Abstract

Under apartheid, district surgeons, as state-employed doctors, have been particularly vilified, largely for their roles in treating detainees and political prisoners. This article presents interview-based research on district surgeons, focusing particularly on how they understood their work in situations of dual obligation. Three main themes emerged. First, dual obligation created structural constraints but also demanded ongoing negotiation and choice. Second, district surgeons operated as uncritical "cogs" in the apartheid machine, failing to engage with in the broader sociopolitical context in which they worked. Third, surgeons' work was made more difficult because they were pressured to collude in a system that facilitated human rights abuse. The article concludes by suggesting that doctors who work in situations of dual obligation should have access to training and active institutional support.

Sous le régime de l'apartheid, les directeurs de la santé de district, en tant que médecins employés par l'État, ont été particulièrement vilipendés, en grande partie à cause de leurs rôles dans le traitement des détenus et des prisonniers politiques. Cet article présente une recherche, basée sur des entretiens avec des directeurs de la santé de district, qui porte en particulier sur la façon dont ils comprenaient leur travail dans des situations caractérisées par une double responsabilité. Trois thèmes principaux sont apparus: premièrement, cette double responsabilité a non seulement créé des contraintes structurelles, mais également la nécessité de faire des choix et de négocier continuellement; deuxièmement, les directeurs de la santé de district ont joué un rôle de «rouage» non critique dans la machine de l'apartheid, et ils n'ont pas participé au contexte socio-politique dans lequel ils travaillaient; troisièmement, le travail des médecins a été rendu plus difficile par le fait qu'ils étaient forcés de collaborer avec un système qui facilitait les abus des droits humains. L'article termine en suggérant que les médecins travaillant dans des situations caractérisées par une double responsabilité aient

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Bajo apartheid, los cirujanos de distrito, como médicos empleados por el estado, fueron especialmente vilipendiados, en gran medida debido a sus papeles al tratar a los detenidos y prisioneros políticos. Este artículo presenta una investigación basada en entrevistas con los cirujanos de distrito y se concentra sobre todo en la forma en que entendieron su trabajo en situaciones de doble obligación. Surgieron tres temas principales: en primer lugar, la doble obligación creó limitaciones estructurales, pero también exigió negociaciones y decisiones continuas. En segundo lugar, los cirujanos de distrito operaron como "piezas del mecanismo" no críticas en la máquina de apartheid, optando por no participar en el contexto socio político en el que trabajaban. En tercer lugar, el trabajo de los cirujanos se hizo más difícil puesto que se vieron obligados a confabularse con un sistema que propició el abuso de los derechos humanos. El artículo concluye sugiriendo que se debería dar capacitación y apoyo institucional activo a los médicos que trabajan en situaciones de doble obligación.

District Surgeons in Apartheid South Africa: A Case Study of Dual Obligations

Paul Gready and Jeanelle de Gruchy

I think that as a group [district surgeons] let detainees down badly.

—George Bizos

In the situation as a district surgeon, I very often felt, "I know what's best for the patient, I know what is best for me—will it be the best for the authorities?" And that worried me. . . . I thought I wasn't free. I was independent but I wasn't free. . . .

—anonymous district surgeon

Central to South Africa's democratic transformation have been attempts to understand how and why human rights abuses were committed under apartheid. The Truth and Reconciliation Commission (TRC) convened Health Sector Hearings in June 1997 to explore how decades of systematic "racial discrimination had shaped South Africa's health services and how the health sector contributed to widespread abuses of human rights under apartheid."[1] In its final report, the TRC found that the health sector's apathy, acceptance of the status quo, and acts of omission helped create an environment in which the health of millions of South Africans was neglected, if not actively compromised, and in which violations of moral and ethical codes of practice were frequent, facilitating violations of human rights.[2]

District surgeons were state-employed doctors, serving in a full- or part-time capacity, whose work combined

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medico-legal duties with seeing patients. Their responsibilities included health care and medico-legal responsibilities for detainees and prisoners. For at least some of the apartheid era, they also provided medical care for certain state employees (recruits to the public service, the police, the army, and the Department of Prisons). A certain stigma and low status were attached to the role of district surgeon, both within and outside of the medical profession. This was in part due to the perception that doctors who were "older," "worked out," "maybe had a problem," or those who "[couldn't] make a living outside" usually became full-time district surgeons.

District surgeons have also been vilified as willing agents of the apartheid system, chiefly for their role in the treatment of detainees and political prisoners, among them Steve Biko, whose detention and subsequent death provided a well-publicized case of professional misconduct.[3] These doctors were the visible tip of the iceberg and have been accused of both active and passive participation in human rights abuses because they carried out examinations in the presence of security police, violated patient confidentiality, conducted cursory examinations that failed to investigate or detect signs of abuse or illness, misdiagnosed conditions and illnesses, provided inadequate or inappropriate treatment, issued misleading and inadequate medical and post-mortem reports, gave false testimony in court hearings, failed to intervene and stop or even to report abuse, did not follow up on complaints or speak out against inhuman practices, and so on.[4] Despite the opportunity afforded by the TRC to deal publicly with this legacy, district surgeons and their testimonies were largely absent from the Health Sector Hearings. Their views about their own role during apartheid remained unknown.

This article presents research on the views and perspectives of district surgeons themselves. In particular, it focuses on how district surgeons understood their custodial work in situations of conflicting or dual obligations to their patients and to their employers—the apartheid state.[5] As discussed in the conclusion, such a study pertains to South Africa today and also has international implications and rel-

evance. We hope to contribute to a greater understanding of dual obligations and medical complicity in human rights abuse, as well as to discussions on the development of mechanisms to minimize and manage conflicts of interest for health professionals working in custodial situations and in other settings of dual loyalties so that human rights may be safeguarded. Among the important initiatives in this area are guidelines and strategies on how to resolve the problem of dual loyalty and human rights in health practice released in March 2003 by an international working group convened by Physicians for Human Rights and University of Cape Town, Health Sciences Faculty.[6]

Researching Dual Obligations

To gain insight into how district surgeons understood their work with detainees and prisoners during apartheid, in January 1999 a collaborative research team conducted in-depth, semi-structured interviews with district surgeons in Cape Town and Johannesburg, as well as in nearby semi-rural towns.[7] A total of 18 people were interviewed, of whom 15 were men and 3 women, 16 white and 2 black. These numbers are broadly demographically representative of the profile of district surgeons in apartheid South Africa. Pseudonyms, chosen to indicate the interviewee's background, were used to maintain anonymity. Five additional interviews were conducted with key informants. These informants' actual names have been used because they occupied official positions or had taken a public stand on the issues discussed here. They are identified by the word "interview."[8] The data were analyzed using qualitative methods, with an emphasis on distilling dominant themes and arguments.

