doctors in Kwanobuhle

township. The doctor phoned for an ambulance. Instead, the security police arrived in a vehicle which was not suitable to transport sick or injured persons. Despite that, the police took the young boy to Uitenhage Provincial Hospital, from where he was transferred to Livingstone Hospital. He was lying in Livingstone Hospital with both eyes bandaged, handcuffed to the bed, with two policemen guarding him 24 hours a day.

On the Sunday before the shootings, members of the Black Sash went to the police station in Uitenhage. There they saw a young man handcuffed to the table, and being beaten by two men with sjamboks.

Apart from this incident, one of the Black Sash members noticed that the officer in charge of the police station on that day, Lieutenant Fouche, was smelling of liquor. When she complained about this to the authorities at the police station, she did not get very far. Therefore she made a complaint to the magistrate.

The very same police officer, Lieutenant Fouche, who had smelt of liquor on that day, was in charge of the unit that started the shooting in Langa on 21 March, a few days later.



The death toll

Immediately after the events of March 21, township residents counted 43 people dead. This has become a significant number. Community leaders have insisted on this number, as against the official figure of 19. A recent statement by Mr le Grange reports that a total of 129 people have been killed and 136 injured in the Eastern Cape since the shootings on March 21. The Minister said that 78 people have been killed in the Eastern Cape by the police or other law enforcement agencies, 25 in Port Elizabeth, and 43 in the Uitenhage area. It appears, therefore, that the death toll given by the community leaders is, in fact, the correct one.

Treatment of the victims

After we heard of the Langa shootings, my wife and I decided to go out there. A centre had been set up in the Catholic church; the local priest had offered the presbytery of his church to us. I went out on the Friday afternoon after the shootings, and continued to go there every day for the next week. People came in increasing numbers. The first few days, two to five people came. Towards the middle of the next week, we were dealing with twenty to thirty people in one evening. (I tended to get there around six o' clock in the evening.)

Why people came to the emergency clinic

The question arose as to why these people were coming to the church, where facilities were inadequate, rather than going to the local doctors or to the hospitals.

There were three reasons, as I saw it. One reason was that two black doctors practising in Kwanobuhle township had been ordered by the police not to treat any of the victims. The second reason why people came to the church was the fact that there was a heavy police presence in the hospitals. The third and maybe most important reason was that all people with gunshot wounds who went to the hospitals would automatically be placed under arrest.

Those who had been able to get away from the shootings on that Thursday had fled into the hills, and there was no way in which they were going to be persuaded to go to the hospitals.

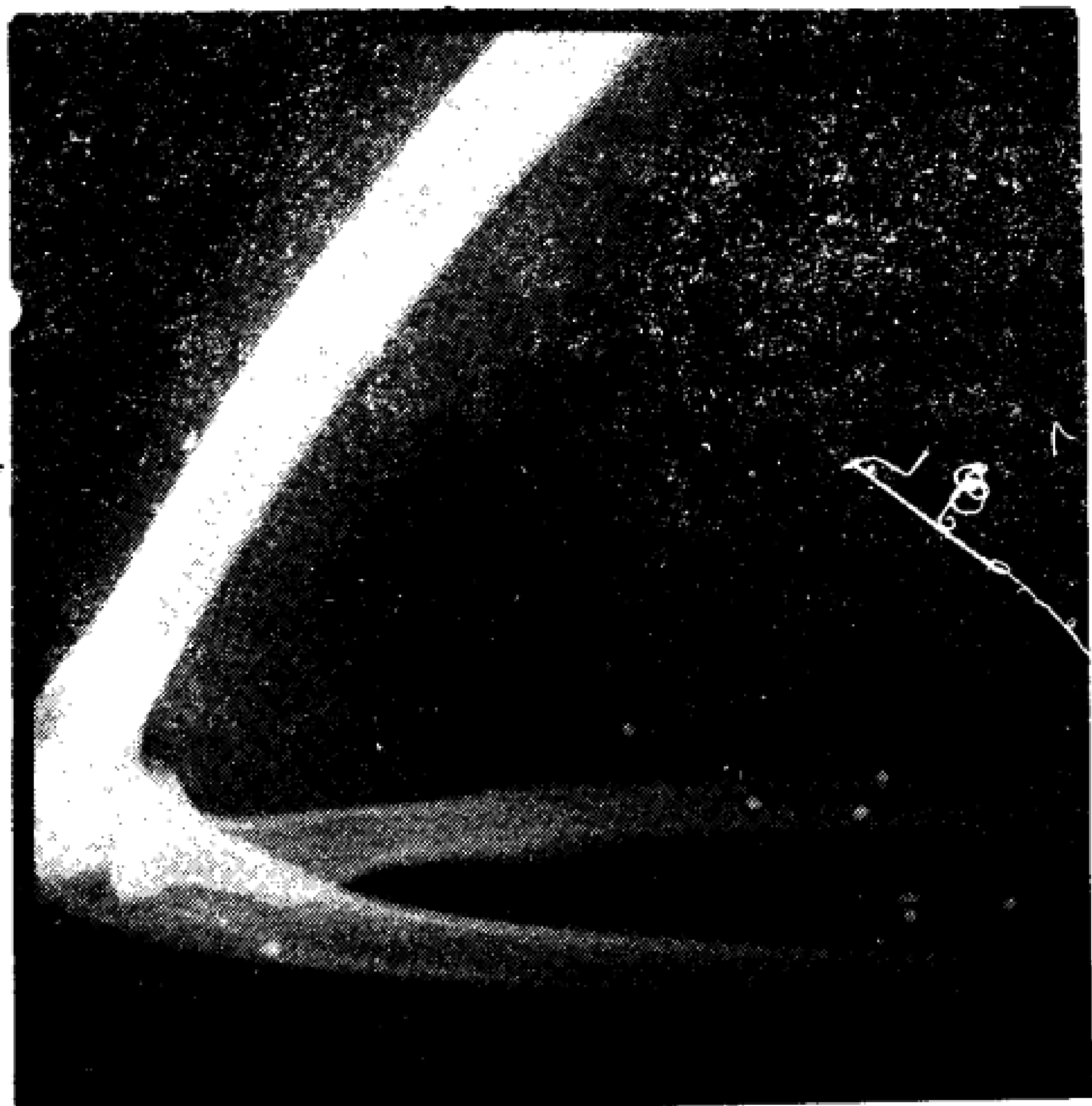
This is why I think people came to the church to be treated. They came in increasing numbers over the following week, not only from Uitenhage, but also from Paterson and Kirkwood, from Fort Beaufort and Adelaide - from everywhere.