A key issue raised by the research is that of dual obligations. Dual obligations can refer to particular work situations in which demands made on health professionals conflict with their medical loyalties. Although health professionals' first and foremost obligation is to their patients, there can be overriding imperatives and pressures to comply with other demands or agencies, notably an employer, which, in this case, was often the state. Practitioners' con-

duct is of particular concern in situations where serving the interests of the employer/state infringes on the human rights of patients. Although the focus here is on doctors, dual obligations affect a range of health practitioners.

Custodial contexts provide a stark case study of the dual obligations dilemma. In South Africa, district surgeons—medical professionals whose calling is to care and heal—worked within a legislative and institutional system controlled by state personnel who were primarily concerned with security and punishment. Torture was also widespread, and district surgeons, along with magistrates, were responsible for overseeing a complaints-and-safeguard system that purportedly protected detainees.[9] Detainees, however, received no legal protection and were therefore particularly vulnerable. The power dynamic central to dual obligations was here made visible in a particularly stark manner. Three main themes created by dual obligations emerged from this research:

- Dual obligations created structural constraints but also demanded ongoing negotiation and choice.
- District surgeons operated as uncritical "cogs" in the apartheid machine.
- District surgeons' work was made more difficult because they were pressured to collude in a system that facilitated human rights abuses.

Structural Constraints and Ongoing Negotiation and Choice

Dual obligations in the context of apartheid resulted from an allegiance to, and structural position within, the state. Links were forged through a shared world view, as well as through the employee-employer contract. But district surgeons also revealed that their position required ongoing negotiation and choices. It therefore involved, however unconsciously, a degree of individual agency. To complicate the situation further, a chosen identity and self-perception had to be set against the expectations of a range of others. In summary, being a district surgeon meant engaging with both constraints and choices, set within a particular

context of structures, attitudes, relationships, and agencies.

The concept of dual obligations was either poorly understood or unfamiliar, and therefore unacknowledged, by the majority of district surgeons interviewed for this study. Wendy Orr, a physician and one of the key informants, stated: "Many district surgeons, I'm sure, don't even see themselves as having dual obligations or, even if they are aware of conflicting loyalties, can't articulate that conflict clearly" (interview). In part this was because dual obligations in apartheid South Africa was more than simply an employment-based affiliation with the state; it was rooted in a broader, ideological world view:

> Apartheid and racism informed the way in which doctors practiced. Health care was a privilege, not a right. Black people were seen to be less deserving of this privilege. Many district surgeons had the attitude that prisoners and detainees were lucky to get any health care at all. *Interview with Wendy Orr*

For many district surgeons, detainees and prisoners were viewed through a prevailing apartheid mind-set dominated by racism and the concern for "security." Confusion about whether they answered to the Department of Health or the Department of Prisons (later the Department of Correctional Services) perpetuated this view, as did interactions with those working in custodial services. For the most part, district surgeons regarded detainees and prisoners as enemies of the state and a threat to "law and order" rather than individuals whose care and well-being should have been a doctor's primary concern. Interestingly, even Mafenya, a black district surgeon who had worked in a former homeland and was ideologically antiapartheid, described how his attitude was initially shaped by the culture of the prisons and society's dehumanization of common-law prisoners, rather than by professional ethics:[10]

> Empathy was needed, it was not just a job. But I had never been introduced to the victim's side. I initially adopted the same attitude as the prison warders and authorities *due to a lack of awareness* [emphasis added]. But through the experience of coming across people I knew socially, I opened my eyes to see them as human

> beings. Society's perception is that if anyone is in prison they are a criminal. When I thought of a criminal I thought of a murderer. By the time I saw politicals, I had the benefit of hindsight from my previous mistakes and attitudes. *Mafenya*

The challenges posed by dual obligations, here in the form of something as seemingly innocent as "a lack of awareness," become apparent. Without other influences, siding with the state, even for a black district surgeon, seemed not only the easiest but also the most obvious, natural thing to do. This seems to indicate that medical training did not emphasize clearly the importance of treating all patients with respect. Mafenya's comments do, however, demonstrate the importance of reflection in changing one's attitudes. Here medical training, societal attitudes, and institutional culture all contributed to a world view in which human rights played no part—a view that had to be refocused and fought against. Contradictions between world views and relationships ultimately led to different choices.

The prevailing influence of apartheid and public servants' status inevitably affected district surgeons' attitudes and behavior, as well as how others perceived them. Secondary literature on torture, autobiographical accounts, and interviews cited in this article reveal that district surgeons were seen as part of the state system and therefore distrusted, particularly by detainees and prisoners.[11,12] In short, they were regarded as part of the security apparatus, a work situation that was undoubtedly difficult. These doctors were well-treated by their employers and the security establishment but were treated with hostility by those they were supposedly trying to help (Orr interview). Although the majority of district surgeons interviewed described their relationships with detainees and prisoners favorably, some acknowledged patients' hostility toward them:

> Yes I think that we were [greeted with hostility by detainees] because . . . you know we were sort of classified as members of the police. *Louw*

> As I say, the main thing is that, those detainees, they didn't trust you, they still don't trust you, they still think you are part of the regime. *Claasen*

Several respondents spoke of encountering negative reactions but described them as something they attempted to, or that could be, overcome:

> If I [were in] their shoes . . . my perception would have been the same. . . . I would think, "He's a puppet of the government." So that didn't worry me much. And I thought that in my attitude towards the detainee, "I'm going to prove to him that I'm on his side as far as his medical condition is concerned." *Claasen*

> You could sometimes see from the way they looked at you, in the eyes, that detainees were suspicious. But you soon overcame that. *Pienaar*

Sometimes district surgeons openly supported their patients in more political terms. Two black district surgeons described their ideological alliances with the communities fighting apartheid:

> My response was not ambivalent. . . . I felt I had to do my best for them, had to be sympathetic, politically and emotionally on the side of the detainees. *Mafenya*

> We were always trying to show them [we] were "one of them" and not on the other side. . . . And this I think showed the community that they could trust us and that we were not part of the so-called system. *Jacobs*

Both doctors did, however, encounter difficulties in communities that were at once suspicious and demanding of them. Unlike white district surgeons, their black counterparts generally lived in these communities. They were caught between the state and the community in ways not experienced by white surgeons and felt they had to continually prove themselves and their political credentials:

> Once or twice when detainees . . . were released and they had been tortured, and then I'd go and visit them, the family was very upset . . . looking at me, you know, "What are you doing? Why couldn't you have stopped this?" . . . "What are you going to do about it?" This was always their last sentence. . . . I'd explain . . . we had limited channels. . . . And eventually they understood that at the end of the day our hands were also tied . . . but we

> were using whatever authority we had to the maximum . . . and I think that satisfied them. *Jacobs*

> Some were hostile because they saw me as a state doctor. . . . I expected this reaction. . . . Some refused to cooperate at all. . . . With the community I had to continually prove my credentials. When local people were detained, there was a general feeling [that] . . . I must have wielded more power than I did. Therefore, I was seen as not doing enough. It was frustrating. . . . The hostility never quite surfaced . . . [but I] sensed it, heard rumors. *Mafenya*

Here, then, is a sense that while district surgeons' powers and options were limited, the constraints imposed by a hostile reception from detainees and communities could at least be reduced by individual actions. The previously cited comments from Mafenya and Jacobs indicate that the nexus of attitudes, relationships, and agency for black district surgeons both overlapped with and diverged from that of their white counterparts. Dual obligations in the previous examples extended to include the state on the one hand and the patient and community on the other, with the district surgeon caught between competing external expectations.

District surgeons who were interviewed for the most part reported that they had good relations with the security police and with those in other branches of the state. "We got on pretty well, most of the time" (Goldstein) was a typical response. Most of the district surgeons appeared to feel that they had cooperative working relationships, that their wishes were respected, and that differences of opinion were resolved in a "gentlemanly manner" (Claasen). Only three interviewees spoke of conflict and hostility in their relationships with state officials; for others it was complex and layered:

> [Because of providing their medical care] . . . I'd built up a rapport with them . . . a friendly basis, even the security police. . . . So that [in] a doctor–patient [relationship] that worked well, but once you stepped outside . . . where there was violence, they would tell you, "Stand back, this is another scenario." *Jacobs*

Discussions with district surgeons about their col-

leagues' relationships with the police were especially revealing. Either as a true picture of reality or as a distancing device, discussing the relationships of others moved the focus away from their own actions and possible complicity in human rights abuses, which allowed them to speak more freely. The kind of relationship described below by Naude was probably fairly typical, particularly in rural areas and small towns.

> *Naude*: But I know of other district surgeons . . . here before me, they were very good pals with the police. Whatever the police wanted them to do they did. Whatever they wanted them to write they did. . . . He would turn a blind eye. He would understand the frustration of police when they catch someone who doesn't want to talk . . . and maybe they need a doctor to work with them . . .
>
> *Q*: What do you mean by working with them in that sort of context?
>
> *Naude*: . . . [If] they have to sort of use a bit of force . . . well quite a bit of force . . . the district surgeon would sort of overlook that . . . work along with it. . . . I don't agree with that, but it's neither here nor there if you don't work along with them. . . . He wasn't that bad. . . . Where do you draw the line?
>
> *Q*: So those sorts of situations . . . would you say that the doctor there had become complicit . . . [in] what was happening to prisoners?
>
> *Naude*: You can be an active accomplice or a passive one . . . maybe in a passive way, not active, you know, and I wouldn't judge them, you know, I wouldn't say that it's bad doing that. Who am I? I'm not the judge, you know.

These comments illustrate the importance of constraints and conditioning—of personal contacts (they were "very good pals with the police") and empathy (understanding police frustrations, working with them)—in shaping attitudes and conduct, and reveal how easily doctors came to operate in accordance with their perceptions of what the criminal justice system required of them rather than in accordance with their responsibilities as medical practition-

ers. They also indicate narrow parameters of concern ("it's neither here nor there if you don't work along with them") and the way in which a doctor can recognize bad practices but still be unwilling to judge, let alone speak out against or possibly take responsibility for, misconduct.

No matter which path they chose, district surgeons could find themselves in the invidious position of generating antagonisms. "The district surgeon is always in the middle of it" (Mafenya). In the only submission to the TRC by a district surgeon, R. Maller, the chief district surgeon of Durban, stated: "We were recognized as the 'soft belly' and were thus harassed from all angles: from Pretoria, from political lawyers, from other medical associations, from the police."[13]

These comments reveal the constraints district surgeons experienced from a range of sources, particularly, but not exclusively, from the apartheid state. At the same time, they may also have perceived constraints where none existed, or exaggerated their lack of options to absolve themselves of responsibility. Negotiating the situation of dual obligations clearly involved choices and individual agency that many district surgeons did not always acknowledge, let alone exploit. Given the range of potentially negative external influences, it seems evident that ethical medical practice and the protection of human rights cannot be left to individual agency alone.

Uncritical "Cogs" in the Apartheid Machine

District surgeons did not clearly or honestly reflect on their particular role within the apartheid security system. In our analysis, we were aware that there was an element of retrospective construction, involving a positioning of the self in relation to the past and present. District surgeons often failed to appreciate the broader context in which they worked or to relate concerns they may have had to the bigger political picture. Through political naiveté, depoliticization, and letting law determine practice, district surgeons distanced themselves from moral responsibility for the shortcomings of the system within which they worked; claimed to be clinically independent in the context of pro-

found injustice; and argued that problems could be overcome through individual action rather than perceiving them to be inherent flaws in a system within which individual action could only achieve so much. All these attitudes served to facilitate and rationalize participation in apartheid medicine.

Political Naiveté

The following extract provides insight into how one district surgeon defined his relations with the Department of Health and the government:

> We didn't regard the government [stammers] as my, our employer. We regarded the Health Department as our employer. They paid our salaries. . . . I know it's arguable, but as a government believe me I had no loyalty to them. If [stutter] I were able to get them out of power I would have done so. . . . The Health Department—that is a different matter. . . . Governments come and go, the Health Department . . . [is] there to look after the health of people and it doesn't matter what the governments are. So they've got to carry on the same way. My Department of Health . . . never prescribed how I should treat patients. . . . They did nothing wrong to me. . . . *Louw*

This distinction between the Department of Health and the government is described as extending into the implementation of policy:

> *Louw*: No, we implemented national policy on health, not the Party's policy. Look, the only thing that we had was a series of Ministers . . . but they didn't interfere with us. I never saw them or heard of them.
>
> *Q*: So you saw it as a Department of Health being kind of independent from the National Party government and making its own policy? . . .
>
> *Louw*: Well, the Minister said, "You must give so much money for welfare," and things like that. That's all. . . .
>
> *Q*: Okay, what about the . . . discriminatory provision and those sorts of things—surely that was the Department of Health implementing government policy?

Louw: Discrimination, how?

Q: Well in terms of financial resources. Much more was spent on white . . .

Louw: We didn't know that. . . . If a doctor was employed by the Health Department, he got the same pay as I did, a black doctor or a coloured doctor. There was no skimping on their salaries or what they could do.

This constructed distinction between the Department of Health and the state is perhaps best understood as retrospective self-positioning and justification vis-à-vis the apartheid state. Claiming ignorance about discriminatory health provision and asserting that doctors' incomes were the same regardless of race are displays of either disingenuousness or extraordinary lack of awareness. Evident through this exchange is the mental and political scaffolding that this district surgeon has erected to distance himself from the government and therefore from a sense of moral discomfort. In the process, he tried to persuade himself that he was only engaged in the neutral and even-handed task of health care provision and that it was possible to act independently within unjust structures and systems. In essence, the exchange provides insight into the self-deception that enabled this apparently reasonable man, who may not have supported the apartheid regime, to nevertheless spend a lifetime implementing its policies.