Problems in treating injured unrest victims

We encountered many problems in treating unrest victims. Firstly, there was the problem with the premisses. We were making do in the presbytery of the Catholic church. The facilities were inadequate. There was no hot water and nowhere to do dressings. It was a room, but it was better than nothing.

The second problem that I had to face was the fact that, at least for the first two or three days, there was no nursing staff, or any medical help. When one has to treat twenty people with multiple wounds such as these, one does not know where to start. I had no X-ray equipment to find out where the bullets were located.

X-Ray of arm at elbow showing birdshot



One of the patients whom I saw was a 65 year-old man who had been lying in bed inside his house when buckshot was fired outside. The shots went through the galvanised iron wall of his house, and hit him. Only an X-ray revealed to me that a pellet had lodged in his liver.

Eventually I decided that there was no way in which I could try and remove the bullets in this situation. All I could do was to screen the patients, and give penicillin injections to prevent infections.

It became more and more difficult to cope with all the injured people, as more and more were coming to the church. Some of them came in the early morning, waiting for the doctor to come. They finally got to see the doctor around 5.30 or 6 pm. By that time, many of them were hungry and thirsty.

Police interference in the medical treatment of the victims

Another problem was the continuing police activity in the Eastern Cape townships. On the Saturday following the shootings, I went to the emergency clinic, only to be received by the police. The police was there in full force, including Colonel Strydom, who is head of the Murder and Robbery Squad. He threatened to arrest me and any other practitioners who treated any of the wounded; he alleged that we were "obstructing the course of the law".

Something similar happened to a colleague of mine. On the Thursday following the first shootings, a man was brought to her with a bullet wound. The wound looked like the man had been hit with a panga, it was so big. The wound was a few days old and it looked very unpleasant. People had seen this young man being carried into my colleague's room. Within a very short time, the security police arrived. They demanded that my colleague should hand the patient over to them, so that he could be sent to hospital. She insisted that the patient was not going to the hospital, saying that she did not

believe that he would get the treatment he needed. She was going to send the patient to Saint Joseph's, a private nursing home in Port Elizabeth.

I have already mentioned the heavy police presence in the hospitals. Apart from being "guarded" and placed under arrest, unrest victims in the hospital were often not allowed to receive any visits from family, friends, and concerned people. This was brought out in the press when two clergymen were denied access to Uitenhage Provincial Hospital. One of them was Allan Boesak. He went to see the superintendent of the hospital, requesting to see the hospitalised unrest victims. The superintendent would not allow that. This prohibition was confirmed by the police. The other clergyman then asked the superintendent whether he would be allowed to administer the last rites to dying parishioners in the hospitals. The superintendent's answer was "no".

Detentions

Many, many people were detained during the weeks prior to and after March 21. I would like to highlight some cases which should be of concern to the medical profession.

All but one of the people helping in the Aid Office have been detained and held for questioning. One of the people to be detained is a leader of a local community. He suffers from hypertension and had been hospitalised before for this condition. He was detained for five days. During his time in detention, he received no medication, although his wife had informed the police that he was on treatment. He had a hard time in detention, both physically and mentally.

Another similar case came to my attention. A man came to me shortly after his release from detention. He was held by the police for 36 hours. He was known to be an epileptic. His mother had taken his medication to the police station; one of the policemen said that the medicine was thrown away.

Comments by the Minister of Law and Order

In a recent statement published by the press, the Minister of Law and Order, Mr le Grange, "said he did not believe the Biko affair would be repeated easily... He said that, from an official viewpoint, it was unlikely that the Biko affair would be repeated, as every member of the police force knew he had to abide by standing instructions. Policemen, however, are only human, and human weaknesses would have to be taken into account. ... Referring to the Uitenhage shootings on March 21, Mr le Grange says the fact that tearsmoke was not issued to the units involved, had been a flagrant disregard of very specific instructions. This had disturbed him greatly. But the human factor had to again be taken into consideration."

The Aftermath

For the police in the Eastern Cape, it is business as usual. The police actions, as I have described them for the period before, during, and after March 21, were continued right through the investigations and the hearing of the Kannemeyer Commission.

We will have to develop ways in which to give sympathetic and appropriate treatment to unrest victims under these conditions. This is a matter of urgency, for I believe that incidents of unrest will recur, as the economic, social, and political conditions under which people live, have not changed.

TOWARDS A JUST PEACE IN OUR LAND

A Declaration to End Conscription

We live in an unjust society where basic human rights are denied to the majority of the people.

We live in an unequal society where the land and wealth are owned by the minority.

We live in a society in a state of civil war, where brother is called on to fight brother.

We call for an end to conscription.

Young men are conscripted to maintain the illegal occupation of Namibia, and to wage unjust war against foreign countries.