A second example of political naiveté provides a more overt illustration of the way in which district surgeons depoliticized their roles. Breytenbach served on the Joint Management Centre (JMC) in her area, an institution that, as part of the National Security Management System, was central to the apartheid government's "total strategy" doctrine of the 1980s. JMCs were the building blocks of a coordinated security and intelligence-gathering system. Her description of the JMC echoes ways in which it was presented by the government as a community-development initiative:

They had it on every level at that stage, where the various government departments interacted with each other . . . for community needs . . . deciding on strategies . . . in

> the community. But . . . I experienced it as a non-political thing. . . . We saw it as uplifting the community. . . . We got the community involved. They had to provide us with lists of what they needed. . . . *Breytenbach*

What is noteworthy here is that even the most politicized undertakings could be seen as a nonpolitical exercise and, in the case of the JMC, as community-oriented service delivery.[14]

These responses illustrate a general set of attitudes held by the majority of district surgeons interviewed: that they managed to combine doing a politically sensitive job with seeming to do it, or believing they were doing it, in a political vacuum. Interviewees showed no awareness that whatever they did in certain situations was political. They practiced medicine, or public health, as though it were an objective, technical science, removed from social and political context. These perceptions and practices, which were a large factor enabling district surgeons to maintain a sense of their own independence, had a significant impact on how they understood medical ethics and human rights:

> The health sector under apartheid constructed a situation where behaving "ethically" with one's patients was separated from the imperative to engage with human rights tenets. . . . The split effectively rationalized violations of human rights as "political," well outside the purview of health professional ethics.[15]

Similarly, repeatedly used assertions about the importance of impartiality and neutrality invariably seem to have been devices used by district surgeons to distance themselves from detainees and prisoners and from actively engaging in their circumstances. Such a stance within a markedly unequal power dynamic served to bolster the status quo in a way that was anything but apolitical. Clinical independence is crucial because it enables medical practitioners to advocate for their patients. Terms such as independence, impartiality, and neutrality must be clearly defined throughout a doctor's education and training. In the same way that a belief in scientific objectivity facilitated unethical behavior, so too did a narrow understanding of the law as justice.

Letting Law Determine Practice

The real question, however, begs to be asked: "How was it ever possible to act legally and ethically at the same time, given the realities of South Africa?"[16]

The laws and regulations governing health care for detainees and prisoners were not always compatible with the requirements of medical ethics. Many district surgeons apparently resolved the tension by adapting their ethical understanding to fit prevailing laws and regulations, thereby creating the illusion of acting legally and ethically. Interviews repeatedly and clearly illustrated that the dominant frame of reference for these practitioners was the law, which trumped any independent or potentially contradictory understanding of ethics and patients' rights.

A common reaction to the law-ethics nexus can be summed up succinctly:

> Certain things I didn't agree with, but it was part of my work. *Botha*

> I served the government of the day. That is how I was brought up. *Claasen*

In the following comment, Claasen states that he had standards that involved adherence to apartheid laws:

> I've got certain standards that I keep. If there's a law, I must abide [by it], whether I like it or not. . . . That's the sort of person I am. . . . It's not a question of whether I agreed with the law or not. . . .

These approaches to law are those of a civil servant—a state bureaucrat—rather than of an independent-minded medical practitioner. In essence, ethics were adapted to the law rather than having priority over it; the law, ultimately, is equated with justice. As a result, medical ethics and the law, both construed in narrow terms as objective and depoliticized, are separated from human rights and can serve, often in collaboration, to violate rights.

By distancing themselves from politics and the state, district surgeons failed, or refused, to see themselves as part of a wider system of oppression and chose instead to ration-

alize their roles. This enabled them to excuse themselves from moral responsibility for the shortcomings of the system within which they worked ("it was the law"), to claim to be clinically independent in the context of profound injustice, and to argue that problems could be overcome through individual action rather than perceiving them as inherent flaws in a system within which individual action could only achieve so much. As a result, district surgeons became "cogs" in a system of repression.

A System Designed for Collusion

In what can again be seen as a strong example of more general processes facilitating complicity, district surgeons operated the complaints and safeguard system for detainees that, far from being designed to safeguard their rights, was designed for collusion with the abuse of these rights. Again, district surgeons found ways of working within the system and justifying their role.

Along with providing health care for detainees and prisoners, specific legislation and regulations evolved ostensibly for these doctors to safeguard the well-being of detainees through a system of periodic visits as there was no independent access or monitoring of detention. This safeguard system had critical flaws that facilitated district surgeon collusion in the abuse of detainees' human rights, thereby rendering them ineffectual. One such flaw relates to dual obligations.

District surgeons had little control over the health care delivered to detainees—access to detainees was limited and they could ensure neither confidentiality nor adequate implementation of treatment plans. These circumstances had a critical impact on doctors' clinical independence. The following comments from a district surgeon are emblematic:

> He [a private patient] is my patient. I'm in control of him. But when he's in a cell he's not my patient.[17]

Although part of the state system, district surgeons were nevertheless subject to obstruction and interference from state authorities. They operated a safeguard system perceived to be necessary to legitimize state behavior, but

that also presented an inconvenience and irritant.

A number of the district surgeons interviewed made strong claims about independence:

> *Snyman*: Nobody ever interfered with me, or what I did, never ever, or prescribed to me, do this or do that. . . .
>
> *Q:* So there was no kind of interference or even pressure to do one thing rather than the other?
>
> *Snyman*: No, never ever. Actually I always felt independent from the whole system. I was just there to examine the person and that was it. I wasn't part of the police system.

Others provided interpretations of independence that were qualified and contradictory. One district surgeon, when asked whether he enjoyed clinical independence, answered: "No doubt whatever," and "completely, completely. There were never any times that they obstructed us, the police" (Louw). But he also talked of there being "no interference . . . by and large." In contrast, Van Zyl gave a categorically negative answer to the question of whether he enjoyed clinical independence: "not then, and not now" (interview). Mafenya was likewise unequivocal about the lack of clinical independence:

> I wouldn't say it was clinical independence. No, I always had to fight back the intervention of security officers . . . orders that went through to hospital and were not done. *Mafenya*

It was evident from the interviews that the district surgeons defined interference and the compromising of independence in very different ways. A sense of independence survived when interference usually took forms other than direct intervention (someone telling the doctor what to do) but failed to offer complete freedom of action. Claasen captures the resulting incoherence:

> In the situation as a district surgeon I very often felt, "I know what's best for the patient, I know what is best for me—will it be the best for the authorities?" And that worried me. That's the only thing that I thought I was-

> n't free. I was independent but I wasn't free. . . . You always have to take into consideration the circumstances in which you are working. . . . *Claasen*

Despite claims of independence, district surgeons detailed how their work with detainees lacked clinical independence.

Access Controlled by Gatekeepers

District surgeons had no absolute right of access to detainees. Although several claimed that they enjoyed freedom of access and even boasted of their power—"We had free entrance to these detainees, anytime. . . . I notify the commanding officer of the station [that] I want to see him and he can't refuse" (Claasen)—others were more circumspect. In the following response to a question about freedom of access, one interviewee moves from categorical certainty, to an admission of unknowing, and back to a measure of certainty within a handful of sentences:

> No doubt whatever, no doubt whatever. That is, yes, we didn't know if we were enjoying it. It appeared to us that we were enjoying freedom of access. I would say yes we were, we were given freedom. *Louw*

Without information from agents of the state, however, district surgeons had no knowledge of who was being held or where they were located. They operated through intermediaries or gatekeepers, on whose goodwill and honesty they depended, and therefore simply did not know if they were enjoying freedom of access. In prisons, the gatekeepers included nurses, medical orderlies, and warders (all prison employees), whereas the police themselves took on these roles for those in police custody—and these personnel, along with their superiors, were the people who controlled access, rather than the patient or the doctor. Orr stated that she had "no idea how many people were prevented from seeing" her (interview). Others confirmed her statement:

> They never stopped us from seeing them, but if in fact the detainee had complained and asked to see a doctor and they hadn't called us, then we didn't know. *Louw*

Restrictions on freedom of access were part of a process that affected detainees' ongoing medical treatment. The transfer of a patient by the police, thereby removing the patient from a doctor's care, for example, also affected access:

> In a hospital situation which you were trained for, you would find your patient there every day. . . . Here, you were looking at a patient and you might come the third day and find he's been removed to another area and this was the frustrating part . . . because you'd made contact with this person. This person might have confidence in you and then he'd been moved . . . to some other hospital and what then happened to him was not really your responsibility. But I think in a way we felt responsible. So this was the feeling which we didn't like. . . . We thought, "Fine if we are going to look after that person, let's look after him all the time. Don't take him out of our area." . . . *Jacobs*

Jacobs explained how a conscientious doctor had to tread a thin line between doing too little and doing too much for a detainee, with the result in the latter case that the detainee was seen as dangerous/valuable and transferred (even possibly precipitating ill-treatment). To cut out a conscientious district surgeon, the police only had to transfer a patient to another area to be seen by a different doctor:

> *Jacobs*: Knowing that if we put pressure on, we exerted too much pressure on the security police to see detainees in our area, they were moved out and then we heard nothing about them. . . . We discussed it, "Do not harass the security police too much." . . . We had to think like they thought. The minute they see you coming to visit a detainee every second day or every third day or phoning, they thought that maybe this person has something to say and he's not telling us, let's move him out to an area where we can probably force it out of him. . . .
>
> *Q*: So if you were too conscientious you felt that it would backfire.
>
> *Jacobs:* Correct, right.

Access to patients was mediated by a third party to the doctor-patient relationship and therefore susceptible to

agendas other than that of safeguarding the health and well-being of detainees.[18]

Confidentiality

Medical codes of ethics, such as the Hippocratic oath, the Declaration of Geneva, and the Oath of Athens, place confidentiality at the center of the doctor-patient relationship, whether or not that patient is in custody.[19] Nevertheless, regulations governing safeguard procedures during apartheid required that district surgeons submit evidence of abuse and complaints to the detaining authorities—the very people against whom the complaint was made. Arguably this was the only way to stop the abuse and ensure treatment, but it also constituted a breach of medical confidentiality and created the opportunity for unethical manipulation of medical information about illness and injury, rendered detainees vulnerable to reprisals, and, unsurprisingly, made them reluctant to confide information or register complaints. The detaining authorities were the source of the problem and invariably were not seen by the detainees as providing any solution. Some district surgeons indicated an appreciation of this dilemma:

> The prisoner may have been assaulted, and he's scared to tell you he's been assaulted because he's scared he'll be assaulted again. *Goldstein*

> He said he fell in the shower. . . . And I said to him, "Look, it's now your chance to tell me whether you were assaulted or not," and he said, "No, I fell," and it appeared later that he was assaulted. Now . . . that patient he thought, "Well, the doctor was sent here to find out whether I am going to talk about the assault." So I quite agree that they were scared, they were terrified in some cases that if they do say that they've been assaulted or tortured it would come down on them once more. *Claasen*[20]

Detainee files, located at the police stations and prisons, contained copies of medical reports. District surgeons had no knowledge or control over who had access to medical notes. Claasen commented on this situation: "I can't

say whether that was available to other eyes and to those who needed to know what was in the file," and "Some information, especially the treatment, was kept at the place of detention, whether that be a police cell or a prison." The distinction between treatment-related information, to which the custodial authorities needed access, and other data, such as recent/past whereabouts or medical history, which might well have jeopardized the safety of the detainee, was crucial.

In instances with potential implications for subsequent court cases where a district surgeon might be called to testify, some district surgeons apparently did not even keep a copy of their own medical reports, which in court would serve to corroborate their testimony: "I kept no notes for myself. You know, the prisoner has a folder [file]. . . . I'd write it down, diagnosis . . . [then] I'd give it back to the orderly" (Eckstein).

Beyond concerns such as uncontrolled access to medical information and whether they themselves kept a copy of the relevant documentation, district surgeons also described the elaborate reporting procedures in relation to detainees that involved copying medical information to a range of individuals within the state and security apparatus:

> I think one went to the Commissioner of Prisoners, one went to the Inspector of Detainees who I think was a magistrate or a judge, one went to the Regional Director of Health, one went to the Station Commander of the particular place, four or five different places. Of course we kept the original. *Goldstein*[21]

Orr described such reporting procedures as "farcical," stating, "How any district surgeon could convince him/herself that this was in the patient's best interest, I don't know" (interview). Apart from violating doctor-patient confidentiality, the elaborate circulation of information frequently seemed to lead to no action or to have been adhered to in theory only. Orr stated that the reporting procedures for Section 29 detainees—held under the Internal Security Act (1982), which allowed for indefinite detention for the purpose of interrogation—"existed, but made no difference," while those for State of Emergency detainees "barely exist-

ed." Jacobs experience with reporting torture to the Department of Health was such that he claimed to have boycotted the system:

> We found it got nowhere. . . . it just got lost in the mass of paper work. . . . It was extremely frustrating. . . . We knew nothing was going to happen to it, so we sat on it. *Jacobs*