Young men are conscripted to assist in the implementation and defence of apartheid policies.

Young men who refuse to serve are faced with the choice of a life of exile or a possible six years in prison.

We call for an end to conscription.

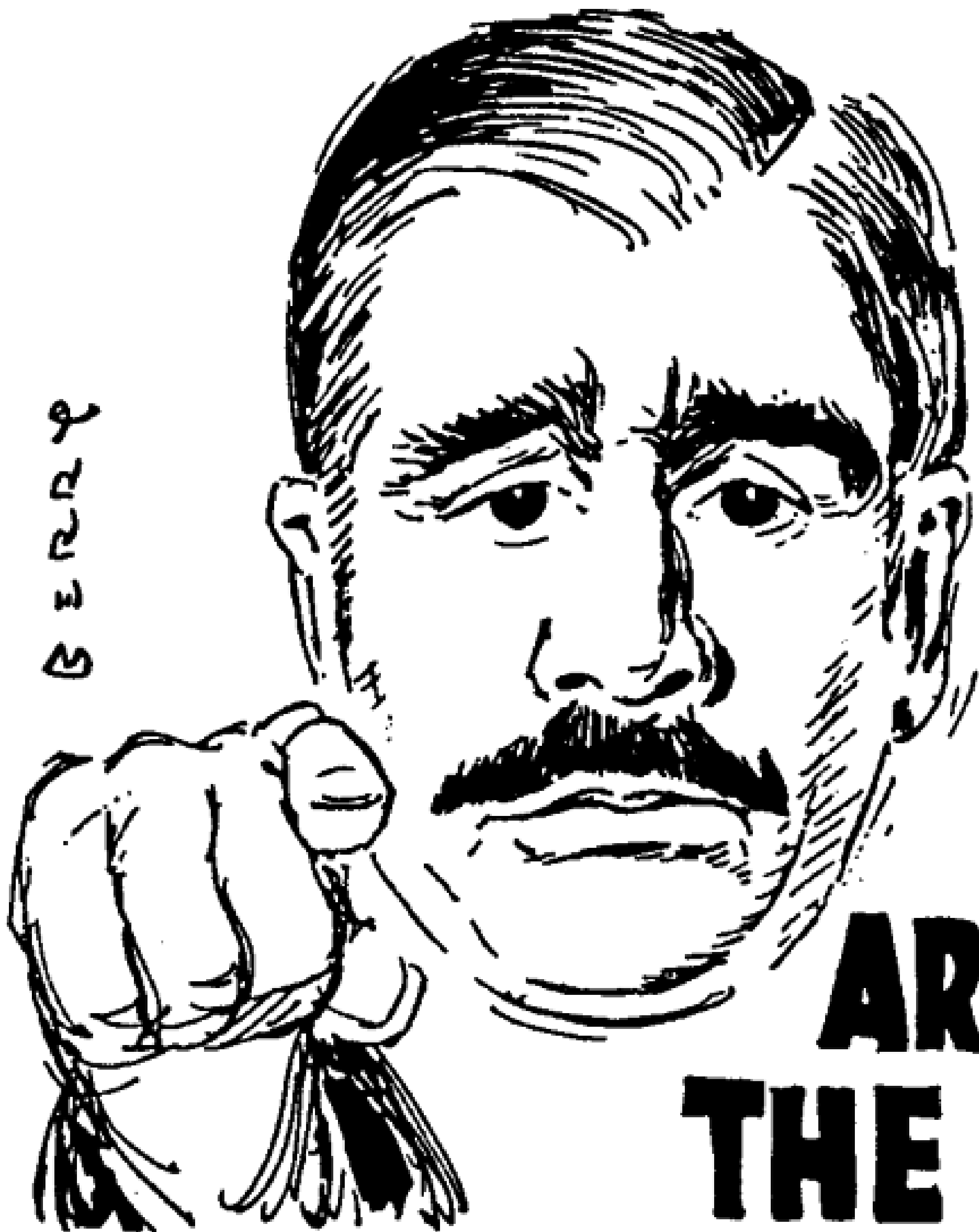
We believe that the financial cost of the war increases the poverty of our country, and that money should rather be used in the interests of peace.

We believe that the extension of conscription to coloured and indian youth will increase conflict and further divide our country.

WE BELIEVE THAT IT IS THE MORAL RIGHT OF SOUTH AFRICANS TO EXERCISE FREEDOM OF CONSCIENCE AND TO CHOOSE NOT TO SERVE IN THE SADF.

WE CALL FOR AN END TO CONSCRIPTION

WE CALL FOR A JUST PEACE IN OUR LAND



I NEED YOU!

JOIN THE ARMY AND SEE THE TOWNSHIPS

LANGA
KWANOBUHLE
BIOPATONG
SEBOKENG
ALEXANDRA
TEMBISA
. . . and others

END APARTHEID

END THE CIVIL WAR

END CONSCRIPTION

A doctor from an Eastern Cape hospital reports

I am working as a doctor in a black hospital in the Eastern Cape. The hospital serves a very wide area and, like most black hospitals, we are under immense pressure for beds. This, and the pressure from police and hospital authorities, made my position very difficult when it came to treating the victims of the recent unrest in the Eastern Cape.