A further factor that influenced the positioning of the district surgeon was that the opening up of the doctor-patient relationship within detention and the safeguard system was accompanied by the closing off of that system from the outside world. Information given by a detainee to a district surgeon was inaccessible to family members and others outside the state apparatus. District surgeons were subject to security clearance and "sworn to silence" in a deliberate attempt to restrict the dangers of adverse publicity—and in a way that bound them even closer professionally, politically, and in societal perceptions to the interests of the state.[22] Morally troubled medical practitioners were therefore confronted with the stark fact that actions that stood any chance of safeguarding detainees—approaching lawyers, the courts, the press—endangered their jobs. Only one district surgeon, Orr, chose to take such action, and she paid a high price, at least in the short term, for her stand.[23]

Perhaps unsurprisingly in this context, doctors did not proactively disclose information in the one circumstance in which they should have: to prevent harm to their detainee-patients.[24] Whistle-blowing was also unheard of:

> The minute you spoke out against the state . . . you were actually biting the hand that was feeding you. This was your pay-master. . . . This is the impression you got, "Tow the line, if you see anything untoward, look the other way." *Jacobs*

A closed system, the exchange of information that blurred distinctions between protectors and perpetrators, the absence of detainee trust in the system and its operators, and the lack of positive action (all related to dual obliga-

tions) meant that reporting procedures—crucial for a safeguard system to succeed—were designed for collusion.

Lack of Control of Implementation of Treatment

The problem in relation to treatment was that district surgeons had no control over the context of their patient's treatment and over conditions of detention and release. With reference to treatment, again claims to independence and authority were carefully framed or qualified: "I had no cause to think treatment was not carried out" (Pienaar). "Yes, to our knowledge [treatment orders were carried out]. I don't know what happened behind our backs but, to our knowledge, yes" (Louw). And "whether the orders were followed or not you don't know. . . . I think a lot of doctors' orders weren't followed" (Breytenbach).

District surgeons were known to have been misinformed about the medical condition of detainee-patients and their instructions for treatment were overruled, ignored, delayed, or selectively implemented. The dilemma of lacking control, operating through intermediaries and within a context of not knowing therefore also applied to the implementation of treatment, as did concerns about access and confidentiality. Indeed, according to Mafenya: "Ninety percent of instructions were not implemented." Despite such shortcomings, district surgeons continued to participate in the charade of appearing to provide care and safeguard against torture and ill-treatment. Several, in fact, claimed that the quality of medical care provided to those in custody had been good and even remarked that detainees/prisoners were "over-doctored" (Naude).

District surgeons detailed innumerable ways in which treatment, and therefore clinical independence, was interfered with. The comments below identify some of the specific forms of interference:

- Avenues of treatment, particularly outside referrals, were questioned, obstructed, and overruled: "not resistance . . . resentment, possibly . . . certainly passive hostility." *Louw*
- Certain referral hospitals were not used—"because there were too many sympathisers" there (Louw)—and

others preferred: "If you sent them to a public hospital . . . you'd get a lot of sympathetic doctors. . . . It was preferable in any case to refer to selected private specialists at private hospitals, who'd know exactly what to do . . . send them straight back." *Goldstein*

- The requirement of nonmedical sanction for medical decisions: "It's difficult for a doctor to go to ask somebody else, it's a nonmedical person, whether I want to send this person to this and this: When can I do it? How can I do it?" *Claasen*

Most district surgeons could identify flaws in the safeguard system without concluding that the system itself was fundamentally flawed. Similarly, admissions of interference, a lack of control, and powerlessness did not lead them to acknowledge that they were not independent or that individual action was not enough. Although interviewees did have insight into many of the problems they faced, they lost sight of the big picture—that they were working within a political regime that supported a system of detention and torture—and therefore of their complicity in and responsibility for human rights abuses. A lack of reflection and engagement again reduced district surgeons to merely "cogs" in a wider political and state machinery. Deeper acknowledgment, when it did occur, came only reluctantly and after persistent questioning:

> *Q*: Can I just come back to the issue of not knowing. Unless you took positive action, would you agree that in several key issues—access to detainees and treatment implementation—you were in a context of not knowing. You didn't actually know who was detained, where they were detained and all kinds of things. So you were dependent on the security police, their good will . . .
>
> *Louw:* Yes.
>
> *Q*: . . . So surely that must compromise clinical independence?
>
> *Louw*: If [pause] that is compromise, yes I suppose so. But there is no way in the world to undo that if you don't know about it?

The apartheid safeguard system for detainees is a useful study of dual obligations. District surgeons were placed in the invidious position of operating a safeguard system that was not intended to safeguard, yet they took on this compromised work and found ways of justifying their actions.

Conclusion

Dual obligations is a complex phenomenon that needs to be understood so that it can be effectively addressed. The research presented here on the experiences of district surgeons in South Africa highlights certain themes about dual obligations:

- It is a position that encompasses constraints and choices, with conduct influenced both by self-perceptions and the perceptions and/or expectations of others (the state, communities, etc.).
- It is a condition exacerbated by a lack of personal reflection, political naiveté, a bureaucratic mind-set where laws trump ethics, and a failure to engage with the social and political context of medicine.
- Work-related difficulties increase for doctors when they are deliberately placed within systems designed to facilitate collusion in human rights abuse. Medical supervision of the complaints and safeguard system for detainees was designed to legitimize the action of the state at minimum political cost. As a Turkish prison doctor once noted: "The state wants us to wash their hands."[25]

These issues are not unique to apartheid South Africa, though their particular manifestations are context specific. Further research into dual obligations might examine how these issues manifest themselves in other contexts and how medical practitioners function within similar situations and respond to the challenges they pose. In situations of dual obligations, doctors can prepare themselves and find support from a combination of educational measures and active institutional backing by, for example, medical associations, which could offer encouragement to doctors who challenge situations in which siding with the state or another third

party could be the easy, "natural" thing to do. District surgeons reported feeling that they were facing the problem of dual obligations alone. They felt isolated, that they lacked support, both professionally and institutionally, within the medical community:

> I can't say they [the medical profession, peers] supported us because who supports you? You're on your own. *Louw*

> We had no support . . . no support at all. . . . We were basically on our own. . . . There was no infrastructure to assist us. *Jacobs*

In such a context, compounded by a hostile custodial environment, it is not surprising that district surgeons looked to one another and to agents of the state, whose ethos and culture often became their own, to form personal, professional, and political bonds. The medical profession and its institutions in South Africa must therefore assume responsibility for the medical misconduct that occurred during apartheid. When Orr spoke out against abuse, she was not supported by professional medical organizations and institutions.[26] Not surprisingly, no other district surgeons followed her example. Clearly, institutions must be proactive in supporting whistle blowers, setting standards of good practice, and investigating and responding to allegations of misconduct and abuse.[27]

District surgeons' lack of understanding of dual obligations and of independence hampered their abilities to recognize that their working environment was problematic or to confront its tensions. As a result, they did not feel compromised by the system within which they operated, or they were able to rationalize away any difficulties. Education and training that focused on the responsibility of all doctors to preserve and protect patients' rights may have helped district surgeons to recognize situations of dual obligations and to devise strategies for dealing with the challenges they faced.