Call for help

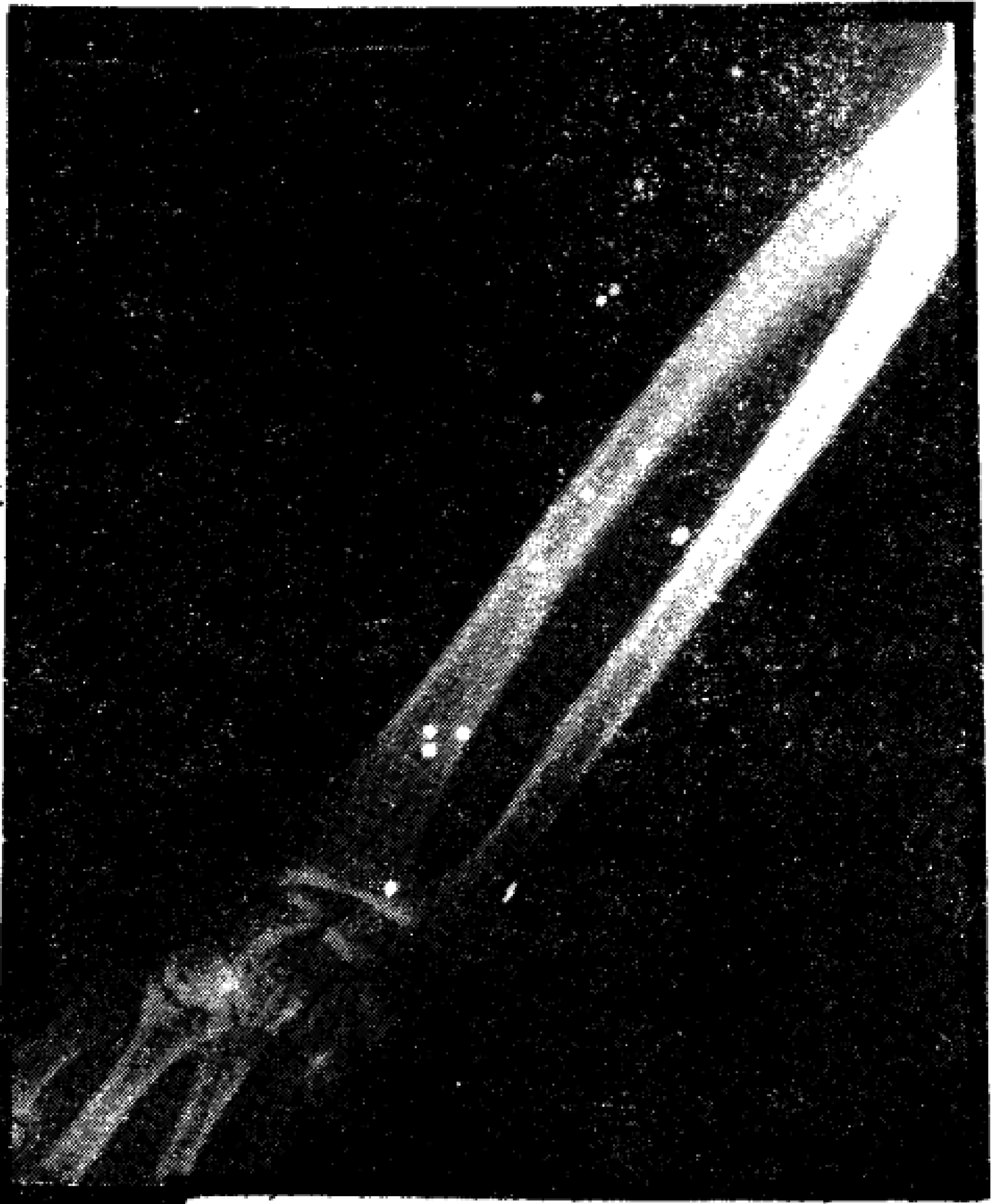
My involvement in the treatment of unrest victims began on the evening of the 21st March. I was working on the fourth and fifth floors of the hospital. The ground, first, and second floors had already been taken over by the police.

I and some of the other doctors working with me received a call for help from members of the Black Sash working at the Aid Office in Uitenhage. I and a colleague from the hospital, went to the Aid Office which was on the premises of the Catholic church in Uitenhage. A police casspir was parked directly opposite the church.

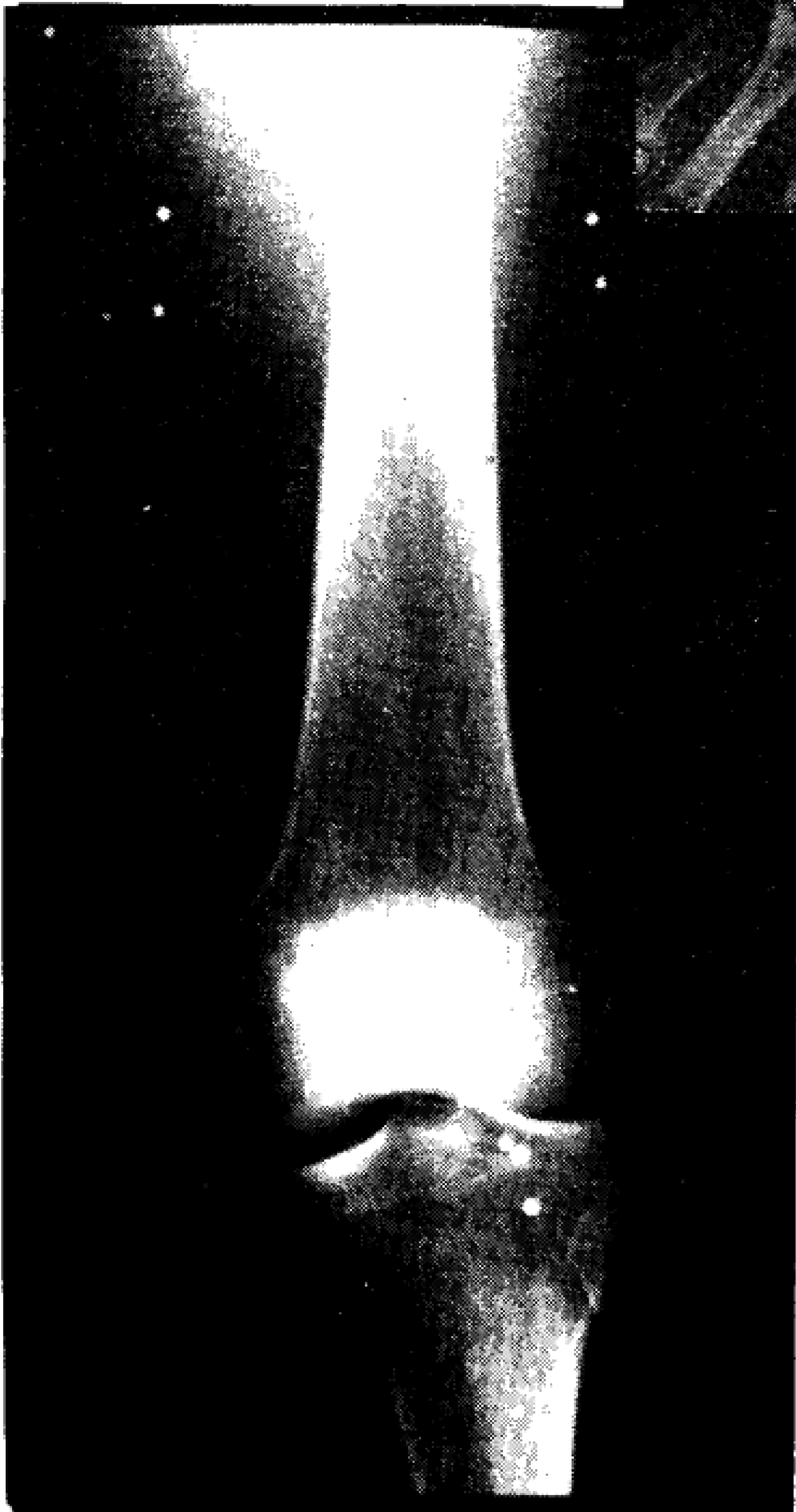
Initial treatment of unrest victims

When we went into the Aid Office, we saw ten to twelve young men with multiple bullet wounds. Most of these young men needed to be examined in hospital, as they had bullet injuries in the areas of the chest, diaphragm and hip. All the patients presented surgical problems. They needed X-rays to find out exactly where the bullets were lodged, and possibly required removal of the bullets.

The Aid Office was just a room, and we examined the patients in the kitchen. We did not have any equipment. The only thing we had with us were penicillin and syringes. So all we could do for these people was to give injections of penicillin in order to prevent secondary infection.



X-Ray of forearm and wrist showing birdshot



X-Ray of leg at knee showing birdshot

Problems with hospitalising unrest victims

The question was how to get these patients into hospital and avoid them being found and arrested by the police. I decided to get some of these patients admitted to one of the hospital wards, and treat their injuries with the help of surgeons.

This involved an element of risk and secrecy. Firstly, these patients had to be admitted to a ward with a false diagnosis. Then it was a matter of getting the nurses to keep quiet about it. That meant talking to the day and night nursing staff. It was not to be expected that the nurses or the medical staff would betray this trust. But it is possible that there is an information link between the nurses and the police. Also, there may be some degree of liaison between matrons and the police. Matrons may sometimes inform the police about patients in the wards, or vice versa. In the wards, there were lists hanging out, on which the names of patients with bullet wounds had to be entered. In some wards, however, some patients with bullet wounds were present, and these were not recorded.

Once the patients were admitted, they had to be treated as quickly as possible, so that thet could be discharged from hospital before the news travelled around.

The other problem was to get help from specialists in other disciplines. It was uncertain how much co-operation could be expected from other medical practitioners, now that these patients were in the ward. How would the admission of these patients be explained to the consultant on the ward-round? One cannot leave these patients in one corner of the ward and forget about them. One cannot pretend that they are no-one's patients.

Injuries and treatment of unrest victims

One of the patients who had been admitted had been seen at the Aid Office in Uitenhage. A bullet had gone through his maxilla (upper jaw bone) and had shattered

his mandible (lower jaw). His face was swollen on one side. He was admitted as a facial palsy. This person had to be treated by a maxillo-facial surgeon. The maxillo-facial surgeon, who was a part-time staff member, came to the hospital about once a week. After about three days, the maxillo-facial surgeon came and saw the patient. It turned out that an anaesthetist and a theatre had to be booked for surgery. Surgery was done a week later. The maxillo-facial surgeon advised to keep the patient in the ward for three days after surgery. For all this time, the patient was occupying a bed in the ward. I grew more and more anxious as time went by, given the need for secrecy and the pressure for hospital beds in the ward.

X-Ray of hip showing birdshot embedded in skin around pelvic area

Other patients with bullet wounds were brought to me. One of them was a young boy - he must have been about 14 years old. When he came into Casualty, he could hardly walk; he had to be supported. When I examined this patient in the ward, he was pyrexial (feverish), had low blood pressure, a fast heart-beat, and had a

pericardial (heart lining) friction rub. On listening to his heart, he had two definite metallic sounds clicking with each heart beat. He was stable for the first two days. After that, he became septicaemic (infected). At this stage, I started getting anxious that this patient would die, and die on my hands. He was a patient with bullet wounds, and was in the ward for a long time. He was a very ill patient - the most critically ill patient in the ward - and the entire nursing staff knew about him. He had been admitted as a case of pericarditis (inflammation of the heart lining).