Medical education should challenge concepts of medicine as an objective and neutral science, and of law as justice—attitudes that enabled many doctors to practice medi-

cine as if it were divorced from social and political context. Under apartheid, the construct of medicine and the doctor as impartial and neutral often served to bolster the status quo, whereas allegiance to the patient would have challenged it. Interviews with district surgeons revealed their focus on tightly drawn moral and ethical concerns and responsibilities and on minimizing responsibility in order to minimize blame. Tensions within the doctor-patient relationship and between this relationship and public health considerations and sociopolitical causation and context need to be acknowledged and explored. How can this be done?

A narrow ethical approach at best addressed symptoms rather than causes and skirted the most fundamental health care challenges under apartheid. Ultimately the best treatment for most detention-related medical conditions was release; many health issues in apartheid South Africa could only be addressed by the removal of apartheid. Medical practitioners need to be able to see themselves as part of the bigger picture and underlying structures of power—to do this they need to expand their ethical horizons. Rubenstein has argued that there is a need for a new medical ethic that looks beyond the individual doctor-patient relationship and goes beyond the avoidance of participation in human rights abuses to the affirmative obligation to promote human rights.[28] The value of human rights within medical education is both that it protects the vulnerable individual and serves to expand the horizons of medical ethics, contextualizing medicine and ethics within a broader political framework and processes that challenge injustice.

Dual obligations is not a problem that can be eradicated. Baldwin-Ragaven et al. write:

> It is somewhat alarming to think that forces giving rise to dual loyalties persist, and may actually be increasing. Given the pressures on the country to achieve safety and security in the context of social transformation, it seems likely that health professionals will continue to be subject to contradictions that mitigate against ethical behaviour in relation to all patients in custody.[29]

State-employed doctors are a fact of life, and some of

their patients will be vulnerable and marginalized. In contemporary South Africa, dual obligations exist not only for state doctors facing such challenges as acute resource shortages, but also for health professionals working for diverse employers and in a range of situations, such as those who work for health insurance companies and private industry. Concerns span civil, political, economic, and social rights and present crucial challenges for a country dealing with dilemmas such as poverty and HIV/AIDS. Therefore, those who work amid dual obligations must have an understanding of their roles and responsibilities and the tools to devise strategies that enable them to attend to the best interests of their patients.

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1. J. de Gruchy, L. London, L. Baldwin-Ragaven, S. Lewin, and the Health and Human Rights Project (HHRP) Support Group, "The Difficult Road to Truth and Reconciliation: The Health Sector Takes its First Steps," *South African Medical Journal* 88/8(1998): 975–979.

2. TRC, *Truth and Reconciliation Commission of South Africa Report* (Cape Town: Juta Press, 1998), Vol. 5, p. 250. See also, L. Baldwin-Ragaven, J. de Gruchy and L. London (eds.), *An Ambulance of the Wrong Colour: Health Professionals, Human Rights and Ethics in South Africa* (Cape Town: University of Cape Town, 1999)—this book, a reworked version of the submission by HHRP, an NGO co-administered by the Trauma Center for Survivors of Violence and Torture and the Community Health Department at the University of Cape Town, to the TRC Health Sector Hearing, addresses two key imperatives for the agenda of transformation: to document and understand the history of abuse through a process of self-study, and to acquire the abilities necessary to recognize and act upon both traditional and "new" human rights dilemmas.

3. See note 2; L. Baldwin-Ragaven, L. London and J. de Gruchy, "Learning from Our Apartheid Past: Human Rights Challenges for Health Professionals in Contemporary South Africa," *Ethnicity and Health* 5/3-4 (2000): 227-241; and J. van Heerden, *Prison Health Care in South Africa:*

A Study of Prison Conditions, Health Care and Medical Accountability for the Care of Prisoners, dissertation for master of philosophy (Cape Town: University of Cape Town, 1996). On Biko, see L. Baxter, "Doctors on Trial: Steve Biko, Medical Ethics, and the Courts," *South African Journal on Human Rights* 1(1985): 137–151; N. B. Pityana, "Medical Ethics and South Africa's Security Laws: A Sequel to the Death of Steve Biko," In: N. B. Pityana, M. Ramphele, M. Mpumlwana, and L. Wilson (eds.), *Bounds of Possibility: The Legacy of Steve Biko and Black Consciousness* (Cape Town: David Philip, 1991), pp. 78–98; and D. Silove, "Doctors and the State: Lessons from the Biko Case," *Social Science & Medicine* 30/4 (1990): 417–429.

4. See, for example, note 2, Baldwin-Ragaven et al., pp. 91–112.

5. Custody in this context refers primarily to police stations and/or cells and prisons where detainees were held. Custodial medical care includes treatment of detainees who had been tortured as well as concerns such as diet, hygiene, exercise, and conventional illnesses.

6. See, the International Dual Loyalty Working Group, *Dual Loyalty and Human Rights in Health Professional Practice: Proposed Guidelines and Institutional Mechanisms* at www.phrusa.org/healthrights/dual_loyalty.html.

7. The article is a collaborative undertaking involving Paul Gready from the human rights program at the Institute of Commonwealth Studies, University of London, and a medical doctor, Jeanelle de Gruchy, while she was a research fellow of the HHRP. The project received ethics committee approval from the Faculty of Medicine at the University of Cape Town. It was partially funded by the Central Research Fund, University of London.

8. Key informants were selected and approached for their particular insights into the work of district surgeons. Only three are cited by name in this article: Wendy Orr (a former district surgeon and TRC commissioner), George Bizos (a human rights lawyer), and I. J. van Zyl (chair of the District Surgeons' and Contracted Medical Practitioners' Association).

9. See, for example, note 2, Baldwin-Ragaven et al.; S. Browde, "The Treatment of Detainees," *Proceedings of the 1987 NAMDA Conference: Towards a National Health Service* (Cape Town: National Medical and Dental Association [NAMDA], 1987); Detainees' Parents Support Committee, *Report on the Health Care of Detainees* (Johannesburg: Detainees' Parents Support Committee, 1982); M. Coleman (ed.), *A Crime Against Humanity: Analysing the Repression of the Apartheid State* (Johannesburg: Mayibuye Books and David Philip, 1998); and D. Foster with D. Davis and D. Sandler, *Detention and Torture in South Africa: Psychological, Legal and Historical Studies* (Cape Town: David Philip, 1987).

10. Ten ethnically based homelands, or Bantustans, formed the cornerstone of the apartheid policy of separate development. The aim was to deny black South Africans the rights of citizenship and residence in "white" South Africa while making them citizens of nominally self-governing or independent territories. Four homelands acquired "independence" (Transkei, Bophuthatswana, Venda, and Ciskei). Homelands were

generally characterized by impoverishment, corruption, and brutality; all were reincorporated into South Africa in 1994.