This patient needed to be seen by a thoracic (chest) surgeon. We do not have a thoracic surgeon at the hospital. There is only one thoracic surgeon for the whole of the Eastern Cape, and he is based at another hospital. He only comes to our hospital twice a week. The question was how to get him to come out and see this patient when it was not his day to come out.

Apart from chest problems, this patient had several other bullet wounds in his chest and around his hips. Later on, I discovered that he also had a bullet in his skull. We treated the patient for shock, for a small haemothorax (bleeding inside the chest cavity) with an intercostal (between the ribs) drain. We treated him for septicaemia with antibiotics, and he seemed to stabilise. But later on, he still complained of headache. I asked him whether he got hurt on the head. But he was not aware of having got hit with a bullet in the head. When I examined his head, I felt a small depression in his occiput (back of his head) that could just take the tip of my finger. An X-ray and a cat-scan revealed thay he had a bullet just below the vertex.

This patient stabilised, and we were able to discharge him.

I saw another patient who was brought to the hospital by the police from Algoa Police Station. He was a young boy of about 13. He was walking abnormally. He was admitted for paraperesis (weakness). On the ward-round the next day, it became obvious that this boy had hys-

terical paraperesis. I was thinking of discharging him. He told me that he had been arrested for public violence. We had reports that this young boy, together with others, had been subjected to homosexual rape, sodomy, etc. in the cells.

I tried to arrange bail for him. This took some time. Two weeks went past before I got a reply from the attorney concerned. For this time, I had to keep this boy in the ward. After two or three weeks, I could discharge him and send him home, after I had heard that charges had been dropped.

People brought other patients to the hospital from the Aid Office. They were terrified and had to be assured that they would not be arrested. This involved getting

Waiting to see injured relatives at the Provincial Hospital

them through the Admissions Office undetected by the police. Casualty was surrounded by police waiting to arrest any patients with bullet injuries.

Most of those patients were treated as outpatients. But even so, this was quite difficult. It involved getting in touch with people from the Aid Office to arrange a time to meet. It also involved getting in touch with other medical practitioners, and keeping the patient concerned overnight in Casualty.

There were some people who came to the hospital three weeks after the massacre with gangrenous legs. This shows how scared they were to come to a hospital.

Shortly after the massacre on March 21, I went around the hospital and took down the names of the injured, and some brief notes on their injuries.

Here are a few examples:

- Moses. Age 14. Abdominal operation. Kidney removed. Colic artery tied off. Duodenum sutured.

- Simon. Age 44. Bowel resection. Laceration of stomach.

- Name unknown. Head injury. Bullet in skull. Fixed dilated pupils. Patient died after 24 hours.

- Sipho. Lacerated colon. Kidney damaged. Severe fracture of the skull. Patient paraplegic. Developed kidney failure and died.

- Name unknown. Removal of kidney. Colostomy. Three pellets and cartridge in abdomen.

- Nel. Gunshot in hip and lower back. Fracture of zygoma (facial bones). Bullet under base of skull. Spinal fluid leaking from right ear. Hearing impaired. Bullet under right shoulder blade.

- Young girl. Depressed fracture of skull. Right sided paralysis. Damaged left eye to be removed.

Death from teargas exposure

One of the patients in my care, a young woman aged 20, died of teargas exposure.

One Wednesday morning, on her way to school, she got exposed to teargas. She was not in a closed space at the time. Immediately after exposure, she became ill. She was taken to a day hospital in one of the black townships near Port Elizabeth where she was treated. But the vomiting and headache continued on Thursday and Friday. She was taken to hospital on Saturday. The main problems were acute respiratory distress and coma. She had been breathing rapidly for the past twelve hours. She showed no neck stiffness, and no response to painful stimuli. The pupils were equal in reacting. She had a pulse rate of 130 per minute, and a blood pressure of 120/80. The respiratory rate was 48 per minute. The patient had bilateral rhonchi (abnormal breath sounds). The chest X-ray was clear.

We admitted this patient to the Intensive Care Unit. We put a tube into her, and connected it to a ventilator, so she could breathe. We contacted the Poisons Centre in Cape Town to find out the contents of teargas. We did get some information on the clinical features. Among other things, we were told that some cyanide was used in the teargas.

The patient had become pyrexial for the next 14 to 20 hours. She died early the next morning.

Police presence in the hospital

The hospital was taken over by the police. There was a prominent police booth outside Casualty. At the time of the crisis, it was like a military camp. Police trucks were moving into the hospital compound as frequently as ambulances.

Most of the policemen were walking around the hospital in military gear, with guns and rifles. This created a feeling of tension and fear. The policemen were walking in and out of the wards and Intensive Care Units without as much as asking permission from the sisters and doctors. Policemen were at the bedside of patients. They were smoking freely in the wards, which are "no smoking" zones. They were also playing cards in the wards.

The superintendent of the hospital received complaints about the behaviour of the policemen. He said that the police were not supposed to shackle the patients, that they were not supposed to be in the wards, but only at the entrance of the wards. The superintendent phoned the police chief. But this did not do much to change the behaviour of the police.

The situation in the hospital was still the same, except that the number of policemen in the hospital went down.

This matter was raised at the meetings of the heads of departments. But there was not much discussion on the issue. That makes me question whether the medical profession is at all concerned about guarding doctors' and patients' rights.

What can be done?

People working in the community need to liaise with members of hospital staff. Civic associations should be geared to handle such a situation; people should know where to go to and to whom to go.

Also, doctors and health workers need to be mobilised to give sympathetic and appropriate treatment to victims of unrest.

Thirdly, a venue needs to be organised where the injured can be seen and treated by medical practitioners.

THE ROLE OF DOCTORS IN THE UITENHAGE UNREST

THE LEGAL PERSPECTIVE

Doctors treating unrest victims have been criticised for neglecting to protect the rights of their patients in the face of police control. In the following article, Advocate Gilbert Marcus from the Centre for Applied Legal Studies at the University of the Witwatersrand spells out the rights of the police and the responsibility of doctors vis-a-vis the patients.

The Uitenhage shootings

The recent shootings at Uitenhage and the treatment of the victims of unrest have raised critical questions about the role of medical practitioners in such situations. It has been a shameful period for both the legal and medical profession. Medical and legal practitioners, with a few exceptions, have neglected their overriding responsibility to their clients. It has also been a period during which government officials have acted in apparent disregard for legality and basic human dignity.

The role of the doctors

Judging from statements of unrest victims in the Eastern Cape, it is especially doctors in the provincial hospitals who are alleged to have neglected their responsibilities towards their injured patients.

The police appear to assume that any person with bullet injuries has been involved in acts of public violence. Such an injury is usually an automatic passport to arrest and imprisonment.

Many people have alleged that doctors have actively co-operated with the police in pointing out patients

with bullet injuries, and these patients are then arrested and taken to the police cells. These reports raise issues that concern the medical profession from both a legal and an ethical point of view. There is a complex relationship between legal obligations of medical practitioners and their ethical obligations. It is a mistake to assume, however, that ethical and legal obligations always coincide. It is quite possible that the conduct of a medical practitioner may be legal and at the same time unethical. This may be applicable to the allgations against the doctors involved in treating the victims of unrest in the Eastern Cape.

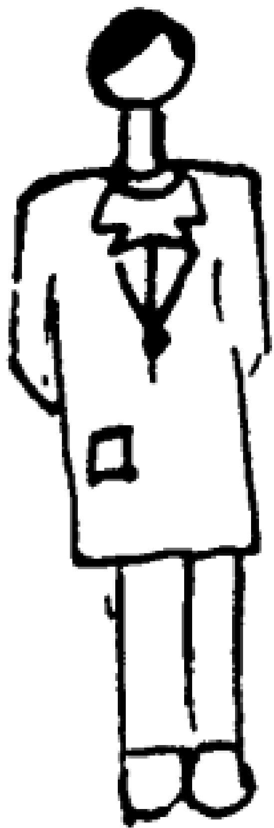
The rights of the police

The present discussion will be confined to the rights of the police as set out in the Criminal Procedure Act 51 of 1977. The details of the Internal Security Act 74 of 1982, which provides for detention in solitary confinement for an indefinite period, will not be discussed here, as other, different laws deal with those detained under this Act.

The Criminal Procedure Act says that a police officer is entitled to arrest any person whom he suspects on reasonable grounds of having committed an offence. If the suspect is in hospital and receiving medical attention, a police officer still has the power to arrest him. So if there are reasonable grounds for suspecting that a patient has been involved in committing a criminal offence, a doctor who hinders a policeman in arresting that patient, could be prosecuted. But such an arrest is lawful only if there is reasonable suspicion that the person to be arrested has been involved in some criminal activity. Normally, the police officer concerned would have to have a warrant of arrest, but there are circumstances in which a warrant is not required. If the arrest and subsequent detention can be shown to be unlawful, the arrested person could sue for damages.

If the police in the Eastern Cape assume that a bullet wound means that the injured person has been involved in acts of public violence, then that does not comply

with the reasonable suspicion of the commission of an offence, as it is stipulated by the Criminal Procedure Act. An arrest on such grounds alone is, in my view, patently without adequate justification.



In addition to the general power of arrest, the police enjoy powers of entry, search and seizure. Such seizure would include the power, in appropriate circumstances, to seize hospital records. A claim of confidentiality as between doctor and patient would be of no avail in such circumstances. Given the fact that the police enjoy these powers, the question arises whether there exists in law an obligation upon medical practitioners to volunteer information concerning their patients. Apart from certain statutory exceptions, such as the duty to report 'notifiable diseases', there exists no general obligation whatsoever upon a medical practitioner to divulge information concerning the commission of an offence. Where there are no grounds for suspecting any patient or patients of having committed an offence, it seems to me that a medical practitioner is not under a general obligation to divulge information to a policeman who arrives at a hospital on a 'fishing expedition' in search of people wounded in the unrest. It may well be that to disclose such information is unethical.

The legal and ethical issues

While not dealing in any detail with medical ethics, some examination of this topic is unavoidable. It has been reported that patients wounded in the unrest have been removed from hospitals and taken to prison with the knowledge and active co-operation of doctors employed at provincial hospitals.

In general terms, a doctor's first duty is to render medical care and assistance to his or her patient. A question to consider is whether that duty ends just because the patient has been removed from the doctor's care and custody. In my opinion, it is not a sufficient answer for a doctor to disclaim responsibility for the treatment of a patient simply because that patient has been removed from the hospital by virtue of a warrant of arrest. At the very least, a doctor in such circumstances would be obliged to compile a medical history of the patient detailing the treatment that was administered, as well as recommendations for future treatment. This information should be made known to the

arresting officer, and more importantly, to the district surgeon for the area. This would at least ensure that the district surgeon, who would then assume responsibility for the treatment of the patient, was fully aware of the treatment received by the patient as well as indications for future treatment. This would then make the district surgeon responsible for ensuring that the patient continued to enjoy proper medical care.