11. See, for example, note 9, D. Foster et al.

12. See P. Gready, *Writing as Resistance: Life Stories of Imprisonment, Exile, and Homecoming from Apartheid South Africa* (Lanham, Maryland: Lexington Books, 2002), pp. 99–132.

13. R. Maller, Submission to the TRC, 12 May 1997 (countersigned by several other district surgeons).

14. District surgeons were subject to various processes of selection when it came to those charged with custodial responsibilities, particularly in relation to detainees. During the 1980s, the selection process became more rigorous and politicized. Claasen described security clearance as a bureaucratic and depoliticized process, presented as a mark of good character and not as a political process vetting doctors for political work. Clearance was clearly designed to protect the interests of the apartheid state and not those of custodial patients: "I'm a sort of person that I think sticks to rules and regulations and if I can't get clearance then there is something in my background, and I just think if a person's visiting my daughter . . . and he was just released from prison, I don't know how I would feel. . . . Look, to get a clearance . . . I think you must never have been sentenced . . . you must be of . . . what's the word? Impeccable."

15. See note 2, Baldwin-Ragaven et al., pp. 8–11.

16. HHRP, *Final Submission to the Truth and Reconciliation Commission* (1997), p. 160.

17. See note 2, Baldwin-Ragaven et al., p. 106. In W. Ebersohn, *Store up the Anger* (Harmondsworth, Middlesex: Penguin, 1984), the author captures the prevailing power dynamic. The doctor: "He was one small weak man who doubted his own authority among five strong ones who were sure of theirs" (p. 36). The interrogator: "Patient? He's not a patient. He's my prisoner, not your patient" (p. 105). The interaction between the two: "It sounds like you have already decided what my diagnosis is to be" (p. 101). And, finally, the detainee: "Their dealings were with each other. They had no dealings with him" (p. 102).

18. According to testimony of detainees, access to doctors was manipulated in a variety of ways. Forms of mediation, obstruction, and denial by state officials included access being integrated into the structure of interrogation (a visit by a district surgeon could be followed by intense interrogation, possibly including torture, and then a recovery period before the next visit) or used as a bargaining chip to cajole cooperation from an ill or injured detainee. A number of previous studies based on interviews with detainees have addressed the issue of access. In a sample of 176 detentions (mainly for the purpose of interrogation) between 1974 and 1984, Foster et al. found that contact with medical personnel, though far from universal, increased from 49% (1974–78) to 66% (1979–82) and finally to 82% (1983–84)—these figures, however, fail to indicate either the quality or the quantity of the contact (see note 9, D. Foster et al., pp. 101 and 202–203). The TRC report, even more critically, states the following: "From evidence presented to the Commission by detainees in the Orange Free State, it appears that district surgeons' fortnightly visits to detainees, provided for by the Internal Security Act of 1982, were neither regular nor

reliable. . . . Not one long-term detainee . . . referred to routine or regular visits by a district surgeon to the detention cells at police stations" (see note 2, TRC, vol. 3: p. 354). Several surveys examined medical care experienced by detainees held during South Africa's States of Emergencies (1985–90). A NAMDA study revealed that less than 50% of the interviewees received medical care in detention; 22% had not seen a district surgeon during their entire period of detention; and almost 66% of those who asked to see a district surgeon alleged that they their requests were rejected (see note 9, Browde, p. 6; also see note 3, van Heerden). The problems associated with access were therefore many and varied.

19. Amnesty International, *Ethical Codes and Declarations Relevant to the Health Professions: An Amnesty International Compilation of Selected Ethical Texts* 3d ed. (London: Amnesty International, 1994).

20. It is worth noting that Mafenya stated that if he found evidence of ill-treatment "copies were not circulated to the head of prison or police." Mafenya, recognizing that the reports could harm his patients, claimed that he evaded the very system that was meant to protect them.

21. The quote indicates that some district surgeons did keep copies of their reports.

22. See note 3, van Heerden, pp. 132, 145, 202, 206.

23. Wendy Orr was a district surgeon in Port Elizabeth during the 1985 State of Emergency. A significant number of the detainees she saw complained that they had been assaulted by the police, and most showed injuries consistent with their allegations. Internal avenues of redress proved fruitless. In the face of a blank wall of minimized responsibility and strategies of self-protection, Orr decided that it was necessary to pursue alternative remedies that were external to the security and state system. In the end, she took an urgent application to the Supreme Court to stop the police from ill-treating detainees in the Port Elizabeth Prisons (an unprecedented step for a district surgeon to take). The judge immediately granted the requested injunction, but only on an interim basis pending final determination of the matter at a future court hearing. When the State of Emergency was temporarily lifted in March 1986, all affected detainees were released, eliminating the immediate need for further legal action. The Minister of Law and Order paid the applicant's court costs but explicitly denied liability. Although Orr received support from some medical practitioners, alternative medical organizations, and the international medical community, the official response from South African professional medical organizations and institutions was equivocal. "My sense was that the medical profession as a whole really let me down. In particular, MASA [Medical Association of South Africa] and SAMDC [South African Medical and Dental Council] were conspicuously unsupportive and, in the case of the SAMDC, actively undermining," Orr said in an interview for this research. Further, some of her office colleagues ostracized her, her phone-calls were monitored, she was barred from seeing detainees/prisoners and performing police-related post-mortems, and her work was reduced to half-days. The system effectively cast her out. In the face of this and other harassment, her position became untenable, and she eventually took another job in Johannesburg. M. Rayner, *Turning a*

Blind Eye? Medical Accountability and the Prevention of Torture in South Africa (Washington: AAAS, 1987), pp. 67–79; see also, R. Abel, *Politics by Other Means: Law in the Struggle against Apartheid, 1980–1994* (New York: Routledge, 1995), pp. 211–258.

24. The limited range of circumstances in which a patient's confidence could legitimately be breached are detailed in D. McQuoid-Mason, "Detainees and the Duties of District Surgeons," *South African Journal on Human Rights* (1986): 56. On this and other aspects of the confidentiality dilemma, see note 2, Baldwin-Ragaven et al., pp. 89–91, 112, 115.

25. V. Iacopino et al., "Physician Complicity in Misrepresentation and Omission of Evidence of Torture in Post-Detention Medical Examinations in Turkey," *Journal of the American Medical Association* 276/5 (1996): 257.

26. See note 23.

27. On the role of health professional institutions, see note 2, Baldwin-Ragaren et al., pp.142–184.

28. L. Rubenstein, "A New Medical Ethic: Physicians and the Fight for Human Rights," *Harvard International Review* (1998): 541–57.

29. See note 2, Baldwin-Ragaven et al., pp. 116–117.