There is a strong case for arguing that a doctor who fails to take these elementary precautions to ensure the continued treatment of a patient, would be guilty of improper or disgraceful conduct. One of the main complaints against the doctors responsible for the treatment of Steve Biko was the fact that they sanctioned his removal to the Pretoria Central Prison hospital, a journey of some 800 miles. The evidence disclosed that he was transported in the back of a landrover, naked, critically ill, and unaccompanied by any medical personnel. It was alleged against Dr Tucker that he showed a disregard for the gravity of the situation by sanctioning the journey in spite of the fact that the patient had shown clear indications of a brain lesion and that he had already collapsed and become semi-comatose. It was argued at the hearing of the application to compel the South African Medical and Dental Council to hear complaints against the doctors concerned, that it was highly improper not only to sanction the journey, but also to fail to provide an adequate medical report of the patient's condition.

The Medical, Dental and Supplementary Health Service Professions Act 56 of 1974 does not define what is meant by improper or disgraceful conduct. It is left to the Medical and Dental Council to decide such matters. In the recent decision concerning the conduct of the doctors responsible for the treatment of Steve Biko (Variawa v President, SA Medical and Dental Council, 1985 (2) SA 293 (T)), the court said the following:

> The Act entrusts the supervision of the conduct of registered medical practitioners to the council which is mainly comprised of members of the medical

> profession who know and appreciate the standards which medical opinion demands of their own profession...The council is thus truly a statutory custos morum of the medical profession, the guardian of the prestige, status and dignity of the profession and the public interest in so far as the members of the public are affected by the conduct of members of the profession to whom they have stood in a professional relationship.

It remains to be considered whether the medical profession can take any action against the doctors involved. The answer, it is suggested, has been supplied by the Supreme Court which heard the complaint against the South African Medical and Dental Council. The court stated:

> "Members of the medical profession have a real and direct interest in the prestige, status and dignity of their profession and have a right to expect of the council to exercise its powers under the Act to protect the prestige, status and dignity of their profession in the event of a complaint being lodged about conduct which is damaging to the profession and in respect of which the Act has given the council powers to deal with. Similarly a member of the public, to whom the practitioner had stood in a professional relationship and who is affected by such conduct in respect of which a complaint has been received by the council, has a right to expect the council to exercise its powers under ther Act. If such complaints of professional misconduct or improper or disgraceful conduct go unheeded, one of the main and important objects of the Act will be defeated and will be rendered nugatory and the medical profession and public interests in so far as members of the public are affected by such conduct will be unprotected."

If there has indeed been disgraceful conduct by the doctors conerned with the treatment of unrest victims, then the remedy lies with the medical profession itself.

The following document is a draft memorandum proposed by the Hillbrow branch of NAMDA. It is intended that hospital authorities be asked to endorse such a document. It is published here to generate discussion. Critical feedback should be sent to Critical Health, P.O. Box 16250, Doornfontein 2028.

MEMORANDUM

HEALTH PROFESSIONALS AND VICTIMS OF CIVIL UNREST -

NAMDA HILLBROW BRANCH

1 Patients' Rights

1.1 Gunshot wounds do not have to be reported to the SAP.
1.2 If a patient is under arrest in hospital, common law privileges apply unless the patient is held under laws which prohibit access. The family has the right to visit the patient.
1.3 The hospital should ensure that the family is informed of a victim's admission and condition. Enquiries should be competently handled. When a patient is removed into police custody, the family must be notified.

2 Health Professionals

2.1 Detailed records must be kept. Records must be safe-guarded against loss and should not be made available to army or police personnel without the appropriate authorisation.
2.2 A special disaster-plan to manage unrest victims may need to be drafted and all hospital staff may need to be trained in its application.
2.3 Special attention may need to be given to the training of personnel to manage the types of injuries occurring during civil unrest.

2.4 Staff should be given clear, unambiguous, and written instructions as to their relationship with the SAP.
2.5 All staff should be aware that divulging the particulars of the unrest victims to army or police personnel is a breach of patient confidentiality. This is unethical behaviour for which action can be taken by the relevant professional registering council.

3 Liaison with the SAP in Hospital

3.1 The patient's life and health needs are the primary concern of health professionals, regardless of race, colour, religion, or political conviction.
3.2 If a patient in hospital is under arrest, the SAP may not be allowed to interfere with his/her medical needs.
3.3 If the SAP wishes to remove a patient before s/he is fit to be discharged into SAP custody, a senior surgeon should be responsible for handing the patient over.
3.4 When removing a patient from the hospital against the advice of a senior surgeon, the SAP must sign a form specially drafted for this purpose. Provision should be made on this form for full particulars of the SAP member.
3.5 When a patient is removed by the SAP, a full report on the patient's condition addressed to the district surgeon must accompany the patient. A copy of the report should be sent under separate cover to the district surgeon. A further copy must be retained by the hospital.
3.6 The patient's family and legal representative must be informed immediately of the SAP's intentions and actions.

CRITICAL HEALTH is a publication dealing with health and politics in South Africa.

CRITICAL HEALTH aims to :

* present a critique of health in South Africa
* provide ideas for the roles that health workers can play in promoting a healthy society
* show that good health is a basic right
* provide a forum for the discussion of health-related issues
* provide insight into the political nature of health

MAKE SURE YOU GET CRITICAL HEALTH REGULARLY.
SUBSCRIBE NOW.

SUBSCRIPTION RATES FOR 1985.

Southern Africa :	students and workers	R2.40
	salaried individuals	R5.00
	organisations	R10.00

Donor subscriptions: R20.00 R30.00 R50.00

Overseas :	individuals	UK 8 pounds
		US 8 dollars
	organisations	UK 15 pounds
		US 15 dollars

CRITICAL HEALTH is printed by the Central Printing Unit of the University of the Witwatersrand, 1 Jan Smuts Avenue, Johannesburg. The views do not purport to be those of the Council or the SRC of the University of the Witwatersrand.